

Policy Reference: 027

DISCHARGE POLICY & PROCEDURE

Version: 7

Name and Designation of Policy Author(s)	Heather Rimmer, Joint Commissioner, Intermediate Care, Wirral PCT / DASS Pat Elliott, Deputy Divisional Manager, Division of Medicine
Approved By (Committee / Group)	Clinical Governance Programme Board
Date Approved	12 th September 2008
Date Ratified by HMB	5 th December 2008
Date Published	16 th June 2009
Review Date	5 th December 2011
Target Audience	All Health & Social Care Agencies and their staff involved with discharge and transfer of patients.
Links to Other Strategies, Policies, Procedures, etc	Consistent with the WUTH business plan, operational procedures relating to bed management and the patient transfer policy.

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment	Margie Davies	17 th April 2008	Full impact assessment completed.
Policy Group	Lesley Metcalfe	21 st April 2008	Checked for workforce / development, medicines, finance, NHSLA standards or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Development	WUTH, Wirral Department of Adult Social Services, Wirral PCT, Cheshire & Wirral Partnership Trust Health & Wellbeing Partnership Board and individual organisations		
Trust Staff Consultation via Intranet	6 th June 2008 – 7 th July 2008		

Date notice posted in the Team Information Exchange (TIE)	Date notice posted on the intranet
December 2008	December 2008

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMBs and other management structures, etc)	By Whom will this be Delivered?
New clinical staff will be made aware of this policy at local induction which will be documented on their personal file. Existing staff will be made aware of this policy through TIE brief. The policy is available to access on the Trust intranet.	Ward / Department Managers

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
May 1994	1	Sue Elliott, Deputy Director of Operations	
Mar 2003	2	Sue Elliott, Deputy Director of Operations	
Mar 2004	3	Sue Elliott, Deputy Director of Operations	
Mar 2004	4	Sue Elliott, Deputy Director of Operations	
Jan 2005	5	Sue Elliott, Deputy Director of Operations	
Dec 2008	6	Heather Rimmer, Joint Commissioner Pat Elliott DDGM (Medicine)	New legislation and guidance in relation to CHC and change required to working practices within partnership arrangements. Discharge action plan updated.
Jun 2009	7	Heather Rimmer, Joint Commissioner Pat Elliott DDGM (Medicine)	Updated for new KPI template - no change in practice

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Patients will have specific discharge requirements met.	100%	Nursing & Midwifery Audit	Clinical Governance Programme Board	Annually	Nursing & Midwifery Audit Team
Patients will have the correct documentation on discharge.	100%	Nursing & Midwifery Audit	Clinical Governance Programme Board	Annually	Nursing & Midwifery Audit Team
Patients will have a completed discharge information sheet to take home.	100%	Nursing & Midwifery Audit	Clinical Governance Programme Board	Annually	Nursing & Midwifery Audit Team
No patients will be discharged after 21:30 hours or before 07:30 hours with the exception of patients from A&E, CDU, MAU, SAU, HAC, OTU, Isolation, Labour and Paediatric wards where discharge can occur at anytime.	100%	Nursing & Midwifery Audit	Clinical Governance Programme Board	Annually	Nursing & Midwifery Audit Team

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Ward / Department Managers	DMB via the risk register	3 monthly

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1 Introduction

This policy has been developed with Wirral University Teaching Hospital, Wirral Primary Care Trust and the Wirral Department of Adult Social Services. It is based on the Department of Health “Discharge from hospital: pathway process and practice guidance” (DoH Feb 03) to ensure the safe discharge of individuals from hospital.

In line with this guidance, all discharges from Wirral University Teaching Hospital NHS Foundation Trust (hereafter known as the “Trust”) should be seen as a person-centred process, not an isolated event. The process should start before admission for elective admissions and as soon after admission as is clinically appropriate for emergency admissions.

Safe, efficient discharge requires input from an experienced practitioner who has an understanding of the Adult Common Assessment Framework (ACAF) and discharge planning process, working closely with the multidisciplinary team and other agencies. The role is usually undertaken by nurses and midwives; however it may be appropriate in a transitional or rehabilitation service for a therapist or social worker to be the care co-ordinator / case manager.

2 Purpose

This policy and procedure describes the framework which exists to facilitate safe discharge where any risks are accounted for and minimised. It supports person-centred discharge where patients receive appropriate and timely packages of care which meet their needs regardless of health and social service boundaries.

3 Scope

This policy applies to all staff who are involved in the discharge of patients from hospital. This may involve discharge to an intermediate or transitional care facility, a nursing or residential home or to a patient’s own home.

It does not cover transfer from one acute setting to another.

4 Principles

The key principles for person-centred effective discharge are that:

- People are treated as individuals and receive appropriate and timely services which meet their individual needs.
- Staff should work within the ‘Adult Common Assessment Framework’ (ACAF) of integrated multi-disciplinary and multi-agency team working to manage all aspects of the discharge process.
- Unnecessary admissions are avoided and effective discharge is facilitated by a ‘whole system approach’ to assessment and the commissioning and delivery of services.

- The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge. Carers and relatives must be informed that if they provide a substantial amount of care they are entitled to an assessment of their own needs via the Local Authority Department of Adult Social Services.
- Discharge and the transfer of care from hospital to primary care is a process and not an isolated event. It has to be planned for at the earliest opportunity across primary, community, hospital, and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate.
- The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient journey. This will usually be the patient's nurse or midwife responsible for their care on the ward.
- Effective use is made of transitional and intermediate care services, whenever appropriate, so that acute hospital capacity is used effectively and individuals achieve their optimal outcome.
- The assessment for, and delivery of, health and social care is organised so that all parties understand the range of health and social care services, their rights, and receive advice and information to enable them to make informed decisions about their future care.

5 Definitions

Adult Common Assessment Framework (ACAF)	A nationally developed process of assessment and assessment documentation which is agreed at a local level and which covers a range of care domains.
Assessment	A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated.
Avoidable Admission	Admission to an acute hospital, which would be unnecessary if alternative services were available.
Care Management	A process whereby an individual's needs are assessed and evaluated, eligibility for services is determined, care plans drafted and implemented, and needs are monitored and reassessed.
Care Manager	A practitioner who, as part of their role, undertakes care management.
Care Package	A combination of services designed to meet a person's assessed needs.
Care Pathway	An agreed and explicit route an individual takes through health and social services
Care Plan	A plan for the care of an individual, which may involve more than one agency. The patient should be provided with a written copy of the plan which should be explained by an appropriate member of the multi-disciplinary team caring for the patient.
Carer	A person, usually a relative or friend, who provides care on a voluntary basis.

Case Manager	A qualified health or social care professional who works with individuals who have a dominant single complex condition but still have intensive needs requiring the development of a personalised plan of care
Commissioning	The process of specifying, securing and monitoring services to meet identified needs.
Community Matron	A nurse who provides advanced clinical nursing care in addition to case management to an identified group of very high intensity users.
Complex	Involving more than one problem. A patient with complex clinical needs has more than one medical/clinical problem, often involving an interaction of conditions leading to difficult control of each condition
Decision Support Tool (DST)	A locally agreed document based on national guidance which contains information in respect of the multi disciplinary assessed care needs of individuals
Independent sector	Includes both private and voluntary organisations.
Multi-disciplinary	When professionals from different disciplines, such as social work, nursing and therapy, work together.
Multi-disciplinary assessment	An assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating this information.

Discharge out of Hours from WUTH is defined as a discharge that has taken place after the 21:30 hours shift change

6 Duties / Responsibilities

6.1 Responsible Nurse / Midwife

Within Wirral University Teaching Hospital Foundation NHS Trust, the discharge process is led by the responsible nurse or named midwife who is accountable for the coordination of the patient's care.

The responsible nurse or named midwife has the lead responsibility for co-ordinating all aspects of the patient's care including discharge planning. This role requires a proactive seven-day approach to ensure that:

- the discharge plan is progressing smoothly
- the specific needs of each patient are met
- the patient is discharged in a safe and timely manner

6.2 Divisional General Managers

The Divisional General Managers are responsible for ensuring that the action plans produced as a result of the discharge audit are programmed into the agenda for the Divisional Management Boards.

6.3 Divisional Matrons

The Divisional Matrons are responsible for ensuring that the Ward/Department managers produce an action plan in response to any deficiencies identified from the discharge audit, and that they are monitored for completion.

6.4 Ward / Department Managers

Ward / Department managers are responsible for producing an action plan on the identification of any deficiencies identified from the discharge questions contained within the Nursing & Midwifery audit.

6.5 Integrated Community Discharge Team (ICDT)

The Integrated Community Discharge Team are nurses employed by Wirral PCT based in the Trust who are responsible for:

- assessing patients who may require an intermediate care service
- providing the Adult Common Assessment Framework documentation
- ensuring that referrals to community nursing services are sent to the correct locality
- acting as the initial point of contact for community nursing teams who wish to raise issues about patient discharge. They will work with the WUTH patient flow manager to resolve such issues and instigate remedial action.
- fast tracking discharge arrangements for patients at the end of life to enable a timely response to their care needs
- acting in the role of ordering officer for community equipment services, ensuring that equipment needs are identified and equipment ordered in time for the discharge date
- identify patients admitted to hospital who are under the care of community matrons communicating with them to expedite discharge

6.6 Wirral University Teaching Hospital Patient Flow Team

The WUTH Patient Flow Team are responsible for providing support and advice about the assessment process and discharge planning to ward based staff involved in the process.

The Team will liaise with Social Services and community based services supporting the responsible nurse and minimising any avoidable delays to the patient journey.

6.7 Multidisciplinary Team

This will include Specialist Nurses, Speech & Language Therapists, Occupational Therapists, Physiotherapists and Dieticians, paediatric continuing care team, ward based medical and nursing staff.

The Multidisciplinary Team will complete and document accurate assessment information relating to the patients clinical condition and care needs in the patient's medical notes and on the appropriate referral or assessment proformas.

7 Discharge Planning

The philosophy at the Trust is to treat all patients as individuals and ensure that they are cared for holistically. An assessment of the specific needs of a patient is made on admission to the Trust, for example the patient may have a healthcare associated infection (e.g. MRSA or C. difficile), their first language may not be English or the patient may have a sensory impairment. It is important to consider and communicate specific needs where appropriate to enhance the patient experience and reduce the risks of incidents, complaints or claims which may result from the sub-optimal discharge of patients.

7.1 Pre-operative Discharge Planning for Elective Admissions

Discharge planning for patients admitted for elective procedures is undertaken at the Pre-Operative Assessment Clinic and the nurse will document relevant information from the patient and carer(s) in order to facilitate a safe discharge plan.

This will include:

- Taking a history of medical conditions/previous hospital admissions/current medication regime
- Asking the patient about services currently being received, including health/social care/adaptations/equipment
- With the patient's consent contact may be made with services to identify the level of service input
- Considering the needs of the carer(s)
- Ensuring that the patient and carer(s) are provided with relevant information so that they understand what is likely to happen when the patient is discharged
- Identification of equipment that may be required

7.2 Discharge Planning for Emergency Admissions

The Trust's nursing documentation used in the Medical and Surgical Divisions (including gynaecological surgery) prompts nursing staff to ask appropriate questions to ascertain any specific needs an individual patient may have and any specific relevant information is recorded in the documentation. This provides a record of the needs assessment, documents any specific needs identified and also acts as a communication tool for patient specific information which may need to be communicated at discharge.

The continuing care checklist (CC1, Appendix 2) forms part of the nursing documentation in Medicine and Surgery (including gynaecological surgery) and must be completed during the inpatient stay for all patients in these areas.

For obstetric patients specific needs are identified during the booking process and recorded and retained in the patient hand held notes to ensure specific requirements are communicated when patients are discharged. The CC1 is not completed for maternity patients unless there are ongoing non obstetric related care needs. In this case the relevant referral for assessment would be made by the named midwife.

The CC1 is not completed for paediatric patients; refer to section 9.2.3.

8 Process for Discharge

Many aspects of the discharge process apply to all patients. The general discharge process begins on admission and the Nurse / Midwife responsible for the patients care will ensure that all communication with the patient regarding discharge is recorded in the patient's medical case notes, nursing documentation or hand held maternity notes. With the patient's consent this will include informing relatives and carers about a potential discharge date which will be documented.

The name of the responsible nurse or named midwife should be clear to all those involved in the patient's care and clearly documented in the nursing documentation or hand held maternity notes.

8.1 Pre-Discharge Action Plan (Appendix 1)

This is initiated within 24 hours of admission (excluding maternity & paediatric services) by the nurse responsible for the patient's care to identify:

- Referrals required to the Intermediate Care Discharge team (ICDT)
- Equipment required
- Transport arrangements
- Dressings and medication required
- Mental capacity assessment

8.2 Continuing Care Checklist (Appendix 2)

Staff must completed a Continuing Care Checklist for every patient once they are clinically stable (excluding maternity & paediatric services) (Appendix 3 describes the process). Following the assessment of the patient's continuing healthcare needs, the nurse responsible will ensure that timely referrals are made and any delays are followed up. If carer issues are identified, a referral is made to Social Services with consent from the patient and carer.

8.3 Adult Common Assessment Framework

For patients identified as requiring intermediate care, a request is made by the nurse responsible for the patient's care to the ICD Team who will initiate and co-ordinate the completion of the Adult Common Assessment Framework.

8.4 Follow-up Appointments

Patients must be informed that follow up appointments required will either be arranged prior to discharge or sent in the post.

8.5 Medication "To Take Home" (TTH)

Prior to the patient leaving the ward, discharge medication is checked against the latest copy of the discharge prescription by two nurses and the discharge prescription is signed and dated by the two nurses who have completed the check and filed in the patient's medical notes.

8.6 Discharge Summary and Patient Discharge Information Sheet

Four copies of the discharge summary are generated from the PCIS. The content must be explained and given to the patient on discharge with instructions about the benefits of sharing it with staff providing care on discharge. A copy of the discharge summary is also filed in the patient's medical notes, sent to General Practitioner and the Consultant in charge.

The patient is given a Patient Discharge Information sheet (Appendix 4) and a copy is retained in the nursing documentation. This excludes maternity services where all post natal women discharged are given their hand held notes to take home with them and any follow up appointments required are made for ante natal and post natal women by the discharging midwife. The discharge letter for post natal women is given to the community midwife and a copy is sent to the relevant General Practitioner and Health Visitor.

8.7 Discharge Lounge

Between 8am and 8pm Monday – Friday (excluding Bank Holidays) all patients who have been identified as medically fit for discharge must be transferred to the discharge lounge with the exception of patients who are violent and aggressive, require palliative care or special supervision. Take home medication can be delivered to the discharge lounge, checked and signed for as correct by two qualified staff members. Private, Hospital or Ambulance transport can be arranged to collect the patient from the discharge lounge.

9 Specific Discharge Requirements

After assessing the needs of a patient on admission to the Trust, specific discharge arrangements may be identified. Consideration must be given to the needs of the following specific patient groups:

9.1 Discharge Arrangements for Patients Who Require Community Nurse Services

If a community nurse is required, a referral should be made on PCIS by the responsible nurse / midwife. Requests after 16:00 hours, at weekends and on bank holidays must be faxed to the GP Out of Hours service 0151 678 0810.

9.2 Patients Who Need to Re-start Packages of Care on Discharge

A request must be made on PCIS to the Re-start Clerk with 48 hours notice of the discharge date. NB: Requests received after 4pm on Fridays to re-start packages of care will not be responded to until 9am Monday.

9.3 Discharge Arrangements for Paediatric Patients

The patient, parent or carer for the child is informed of the discharge. The Nurse in Charge of the patient's care will arrange take home medication, any follow-up appointment required and a copy of the discharge summary generated from PCIS will be given. A copy will be filed in the medical records and sent to the General Practitioner and Consultant in charge.

The Nurse in Charge of the patient's care will notify the Health Visitor of all discharged children under 5 years of age. A copy of the discharge letter is sent to the relevant Health Visitor.

Children assessed as suitable for hospital at home care are discharged by the Hospital at Home Nurse according to specific care pathways.

Children over 5 years of age with complex social, medical or continuing care needs are referred on discharge to the appropriate agency by the Nurse in Charge of the child's care and includes:

- Continuing Care Team
- Social Worker
- School Nurse
- Child and Adolescent Mental Health Team

On discharge all paediatric patients and parents/carers are advised that advice is available from Ward 11 and 12, Assessment Ward or Hospital at Home for 48 hours.

9.4 Discharge Arrangements for Homeless Patients

Homeless patients should be identified on admission and made known to the Local Authority Housing Department.

24 hours prior to discharge the housing department must be notified of their planned discharge and arrival by taxi to their office before 11am, if the patient is unable to pay for the taxi the cost will be met by WUTH.

Homeless patients must not be discharged without referral to the housing department unless it is their expressed wish and the patient does not lack mental capacity.

9.5 Discharge Arrangements for Patients at the End of Life

Patients identified as being imminently at the end of life and wishing to return home will be referred to the Integrated Community Discharge Team to enable fast tracking discharge arrangements.

9.6 Discharge Arrangements for Patients Who Require Equipment

In order to facilitate the timely discharge of patients into the community, consideration must be given to any need there may be for the provision of equipment from the Community Equipment Service (CES) to support the personal independence, health, safety, wellbeing and safe handling of patients as well as contribute to the wellbeing of potential carers. For further information regarding the provision of equipment refer to Section 10.

10 Equipment

The range of equipment supplied is detailed fully in the Community Equipment Catalogue available from the Integrated Community Discharge Team or the ward based occupational therapists.

Broadly, the equipment available from the CES falls into the following major categories:

- Mobility equipment
- Moving and handling equipment
- Bedroom and nursing equipment
- Bathing and toileting equipment
- Living room equipment
- Kitchen / dining equipment
- Miscellaneous equipment

10.1 Assessment for Equipment

Patients who may require equipment must be assessed by a member of the Multidisciplinary Team to identify their particular equipment needs in order to facilitate safe discharge planning.

A referral to order equipment identified by a member of the Multidisciplinary team to meet the patient's needs will only be made to the CES by the "Ordering Officers" listed below:

- Integrated Community Discharge Team
- Occupational Therapy and Physiotherapy staff from WUTH
- Wirral PCT Community Services
- Occupational Therapy staff from Wirral Social Services and Cheshire & Wirral Partnership NHS Foundation Trust
- Specialist Tissue Viability Nurse for Nursing Homes

10.2 Ordering Equipment

10.2.1 Standard Stock

The CES Standard Stock Requisition Form must be completed by the 'ordering officer'. Failure to complete this documentation accurately will introduce delay to supply of the required equipment and may affect discharge date.

The completed requisition form must then be faxed to the CES Manager for action on ext 482 8610 (safe haven fax).

Requisitions will be processed and equipment will be made available for supply in no more than 7 working days. Delivery will be dependent upon ready access to the proposed delivery address and the premises being prepared for the installation / delivery / fitting of the equipment, e.g. room cleared appropriately for delivery of bed.

The CES staff will contact the ward to confirm delivery of the required equipment at the relevant destination.

10.2.2 Non-Standard Stock Equipment / Bespoke Equipment

Equipment that is not listed in the Equipment Catalogue as a standard stock (standard supply) item is considered bespoke / specialist. The delivery time for these items will be outside the 7 working day delivery arrangements and will be subject to the response and availability from the supplier / manufacturer of the equipment.

In the event that the need for such equipment is identified, it is imperative that the CES Manager is contacted as soon as possible to discuss the exact requirements to expedite the supply of the required items and support timely discharge. In circumstances where a Purchase Order for the equipment will need to be raised with an external provider (supplier / manufacturer), a counter-signature from the Ordering Officer's Manager will be needed on the Non-Stock Item Order Form before the CES can process the requisition.

The CES Manager can be contacted at any stage of the equipment ordering / supply process for advice and guidance to support discharge.

10.3 Community Equipment Provision Exceptions

Equipment will not be issued from the CES for communal use within Residential Homes and Nursing Homes.

If the discharge destination is a Nursing Home, the CES will supply the patient with walking aids if required. Pressure Relieving Equipment will be supplied following assessment from the Specialist Tissue Viability Nurse with dedicated responsibility for Nursing Homes.

Where the discharge destination is a Residential Care Home in Wirral, community equipment can be provided for the use of the individual patient in the Home.

An "ordering officer" must carry out an assessment of need in the usual way and identify and order equipment required by the patient on discharge.

Moving and handling equipment will only be supplied to patients being discharged into Residential Care Homes to support the delivery of ongoing care from the Community Nursing Service. This equipment must be withdrawn when the nursing input ceases.

It is the responsibility of the Residential Home to ensure that there are adequate arrangements in place to protect the safety of residents and their staff when equipment is in situ.

If the discharge destination is an intermediate care bed for on-going rehabilitation prior to discharge home, ordering officers from that facility can requisition community equipment for supply to the patient's home when needs are assessed, identified and discharge from the facility is agreed.

The CES will not supply equipment for use outside the boundaries of the Metropolitan Borough of Wirral.

11 Process for Discharge Out-of-Hours

Patients should not be discharged after 21:30 hours or before 07:30 hours, with the exception of patients from A&E, CDU, MAU, SAU, HAC, OTU, Isolation, Labour and Paediatric Wards when discharge may occur at any time as patients are identified as medically fit for discharge. An incident form will be completed by the nurse / midwife when a discharge has taken place after the 21:30 hours shift change and the reason for the discharge documented in the patient's medical record.

12 Discharge Documentation / Information

12.1 Documentation to Accompany the Patient on Discharge

The following information will accompany the patient on discharge:

- Transfer documentation for Residential / Nursing Home discharge
- Adult Community Assessment Framework documentation for patients going to an Intermediate care bed
- Primary Care Medication Administration Chart if required
- Hand held notes for maternity patients

12.2 Information Given to the Patient on Discharge

The following information must be given to the patient on discharge:

- A copy of the discharge summary generated from PCIS
- Clinic appointment if required
- Discharge medication checklist provided Completed Discharge Information sheet (Appendix 4)
- Other relevant Information sheets e.g. post operative advice sheets

13 Process for Monitoring Compliance

Each ward is subject to an annual Nursing & Midwifery audit which includes a range of key performance indicators including patient discharge questions. Wards who fall into the white, red or amber section for results are required to complete an action plan within 2 weeks. This action plan will be presented to the Care Standards Executive which is chaired by the Director of Nursing & Midwifery. Actions that have not been completed will be recorded onto the Trust risk register and will be monitored for completion through the existing risk management system in place within the Trust.

14 References

DOH: National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care: DOH 2007.

DOH: Discharge from hospital: pathway, process and practice: Health & Social Care Joint Unit & Change Agent Team: DOH 2003.

Pre-Discharge Action Plan for Patient

This action plan should be commenced as early as possible following admission to hospital and at least 48 hours before discharge.

Task	Record Details of Communication	Date / Sign																		
Discharge action plan discussed with patient,																				
With patient's informed consent, care and discharge arrangements discussed with family and carer(s).																				
NHS Continuing Healthcare considered and appropriate action taken.																				
Discharge date agreed with patient and carer(s).																				
Arrangements agreed for bringing in patient's outdoor clothes, accessing the discharge destination, ensuring heating will be on and food will be available on patient's discharge.																				
New / restart care package in place and date confirmed. HARTS re-ablement commencement date confirmed.																				
Agreement obtained for return to residential / nursing home. Transfer form completed.																				
Has the patient had an appropriate assessment from Nursing, Physiotherapy and Occupational Therapy (including Nurse Specialists where necessary)?	<table> <tr> <td></td> <td>Yes</td> <td>N/A</td> </tr> <tr> <td>Physio</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>OT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Spec Nurse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Nursing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>SALT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	N/A	Physio	<input type="checkbox"/>	<input type="checkbox"/>	OT	<input type="checkbox"/>	<input type="checkbox"/>	Spec Nurse	<input type="checkbox"/>	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	<input type="checkbox"/>	SALT	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	N/A																		
Physio	<input type="checkbox"/>	<input type="checkbox"/>																		
OT	<input type="checkbox"/>	<input type="checkbox"/>																		
Spec Nurse	<input type="checkbox"/>	<input type="checkbox"/>																		
Nursing	<input type="checkbox"/>	<input type="checkbox"/>																		
SALT	<input type="checkbox"/>	<input type="checkbox"/>																		
Has the equipment order been completed by the assessor and FAXED to community equipment services for action?	<table> <tr> <td></td> <td>Yes</td> <td>N/A</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	N/A		<input type="checkbox"/>	<input type="checkbox"/>													
	Yes	N/A																		
	<input type="checkbox"/>	<input type="checkbox"/>																		
Delivery date of equipment to discharge destination confirmed and shared with the patient, carer(s) and teams providing care																				
Do the patient and carer(s) understand how to use any equipment provided?	<table> <tr> <td></td> <td>Yes</td> <td>N/A</td> </tr> <tr> <td>OT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Spec Nurse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Dietician</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	N/A	OT	<input type="checkbox"/>	<input type="checkbox"/>	Spec Nurse	<input type="checkbox"/>	<input type="checkbox"/>	Dietician	<input type="checkbox"/>	<input type="checkbox"/>							
	Yes	N/A																		
OT	<input type="checkbox"/>	<input type="checkbox"/>																		
Spec Nurse	<input type="checkbox"/>	<input type="checkbox"/>																		
Dietician	<input type="checkbox"/>	<input type="checkbox"/>																		
Transport arranged: <ul style="list-style-type: none"> ▪ Own (wherever possible) ▪ Hospital ▪ Taxi for homeless patient before 11am 																				
14 days prescription for drugs, 4 days dressings, catheters (NB: 48-hrs notice required for blister packs).																				
Prescription checked and dispensed. Checked by 2 nurses.																				
Dressings / appliances / medication instructions discussed with patient and/or carer(s).																				
Relevant community therapies involved.																				
Relevant community teams informed (e.g. District Nurse).																				
Information about outpatient appointment given.																				
Discharge Summary given to patient.																				
Cash & Valuables / property returned to patient.																				
Cannulae removed.	<table> <tr> <td></td> <td>Yes</td> <td>N/A</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	N/A		<input type="checkbox"/>	<input type="checkbox"/>													
	Yes	N/A																		
	<input type="checkbox"/>	<input type="checkbox"/>																		
Homeless patient discharged to Birkenhead Housing Dept																				
All patients transferred to the discharge lounge (10am)																				
Discharge Questionnaire?	<input type="checkbox"/> Yes																			

Appendix 2

NHS Continuing Healthcare Needs Checklist

Name: **D.o.B:**

Current Location: **D.o.A:**

Domain	Description	A Meets / Exceeds the Described Need	B Borderline – Nearly Meets the Described Need	C Clear Does Not Meet the Described Need
Behaviour****	“Challenging” behaviour that poses a predictable risk to self or others. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.			
Cognition	High level of cognitive impairment which is likely to include marked short-term memory issues and maybe disorientation in time and place. The individual has a limited ability to assess basic risks with assistance but finds it extremely difficult to make their own decisions / choices, even with prompting and supervision.			
Psychological / Emotional	Mood disturbance or anxiety symptoms or periods of distress that has/have a severe impact on the individual’s health and/or wellbeing. OR Withdrawn from any attempts to engage them in support, care planning and daily activities.			
Communication	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to do so have been taken.			
Mobility	In one position (bed or chair) but due to risk of physical harm or loss of muscle tone or pain on movement, needs careful positioning and is unable to cooperate. OR At high risk of falls. OR Involuntary spasms or contractures placing themselves and carers or care workers at risk.			
Nutrition	Dysphagia requiring skilled intervention to ensure adequate nutrition / hydration and minimise the risk of choking and aspiration to maintain airway. OR Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. OR Nutritional status “at risk” and may be associated with unintended, significant weight loss. OR Problems relating to a feeding device (for example P.E.G.) that requires skilled assessment and review.			
Continence	Continence care is problematic and requires timely and skilled intervention.			
Skin Integrity	Open wound(s), pressure ulcer(s), with “full thickness skin loss involving damage or necrosis to subcutaneous tissue but not extending to underlying bone, tendon or joint capsule” which are not responding to treatment and require a minimum of daily monitoring / reassessment. OR A skin condition which requires a minimum of daily monitoring or reassessment. OR Specialist dressing regime in place which is responding to treatment.			

Signature: **Date:**

Designation: **Location:**

Contact Number: **Fax Number:**

NHS Continuing Healthcare Needs Checklist

Name: D.o.B:

Current Location: D.o.A:

Domain	Description	A Meets / Exceeds the Described Need	B Borderline – Nearly Meets the Described Need	C Clear Does Not Meet the Described Need
Breathing****	Is able to breath independently through a tracheotomy that they can manage themselves or with the support of carers or care workers. OR CPAP (Continuous Positive Airways Pressure). OR Breathlessness due to symptoms of chest infections which are not responding to therapeutic treatment and limit all activities of daily living.			
Drug Therapies & Medication: Symptom Control****	Requires administration of medication regime by a registered nurse or care worker specifically trained for this task and monitoring because of potential fluctuation of the medical condition or mental state that is usually non-problematic to manage. OR Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.			
Altered States of Consciousness****	ASC that require skilled intervention to reduce the risk of harm.			
Total from Both Pages				

A full consideration of eligibility is required if there are:

- Two or more ticks in column A
- Five or more ticks in column B **OR** one tick in A and four ticks in B
- One tick in column A in one of the boxes marked with an ****asterisk**** (i.e. the domains which carry a priority level in the Decision Support Tool), with any number of ticks in the other two columns.

There may also be circumstances where you consider that a full consideration for NHS Continuing Healthcare is necessary even though the individual does not apparently meet the indicated threshold.

Please ensure all eleven care domains have a tick in one of the three boxes, A, B or C

Outcome: (i.e. Complete Decision Support Tool (CC2) for a full consideration or the summary on the following page).

.....
.....

Signature: Date:

Designation: Location:

Contact Number: Fax Number:

NHS Continuing Healthcare Needs Checklist

Name: D.o.B:

Current Location: D.o.A:

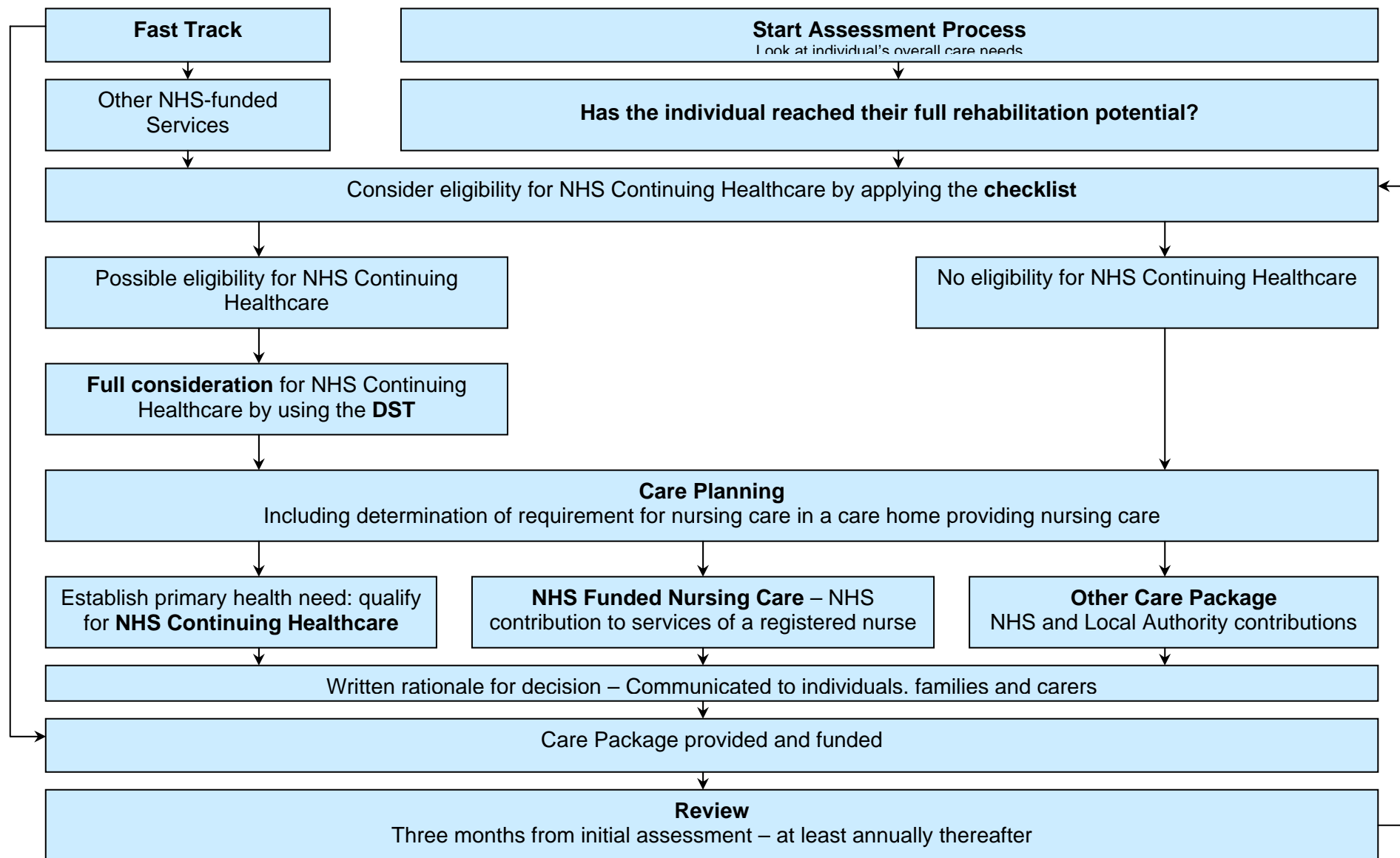
Summary
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Recommendation of MDT Completing the Checklist
Give a clear rationale based on the evidence above for the recommendation.
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.....
.....

Assessors (including MDT members) Name / Address / Contact Details Noting Lead Co-ordinator
.....
.....
.....
.....

Signature: Date:
Designation: Location:
Contact Number: Fax Number:

Continuing Care Process (October 2007)



PATIENT DISCHARGE INFORMATION

Patient's Name Casenote No

This information is to help you and your family/carer following your discharge from hospital

Ward Direct Line No Discharging Nurse

*Your GP will receive a full account of your treatment from the Consultant. If you have been given a letter addressed to your GP, take this to the Surgery or on your next visit or within the next few days*Skin Care Yes N/A

If Yes

Exercise/Lifting Yes N/A

If Yes

Breathing Yes N/A

If Yes

Bathing/Showering Yes N/A

If Yes

Eating/Drinking Yes N/A

If Yes

Bowels/Urine Yes N/A

If Yes

Resuming Sexual Relations Yes N/A

If Yes

Medicine and Pain Relief/Dressings Yes N/A

If Yes

Specific Instructions:

- Driving
- Returning to Work
- Specific advice sheet given
- Equipment delivered on

Outpatient Attendance

a) You will receive an appointment through the post to attend clinic in weeks

b) You have been given an appointment to attend clinic on

Your Social Worker is