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OPERATION AND NURSING PROCEDURE

Discharge Procedure v1.0

CATEGORY:	Procedure
CLASSIFICATION:	Operations and Nursing
PURPOSE:	To set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for all patients
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Distribution: • **Essential Reading for:** • **Information for:**	All staff involved in the discharge of patients For further information contact Sean Henry, AHN.

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1 Introduction

This procedure should be read in conjunction with the <Discharge Policy>

2 Key Principles of Discharge Planning and Implementation

Discharge planning and implementation must be based on a person-centred approach that treats individuals with dignity and respect and meets their diverse or unique needs to secure the best outcome possible.

Patients and carers (where appropriate) must be involved at all stages of discharge planning, given good information and helped to make care planning choices.

All decisions regarding discharge must be based upon clinical (physical and psychological), and social criteria. Discharge planning and assessment requires the use of a complete multi-professional approach to ensure that all of the patient's discharge criteria are met prior to discharge.

Decisions regarding long term care may require a period of temporary support this should be considered a complex discharge.

Planning for discharge should commence with the patient and/or their carer(s) at the earliest opportunity to anticipate/identify problems and agree an expected discharge date.

The discharge planning process must be co-ordinated effectively to dovetail processes with the MDT working collaboratively to plan care, agree who is

responsible for specific actions and make decisions on the process and timing of discharge.

Where Social Services or other external care agencies are involved in the patient's discharge plan effective communication is established and the requirements for the assessment notification and discharge notification are met.

Person-centred care and patient empowerment are particularly important for individuals who have physical impairment, dementia, learning disability or mental health needs. Clinical staff must ensure that the patient is fully aware of their circumstances and able to give informed consent, in that they must have sufficient information, and understand that information, to be able to make specific decisions pertinent to discharge.

Patients who do not have capacity to make decisions regarding their discharge are not disadvantaged and are cared for safely under the Mental Capacity Act 2005

The patient's carer must be considered when making discharge plans as appropriate.

3 Predicted Date of Discharge (PDD)

The Predicted Date of Discharge (PDD) is based on the expected time required for diagnostic tests and interventions to be completed, the integrated care pathway and the time it is likely to take for the patient to be clinically stable and fit for discharge.

The PDD should be set within 14 hours of admission, and at pre-op for elective patients based on the predicted length of stay and this should be communicated with the patient and/or carer and all relevant staff within 24 hours of admission.

Patients who are transferred from an admissions/assessment area to a ward due a change in their presenting condition may be given a new PDD within 24 hours.

The PDD must be recorded on the Jonah system.

The Bed Utilisation Guide must be utilised in conjunction with this policy in order to appropriately communicate PDDs and Discharge/Transfer of care expectations.

4 Planning Discharge

Discharge planning should be delivered over seven days to deliver continuity of care for the patient with a discharge checklist being completed prior to discharge

The patient must agree the discharge plan. Should the patient disagree with plans, identified risk must be discussed with the patients and this must be documented in the patient's record.

If the patient is deemed as not having capacity to make decisions about discharge a transfer of care should be completed and sent to the discharge hub.

There must be effective communication between the patient, their careers, where necessary, members of the core MDT and social care/community agencies to ensure the relevant discharge information is disseminated.

If an existing care package needs to be restarted, the nurse or therapist responsible for the patients care must contact the relevant care provider (when not referred to discharge team) who can re-start the care package.

On admission the delegated nurse must check how the patient will be able to gain access to the property they are being discharged to and ensure that any keys are available on the ward and sent with the patient or in the patient's key safe (if applicable).

Arrangements must be made where possible for the patient's clothes and footwear to be available to wear on discharge.

Patients who will be discharged with a wound(s) or require on-going treatment must be referred to the District Nurse Service (unless discharged to a nursing home) and be given a copy of their wound care plan, discharge summary and a supply of dressings/treatment and when necessary urinary night bags, stoma bags (a minimum of 3 day supply must be provided and 5 day supply if the patient is discharged before or during a weekend/bank holiday period to allow sufficient time to obtain a prescription).

Staff must ensure that information about infections including any particular care needs related to those infections and their control are communicated when a patient moves to the care of another organisation, e.g. community nurse, GP, nursing home or community hospital other acute provider.

4.1 **Referral to the Complex Discharge Hubs**

All patients with complex discharge needs must be referred to The Complex Discharge Hubs who can provide expert advice and assessment to: Identify

patients with on-going care needs. Support ward staff in assessment of patient discharge needs and assist ward staff in making alternative discharge plans, as appropriate. Consider patients eligibility and process for accessing Continuing Health Care (CHC) funding and Supported Integrated Discharge Team (SiD) for support and lead if required on Best Interest Meetings and CHC Meetings and to provide access to Discharge to community beds for on-going health and social care needs of the patients referred to the service.

4.2 Complex Discharge Procedure

Complex discharge will apply when a patient has been identified as requiring support upon discharge as described. On admission to the ward/department, the delegated nurse must establish where possible the patient's baseline, current care requirements and future arrangements for discharge. A referral to the Complex Discharge Hubs must be made by the delegated nurse at least 72 hours prior to Predicted Discharge Date. Where required the referral will be made using the TOC (Transfer of Care) referral process or a Section 2 for 'out of area patients.

Upon receipt of a TOC or section 2 referral, a member of the Complex Discharge Hubs will liaise with the patient and/or carer(s) ward staff and associated medical or social care staff and document in the patient's medical records as appropriate.

The patient and carer (including informal carers) must be central to the Discharge Plan. They must be kept informed of progress on a regular basis by the ward. Where appropriate the patient and carers will be invited to attend MDT meetings, discharge planning and case conferences.

4.3 Discharge Medication (TTO)

Patients requiring discharge medication must have a discharge prescription completed and sent to pharmacy *at least 24 hours prior to discharge* to ensure it is available for the time of discharge. This will include medication required to be dispensed in blister packs.

A robust assessment should take place of the ability of the patients to self-medicate / understand and open the packaging.

Prior to discharge the patient / carer must be educated about their medication by the nurse or pharmacist and given the opportunity to ask questions, advice regarding any potential adverse reactions or side effects and provided with the contact details of whom to contact if they have any concerns about their

medication. It should be explained to the patient when and how they should obtain further supplies where appropriate.

If a District Nurse is required to administer a patient medication, an authority to administer chart must be sent home with the patient's discharge medication.

Patients who are discharged to a Community Bed must be discharged with an adequate supply of medication and dressings – advice can be gained from the Complex discharge Hub or team facilitating the discharge.

All patients discharged on an Enteral Feed must be given a 14 days supply medication.

When discharging a patient on TB medication contact must be made with the Birmingham and Solihull TB Services for on-going management.

4.4 Patient Transport

The delegated nurse, when completing the discharge checklist, must establish if the patient is eligible for hospital transport.

Where possible, patients who are able to transfer and mobilise unaided must be encouraged to arrange their own transport to return home safely.

Where a patient requires hospital transport / ambulance the booking must be made with adequate notice (at least 24 hours where possible) given for transport services in order to minimise delay in discharge. Any equipment must be booked onto the journey i.e. mobility equipment.

5 Day of Discharge

The ward nurse must complete the discharge checklist.

If a patient is being discharged and requires an escort from HEFT then the Operational Procedure for appropriate escort and transfer of patients should be followed.

The nurse must ensure that the patient/carer receives instructions and details of the on-going care required after leaving hospital. This must include:-

- Out-patient appointments.
- Date the first visit requested by the district nurses and telephone number if there is any change in situation.

- Date and time of first visit from local authority / private provider home care service.
- Patients discharged on anticoagulant therapy and requiring blood tests must be given the date/time of their first appointment with details of the appropriate clinic/GP surgery.
- All valuables held in the ward safe or cashiers department must be returned to the patient and signed for before discharge.
- All other personal property must also accompany the patient. If the patient is travelling on 'patient transport' they and their relatives must be forewarned that the transport can only carry minimum luggage. Equipment must be booked.
- The patient must be fully clothed and offered appropriate foot wear on discharge and not discharged in their night clothes unless the patient declines the offer of clothes, or alternative clothing is not available.
- All patients should be transferred to the Discharge Lounge prior to discharge where possible.

5.1 Discharging Patients Out of Hours

The majority of patients should be discharged before 5pm.
It is the responsibility of the healthcare professional to ensure that the patient is safe to be discharged out of hours.

When elderly or vulnerable patients are discharged after 5pm, extra considerations need to be made by the healthcare professional responsible for the discharge. This should be considered as a complex discharge. A robust discharge plan should be evident and implemented.

The healthcare professional must ensure that the patient has access to their property, and that they are dressed appropriately to be discharged.
It should be established that the patient has a relative / carer to receive them upon arrival.

5.2 Patient Discharge Summary

The patient must be discharged with a copy of the discharge summary.

A copy of the discharge summary must be sent to the patient's GP within 24 hours or other hospital/institution to which the patient is discharged.

Copies of the discharge summary must be filed in the patient's notes within 24 hours.

If the patient is employed they may require a sick certificate. A Medical certificate stating the patient has been an inpatient may be completed by the nursing/medical staff coordinating the discharge.

5.3 Patients with on-going Safeguarding Concerns

The discharge arrangements for any patient with on-going safeguarding concerns should be discussed amongst the wider multi-professional team. This should include the Consultant responsible for the patient's care or a nominated deputy who can make appropriate decisions, the Senior Sister/Charge Nurse or their deputy, the Social Worker, and the patient if appropriate, or the patient's representative.

All decisions, outcomes and ongoing care needs should be clearly documented within the patient's medical notes and the name of the Social Worker responsible for the patient's on-going needs must be consulted with and agree with the safe discharge plans prior to discharge.

The outcome of any safeguarding meetings should only be shared with the appropriate agencies prior to the patient being discharged .e.g. Care Homes, G.P, District Nurses with the agreement of the responsible Social Worker.

6 Specific Destinations

When discharging a patient with continuing nursing needs e.g. district nurse/hospital/hospice/nursing home, the A3 Discharging Patients to external agencies form must be completed with the appropriate information and sent to the receiving organisation. A copy must be filed in the medical notes. A3 Discharge Checklists can be purchased through usual routes.

6.1 Discharge of Patients Back to Residential or Nursing Homes.

The nursing/residential home must be contacted regularly to report on the patient's progress. The ward must contact the nursing/residential home at the earliest opportunity to inform them of the intention to discharge the patient. When a patient's condition has altered from their pre admission state the nursing/residential home must be invited to come and assess the patient to confirm that they are still able to meet the needs of the patient and arrange an appropriate date of discharge.

Diligence should be applied if the patient's ability to swallow has changed and a different type of diet is needed. This should be clearly communicated and

documented to the carer/ care home provider. The relevant care plans and nutrition regime must be sent with the patient.

Do not discharge a patient to a NEW nursing or residential home without first discussing this with the Complex Discharge Hubs, Social Services and the home to which the patient is being discharged to.

The patient must be discharged with a copy of their discharge summary and care plan including wound care plan.

The patient must be discharged with an adequate supply of dressings, catheter & bags and any other devices.

Patients discharged to a residential home and require dressings or treatment must be referred to the District Nurse service.

6.2 **Transfer to 24 hour Care**

Most people return home after a period of acute care, some after a period of rehabilitation care.

Patients for whom an agreed MDT assessment has identified that discharge from hospital is appropriate but who require nursing or residential care the placement will be funded by Social Services, the NHS or the patient, dependant on the outcome of financial and health assessments.

Where a place is not available in the individuals preferred care home, remaining in an acute hospital setting is not ideal for the welfare of the patient. The Bed Utilisation Protocol must be followed in these circumstances.

It is best practice for permanent 24 hour care to be planned and assessed over a period of time rather that in the acute setting. Temporary care and community beds for assessment should be considered as the alternative where possible.

6.3 **Transfers to Discharge to Community Beds**

Following a discharge assessment by the MDT and Complex Discharge Hubs some patients will be identified as suitable for Discharge to Community Beds to provide further clinical support to maximise their independence and/or assess and establish long term needs.

Following agreement with the patient and their relatives/representative the patient will be given a copy of the relevant letters according to the Bed Utilisation Policy

6.4 Discharge of Patients from Emergency Department (ED)

On attendance to the ED department patients may be discharged home following appropriate treatment with relevant discharge information e.g. head injury advice.

As with discharge from inpatient areas the principles of good discharge planning are of equal importance for patients discharged from ED.

Consideration must be made for admission avoidance. For support needs on discharge contact must be made with the relevant agencies for support and an MDT approach.

6.5 Delayed Patient Discharge/Transfer

A delayed patient discharge is defined as being when a patient is ready for discharge or transfer from a hospital bed, but is still occupying such a bed.

If the discharge/transfer process is delayed due to lack of availability of a nursing/residential care home or package of care notification must be given to the accepting provider

6.6 Patients Who Lack Mental Capacity

The patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination.

Where there are concerns that a patient lacks mental capacity to decide where to be discharged to (i.e. whether to go to their own home or a care home), an assessment of mental capacity should be undertaken. An assessment regarding discharge plans will take place. This is to be considered a Complex discharge and a transfer of care should be sent.

Consideration of Advanced Decisions, Lasting Power of Attorney Health and Well-being must be made. If the assessment identifies that the patient does currently lack the capacity to make that decision and requires support for discharge, a Best Interest Meeting will be required to identify the type of placement that can most appropriately meet the patient's needs. A referral to an Independent Mental Capacity Advocate (IMCA) should also be considered alongside criteria.

Any concerns regarding a patient with mental health needs or learning disabilities must be taken into account and the discharge planning process must involve the

appropriate specialists to ensure the discharge is safe and appropriate for their on-going care needs

6.7 Homeless Patients / No Fixed Abode

Patients identified as homeless or with no fixed abode on discharge may be referred to the homeless assessment team on admission and the Complex Discharge Hubs if required.

Patients who are homeless and have no on-going health or Social Care needs can present to their local housing office and be assessed for vulnerability with a view to possible placement. Housing issues are not dealt with by Social Workers under usual circumstances, although they may be able to offer advice.

Patients who are homeless and have on-going health or social care needs need to referred to the Complex Discharge hub.

Respect for the patient's choices must be given at all times

6.8 Rapid Discharge for Patient requiring End of Life (EoL) Care at Home

If a patient and/or family/carer expresses the wish for a patient to die at home and they are approaching the last few hours to days of their life the Rapid Discharge Pathway is available to coordinate discharge safely and should be used to expedite this request

Staff must refer to the Complex Discharge Hubs

6.9 When Patient Refuses Discharge

Where patients have been assessed as not requiring NHS continuing inpatient care, they do not have the right to occupy indefinitely an NHS bed.

When the patient refuses discharge the patient's medical and nursing team must discuss the discharge options with the patient and understand the underlying reasons for refusal. Where there are concerns that a patient lacks mental capacity to decide where to be discharged to (i.e. whether to go to their own home or a care home), an assessment of mental capacity should be undertaken.

Patients with mental health needs or learning disabilities must be referred to the appropriate specialist teams for further assessment regarding the patients on-going care needs.

The management of patients who refuse to leave hospital must be managed on a case by case basis. Every attempt must be made to achieve an outcome that is in the patient's best interest. Escalation and management of such cases should follow the same approach described in the Bed Utilisation Policy.

If the patient has been transferred to a step down ward/Discharge Lounge within HEFT the Consultant retains accountability for the patients care. If the ward manager/staff cannot progress the discharge, than this must be escalated to the accountable Division.

6.10 Management of Patients Who Wish to Self-Discharge Against Health Professionals Advice

When a patient wishes to discharge him or herself against health advice and every effort has been made to avoid this, the patient should be encouraged to complete a 'discharge against advice form' and details recorded in the patients notes and on the Jonah system.

If the patient requires on-going community health or social care services input a referral must be made to the service as with a medical discharge and informing them of the patients discharge against medical advice.

Where the patient lacks the mental capacity to make the decision to self-discharge the patient must be reviewed by the medical team and a DOLs considered.