University Hospitals of North Midlands NHS Trust

Policy No. (C05)
Trust Policy/Operational Guidelines for the Discharge of Adult Patients

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff involved in the discharge and transfer of patients**

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Statement on Trust Policies

Staff Side and Trade Unions
The University Hospital of North Staffordshire NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospital of North Staffordshire aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.'

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the "right and freedom" of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates, the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act
Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections

The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights

The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development

The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): *Our 2020 Vision: Our Sustainable Future* which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

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1. INTRODUCTION

This policy has been produced to provide clear and consistent information to all staff involved in the discharge of adult patients from University Hospital of North Staffordshire, and to reduce the risks associated with that discharge.

This policy does not relate to the transfer of patients between the Trust's wards and departments, which is dealt with in Trust Policy C24: *UHNS Policy for the Transfer of Patients between Wards and Departments.* Likewise, the transfer/discharge of children is dealt with in policy C21: *Transfer/Discharge of Children*. And the discharge and transfer of maternity patients is dealt with under the ASQUAM Guidelines (maternal, paediatric and neonatal transfers), which can be accessed via UHNS Intranet (Clinical Section – Clinical Guidelines – Obstetric Guidelines ASQUAM Second Edition 2008 – Postnatal Guidelines). This policy should also be considered alongside the Staffordshire Supporting Patient's Choices to Avoid Long Hospital Stays Operational Procedure.

Additional information relating to matters contained within this policy can be obtained from the following policies, accessible via the Trust Intranet (Trust Section - Policies and Procedures)

- *Trust Policy C21: Procedure for the Transfer/Discharge of Children*
- *Trust Policy C31: Inter-Hospital Transfers & Repatriations*
- *Trust Policy C36: Protection of Vulnerable Adults from Abuse*
- *Trust Policy C23: Managing the Risks Associated with Safeguarding Children*
- *Trust Policy C13: End of Life*
- *Trust Policy C43 Policy and Procedure for Obtaining Consent (Inc. the Application of the MCA 2005)*
- *Trust Policy F01 Policy for Standing Financial Instructions*
- *Trust Procedure FA06 Financial Procedures: Patients' Property – Valuables – Finance are currently working on a new policy to cover this*
- *Trust Policy G04: Trust Policy and Guidelines for the Production of Written Clinical Information for Patients & Carers*
- *Trust policy IG10: Data Protection Policy*
- *Trust Policy Ip01a: Trust Policy for Infection Prevention*
- *Trust Policy Ip01b: Infection Prevention Manual*
- *Trust Policy MM01: Trust Policy for Medicines Reconciliation*
- *Trust Policy MM03: Policy for the Storage, Prescription, Supply and Admin of Medicines (Inc. MM09)*
- *Trust Policy MM06: Policy for the Prescribing, Storage, Supply and Administration of Controlled Drugs*
- *Trust Policy Re01 Multidisciplinary Health Records*
- *Trust Policy RM01 Risk Management Policy and Strategy*
- *Trust Policy RM03: Trust Policy and Procedure for the Management of Missing, Absconding or Abducted Adult Patients*
- *Trust Policy RM07: Reporting and Management of Incidents including SIRI and STEIS Reportable Incidents*
- *Trust Policy Op14: Outlier Policy*
- *Operational Plan Opp09 Full Capacity Protocol*
- *Operational Plan Opp12 Patient Flow and Capacity Escalation Plan*

An "Equality Impact Assessment" has been undertaken and no actual or potential discriminatory impact has been identified relating to this document.

2. POLICY STATEMENT

This policy aims to inform all staff within UHNS of the principles underpinning good discharge planning, and to clarify the roles and responsibilities of all those involved in the process. It embraces the principles of the National Health Service and Community Care Act 1990, and good practice guidance outlined in the Department of Health document 'Ready to Go? Planning the discharge and the transfer of patients from hospital and intermediate care.' 2010. It operates within the framework of the Community Care (Delayed Discharges etc.) Act (2003) and The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - July 2009 (revised).

Simple Timely Discharges (ST) – the responsibility for ST discharges is shared between the designated Registered Nurse in charge of the patient's care, and the medical staff planning the patient's acute medical care.

Complex Discharges (CD)–whilst responsibility for overseeing the patient's discharge progress lies with the designated Registered Nurse, these patients will require further assessments and referrals to other healthcare professionals to achieve timely and safe discharge utilising the Discharge to Assess process.

SAFER Patient Flow Bundle and Red and Green Days – the SAFER bundle blends five elements of best practice. It is important to implement all five elements together to achieve cumulative benefits. It works particularly well when used in conjunction with the Red and Green Days approach. When followed consistently, length of stay reduces and patient flow and safety improves (Emergency Care Improvement Programme 2016). The SAFER Patient Flow Bundle and Red and Days are outlined in Appendices TBC.

Every effort must be made to gain the patient and carers/relatives (through an independent interpreter if required) agreement to the discharge arrangements for on-going health and social support, and their involvement is paramount to successful discharge planning. However, if agreement cannot be reached reference to the North Staffordshire Direction on Choice documents should be made.

3. SCOPE

The guiding principle within the policy is to support individual needs whilst identifying and respecting the individual's choice on discharge from the Trust.

This policy applies to all areas across UHNS for patients aged 16 years and over, with the **exception** of Maternity, Neonates and Paediatrics, where individual arrangements exist (The ASQUAM Guidelines). However, should a pregnant patient be admitted for care outside of the Maternity centre, then the maternity community office should be informed of their discharge in-hours, and the coordinator in the Midwife Birth Centre (MBC on (6)72200) should be informed out-of-hours, once discharge has taken place. Advice can be obtained from the coordinator in MBC for any pregnancy related issues.

4. DEFINITIONS & ABBREVIATIONS

Carer The term "carer" used throughout this policy refers to a person who, not always out of choice, *may* lead a restricted life in order to care for another adult.

Discharge The discharge of a patient to-

- Own home
- Own home with support from community health/social care providers
- Alternative community health or social care providers

- Alternative acute health provider
- **Simple Timely** – discharge back to a patient's normal place of residence, with no change in their nursing or social care needs
- **Complex Discharge** – a discharge where the patient has been identified as having an increase in their nursing or social care needs, sometimes requiring assisted accommodation.

Healthcare Professional

includes doctors, dentists, pharmacists, registered nurses, midwives, physiotherapists, occupational therapists working in any setting

Patient The term "patient" refers to all adults aged 16years and over

AMU	Acute Medical Unit
CCA	Community Care Act
CCD	**Clinical Criteria for Discharge**
CCU	Coronary Care Unit
CDS	Central Delivery Suite
CTS	Central Treatment Suite
DL	Discharge Lounge
ECC	Emergency Care Centre
EDD	Expected Date of Discharge
IMCA	Independent Mental Capacity Advocate
LOS	Length of Stay
MCA	Mental Capacity Act
MBC	Midwife Birthing Centre
MFFD	Medically Fit For Discharge
POD	Patients Own Drugs
SAU	Surgical Assessment Unit
SSU	Short Stay Unit
TTO	Tablets to Take Out

5. ROLES AND RESPONSIBILITIES

5.1 Consultant/ Medical Team

Medical staff actions for discharge can be found within Appendix D, additionally medical staff should:

- Be familiar with the overarching principles for discharge ensuring SAFER Bundle principles are applied and patients have recorded in the medical notes;
  - EDD
  - CCD
- Ensure effective communication between staff, staff and patients, staff and carers/family

5.2 Ward Sister/Charge Nurse and the Nursing Team

Ward Sister/Charge Nurse/designated Registered Nurse actions for discharge can be found at Appendix E additionally they should:

- Be familiar with the overarching principles for discharge see Appendix A
- Ensure effective communication between staff, staff and patients, staff and carers/family
- At an early stage assess the potential for increased care needs on discharge through discussions with staff, staff and patients, staff and carers/family

- Work with Clinical Audit Department to develop action plans in response to results of the ward spot check audits

5.2.1 Criteria Led Discharge

Nurses competent to undertake Criteria Led Discharge must only do so in accordance with Trust Policy No C02, *Trust Policy for Expansion of Professional Practice* and as per the Trust Criteria Led Discharge Standard Operating Procedure (Appendix F). A completed Discharge Summary and Take Home Medications should be available in preparation for the Nurse to carry out Criteria Led Discharge.

5.3 Discharge to Assess

In collaboration with local health and social care economy UHNM are implementing a system of discharge to assess which ensures that patients are discharged either to their home or another place of care to undertake assessment rather than undertaking assessment on site. The key parts of this team are the Track team and Triage team as described below.

5.3.1 Track Team

The Integrated Track Team will provide one integrated point of referral, patient tracking and LHE information data flow to include home and bed based services. The Track Team will sit alongside the Triage Team and all functions will be fully aligned across the two.

The Track Team will coordinate the flow of information for the local health economies across Staffordshire and Stoke-on-Trent. As soon as someone presents at a key point of entry, which may be Front of House at the acute, another access portal or community crisis, the track team will be informed and start to track that individual's experience within services and on to the next stage, whether to a long term service or no services. They will chase progress reports on a daily basis, support the monitoring of unmet demand across the systems, community, bed based and acute and provide appropriate information as required within the LHE that they are supporting.

There may be a number of Track Teams across Staffordshire and Stoke on Trent aligned to the main acute hospital provider within the area. The locations of these teams across the Staffordshire footprint are to be determined and linked to the outputs of the Demand and Capacity Work Stream.

5.3.2 Triage Team

The Integrated Triage Team will provide one integrated point of referral for all people that present in an acute hospital including A&E, other portals such as AMU and for in-patient wards. The Triage Team will sit alongside the Track Team and all functions will be fully aligned across the two.

The Triage Team will be a fully integrated team responsible for determining where people that are deemed to have complex needs within the acute setting are supported to access rehabilitation, enablement, care and support and an assessment of their long term needs where required. The team will be made up of a highly skilled multi-professional group of staff who have expertise and knowledge of the functions of community services and can manage patients in a safe and effective way supporting both health and social care needs.

The team will receive the Patient Profile and, using this, determine whether the person will go home or to a commissioned bed in either a community hospital or care home dependent on local commissioned capacity. It is anticipated that the decision as to next steps for the person will usually be made based on the information in the Patient Profile but there may be a need to visit the person to confirm the best outcome; it is anticipated that this will be the case in approximately 30% of all referrals.

The referral to the Triage Team will be monitored by the Track Team and will meet the requirement under the care Act of a 'Notification' where that is needed. The team will respond to all referrals on a same day basis and this will be monitored via the Track Team.

The team will also undertake assessments by exception linked to:

- Front of House referrals and requirements
- In portals to avoid admission as an in-patient
- People with highly complex needs and who cannot be safely discharged without an assessment being completed e.g. people with a significant cognitive impairment requiring complex Best Interest Decision making.

5.4 Physiotherapy (PT) and Occupational Therapy (OT)

Referral to Physiotherapy and Occupational Therapy is via the electronic order comms system. Referrals are received directly onto staff iPods however if urgent interventions are required this should be followed up by bleeping the therapy team on the area. All patients will be seen on the day of referral if they are a priority for discharge or require a critical intervention

5.4.1 Occupational Therapists

- Assess patients' functional abilities in relation to their normal daily activities
- provide assistive equipment to patients with a view to facilitating safe discharge from hospital
- Liaise with relatives/carers, social workers, discharge liaison and primary care teams to determine the most appropriate discharge destination and support/care arrangements for patients
- Carry out access visits (where a patient's home is assessed) where this is deemed essential to facilitate discharge this may be carried out by acute based staff if there is an urgent need for this type of intervention
- Recording discharging a patient from care within the medical record and/or on the Trust's electronic record
- Ensure timely referrals to therapists in community based services for on-going intervention and support if required.
- Ensure timely referrals to therapists in community based services for on-going intervention and support if required.

5.4.2 Physiotherapists

- Undertake assessment/intervention according to identified individual patient need or Patient Care Pathway.
- Liaise with relatives/carers, social workers, discharge liaison and primary care teams to determine the most appropriate discharge destination and support/care arrangements for patients
-
- Ensure patients are safe for discharge or meet the criteria for transfer to other care providers/in patient based services for on-going support.

- Ensure timely referrals to therapists in community based services for on-going intervention and support if required.
- Assess for, and provide, appropriate mobility aids required by the patient and advise on the provision of other assistive rehabilitation equipment.
- Recording discharging a patient from care within the medical record and/or on the Trust's electronic record

5.5 Dieticians.

Initiate nutrition treatment planning and follow up to discharge to include:

- feeds to Take Out from the ward
- diets for patients requiring changed food texture
- therapeutic diet such as a low potassium diet
- where Home Enteral Feeding is initiated
- where patient is discharged on Total Parenteral Nutrition, arrangements and funding for TPN need to be in place and secured for discharge

(NB: Dieticians require at least 3 days' notice to set up home enteral feeding)

5.6 Speech and Language Therapy (SALT)

If swallowing difficulties and communication disorders have been identified a referral should be made to the SALT department for formal assessment and advice in a timely manner, before preparing for patient discharge. An in-patient will be seen within 2 working days of the referral being made. A referral signed by the appropriate Consultant, or designated and agreed representative, is required for the assessment to take place.

The SALT service is responsible for:

- providing assessment and advise on diet and fluid modification and safe swallowing, ensuring that all possible aspiration risks are reduced
- providing advice on communication strategies and communication aids as appropriate
- arranging follow up in the community as appropriate, usually in an out-patient setting
- contacting the patient's home or care setting if on-going SALT needs to provide relevant information on discharge from hospital prior to community follow up

5.7 Pharmacy Services

The Pharmacy Team is organised to provide services within the Pharmacy Department and Peripatetic Clinical Pharmacy teams (PCPs) which work across designated wards. Communication between PCPs and ward based nursing and medical teams is vital for the success of the discharge process.

Please see Appendix G (i) How the Pharmacy Team supports patient discharge. And G (ii) and G (iii) for process to follow to obtain patients medication for discharge.

5.8 Social Care

Assessments of future health and social care needs on site will now only be carried out by exception. They will be triggered by a discharge to assess referral and will only be approved

5.9 Ambulance Services

The ambulance service will:

- Inform nursing staff on arrival to the ward of the patient's name and destination they have come to collect
- Transport the patient, together with any escort and assistive equipment which have been agreed in advance, to the location requested. Please note that it is up to the discretion of the crew as to whether certain pieces of equipment can be taken dependent upon the ability to secure larger items
- Inform the staff on the ward/department from which the patient has been discharged if:
  i. There is no one at home to receive a patient when they have been told that they should not leave the patient alone in the house.
  ii. They are unable to gain access to the house.
  iii. They intend to return the patient to the ward/department from which they were discharged.
- Return the patient to the ward/department from which they were collected, if they consider that leaving them at the intended destination would put their safety or wellbeing at risk.

5.10 Divisional Governance and Quality Managers (DGQM)

The DGQM's are responsible for reviewing DATIX adverse incident reporting relating to discharge and monitoring at the Divisional Governance Groups

5.11 Clinical Audit Department

Are responsible for undertaking the ward spot check audits, reporting results and assisting the ward managers/matrons in developing action plans where required.

6 EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

Discharges planning, and the issues surrounding provision of social support and healthcare in the community, are covered within the educational syllabus of pre-registration training. All staff involved in the discharge of patients from Hospital must be made aware of this Policy and familiarise themselves with the particular part that they are called upon to play in the safe discharge of patients.

The Trust's Preceptorship Portfolio, which is primarily used for all newly qualified nursing and midwifery staff, but is also available to staff new to the Trust, covers issues relating to discharge as one of the generic competencies which those staff are required to demonstrate.

No other formal training is required for staffShadowing opportunities are always available with both the Track and Triage team, and the Site matrons.

7 MONITORING AND REVIEW ARRANGEMENTS

C05Trust Policy for the Discharge of Adult Patients Monitoring Table					
Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or department responsible for the monitoring	Frequency of the monitoring activity	Group/committee/ forum which will receive the findings/monitoring report	Committee/ individual responsible for ensuring that the actions are completed
Discharge requirements for all patients	Datix adverse incident reporting trends report Divisional Quality and Performance Report	DGQM's	Quarterly	Divisional Clinical Governance Group	Quality and Safety Forum
Information to be given to the receiving healthcare professional	Spot checks	Clinical Audit	Quarterly	Divisional Clinical Governance Group	Quality and Safety Forum
Information to be given to the patient when they are discharged	Datix adverse incident reporting trends Spot checks	DGQM's Clinical Audit	Quarterly Quarterly	Divisional Clinical Governance Group	Quality and Safety Forum

This policy will be reviewed in three years unless guidance or legislation indicates it is required sooner.

8 REFERENCES

- National Assistance Act 1948 (Choice of Accommodation) Directions 1992, LAC (92)27, DoH, followed by LAC (2004)20: Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001, DoH.
- The ASQUAM Guidelines, Second Edition 2008, NSMH.
- The NHS Continuing Healthcare Practice Guidance, 2010, DoH
- The Mental Capacity Act 2005
- The national framework for NHS continuing healthcare and NHS-funded nursing care - July 2009 (revised), DoH.
- ?REFERENCE TO SAFER

APPENDIX A

KEY CONSIDERATIONS FOR DISCHARGE

Overarching Principles

- Ensure discharge remains patient and carer focused, relevant to the patient's cultural context and progresses alongside all assessments/management plans

- On admission, give each patient a 'Discharge Information Leaflet' which should be provided in the language or format preferred by the patient

- Within 24 hours of admission: identify the **EDD** and discuss with the patient/relatives/carer; ascertain any concerns, worries or on-going care needs; commence Discharge Checklist; document all actions and discussion in the patient's notes.

- After discussion with the patient/relative/carer, if complex discharge needs have been identified, complete checklist and section 2 paperwork

- Forward paperwork to *control.room@uhns.nhs.uk,* for checking and referral to ICAB

- Update and review discharge plan daily, ensure patient/carer training needs have been addressed, communicate with patient, carer, relatives and any professionals involved, and record progress on discharge checklist, updating discharge plan accordingly

- Assist with any assessments required, complete any paperwork/tests etc. identified by ICAB in a timely manner

- 24/48 hours prior to EDD ensure TTO medication is correctly prescribed. Once TTO is prescribed nursing team to refer TTO to the peripatetic clinical pharmacy team to facilitate dispensing of the TTO. Where this is not possible the whole prescription chart should be sent to the pharmacy dispensary during pharmacy opening hours. All PODs should be checked by an appropriately trained nurse and TTO annotated appropriately, if this is not possible all PODs should be sent with the prescription to the dispensary.

- 24 hours prior to EDD forward Section 5 notification to *control.room@uhns.nhs.uk*. Confirm discharge with community professionals, ensure all arrangements are in place and confirm with patient and carer

- 24 hours prior to discharge: ensure medicines and dressings to take home are correct and available and match the inpatient medicine requirements. Ensure any follow up appointments are made to monitor medicines e.g. warfarin clinics. Patients should be provided with any information they require about their medicines. Transport is arranged, confirm keys available or access to discharge destination, property and valuables returned, and confirm all community support services arranged.

- Day of Discharge: recheck all as per 24 hours prior to discharge. Give patient and or carer details of whom to contact if difficulties arise after discharge and confirm follow up appointment details. Complete relevant discharge planning documentation, ensure all invasive lines are removed as appropriate and infection control measures adhered to

- Discharges should be timed to occur before lunchtime, so that speciality capacity can be created to prevent patients waiting in admission portals.

- Transfer to discharge lounge if available and clinically appropriate. Declare empty beds to capacity team immediately, to allow improved patient flow and prevent persistent phone calls.

Escalate to Ward Manager / Directorate Manager if there are any difficulties in adopting this process.

Ambulance Bookings for Discharge

- Arrange transport 48 hrs. before discharge date if there is a recognised clinical need, and confirm on the day of discharge giving a time at which the patient will be ready. Reference should be made to Trust SOP: Op_004 *Requesting Non-Emergency Patient Transport*, available on the Trust intranet (Trust Section – Policies and Procedures – Standard Operating Procedures - Trust Standard Operating Procedures Database)

- Inform transport services of DNAR CPR Orders

- Inform transport services of any infection control issues which have been identified and any precautions required.

- Inform the ambulance service of any luggage or equipment to be transported with the patient (clearly labelled). There is limited space for the transport of non-essential equipment, and staff need to ensure that carers/relatives/friends are advised to take any unnecessary luggage/equipment home

- Ensure the ambulance service is made aware of those patients who should not be left in the house alone and the arrangements made to meet the ambulance. If discharging to home with support of the Intermediate Care Team advise the relevant team when the patient has left the ward area.

Property and valuables

- Ensure that any property, including valuables, has been returned to the patient. Facilities are not available for obtaining valuables outside normal working hours. Reference should be made to Trust procedure: FA06 *Financial Procedures: Patients' Property – Valuables*

Data Collection/Performance Management

- LOS data is maintained by the Complex Discharge team, and reports are produced on a weekly basis. Divisional meetings take place to discuss any issues which have been raised within this data, and action plans devised as appropriate.

- Data on current status of ICAB referrals, patients under section two, and delayed transfers of care is maintained by the Complex Discharge Team. This data is used to analyse community demand by PCT.

- This analysis is reported daily to Trust Directors via the Clinical Site Managers' 07.00 report.

- Monitoring and validation of delayed transfers of care from beds designated as acute will be carried out by UHNS with support from ICAB. The information on delays will be collated and validated weekly with Hospital Social Services Senior Managers, prior to reporting for SITREP. Actions to resolve delays will be agreed and progressed with the appropriate departments/agencies.

- The number of complaints related to inadequate or unsatisfactory discharge arrangements for those patients requiring community nursing services will be monitored on an on-going basis by the Associate Directors, Divisional Nurses/Matrons in conjunction with ICAB.

APPENDIX B

Emergency Care Improvement Programme
Safer, faster, better care for patients

Improvement

Rapid Improvement Guide to:

The SAFER Patient Flow Bundle

Introduction

SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity).

The SAFER bundle blends five elements of best practice. It's important to implement all five elements together to achieve cumulative benefits. It works particularly well when it is used in conjunction with the '**Red** and **Green** Days' approach. When followed consistently, length of stay reduces and patient flow and safety improves.

The SAFER patient flow bundle

S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.

F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set.

S - Senior Review. All patients should have a senior review before midday.

- Use simple rules to standardise ward and board round processes.
- Minimise variation between individual clinicians and clinical teams to ensure all patients receive an effective daily senior review.
- Daily review undertaken by a senior clinician able to make management and discharge decisions is essential seven days a week.
- Effective ward and board rounds are crucial to decision making and care co-ordination.

Ward rounds - should add value, leading to clear actions, written up in notes and acted upon. A detailed description of ward round best practice is contained in the RCP/RCN document here.

- Use check lists to reduce variation and prevent actions being omitted.
- Always include a qualified nurse, other members of the MDT and involve the patient.
- Use a 'consultant of many days', to lead on the management of ward patients. Let specialty colleagues focus on elective and other activities.
- Most tasks (e.g. the writing up of TTOs or the ordering of a scan) to be completed before the round moves onto the next patient to avoid overloading junior staff, batching tasks and creating delays, with a mobile computer as an enabler.

Board Rounds – if undertaken daily, in the early morning, enable teams rapidly to assess the progress of every patient in every bed and address any delays to treatment or discharge. A second, afternoon board round is best practice to review progress.

'**Red and Green Days**' are a useful approach to optimising flow. The team discuss for every patient whether the day ahead is 'red' (a day where there is little or no value adding care) or 'green' (a day of value for the patient's progress towards discharge). If 'red', action needs to be agreed by the team to create a 'green' day instead.

The purpose of board rounds is to ensure as many days are 'green' for the patient as possible. If patients require an investigation to progress care, then investigations need to occur that day and need a clear plan of action following results. Where patients are receiving active interventions to meet clinical criteria for discharge tomorrow, the day is only 'green' if the discharge prescription medications are ready by the evening before. 'Red' days should be recorded so that common causes of delays can be identified and addressed.

Measuring compliance is important. During early afternoon bed meetings, patients who have not had a senior review should be highlighted, discussed and mitigating action taken. Ongoing measurement of day to day compliance using statistical process control (SPC) run charts should be used to identify how many patients are receiving a senior review before midday every day, and any trends.

A - All patients will have an expected discharge date and clinical criteria for discharge

All patients should have a consultant approved care plan containing an EDD and CCD, set within 14 hours of admission.

The CCD should include physiological and functional criteria, but not focus on medically 'optimising' a patient or returning them to their pre-admission baseline. A period of post-hospital recovery and rehabilitation should be anticipated and allowed for.

EDDs should be set by a consultant with the MDT, and represent a professional judgement of when a patient is anticipated to achieve his/her clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence).

A challenging EDD 'goal' should be set to reduce procrastination and help teams focus on getting patients home promptly (rather than focusing on getting the EDD exactly 'right').

Patient progress towards EDD should be assessed every day at a board or ward round led by a senior clinical decision maker (normally the consultant). Patients should be routinely involved and aware of the progress they are making. Patients (and/or their next of kin) should be able to answer these questions:

1. What is wrong with me or what are you trying to exclude?
2. What have we agreed will be done and when to 'sort me out'?
3. What do I need to achieve to get me home?
4. Assuming my recovery is 'ideal' and there is no unnecessary waiting, when should I expect to go home?

All members of ward / departmental teams should be able to discuss and explain the EDD. Simple patient information cards can help by clearly stating what is going to happen to patients today and tomorrow.

If the EDD is exceeded for non-clinical reasons, it can be helpful to record this on 'at a glance boards' as the EDD plus the number of days (e.g. EDD+1, EDD+2 etc.).

F - Flow early from assessment units

Every ward that routinely admits patients from assessment units should ensure they 'pull' the first patient to their ward before 10am every day.

Ward teams should be in regular communication with assessment units to agree the first patient, with assessment unit teams reviewing patient care at the ward/board round and ensuring patients are informed beforehand that they will be transferred to the receiving ward at a specified time (before 10am).

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Ward teams should be in regular communication with assessment units to agree the first patient, with assessment unit teams reviewing patient care at the ward/board round and ensuring patients are informed beforehand that they will be transferred to the receiving ward at a specified time (before 10am).

If discharges on the receiving wards are late, ward teams should consider sitting patients out, transferring patients to the discharge lounge or expediting discharge.

It is essential for flow that patients are transferred early morning from assessment units, to ensure space for incoming patients and to reduce ED crowding and associated safety risks.

E - Early discharge – a third of patients should be discharged before midday from inpatient wards

Morning discharges should be the norm, with at least one in every three of the day's discharges to have left their wards by midday. This reduces emergency department (ED) crowding and allows new patients to be admitted early enough to be properly assessed and a treatment plan to be established and commenced.
Early morning ward and board rounds should set the pace for early discharge. Teams should prioritise activities associated with discharge, particularly TTOs (medication to take home) and discharge letters, which should be prepared beforehand or during one-stop ward rounds. If staff have to continually chase up TTOs, it is highly likely this is an opportunity to improve current processes and facilitate earlier discharge.

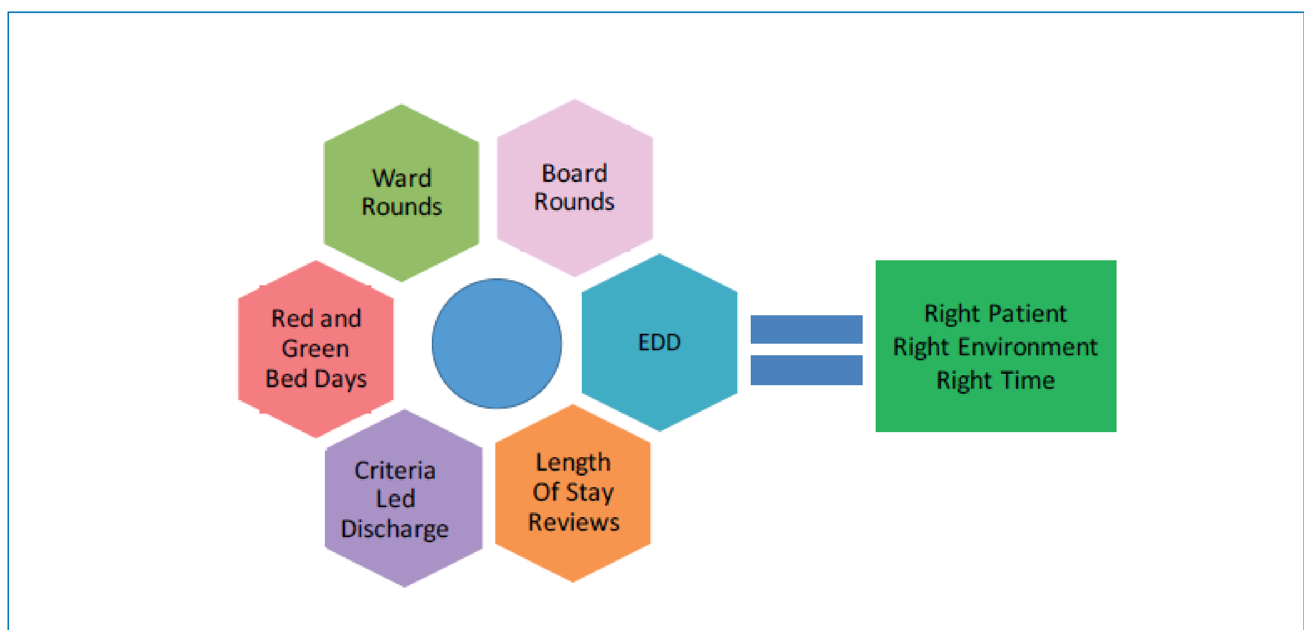
Pharmacy teams should be actively engaged to help reduce delays with TTO processes. Examples include the introduction of generalist prescribing pharmacists and satellite pharmacies nearer ward areas as described here.

R – Review all 'stranded' patients (all patients in hospital seven days or more)

Patients should be transferred to their usual place of residence as soon as they cease to benefit from acute care (i.e. have achieved CCD). The risk of deconditioning and decompensation for older patients increases with each day in hospital. At every board and ward round, the following should be considered:

- Today is a red day until we prove otherwise and take actions to make it a green day.
- If the patient was seen for the first time as an outpatient or in the ED today, would admission to hospital be the only option to meet their needs?
- Considering the balance of risks, would the patient be better off in an acute hospital or in an alternate setting?
- Is the patient's clinical progress as expected?
- What needs to be done to help the patient recover as quickly as possible?
- What are the patient's views on their care and progress?

Prescribing long term 'solutions' for patients (e.g. nursing home placements) may set inappropriate expectations for professional teams, patients and their families and lead to self-fulfilling prophecies. Most patients benefit from assessment in their normal place of residence where they can surprise professionals with their ability to cope in familiar surroundings.



There should be an effective process that enables a daily MDT (health and social care) review of all stranded patients with the default assumption that patients will be discharged to their normal place of residence. To enable this, system partners need to agree a process that should include:

- Agreement between health and social care services that packages of care can be restarted, without reassessment, where a patient's care needs remain largely unchanged. This can be facilitated by implementing a 'trusted assessor' model.
- For the majority of patients, definitive assessment of social care needs should occur outside of hospital (discharge to assess).
- The MDT should have same-day access to social care advice, ideally at the morning board round, or by phone.
- Agreement between health and adult social care to share the risk of 'funding without prejudice' while responsibility for the long term funding of a patient's care is being established. This will allow assessment to take place outside hospital, ideally at home with support.
- Agreement by health and social care communities that all referral processes are as simple as possible (i.e. using simple, brief electronic documentation that is quick and easy to complete).

This should be measured using the 'stranded patient metric', with information presented in SPC run charts so trends and real improvements can be seen.

Conclusion

Many hospitals find that where SAFER becomes 'business as usual' on all wards, length of stay falls and clinical outcomes improve. Essential components of successful implementation of SAFER are:

- **Clinical leadership** – implementation and sustaining momentum requires great clinical leadership to support operational teams
- **Communication** – staff need to be fully briefed and understand all elements of SAFER and why it will help patient flow and benefit patient safety
- **Executive support** – senior teams need proactively to support the implementation of SAFER. The active involvement of all members of the executive team is important to success
- **Measurement** – all elements need to be measured using SPC run charts (statistical process control). All wards should have 'know how you're doing' boards to demonstrate success in delivering the five elements of the bundle
- **Social movement** – implementation needs to be part of a well-managed improvement programme with clear plans and deadlines. A 'social movement' needs to be created to win hearts and minds, involving leaders who are passionate about patient care, creating compelling narratives that describe the link between implementing SAFER and improving patient care.

APPENDIX C

Emergency Care Improvement Programme
Safer, faster, better care for patients

Rapid Improvement Guide to:

Expected Date of Discharge and Clinical Criteria for Discharge

Introduction

Expected Date of Discharge (EDD) and Clinical Criteria for Discharge (CCD) are essential care coordination tools mandated by:

- The Royal College of Physicians
- The Royal College of Surgeons
- The Enhanced Recovery Programme
- The Keogh Review
- The Seven Day Programme

EDD and CCDs must be clearly defined and used consistently if they are to work effectively. They should be set using simple rules as part of clearly constructed clinical case management plans.

The aim is to get the whole multi-disciplinary team (MDT) aligned to specific objectives for every in-patient stay. EDDs and CCDs flush out the constraints or waits (both internal and external). It is the rigour with which the constraints or waits are identified and proactively managed that reduces length of stay.

The guidance in this short paper is based on experience across a large number of organisations and the principles of the 'Theory of Constraints'.

The Process

Clinical Criteria for Discharge

1. This is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge. It should be agreed with the patient and carers where necessary.

2. The CCD should not be stated as 'back to baseline'. For example, the BTS/SIGN (British Thoracic Society) guidance 2014 states that there is no one physiological parameter that defines absolutely the timing of discharge. A patient admitted with acute severe asthma who normally runs a PEFR (peak expiratory flow rate) of 90-95% may not need to achieve this level at the point of discharge, but does need to achieve a PEFR >75% with less than 25% variability due to the higher risk of relapse.

3. For patients with frailty or impairments in activities of daily living, the clinical criteria should include functional factors. For example, a patient with dementia and reduced mobility who has a normal exercise tolerance of 25 yards but whose toilet is only five yards from their bedroom, may well be fit for discharge if mobile with a frame and has the supervision of one person for five yards. It is important to anticipate that patients will continue to recover at home with or without support.

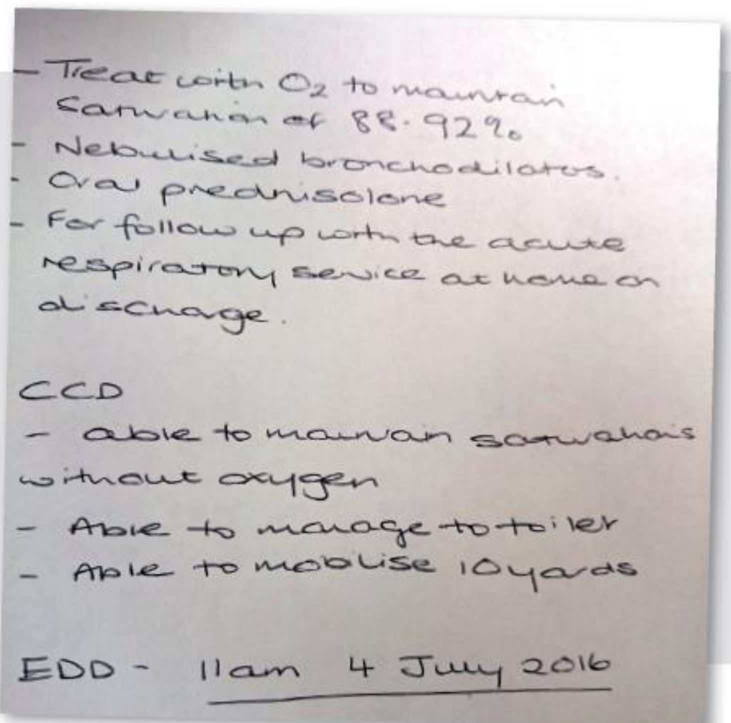
4. For a proportion of patients, the CCD can be used to trigger discharge if agreed with the patient and well communicated across the team. For other patients, the CCD are a guide, and sign off for discharge by a senior clinician may still be required.

5. The CCD can be a short list of objectives and the aim is to keep them simple to act as an aid to maintain team focus.

Expected Date of Discharge

1. EDDs should be set at the first consultant review and no later than the first consultant post-take ward round the next morning. If a patient is to be transferred to a ward based specialty team, then the EDD and CCD should be set by the team who will be responsible for their discharge. Crucially, the sooner the patient is identified as in need of sub-specialty care and that sub-specialty team reviews and sets the EDD and CCD, the sooner that patient's care will be progressed.
2. For patients with an expected length of stay of two days or less, it is also appropriate to set an expected time of discharge.
3. It is important that EDDs are set assuming an ideal recovery pathway unencumbered by either internal or external waits. If the EDD is set embedding anticipated waits and delays in the system (for example waits for clinical decisions, diagnostics, inter-specialty referrals, social care decisions etc.), then these waits become hidden and thus not amenable to resolution.
4. The EDD and CCD are clinical, not managerial, tools. Together with a comprehensive clinical care and discharge management plan, they describe the objective for the admission. They can be used to co-ordinate care and minimise unnecessary waits in the patient's journey. The system's managerial capacity should focus on tackling unnecessary waits in support of the clinical team. In most circumstances, it will be the internal waits within the acute hospital that predominate.
5. If a patient's stay goes beyond the EDD, best practice is to highlight this as EDD +1, +2 etc. and clearly identify the constraint(s) that caused this (for example, delays in critical inter-specialty referral responses).
6. The use of **Red Green Bed Days** at Board Rounds and the implementation of the **SAFER patient flow bundle** help teams identify and manage constraints to delivering the EDD.

Management plan for a patient with an acute exacerbation of COPD



APPENDIX

Emergency Care Improvement Programme

Safer, faster, better care for patients

Improvement

Rapid Improvement Guide to:

Red and Green Bed Days

Introduction

'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. Applicable to in-patient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. It is not appropriate for high turnover areas such as Emergency Departments, Assessment Units, Clinical Decision Units/Observation Units, and Short Stay Units where using Red and Green on an hours/minutes basis may be more appropriate.

A green day progresses the discharge and care pathway:

When the patient receives care that can only be given in an acute hospital bed

When any wait for a procedure /process /diagnostic that is within the patients Care Plan and does not lengthen the patient stay

When a patient receives acute care that progresses their route towards discharge (e.g. on-going IV antibiotics for a fixed time period)

A red day recognises a 'delay' to the discharge and care pathway :

When a patient does not require an acute hospital bed (e.g. MFFD awaiting package of care)

When a planned procedure/process/diagnostic does not occur (e.g. USS unable to be completed today)

When there is no daily Senior Review (as required), Clinical Criteria for Discharge or EDD (EDD to be set within 12 hours of admission)

At the centre of the system is the person receiving the acute care whose experience should be one of involvement and personal control, with an expectation of what will be happening. It can be useful to consider whether that person is able to answer these simple questions as soon as possible after their arrival at hospital:

1. *Do I know what is wrong with me or what is being excluded?* This requires a competent senior assessment and discussion.
2. *What is going to happen now, later today and tomorrow to get me sorted out?* The 'inputs' needed (diagnostic tests, therapeutic interventions etc.) with specified timelines.
3. *What do I need to achieve to get home?* The 'clinical criteria for discharge' (CCD), a combination of physiological and functional parameters. 'Back to baseline' is rarely a useful phrase.
4. *If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?* This is the 'expected date of discharge' (EDD) which should be set along with the CCD at the point of admission.

Lack of clarity to the answers to any one of these four questions will result in delays, with frustration and confusion for the patient. Questions 3 and 4 together can be used together to flush out unnecessary waiting along the pathway.

On a Red day, patients typically receive care that could be provided in a non-acute setting (such as personal care, routine observations, IV antibiotics, usual medication). The key question is *what is this patient waiting for to progress to the next phase of their care?* It is only a Green day if any action undertaken could only be done as an inpatient for that particular patient's circumstances on that day. If an investigation is being undertaken that day, the day remains a Red day until the result of the investigation is acted upon. Likewise, if a patient is due for discharge that day and the discharge prescription medications are not ready, then it is a Red day. For many patients, weekends and Bank Holidays are frequently Red days. Another way of looking at this is to ask the question *if this patient was seen in out-patients as they are physically presenting today, would they immediately be admitted to hospital?*

If the approach to judging days as Red or Green is less than rigorous, few Red days will be identified and opportunities for reducing patient length of stay will be lost. Those wards that rigorously apply the process will identify many Red days and will be proactively trying to resolve the unnecessary waiting. Those wards that are not actively identifying many Red days or only around 'discharge processes' are either already extremely efficient (relatively rare) or are missing an opportunity to improve care delivery and flow.

The Process

1. Start the daily, morning multi-disciplinary Board Round with all patients marked as 'Red'.
2. The day remains as 'Red' if there is inadequate senior presence at the Board Round to allow firm decisions to be made
3. The day remains as 'Red' if there is no clinically owned expected date of discharge (set assuming ideal recovery and no unnecessary waiting) with clinical criteria for discharge and a clear case management plan.
4. The Board round should ensure that a patient's case management plan is progressed and converts the day to Green. If a patient requires an investigation that day to progress their care, then the day will only become Green if the investigation occurs that day and there is a clear plan of action with regard to the result. If the patient has not met their CCD and is receiving active interventions to get them to that state by tomorrow, the day is only 'Green' if the discharge prescription medications are ready by the evening before the expected date of discharge.
5. The team must be clear what actions constitute a day being 'Green'. For example, these do not include observations being undertaken, oral medications, IV antibiotics etc. as these can be delivered out of hospital unless the patient is physiologically unstable.
6. The Red and Green days process is linked to the **SAFER patient flow bundle**
7. It is helpful to link flow, safety and reliability with visual demonstration using a 'Ward Improvement Board' as described in the Productive Ward Programme. Examples of ward level metrics that might be used include:
   a. Impact Metrics – statistical process control run chart (SPC) of weekly average length of stay of discharges from the ward. These should reduce significantly as Red days are proactively reduced.
   b. Process Metrics – e.g. % discharge drugs ordered and prepared the day before discharge, % of patient records with an EDD and CCD recorded in the medical notes etc.
   c. Balancing Metrics – number of unplanned re-admissions
   d. Quality Metrics – pressure sores, HCAI, catheter days, cannula days, falls.
8. The constraints identified by wards to converting a Red day to a Green day need to be proactively managed at the Board round. Those that cannot be immediately resolved need an in-day escalation process.
9. The escalation process needs to pro-actively manage the constraint. Failure to resolve constraints proactively and just 'report them' is a non-value adding process.
10. At the end of each week, the top five constraints that could not be resolved by ward teams or following escalation should be considered by senior operational managers and where appropriate, added to local improvement plans.

A YouTube video on Red and Green Bed Days, presented by the ECIP Team and Ipswich Hospital NHS Trust, can be found here: https://youtu.be/Dc-b6GclTq4

APPENDIX D

University Hospitals of North Midlands NHS
NHS Trust

Standard Operating Procedure

Discharge Requires – Medical Actions

Purpose:	This document highlights the procedure which should take place for patients being discharged safely from UHNS NHS Trust. Actions are defined in order for patients to be managed correctly and safely discharged in a timely manner. This SOP supports the UHNS Policy C05 – Policy for the Discharge of Adult Patients
Scope:	This procedure aims to ensure the safe discharge of patients from UHNS NHS Trust. This procedure applies to all Medical Staff involved in the discharge of patients from UHNS NHS Trust.
SOP Reference Number:	C05 – SOP – 1
Policy SOP Relates To:	Trust Policy for the Discharge of Adult Patients
Date of Issue:	August 2017
Date of Review (Align to Policy Review Date):	August 2020
Version Control:	7

	Instruction	Rationale
1.	Discuss with patient and/or carer likely outcome, LOS, support required to include Primary Care and Social Care Involvement and record same in medical notes Note communication from patients' GP and act if discharge will be affected	To ensure the coordination of all elements of care To ensure the appropriate level of care can be delivered
2.	Establish and record an EDD based around the patient's clinical condition and the treatment required for the acute inpatient episode, with permission, discuss this with carers/relatives/friends as well as the patient along with any likely follow-up arrangements and record in this in the patient's medical notes.	To ensure effective discharge planning

3.	Document CCD around the patient's clinical condition and the treatment required for the acute inpatient episode, with permission, discuss with carers/relatives/friends	To prevent delays in discharge
4.	Discharge planning for over the weekend or when the patient's own medical staff are not expected to be available, clearly documenting delegated authority to discharge to the on call medical team, Nurse Practitioner/Consultant or designated Registered Nurse. In line with Trust Criteria *Led Discharge SOP*. Appendix F Planning and consideration needs to be given regarding availability of diagnostic test results which may be needed prior to discharge	To prevent delays in discharge
5.	If the patient requires medication to take home, write up the discharge prescription allowing sufficient time for it to be dispensed, preferably *at least 24hours* prior to the EDD see Appendix G. Ensure Patient is counselled on any new medicines and any monitoring required for medicines is explained and follow up appointments booked for monitoring of medicines, for example –warfarin, Ensure patient safety after discharge by ensuring all medicines are available and patient counselled appropriately. Once the TTO is dispensed ensure the e. discharge letter accurately reflects any changes that may have been made to the TTO. If the patient has been advised to refrain from work a Sickness Certificate (Form Med 3) should be issued	To prevent delays in discharge
6.	To make the final decision to determine whether a patient is medically fit for discharge, although this duty may be delegated to *other members of the multi-disciplinary team.*	To promote safe effective discharge
7.	When a patient wishes to self-discharge the responsible clinician should make sure the patient is aware of the implications of this decision	
8.	Inform the Local Health Protection Unit Consultant in Communicable disease (CCDC) if an infectious disease detected see IC07 Procedure for Reporting Notifiable Diseases	
9.	e-discharge letters should ideally be produced before the patient leaves the ward; so that a copy is available for them to take home with them should they request one. These letters have to be available to the Patients GP within 24hrs of discharge to enable continuity of care between secondary and primary care providers. Ensure this letter contains an accurate record of the medicine requirements, ensure all medicines started and stopped during the inpatient stay are clearly recorded on the letter and the TTO list includes any changes discussed with pharmacy This letter is automatically delivered to patients GP practice electronically, or printed centrally and posted out.	To ensure continuation of care by effective communication

APPENDIX E

University Hospitals of North Midlands NHS
NHS Trust

Standard Operating Procedure

Discharge Requires – Nursing / Midwifery Actions

Purpose:	This document highlights the procedure which should take place for patients being discharged safely from UHNS NHS Trust. Actions are defined in order for patients to be managed correctly and safely discharged in a timely manner. This SOP supports the UHNS Policy C05 – Policy for the Discharge of Adult Patients
Scope:	This procedure aims to ensure the safe discharge of patients from UHNS NHS Trust. This procedure applies to all Nursing/Midwifery Staff involved in the discharge of patients from UHNS NHS Trust.
SOP Reference Number:	C05 – SOP – 2
Policy SOP Relates To:	Trust Policy for the Discharge of Adult Patients
Date of Issue:	August 2017
Date of Review (Align to Policy Review Date):	August 2020
Version Control:	7

	Instruction	Rationale
1.	Ensure that every patient receives a Patient Information on choice Leaflet on admission and to record this in the patient's notes. This should be provided in the language or format preferred by the patient	To ensure there is understanding of care provided in acute setting
2.	Take overall responsibility for the planning/direction of discharge arrangements	To ensure co-ordinated approach to discharge planning
3.	Commence planning for discharge within 48 hours of admission. For elective patients it is expected that discharge planning should be commenced pre-admission.	To allow for
4.	Start completing the Discharge Checklist (Appendix H). This must be updated throughout the patient's hospital stay, and must remain accessible to all professionals involved in the patient's care	To ensure all potential barriers to timely discharge are minimised and to ensure all involved in care are aware of status

5.	Document the discharge plan in the nursing notes/ patient record /management plan and monitor and review daily.	To maintain accurate records and ensure continuation of care by effective communication
6.	When the patient is subject to assessment by a member of the ICAB team, that team member will take responsibility for co-ordinating the assessment but the Ward Sister/Charge Nurse retains overall responsibility for discharge planning.	To ensure co-ordinated approach to discharge planning
7.	Discuss discharge plans with the patient and, with consent, with carers/relatives/friends or independent interpreter, as required, prior to finalising any discharge arrangements. See Appendix A for Considerations around discharge If EDD is changed (only if there is a change in the patient's clinical condition) ensure that the patient, transport, carers and appropriate professionals are informed immediately, this includes informing UHNS Complex Discharge team via e-mail (*control.room@uhns.nhs.uk*) and that any necessary changes are made to arrangements for care in the community	To ensure all involved in discharge are aware of changes to plan. To maintain effective use of services and avoid unnecessary continuation of care by effective communication
8.	Ensure re-instatement of Social Care services on discharge. For advice or assistance with this contact ICAB.	To ensure patient safety and continued care
9.	Establish whether the patient could potentially require support after discharge. If so utilising EDD complete a checklist and Section 2 notification, from Trust Intranet (Clinicians – Clinical Guidance – MCA, DOLS & Consent – Complex Discharges), and forward both documents to *control.room@uhns.nhs.uk* which are then forwarded to ICAB for assessment	To avoid avoidable delays in planned discharge, to ensure patient safety and support capacity planning
10.	Ensure TTOs are prescribed by medical team and referral made to the peripatetic clinical pharmacy team or arrangements made via the dispensary for TTO medicines to be dispensed – please refer to appendix G(i) + Gii). Allow time for TTOs to be dispensed. Give consideration to assessing patient if a venalink may be required for Discharge medicines or if the patient has complex requirements for medicines to take home for example – Controlled drugs. Remember venalinks and complex prescriptions will take longer to dispense needs to be planned into the discharge process. Ensure patients are counselled on all new medicines and follow up appointments for monitoring medicines such as warfarin are arranged.	
11.	Complete and forward Section 5 notification of complex discharges who are under ICAB assessment, to *control.room@uhns.nhs.uk* 24Hrs before discharge	To promote effective discharge and promote patient safety.
12.	Ideally book patients to the Discharge Lounge the day before discharge	
13.	Liaise with the District Nursing/Health Visitor/Community Learning Disability Nurse or Community Psychiatric Nurse Services giving full details of nursing requirements and any	To ensure prompt transport

	continuing medication preferably 24 hours prior to discharge. See and complete the appropriate Nurse to Nurse communication form (District Nurse/Community Hospital) (Appendix K /Appendix L).	
14.	Before booking Transport ensure TTOs have been dispensed and are correct and available on the ward –please see Appendix Gi for the process to follow. Provisionally arrange transport 48 hrs. before discharge date if there is a recognised clinical need, and confirm on the day of discharge giving a time at which the patient will be ready. Reference should be made to Trust SOP: Op_004 *Requesting Non-Emergency Patient Transport* and additional information	To ensure prompt transport and support capacity planning
15.	Check that the patient has been provided with any necessary equipment, dressings and medicines –check medicines are correct and that they understand any instructions regarding taking their medication and diet see Appendix G Ensure that any property, including valuables, have been returned to the patient. Facilities are not available for obtaining valuables outside normal working hours. Reference should be made to Trust procedure: FA06 *Financial Procedures: Patients' Property – Valuables*	To prevent loss of property during the discharge process
16.	In consultation with the patient and/or carers, arrange any follow up appointments necessary. Confirm these arrangements with them and provide written details, or ensure that these will follow by post. These should also be recorded on the e-discharge letter.	
17.	Ensure medicines are correct and available to take home. Ensure all documentation is prepared for discharge see Appendix A	
18.	Advise patients taking their own discharge that all the usual facilities are available to them see Appendix A	
19.	If a Do Not Attempt Resuscitation order has been agreed; ensure that the transport service is aware see Appendix A for full requirements regarding ambulance transfers.	
20.	Accompany ambulance staff to the patient, to ensure that they are transferring the correct patient, with their property and correct TTO medication clearly identified (this may be delegated to nursing assistant staff)	
21.	Where instructions exist, utilise delegated authority to discharge as designated Registered Nurse in line with the Trust's criteria led discharge SOP *(when clearly documented in medical notes*.) See Appendix F	

APPENDIX F

University Hospitals of North Midlands NHS
NHS Trust

Standard Operating Procedure

Criteria Led Discharge

Purpose:	To facilitate a planned, safe and timely discharge from the acute hospital utilising the medical management plan and a criteria led approach, agreed by the multidisciplinary team in advance of the Expected Date of Discharge (EDD).
Scope:	Simple and timely discharges from all adult inpatient wards
SOP Reference Number:	C05 – SOP – 3
Policy SOP Relates To:	Trust Policy for the Discharge of Adult Patients
Date of Issue:	August 2017
Date of Review (Align to Policy Review Date):	August 2020
Version Control:	7

	Instruction	Rationale
1.	The Patient should be identified as being suitable for Criteria Led Discharge on the ward round	See Ward Round SOP
2.	The clinical criteria should be defined, parameters established and documented as part of the clinical management plan The Consultant/SPR should document these on the form The discharge date is often set provisionally and subject to confirmation that the patient's clinical observations and test results are within an acceptable range. The criteria set must be clear and detailed and may include, for example: - TPR and blood pressure within an acceptable range - Blood tests within an acceptable range - X-rays reviewed and satisfactory - Wound clean and healing well - Pain controlled - Stair assessment completed to the satisfaction of the physiotherapist The authorising doctor which should be	Ensures clarity and good clinical governance practice

	a Consultant or SPR, must then sign and write their bleep number in the notes The TTOs and Discharge Letter must be prepared by the medical	
3.	Functional/Social Care arrangements In order to ensure safe discharge the multidisciplinary team should confirm, and document in the medical and nursing notes, the patients individual functional requirements which must be in place prior to discharge. Examples could include: Confirmation of patient/carer agreement with discharge arrangements Care package start date and time The provision of equipment and required training Confirmation that the care home bed is available and that the patient is expected	Ensures clarity and good clinical governance practice
4.	Reviewing the Criteria The discharge criteria, both clinical and functional will be reviewed by the nurse who will also assess any other additional factors to ensure safe discharge e.g. vital signs should be reviewed	Ensures patient safety
5.	If all the criteria have been met to the expected EDD within the accepted parameters and there are no other additional issues the nurse will **sign in the medical and nursing notes that the criteria has been met and the patient can be discharged:** record date and time The nurse should also be satisfied that the patients vital signs and any other additional observations are within acceptable limits and record this is the nursing notes	Ensures patient safety Ensures good clinical governance practice
6.	If in doubt, always seek further advice with the multidisciplinary team If the criteria have not been met, seek further advice and review with the multidisciplinary team on the next ward round/board round or contact the medical staff responsible for the patient's medical care	See Ward Round SOP, Board Round SOP

APPENDIX G (i)

THE PHARMACY TEAM SUPPORTING PATIENT DISCHARGE

The Pharmacy Team is organised to provide services within the pharmacy department and peripatetic clinical pharmacy teams working across wards.

Peripatetic Clinical Pharmacy Teams
These teams work across designated wards. Communication between these pharmacy teams and ward based nursing and medical teams is vital for the success of the discharge process.

Once the prescriber has written the discharge prescription, and nursing staff have referred this patient's TTO to the clinical pharmacy team, wherever possible the pharmacy team will facilitate rapid turnaround of the TTO on the ward using one stop medication, patient's own medicines and dispensed items from the Pharmacy Computer on Wheels(COWs), Where this is not possible for example for complex TTOs including Controlled Drugs or where venalinks are required, the TTO will be clinically screened by the pharmacist and the TTO section of the prescription detached and sent to the dispensary – this facilitates the inpatients section of the prescription chart being kept on the ward to reduce missed doses of medicine.

In order to facilitate timely processing of TTOs the prescriptions should be available in time for the pre-planned pharmacy ward visit. If other TTOs are required at a time when the pharmacy team are not on the ward, they are available via bleep. Again if the team are bleeped then all required prescriptions should be available for processing when they arrive.

The Dispensary Pharmacy Team
When the TTO cannot be completed by a peripatetic clinical pharmacy team on the ward, or in exceptional circumstances when this team is not available to clinically screen the prescription, then the whole prescription chart should be sent to the pharmacy dispensary. In this situation it is important for an appropriately trained nurse to check the medicines in the patients POD locker for suitability for use as part of the TTO and mark the TTO accordingly or send all PODs to the dispensary in an appropriate bag.

This should be done well in advance of the patients estimated time for discharge-preferably the day before. The pharmacy team in the dispensary will aim to process the TTO within the Departmental turn around target time upon receipt in the pharmacy dispensary, however complex TTOs containing Controlled Drugs or where Monitored Dosing systems (MDS e.g. venalinks) are required the TTO will take longer to process – this is the turnaround time in the dispensary and time will also need to be allowed for transportation of the prescription to and from the dispensary, it is important not to give our patients a false impression of how long this process takes.

APPENDIX G (ii)

MEDICATION FOR DISCHARGE –PROCESS AND ACTIONS TO TAKE

Does the Patient need continued treatment with Medicines at home? – If Yes then - Are All Discharge Medicines available on the Ward? Or do some medicines need to be dispensed?

UHNS patients discharged from hospital requiring continued treatment usually receive a 14 day supply of medication in accordance with Department of Health guidelines, unless a shorter course of treatment is indicated or a specific protocol is in place for a specific scheme.

UHNS operates a 'One Stop Dispensing or Dispensing for Discharge' pharmacy supply system. If patients own medicines (PODS) are not available or if new medicines are prescribed and will continue beyond discharge, then an inpatient supply is dispensed with directions for use on the label. Normally 28 days supply is provided at this point and if 14 days supply still remains at the point of discharge then a further supply from pharmacy is **not** required. The aim of this service is for most medicines to be available in the patents bedside medicines locker ready for the patients discharge. Only short courses of antibiotics for example or medicines which have required dose titration during inpatient stay should need to be dispensed by pharmacy at the point of discharge, often these items can be dispensed from the pharmacy wards based Computers on Wheels (COWs).

Patients Own Medicines

Patients are increasingly being encouraged to bring their own medication into hospital from home. Following assessment of their suitability of use, patient's own drugs (PODS) may be used for that individual patient only during their in-patient stay and/or on discharge. When a patient's own drugs are issued on discharge, following assessment by the pharmacy service or appropriately trained member of nursing staff, they will be suitably packaged, in date, labelled will full dosage instructions and additional written information may be supplied.

Any patients own medicines brought in from home remain the property of the patient and should be securely stored in the individual patient medicines lockers during the in-patient stay. Following patient consent unsuitable PODs should be removed from the bedside locker and sent for destruction (following the medicines waste SOP). The exception to this is patients own controlled drugs which should be dealt with as per Trust policy MM06: *Policy for the Prescribing, Storage, Supply and Administration of Controlled Drugs*. On discharge any patients own drugs should be either reviewed by a suitably trained nurse on the ward, the peripatetic clinical pharmacy team, or sent down to the dispensary in a green 'patient own drug' bag with the discharge prescription, to be used in the TTO dispensing process.

Discharge Medication

48 hours before the patient's EDD, the prescriber should review his/her treatment and write the discharge prescription.

On wards which have a regular peripatetic clinical pharmacy team visit - the nursing team should refer TTOs to the peripatetic clinical pharmacy team if the pharmacy team are due to visit the ward. If the pharmacy team are not due to visit the ward the nursing team should follow agreed protocol for that ward and either bleep the peripatetic clinical pharmacy team or send the TTO to the Pharmacy dispensary - suitably trained nurses should check all of the patients 'one stopped' medication and PODs and endorse the items on the discharge prescription 'PODs o.k signed and dated'. The Prescription should be sent to the Dispensary for dispensing medicines that are required. If there is no suitably trained nurse able to check the patients 'one stop' medication and PODs for suitability for use - all PODs and one stop medication for that patient should be sent with the discharge prescription to the pharmacy.

Once the Patient's discharge prescription is referred to the peripatetic clinical pharmacy team, the pharmacist will check the discharge prescription against the in-patient prescription chart.

The peripatetic pharmacy team will check all of the patient's one stop medicines and PODs against the discharge prescription and dispense items as required from the pharmacy computer on wheels or order from the dispensary.

The peripatetic clinical pharmacy team will endeavour where possible to complete the process on the ward using the pharmacy computer on wheels (COWs). However where applicable, and necessary the TTO section of the prescription chart will be torn off by the pharmacist and sent to the pharmacy for dispensing. This ensures that the prescription chart itself does not have to leave the ward and so medicines can continue to be administered to the patients reducing missed doses. The torn off TTO section of the prescription must be reconciled with the inpatient prescription chart and filed in the patients medical notes once the returned TTO has been checked as correct.

For any discharge prescriptions that have **not** been checked by a pharmacist on the ward, the in-patient prescription must accompany the discharge prescription to the dispensary so that any transcription errors can be identified, clarified, and amended where appropriate. Where possible appropriately trained nursing (reference training) staff should check PODs and appropriate endorse the TTO prescription if this is not possible all PODS should be sent to the dispensary with the prescription.

The prescribed TTO should be checked against the inpatient prescription and discrepancies resolved before sending to the pharmacy dispensary.

Ensure that all demographic and patient information is completed on the front of the prescription chart and ensure the date and time of discharge is written on the TTO section of the prescription. It is the prescriber's responsibility to ensure that any clinically significant amendment(s) to the discharge prescription are amended accordingly on the e-discharge letter, should this have been completed.

Special prescription writing requirements exist for the writing of discharge prescriptions for **controlled drugs**. Stringent legal requirements apply. It is illegal for a pharmacist to dispense a prescription for a controlled drug which does not meet the legal requirements.

If in doubt, see the relevant sections of the British National Formulary, contact Pharmacy staff for advice, or refer to Trust policy MM06: *Policy for the Prescribing, Storage, Supply and Administration of Controlled Drugs.*

Venalinks/monitored dosage system (MDS)

These systems take a huge amount of pharmacy resource and time to complete. Careful consideration should be given to the appropriateness of these devices for the on going benefit of patients. They should not be ordered for patients discharged to nursing homes and if patients are discharged home – plans should be in place for the re-order of the MDS in community before the patient is discharged.

Consideration should also be given to the number of medicines which cannot be put into such a devices – for example dispersible tablets or tablets with special storage requirements, liquids, when required medicines cannot be put into these devices. Inhalers, eye drops, ointments etc. cannot be put in to such devices. If the patient requires any of these medicines then a venalink is probably not appropriate for the patient.

All discharge prescriptions requiring further dispensing should be sent to the pharmacy within normal opening hours (see intranet document) and ideally the day before discharge, to allow for any specific problems to be dealt with. In any event, time should be allowed for dispensing of the prescription and for the completed prescription to be delivered back to the ward before the patient's transport is due. Ward staff should be aware of the limited Pharmacy opening hours during the weekends and bank

holidays. The progress of discharge prescriptions through the dispensary can be tracked using the prescription tracker system available via the WIS boards /Trust Intranet site.

Out of Hours Discharge

Supply of medicines for TTOs for routine discharges out-of-hours is not a normal duty of the emergency duty on-call pharmacist. The emergency duty pharmacist is not based on site and only in exceptional circumstances, such as when drugs are required for patients going through the fast track palliative care service, should the emergency duty pharmacist be called for the dispensing of discharge prescriptions.

For planned and routine discharges TTOs should be ordered during Pharmacy opening hours. If a routine discharge occurs out-of-hours and medicines have not been ordered in advance the following options may be considered:

1. Patient's own medicines/one stop dispensing – these medicines can be used provided the nurses follow the procedure for checking PODs listed under OSD Procedure Out of Hours in the document One Stop Dispensing, Registered Nurse Training and Competency Pack. This can be found on trust intranet – Clinicians/Support Services/Pharmacy/Medicines Management
2. Use of pre-labelled TTO packs. Certain units and wards for example A&E, AMU and SAU have access to their own limited stock of TTO medicines. These are pre-packed and pre-labelled by the Pharmacy Department and can be issued to a patient against a prescription by two registered nurses. In addition a limited number of pre-labelled TTOs can be accessed in the Emergency Drugs cupboard by the Nurse Practitioner and Clinical Site Manager. A list of available medications can be seen on the Trust intranet (Clinical Section – Divisional Sites – Pharmacy Services – Out of Hours – Emergency Drug Room Stock). Staff should check the availability of any medication before contacting the Nurse Practitioner/Clinical Site Manager to request supply.
3. Use of FP10HP prescriptions (available from SAU/AMU). For those patients who do not pay prescription charges it may be possible to issue a FP10HP so that the items can be collected form a community pharmacy convenient to the patient/relatives. Please note FY1 doctors may not prescribe on FP10HP prescriptions.
4. If the patient does not require any doses of the medicines before the next day, ask relatives to come back the next day when Pharmacy is open if possible. Medications should **not** be sent to follow the patient's discharge in a taxi.

Receipt on Ward - On receipt of the dispensed TTO, Nursing staff should check the patients name is correct on the outer bag, the pharmacy notified immediately of any discrepancies.

TTO medication not given immediately to the patient must be securely stored in the patient bedside locker or if too large in a designated locked cupboard in the Clinic room until it is issued for discharge. **NB** any controlled drugs within the TTO medication must be stored in the ward Controlled Drugs cupboard, and records made in line with Trust policy MM06: *Policy for the Prescribing, Storage, Supply and Administration of Controlled Drugs*

Issue to patient

At a suitable time prior to discharge, a registered nurse should:-

- Check the discharge medicines against both the discharge prescription and the in- patient prescription chart to ensure that the dispensed discharge medicines are still required, correct, and that no alterations (additions or deletions) to either the in-patient prescription or discharge summary have occurred in the intervening period. Check that all items on the TTO are collated together for the patient e.g. CDs, fridge items. Also remember to include medicines such as inhalers; eye drops etc, which have previously been supplied to the ward, appropriately labelled.

- Check the expiry dates of medicines such as reconstituted antibiotic mixtures, preparations made by the pharmacy manufacturing department, eye drops and ear drops.
- Ensure no medicines are given to patients that are labelled with a “Hospital Use Only” sticker.
- Ensure that the patient and/or carer, as appropriate, understand the correct use of their medication.
- Review any written information supplied by the pharmacy with the medication. This should be discussed with the patient and/or carer before being given to them. Patient information booklets supporting the safe use of oral anticoagulants and oral methotrexate should be updated by the prescriber to reflect any changes in dosage made during the in-patient stay. Where additional patient counselling is appropriate, it may be possible to arrange this with a ward pharmacy technician or the pharmacy department.
- Ensure any Nutritional feeds or dressings required which are provided from the ward are given to the patient

E-discharge Letter

It is the prescriber’s responsibility to ensure that any clinically significant amendment(s) to the discharge prescription are amended accordingly on the e-discharge letter, should this have been completed.

MEDICATION TO TAKE HOME (TTO)

APPENDIX G (iii)

Does the patient need continued treatment with medicines at home?

YES

24/48 hrs. (Depending on stability of Patient's Medicines). Prior to EDD, prescriber to write discharge prescription (consider at this point if a modified dosage system is required – ensure this is discussed with Clinical Pharmacy team)

NO

Follow Discharge Process recording that no medicines are required

Is your Peripatetic Clinical Pharmacy team due to visit the ward? Check Referral Form.

YES

Refer Discharge prescription to your Clinical Pharmacy Team.

The prescription will be clinically screen by a Pharmacist. TTO's will be dispensed on the ward wherever possible or if necessary TTO will be detached and sent to dispensary (necessary for example if CD or Venalink)

TTO available for patient.
Once TTO received on ward TTO should be checked against the prescription by a member of nursing staff.

All medicine should be stored in POD lockers with exception of CDs which should be stored in CD cupboard (See MM06)

Before patient leaves check patient understands all instructions regarding medication.

NO

Is there an appropriately trained nurse on the ward to check PODs?

YES

Suitably trained nurse should check all of the patient's 'one stop' and 'POD' medication – endorse the TTO prescription – "POD OK signed and dated". Keep appropriately check medicines on ward – check demographic information is complete on the prescription .Send whole prescription to dispensary for dispensing

NO

Whole prescription (ensure all demographic information is complete) together with all PODs to be sent to the dispensary

PROUD TO CARE | A NEW KIND OF TRUST | **DISCHARGE CHECKLIST** V7 Mar 2017 | FINAL | University Hospitals of North Midlands NHS Trust

Patient's Name:		Unit Number:	
Admission Date:		EDD:		Patient informed of EDD (tick): ☐

Date Commenced		Time	

ON ADMISSION	YES	N/A	
'Planning Your Discharge' leaflet given	☐	☐	
Simple Timely	☐	☐	
Complex	☐	☐	

PLANNING FOR DISCHARGE	YES	N/A	
Expected Destination on discharge	....		
DNAR completed	☐	☐	
DMH referral completed	☐	☐	
Patient & family/carers informed of discharge arrangements	☐		
Warfarin prescribed / Appt arranged	☐	☐	
Follow up appointment made	☐	☐	
Discharged by therapies – PT/OT	☐	☐	☐ On-going Comm. Therapy
Equipment insitu	☐	☐	
Bed/Mattress in place Please specify	☐	☐	
TTOs Prescribed	☐	☐	
Palliative TTOs Prescribed	☐	☐	
Palliative Prescription Chart	☐	☐	
Pharmacist check when available	☐	☐	
Blister Pack Requested State reason required	☐	☐	
POD Medication checked	☐	☐	
If complex, TOC initiated	☐	☐	

DAY BEFORE EDD	YES	N/A	
District Nurse referral completed	☐	☐	
Transport booked	☐	☐	☐ Disch Lounge
Medicines required for TTO ordered	☐	☐	
Dispensed medicines returned to Ward	☐	☐	

ON DAY OF DISCHARGE	YES	N/A	
Cannula removed (1st check by RN, 2nd check by RN or NA)	☐	☐	2nd check initials:......
Clothing/Appearance appropriate for discharge	☐	☐	
DNAR to crew	☐	☐	
Friends & Family Survey completed	☐		
POD locker emptied	☐	☐	
TTOs discussed with patient	☐	☐	☐ to be completed in Disch Lounge
TTOs checked when given to patient by two members of staff, one must be a registered nurse	☐	☐	☐ checked in the Discharge Lounge
If complex, TOC submitted to Track & Triage Team	☐	☐	

FINAL SIGNOFF	
Date Completed	
Print Name	
Signature	

APPENDIX H

APPENDIX I

UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE

PATIENT TAKING OWN DISCHARGE

I, ……………………………………………………………….. of ....

…………………………………………………………………………………………

hereby declare that I wish to be discharged immediately from the ……………….. Hospital, and affirm that I have made the decision now to leave the Hospital freely and of my own volition, fully realising that it is contrary to the medical advice which I have received.

I hereby agree that the …………………………..Hospital, responsible for its officers, servants and agents is wholly absolved and discharged from any responsibility or liability of any description whatsoever arising directly or indirectly out of my taking my own discharge from the Hospital.

DATED this …….………………... day of ……………..………………… 20 …..

(Signature of patient) ……………………………………………………….

Witness (Signature) ………………………………………………………………

Address ………………………………………………………………………………

…………………………………………………………………………………………

…………………………………………………………………………………………

Interpreter Required   Yes/No

Name:……………………………………………. Telephone:……………………..

APPENDIX J

PATIENTS REQUIRING SUPPORT IN THE COMMUNITY

Individuals requiring support in the community should not be discharged except when the safety of the patient can be assured, discussion has taken place and arrangements made with:-

- The patient's General Practitioner (Where a patient has no registered GP, it is their responsibility to register. This can be done by contacting Heron House on 0300 7900 231).-
- The patient
  - His/her carers/relatives/friends
  - Social Care personnel
  - Community Nursing Services (as appropriate)
- Sheltered and supported housing wardens (as appropriate)

The manner of a patient's discharge back into the community from hospital should not compromise his/her physical, mental or social wellbeing or that of those within his/her community environment and should be relevant to the patient's cultural context. If, however, a patient is informed of a physical, mental or social risk and having assessed the risk chooses to go home, it should be documented in the medical and nursing notes. For patients taking their own discharge, the Patient Taking Own Discharge form (Appendix i) should be completed. For patients who lack capacity to make such a decision, reference should be made to the following section.

Patients Requiring Special Care for Discharge Planning
Special care must be taken in planning the discharge of the following categories of patients who may have additional needs;

- Those requiring a Community Care Assessment
- People who are living alone (including those living in sheltered housing or other warden-assisted accommodation).
- Vulnerable Adults, refer to Trust policy C36: *Protection of Vulnerable Adults from Abuse*
- Older people who have mental health needs.
- Young persons (16-21 years) with special needs.
- People with chronic, serious or terminal illness, sensory impairment or with continuing disability.
- Patients who have been assessed as lacking capacity
- Patients suffering from a mental illness (Provisions of The Mental Health Act 1983 ((amended 2008) also apply) or dementia.
- People with learning disabilities.
- Those who may need environmental control equipment, e.g. possum.
- People who are at significant risk of falls.
- People who have been in hospital for an extended stay.
- In reference to the Acheson Report 1998, and the 10 year review of policy 2009, people from 'disadvantaged' groups of society require additional support (e.g. minority ethnic communities will require cultural/religious/language needs to be assessed.)
- People who are homeless – care must be taken to try and ensure, as far as is possible, that patients are not discharged without a safe home to go to. Outreach Services to support homeless people can be contacted via the Integrated Community Assessment Bureau (ICAB). If they insist on leaving the hospital without support, and they have capacity to make that decision, then provide contact number/address of voluntary sector support services and advise the patients next of kin if appropriate to do so. A Patient Taking Own Discharge form should be completed (Appendix I).
- People who have been admitted to UHNS whilst away from their normal area of residence.
- People who require end-of-life care.
- Bariatric patients, who may require specific transport arrangements which may require careful planning

All professionals are required to work together to ensure that assessments and care planning are fully coordinated into a single process. In order for discharge to be successful it needs to be well timed and supported by good communication, and all appropriate avenues of care must be considered to ensure the patient's continuing health or social care needs are met. Discharge planning should always consider the medium and long term outcomes for the patient, in consultation with the patient's family/carers/friends as appropriate.

To comply with legal requirements, patients admitted for treatment who are detained under a Section of the Mental Health Act 1983 **must not** be discharged from UHNS unless guidance has been sought from the Clinical Site Manager (contactable via bleep 479).

Patients who are subject to Section 47 of the National Assistance Act 1948 must not be discharged or transferred unless this is with the agreement of Social Care or the Community Physician.

Patients who are under an Adult Protection investigation should not be discharged to the place where the alleged abuse occurred, without first contacting the investigating Social Worker. A risk assessment will be undertaken by the Social Worker, and a plan for discharge can then be made. Patients may be discharged to the same address, or to an appropriate alternative location, following the advice of the Social Worker

Consent - Adults who are not competent/lack capacity to give consent or make specific decisions

The Department of Health 'Good Practice in Consent Implementation Guide' clearly states that: - 'Best interests go wider than best medical interests'. The Mental Capacity Act 2005 states – Capacity should be assumed unless assessed as otherwise.

It is important to highlight that no-one can give or withhold consent on behalf of another adult. In relation to discharge the hospital policy on consent (policy C43: Policy and Procedure for Obtaining Consent (Inc. the Application of the MCA 2005) should be consulted. Staff must check if a Lasting Power of Attorney for Health/Welfare or Property has been registered and, if in place, involve them in the discharge plan and decision making process.

People close to the patient (i.e. relatives, carers and friends) views and experiences should be sought and a record made of the discussions and decisions. Ultimately, admission and discharge, as with treatment, should be reviewed in line with 'Best Interest' for adults who are not competent or lack capacity. If a patient lacks capacity there should be clear evidence in the patient's record of assessment being undertaken in line with the process laid out in the Mental Capacity Act 2005. An Independent Mental Capacity Advocate must be instructed if a decision must be made regarding; the provision, withdrawal, or withholding of serious medical treatment; long term NHS or Local Authority accommodation is being proposed, and the patient has been assessed as lacking capacity to make that decision, and they have no-one else who it is appropriate to consult. The IMCA will ascertain all relevant factors that will be needed in making the 'Best Interest' decision for the individual. For advice and support with matters relating to the MCA 2005, contact should be made in-hours with the Matron, and out-of-hours with the Site Manager.

Urgent Psychiatric Assessment

When urgent psychiatric assessment is deemed necessary, this must take place prior to discharge. The Doctor should refer to the on-call Psychiatrist (contactable via switchboard) this may be particularly relevant for those patients attending the emergency department. For those patients presenting with deliberate self-harm/intentional overdose, an assessment protocol is used. In the case of a low risk score this will trigger an out-patient follow up and, providing risk assessment is satisfactory, discharge can progress. If these patients are admitted to a ward environment for on-going care, referral should be made to the Crisis Management team before 10.00Hrs on the EDD to ensure a visit can be arranged on the same day. These patients will need to be 'fit for discharge' from a medical management perspective, before they will be seen.

For patients over the age of 65, the Trust is able to contact the Psychiatric Liaison Nurse for Older Persons Mental Health, where an in-patient assessment is required prior to discharge. Contact on Ext. 3546, or by fax to ICAB using the Referral Form **(Appendix M)**

Patient Taking their Own Discharge

Referral to Community Nursing Services and Social Care should be made in the usual way and discharge documentation completed. An independent interpreter should be contacted if appropriate.
When patients wish to discharge themselves against medical advice, the role and responsibilities of the designated Registered Nurse are to:-

- Consult the doctor responsible for the patient's care, involve them in the patient's discharge and ensure that all actions are documented in both the medical and nursing records.
- Ensure the patient is supplied with medication, as long as the patient is prepared to wait for it to be dispensed from pharmacy.
- Ensure that the Patient Taking Own Discharge form (Appendix I) is signed by the patient and witnessed; one copy should be secured in the patient's medical notes and the second copy given to the patient.
- In the event of the patient refusing to sign the self-discharge form, ensure that a dated and timed note is made in both the nursing and medical records.
- Ensure that the patient's General Practitioner is informed by telephone. If out of hours or weekend contact the General Practitioner at the earliest opportunity. If concerned contact the Community Nursing service as below.
- The e-discharge letter should be completed within 24 Hrs of the patient's discharge so that the General Practitioner receives confirmation of any on-going care needs.
- Contact the Community Midwifery Office (in-hours) for women requiring antenatal or postnatal care, or the coordinator at the MBC (out-of-hours).
- Where there is concern regarding a patient's safety, or that of other members of the community, involve outside agencies immediately. Social Care, Community Nursing Services and the Police should be notified as appropriate. Such patients may be classified as at risk by the above agencies requiring immediate action.
- With the patient's permission, contact relatives or friends.

Direction on Choice of Accommodation

Should a patient's first choice of accommodation be unavailable, and a delay in discharge is envisaged, then the patient/carer must be advised of the need to consider an interim placement whilst waiting for a vacancy in the home of choice. This process has been outlined by DoH guidance 'Direction on Choice of Accommodation', and locally agreed letters are available).

Patients refusing to leave the Trust

For patients who refuse discharge due to choice of future accommodation, where it has been determined that they have specific social or health needs, there is a process laid down in the DoH guidance 'Direction on Choice of Accommodation', and locally agreed letters are available. In the first instance, nursing staff should contact their Matron for advice and guidance.
For patients who are deemed not to require on-going acute medical care, and are refusing to take up offers of community placement, an initial discussion should take place between the nurse in charge of the ward and the patient to determine the reason why this is so. Where the patient's continuing needs can be met in a community location, and acute care has ended, this needs to be explained clearly to the patient and their relatives. If the patient or relatives continue to refuse discharge, then this should be escalated to the Matron, Directorate Manager and, ultimately, to the Divisional Associate Director.

Liaison with District Nursing, Social Care and Support Agencies

When discharging a patient home, liaise with the patient/carers and any appropriate agencies to ensure that arrangements are in place for safe discharge. Nurses should reinstate services that have been suspended during the patient's admission by contacting the duty Social Worker at the appropriate Social Care department

Patients requiring input from Community Nursing Services must only be discharged out-of-hours when contact has been made with the out-of-hours District Nursing Service on 01782 425256. For patients living outside North Staffordshire please refer to the District Nurse Service folder on your ward for contact numbers. Note some of these numbers are for use Monday-Friday only and messages should not be left on answer-phones as potentially the message will not be picked up until after the first visit is due.

If it is not possible to ensure that the above arrangements have been made, a delay in discharge may need to be considered. Advice and support can be obtained from the Matron in-hours (contactable on pager via switchboard), or from the Clinical Site Manager (contactable on Bleep 479) out-of-hours.

NB patients transferring to some community care facilities must arrive before certain times of the day, as there is only limited access to medical/senior nursing cover. ICAB will advise of any restrictions in place when arrangements are made for a patient to be discharged to one of these destinations.

Discharge Medication

Where discharge medication is required, it is essential that the discharging doctor, nurse and pharmacist check no changes have occurred between dispensing and actual *discharge*. Information to the General Practitioner must include the reason for any changes in medication. Assessment for compliance should also be made. Patients transferred to NHS community hospitals will need to be supplied with standard TTO packs; those transferring to Social care placements or NHS funded nursing home assessment beds may require specialist pre-pack arrangements. Once ICAB have confirmed the discharge destination they will advise of these requirements. Pharmacy must be notified a minimum of 24Hrs in advance where blister packs are required. See Appendix G for further information.

Health Records

It is the Ward Sister/Charge Nurse's responsibility to ensure that accurate information is entered on to the EPR system; however this duty can be delegated to other staff.

The Ward Sister/Charge Nurse or delegated responsible person should record on all discharge documentation, the patient's ethnicity and language requirements, and indicate if an interpreter is required.

- Enter the date and time of discharge and the discharge method accurately onto EPR.
- Ensure that any outstanding results of investigations, and any letters and medical and nursing notes are filed correctly in the patient's health record, and that the record is transferred without delay to the appropriate medical secretary or department. All health records should be tracked accurately on the Electronic Case-note tracking system. Reference should be made to Trust policy Re01: *Multidisciplinary Health Records Policy*
- It is the discharging ward staff's responsibility to forward any outstanding written results to the medical secretary for the Doctors attention

General Documentation to be Completed

- For patients who require District Nursing input, the Nurse to Nurse communication form (Appendix K) needs to be completed.
- For patients returning to the community who are susceptible to tissue damage, or who have pre-existing pressure damage, a Pressure Ulcer Communication form should be completed. (Available within the North Staffordshire Pressure Guidelines via Trust intranet: Clinical Section - Clinical Guidelines - Tissue Viability Guidelines).
- Patients being discharged to a residential or nursing home should have a copy of the discharge letter sent with them to the home on discharge.
- Patients who have attended Accident & Emergency, and have not been admitted but require on-going care, or who have received treatment, should have a letter generated via EPR/ e-discharge. This will be forwarded to their GP, either electronically or printed centrally and posted out.

APPENDIX K

NURSE TO NURSE COMMUNICATION FORM

TO: COMMUNITY NURSING SERVICE / INTER HOSPITAL TRANSFER / CARE HOME

PART ONE *(Must be completed)*

From: COMMUNITY HOSPITAL …………………………… Ward/Dept. ……………………………………Tele No…………...

Consultant ……………………..………… Name of Nurse completing form…………….…………………Date……………….

IENT'S NAME …………………………………………… RESS ………………………………………..……… …………………………………………………………… .B……………….…... PHONE ………………………… CHARGE ADDRESS …………………………………… fferent) …………………………………………………	G.P. …………………... PRACTICE ………………………. DATES OF ADMISSION:…………………………………………… OPERATION …………………………………………… DISCHARGE/TRANSFER ……………………………… DISTRICT NURSE FIRST VISIT ……………………
T OF KIN ……………………………………………… …………………………………………………………… ……………………………………………………………	Have relatives been notified of discharge/ transfer YES / NO — Is diagnosis and prognosis known to:- PATIENT/RELATIVE/BOTH
Diagnosis and Reason for Admission	Interpreter/ language required Yes/No Contact Details Name:…………………………..Tel No…………
RSING TREATMENT RECEIVED/REQURIED ne of District Nurse Contacted………………………………	MEDICATION KNOWN ALLERGIES
e of Pressure Areas and Treatment	N.B Please ensure patient takes home a minimum supply of Dressings, Lotions and Medication to last until a Prescription can be obtained
ent lives with	Help Available

RT TWO To be completed for all Elderly and High Dependence patients. PLEASE TICK BOX.

PENDENCY	MOBILITY	SPEECH	CONTINENCE	WALKING AIDS
ependent ☐	Fully Mobile ☐	Good ☐	Continent ☐	Stick ☐
equires help to:	Or requires help to:	Impaired ☐	Incontinent ☐	Crutches ☐
			Urine ☐	Elbow crutches ☐
			Faeces ☐	Tripod ☐
sh ☐	Stand ☐	SIGHT	Stoma ☐	Zimmer Frame ☐
ss ☐	Walk ☐	Good ☐	Catheterised ☐	
d ☐	Sit ☐	Partial ☐	Size ☐	NURSING AIDS
et ☐		Blind ☐	Date inserted ☐	Bedpan ☐
			MENTAL STATE	Urinal ☐
	Transfer: ☐	HEARING	Alert ☐	Commode ☐
TIVATION	Into bed ☐	Good ☐	Sensible ☐	Other: ☐
od ☐	Out of bed ☐	Poor ☐	Confused at times ☐	DIET (please specify)
r ☐	Chair fast ☐	Deaf ☐	Confused ☐	
eds encouraging ☐	Bed fast ☐		Disorientated	

RT THREE (Tick Please) HER SERVICES NOTIFIED/INVOLVED	HOSPITAL AFTER CARE	ANY COMMENTS
lth Visitor ☐	O.P.D. ☐	
ial Worker ☐	Relief Scheme ☐	District Nurse Contacted
ne Help ☐	OCC Therapy ☐	Name:…………………………………….Date:……………
als on Wheels ☐	Physio ☐	
.N.'s ☐	Speech Therapy ☐	
er ☐	Day Hospital ☐	
	Hospital ☐	
	Days attending ☐	

FOUR (Inter Hospital Transfer Only) he patient got money or valuables in the Hospital Finance Department YES/NO ture of Nurse	For Community Use Only Referred to:

Staffordshire and Stoke on Trent Partnership NHS Trust

APPENDIX L

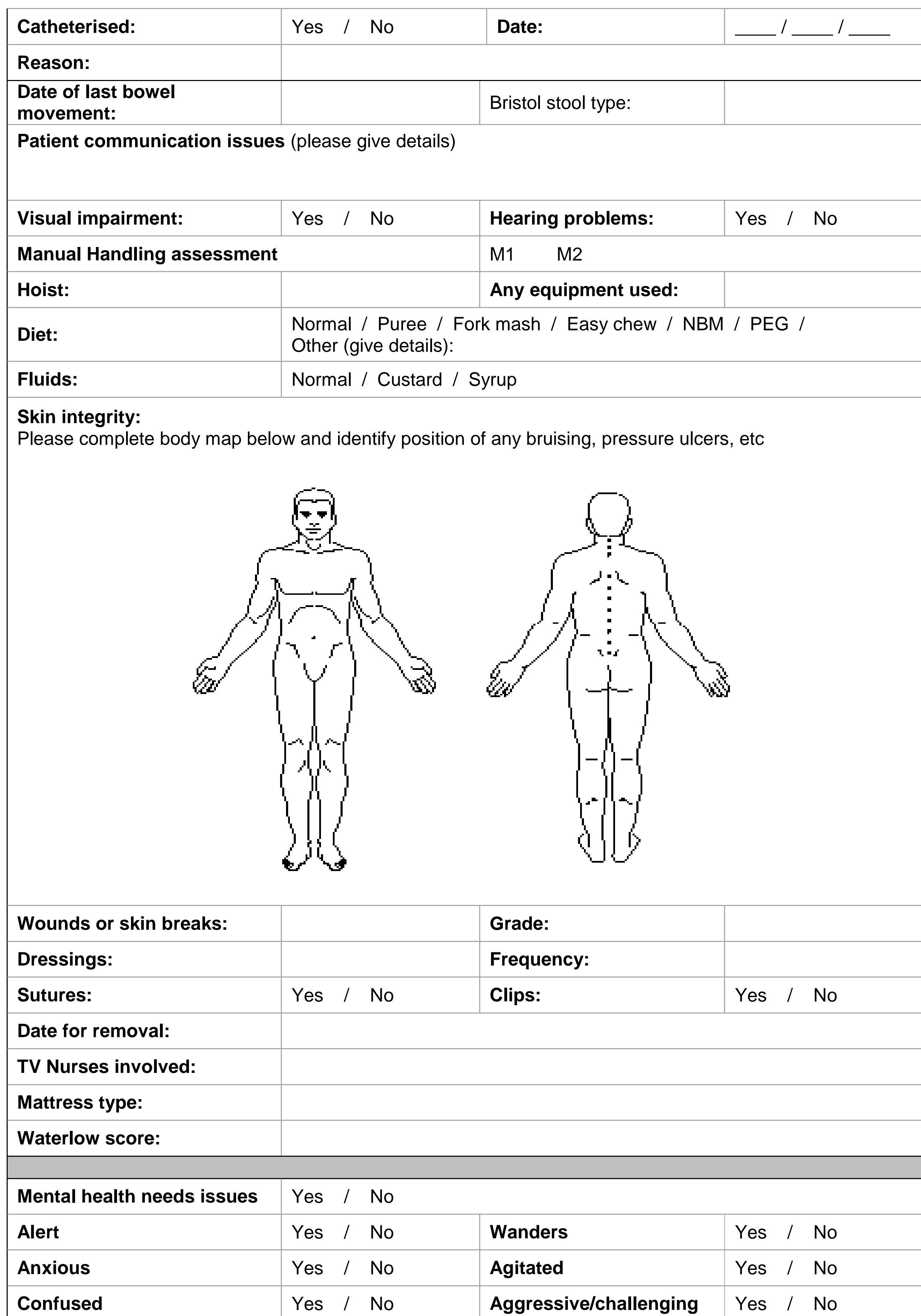
Name of person completing form:			
Receiving Ward:		**Transferring Ward:**	
Name of nurse providing information:			
Patient Name:		**Unit No.:**	
		NHS Number:	
		Date of birth:	
Patient Informed:	Yes / No	**Family informed:**	Yes / No
		Name/ Relationship:	
Are patient and family aware of reason for transfer:		Yes / No	
Please document reason given for transfer (i.e. Rehabilitation)			
DNAR			
Consultant signed:		**Date reviewed:**	
Patient Informed:	Yes / No	**Family informed:**	Yes / No
		Name/ Relationship:	

Falls:	Yes / No	**Multiple Falls:**	Yes / No	**Injury:**	Yes / No
If yes, details of injury sustained:					

Warfarin/Dalteparin:	Yes / No	**Reason:**
INR:		

Infection Control Information		
MRSA screen date:	____ / ____ / ____	
Result:	Negative / Positive	Nasal / Perineum / Wound / CSU / Sputum
Treated:	Once / Twice	
C DIFF date:	____ / ____ / ____	
Result:	Negative / Positive	
Has the need for a side room been discussed with IPCNs if appropriate?		Yes / No
Name of IC Lead:		
Have any infections been tagged ESBL or other? (please give details)		

Cannula in situ:	Yes / No	**Insertion Date:**	____ / ____ / ____
		Current VIP score:	



Catheterised:	Yes / No	**Date:**	____ / ____ / ____
Reason:			
Date of last bowel movement:		Bristol stool type:	
Patient communication issues (please give details)			
Visual impairment:	Yes / No	**Hearing problems:**	Yes / No
Manual Handling assessment		M1 M2	
Hoist:		**Any equipment used:**	
Diet:	Normal / Puree / Fork mash / Easy chew / NBM / PEG / Other (give details):		
Fluids:	Normal / Custard / Syrup		
Skin integrity: Please complete body map below and identify position of any bruising, pressure ulcers, etc			
Wounds or skin breaks:		**Grade:**	
Dressings:		**Frequency:**	
Sutures:	Yes / No	**Clips:**	Yes / No
Date for removal:			
TV Nurses involved:			
Mattress type:			
Waterlow score:			
Mental health needs issues	Yes / No		
Alert	Yes / No	**Wanders**	Yes / No
Anxious	Yes / No	**Agitated**	Yes / No
Confused	Yes / No	**Aggressive/challenging**	Yes / No

Any other relevant information (please give details):			
Known to Social Services:	Yes / No		
Name of Social Worker:			
Previous care:			
Living arrangements:	Alone or with (give details)		
Future plan/goals:			
Patient accepted:	Yes / No		
If no please give reason why			
Before Transfer			
TTO's:		**All medical notes:**	
CD/X-rays:		**DNAR form if applicable:**	Yes / No
Prescription chart (must be valid to Monday if transferred over weekend):			
Additional information:			
Qualified nurse providing information:		**Nurse accepting patient:**	
Date:	____ / ____ / ____	**Date:**	____ / ____ / ____

APPENDIX M

RAID referral form for UHNS inpatient wards

Please complete ALL sections. Incomplete forms will be sent back to the referrer

Is the patient aware of the referral? Yes/No (If no state reason)
What is the ACUTE psychiatric need?
Reason for admission to hospital: (Include relevant past medical history)
Were they transferred to you from a Harplands ward? If so which ward?
Current medications:
Has this patient been involved with psychiatric services before? (If they know a team/consultant please mention this)
Is the patient currently medically fit for discharge?
What intervention would you like from the RAID team? (E.g. mental state review, medication advice?)
Thank you for taking the time to complete this referral form. Should any further information be needed then you will be contacted by a member of the RAID team.

raid.referral@northstaffs.nhs.uk