Yeovil District Hospital NHS
NHS Foundation Trust

DISCHARGE POLICY

Version Number	2	Version Date	25 November 2018
Policy Owner	Director of Nursing		
Author	Associate Director Of Urgent Care and Patient Flow		
First approval or date last reviewed	October 2009		
Staff/Groups Consulted	Clinical Directors Heads of Department Associate Director of Nursing Matrons Ward Sisters Health and Social Care Team Discharge Facilitator Trust Risk Manager Safeguarding Clinical Lead Acute Learning Disability Liaison Nurse		
Draft agreed by Policy Owner			
Discussed by Policy Group	November 2018		
Approved by [Committee Name]	Yes		
Next Review Due [6 month prior to expiry date]	April 2020		
Policy Expiry Date	October 2020		
Policy Audited	2009		
Equality Impact Assessment Completed	Yes		

CONTENTS

1. BACKGROUND

1.1 In all hospitals today, there is a drive to reduce both length of stay and delays in transfer and discharge. This requires a close working partnership with other organisations, including primary care, hospital services, Social Services, Mental Health Services, Mental Health Services, Intermediate Care Services, Voluntary Services and the independent sector to deliver improved outcomes for patients.

1.2 The purpose of a properly planned discharge is to ensure that the patient can function appropriately and safely in their home immediately after discharge with no or minimal deterioration in their quality of life. This includes making appropriate alternative arrangements should the patient be unable to return home, requires additional support at home or end of life care.

1.3 Communication and consultation with the patient, their family and careers are of prime importance in ensuring the patient experiences care as a coherent and coordinated.

1.4 The process of assessment and decision making should be patient-centered, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process. Where consent of an adult cannot be obtained then decisions about their personal welfare, which includes discharge planning, should be determined in accordance with the Mental Health Capacity Act 2005 and the accompanying Code of Practice. This act is designed to protect the rights of individuals and empower people.

2. AIM/PURPOSE

2.1 Discharge planning is a multi-agency, multi-professional activity in which all professions have a contribution to make. Multi-professional involvement prior to, or as soon as possible after admission, is the key to successful discharge planning.

2.2 All staff should make every effort to ensure the patient is supported to make as many decisions as possible for themselves and to involve them in discharge planning.

2.3 Early referrals for assessment, pre-admission where practical, or immediately on admission, are essential. Continuing support and information for the patient's family and carers, with due regard to their rights to confidentiality and privacy, is of prime importance.

2.4 For patients with long term care or those requiring end of life care, identification of a suitable place for discharge that meets the expectations of the patient and their carers.

3. PATIENT/CLIENT GROUPS

3.1 All patients will be assessed for discharge in terms of health, functional and social care needs, at or before admission, and these needs will be regularly reviewed during the patients stay in hospital. This should include an assessment of the patient's mental capacity to make decisions about their personal welfare which includes decisions relating to discharge planning, their ability to be involved in the process and what may be needed to support them to be fully involved in the process.

3.2 This policy covers all inpatients being discharged from YEOVIL DISTRICT HOSPITAL NHS Foundation Trust as set out in the following groups:

3.3 Simple Discharges

Most patients will not require additional ongoing support from health or social services following discharge and so will follow a simple discharge pathway as set out in this policy.

- Inpatient discharges requiring no additional health or social services support

- Patients discharged from the Emergency Department

3.4 Complex Discharges

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

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

3.5 Exceptions/ Contraindications

There are no exceptions to this policy

4. CLINICAL MANAGEMENT

Staff Responsibilities

4.1 All staff

- All staff are responsible for ensuring that the discharge plan in the patient record documents the individual members of the multi-professional team involved in care, dates of referrals, actions to be taken and set agreed discharge criteria. The plan is a record of communication between the patient, family, carers and multi-professional team.

- All staff are responsible for keeping the patient and family or friends (if applicable) informed of the proposed length of hospital stay, and where possible, 24 hours' notice of the actual date of discharge will be given to the patient and carers where appropriate in order to allow preparatory arrangements to be made. The multi-disciplinary team works collaboratively with the patient and their carers to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharge.

- Each ward will hold a "board round" each weekday where nursing and medical staff, allied health professionals and social workers have a responsibility for attending. This meeting compliments the discharge planning process, discussing each patient and focuses on improved communication, timely decision making and reducing delays and barriers to discharge.

- Patients requiring Homefirst support on discharge will be discussed further at 11.00 each weekday at the Homefirst review meeting and allocated discharge dates/slots will be given to the therapy team presenting

4.2 Medical Staff

- The Consultant, or his/her nominated deputy, is responsible for deciding and documenting when a patient is medically fit for discharge and for setting criteria that allows the patient to be discharged by a non-consultant to avoid unnecessary delay.

- Medical staff are responsible for completing the multi-professional discharge summary and prescription, which will accompany the patient on discharge and will be faxed directly to the GP within 24 hours of discharge. (The Trust is in the process of trialling an electronic discharge summary).

4.3 Nursing

- The nurse in charge of each ward is responsible for the overall co-ordination of effective discharge planning. The Registered Nurse is accountable for co-ordinating the discharge plan for each patient they are responsible for on a shift by shift basis (The Registered Nurse is referred to as the nurse throughout this policy).

- The nurse is responsible for assessing the patient's health and social care needs at pre-admission clinic, on admission or within 24 hours of admission and must complete the admission assessment document identifying the discharge needs for that patient.

- All patients must have a discharge date set and documented within 24 hours of admission. This date should appear on TrakCare and the white boards

- The Registered Nurse is responsible along with the ward pharmacist for ensuring that the prescription is dispensed prior to discharge and that the medications are explained to the patient.

- The nurse in charge of the shift is responsible for ensuring that the Hospital Site Sister/Charge Nurse is informed of all actual and potential discharges for that day. Where possible and if appropriate the Discharge Lounge staff will be informed of the discharge and will arrange to collect patients from the ward as soon as possible.

4.4 Therapists

- The Physiotherapist will assess, if required, the patient's mobility and ensure that the patient receives equipment aids and that the patient and carers are safe and competent to use them.

- The Occupational Therapist will assess, if required, the patient's functional ability, and ensure that the patient receives equipment aids and that the patient and carers are safe and competent to use them. This may include undertaking when appropriate visits to the patient's own home.

- Therapists and Allied Health Professionals who have been involved in the patient's care whilst an inpatient must document in the patient record all interventions and planning that they have undertaken in relation to discharge, including the provision and ordering of aids and equipment.

4.5 Discharge Facilitators

Discharge Facilitator will assist the ward staff in preparing the patient for discharge – they may be required to make appropriate telephone calls, book transport or pack up the patient for transfer to the Discharge Lounge. They will be responsible for listing patients for community hospitals, and identifying any delays in the system and escalate accordingly

5. METHOD/PROCEDURES – DISCHARGE REQUIREMENTS & DOCUMENTATION

5.1 All Patients

All patients as a minimum should have the following steps and documentation completed. For the majority of patients who constitute a "simple" discharge this will be all that is required. The Discharge checklist (appendix 2) should be completed for all patients.

5.2 Assessment

The nurse will assess the patient's health and social care needs either at preadmission clinic, on admission or within 24 hours of admission. This involves early communication with all members of the multi-professional team in the hospital and the community, and with the patient, family and carers. The nurse must complete the admission assessment of discharge needs for all patients. This should be handed over between wards when patients are being transferred within the Hospital.

5.3 Day of Discharge

On the agreed day of discharge the nurse in charge of the ward is responsible for executing the discharge and ensuring the following information accompanies the patient on discharge along with any documentation required for speciality: From inpatient areas the patient will, wherever possible, be transferred to the discharge lounge while awaiting discharge and where not appropriate will be agreed by the ward Matron

- Nursing discharge / transfer communication both documented in the medical/nursing notes and verbally communicated by phone should take place by the discharging ward when patients are going to other healthcare environments.
- Doctors discharge summaries and TTOs should be handed to patients at the time of discharge, the take home medicines must be explained by clinical staff, this process can take place in the Discharge Lounge if necessary .There should be copy for the patient and the patient's GP with one copy filed in the health record. The letter will give the reason for the hospital stay, any follow up requirements if necessary and patients' discharge medication.
- Discharge summaries are electronically transferred to GPS and a printed copy is given to the patient.
- 'Understanding You' document (if applicable).
- Patients who self-discharge are to be provided with the letter of self-discharge
- Patients undergoing the reluctant discharge procedure (see Section 5.6) must be provided with appropriate letters as outlined in Annex E.
- Details of medication to take away must be included and the method of taking medication communicated.
- Any care advice or leaflets that may be relevant are to be provided to take away.
- Any instruction for use of equipment and safety information.
- Infection control advice.

5.4 Timescales for Discharge

Under normal circumstances, discharge to care homes and community hospitals will be undertaken before 18.00 hours. At time of extreme bed pressures, this timescale may need to be extended in collaboration with the Clinical Site Management Team and the receiving hospital.

The process for out of hours discharge should not differ to that of discharges within the working week. The Clinical Site Manager is available to ward staff for support/ guidance to arrange transport and medications to take home. The nurse in charge of the ward at the time of an out of hours discharge is responsible to ensure that patients are discharged to a safe environment with the appropriate level of care and information **to accompany them.**

5.5 Patients Requiring Ongoing Health and Social Care Needs/Placement

Social Services:

Where indicated referrals to Social Services should be made as soon as possible through the board rounds or by completing a notification 2.1. This may be before a provisional date for discharge has been identified. Social Services must respond to referrals within 48 hours of receipt. As soon as a discharge date has been agreed by

the Multi-Disciplinary Team, this should be passed to Social Care If the discharge date changes due to a change in the patient's situation this should be communicated to Social Services

5.6 Best Interest Meetings Regarding Discharge Destination/Care Needs – Put In Our Agreed Timescales

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

5.7 Community Nursing

Patients requiring community nursing following discharge must be referred not less than 48 hours prior to discharge. All patients with a Somerset GP should be referred through "Access to Care" via the Discharge Office using the completed Access to Care Clinician Screening tool form (Appendix 7). For patients from other areas this should be arranged through District Nurses in the patient's GP practice.

5.8 Dietetics

For patients who have been identified as requiring home enteral feeding post discharge, 7 days' notice must be given to the dietitian to organise pre-discharge training with patient/carers and set up the system for home - if this has been instigated during this hospital stay. Where patients are being transferred to Nursing or Care homes or other hospitals where staff are identified as competent users of feeding systems then 2 working days' notice is needed. For complex patients with established home enteral feeding systems this is not required.

5.9 Discharge To Another Care Setting E.G. Community Hospital, Nursing Or Residential Care Home, Or Receiving A Care Package At Home.

(This does not include transfer to another hospital for ongoing acute care – in these cases the Trust's transfer policy should be used).

- Patients discharging or transferring out onto a homefirst pathway will be accepted at least 24hours before day of discharge and all referrals completed
- Homefirst discharges/transfers will all go via the discharge lounge.
- The nurse/DF must telephone and confirm availability of the bed/care package on the day of discharge.
- The nurse must give a verbal handover to the receiving care setting prior to discharge.
- A Transfer of Care form (appendix 4) must accompany the patient together with a copy of their prescription and supply of medicine (keep a copy in the patient's records).

Patients who will be fit for transfer to a community hospital will be referred 24 – 48 hours before the expected dates of transfer. For Somerset patients only SPL staff will

assess the patient's suitability for transfer to the chosen community hospital within 24 hours of referral., this will be in conjunction with the Trust Discharge pathway manager. Dorset and out of area patients who require a community hospital bed should be referred to the Discharge Facilitator or the ward staff should contact the hospital direct

The aim is for patients to be transferred within 24 hours of acceptance to the waiting list, and within 2 days of referral. The 'Understanding You' documentation, where used, should be transferred with the patient.

5.10 Patients Who Lack Capacity to Make A Decision about Their Long Term Care Needs

A patient should be supported to make their own decisions in connection with discharge planning. Where a patient is assessed as lacking capacity to do so then staff making decisions must do so in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice. This requires decisions to be made in best interests which includes involving the patient and consulting with family/friends and unpaid carers about the discharge plan wherever practicable and appropriate. If there is a Lasting Power of Attorney for Health & Welfare the named attorney is the Decision Maker. If a patient lacks capacity to make a discharge decision and the patient is likely to need placement or a care package the Social Work team must be involved to lead the best interest decision.

5.11 Independent Mental Capacity Advocate (IMCA)

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

If a patient lacking capacity, is un-befriended, and is expected to remain in a hospital setting for more than 28 days or will be discharged to a Care Home setting for more than 8 weeks, an IMCA must be instructed by the Ward or Social Care staff.

5.12 Lasting Power of Attorney for Health and Welfare (LPA) / Court Appointed Deputy

A patient can appoint one or more people to make health and welfare decisions on their behalf (an Attorney). In circumstances where the patient looses capacity and is unable to make their own decision, the attorney/s can make decisions where the Health and Welfare LPA gives them the authority to do so. The LPA must be registered with the Office of the Public Guardian. The LPA can only be used when the patient no longer has capacity to make such decisions for themselves. The Attorneys are not just there to be consulted with, but importantly they must not make decisions that are contrary to the patient's best interests. Where the Health and Welfare LPA does not give the person authority to make the particular decision (or perhaps the LPA is a Property and Finances LPA and not a Health and Welfare LPA) then staff should still consult the attorney(s) about any decisions which are being make in best interests. Staff must request sight of the LPA in order to establish whether the LPA gives appropriate authority for the decision in question and whether the LPA has been

registered with the Office of the Public Guardian (it will have the seal of the OPG showing on each page if it has been registered). If there are any doubts or concerns staff should seek advice from the Trust's MCA lead or Head of Litigation

Rarely, the Court of Protection will appoint a deputy to make health and welfare decisions on behalf of a person who lacks capacity and staff should refer decisions to them which the patient cannot make due to incapacity. Again a copy of the court order appointing the deputy must be inspected to determine its validity and to verify that the authority given applies to the matter in question. If in doubt – seek advice.

It must be noted that appointment under a registered Enduring Power of Attorney (pre Mental Capacity Act) or a registered Property and Finance Lasting Power of Attorney (post Mental Capacity Act) does not entitle a person to make health and welfare decisions on behalf of the patient. However that person should be consulted with and is authorized to make decisions relating to property and financial affairs, including funding a care home placement.

5.13 Adults with Learning Disabilities

All adults with Learning Disabilities should be referred to the Community Team for People with Learning Disabilities (CTPLD) on admission and prior to discharge, and to the Social Care and the Trust's Discharge Team. At this time the patient's local authority should be informed for an "assessment of changed needs". Staff can refer to the Trust's Adults with Learning Disabilities Policy.

5.14 Mental Ill Health

All in-patients with mental health issues where it is felt they require a Mental Health assessment should be referred to the On Call team at Fountain's Way. Over 65s can be referred to the Older Person's Mental Health Liaison Nurse for assessment via the discharge office. The Short Stay Emergency Unit make arrangements each weekday with the Crisis Team to review patients who have been admitted due to deliberate self-harm.

5.15 End of Life Care

For patients who are near the end of their life and who wish to be discharged home for their remaining days, the NHS Continuing Healthcare Fast Track Tool should be completed by relevant staff together with the appropriate consent form (Appendix 5a and Appendix 5b). Once completed these forms should be faxed to the Hospital **Discharge Team.**

5.16 Patients who are Homeless

For people who are ready for discharge and are homeless, contact the Community 4 office for South Wiltshire on telephone 742191.

5.17 Prisoners

For patients returning back to a prison, the nurse should liaise with the prison officers who are accompanying the prisoner and contact the prison as required to arrange discharge. Many patients are discharged to the prison's hospital wing. A discharge summary and transfer of care form will accompany the patient.

5.18 Children (including neonates) and Young People at Risk of Harm

If a child or young person who is to be discharged has been or may be at risk of harm a multi-agency discharge planning meeting must be arranged by the consultant paediatrician or the designated lead for discharge, and an action plan agreed and documented before the child leaves hospital in accordance with South West Child protection procedures**.**

5.19 Patients Taking Their Own Discharge

Patient Choice - Where a patient wishes to discharge themselves against medical advice this can be done for one of two reasons:

- The patient understands the risks they are taking in discharging themselves after discussion with staff about these risks, and/or;
- The patient lacks mental capacity to understand the risks they are taking in discharging themselves either due to medical or mental health issues affecting their judgement (see above)

5.20 Patients with Capacity Who Are Medically Fit For Discharge But Are Refusing To Leave the Hospital.

When a patient refuses to comply with the discharge planning process and is assessed as having capacity, the following steps should be undertaken:

- A meeting should be held between a senior member of the Medical Team (registrar or above), a senior member of the nursing team (Ward Sister or above), the patient, and if appropriate their family and/or carers, in order to explore the issues that they have in relation to discharge including any concerns that they may have about the discharge. During this meeting it should be explained to the patient that it is not appropriate for them to continue to occupy a hospital bed when they no longer have a clinical need for this. The patient should be given a discharge time and date and informed they will be expected to leave the hospital by this time. A senior member of the Medical Team (Registrar or above) and a senior member of the nursing team (ward sister or above) should clearly document the minutes of this meeting in the patients records.

- Following the meeting a letter from the Trust should be given to the patient from the Trust confirming the date any ongoing needs were assessed and how those needs are intended to be delivered in the community (if applicable) . The letter should address any of the concerns raised, if appropriate, and make it clear that the patient has been assessed as ready for discharge and the Trust should specify the date and time by which the patient will be discharged.

- If the patient still then refuses to leave, the member of the medical team and member of the nursing team should contact the Trust's Security Management Specialist who will arrange for members of the RED team to attend and escort the patient from the premises. Whilst it is appropriate to escort the patient, the security team should not restrain or physically coerce the patient in any way. Transport can be arranged prior to this to the patients usual discharge destination.

6. COMPLIANCE AND MONITORING

The following measures will be used to annually review the compliance against this Discharge Policy:-

- Patient Re-admission Rates – this information is collected monthly and forms part of the divisional dashboard that is reviewed monthly.

- Policy Audit – annual audit of patient notes reviewing adherence to the discharge policy will take place, informing future work projects.

- Patient satisfaction survey – this information is reviewed by individual Directorates and monitored through the Clinical Governance Committee on a quarterly basis.

- Delayed discharges/delays in the patient pathway and reviewed daily through the SITREP process at the Delayed Discharge meeting chaired by patient Flow Manager.

- Review of Discharge lounge figures by Matrons and Sister .

- Investigation of incidents in relation to discharge will be undertaken and actions put in place as appropriate.

- Investigation of complaints in relation to discharge will be undertaken and actions put in place as appropriate.

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes / No / N/A	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	no	
	• Ethnic origins (including gypsies and travellers)	no	
	• Nationality	no	
	• Gender	no	
	• Culture	no	
	• Religion or belief	no	
	• Sexual orientation including lesbian, gay and bisexual people	no	
	• Age	no	
	• Disability	no	
2.	Is there any evidence that some groups are affected differently?	no	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	no	
4.	Is the impact of the policy/guidance likely to be negative?	no	
5.	If so can the impact be avoided?	n/a	
6.	What alternatives are there to achieving the policy/guidance without the impact?	n/a	
7.	Can we reduce the impact by taking different action?	no	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust's lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust's lead for Equality & Diversity.

Signed – Mandy Carney **Date –** 26 November 2018