# DISCHARGE PLANNING POLICY

<table>
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<th>3</th>
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1 INTRODUCTION

Good discharge planning is an integral part of a high quality approach to meeting the health and social care needs of patients. This policy, which focuses on adults but excludes maternity, outlines the responsibilities of the three partner agencies listed below, and offers guidelines for the implementation of an effective discharge process.

Croydon Health Services NHS Trust, the London Borough of Croydon, and the Croydon Primary Care Trust are committed to ensuring a robust system is in place, which supports the safe return of the patient to their community wherever possible, and to ensure that appropriate health and social care services are in place to meet their needs.

The process is designed to be responsive to the needs of patients and their carers, whilst making the best use of acute sector resources and ensuring that the health care needs of patients are met in the best way and in the most appropriate setting possible. It is also designed to be consistent across the Trust, and will be measured and audited on an annual basis.

This policy replaces all previous existing policies pertaining to discharge planning and collaborative working between health and social care agencies.

This policy looks to provide clarity for both patients and staff across Croydon’s health service on the process steps for planning the discharge of patients who have been admitted to the acute hospital. The policy describes the patient journey from admission to discharge. To ensure that discharge for the patient is timely it is essential that discharge planning occurs as early as is clinically possible in the patient’s acute episode of care.

Health and Social Care partners work closely within Croydon Health Services NHS Trust to expedite discharge for patients. Department of Health (DH) Guidance (2003) stresses the importance of moving patients to the most clinically appropriate care setting: ‘When a person’s acute episode of ill-health has been treated it is not appropriate for them to remain on an acute hospital ward.’ This is providing they are clinically fit and have been assessed as safe to transfer.

The policy’s purpose is to offer guidance to staff to assist in reducing the number of delays in discharge and to promote successful and effective discharges. Equally, it is to ensure that patients have appropriate assessments of their health and social care needs, including their ability to benefit from rehabilitation and interim and/or intermediate care services; ensuring their needs are met in the best way following discharge from hospital. Patients will also be assessed in consideration of Continuing Healthcare Funding.

Admission to and discharge from hospital can be a distressing time for individuals and their families. For many patients, treatment will be completed successfully and they will return to their usual way of life quickly. However, some patients will need additional help over and above medical treatment and rehabilitation, and their needs can be many and varied. This might see the involvement of a range of different health and social care staff both within the hospital and in the community.

1.1 Background

This policy is designed to meet the needs of adults and older people and has been updated in the light of legislation and government guidance. It has been written in conjunction with guidance from national legislation which includes:
The National Service Framework for Older People (NSF) (DOH 2001)
This sets new national standards of care for all older people, whether they live at home, in residential care, or are cared for in hospital. It represents an ambitious agenda and is the first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people.

At its launch the Secretary of State for Health stated:

“...services sometimes fail to meet older peoples' needs – sometimes by discrimination against them, by failing to treat them with dignity and respect, by allowing organisational structures to become a barrier to proper assessment of need and access to care, and because best evidence-based practice is not in place across important clinical areas. The NSF sets out a programme of action and reform to address these problems and to deliver higher quality services for older people”

Standard Four of the NSF proposes that when older people on medical and surgical wards require Old Age specialist team input that they will be referred. Within the hospital, if such an assessment is required, the ward manager will liaise with the elderly care department.

It is important that this process becomes the basis on which good discharge planning practice is implemented, highlighting as it does that assessment should be based on individual need, and should support active and independent living, and that older people themselves are at the centre of the process.

The Community Care (Delayed Discharges etc.) Act (2003)
The Community Care Act (2003) established a reimbursement system for patients delayed in hospital whilst awaiting input from Social Services, for the first time making Social Services financially responsible for patients who had completed their acute episode of care and who inappropriately remained in the acute environment whilst their social needs were being organised. This document recognised the importance of meeting patients’ needs in the most appropriate environment for the patient in relation to the clinical and social outcomes of the patient.

Locally, these are managed at the weekly Delayed Transfer of Care meetings.

Mental Capacity Act (2005) (MCA)
The Mental Capacity Act (2005) governs decision-making on behalf of adults, where they lose mental capacity or where the incapacitating condition has been present since birth. The Act received Royal Assent on 7 April 2005 and came into force in April 2007.

The MCA brings with it several legal duties for professionals which include following the Code of Practice, the MCA principles and the Best Interest check list.

It also includes:
- A definition of capacity
- Lasting Power of Attorneys (LPA), made by the patient when they had capacity, the LPA may have the power to take health/welfare decisions on behalf of the patient
- Personal welfare deputies appointed by the court, who may take certain health/welfare decisions on behalf of the patient if so directed by the court
- Requirement to follow Advanced Directives to refuse treatment
A new criminal offence of ill treatment or wilful neglect of a person who may lack capacity. This could potentially cover failure to provide care as well as more commonly understood forms of abuse

Independent Mental Capacity Advocate (IMCA). The NHS/LA have a legal duty to instruct an IMCA where:

- A decision is being made about a change to discharge destination or serious medical treatment
- And there is a reasonable belief that the person lacks capacity to make that decision
- And there are no appropriate family/friends to consult with
- The NHS/LA may also choose to instruct an IMCA in care reviews and adult protection proceedings

2 PURPOSE

The purpose of this policy is to provide guiding principles and processes to ensure safe, effective and timely discharge from hospital.

2.1 Scope

The discharge policy applies to all healthcare professional and support staff working directly and indirectly with patients within Croydon Health Services NHS Trust. It incorporates the needs of both children and all adult patients regardless of where they were admitted from and where they are being discharged to. The policy does not apply to those patients being discharged from Croydon University Hospital to a tertiary hospital/service or to maternity patients being transferred to the community. For guidance on these discharges, please refer to the Transfer and Clinical Handover of Care Policy, the Postnatal Care Planning and Information Maternity Guideline and the Communication and Handover of Care Between Professionals Maternity Guideline which are available on the Trust intranet.

3 DEFINITIONS

Non complex: Patients with non complex discharge needs make up the majority of all discharges. They are defined as patients who:

- Have simple ongoing care needs which do not require complex planning and delivery

Complex: The remaining patients in hospital who have more complex needs require referral for assessment by other members of the multidisciplinary team. Complex discharges relate to patients:

- Who will be discharged home or to a Nursing or Residential Home, and
- Who have complex ongoing health and social care needs which require detailed assessment, planning and delivery by the multi-disciplinary team and multi-agency working, and whose length of stay in hospital is more difficult to predict

Delayed Transfer of Care (DTOC): A delayed transfer of care occurs when a patient is deemed medically fit for discharge, no longer requiring an acute bed but is still occupying one.
Delays may be attributable to either the NHS or Social Services and are reported to the Department of Health (DH) monthly.

**Medically fit for discharge:** A patient, who, clinically and following where necessary, assessment by the multidisciplinary team, no longer requires inpatient investigation, treatment or care in an acute unit. A patient being medically fit for discharge does not necessarily mean the patient is safe for discharge.

**Out of hours discharge:** A discharge that takes place between 6pm and 6am hrs

**Self discharge:** Related to patients wishing to self discharge against medical advice

**Vulnerable person:** Any patient with recognised difficulty communicating their needs; this may be due to a physical, psychological or learning disability.

**Abbreviations**
These abbreviations can be found in the main policy:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACOT</td>
<td>Adult Community Occupational Therapy Service</td>
</tr>
<tr>
<td>ADN</td>
<td>Associate Director of Nursing</td>
</tr>
<tr>
<td>ADO</td>
<td>Associate Director of Operation</td>
</tr>
<tr>
<td>AMU</td>
<td>Acute Medical Unit</td>
</tr>
<tr>
<td>CCES</td>
<td>Croydon Community Equipment Service</td>
</tr>
<tr>
<td>CICS</td>
<td>Croydon Intermediate Care Service</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DToC</td>
<td>Delayed Transfer of Care</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>IMCA</td>
<td>Independent Mental Capacity Advocate</td>
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<tr>
<td>LPA</td>
<td>Lasting Power of Attorney</td>
</tr>
<tr>
<td>MCA</td>
<td>Mental Capacity Act (2005)</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-disciplinary Team</td>
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<tr>
<td>MoW</td>
<td>Meals on Wheels</td>
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<tr>
<td>NH</td>
<td>Nursing Home</td>
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<td>NNA</td>
<td>Nursing Needs Assessment</td>
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<tr>
<td>NoK</td>
<td>Next of Kin</td>
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<tr>
<td>NSF</td>
<td>National Service Framework</td>
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<tr>
<td>OT</td>
<td>Occupational Therapy/Therapist</td>
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<tr>
<td>PACE</td>
<td>Post-Acute Care Enablement</td>
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<td>PoC</td>
<td>Package of Care</td>
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<tr>
<td>RH</td>
<td>Residential Home</td>
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4 **ACCOUNTABILITIES AND RESPONSIBILITIES**

**Director of Operations**
Has overall responsibility to ensure that there is an appropriate and effective system in place for the discharge of patients from the trust.

**Clinical Directors and Executive Committee:**
Has the overarching responsibility for ensuring all members of trust staff involved in discharge planning are compliant with the policy. The committee will receive information in relation to the monitoring and duties contained in this policy and any recommendations that are made by other committees for improvement. It is the responsibility of these individuals to ensure appropriate actions are implemented.

**Clinical Governance and Risk Committee:**
Will receive a quarterly safety report which will include data on incidents and complaints in relation to discharge issues. It is the responsibility for ensuring this information is forwarded for any necessary action to be managed through liaison with the Directors of Operations and subsequently the Clinical Directors and Executive Committee.

**Associate Directors of Operations (ADO)/Associate Directors of Nursing (ADNs):**
ADOs/ADNs are responsible for ensuring safe discharge methods are communicated and implemented with their areas of responsibility. Any on-going patient discharge/transfer risks should be assessed and registered on the Directorate Risk Register (see the Trust Risk Management Strategy)

**Head of Hospital Avoidance:**
Has the responsibility of managing the Integrated Discharge Team; ensuring that all complex discharges are co-ordinated and case managed by this team and are managed in accordance with local and national policy and legislation. The Head of Hospital Avoidance is also responsible for reporting the Delayed Transfer of Care data to both the NHS and trust board. This postholder, along with members of the Integrated Discharge Team, is there to support the MDT in safe discharge planning, liaising with internal and external agencies and services that can assist in the planning process, and ensure that any delays are kept to a minimum. Further to this, the individual will ensure this policy is adopted and followed; carrying out audit as required, whilst also being the lead on complaints pertaining to poor discharges; changing practice through teaching and development. The Head of Hospital Avoidance (or an appointed deputy) will attend Family Meetings and Best Interest Meetings at the expressed wish of the MDT, the family or the patient. Their role in these meetings is to ensure that the principles of good discharge planning are followed.

**Multi-Disciplinary Team:**
The MDT is responsible for ensuring that they fully understand the procedures and policies for safe discharge planning; being mindful of their limitations and the responsibilities of others in the discharge planning process. They must not make a decision they do not have responsibility for; however their recommendations must not go ignored either. The MDT is responsible for attending all relevant meetings for discharge planning, and that the discussion and outcomes of these meetings are documented clearly. The MDT is also responsible for ensuring any assessments and documentation that is required for the patient’s discharge is completed within the timeframes as stipulated (Appendix D). Failure to comply with these timeframes will result in a coded delay in accordance with the Community Care (delayed discharges etc) Act (2003).

Consideration must be given to all services that are available to support the patient on discharge to maintain their independence. Therefore referral to services that can support the patient should be considered and made as appropriate (for example; Intermediate Care services, voluntary sector, reablement)

It is also the responsibility of the MDT to ensure that everything is in place before the patient is discharged home. Failure to ensure this may result in an unsafe discharge and readmission to the hospital. The medical team must ensure that the TTOs are requested in a timely manner, preferably not on the day of discharge so as to avoid a delay in discharge, or the patient being discharged without medication.
In the event of a problem arising, either during the planning of the discharge, or after a discharge, the Head of Hospital Avoidance should be informed to assist in rectifying the situation.

**Pharmacy:**
Pharmacy staff have the responsibility to ensure timely preparation of TTOs. Ward pharmacists will provide medication counselling to patients in conjunction with ward and medical staff as required.

**PACE:**
Post-acute Care Enablement are responsible for helping the MDT identify patients who might be able to have an Early Supported Discharge. The aim of PACE is to provide the latter part of the traditional acute episode of care safely and appropriately in the patient’s own home. Intervention can be provided by the District Nursing and CICs services in the patient’s own home, whilst the patient remains the responsibility of the ward consultant. Patients can be with the PACE service for up to one week. Common services the PACE Team provide include monitoring blood/drug levels and monitoring vital signs.

The PACE Case Finders will attend the wards daily to identify patients; attending MDT meetings, board rounds and ward rounds to identify potential patients. Equally the MDT can refer directly to the PACE team (bleep 355) and discuss any potential patients with the PACE Case Finder. Once a patient has been identified, signed consent from both the senior clinician (registrar or consultant) and the patient must be sought before discharge can proceed.

### 5 DISCHARGE PROCEDURE / ACTIONS REQUIRED

**The principles of good discharge planning are:**

- **Start as early as clinically possible:**
  - Identify the current home situation for the patient, carry out assessments, and determine when the patient is at their baseline (either new or previous level)
  - Invite members of the MDT to carry out assessments in a timely manner; anticipate what the patient may require early and seek referrals quickly
  - Convene meetings (for example family meetings and best interest meetings) in a timely manner not forsaking the attendance of key professionals. Ensure these meetings have a purpose and a focus

- **Co-ordinate the discharge plans:**
  - Ensure the patient and their family (or significant others) are involved in the discharge plans
  - Ensure members of the MDT are fully briefed on the progress plans are making; document in nursing and medical notes in accordance with governing body and local policy standards
  - Ensure any equipment that is required is ordered at the same time to reduce the risk of delay. Liaise with family members about accepting delivery of this; ensuring they have adequate time to prepare the home as necessary
Utilise the skills and knowledge of the Integrated Discharge Team to help coordinate and facilitate the discharge if it is complex

- Ensure everything is in place before the patient is discharged:
  - Never allow a patient to be discharged without confirmation that all equipment and services are in place. It is the responsibility of the professional who has organised the service to ensure it is set up
  - Where services are not in place, discharge should be delayed until it is safe to allow the patient to be discharged
  - Ensure a smooth discharge from hospital; so no surprises for the patient. They, and their family, should know in advance when they are going home and what services they will receive

5.1 Elective Care

The patient’s journey should start in the community. Pre-admission screening for all routine elective admissions allows for anticipated problems to be identified and planned for before the patient is admitted. This will not only avoid any delays in discharge after the procedure, but will also allow for the patient to prepare for the effects the procedure may have on their ability to cope afterwards. It allows a time for planning which is controlled and organised. The procedure for such patients is as follows Flowchart 1 (see overleaf):
**Flow Chart 1: Pre-admission discharge planning**

- **Pre admission Outpatient Appointment**
- **At appointment discuss with patient, their NOK or carers, the outcome of admission & anticipated length of stay**
- **Document existing support (PoC, MoW, Day Centre etc.)**
- **Anticipate new needs**
- **Complete Social Services checklist**
- **If the patient requires social services support on discharge then refer to social services at Taberner House (telephone #6023 and ask for Contact Centre)**

- Identify support networks
- Ascertain patients/family carers wishes
- Determine mental/physical capacity of patient
- Consider contacting an IMCA if patient does not have capacity
- Ensure support is in place when patient is admitted for operation

5.2 Emergency Care

Patients who attend the Emergency Department (ED) may be admitted to the Acute Medical Unit (AMU). From either the ED or the AMU, they could be deemed medically fit for discharge and able to go home. However, following discussion with the patient, and/or family/carers, it might be identified that the patient will require support on discharge home. In such cases the ED/AMU staff should consider referral to the PACE and A&E Liaison Team. The PACE and A&E Liaison team can discharge patients with nursing, OT, physiotherapy and social care support for up to two weeks. The procedure for such patients is as follows flowchart 2 (see overleaf):
Flowchart 2: Discharge Planning in the ED/AMU

PATIENT ATTENDS ED

Assessed by ED Clinicians

Medically fit for discharge

Yes

Needs home support?

No

Yes

Refer to A&E Liaison

Assessed by team

Refer to Community Services (CICs, DNs, Falls Services, CMHT, GP, Community Matrons)

HOME

No

Admit into CUH

Safeguarding Vulnerable Adult

Discharge not recommended?

Input required?

Yes

Is patient Croydon resident?

No

Refer to S/S in appropriate borough

Is patient main carer for spouse?

Yes

Refer to S/S for support in the community for spouse

No

Period of observation treatment

Admit to MAU or ED observation ward

Medically fit for discharge

No

Yes

Refer to A&E Care Management

Refer to A&E Care Management

Refer to Community OTs for Reablement assessment within 24hrs of discharge

HOME

Will discuss with ACT Team manager or appointed deputy

Short term?

Yes

Does patient need PoC?

No

Enara carers or up to 2/52

Enara to provide initial 48hrs care

Send paperwork to Brokerage & confirm start date

Yes

Assess against FACs, complete SSAQ & develop support plan

HOME

November 2012

If after 2/52 it is felt patient needs longer PoC, paperwork to be completed & sent to Brokerage

KEY

Decision

Action
5.2.1 Vulnerable Patients in the ED

Where vulnerable patients attend the ED/AMU and need to be discharged, extra care must be given to the discharge process. This group includes:

- The frail, elderly who live alone
- Patients who have fallen – this group should be identified, coded as having fallen, screened and referred to the falls services
- Terminally ill
- Young chronically sick
- Patients in a vegetative state
- Patients with tuberculosis
- Patients with sensory impairment and/or communication difficulties
- Patients with Learning Disabilities
- Patients where there are safeguarding issues
- Patients with alcohol, drug misuse and mental health problems

If patients have come from a Residential Home, and the home is stating that the resident’s needs have changed, the home should be advised that the resident cannot be admitted into hospital for this reason. Instead the home must be advised to contact the care manager who originally placed the resident and discuss the change in condition with them. If it is evident that following assessment by the ED staff that there are no medical problems that would require the resident to be admitted, the patient must be transferred back to their residential home. Any problems arising from this should be escalated as soon as possible to the Head of Hospital Avoidance.

5.2.2 Discharge of Patients from ED

Patients who have an unplanned re-attendance to the ED within 72 hours of discharge, and are subsequently deemed medically fit for discharge must be screened by a senior ED clinician and the ED Checklist completed (available in the Emergency Department). This must be filed in the patient’s ED records.

5.3 In-patient Care

Members of the MDT should start planning for discharge on the day of admission. By discussing the anticipated length of stay, estimated date of discharge and ward processes to the patient, their next of kin or significant other, possible delays could be identified early and avoided. If support is required from OT, Physiotherapy or Care Management services, these referrals should be made in a timely manner to reduce non-clinical bed days. Table 1 overleaf, outlines the tasks that needs to be completed and who is responsible for the task. Please note that clear communication/documentation is required amongst the MDT to ensure no duplication of actions taken:

Services within the Trust the patient may need to be referred to for support:

- Therapies service (OT and Physiotherapy)
- Nutrition and dietetic services
- Speech and language services
- Palliative care team
- Mental Health for Older Adults/Liaison Psychiatry
- Red Cross
- Integrated Discharge Team
- Intermediate Care Team
- Staying Put (contracted to the Trust)
**Table 1: Discharge actions to be taken by the MDT**

<table>
<thead>
<tr>
<th>Action</th>
<th>Person Responsible</th>
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<tbody>
<tr>
<td></td>
<td>Nurse</td>
</tr>
<tr>
<td>Determine existing services</td>
<td>●</td>
</tr>
<tr>
<td>Ensure these services are informed of the patient’s admission</td>
<td>●</td>
</tr>
<tr>
<td>Complete thorough assessment of needs &amp; determine who patient may need to be referred to for further assessment &amp; support</td>
<td>●</td>
</tr>
<tr>
<td>Where appropriate a falls assessment must be completed to ensure risk of falls is reduced</td>
<td></td>
</tr>
<tr>
<td>Carry out capacity assessment &amp; refer to IMCA as required</td>
<td>●</td>
</tr>
<tr>
<td>Consider whether the patient is eligible for Continuing Healthcare funding</td>
<td>●</td>
</tr>
<tr>
<td>Complete NNA for a change of discharge destination (from RH to NH)</td>
<td>●</td>
</tr>
<tr>
<td>Complete Continuing Healthcare documentation if the patient screens in as eligible</td>
<td>●</td>
</tr>
<tr>
<td>Co-ordinating &amp; arranging Family Meetings/Discharge Planning Meetings</td>
<td>●</td>
</tr>
<tr>
<td>Co-ordinating Best Interest Meetings</td>
<td></td>
</tr>
<tr>
<td>If the patient is complex, refer to the Integrated Discharge Team</td>
<td>●</td>
</tr>
<tr>
<td>Identify social care needs required on discharge</td>
<td>●</td>
</tr>
<tr>
<td>Where there are concerns regarding an Adult Protection issue, refer to the Safeguarding Team at Taberner House</td>
<td>●</td>
</tr>
<tr>
<td>Lead on any safeguarding/adult protection issue within the given timeframe</td>
<td></td>
</tr>
<tr>
<td>Involve patients, next of kin, significant others &amp; carers in discharge planning²</td>
<td>●</td>
</tr>
<tr>
<td>Re-start of existing services where a patient is discharged with the same PoC/services (see flowchart 4 page 19)</td>
<td>●</td>
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</tbody>
</table>

² Patients must be asked who they would like to be involved in their discharge planning, and these wishes must be respected. Where a patient lacks capacity to make this decision, the best interest of the individual must be considered and the Mental Capacity Act adhered to.
5.3.1 Non-Complex Discharge Planning from In-patient Care

Flowchart 3 demonstrates the responsibilities of the nursing and medical teams for non-complex discharges. If there is any doubt over the complexity of the discharge, please contact the Integrated Discharge Team.

Flowchart 3: Non-Complex Discharge Planning from in-patient care

**Decision to Discharge**

**Nurse Responsibilities**
- Assist patient to make transport arrangements. Encourage family to collect patient if possible
- Ensure patient has all medication and dressings. Explain all medications and give opportunity to ask questions
- Ensure patient has all their belongings including walking aids, hearing aids and glasses
- If patient has existing services, ensure these are restarted 24hrs before discharge
- Refer to District Nurse services if required for dressing changes. This should be done 48hrs before discharge
- Ensure patient has a copy of their discharge letter

**Medical Team Responsibilities**
- Inform patient of outcome of investigations – action and any follow-up required
- Order TTOs (see Section 5.3.7)
- Complete discharge letter with ongoing instruction for GP
5.3.2 Complex Discharge Planning from In-patient Care

**Flowchart 4** demonstrates the processes and responsibilities of the MDT in planning for a complex discharge. If there is any doubt over the discharge process, then please contact the Integrated Discharge Team.

5.3.3 Family Meetings

Family meetings should be arranged as a means to meet with the patient, their next of kin or significant others to discuss and plan the discharge. Not all patients will require a formal meeting to do this, however this is best practice where there has been a significant change in the patient’s circumstances or where a change to the home situation is anticipated (for example PoC, or equipment). If it is felt that the discharge is complex, it is advisable to refer the case to the Integrated Discharge Team to be involved.

5.3.4 Best Interest Meetings

A best interest meeting may be arranged if the patient lacks capacity to make a decision about discharge planning and has no one to act in their best interest. Or the patient lacks capacity and there are concerns that the next of kin are not acting in the patient’s best interest. In this situation the patient will have been referred to the IMCA and they will have assessed the patient before the Best Interest Meeting. If it is felt that the discharge is complex, it is advisable to refer the case to the Integrated Discharge Team to be involved.

5.3.5 Croydon Intermediate Care Service (CICS)

Provide rehabilitation in the community either in the patient’s own home or in a care home bed. The patient must have two out of three needs – physiotherapy, occupational therapy or nursing needs. Referral to this service is completed by the ward based therapists. The patient needs to be registered with a Croydon GP or depending on the areas have a Croydon address with an out of borough GP (agreements regarding this vary depending on the area).

If the patient is being discharged to one of the beds the patient needs to be able to transfer consistently with one and there also needs to be an agreed discharge address to go to from the bed and potential to achieve the goals that will allow them to return home within two weeks.

For all discharges, either to home or the beds, the following is required:

a) Copy of the discharge summary
b) All TTOs
c) Wound dressings if appropriate
d) Cather care if appropriate
e) Any walking aid they have been mobilising with in hospital

5.3.6 Reablement Service

Provide reablement in the community in either the patient’s own home or in a care home bed. Includes Occupational Therapy and physiotherapy. Patients must be motivated towards regaining their independence and be willing to participate in a programme. Clients who are referred with cognitive impairment will be triaged prior to any intervention and any intervention offered will be based on a risk factor assessment and where the intervention is appropriate.

Where reablement is carried out in the patient’s own home, the OT will set up a reablement programme with the patient, their family and any carers. The programme is offered for up to six weeks with the aim being for the patient to be as independent as possible in their own home with a minimal amount or no care provided by carers. An OT will contact the patient once a week to check on progress and change goals as appropriate.

Where reablement is carried out in a care home, the OT will set up a reablement programme with the patient, their family and staff from the care home. The programme is offered for up to
four weeks with the aim being for the patient to return home as independent as possible with a minimal amount or no care provided by carers. An OT will visit up to twice a week and physiotherapy will be referred to as required. The rest of the time the care staff follow the reablement programme under the direction of the OT. The staff covering the reablement beds are not nursing staff.

There is GP cover. Patients must be discharged with their full medication otherwise they will not be accepted. The reablement unit is not a rehabilitation unit. If there are issues such as a patient needing special medical attention e.g. pressure care, oxygen, catheters, bariatric, etc this would need to be discussed prior to any referral.

5.3.7 Community Service

There is a vast array of community services that a patient could be referred to. These may provide additional support for the patient on discharge:
- District Nursing Service
- Adult Community Occupational Therapy Service (ACOT)
- Physiotherapy services
- Croydon Community Equipment Service (CCES)
- Social Services Visual Impairment Team
- Social Services Deaf Team
- Integrated Mental Health
- Health Visitor for Older Adults
- Virtual Ward/Community Matrons

5.3.8 Referrals to District Nurses

A referral must be made to the DN service if:
- A patient is discharged with a pressure sore
- A patient is discharged with a hospital bed and/or a pressure mattress
- A patient is discharged with leg ulcers/chronic wound problems
- A patient is discharged who was, before admission, being seen by the DN service
- A patient is a newly diagnosed diabetic and requires glucose monitoring/support in the community
- A patient is discharged for End of Life Care or for care funded by Continuing Care
- A patient requires medication management/support
- A patient requires IV anti-biotics in the community

This is not an exhaustive list, and if you are unsure if a patient requires DN support please either contact the Community Liaison Service (ext 3147 or pager: 07659 135 956) for advice.

5.3.9 Voluntary Sector

Consideration should be given to referring patients to Croydon’s many voluntary sector providers. These include:
- Age UK
- Croydon Care Association
- POP Service
- Croydon Neighbourhood Care
- Red Cross

This is not an exhaustive list and if more advice is required please contact the Integrated Discharge Team.
5.3.10 Discharge Prescribing

All discharge medicines are prescribed on paper or electronically on the discharge summary. The electronic prescription provides a permanent record of the medicines that the patient is taking on discharge. This must comply with the Trust policy and procedure for the prescribing and supply of monitored dosage systems and compliance aids. All medicines that the patient is taking, not just those required on discharge, must be prescribed, including their own supplies.

The prescriber must write:
- Full details of the prescription – name of medicine, dose and frequency
- Indication and how long treatment is to continue for
- Medicines started, stopped or amended during the admission episode
- Where, if necessary, further supplies should be obtained

All information on the discharge summary must be complete and accurate at the time of writing. Once the prescription has been written the ward staff or pharmacist must be informed.

Discharge medications should be prescribed well in advance to facilitate a timely departure from hospital. Discharge prescriptions for patients with special requirements (e.g. monitored dosing systems) should be presented to pharmacy staff 48 hours before discharge is planned.

5.3.11 Information/Documentation for Patients/Carers on Discharge

The recording of information provided on discharge is documented by the nurse responsible for the patient who must ensure the Discharge Checklist (Appendix C) is completed:

All patients leaving hospital will receive the following information:
- Any services that the patient is going to receive on discharge (community nursing services, social services) and when these will start
- Advice about any outpatient appointments
- Date for removal of sutures if appropriate
- Any further wound dressings that are required and where to go for these
- Copy of the GP discharge summary
- Specific written instructions/information relating to the patient’s condition/treatment
- Any required medication to take home must be provided and any written information about medication and its guidance on administration
- Contact telephone numbers for emergency or continuing care

At the point of the patient leaving the hospital, the discharging nurse must:
- Ensure property has been checked and returned to the patient
- Medication checked with explanation given to the patient
- Explanation of next steps in their treatment plan i.e. outpatient appointment, visit to GP, district nurse
- Check method of transport home
- Discharge patient from the Computer system

Footnotes for Flowchart 4
3 To include existing PoC, whether it needs to be increased or restarted on discharge
4 Medically fit for discharge
5 Blister pack for anyone already on one or who is going to a residential Home, or anyone who is going home who has cognitive impairment and is unable to self-medicate
6 NNA 3 page document for Croydon Residents & HNA for all OOB residents. One working day is given to complete NNA and 3 working days is given to complete a HNA
7 Paperwork to be seen by Integrated Discharge Team before submission
5.3.12 Information/ Documentation for the Receiving Healthcare Professional

On the day of discharge, the nurse allocated to the patient must ensure all elements of the discharge process are completed before the patient leaves. The minimum information provided to any healthcare professional (District Nurse, GP, Nursing Home) on discharge is the following:

- Discharge summary is sent to the GP within 48 hours of the patient’s discharge which sets out the diagnosis, treatment, procedures and operations, investigations and medication on discharge.
- District Nurse referral form which sets out the patients specific needs and package of care. This must be sent to the Single Point of Referral Team on the day of discharge before 16.30 if a visit is required the following day.
- Nursing transfer letter for patients discharged to a Nursing or Residential home

The recording of the information provided on discharge must be documented by the nurse responsible for the patient who must ensure the Discharge Checklist is completed (Appendix C). See also section 5.4 to 5.9 for patients with specific discharge requirements.

5.4 Discharge of Vulnerable Patients

There are a number of patient groups where special attention must be given to discharge planning:

- The frail, elderly who live alone
- Terminally ill
- Young chronically sick
- Patients in a vegetative state
- Patients with tuberculosis
- Patients with sensory impairment and/or communication difficulties
- Patients with Learning Disabilities
- Patients where there are safeguarding issues
- Patients with alcohol, drug misuse and mental health problems
- Patients who are homeless/asylum seekers

It is imperative that these patient groups should only be discharged if all the support services required for them are in place, and have been confirmed as being in place by the nurse before discharge. Extra caution should be given to these patients when discharged on a Friday or over the weekend, as additional support either in the community or in the hospital may be limited. If it is the patient’s/carer’s/family’s expressed wish that the patient is discharged home on a Friday or over the weekend, and services are not in place, the family/carers must agree to take responsibility for meeting the patient’s care needs over this period of time.

Also consider the Red Cross when discharging vulnerable patients who live alone. They are able to ensure there is heating on and basic food essentials in the house ready for the patient. They will also be able to meet and greet the patient on arrival home and this can reassure the patient and reduce the risk of readmission.

5.4.1 Discharge of Patients who Lack Capacity to Consent to their Discharge

The Mental Capacity Act and its code of practice must be adhered to. It must be established as to whether the patient has a registered lasting Power of Attorney or a court appointed Personal Welfare Deputy to deal with their personal welfare decisions. If so this person should be contacted.

A best interest decision about where the patient is discharged must be taken following a best interest meeting (see section 5.3.4). Where a patient meets the criteria for an Independent Mental Capacity Advocate (IMCA), there is a legal requirement to instruct one and to take account their submissions when making the best interests decision.
5.4.2 Discharge of Admitted Patients Out of Hours

Wherever possible the Trust discharges people from the hospital at times that are convenient for the individual. Out-of-hour discharges are those that occur after 6pm and before 6am. Staff discharging patients between 6pm and 6am must complete Appendix E. **Between 11pm and 6am admitted patients will only be discharged in exceptional circumstances** i.e. Major Incident. If patients are to be discharged for any other reason, the ward staff must seek authorisation from the Site Practitioner and document reason for discharge in the patient’s notes. A Datix must be completed.

Wherever possible an elderly patient should be discharged in the morning, or by mid-afternoon at the latest. Exceptions to this may be patients returning to residential homes or nursing homes, or where family are collecting their relative from the ward.

If a discharge is occurring out-of-hours, then the Out-of-Hours Checklist *(Appendix E)* must be completed, regardless of the age of the patient, or whether the patient is considered to be vulnerable or not. The checklist must be filed in the patient’s notes.

5.5 Discharge of Patients who are Homeless

Homelessness is a term used to describe a wide range of people who are in need of housing. The term includes who are sleeping rough, and people in temporary, insecure or inappropriate accommodation. The term may also be used for the travelling community and refugees. **Flowchart 5** demonstrates the process to follow when discharging a patient who is homeless. Please note that patients sent to Taberner House inappropriately dressed will be returned back to the ward at CUH. Please ask the Red Cross to help with clothes if the patient does not have any.
Please note that not all patients referred to Housing will be housed immediately

5.6 No Recourse to Public Funds

Some patients may not be entitled to health and social care for several reasons. If there is concern that a patient may not be entitled to these services, in the first instance please contact the Overseas Department (ext. 3569). If the patient requires on-going care or housing on discharge please contact the Integrated Discharge Team for assistance. Support and advice will be sought from the No Recourse to Public Funds team in the appropriate borough.

5.7 Discharge Against Medical Advice

The medical team must be notified and they will advise the patient of any risks. These must also be clearly documented in the medical notes. A disclaimer form must be signed where possible. Staff must refer the patients on to other relevant agencies as appropriate. A discharge summary must be sent to the GP within 48 hours.

5.8 Patients Legally Retained Under the Mental Health Act (1983)

Patients should have special attention given to legal requirements before discharge. The care manager must be involved at all stages of discharge to ensure that the legal requirements of the Act are properly dealt with. Patients who are discharged from Croydon Health Services under the Mental Health Act (1983) must be accompanied by the appropriate documentation. This discharge is usually to another hospital. Authority for transfer from one hospital to another under different managers required the completion of the following:

- Section 19 Form – Completed by the Site Practitioners and must accompany the patient to the receiving hospital. A copy is retained in the Operations Centre

5.9 Discharge of Paediatrics

As with adults, a child’s discharge should be planned on admission. The aim is to keep children out of hospital wherever possible. When planning discharges, staff must work closely with Croydon’s Children Hospital at Home Paediatric Nursing Team. Where there are child protection issues, children will not be discharged without a discharge planning meeting.

Discharge Planning must begin on admission with multi-professional and family involvement focus, to ensure all needs are met. The focus of discharge is always that the safety and developmental needs of the child are maintained on discharge, supported by and giving to, those with whom they live.

Social and emotional needs are taken into account and staff must work with Mental Health services and Social Services. There must be close links with education via school teachers and nurses.

Paediatric standards include the National Service Framework for Children, Young People and Maternity Services. These must be referred to and adhered to, to ensure children and their families are given appropriate support both in hospital and when discharged from it.

5.10 Discharge of Maternity Patients

Discharge of a postnatal mother and baby is outlined in the Postnatal Care Planning and Information Maternity Guideline. The communication on discharge is outlined in the
Communication and Handover of Care Between Professionals Maternity Guideline. Both of these are available on the Trust intranet.

5.11 Delayed Discharges

The Integrated Discharge Team should be involved in any complex discharges from the hospital as these often involve patients who have had an extended length of stay. Referral to this team can be done by contacting the Head of Hospital Avoidance (bleep 584) or the Discharge Coordinator (bleep 516).

The Delayed Transfer of Care meeting takes place every Tuesday, and aims to review the progress of all patients who are in hospital for 10 days or longer. Any actions or advice from this meeting is then shared with the MDT via the medical notes. The MDT is asked to take action on this advice quickly to ensure no further unnecessary delay.

Delayed discharges are reported to the Department of Health on a monthly basis (SITREP report). The delays must be agreed by the Head of Hospital Avoidance (or agreed deputy in their absence), the Head of Therapies (or agreed deputy in their absence) and the Adult Care Team Manager (or agreed deputy in their absence). Any out-of-borough delays must be discussed with the Adult Care Team Manager for that borough.

5.11.1 Timely Discharges
To ensure patients are discharged in a timely manner, all potential delays should be identified early and managed according to the policy or after seeking advice from the Integrated Discharge Team.

5.11.2 Discharge to Existing Placement
The MDT, usually led by the Physiotherapist, should be in regular contact with the Residential Home to determine baseline for mobility and should be aiming to rehabilitate the patient back to this. The manager or appointed deputy should be invited in to assess the patient and determine if and when the patient can return. If the patient is able to return, this should be done as quickly as possible, ensuring that any new equipment that patient requires is in place.

However, in the event that this is not possible and there is a change in care needs, the manager or appointed deputy should come to assess the patient as soon as possible to confirm this. Please refer to Flowchart 4 for actions to then be taken.

5.11.3 Discharge to a New Placement (first time)
If a patient is going into placement for the first time, this should be agreed with the Care Manager before any assurances are given to the patient/family.

Regardless of how the placement is being funded (self-funded or by Social Services), it is aimed that a suitable placement is found within 7 days, and discharge is completed within 10 days.

It is the responsibility of the ward staff to ensure that the family are aware they have 7 days to find an appropriate place. The Integrated Discharge Team or Care Manager can support them in this by providing a list of homes with current vacancies. Please issue Letter A (Appendix F) to the patient/relative when placement is identified, and document in the medical notes when this has been done.

Under no circumstances should the MDT agree to placement with the family as this leads to unnecessary disputes and delays.

5.11.4 Patient/Family Delays
Once a patient is deemed medically fit for discharge a discharge date should be set. If a patient refuses to leave the hospital at this time, or where the patient/family disputes the discharge plan, it is imperative that the Integrated Discharge Team is contacted. The team will help liaise and facilitate the discharge; however it is important that this is done in a timely manner to
ensure no unnecessary delays. Furthermore, failing to contact the Integrated Discharge Team early may make the situation more complex than necessary.

When dealing with these issues the following must be done:

- Determine clear reasons for the dispute with the patient or carer/relative so obstacles can be overcome where possible
- Ensure effective communication; keeping all agencies informed and up to date in a timely manner. Document in the medical notes to ensure the MDT are informed
- Encourage the patient or carers/relatives to set out their views in writing
- Appoint a lead co-ordinator (usually from the Integrated Discharge Team or Adult Care Team). The lead should not be the consultant responsible for the patient’s care to preserve the relationship between the patient and clinician.
- Arrange family meetings as required (see section 5.3.3)
- Negotiate with the patient or family/carer to compromise and allow discharge to take place

If the dispute remains at this point support needs to be sought from the Director of Operations. A decision to enforce discharge can only be made when agreement is sought from the Head of Hospital Avoidance, Director of Operations from Croydon Health Services, with Divisional Director representation from Social Services and Director level support from the PCT.

6 TRAINING

The Discharge team provide monthly sessions on basic discharge planning and staff are given the opportunity to attend Continuing Care Panels for further professional development

6.1 Equality Impact Assessment

The Equality Impact Assessment for this policy is attached in Appendix A.

7 MONITORING COMPLIANCE

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<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
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<td>Head of Hospital Avoidance</td>
<td>Health Record Keeping Audit</td>
<td>Annual</td>
<td>Nursing &amp; Midwifery Board Directorate Quality and Performance Boards, Patient Safety Committee</td>
<td>Matrons, Associate Directors of Nursing</td>
<td>Audit report will highlight recommendation for actions and appropriate leads will be identified</td>
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<td>b) Information to be given to the receiving healthcare professional</td>
<td>Head of Hospital Avoidance</td>
<td>Health Record Keeping Audit</td>
<td>Annual</td>
<td>Nursing &amp; Midwifery Board Directorate Quality and Performance Boards, Patient Safety Committee</td>
<td>Matrons, Associate Directors of Nursing</td>
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<td>c) Information to be given to the patient when they are discharged</td>
<td>Head of Hospital Avoidance</td>
<td>Health Record Keeping Audit</td>
<td>Annual</td>
<td>Nursing &amp; Midwifery Board Directorate Quality and Performance Boards, Patient Safety Committee</td>
<td>Matrons, Associate Directors of Nursing</td>
<td>Audit report will highlight recommendation for actions and appropriate leads will be identified</td>
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<td>e) How the organisation records information</td>
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<td>Health Record Keeping Audit</td>
<td>Annual</td>
<td>Nursing &amp; Midwifery Board Directorate Quality and</td>
<td>Matrons, Associate Directors of Nursing</td>
<td>Audit report will highlight recommendation for actions and</td>
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given

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<th>given</th>
<th>Performance Boards, Patient Safety Committee</th>
<th>appropriate leads will be identified</th>
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<td>f) Out of hours discharge process</td>
<td>Head of Hospital Avoidance</td>
<td>Health Record Keeping Audit</td>
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8 REFERENCES

- Discharge form Hospital: Pathway Process and Practice DH2003
- Active Timely simple discharge from hospital- A toolkit for the multidisciplinary Team; DH
- Ensuring the Effective Discharge of older patients from NHS Acute Hospitals: The National Audit office
- Ready to Go? : DH

9 ASSOCIATED DOCUMENTATION

- Patient Identification Policy
- Transfer/ Handover and Escort Policy

10 VERSION HISTORY TABLE

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Ratified by</th>
<th>Comment/Reason for change</th>
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<td>Lorraine Walton</td>
<td>IGCGC</td>
<td>New</td>
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<td>Lorraine Walton</td>
<td>IGCGC</td>
<td>Updated in line with NHSLA requirements</td>
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<td>October 2010</td>
<td>Lorraine Walton</td>
<td>IGCGC</td>
<td>Updated to reflect integration</td>
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<td>3</td>
<td>November 2012</td>
<td>Rachael Colley</td>
<td>Policy Committee</td>
<td>Update Policy</td>
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# APPENDIX A – EQUALITY IMPACT ASSESSMENT

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<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
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<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
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<tr>
<td></td>
<td>Race</td>
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<td>Sexual orientation including lesbian, gay and bisexual people</td>
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<td>Age</td>
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<td></td>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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<td>2. Is there any evidence that some groups are affected differently?</td>
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<td>3. If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?</td>
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<td>4. Is the impact of the policy/guidance likely to be negative?</td>
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<td>5. If so can the impact be avoided?</td>
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<td>6. What alternative are there to achieving the policy/guidance without the impact?</td>
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<td>7. Can we reduce the impact by taking different action?</td>
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**APPENDIX B – CONSULTATION TEMPLATE**

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| 3. | Group/Committee Consulted: | **Therapies:**  
|   |   | Maria Knopp  
|   |   | Sarah Vernon  
|   |   | Matthew Bourne  
|   |   | Mary Brooks  
|   |   | Mary O’Hara  
|   |   | **Taberner House**  
|   |   | Janet McPherson (Housing)  
|   |   | Chioma Ejiofor (NRPF)  
|   |   | **Pharmacy**  
|   |   | Louise Coughlan  
|   |   | **Community Services**  
|   |   | Elaine Clancy (Director review on behalf of Sharon Jones)  
|   |   | Patricia Murphy  
|   |   | Janet Clark  
|   |   | **Social Services (Adult Care Team)**  
|   |   | Nicola Gage  
|   |   | **Legal Services**  
|   |   | Diane-Kareen Charles |
|   |   |   |
| 4 | Date of Consultation: | Monday 12th – Friday 16th November 2012 |

5. **Comments Received:**

A request to make alterations was received from:
- Louise Coughlan (Section 5.3.9)
- Janet Clark (Sections 5.3.5 and 5.3.6)
- Elaine Clancy (Section 4)
- Janet McPherson (Section 5.5)
- Patricia Murphy (Section 5.3.8)

No response was received from:
- Sarah Vernon
- Matthew Bourne
- Mary Brooks
- Mary O’Hara
- Nicola Gage
- Diane-Kareen Charles

Agreement was given by:
- Maria Knopp
- Chioma Ejiofor (NRPF)

I also met in person with Patricia Murphy, Chioma Ejiofor and Janet McPherson before
6. Highlight where policy changed following consultation or state reasoning why comments not incorporated:
   All comments and alterations raised were accepted into the policy.
APPENDIX C – DISCHARGE CHECKLIST

Name of Patient: ........................................ Hospital No: ........................................


Admission Date ............. Expected Length of Stay........ Expected Discharge Date .......... Discharge planning must commence on admission or prior to admission when possible. It is the responsibility of the named nurse/team leader to complete the following: NB All fields must be completed. Please use N/A if action is not applicable.

GREEN PHASE (FROM ADMISSION TO 3 DAYS BEFORE EXPECTED DISCHARGE)

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<td>Discuss plans with patient and family, including asking family to</td>
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<tr>
<td>provide transport for discharge by 10am (if appropriate), and use of</td>
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<tr>
<td>the Discharge Lounge. Provide Discharge Leaflet. Consent obtained.</td>
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<td>OT referral made</td>
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<td>Physio referral made</td>
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<td>Dietetic/Speech &amp; Language referral made</td>
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</tr>
<tr>
<td>Community Nurse referral made</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Nurse/Team referral made (e.g. Palliative care team,</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Complex Discharge Co-ordinator)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Psychiatric referral made</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Red Cross referral made</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Referral to Voluntary Sector services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Croydon Intermediate Care Service referral (CICS) made</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients admitted from Care Homes, Care Home contacted to</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>reassess.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Home IV therapy referral made</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For complex patients consider if discharge planning meeting needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>arranging</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

AMBER PHASE (3 DAYS BEFORE TO DAY BEFORE EXPECTED DISCHARGE)

<table>
<thead>
<tr>
<th>Action</th>
<th>Tick</th>
<th>Comments</th>
<th>Date</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge plans confirmed with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant/Medical team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next of Kin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietetics/Speech &amp; Language</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Manager (i.e. Care Package is arranged)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CICS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Nurse/Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Home IV therapy Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Cross</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

AMBER PHASE (3 DAYS BEFORE TO DAY BEFORE EXPECTED DISCHARGE)

<table>
<thead>
<tr>
<th>Action</th>
<th>Tick</th>
<th>Comments</th>
<th>Date</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Actions:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement form faxed (Section 5 (3) CC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/relatives/carers provided with relevant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
education and training. State by whom.

Patient informed of services arranged post discharge and given service contact numbers

Transfer letter to care home written

Check if patient requires medical certificate

Medical team to complete GP referral if required (e.g. if oxygen is required, follow-up bloods needed)

TTOs ordered

Transport arranged/booked – confirm stretcher/chair or walker. Inform transport if patient is not for resus.

Does patient have house key/suitable clothing for discharge?

Contact Discharge Lounge to arrange transfer

Explain TTOs to patient

Supply of dressings, needles etc ordered if appropriate (5 days supply suggested)

### DAY OF DISCHARGE

<table>
<thead>
<tr>
<th>Action</th>
<th>Tick</th>
<th>Comments</th>
<th>Date</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation to Discharge Lounge of discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removal of Venflon Clips/Sutures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice given on wound management if appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressings/Incontinence pads supplied (if appropriate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valuables returned to patient and documented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients appointment given (if appropriate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other equipment or discharge information given to the patient including the “Leaving Hospital” leaflet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge summary sent to GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer letter/verbal handover given to care home if appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IMMEDIATELY ON DISCHARGE

<table>
<thead>
<tr>
<th>Action</th>
<th>Tick</th>
<th>Comments</th>
<th>Date</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property listed and returned to patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication checked and given to patient with explanation (this action can be performed either on the ward or in the Discharge Lounge).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanation of Next Steps i.e. Outpatients appointment, visit to GP, District Nurse visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check method of transport home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged from the ComputerSystem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SUMMARY OF THERAPY INPUT:

<table>
<thead>
<tr>
<th>Intervention Complete</th>
<th>Date</th>
<th>Sign</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF NURSE COMPLETING THE FORM**

Date and Time

---

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## APPENDIX D – TIMEFRAME FOR COMPLETED DOCUMENTS

<table>
<thead>
<tr>
<th>Type of Document</th>
<th>Completed by *</th>
<th>Timeframe for completing document</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctor</td>
<td>Nurse</td>
</tr>
<tr>
<td>Continuing Care Checklist</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Decision Support Tool Full Continuing Care documents</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Health Needs Assessment</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Continuing Care Fast Track</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Nursing Needs Assessment</td>
<td>x</td>
<td>√</td>
</tr>
</tbody>
</table>

* This is not an exhaustive list. Please invite reports from any healthcare professional, where it is felt it will contribute to the assessment of the individual

<table>
<thead>
<tr>
<th>Key</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>√</td>
<td>Yes, need to be involved</td>
</tr>
<tr>
<td>x</td>
<td>No, do not need to be involved</td>
</tr>
<tr>
<td>~</td>
<td>Possibly need to be involved</td>
</tr>
</tbody>
</table>
APPENDIX E – OUT OF HOURS DISCHARGE CHECKLIST

Out of Hours Discharge Checklist
To be completed for all patients discharged between 6pm- 6am

BETWEEN 11PM AND 6AM PATIENTS SHOULD ONLY BE DISCHARGED IN EXCEPTIONAL CIRCUMSTANCES

Demographics

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Ward:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoB:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Address being discharged to, if different:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 1

Services/Agencies

<table>
<thead>
<tr>
<th>Is there a PoC?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes -</td>
<td>Name of agency:</td>
</tr>
<tr>
<td></td>
<td>Phone number:</td>
</tr>
<tr>
<td></td>
<td>Confirmed number of visits a day:</td>
</tr>
<tr>
<td></td>
<td>Confirmed date and time of first visit:</td>
</tr>
<tr>
<td></td>
<td>Confirmed with: (name of agency employee)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there MoW?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>When will MOW start?</td>
<td></td>
</tr>
</tbody>
</table>

Section 2

<table>
<thead>
<tr>
<th>NoK informed?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Phone number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Site Practitioner Informed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed by</td>
<td></td>
</tr>
<tr>
<td>on</td>
<td></td>
</tr>
<tr>
<td>(date/time)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Returning to RH/NH?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Have they been informed?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person informed:</td>
<td></td>
</tr>
<tr>
<td>Informed by:</td>
<td></td>
</tr>
<tr>
<td>Date and time of call:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Keys/Access to property</th>
<th>TTOs</th>
<th>Discharge summary</th>
<th>Transport</th>
</tr>
</thead>
</table>

Form completed by:  
Print name  
Signed  
Date/time  
Datix completed by:  

APPENDIX F– PLACEMENT LETTER TO BE GIVEN TO ALL PATIENTS/NEXT OF KIN WHERE PLACEMENT IS IDENTIFIED

Dear (insert relative’s/solicitor’s name)

Re: (insert patient’s name)

Following discussion with the doctor, therapists, nursing staff and a care manager, I understand that the above-named person’s future care needs would be best met in a Residential or Nursing Home.

The care manager will help you identify if the placement to a Residential or Nursing Home will be funded by Social Services or whether the cost will need to be met by the individual. They will also supply a list of homes that will best meet their care needs.

Please ensure you have identified a Residential or Nursing Home as soon as possible, and seven days from the date of this letter. Please inform the Ward Sister of your choice so she can arrange for the home to come and assess the above-named person on the ward and then arrange discharge.

Please also be mindful that vacancies in Residential and Nursing Homes are filled very quickly, and many homes have a waiting list. Therefore we ask that you act quickly to ensure you get your first choice home. If the home you choose does not have vacancy, we would ask that you choose either another home or a temporary home until your preferred choice becomes available.

Please discuss any queries you have with the Ward Sister in the first instance. If necessary they will refer you to the Integrated Discharge Team who may be able to assist you further.

I offer to you my personal best wishes for the future, and thank you for your co-operation.

Yours sincerely

Rachael Colley
Head of Hospital Avoidance
Croydon University Hospital