

DISCHARGE OF PATIENTS FROM HOSPITAL POLICY

This procedural document supersedes: PAT/PA 3 v.3 - Policy for the Discharge of Patients from Hospital

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DISCHARGE OF PATIENTS FROM HOSPITAL POLICY**Policy Amendment Form****To be completed when reviewing an existing policy**

Please record brief details of the changes made alongside the next version number.

If the procedural document has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author
Version 4	September 2011	<ul style="list-style-type: none"> ▪ DNACPR added to 1.3 Definitions ▪ Addition of section 3.12 to reflect patients who are discharged from the Trust with an active DNACPR order in place. ▪ The associated documents now listed under 'Associated Trust Procedural Documents' and PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) added to the list. 	Pat Johnson
Version 3	May 2010	<ul style="list-style-type: none"> ▪ Title change ▪ Several additions to Section 1.3 – Definitions ▪ Additions of new roles to section 1.5 – Roles & Responsibilities ▪ Changes to section 2.5 to reflect changes in documentation ▪ Changes to section 3 to reflect different processes across different sites. ▪ Addition to section 3 to include deprivation of Liberty ▪ Change to section 3.4 to reflect fast track process 	Pat Johnson/ Callum Nile
Version 2	September 2007	Significant changes throughout. The policy will need to be read in full	P Johnson L Jones

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DISCHARGE OF PATIENTS FROM HOSPITAL POLICY

1. KEY PRINCIPLES OF THE POLICY

1.1 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.

This policy is intended to assist all staff, working across all sites within the Trust, who are involved in the discharge process.

Although planned discharges are between 8am and 9pm, there are occasions when discharge will occur outside these times. This policy is to be followed out of the stated hours also.

During the development of this policy, Doncaster & Bassetlaw Hospitals NHS Foundation Trust has reviewed previous discharge policies and consulted with partner organisations in the Health and Social community.

Although applying equally to patients of either sex, for simplicity, throughout the policy, the patient will be referred to as male.

1.2 Policy Statement

Discharge planning is a process, not an isolated event, which will start at the point of admission for patients undergoing unplanned care, or before (for those undergoing elective care). It will be a systematic and integrated process resulting in a safe and timely discharge.

A plan will be developed and agreed with each patient and carer to ensure a smooth transition from hospital care to care in the community.

Continuity of Care will be maintained when a patient transfers from one care setting to another.

Professionals will work within the principles set out by the Single Assessment Process, contributing to the discharge planning process in an integrated and effective way.

1.3. Definitions

- **Clinical Nurse Specialist (CNS)** a senior nurse who specialises in a particular area of nursing, caring for patients suffering from specific illnesses. A CNS provides direct care, as well as providing support and education to the patient, and where appropriate, their family or carers,

around the management of their illness. A CSN will support the patient during admission and following discharge.

- **Clinical Site Manager** A team of senior Nurses managing the site over 24hr period offering clinical support to junior nursing and medical staff, ensuring the safety of patients, staff and the environment. Manages patient flow from the point of admission to the appropriate speciality An advocate for the senior manager out of hours.
- **Continuing Healthcare and NHS funded nursing care** – the term NHS continuing care means fully funded care for people who do not require care in an NHS acute hospital, but require a high degree of ongoing health care. Anybody can qualify for NHS continuing care funding if their needs satisfy eligibility criteria.

An individual who needs continuing care may require services from NHS bodies and/ or local authorities. If a person does not qualify for NHS continuing healthcare, the NHS may still have responsibility to contribute to that person's health needs. A joint package of continuing care may be required.

The Discharge Facilitator and Dynamic Case Facilitators can advise on issues relating to continuing care.

- **Community Matron** – a senior nurse who will take on a caseload of patients who have Long Term Conditions. The patient will be managed at home, or in a residential home. The Matron will support the patient and his family and co-ordinate his health and social care needs, thereby facilitating discharge or preventing admission or readmission. To meet the criteria for the Community Matron Service the patient must have:
 - Two or more long term conditions
 - Two or more unplanned hospital admissions within the last 12 months
 - Polypharmacy: i.e. six or more prescribed medications
 - A high volume of input by A & E, Out of Hours Service, Primary or Social Care Services
 - A prolonged stay in an acute hospital bed.

Any queries related to the service, or for patients who may benefit from the input of a Community Matron, but who do not fulfil all the above criteria, please contact any of the Community Matrons directly. An information leaflet and contact numbers can be found on the wards.

- **Delayed Discharge/Delayed Transfer of Care** – occurs when a patient is ready for discharge, or transfer to another service, but is still occupying a hospital bed. A patient becomes a delayed discharge/transfer when:
 - A clinical decision has been made that he is ready for discharge
 - A Multi Disciplinary decision has been made that he is ready for discharge
 - He is safe for discharge or transfer

The patient may be unable to be discharged because he is waiting for:

- assessment by any member of the MDT
 - a Community Care Package to commence
 - funding for placement into Residential/Nursing care
 - a vacancy in Residential/Nursing care.
- **Deprivation of Liberty Safeguards.** Provision, under the Mental Capacity Act 2005, to protect those individuals who, for their own safety, & their best interest, need to be accommodated to undergo treatment and/or care. This accommodation may have the effect of depriving them of their liberty, whilst they lack the capacity to consent.
 - **Discharge Facilitator** - Lead person for discharge planning and guidance within the Trust.
 - **Discharge Lounge** – is a specified area within the hospital to facilitate timely discharge from the wards. If a patient has been medically and clinically discharged, they will transfer to the discharge lounge whilst awaiting final arrangements to be made e.g. transport, or medications to take home. The facility will enable more timely admissions, as beds can be made available earlier. The discharge lounge is staffed by qualified nursing staff who can continue the care of the patient. For further guidance, please refer to the Trust’s Discharge Lounge Operational Policy.
 - **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)**
A clinical decision not to commence cardio pulmonary resuscitation to restart a patient’s heart, and breathing in the event of a cardiac or respiratory arrest. [Previously Do Not Attempt Resuscitation – (DNAR)]
 - **Dynamic Case facilitator** work with the MDT to co-ordinate discharge plans. Are allocated to specific wards.
 - **Fast Track Discharge** – for those patients having been assessed by their Consultant as having a rapidly deteriorating condition, which may be in a terminal phase and increasing level of dependency. These patients and their carers are given a choice as to where their care may take place; ie at home, or in a Care home.
 - Some patients may reach the stage of their illness where it is appropriate for the Integrated Pathway of Care for the dying to be used. These patients can remain in hospital for the appropriate care to be given.
 - For those patients being discharged home, or into a Care Home, the discharge will be treated as a priority. The discharge will be arranged in accordance with the Fast Track Flow Chart, using the Healthcare fast track tool. These can be found on the ward or by contacting the case facilitator.
 - **Intermediate Care (IC)** – a range of Intermediate care services that have been developed in order to promote active recovery and rehabilitation and to prevent unnecessary loss of independence for older people and other

care groups. Local service developments are mainly targeted at people who would otherwise face unnecessarily prolonged hospital stays, inappropriate admissions to acute in-patient care or long term residential care.

The eligibility criteria and referral procedures for these schemes are available from the discharge co-ordinators.

The discharge co-ordinators or the social work team can also advise on local interim care arrangements available for people who's acute treatment is completed but where, for various reasons, their discharge is delayed.

- **Mental Capacity** – the ability of a patient to make an informed decision based on the ability to receive, retain and understand information relevant to the decision being made. From April 2007, all adult patients should be assessed for Mental Capacity in accordance with the Mental Capacity Act 2005. (Please refer to the Trust Policy, *Mental Capacity Ref: PAT/PA 19*) **Individuals should be assessed *only* on their capacity to make the decision required.**
- **Multi Disciplinary Team (MDT)** – the team of staff involved in the care of the patient. It will include some, or all, of the following: Nursing Team, Medical Team, Physiotherapist, Occupational Therapist, Speech and Language Therapist, Social Worker and/or Assessment Officer, Community Nursing team, Specialist Nurse, and other Allied Health Professionals.
- **Predicted Date of Discharge (PDD)** (Also known as Estimated Date of Discharge, or Expected Date of Discharge) – an estimated date for the patient to be discharged is determined on admission, or before admission for those patients undergoing elective treatment. It is based on an anticipated Length of Stay in hospital needed to ensure that all diagnostic tests are completed and that the patient has responded to treatment and is clinically stable. The MDT must be confident that the patient's actual Length of Stay is determined by clinical need. It is important to note that this is an estimated date, and can/will be reviewed by MDT. It is a date that is shared with both patient and relatives to ensure seamless process. Sharing the Predicted Discharge Date with the patient, relatives and members of the MDT can facilitate and ensure seamless care and improve patient flow through the healthcare process.
- **Re-imburement** – a system introduced by the Department of Health in order to reduce the number of patients whose discharge is inappropriately delayed. The Trust has an arrangement to cross charge Social Services for any patient whose discharge is delayed as a result of their systems. (See Section 4.2 of this policy).
- **Self Discharge** – if a patient insists on being discharged before being assessed as fit for discharge, and against medical advice, he will be taking Self-discharge. The process for co-ordinating a self Discharge is described in section 3.4.

1.4 Aims of the Policy

- The discharge process will provide an optimal care experience for patients and families.
- The patient and, where appropriate, their relatives/carers will be fully involved at all stages of the discharge process.
- Patients and their carers will be provided with information on what to expect and what their own contribution to the process will be, with particular reference to the Predicted Date of Discharge (PDD). They will be updated in the event of any change to the plan.
- Patients will be provided with details of arrangements, including contact details and any relevant information regarding their continuing care or treatment.
- Professionals and Organisations will be aware of their responsibilities within the discharge planning process.
- Discharge planning will be clearly documented, using checklists and integral records.
- Risk assessment processes will be integral to assessment and care planning.
- Effective communication will take place between multi-disciplinary team members and community based staff.
- Discharges are planned to take place between the hours of 8am and 9pm. Out of hours discharge may occur and the same process is followed as during the day.

1.5 Roles and Responsibilities

- **Trust Board.** – the Director of Strategic and Service Development has overall responsibility for ensuring that effective systems are in place to support the safe, timely discharge of patients. The Director of Nursing Services is responsible for the Clinical Governance and professional nursing issues relating to the policy.
- **Medical Staff** – the decision that a patient is fit for discharge is made by the patient's Consultant, or someone to whom the Consultant has delegated responsibility or other doctor responsible for the care of the patient. Documentation of the decision must be clear, concise and accessible to all members of the MDT. Medical staff should consider proactive prescribing of Discharge Medications, for patients approaching their discharge date.

- **Matrons** – responsible for ensuring that the policy is implemented within their area of management. This will be determined by regular audit and the development of any resultant service improvement.
- **Ward Managers** – 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 predicted date of discharge.
- **Ward Nurses** – responsible for the commencement of early discharge planning, using the predicted date of discharge as guidance, on or before admission. They should use the systems and procedures in place to co-ordinate the process effectively, to enable the patient to leave hospital in a timely manner. In order to facilitate this process, the nurse should consider proactive prescribing of Discharge Medications, for patients approaching their discharge date. All discharges should, where possible, be planned to take place before 10am. This not only enables beds to be prepared for new patients in a timely way, thereby reducing delays within the admission process, but leaves patients sufficient time within the working day to contact the ward or appropriate professional (SN, Community Matron) to discuss any remaining concerns he may have. These concerns, if left unanswered, may result in a further unnecessary admission. Appropriate patients meeting the criteria should be transferred to the discharge lounge on the morning of discharge.
- **MDT** – all members of the MDT should be aware of the PDD and have the responsibility to ensure that they contribute effectively to the planning process. They will contribute to the decision to discharge and identify and implement any arrangements required to facilitate that discharge. Communication with patients and relatives/carers must be consistent.
- **Discharge Facilitator** – To provide an expert clinical leadership role in relation to Adult Complex and Delayed Discharges, Continuing Care and the Reimbursement process.

To work at a strategic level across the health and social care community, fostering and facilitating multi-professional interagency working and training in respect of adult complex and delayed discharge management, the continuing care process and in line with the Reimbursement service level agreement (SLA 2006).

To act as an expert resource on Adult Complex and Delayed Discharges, Continuing Care and the Partnership Reimbursement protocol, providing accessible, accurate and relevant information to managerial, medical and nursing staff within the Trust.

- **Dynamic Case Facilitator (DCFs)** – DCFs work within specific Divisional teams and manage the discharge process of an identified caseload of patients. They ensure that the discharge plan is set up and managed in a timely way in order to reduce delays in discharge and to ensure that safe and effective discharges take place. DCFs link with the ward staff and the multi disciplinary team, supporting them in complex discharge planning and setting up case conferences for patients who require a complex discharge plan.
- **Clinical Site Managers (CSM)** – CSM on duty will have information regarding the booked discharges throughout the next 24-48 hrs. The CSM may become involved in facilitating timely discharge, by encouraging transfers to the discharge lounge of any patients meeting the criteria. It may be necessary for the CSM to be involved in writing Discharge Medications for those patients who have a well documented discharge plan, in accordance with the CSM non medical prescribing policy. Out of hours the CSM may be involved in the planning of transport in order to facilitate discharge from hospital.
- **Social Care Co-ordinator / Integrated Discharge Team** – actively seeks solutions to delays in discharge and pursues all options for effective discharge in order to expedite a safe, smooth and seamless transfer of care.
- **Social Worker/Assessment Officers** – work within the wider multi-disciplinary team to achieve effective safe and timely discharge from hospital. They undertake Community Care Assessments in accordance with Fair Access to Care legislation, the NSF for Older People, other appropriate legislation and develop and implement individual care plans with an emphasis on independent living.

2. OPERATIONAL PROCEDURES

2.1 Starting the Discharge Planning

The discharge planning process should begin at the point of admission or before, for planned episodes of care.

When starting to plan for a patient's discharge, the following factors must be considered.

- Complexity, stability and predictability of the patient's physical and mental condition.
- Environmental considerations – will the patient be able to return to his home, taking into consideration any changes in ability or dependency he may have undergone
- Level of support required. – Has the patients care needs changed; if so are carers/relatives still able to give appropriate amount of support.
- Ward staff should identify if NOMAD system will be required on discharge.

Home Assessment – Changes in one or more of the above may indicate the need for a home assessment.

- Referral should be made to the Occupational Therapist as soon as clinically appropriate.
- If decided necessary by the multi-disciplinary team, the Occupational Therapist will carry out a Home Assessment, with or without the patient as appropriate.
- If the patient has complex nursing or social care needs, other professionals will need to be involved (e.g. Community Nurse Liaison, Social Worker, Care Manager) and may need to be present at the Home Assessment
- The patient will be given the leaflet “Home visit information for patients and relatives”
- The patient's relatives will need to be kept informed of any arrangements made and should be present at the assessment if appropriate.

Social Care Assessment. – Not everyone who is admitted to hospital will need Community Care Services after discharge. However, when it becomes apparent that social care intervention may be required:

- A referral should be made to the Hospital Social Care Team. (In Doncaster this will be via the Hospital Discharge Facilitator) as soon as is deemed appropriate following admission, by completing Section 2 notification form indicating needs and a proposed discharge date. The formal assessment notification (Section 2 notice) should be given when professionals judge that an accurate assessment can be made of the care the patient will need when they leave hospital. Contact should be made by the Social Worker within 72 hrs of receipt of section 2.

- If a patient has an existing community social worker, that worker will be responsible for the patient's care needs unless a transfer to a hospital worker is negotiated and authorised by Managers.
- Patient and carer should be made aware of the name of the worker involved with their assessment and given a contact number for that worker.
- **Transport**
 - When starting the discharge planning process, consider the transport arrangements. (*Refer to Non Urgent Patient Transport Policy and Procedure CORP FAC 2*)
 - **Please note: The Trust will only provide transport if there is a clinical need to do so.**
 - The patient should be asked to make his own arrangements wherever possible. This should be determined when discharge plans are first discussed with the patient.

2.2 Communication

- It is the responsibility of all individuals involved in the patients care to maintain effective and consistent communication channels with
 - the patient and carer
 - relevant members of the Multi Disciplinary Team involved in the patients care
 - other relevant departments within the Trust
 - other agencies and organisations.

Communication should be documented in patients care record.

- The person assessing the patient on admission will assume responsibility for ensuring that all relevant information is given to him or, where appropriate, his carer, in a timely manner:
 - Proposed length of stay, and Predicted Date of Discharge should be discussed with patient and carer
 - All patients should be given a copy of the information booklet – “Leaving Hospital – Information to help you prepare for your discharge”
 - If a patient has complex requirements, discuss the need for a case conference. The patient and carer should be present wherever possible.
 - If arranging a case conference, all professionals involved in the patient's care should be invited, including Home Care Manager, and Community Liaison Nurse
 - The patient is to be kept informed at all stages of care planning, e.g if referrals made to other disciplines.
 - Discuss the method of transport for discharge as in section 2.1. Ask if patient or carer will be able to arrange transport.

- For those patients who are unable to communicate in English, translators are available and can be booked Doncaster Interpretation and Translation Unit. Information is available on all wards.
- For those patients who use British Sign Language and don't have their own communicator present, ward staff can arrange for a 'signer' through the RNID.

2.3 Preparing for discharge

When the date of discharge has been confirmed, the nurse caring for the patient has responsibility for informing all professionals involved and co-ordinating the appropriate services and documentation.

- **Social Care Team** – if involved should already be aware of the predicted or proposed discharge date (as indicated on Section 2).
- Once MDT assessment has been completed and agreed discharge date determined, a Discharge Notification (Section 5) should be completed and sent to the Social Care Team, (In Doncaster this will be via the Hospital Discharge Facilitator).
- **Withdrawing Notifications** – there may be occasions when the assessment or discharge notifications should be withdrawn or cease to have effect, because of a change in the patient's needs or condition. A Withdrawal Notification (Section 3) will be completed. This is to ensure that no one continues unnecessarily to arrange a care package which is no longer needed or to work to dates which have changed.

PATIENT AND CARER INVOLVEMENT – the patient and carer should be consulted at each stage in the discharge process. Full involvement of patients and their carers, in both assessment and care planning, needs to be recognised as good practice. Patients should be informed and consulted about future care arrangements and all reasonable efforts made to take their wishes and concerns into account. If they are unhappy with the outcome of their assessment or care plan, they should have access to the appropriate complaints procedures (depending on which services are causing concern). If a patient does not wish to be referred to the Social Care Team, and maintains that he can manage independently, hospital staff will need to consider whether this patient will be safe to discharge without social care support. The hospital staff should then establish that the patient's family or carer is genuinely able and willing to provide all the support required. If it is deemed that discharge will not be safe, they will need to explain further to the patient and family their concerns which must be documented. A referral could be made to the Social Care Team to discuss and determine options.

- **To Take Out Medication (Discharge Medications)**

- As soon as the decision to discharge is made, the discharge medications should be prescribed in accordance with the current Medicines policy; ***Policy for the safe and secure handling of Medicines. (PAT/MM 1 Section 4.10)***
- If the patient requires a NOMAD system on discharge, Pharmacy should be made aware at least 48 hrs prior to the discharge date in order for them to liaise with the identified chemist.
- Pharmacy has a current standard time of 3 hours from receipt of prescription to delivery of the medications to the ward. This should be taken into consideration when planning discharges
- Where possible the patient and his carer should be given an approximate time that the medications will be available

Community Liaison Teams – (Doncaster only) A team of nurses employed by Doncaster PCT who aim to ensure continuity of nursing care from hospital to home.

Criteria for referral to Community Liaison:

- Patients with complex needs who require multi-disciplinary team approach to discharge planning.
- All patients diagnosed with a palliative/terminal illness.
- All Fast Track discharges
- All patients needing assessment for specialist pressure relieving mattresses for discharge.
- All patients requiring District Nurse or Community Matron care in the community on discharge from hospital.

Liaison staff should be involved at an early stage of discharge planning and included in MDT meetings, Case Conferences and Best Interest meetings.

Up to date information provided for referral & contact procedures on each ward and dept

If the patient is able to visit his/her GP for the continuation of nursing needs, he/she should be asked to contact the practice nurse on discharge and make an appointment. A patient discharge/transfer summary should be completed for these patients with relevant information for the practice nurse. The patient should be given this summary to take to the appointment.

- **Community Matrons**

- Some patients may benefit from the input of a Community Matron after discharge from hospital and should be referred prior to discharge, using the Community Matron Referral form.
- If a patient may benefit from the input of a Community Matron, but does not currently meet all the referral criteria, the Matrons can be contacted directly. Contact numbers can be found on the Wards.

- For patients in Bassetlaw, contact is made via Single point of Access (SPA). For those patients without a Bassetlaw based GP, contact will be made directly via their GP.
 - If a patient is already known to a Community Matron that Matron should be kept informed of the patient's Predicted Date of Discharge and of his progress, as well as any changes to his treatment management plan.
- **Clinical nurse specialist (CNS)**
 - Where a Specialist Nurse has been involved with the patient during his admission, she should be made aware of the patient's date of discharge as soon as it is known
 - If a new referral is required for care after discharge, it should be made as soon as possible, to enable the Specialist Nurse to meet the patient before his discharge.
 - A list of Specialist Nurses and their contact details can be found on the wards, or via switchboard.

- **Equipment**

It may be necessary to arrange for equipment or minor adaptations to be provided prior to discharge, to ensure that patient can manage independently or can be cared for safely at home.

- The Occupational Therapist will determine what equipment/adaptations are required through assessment on the ward, or on a home assessment
- Equipment essential for discharge will be requisitioned by the Occupational Therapist from a comprehensive list and delivered by the Red Cross
- For equipment outside the prescribing rights of the Occupational Therapist, i.e. pressure mattresses, walking aids etc. the requisition will be completed by the appropriate staff e.g Community Nurse Liaison/Physiotherapy.
- When a commode only is required for discharge, referral can be made via the Community Nurse Liaison team without the need for an Occupational Therapy assessment.
- Accessing equipment for Out of Area patients requires referral into their local equipment provider system. There may some delays in provision because of this.

The OT/ Community Nurse Liaison should be informed of the discharge date as soon as it is known, to enable timely ordering of equipment.

- **Transport**

- If, after assessment of the patient's clinical needs, it is decided that he will need transport on discharge, follow the Trust Policy - ***Non-Emergency Patient Transport Policy & Procedure*** (CORP/FAC 2)
- Staff should be aware of the various transport options, and the booking process, as described in this Policy. Confirm the patient's

discharge address. Not all patients return to the same address they were admitted from.

- Consideration must be given to:
 - The complexity, stability and predictability of the patient's physical and mental condition.
 - The patient's level of mobility
- The discharge environment should be taken into consideration, particularly for those patients assessed as needing stretcher facilities
 - Are there steps or narrow corridors or hallways etc. A stretcher will not be appropriate for these patients, as they will have to be carried into the property.
 - Consider reassessment: If the patient is able to sit up, he will be able to utilise a two man crew who will then use a transfer chair to access the property.
- Ensure that the patient has his key or that there will be someone at the property to allow access.
- If a walking aid is to be taken with the patient on discharge, this information should be given when booking the transport.
- **Patient's property**
 - Where possible ask relatives or carers to take excess property home prior to discharge, especially if the patient will be using hospital transport. Patients are only able to take 1 bag with them on the transport, due to space constraints.
 - Ensure that any property handed in for safe keeping is returned to the patient in accordance with the ***Trust Policy for the Safe keeping of Patients' Monies And Valuables (PAT/PA 12)***
 - Ensure that walking aids/equipment are taken on discharge.
- **Communication.** It is the responsibility of the Nurse co-ordinating the discharge to maintain effective communication with the patient and his relatives/carers. He should ensure that:
 - The patient and his relatives/carers are kept informed of the discharge date and of any changes that occur.
 - The patient has a key or that someone will be at the property to ensure access. **The patient will be returned to the discharging ward, if access to property cannot be gained.**
 - The relatives/carer will check that the heating will be turned on if appropriate and that there are basic supplies available at the time of discharge, (bread, milk etc)

2.4 Completing the Discharge

On the day of discharge, it is the responsibility of the nurse caring for the patient to co-ordinate the discharge, thereby ensuring a smooth and seamless discharge and transfer of care where appropriate.

- **Discharge Medications**
 - The Discharge Medications should be available at the time of discharge from the ward or discharge lounge where appropriate
 - Discharge medication will be checked against the discharge prescription and inpatient medication record in accordance with Pat MM1 the Policy for the Safe and Secure Handling of Medicines
 - The nurse discharging the patient will ensure that he and/or his carer understands his medication regime, how and when to take his medications and any possible side effects, prior to handing them over.
 - The discharging nurse will ensure that the patient and his relatives know how to access further supplies of his medication as appropriate after his discharge.
- **Medical Certificates.**
 - A medical certificate may have been issued to the patient to cover the inpatient period; Med 10 – A yellow certificate. This can be issued by a Doctor or a Registered Nurse.
 - If a further certificate is required after discharge, **this can only be issued by a Doctor**, who will take into account the amount of time the patient should refrain from work; Med 3 – A white certificate
 - The certificate should be completed and available to the patient on discharge.
- **Out Patients appointment.**
 - If an outpatients appointment is required after discharge, the Nurse or Ward Clerk should contact the appointments Clerk for the appropriate speciality.
 - The following details will be required.
 - Name of Consultant
 - Number of weeks before appointment is required
 - Patient's name and hospital number
 - Ensure that the patient is aware of the date and time of the appointment and that he knows where the appointment will be held.
 - If the details of the appointment are not available at the time of discharge, they will be posted to the patient's discharge address
 - If an ambulance is required for the appointment, this should be booked in accordance with the Trust's **Non-Emergency Patient Transport Policy & Procedure** (CORP/FAC 2).

Please note: The Trust will only provide transport if there is a clinical need to do so.

- **Dressings / Contenance products**
 - Supplies of the above products should be given to the patient on discharge, if still required, as Community Nurses do not hold stocks of products.
 - Patients should be given 3 days supply of Wound Management products, and any other item available on prescription (such as catheters)
 - The Community Nurse Liaison team should be given details of any product being used, to enable further supplies to be prescribed
 - Patients should be given 7 days supply of items not available on prescription, e.g. pads, and pants, and details of products used should be given to the Community Nurse Liaison team on referral
 - All patients using wound care / continence products should be referred prior to discharge, for supply of a clinical waste bin, to ensure safe, hygienic disposal of used products. Contact details available in the Ward Resource Pack
 - Any queries with regard to the supply of these products should be referred to the Community Nurse Liaison Team or the Continence Advisory Service

2.5 Discharge Documentation

All discharge planning will be clearly documented in the clinical notes. Departments and CSUs have local procedures in place identifying the documentation used with regular review of this documentation to ensure it remains appropriate. A discharge letter, completed by the doctor, will be sent to the General Practitioner by the Ward Clerk within 3 working days of the discharge.

- **Out Patients Appointment.**
 - If an outpatients appointment has been arranged as above, the discharging nurse should ensure that details are given to the patient on discharge.
 - If the details of the appointment are not available at the time of discharge, they will be posted to the patient's discharge address
- **Patient Information Leaflets**
 - Patient information leaflets will be given to the patient as appropriate and will be specific to that individual patient
 - These may be information about his diagnosis or condition, eg leaflets about heart disease, diabetes etc
 - There may be instructions for continued management, eg physiotherapy exercises
 - If a patient is to undergo further investigations or tests, he may be given information to explain the procedure.

3. GUIDELINES FOR SPECIFIC DISCHARGES

Whilst the operational procedures apply to all discharges, in addition the guidance in this section will apply to specific discharges from, or to, various settings and for specific groups of patients. These guidelines also apply to those patients with Asylum Seekers status.

3.1 Transfers to other Hospitals/Trusts

As well as following the operational procedures in section 2, the Nurse co-ordinating the discharge has added responsibilities in respect of transfers to other Trusts, or other sites within this Trust. The nurse is responsible for ensuring a safe transfer, in accordance with the Trust policy – ***Policy for the transfer of patients and their records*** (PAT/PA 24).

3.2 Patients wishing to self-discharge

On occasion, and for a variety of reasons, a patient may wish be discharged against medical advice.

The patient should be assessed with regard to his Mental Capacity, as per the Trust policy ***Mental Capacity Act 2005 – Policy for Staff (PAT/PA 19)***

- If the patient is assessed as having capacity, he has the right to make what others may see as an unwise decision (as stated in principle 3 of the Act, section 4 of the policy)
- If the patient is assessed as lacking capacity to make a decision, he can be refused discharge if it can be demonstrated that staff are acting in his best interest (see section 9 of the policy)

If capacity has been determined, the nurse caring for the patient is responsible for ensuring that a safe discharge process is in place. She may wish to contact a Senior Nurse or Matron for advice and support.

- The Nurse should try to establish the patient's reason for wishing to self-discharge and address any issues that can be resolved at this point.
 - A member of the medical team should talk to the patient and explain the reasons for, and the benefits of, the patient remaining in hospital.
 - Give the patient all relevant and appropriate information, in order for him to make an informed decision.
 - If the patient still wishes to self-discharge, it may be appropriate to involve friends or family, who may help to dissuade the patient against this course of action. **This must only be done with consent of the patient**
- If the patient still insists on self discharge, the discharge process should then be followed, as for any other discharge
 - Discharge Medications should be prescribed and supplied

- Next of Kin or relatives should be informed, if the patient has given his consent.
- Transport should be arranged for the patient , as per the Trust's Transport policy
- The patient's GP should be informed by phone, as well as via the normal communication channels.
- The patient should be asked to complete form **WPR10390A - release from responsibility for discharge**, which will then be filed in the patient's health care records.
- All details of the incident should be documented in the patient's nursing notes.

Staff must ensure that they do not put themselves at risk from violence or aggression from a patient whilst managing this situation.

3.3 Discharge of Patients into the Prison Service

Patients admitted from the local prison service will have prison staff in attendance at all times, in accordance with the Trust policy ***Policy for the care of prisoners and patients from high secure hospitals*** PAT/PA 10. Prisoners will be discharged using the operational procedures within this policy, whilst taking into consideration the following:

- Communication about the patient should always be directed through the prison service staff. No information should be passed to friends or family. Any enquiries about the patient from an outside source should be directed to the escorting staff, as per the above policy.
- At the time of discharge, all items of property belonging to the patient, including any equipment or medications issued by the Trust, will be handed to the escorting staff and not the patient.

All the above guidance is in accordance with the above policy.

3.4 Discharge of Fast Track Patients

For those patients having been assessed by their Consultant as likely to have a rapidly deteriorating condition, which may be in a terminal phase and increasing level of dependency, the Fast Track discharge process will be initiated.

- Once the assessment decision has been made, the Consultant or Registrar in charge of the patient's care will complete a Fast Track Application form - Healthcare fast track tool
- If a Dynamic Case Facilitator is already involved, she should be made aware of the decision. If there has been no involvement to date, a referral should be made
- The patient and his relatives, where appropriate, will identify their preferred place of care – e.g. Home with an appropriate Care Package, or Residential/Nursing home placement.
- Depending on the patients medical condition it may be clinically appropriate for him to remain in hospital in order to be given the

appropriate care. In these instances the patient will be cared for using the Trust's Integrated Pathway of Care for the dying

- For those patients not remaining in hospital, a Case Conference will be arranged and the discharge planning process will then be initiated. The discharge will be treated as a priority, in accordance with the Fast Track Flow charts (area specific) which area available on all wards.
- All disciplines and agencies involved with the patient's transfer of care should be informed of the progress of the discharge planning.
- Ensure that the patient's GP is informed of the discharge and any subsequent arrangements made for the transfer of care
- It is important that all communication is accurate and timely, in order to facilitate a safe, speedy discharge and therefore a positive outcome for the patient and his family.

3.5 Discharge to Care Homes

- **First Time Placements**

Assessments should only be undertaken once the patient has realised his/her full potential for rehabilitation.

Most patients who transfer to a care home will have a full and comprehensive assessment completed prior to the transfer. This will include a financial assessment, which will be carried out by a member of the Financial Social Care staff and will involve the patient and relatives as appropriate. The outcome of assessment will establish the eligibility for Local Authority funding to facilitate the placement. Where a patient is self-funding, he may choose not to undergo assessment but it is in his best interests to consult with a member of the Social Care Team.

In addition, those patients for whom nursing input is indicated will need further assessment (Continuing care). This is a joint health and social care assessment which indicates the percentage of funding between PCT and Local authority. The Dynamic Case Facilitator, or appropriate nurse who has had training in undertaking such assessments, will carry out the assessment.

Where Local Authority funding is required, the patient should not be discharged until it has been confirmed in writing by the admissions panel that funding has been released.

Where Local Authority funding is not appropriate and the patient is self-funding, the MDT will continue to manage the discharge process so that transfer arrangements can be made in a timely manner. The patient may request a Local Authority voucher. This request will be authorised by the admissions panel after social and financial assessment.

Once placement has been confirmed, the discharge will be managed in accordance with section 2 of this policy.

The nurse co-ordinating the discharge will check if the patient will be transferring to the care of a different GP; if so, copies of all relevant documentation will be sent to the new GP as well as the existing GP.

Care should be taken to ensure that the correct discharge address is used in all communication.

- **Patients already in Residential Care**

For those patients admitted from a residential care home there may be issues around their return on discharge. If the patient's condition has not deteriorated, he will be able to return to the home without re-assessment, whilst for others re-assessment may be indicated. For those patients who will need reassessment the manager from the residential care home should be informed as soon as the discharge process is started and arrangements made for the reassessment to take place as soon as is practicable.

The patient and carers should be kept informed at all stages of the care planning process.

3.6 Discharge from Emergency Department, Unplanned Care & Clinical Decision Unit, MAU and Minor Injuries Unit

Patients attending these units must undergo an assessment of their social circumstances and the impact of their present condition on their ability to manage safely, when deciding to discharge back to the community.

- Referrals to community services should be made after consultation with the patient and his family where appropriate.
- Consideration should be given to delaying discharge until appropriate arrangements can be confirmed. Involvement of Community Intervention Team in Doncaster or the Rapid Response Team in Bassetlaw can be undertaken where appropriate.
- Consideration should be given when discharge is planned for late evening or during the night and in circumstances that might cause hardship to the patient. i.e. vulnerable people being discharged to an unheated property in the winter.
- Medication, equipment and dressings will be supplied as appropriate. The discharging nurse should ensure that the patient and/or relative understands instructions as to the use of supplies.
- If the patient is unable to work due to his condition, a member of the medical team should issue a medical certificate for the appropriate length of time.
- A letter will be sent to the GP, detailing the reason for attendance, the diagnosis and relevant treatment given.
- Details of any follow up arrangements should be given to the patient ensuring that he fully understands these.
- Transport should be arranged only if there is a clinical need, in accordance with the Trust transport policy and procedures.
- Ensure any property is returned to the patient prior to discharge.

3.7 Discharges from Maternity Services

Planning for transfer to community services starts in the antenatal period. Length of stay should be discussed with the woman by the community midwife. All discussions are to be documented.

The length of time the woman stays in hospital is not prescriptive but will depend on a number of factors –

- The type of birth
- Condition of the mother after the birth
- Condition of the baby after the birth
- Level of support available at home

If a woman feels well and there are no complications, she may go home from hospital as early as 2 hours after the birth. In this case, the woman can be transferred home from the Central delivery Suite/Labour Ward following the guidelines.

3.7.1 For those women who are admitted to the postnatal ward, planning for transfer to community maternity services should begin as soon as is reasonable after admission. The midwife should discuss with the woman and, if appropriate, her family when she intends going home and this, along with professional advice on length of stay should be recorded in the midwifery record. The midwife should enter the proposed date of transfer into the care plan.

3.7.2 All babies need to have the first examination of the newborn performed. Where possible, this will be performed on the ward by an appropriately qualified midwife (N 96) or a paediatrician. Where this is not possible, e.g. if the mother wishes to go home before this can be arranged, if the baby appears well, then this examination can be performed in the community by an appropriate midwife. Alternatively, an appointment can be made for this to take place on the maternity ward. Clear documentation must show this examination has not taken place and to advise the Community Midwife and the GP that the baby has not had the examination. The Discharge checklist should be utilised.

The ward midwife, as lead professional in the post natal period for women who have had an uneventful labour and a vaginal birth, will arrange transfer home. However, all women who have had a Caesarean Section or a third degree tear, must be seen by a doctor before transfer. The documentation of all postnatal care must be completed prior to leaving the ward and the discharge checklist utilised.

The ward midwife should ensure that the woman's correct address is recorded in the written and the computer record.

3.7.3 On the day of transfer, the woman's details should be rechecked, i.e. that she is still fit to go home and the accuracy of the address to which she is going. The Community midwife is informed via the discharge

book and receives a copy of the discharge letter. The GP is informed via a copy of the discharge letter, which at the BDGH site is faxed.

3.8 Discharging Children and Babies (Awaiting electronic references)

There are local procedures in place on the children's ward:-

- Children's ward discharge policy;
(Children's/Clinical Guidelines/Wards/no22.
- Neonatal Services discharge policy ;
Children's/C/NNN/Neonatal/gen/no3

3.9 Discharge of homeless patients

The law requires the Local Authority to provide housing only for some people who are homeless.

In order to qualify for housing, a person must fit all of the following criteria:

- they must be homeless
- they must be in priority need
- they must be unintentionally homeless
- they must have a local connection to the borough in which they are applying.

The only way to establish whether a person fits these criteria is for them to be assessed by a social worker.

It may help to have a letter from the hospital saying when and why they were admitted and if they have any continuing problems with their health.

If the Local Authority decides that the person is not eligible for housing, the dynamic case facilitator or a member of the nursing staff will contact open house and arrange for the patient to attend in person. They will then assess and signpost the person to an appropriate place for them to stay.

3.10 Discharge of patients with Safeguarding Adult Issues (formerly known as Adult Protection)

- If a patient is the subject of a safeguarding Adults investigation, or it is felt that discharging the patient may put him at risk, discharge should not be considered.
- If there is a Social Worker or Assessment Officer involved with the patient, he or she should be kept informed at each stage of the planning process.
- Where there has been no previous social work involvement, there should be discussions with the social care management team regarding who would be the most appropriate agency to investigate and decision make.
- It may not be appropriate for the patient to remain in an acute hospital setting; therefore a transfer to intermediate care, or a non-acute area, may be considered.
- Short term or temporary placement in a Care Home should be considered until the Safeguarding Adult procedures are resolved.

All actions in respect of Safeguarding Adults should be in accordance with the Documents;

South Yorkshire's Adult Protection Procedures

Safeguarding Adults - Practice Guidance for Doncaster - November 2007

Nottinghamshire Safeguarding Adults procedures.

3.11 Discharge of patients who are being deprived of their Liberty

- In accordance with the Deprivation of Liberty Code of Practice, it is possible for a patient to be discharged from hospital, even if he is being deprived of his liberty whilst he is in hospital. This is irrespective of whether discharge is to either to his home address, or another hospital or a care home,
- As soon as a discharge date is established, a form 19 (Request for review by Managing Authority) should be completed and sent to the Deprivation of Liberty Administration office, informing them of the intention to discharge. This can be done in liaison with the Trust's Lead for Safeguarding Adults

3.12 Discharge of patients with a DNACPR order in place

- The Trust in conjunction with the community, GP's and independent sector have rolled out an Strategic Health Authority wide single DNACPR form (to replace our current DNAR directive) for use across all agencies. This is a Yorkshire & Humber regional initiative, which has also been accepted by East Midlands Ambulance service.
- This means that if a patient has an active DNACPR order in place, the decision will still be applicable when the patient is transferred to another care setting, or discharged home unless it is revoked at time of discharge following an appropriate review. Please see – *PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy* for full policy information.
- It is important that on transfer/discharge, the decision is reviewed, and the DNACPR order updated, and clearly documented, in line with *PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy*.
- Whenever a patient is transferred between care settings, or discharged home, it is imperative that DNACPR decisions are communicated to the patients GP, and any other service involved in the patient's ongoing care, including the ambulance service and the receiving organisation/team. (See appendix 6 of the DNACPR Policy for the communication information form.)

4 DELAYED DISCHARGE

4.1 Guidance for patients refusing discharge

Occasionally situations occur where a patient refuses to be discharged or unreasonably prolongs the discharge planning process. If a patient is refusing to be discharged and is not eligible for review of their case under the continuing care criteria, consideration must be given to each individual case.

The Divisional Matron and the Discharge Facilitator must be consulted.

It is important that staff identify these cases as early as possible and that they are managed firmly but with a consistent and sensitive approach.

The outcome must be recorded in both the medical and nursing notes.

The discharge facilitator will work in collaboration with the social care department, and the consultant in charge of the patients care.

4.2 Reimbursement

The Community Care (Delayed Discharges etc) Act 2003 sets out:

- (a) a statutory duty on NHS bodies to notify Local Authority departments that a patient receiving acute hospital care is likely to need social care services on discharge (Section 2 notification) and to notify the Local Authority of the proposed date of discharge (Section 5 notification).
- (b) A requirement for the NHS body to identify the responsible Local Authority prior to notification.
- (c) A defined timescale for Local Authority to complete assessments and provide services (a minimum of 2 days from a section 2 notification and 1 day from a section 5 notification).
- (d) Requires Local Authorities to make a set payment (currently £100 per day to the Acute Trust for each day's delay, if the reason for any delays in arranging transfers of care is solely the responsibility of the Local Authority

The Department of Health also emphasises that reimbursement should not be approached as a stand alone policy, but should be addressed within the policy framework of the National Service Framework for Older People.

For further details of requirements, agreement and implementation, please refer to ***The Joint Protocol for Delayed Transfers of Care and Reimbursement*** as agreed by Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Doncaster Primary Care Trust and Doncaster Metropolitan Borough Council.

5 MONITORING OF THE POLICY

5.1 Monitoring delays

The number of patients delayed in hospital beds form part of the weekly SITREP submitted to the strategic health authority and the Doncaster health authority. The delays reported are a 'snap shot' of the number of patients whose discharge/transfer of care is delayed on Thursday of each week.

It is the responsibility of the ward sister to ensure that accurate information about any delays is collected using the Trust's discharge form and sent to the Trust discharge facilitator on a weekly basis. This will ensure that the Trusts return can be verified with social care and submitted to PCT by Monday afternoon

In January 2004 reimbursement systems around hospital discharges was introduced. It is essential that these arrangements be underpinned by effective discharge planning procedures and robust monitoring of any delays in the system.

A reason for each delay needs to be given. A patient should only be counted in one category, which should be the one most appropriately describing the reason why his discharge was delayed. If a patient is delayed for more than a week, the reason for his delay may change and this should be reflected in the monitoring information.

5.2 Monitoring Effectiveness of the Policy

The effectiveness of the policy will be monitored by:

- An annual audit of GP discharge letters
- Complaints analysis by Matrons
- Monitoring of adverse Incidents

Associated Trust Procedural Documents

- *Safe Keeping of Patients Property and Valuables (PAT/PA 12)*
- *Medicines Management Policy (PAT/MM 1)*
- *Policy for the Care of Prisoners and Patients from High Secure Hospitals (PAT/PA 10)*
- *Mental Capacity Act 2005 Policy and Guidance (PAT/PA 19)*
- *Non-Emergency Patient Transport Policy & Procedure (CORP/FAC 2)*
- *Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) (PAT/EC 2)*

REFERENCES

Department of health

Achieving timely simple discharge from hospital: A toolkit for the multi-disciplinary team 2004
www.dh.gov.uk

South Yorkshire's Adult Protection Procedures

Safeguarding Adults - Practice Guidance for Doncaster 2007

Deprivation of Liberty Code of Practice

Achieving Timely Simple Discharges from Hospital DOH 2004