POLICY: DISCHARGE FOR ADULT PATIENTS

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<td>Jan 2011</td>
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<td>Document has been fully revised to separate procedures from overarching policy. All procedures are now accessible on Trustnet under Discharge Framework</td>
<td>K. Lillington</td>
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Compiled by: Karen Lillington/Claire O’Brien

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Policy Owner: Karen Lillington/Claire O’Brien
ASHFORD & ST PETER’S HOSPITALS NHS FOUNDATION TRUST

DISCHARGE FOR ADULT PATIENTS

See also:
Trust Standard Discharge Framework for Referral and Procedures including additional interagency information.
Transfer Policy
Paediatric Discharge Policy
Medicines Management Policy & Policy and procedure for nurse checking and issuing of discharge medication
Guidelines for using Interpreting services
Learning Disability Policy
Safeguarding Adults Policy

1. INTRODUCTION

This document sets out for staff across the Trust and other partner agencies what is required to ensure effective discharge planning. It includes an outline of the roles and responsibilities of the multi-disciplinary/multi-agency team, key principles fundamental to effective discharge, and the range of factors that need to be considered with patients and carers during the discharge pathway.

It outlines all matters pertaining to the process of patient discharge and follows guidance in “Discharge from Hospital: Pathway, Process and Practice” DH Jan 03, “Achieving Timely Simple Discharge from Hospital” DH Aug 04 as well as key legislation including Community Care (Delayed Discharges etc) Act 2003 and the Mental Capacity Act 2005.

This policy operates alongside the Trust’s Standard Discharge Framework to ensure effective integrated multi-disciplinary and multi-agency team working. The standards outlined in this policy should be adhered to regardless of the nature of the discharge being planned or time of day or the borough/county to which the patient is being discharged.

2. PURPOSE

2.1 RATIONALE

Discharge planning is a process and not an isolated event. This process therefore needs to be planned at the earliest opportunity and actively managed 7 days a week. It also needs to fully involve patients, relatives and carers. Appropriate, timely discharge planning is fundamental to the provision of effective health care. Poor discharge planning leads to inefficient use of beds, increases in waiting times/costs, higher re-admission rates, increased dependency for the patient, carer breakdown as well as increased workloads for Acute Trust and our colleagues in the community and social care.
2.2 **ACHIEVING POSITIVE OUTCOMES**

This policy makes clear to staff what is required during the discharge process and the principles that need to underpin day to day practice. It provides a reference for staff of all agencies so that they might understand both their individual and team’s responsibilities. It will ensure that there is a clear and consistent process in place for dealing with discharge thus ensuring a positive outcome for both patients and carers. Furthermore it will ensure that the Trust meets all its legal responsibilities and conforms to the relevant NHS LA Risk Management standards.

3. **DEFINITIONS**

3.1 **PATIENT**

People receiving acute/rehabilitation treatment in hospital are referred to as patients.

3.2 **CARER**

The term carer is used as the generic term for relatives/friends/neighbours who are providing unpaid care to the patient. They may not necessarily be living in the same household as the person they are caring for.

3.3 **YOUNG CARER**

A child or young person under the age of 18 whose life has been affected by caring for a person with a disability or illness is a young carer.

3.4 **DISCHARGE**

Discharge is used generically to describe discharge from hospital with or without transfer of care to health or social care organisations/agencies in the community.

3.5 **MULTI-DISCIPLINARY TEAM (MDT)**

This team consists of staff who contributes to the patient’s care and/or discharge. It is likely to consist of members of the ward and specialist nursing staff, the consultant and their team, professions allied to medicine eg. Physiotherapists, Occupational Therapists, Speech and Language Therapists, Dieticians and Pharmacists. There will also be representatives from other agencies such as General Practitioners, Social Workers/Care Managers, Discharge Coordinator, Intermediate Care staff, District Nurses, Community Matrons, Psychiatric Liaison Nurses.

*(See Standard Discharge Framework: Multidisciplinary Working, MDT)*
3.6 IN-PATIENT LIST (IPL)
The IPL is an in-house tool that is used by members of the MDT to record significant care outcomes/needs for handover between shifts and support the generation of the Discharge Summary.

3.7 LENGTH OF STAY (LOS)
This is the expected length of time that the patient will require care in the acute setting so that their health needs can be met and the plan for their safe discharge agreed and implemented.

3.8 ESTIMATED DATE OF DISCHARGE (EDD)
This is the estimate date when it is expected that the patient will be ready to be safely discharged from acute care to their normal or new place of residence or transferred to a non acute setting for ongoing care.

4. DUTIES/RESPONSIBILITIES

4.1 KEY PRINCIPLES

Five key principles underpin this policy and should be adhered to by individual members of staff and multi-agency teams during the process of discharge:

4.1.1 Principle One: Discharge will be facilitated by a 'whole systems' approach to the assessment and the commissioning and delivery of services. The MDT will work together in an atmosphere of collaboration and co-operation to provide information, medication, equipment or specialist input.

4.1.2 Principle Two: Patients and their carers will be encouraged to engage and participate in the process of discharge as equal partners. The needs, wishes and rights of both the patient and the carer will be paramount throughout the process.

4.1.3 Principle Three: Discharge must be timely. In other words, patients will only remain in the Acute Trust inpatient facilities for as long as they require acute/rehab care i.e. inpatient investigation, treatment or therapy. Equally, patients will not be discharged until they are medically fit and safe to be transferred to a non acute setting or return home.

4.1.4 Principle Four: Discharge planning will be a co-ordinated process. This will be facilitated by the nurse (supported by the Discharge coordinator as appropriate) who will have responsibility for co-ordinating all stages of the 'patient and carer journey'.

4.1.5 Principle Five: Assessment relating to discharge will commence at the earliest opportunity. Assessment (including screening for potential/actual risk) will start prior to admission if possible, and within 24 hours of admission for all other cases. Discharge planning should then be considered at all times during the patient and carer journey.

(See Standard Discharge Framework: Vision for Discharge)
4.2  **SINGLE ASSESSMENT PROCESS (SAP)**

4.2.1 Members of the MDT will ensure joint assessment and planning in accordance with the Single Assessment Process (SAP) by:

- Working collaboratively across agencies
- Sharing skills and information
- Recognising each other’s skills and expertise
- Providing timely and effective communication, both written and verbal, to each other and to patients/carers
- Ensuring trust documentation is accurate and up to date
- Agreeing issues relating to mental capacity and the patient’s ability to give informed consent
- Agreeing levels of risk and how risks can be managed

4.2.2 SAP came about as a result of recognising that many people have wide ranging welfare needs and that organisation/agencies need to work together to ensure that assessment and subsequent care planning is effective and co-ordinated and that care should be person centred and holistic. By applying the SAP model the Trust is supporting the principle that the scale and depth of assessment is proportionate to all people’s needs; that agencies do not duplicate each other’s assessments; and professionals contribute to assessments in the most effective way. (National Service Framework for Older People 2000).

4.2.3 Completing the SAP documentation within 24 hours of admission is the beginning of the discharge plan. (See Discharge Framework for SAP including Discharge Care Plan)

4.3  **MINIMUM STANDARD REQUIREMENTS FOR DISCHARGE**

The Nurse has ultimate responsibility to ensure the Discharge Care Plan/Checklist is completed and used as a guide to ensure safe discharge.

4.3.1 The Discharge Care Plan sets out the four key planning stages to support/ensure safe effective discharge. The following outlines the minimum requirements expected to be followed for all patients. (NB: where a referral is not required NA non applicable should be noted).

1) Green Stage: early identification of need appropriate referrals and essential communication required.
2) Amber Stage: Coordination of MDT assessment and outcomes Planning Discharge,
3) Day Before Discharge: Essential checks to ensure all recommended services, equipment are in place (and medicines ordered)
4) Red Stage: Day of Discharge: Final checks including confirm patient medically fit, explain medication and discharge information required to ensure patient, family/carer understand any ongoing care/follow up services to be provided.
NB: refer to Section 4.9. Stages 1 - 3 Assessment for Discharge, for further detail including complex discharge care planning.

4.4 KEY ROLES

Whilst all MDT staff need to be fully involved in discharge planning there are three key roles which help to ensure the process is followed in as a consistent and co-ordinated way as possible.

- **Ward Manager/Matron:** Ultimate responsibility for the discharge rests with the ward manager or matron. They will also be responsible for ensuring discharge is implemented in a standard way right across the Trust.

- **Nurse:** It is the nursing profession with whom patients will have continuous contact. Nurses will ensure effective hand-over (both verbal and written) of patients assessment/care needs and be responsible for day to day co-ordination of discharge; acting as a point of contact and conduit for effective communication for all members of the MDT.

- **Discharge Co-ordinator:** The discharge co-ordinator will be responsible for assisting the ward manager/nurse with complex discharges (see section 4.8.3) by ensuring delays in the patient process are minimised and escalating all relevant services to ensure timely discharge.

- **Doctor:** On or before admission the doctor will be required to set an expected date of discharge and ensure that a clear management plan is documented and communicated to facilitate timely discharge. The doctor will be required to review the patient on the day of discharge to ensure the patient is medically fit and any outstanding assessments required are communicated to the nurse/ward manager. A doctor will be required to support a daily board round and weekly multi-disciplinary (MDT) team meeting as appropriate. (see Discharge Framework for MDT Roles & Responsibilities)

(See Standard Discharge Framework: Roles and Responsibilities, Discharge Co-ordinators, ward manager/Matron and Multi Disciplinary Working)

4.5 INFORMATION TO PATIENTS AND CARERS (VERBAL AND WRITTEN)

4.5.1 All disciplines are responsible for ensuring patients and carers are given the necessary information at all stages of the discharge planning process. This information will be given in a format or language which they can understand and should include what to expect and how they can contribute. Time must given to patients and carers to ask questions about the information provided and other queries that they might have regarding their ongoing care.

4.5.2 Staff must ensure that patients whose first language is not English receive the information they need in the appropriate language. If there are concerns about the patient or carers understanding of, or ability to communicate in English it will be the responsibility of the ward manager/nurse to ensure a professional interpreter is identified who is trained in interpreting in the language required. It is not appropriate for children, or other family members, to be used to interpret.
4.5.3 Where a patient has a sensory impairment or learning disability, information about their discharge or transfer of care must be conveyed to the patient in such a way that is appropriate to their individual needs e.g. written information is provided in easy read format.

4.5.4 The ward manager/nurse will ensure the patient and carer is fully involved in decision made relating to discharge and kept informed of progress at all stages of the discharge pathway.

4.5.5 **Documentation:** The following documentation relating to the discharge plan should be provided to the patient and where there is a carer it should be documented as having been given:

- Discharge information booklet “Leaving Hospital”. This should be given at the pre-admission assessment or at the earliest appropriate time, taking into account the patient’s clinical condition.
- Carers pack: *(Obtained from Social Services Department)*
- Discharge support: Provision where Social Services or ICT are involved the agreed care plan (following assessment) should be verbally communicated or a copy given prior to discharge or to patient on first visit following discharge *(see Discharge Framework for discharge information)*.
- Discharge Summary (GP letter): on discharge a copy of this should be given to both patient and carer with a copy being sent direct to the patient’s GP.
- Copy of District Nurse referral form (where appropriate)
- Copy (to cover i.e. Nursing Home) of Transfer form/body map for patients discharged with wounds or injury.
- *Follow up appointment* – where needed follow up appointments should be arranged and an appointment card given to the patient/carer.

4.5.6 As part of the pre-admission assessment or at the earliest opportunity the patient/carer should be informed of the following:

- On the day of discharge they will vacate their bed (where appropriate by 10am) and be transferred to the discharge lounge to wait for mediation or transport.
- Transport home is not usually provided unless the patient is assessed as needing specialist transport for clinical needs. It must be discussed with the patient, and where relevant their carers, as an alternative method of transport to be agreed.
  *(See Standard Discharge Framework: Transport – Booking Criteria)*
  *(See Standard Discharge Framework: Patient Discharge Lounge Information)*

4.5.7 Patients and carers must be given as much notice as possible of their estimated discharge date (EDD) and be involved in agreeing this date. If the discharge is likely to happen with short notice then the patient/carer should be advised accordingly.
(See Standard Discharge Framework: Information used in the framework, Providing Information to all parties)

4.6 SUPPORTING CARERS

4.6.1 All staff must recognise that it is a carer’s choice whether or not to look after an adult. It should not be assumed that the carer is willing and able to care. This does not mean the carer does not care about the patient; a carer might have other caring responsibilities, might be the main breadwinner or is finding the stress of long term caring detrimental to their own emotional and physical wellbeing.

4.6.2 When a patient leaves hospital a carer will be faced with important decisions and pressures. They may be taking on a caring role for the first time or they may not know what to expect. They may be anxious to get the patient home or feel pressure from other family members, staff or the patient themselves to get home as quickly as possible.

4.6.3 The ward manager/nurse must ensure the carer has an opportunity to discuss their concerns and their support requirements and with their permission make a referral to the Social Care Team for a carer’s needs assessment. A carer has the legal right to a carer’s needs assessment if they are providing regular and substantial care. This assessment will consider their own physical and mental health, needs relating to their employment, their own education and training, planning for an emergency and the need for respite, leisure and a social life. (Carers (Recognition & Services) Act 1995, Carers and Disabled Children’s Act 2000, Carer Equal Opportunities Act 2004).

4.6.4 Carers may need specific training in order to carry out their caring role following discharge. The risks of caring should be addressed by all disciplines and appropriate information, advice and education must be provided e.g. moving and handling, in order to keep the carer safe.

4.6.5 In situations where the patient does not want the carer to be involved or have information about their care, the carer should be informed of this and advised of their (the carer’s) own right to their own assessment of their needs. Enough general information about the patient’s condition must be provided to the carer to enable them to care safely.

4.6.6 If the patient lacks mental capacity, the carer may have legal authority to make certain decisions about health and welfare matters, if they have Lasting Power of Attorney (LPA). If there is no LPA in place, professionals are required to act in the best interests of the patient. However the best interest’s checklist still requires professionals to seek the views of carers (Mental Capacity Act 2005)

4.6.7 The carer’s view of the patient’s needs should be included when the multi-disciplinary team assesses eligibility for NHS continuing care assessment. Carers are entitled to an assessment of their own needs even where the patient is eligible for continuing care. The ward manager/nurse (supported by the Discharge
Coordinator) should consult with the carer as to whether to make a referral to the Social Care Team. (National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, Revised July 2009)

4.6.8 Case Conference: Where there are concerns raised by any family member/carer a case conference should be arranged by the ward manager/nurse; inviting all key MDT personnel to ensure both patients and family have an opportunity to express any concerns and for the MDT to ensure the patient/carers are fully briefed on care options and discharge plans

4.7 SAFEGUARDING VULNERABLE ADULTS

4.7.1 Safeguarding Vulnerable Adults: All trust staff must be aware that there is potential for vulnerable adults to be abused. Staff should always take seriously any allegation of abuse and be aware of signs that may indicate that someone is being or could be abused upon discharge. Staff have a duty to report their concerns to the Social Care Team even if the patient is reluctant for them to do so. Where any form of indecent or sexual assault or serious physical assault has been reported the Police must be called immediately.

(See Trustnet Safeguarding Adults Policy)

The Mental Capacity Act 2005 provides legal safeguards to those patients aged 16 and over who lack capacity, either permanent or temporary, to make particular decisions. This includes decisions relating to discharge. The Act also provides a best interest checklist which is to be used when staff make a best interest decision on behalf of a patient. The principles of the Act requires Trust staff:

- To assume a patient has capacity unless it is established that he/she lacks capacity
- Not to treat patients as unable to make decisions until all practical steps have been taken to help the patient make their own decision
- Not to treat patients as unable to make a decision merely because she/he makes an unwise or eccentric decision
- To carry out actions or make decision in the best interests of the patient who lacks capacity
- To ensure that before the action is carried out, or the decision is made, regard is given to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

(See Standard Discharge Framework: Referral Forms, Mental Capacity Checklist)

4.7.2 Introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007, the Deprivation of Liberty Safeguards (DOLS) are to prevent arbitrary decisions being made that deprive vulnerable people who lack capacity of their liberty. Sometimes trust staff may have to place restrictions on people for their own safety. There are different levels of restriction ranging for example from a locked door to
physical restraint. At some point the degree and intensity of these restrictions become what is legally known as a deprivation of liberty. Examples of deprivation might include:

- Force being used to prevent a person leaving hospital where they are persistently trying to leave
- Severely restricting access to the patient by relatives and carers
- Denying a carer’s request to have the patient discharged into their care
- Severely restricting movement within the hospital

Where it is believed a patient is being deprived of their liberty it is the responsibility of the ward manager/Matron to seek authorisation from the relevant supervisory body.

A DOLS authorisation is not required on hospital discharge to a care home if the person is already subject to a DOLS authorisation in hospital. *(See Deprivation of Liberty Safeguards: Code of Practice, Department of Health & Safeguarding Adults Policy)*

4.7.3 **Safeguarding Children and Young Carers:** Where the patient is a parent or parent carer or where the patient is being discharged to a residence where a child is residing, and their discharge may lead to the child becoming a ‘child in need’ (i.e. the child is at risk), a referral should be made to the Social Care Team to ensure appropriate assessment and support. Furthermore, an assessment by the Social Care Team is essential where a child or young person under the age of 18 is likely to be carrying out regular and significant caring tasks which assume a level of responsibility that would normally be associated with an adult. Young carers should not be expected to undertake unreasonable levels of care.

*(Refer to Assessment of Children in Need and their Families 2000, Department of Health)*

4.8 **DISCHARGE PATHWAY**

4.8.1 There are two discharge planning pathways that the Trust will use to describe the patient’s needs. These are described as ‘simple’ and ‘complex’. Patients will fall within one of these two pathways regardless of whether or not they are admitted as an emergency or as a pre-planned elective patient. At least 80% of patients discharged from hospital are likely to be classified as simple discharges, so changing the way in which discharge occurs for this large group will have a major impact on the effective use of bed capacity and improve the patient/carer experience.

4.8.2 It will be the responsibility of the pre-assessment nurse (in the case of elective patients) or the ward manager/named nurse (in the case of emergency admissions) to establish at the earliest opportunity which pathway the patient falls into.
4.8.3 The following table highlights those triggers which will help determine whether a patient follows the 'simple' or 'complex' pathway: See discharge pathway flowchart, Appendix 1

<table>
<thead>
<tr>
<th>Simple Discharge</th>
<th>Complex discharge</th>
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<tbody>
<tr>
<td><strong>NB: Complete Discharge Care Plan</strong></td>
<td><strong>NB: Complete Discharge Care Plan +</strong></td>
</tr>
<tr>
<td>Have simple ongoing care needs which do not need complex planning and delivery</td>
<td>Has ongoing health and social care needs Refer to Social Services. +Complete Health Needs Assessment Form (HNA) - See Framework (Forms)</td>
</tr>
<tr>
<td>Are returning to their own home or place of residence</td>
<td>Lives alone and/or frail or elderly (appears neglected)</td>
</tr>
<tr>
<td>Do not require a change in support offered to the patient or the carer when living at their usual place of residence</td>
<td>Supported by a carer who may have difficulty meeting the caring needs or is the carer of another dependent person or is unwilling or unable to care +Refer Social Services (Section 2) – Pas (see Framework)</td>
</tr>
<tr>
<td>Are Independent presenting no functional or cognitive concerns which would require OT/PT assessment</td>
<td>Life expectancy is limited or the patient has a serious illness which may require frequent visits to hospital for treatment +Complete HNA, &amp; Fast-track (see Framework – forms)</td>
</tr>
<tr>
<td><strong>Refer to MDT as/if appropriate.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Following Discharge Care Plan - Appendix 5, ensuring all sections are completed as appropriate</strong></td>
<td>Have a physical disability or sensory impairment or recognised learning disability and a newly identified health or social care need or previous unmet need + Refer Social Services section 2</td>
</tr>
<tr>
<td></td>
<td>Is to be discharged home with a complex package of care which requires monitoring and on going review + Refer Social Services (Section 2)</td>
</tr>
<tr>
<td></td>
<td>Adults at risk from abuse and/or with safeguarding issues +Refer Social Services section 2 (See Framework for risks)</td>
</tr>
<tr>
<td></td>
<td>Have cognitive impairment with newly identified health or social care needs or previous unmet need + Complete Mental Capacity Check-list (See Trustnet forms)</td>
</tr>
<tr>
<td></td>
<td>Known to be homeless and/or to misuse substances +Refer Social Services section 2, see framework - forms</td>
</tr>
<tr>
<td></td>
<td>Patients whose first language is not English – +use Interpreters service (See Trustnet for guidelines)</td>
</tr>
</tbody>
</table>
4.8.4 The discharge planning process must take account of the patient’s and carer’s needs whether they are simple or complex. As the patient and carer journey moves through acute care there must be continuous monitoring through the use and development of the discharge plan, the main purpose of which is to identify any change in the patient or carer’s needs that may impact on discharge i.e. cross from simple to complex or vice versa.

(See Standard Discharge Framework: Collect Discharge Data, Create a Discharge Plan, Continue to Review and Update EDD and Discharge Plan)

4.8.5 Whichever pathway, all patients and carers must be informed of their expected length of stay date for discharge (EDD) and this date entered on the Inpatient List (IPL) within 24 hours of admission. For many elective patients the expected length of stay and therefore the EDD can be identified with the patient and/or carer at pre-assessment by the pre-assessment nurse.

4.8.6 The EDD must take into account the time it will take to ensure the patient is safe for discharge from a multi-disciplinary perspective. This date must be reviewed on a daily basis by the MDT, the purpose of which is to ensure that all the elements of the medical/surgical management and discharge plan will come together in a timely manner to support a safe discharge and any blocks to this can be identified and action to mitigate delays can be taken.

4.8.7 Patients and carers as well as member of the MDT should be advised of any changes to the EDD. The ward whiteboard and IPL should be used to track the EDD.

(See Standard Discharge Framework: Set Estimated Date of Discharge, Inpatient List)

4.8.7 The discharge process consists of three key stages:

- Assessment for discharge
- Planning for discharge
- Discharge/Transfer of Care

Appendix 1 provides a diagram to illustrate the pathway through these three stages for both simple and complex discharges.

(See Standard Discharge Framework: Diagram of key activities, information and decisions in the discharge process)

4.9 STAGE ONE: ASSESSMENT FOR DISCHARGE

4.9.1 Assessment of the patient will start either at pre-admission (elective) or as part of the admission assessment for patients (emergency). Early assessment is essential
to support timely and safe discharge and wherever possible assessments should be undertaken in parallel to ensure the minimum amount of time is spent in the assessment phase and to avoid serial assessment. The range of assessments may include:

- Mental capacity assessment – ability to make decisions about their health treatment and care
  (see Standard Discharge Framework: Referral Forms/Mental Capacity Checklist)
- Functional assessment - ability to carry out activities of daily living
- Mobility assessment – to establish need for equipment
- Home assessment – to identify access issues, equipment needs, carer needs

4.9.2 The purpose of the assessment for discharge is for the MDT to work within SAP to:

- Determine pre-admission support that the patient and carer was receiving from health and social care
- Understand the needs of the patient and carer and corresponding risks relating to how the patient can be safely discharged from acute care and what actions need to be taken to mitigate those risks. *(See Standard Discharge Framework: Discharge Risk Assessment)*
- Determine whether the patient and/or carer has any new altered needs (or has previously unmet needs that will render the discharge unsafe if not addressed)
- Determine the wishes of the patient/carer with regard to the provision of ongoing care on discharge
- Identify the likely length of stay and EDD
- Identify which specialist assessments are needed so that all the relevant information is available when moving to the planning stage. These may include:
  
  - A comprehensive assessment (SAP) supported by input from relevant members of the MDT
  - A Community Care Assessment and/or Carer Assessment, if requiring adult social care input
  - Assessment to identify if the patient qualifies for NHS Continuing Health Care funding.

*(See Standard Discharge Framework: Meet Discharge Needs/Referrals, Patient Cohorts most at risk of delay, Referral Forms)*

4.9.3 Community Care Assessment and Carers Assessment: Where a patient appears to be in need of social care upon discharge, following discussion with the patient/carer, the named nurse/ward manager must ensure a referral for assessment is made to the Social Care Team using the relevant Section 2
notification. In accordance with the Community Care (Delayed Discharges etc) Act 2003, within three days of receiving this notice, the Social Care Team must undertake a community care assessment of the patient’s needs and an assessment of any person caring for the patient who may be entitled to be assessed under the Carers Acts (i.e. a carer who will on discharge take on substantial and regular caring tasks for the patient).

4.9.4 **NHS Continuing Care Assessment:** The process that is followed for this specialist assessment is laid out in the revised National Framework for NHS Continuing Healthcare and NHS funded nursing care (July 2009). Once the patient’s needs on discharge become clear, the discharge co-ordinator/care manager will then complete a Checklist to determine if the patient should be considered for continuing health care. If the checklist indicates a need, then a full assessment of eligibility will be carried out by discharge co-ordinator and appropriate care manager using the Decision Support Tool. This process should be carried out with the full consent and knowledge of the patient/carer and they should be given every opportunity to participate.

Occasionally individuals with a rapidly deteriorating condition that may be entering a terminal phase will require ‘fast tracking’ for immediate provision of NHS continuing healthcare because they need an urgent package of care or placement. The Fast Track Pathway Tool should be completed by a member of the clinical team, specialist palliative care nurse and/or discharge co-ordinator.

**Appendix 2** provides an overview of the process for determining eligibility for NHS Continuing Health Care.

(See Standard Assessment Framework: Referral Forms/ Surrey NHS Funded Healthcare forms Fast Track and Non Fast Track Assessment procedure and flowchart; & Hounslow Social Services, NHS Fast track and Non Fast Track Assessment Procedure)

(See Discharge Framework: Referral Forms)

4.9.5 As part of the initial discharge assessment; if a patient is homeless the discharge co-ordinator, ward manager or patient should alert the local housing office as soon as housing needs are identified. The law requires the local authority to provide housing in some cases. In order to qualify for housing, a patient must be:

- Homeless
- In priority need
- Be unintentionally homeless
- Have a local connection to the borough in which they are applying. The housing office will then assess the patient as to their eligibility.

If the housing officer decides the patient is not eligible (those clients who present with no care needs) they will provide a list of local hotels and hostels to contact or
will be advised to present at the Council office. Patients should be registered with a GP prior to the Council accepting responsibility.

(See Discharge Policy Referral Guidelines (Trustnet), Referral for Homeless Patients)

4.9.6 Once the outcome of the required assessments is agreed, the nurse will discuss with the ward manager and the patient/carer those services likely to be required. A verbal explanation will be given to the patient/care regarding the expectation around timescales and possible short term solutions. This conversation must be recorded in the discharge plan.

4.10 STAGE TWO: PLANNING FOR DISCHARGE

4.10.1 The discharge planning phase requires the MDT to clarify and agree, in consultation and with input from the patient/carer the elements needed for a safe and timely discharge from acute care. The discharge social support checklist (SAP) should be used to develop the discharge plan and to ensure all the elements come together in parallel so that the length of time spend in acute care is kept to a minimum.

4.10.2 The following aspects have to be covered within the discharge plan:

- Where and by whom the patient’s needs will be met
- The relative/carer provision that is proposed and agreed with the carer and any risk associated with this provision and how they will be mitigated
- What services and support are required
- When the services and equipment are required
- Who is responsible for putting in place the services/equipment
- When the services need to be started or when services will be available
- EDD as described in section 4.7.4

4.10.3 Once the plan is agreed with the patient/carer and by the MDT, arrangements need to be made thus ensuring the transfer of care is seamless. Where appropriate the social care team should be notified as per section 5 notification arrangements in line with local procedures and national legislation and guidance on reimbursement.

4.10.4 Case Conference: In some instances it is helpful to convene a discharge planning meeting. This must be an inclusive meeting which aims to bring transparency to all the issues that need to be addressed when putting in place a safe and timely discharge plan. Examples of where this might be helpful include:

- Ongoing plan is extremely complex and requires multi-agency co-ordination and/or there is difficulty in getting agreement to the plan
- There are concerns that it is not possible to ensure the patient/carers wishes have been included or can be included in the discharge plan
Invitees should include relevant members of the MDT, representatives from outside agencies i.e. care provider, community matron, district nurse, sheltered housing manager and most importantly the patient and/or carer. Discharge Co-ordinator, Patients clinician, other specialist as appropriate.

4.11 STAGE THREE: DISCHARGE /TRANSFER OF CARE

4.11.1 The final decision as to when a patient is safe to be discharged is made up of three parts:

- The clinical decision – the patient’s acute condition has been stabilised. This is usually decided by the Consultant’s team but can be made by other healthcare professionals where criteria have been agreed
- The multi-disciplinary decision - where other medical, nursing and therapy professionals decide the patient will not benefit from further acute treatment
- The safe to transfer decision – as assessment of immediate risk to the patient and carer, focusing on social needs and destination.

(See Standard Discharge Framework: Clinically stable, Decision Discharges Guidelines, Safe to Discharge)

4.11.2 The decision to discharge and the follow up arrangements must be clearly communicated to the patient/carer, ensuring they understand how the decision to discharge has been made.

4.11.3 Once the decision to discharge has been made the EDD should be revised on the discharge care plan and on the IPL.

4.11.4 People discharged from hospital should be supported in being able to leave in their own clothes and leaving hospital in nightclothes as a norm is not acceptable.

4.11.5 Where the patient requires on going care, the discharge must be carried out so that the transfer of care happens smoothly and patient and carer needs are met at all times. This can be facilitated through:

- Provision of medical supplies – where necessary this will include a minimum of 3 days supplies such as drainage bags, pads, catheters etc. There may be exceptions where a greater supply is needed e.g. when the patient is being discharged at bank holiday weekend e.g. VAC (see Framework)

- Transport arrangements – transport to their transfer destination can only be arranged where there is clinical need. If there is no clinical need then the patient/carer should be asked to make their own transport arrangements. Where transport is provided patients are only permitted one bag and one piece of equipment. Additional equipment/baggage should be collected by a family member prior to discharge

- **Pharmacy supplies** - requests for medication on discharge (commonly referred to as TTOs (tablets to take out)) should be planned well in advance of the discharge date. When the TTO returns to the ward it is the responsibility of the nursing staff to ensure the patients own drugs (PODs) are added to the TTO from pharmacy. Any PODs not required should be returned to the pharmacist for destruction.

It is the responsibility of the registered nurse looking after the patient to ensure that they and/or their carer has received education about their medication and a registered nurse must check that the medication that the patient is taking away matches the medication on the TTOs list.

(See Trust policy and procedure for nurse checking and issuing of discharge medication)

- **Discharge summary** – A discharge summary completed by the patient’s clinical team should accompany the patient on discharge. This will inform patients and carers of what services, appointments etc. to expect post discharge and any special information they need to know. Information on ongoing care arrangements should be confirmed as necessary on the summary if not already given as part of the discharge planning process. Discharge summaries can be sent electronically to the majority of GP practices in the area using IPL.

- **Equipment supplies** – only in exceptional circumstances should a patient be discharged prior to necessary equipment being obtained and/or fitted. If following a home visit or hospital assessment it is determined that essential aids and equipment are required, the Occupational Therapist will order such items from the Surrey Community Equipment Service. It is the responsibility of the therapist requesting the equipment to ensure that training is provided to the patient and the carer so that they can undertake correct and safe use of any such equipment.

(See Discharge policy referral guidelines (trustnet) for Equipment Required on Discharge)

4.11.7 Out of Hours

Wherever possible, patients should be transferred prior to 22.00 hrs. It is however recognised that due to changes in patients’ conditions and increased patient throughput, some transfers will need to take place outside of these hours. It is of paramount importance to ensure prior to discharge consent from patient and next of kin has been obtained. (See Trustnet for Out of hours Discharge of Frail elderly patients)

4.12 PATIENT CHOICE

4.12.1 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
- 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

A Mental Capacity Assessment will need to be undertaken to establish which of the above reasons is applicable. If the patient lacks capacity then the clinical team involved in their care will need to consider applying for the patient to be detained under the Mental Health Act 1983 or via Deprivation of Liberty Safeguards (Mental Capacity Act 2005). If the patient has capacity, they must sign a disclaimer form. This should be filed in the patient’s notes and a brief description of the events documented in their notes.

(See Discharge Policy Referral Guidelines (Trust net) for Adult Self Discharge Form, See Standard Discharge Framework: Referral Forms/Mental Capacity Checklist)

4.12.2 There are many care options that need to be considered during the assessment and discharge planning stages and it is vital that the patient and carer is involved in finding the right care option to meet their own individual needs. These care options might include:

- A care package to the patient at home provided jointly or separately by the NHS or social care
- A support package for the carer
- Intermediate care in the patient’s own home or in a residential setting
- NHS Continuing Health Care
- Care home provision (nursing or residential)
- Rehabilitation at a Community Hospital
- Hospice

4.12.3 Ideally all patients should be discharged back to their usual place of residence; sometimes the patient is assessed as unable to return to their own home and in need of residential/nursing care. Both patient and carer must be offered information and advice, and possibly support from an advocacy service, when making this type of decision. In most cases adult social services do not have the power to force the patient to go into residential care or a particular care home. Equally, where residential care is refused, the patient does not have the right to stay in an NHS acute bed, therefore the social worker/care manager/discharge co-ordinator and the ward manager will need to work with the patient and carer to explore other options.

(See Standard Discharge Framework: Prevent Delays – Guidance, Delay Escalation Process)

4.12.4 There are government ‘Choice of Accommodation Directions’ which sets out how the patient should be allowed to choose their preferred accommodation. This is subject to certain conditions, such as adult social services deciding that the
accommodation is suitable and that the cost of them providing this accommodation is not more that they would normally pay to meet those assessed needs. If their preferred choice is not available then a Protocol of Choice Letter should be sent to both the patient and carer outlining their options.

(See Appendix 3 for flowchart for Managing Discharge to Care Home of Choice and Temporary Placements and see Standard Discharge Framework for Protocol Choice Letter).

4.13 ADVOCACY

4.13.1 The Patient Advisory Liaison Service (PALS) can offer on-the-spot advice and information when a patient or carer has any queries or difficulties regarding the services they receive. They will listen to patient/carer concerns and help find ways of resolving them. They will also note of ways in which services might be improved for patients and carers in the future. The ward manager/nurse will ensure information about PALS is provided to the patient/carer where it is felt a difficulty cannot be quickly and easily resolved.

4.13.2 The ward manager/nurse will be responsible for making a referral to the Independent Mental Capacity Advocacy (IMCA) Service where a patient has been assessed as lacking capacity to make decisions about their discharge and where there are no family or friends that can be consulted regarding their best interests. The Trust has a legal duty under the Mental Capacity Act 2005 to refer to the IMCA service where:

- The patient has been in hospital, or is likely to be in hospital, for more than 28 days
- The patient requires serious medical treatment
- The patient is to be discharged long term (8 weeks or more) to a residential care/nursing home.

(See Standard Discharge Framework: Referral Forms, Independent Mental Capacity Advocate, Mental Capacity Checklist and see Trust Policy – Mental Capacity Act & Advance Decisions)

5. DISSEMINATION AND IMPLEMENTATION OF THIS POLICY

This policy will be disseminated through the Trust email system. The policy will be circulated to Chairs and Secretaries of ratifying Committees. Policy training days will be set up at a ward level to support staff in its implementation.
6. MONITORING OF THIS POLICY

This policy will be monitored for effectiveness through Programme Group 1 (Patient Experience) of the Delivery Programme Board. The following elements will be monitored:

6.1 Measures identified within the Standard Discharge Framework e.g. unplanned readmissions within 30 days, total number of current, vacant and past dates for EDD versus number of patients by ward

(See Standard Discharge Framework: Meaningful Measures)

6.2 Monthly feedback of issues and improvements via Interface Meeting with health and social care partners resulting in joint review and actions needing to be taken

6.3 Review of issues raised through complaints and PALS

6.4 Review of Cause for Concerns and lessons learnt

6.5 Discharge Lounge user satisfaction survey

6.6 Trust internal patient satisfaction survey

7. EQUALITY IMPACT ASSESSMENT FOR THIS DOCUMENT

This can be found in Appendix 4

8. ARCHIVING OF THIS POLICY

This is a Trust-wide document and archiving arrangements are managed by the Quality Department who can be contacted to request master/archived copies.
9. REFERENCES AND BIBLIOGRAPHY FOR THIS POLICY

www.nhsla.com

Health & Social Care Joint Unit and Change Agents Team: Discharge from hospital: pathway, process and practice, Department of Health 2003
www.dh.gov.uk

Achieving Timely Simple Discharge from Hospital: A toolkit for the multi-disciplinary team, Department of Health 2004
www.dh.gov.uk

Community Care (Delayed Discharges etc) Act 2003,
www.legislation.gov.uk

Mental Capacity Act 2005
www.legislation.gov.uk

Mental Capacity Act 2005: Code of Practice,
www.publicguardian.gov.uk/mca/code-of-practice.htm

Deprivation of Liberty Safeguards: Code of Practice
www.publicguardian.gov.uk/docs/draft-dols-code.pdf

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, Department of Health, 2009
www.dh.gov.uk

Age Concern, Choice of Accommodation: Care Homes (Information Sheet 25) Age Concern 2008
www.ageuk.org.uk

Carers UK, Coming out of Hospital Factsheet, A Guide for Carers, 2010
www.carersuk.org

Carers (Recognition & Services) Act 1995
www.legislation.gov.uk

Carers and Disabled Children’s Act (2000)
www.dh.gov.uk

Carers (Equal Opportunities) Act 2004
www.dh.gov.uk

The Equalities Act 2010
www.equalities.gov.uk
10. APPENDICES

Appendix 1  Discharge Pathway Flowchart
Appendix 2  Overall process for determining eligibility for NHS Continuing Healthcare
Appendix 3  Flowchart for Managing Discharge to Care Home of Choice and Temporary Placements
Appendix 4  Equality Impact Assessment
Appendix 5*  Discharge Care-Plan
Appendix 1: Discharge Pathway Flowchart

**DISCHARGE PATHWAY**

**Emergency**

- Assessment & Intervention/treatment

**Elective**

- Pre-admission assessment
  - Clinical
  - Functional
  - Social

- LOS/EDD discussed with patient and carer

- Referral for MDT for assessment of needs

- Patient admitted for elective surgery

**EXPECTED DATE OF DISCHARGE BASED ON ANTICIPATED LENGTH OF STAY**

**STAGE 1 ASSESS**

**STAGE 2 PLAN**

**STAGE 3 TRANSFER CARE**

**SIMPLE PATHWAY**

- Nurse initiated – consultant supported

- Clinical Management Plan including EDD based on LOS
  - Patient/carer involvement
  - Discharge planned
  - Daily review of EDD

**COMPLEX PATHWAY**

- MDT led – nurse facilitated

- Relevant referrals to MDT including Social Care Team & Discharge Coordinator

- Clinical Management Plan including EDD based on LOS

- Patient/carer involvement

- HNA/DST/Check-list, fast-track (as appropriate)

- Planning for discharge
  - Where/what and by whom patients needs are to be met
  - Confirm in writing
  - Section 5 notification to Social Care Team
  - Notification to CHC
  - Documentation/Information

- EDD regular review

- 24 hours before EDD: Patient is safe to be discharged & care-plan is completed

- Morning of discharge: Transfer to Discharge Lounge or home
Appendix 2: Overall process for determining eligibility for NHS Continuing Healthcare (NHS CHC)

**Fast track**

Discharge assessment/planning or other trigger

**Yes**

Could NHS Services enable improvements that could alter outcome of eligibility decision in the short terms?

**No**

**HNA Checklist**: Screen patient for possible eligibility (joint assessment with Discharge Coordinator and Care manager, & patients/carer)

Possible Eligibility

**Decision Support Tool**: Full consideration for NHS CHC

Establish primary health need: qualify for NHS CHC

**Funding agreed**: find placement

**Care Planning**

Written rationale for decision – communication to patients, representatives and carers

**NHS CHC package/placement funded**

Review

**No eligibility**

Care Planning: Consider need for joint package, including registered nursing care

Via Single point of Access (SPA)

**NHS funded nursing care**: contribution to services of a registered nurse

**Other care package**: NHS and LA contributions

Funding agreed: find placement

Joint care package funded or provided

Review

**Fast track**
Appendix 3: Flowchart for managing discharge to care home of choice or temporary placement

NOTE: This flow chart assumes active discharge planning throughout admission and:
- Screening for NHS Continuing Health Care completed as part of admission procedure
- Discussions with person/family about their needs & care plan options – take place as early as possible.

---

Clinical MDT team responsibility
Need for long term care agreed by MDT and discussed and agreed with patient/family/carers. Expected date of discharge must be estimated at this stage and family and patient informed that this is the plan. EDD must be documented and recorded on inpatient lists.

Family and patient provided with following information by the Social Worker/Care Manager/Discharge Coordinator
- Eligibility for NHS care.
- Moving to long term care.
- Vacancy details

If patient/family/carer does not agree with assessment outcome.
1) Review assessed process and outcome with patient/family.
2) Follow usual complaint process.
3) NHS to apply ‘Protocol of Choice’.
NB: Person does not have the right to remain in hospital

---

Care home is actively being sought by patient/family/carers or has already been chosen from vacancies already identified by SS or Health (maximum 3 offered)

Joint approach by Social Worker/Care Manager and Discharge Team member
Discuss with patient/family/carers the need to move on and the timescales. Copy of Protocol of Choice care letter (1) given, copy needs to be put in records and recorded details of the

NO

If not chosen or no vacancy foreseeable by the 6th day after clinically fit for discharge

YES

Vacancy in home of choice

If patient/carer/family respond & agree home of choice

Placement arranged

Discharge to home of choice or temporary placement as soon as clinically fit to be discharged

Move as soon as clinically fit to be discharged

Institute ‘Protocol of choice’ immediately

YES

Patient/carer agree to discharge.

NO

Move to home as soon as clinically fit to move

Arrange interim care placement

NO

If within 7-10 working days of being medically fit for discharge patient/family /carers still do not appear to be finding a home of

NHS/SSD staff secure (interim) placement to meet assessed needs.

Explain arrangements to patient/family and arrange to move as soon after clinically fit for transfer as possible

NO

Institute ‘Protocol of choice’ immediately

Discharge to temporary care as soon as possible
# Equality Impact Assessment Summary

**Name:** Claire O’Brien  
**Policy/Service:** Discharge for Adults

<table>
<thead>
<tr>
<th><strong>Background</strong></th>
</tr>
</thead>
</table>
| • Description of the aims of the policy  
• Context in which the policy operates  
• Who was involved in the Equality Impact Assessment |  

• The Policy sets out minimum standards required to ensure safe effective discharge  

• The Policy operates within key Department of Health policy guidance/legislation and alongside the Trust’s standard Discharge Framework  

• The Equality Impact Assessment has involved senior multi-disciplinary staff including: Therapies, Social Care, Intermediate Care, Specialist Nurses etc.

<table>
<thead>
<tr>
<th><strong>Methodology</strong></th>
</tr>
</thead>
</table>
| • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)  
• The data sources and any other information used  
• The consultation that was carried out (who, why and how?) |  

The Policy outlines discharge policy/process for all adult clients. The Policy ensures key standards are met irrespective of sexual orientation, culture, gender, religion, belief or disability. It is however recognised that although access to all services and assessments is the same for all age groups, delay in placement for some ‘younger persons’ presenting with older persons needs/disability is evident. This is not discrimination but resource constraint as limited specialist provision delays access.

<table>
<thead>
<tr>
<th><strong>Key Findings</strong></th>
</tr>
</thead>
</table>
| • Describe the results of the assessment  
• Identify if there is adverse or a potentially adverse impacts for any equalities groups |  

The assessment concludes recognition that access to younger persons (physically disabled provision) maybe delayed, however equal access is evident albeit limited.
Conclusion

- Provide a summary of the overall conclusions

The Policy covers all clients (adult) irrespective of equalities groups, the Policy aims to ensure standardisation of provision of key processes, assessments to ensure all clients receive full and thorough appropriate assessments prior to discharge where need dictates.

Recommendations

- State recommended changes to the proposed policy as a result of the impact assessment
- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified
- Describe the plans for reviewing the assessment

Ensure early identification of need specifically for Young Physically Disabled (YPD) to ensure early assessment and access to provision triggered.

Guidance on Equalities Groups

<table>
<thead>
<tr>
<th>Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</th>
<th>Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
</tr>
<tr>
<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)</td>
</tr>
<tr>
<td>Culture (consider dietary requirements, family relationships and individual care needs)</td>
<td>Social class (consider ability to access services and information, for example, is information provided in plain English?)</td>
</tr>
</tbody>
</table>

Under the Equalities Act 2010 this list should now incorporate Carers as a specific Equalities Group (consider whether the policy promotes a culture of carer inclusion and takes into accounts the individual needs of carers)
## APPENDIX 5

### DISCHARGE CARE PLAN

**STAFF TO SIGN CHECKLIST AS EACH SECTION IS COMPLETED**

Discharge planning must commence on admission or prior to admission when possible. The discharge checklist must be completed before a patient is transferred to the discharge lounge. All fields must be completed using n/a if action if not applicable.

<table>
<thead>
<tr>
<th>Patient addressograph:</th>
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<tbody>
<tr>
<td>Name:</td>
<td>--</td>
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<tr>
<td>Hospital No:</td>
<td>--</td>
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<tr>
<td>NHS No:</td>
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</tbody>
</table>

### GREEN PHASE (ON ADMISSION)

<table>
<thead>
<tr>
<th>Action</th>
<th>Yes/No /N/A</th>
<th>Comments</th>
<th>Date &amp; time</th>
<th>Health Care Professional Name, Signature, Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge process discussed with patient &amp; family, including any concerns</td>
<td></td>
<td></td>
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<tr>
<td>Discuss EDD with patient/carer/family (within 24hrs of admission)</td>
<td></td>
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<tr>
<td>Ensure information given to patient/carers i.e. Leaving Hospital booklet</td>
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<tr>
<td>Section 2 sent to social services (for patients with existing care, or likely to need care prior to leaving hospital)</td>
<td>Date sent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure referrals to all appropriate MDT members inc. OT/PT/ICT/SLT</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Risks to discharge identified &amp; escalated?</td>
<td></td>
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<tr>
<td>Referral to Discharge Coordinator (for complex discharges)</td>
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</table>

### AMBER PHASE (Planning Discharge))

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<tr>
<th>Action</th>
<th>Yes/No /N/A</th>
<th>Comments</th>
<th>Date &amp; time</th>
<th>Health Care Professional Name, Signature, Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential assessments taken place in OT/PT/ICT/SLT/Discharge Coordinator</td>
<td></td>
<td></td>
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<tr>
<td>Discharge plans, identified and communicated with □ Medical Team / MDT □ Patient □ Carers □ Next of Kin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have house keys or access to a key safe? Safe no.?</td>
<td></td>
<td></td>
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<tr>
<td>Pendent / alarm / telecare information given / considered</td>
<td></td>
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<tr>
<td>ICT/Care manager i.e. care package is arranged</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Health needs assessment required /completed</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Patient/relatives/carer provided with relevant training, support &amp; information – state by whom and for what</td>
<td></td>
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</tr>
<tr>
<td>Consider need for case conference (for complex discharges)</td>
<td></td>
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</tbody>
</table>
Specialist Nurse review, i.e. VAC, Stoma, Diabetic
If equipment required, ordered & confirmed delivery date (ie Hoist bed etc)
HOOF completed and faxed

**DISCHARGE CHECKLIST**

**STAFF TO SIGN CHECKLIST AS EACH SECTION IS COMPLETED**
Discharge planning must commence on admission or prior to admission when possible. The discharge checklist must be completed before a patient is transferred to the discharge lounge. All fields must be completed using n/a if action if not applicable.

<table>
<thead>
<tr>
<th>Action</th>
<th>Yes/No/N/A</th>
<th>Comments</th>
<th>Date &amp; time</th>
<th>Health Care Professional Name, Signature, Designation</th>
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<tr>
<td>Patient addressograph:</td>
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<td>Name:</td>
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<td>NHS No:</td>
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</table>

**DAY BEFORE DISCHARGE:**

- TTO's written & ordered, consideration given to dosset box
- Section 5 agreed with Social Services
- Confirming transport arrangements / transport booked & time
- Is the heating switched on in the patients accommodation?
- Next of kin/nursing/residential home / warden informed of discharge time & date (assessed / agreed to transfer)
- Package of Care/ICT in place? (Conform start time)
- Does the patient have outdoor clothes to wear on discharge?
- Community Matron / District Nurse referral made (copy in patient record & copy given to patient)

**RED PHASE – DAY OF DISCHARGE**

<table>
<thead>
<tr>
<th>Action</th>
<th>Yes/No/N/A</th>
<th>Comments</th>
<th>Date &amp; time</th>
<th>Health Care Professional Name, Signature, Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient confirmed as medically fit for discharge &amp; documented in the medical notes?</td>
<td></td>
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<tr>
<td>Removal of cannula/clips/sutures &amp; site condition documented</td>
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<tr>
<td>Medication given to patient &amp; explained (this action can be performed on the ward or in the Discharge Lounge)</td>
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<tr>
<td>Valuables returned to patient &amp; documented</td>
<td></td>
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<tr>
<td>Key from locker returned (if self administering medication)</td>
<td></td>
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<tr>
<td>Outpatient appointment given (if appropriate) &amp; relevant follow up documents given</td>
<td></td>
<td></td>
<td></td>
<td>With...</td>
</tr>
<tr>
<td>Patient is suitably dressed in outdoor clothes</td>
<td></td>
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</tr>
<tr>
<td><strong>Is there food in house? Food pack issued (if required). Meals on Wheels restarted?</strong></td>
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<tr>
<td><strong>Contact family/community hospital/NH if delay in discharge</strong></td>
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</tr>
</tbody>
</table>
| **Dressing & equipment supplied [including catheter packs and 5 night bags]**  
**Please list other items:** |
| **Final equipment supplied if applicable ie commode** |
| **Copy of discharge summary with patient & any other appropriate information (Medical certificate given if required)** |
| **Transfer letter written (for transfers to community hospitals/Nursing homes)** |
| **Transfer patient to Discharge Lounge** |