**POLICY FOR DISCHARGE FROM HOSPITAL**

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<td>Guideline for the Transfer of Mothers and Babies to the community Section in the Trust’s Discharge Directory which gives detailed guidance and information on the roles of the different staff groups in discharge planning.</td>
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<th>AUTHOR / FURTHER INFORMATION:</th>
<th>Holly Ashforth, Divisional Nurse, Medicine and Surgery</th>
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<td>Updated with clarification of information provided on discharge and how this is recorded. Updated to reflect 2-year review period as this is an existing and established Policy.</td>
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1. INTRODUCTION

This policy has been drawn up in consultation with commissioning Primary Care Trusts, Social Services departments, carers and service users. It gives guidance on preparation for safe and effective discharge of patients from the Trust.

Discharge planning is a multi-agency, multidisciplinary activity in which all professions have a contribution to make. It is acknowledged that whilst the majority of patients in secondary care will not require a lengthy and in-depth discharge planning process it should be assumed that the discharge will be complex until proven otherwise. Individually focused discharge plans, built through bilateral communication and consultation with the patient and their relatives / carers (as appropriate) remains of prime importance regardless of length of stay.

Multidisciplinary, multi-agency involvement prior to, or as soon as possible after admission, is key to successful safe discharge planning.

2. SCOPE

This policy and procedure applies to all NHS and private patients within Chelsea and Westminster Hospital Foundation Trust.

The Multi-Disciplinary Team (MDT) is responsible for planning discharge in conjunction with the patient or advocate.

It is the MDT’s responsibility to identify the need for an advocate if there is any doubt about the patient’s capacity to make decisions.

This policy ceases to apply when:

- The Major Incident Plan is activated
- The Business Continuity Plan is activated
- The Pandemic influenza plan is activated.

3. DEFINITIONS


“Tell (someone) officially that they can or must leave, in particular: allow (a patient) to leave hospital because they are judged fit” (http://oxforddictionaries.com/definition/english/discharge)

Transfer: “Move from one place to another” (http://oxforddictionaries.com/definition/english/transfer)

“To convey the responsibility for the care of a patient from one entity to another. It may involve the discharge from one entity and the admission to another along with the patient’s medical/dental records or copies”. (http://medical-dictionary.thefreedictionary.com/patient+transfer)

Out of hours: The term out of hours is required to be flexible and is inclusive of a variety of factors such as the weather (snow, cold, and rain), darkness, and time of day. However, it should be generally understood, for the terms of this policy, out of hours would be after 8pm at night until 8am in the morning and all hours during the weekend. These hours are a guide and flexibility may be required during differing seasons, circumstances and public holidays. It is expected staff should take these factors into consideration when assessing risk.

N.B: This does not include patients undergoing late procedures where patients may be planned for discharge out of hours e.g. day cases who are not ready for discharge until 21:00 but the family still wish to go home at this time.
**Assessment**: A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated

**Capacity**: See Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Practice and Procedures Guidance

**Care package**: A combination of services designed to meet a person’s assessed needs. This may be provided by Social Services, Health (PCT) or a combination of both.

**Carers**: Carers provide unpaid support to family or friends who couldn't manage without this help, whether they're caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems

**Continuing Care / Assessments**: Refers to the process of the Health and Social Service Assessments to determine the on-going care requirements for a patient. This could be fully funded NHS, Social Services Funded or a combination of both. Usually results in a placement or supported care at home.

**Multi-disciplinary team (MDT)**: A team of professionals (inter-disciplinary working) from different disciplines working together to improve the patient care pathway.

**Vulnerable adult**: Any person aged 18 years or over ‘who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him/herself, or unable to protect him/herself against significant harm or exploitation’. (From ‘who decides’ Lord Chancellors Department 1967)

**Medically Fit**: Medically fit is defined as a patient who has no acute medical problems and is fit for discharge or when a patient’s medical condition or treatment could be managed in the community setting. For the purposes of this policy a patient would become medically fit when all required acute intervention is complete for the associated hospital admission. The decision as to a patient’s medically fit status will be made by the medical team and consultant in charge, with input from the ward Nursing and MDT staff where required.

**Team Fit**: Team fit is defined as a patient who has been deemed medically fit and also has no acute therapy or nursing need. For the purposes of this policy a patient would become team fit when all required acute intervention/ therapy/treatment is complete for the associated hospital admission. The decision as to a patient’s team fit status will be made by the multi-disciplinary team.

**Delayed Discharge**: A delayed discharge occurs when a patient is team fit for discharge, but is still occupying an acute bed. For example; waiting for the completion of a continuing care assessment or a panel review to establish whether funding is agreed.

**Reportable delayed discharges**: A delayed discharge occurs when a patient is team fit for discharge, but is still occupying an acute bed. The delay is reportable when the patient remains in an acute bed beyond the agreed time frame from the point that a decision has been made, for example regarding funding/ equipment delivery or social/ health care starts (Appendix 3)

**4. STAKEHOLDERS**

The following stake holders were consulted as part of the ratification:

- Royal Borough Of Kensington And Chelsea
- Chelsea And Westminster Hospital Foundation Trust Executive & Senior Management Team
- London Borough Hammersmith And Fulham
5. POLICY STATEMENT

Our patients can expect to spend no more time in hospital than is absolutely necessary. At Chelsea and Westminster Hospital Foundation Trust our aim is to discharge our patients in a timely and safe manner. The predicted date of discharge, set within the first twenty four hours of admission by the multi-disciplinary team and reviewed each day, enables us to work in partnership with patients, family/ carers, our partner organisations and the whole health community to achieve this.

- A standardised, equitable approach will be taken for all discharge planning regardless of who is case managing the care of the patient.

- Discharge planning should, with the exception of extraordinary and complex discharges be managed by the Registered Nurse leading the patient’s care.

- Discharge planning should start at the point of admission with the PDD (Predicted Discharge Date) communicated to the patient and family.

- Discharges should occur before 11:00am and where discharges are planned on the day they should occur before 14:00pm where clinically indicated.

- Discharges should be planned in a collaborative manner with the patients and their families/ carers where applicable.

- Any patients considered vulnerable will be managed under the relevant adult or child safeguarding protocols.

6. AIMS OF THE POLICY

The aims of the policy are to:

- Ensure each patient is discharged to a safe environment.
- Ensure each patient has an appropriate and safe method of transport organised.
- Ensure each patient being discharged is appropriately dressed.
- Ensure each patient is in receipt of a discharge/follow up plan and a supply of any appropriate new/urgent medicines, devices and dressings as required.
- Ensure each patient’s rights and wishes are respected and listened to.
- Ensure we as an organisation work in partnership with the patient and their families to facilitate safe discharges whilst actively attempting to meet their wishes.
- Ensure any vulnerable patient or situation is highlighted and appropriate measures are put in place to optimise patient safety.
- Ensure a patient’s next of kin have been contacted (where appropriate).
- Ensure this process and any decisions made have been well documented.
7. DUTIES

7.1 Chief Operating Officer

- Is the lead director for this policy
- Has overall corporate responsibility, on behalf of the Chief Executive Officer for ensuring that there are policies, procedures and guidelines in place to facilitate and ensure safe discharge practices.

7.2 Chief Nurse

- The Chief Nurse is responsible for providing professional support for initiatives concerned with nursing practice in relation to discharge
- Is responsible for the operational aspects of this policy and ensuring the management and compliance of out of hours discharge

7.3 Divisional Director of Operations

- General Managers, Ward Managers are aware of the policy and it is circulated to staff
- Systems are in place to identify shortcomings and additions to control measures are identified and implemented
- Holds overall accountability, to the lead director for discharge management across the Trust and where applicable across organisational boundaries
- Where a discharge is considered extra ordinary by the discharge team leader or carries significant risk, the relevant General Manager is responsible and accountable for ensuring that all care is taken to protect the wellbeing of individual patients and protecting the Trusts interests.
- Is responsible for working with external stakeholders ensuring that safe and effective discharge processes/pathways are developed to support timely discharge from hospital
- Is responsible for working with and informing PCTs of additional community support required to demand manage patients

7.4 Divisional Nurse – Medicine and Surgery

- Is responsible for the Discharge Team and ensuring that complex discharges are managed to ensure safe and timely discharge from the hospital
- Is responsible for ensuring that those managing standard and complex discharges have the resources and information they need to execute their duties
- Is responsible for working with the Divisional Director of Operations informing them if a discharge is considered extra ordinary by the discharge team leader or carries significant risk ensuring that all care is taken to protect the well being of individual patients.
- Is responsible for working with external stakeholders ensuring that safe and effective discharge processes/pathways are developed to support timely discharge from hospital.
7.5 Divisional Nurse – Paediatrics

- Is responsible for ensuring that those managing standard and complex discharges have the resources and information they need to execute their duties.
- Is responsible for working with the Divisional Director of Operations informing them if a discharge is considered extra ordinary or carries significant risk ensuring that all care is taken to protect the well being of individual patients e.g. Children and Adolescent mental health patients.
- Is responsible for working with external stakeholders ensuring that safe and effective discharge processes/ pathways are developed to support timely discharge from hospital.

7.6 Clinical Site Manager (CSM), Senior Nurse Bleep holder for Children’s areas/ Neonatal Unit coordinator

- Ensure this policy and the concerns surrounding safe and appropriate out of hours discharges are considered (see appendix 4)

7.7 Discharge Team Leader and Discharge Liaison Team

- Ensure the participation of patients and significant others in discharge planning
- Ensure the provision of relevant information to patients and significant others regarding discharge
- Responsible for undertaking continuing care or complex health needs assessments in a timely manner
- Responsible for ensuring that carers needs are identified and that any relevant assessments are completed
- Are responsible for case managing discharges that are considered complex as per the definitions that follow in this policy
- Are responsible for responding to requests for information and guidance from other Trust employees regarding simple and standard discharges
- To escalate any undue delay or trends in delays to the Divisional Director of Operations or the Divisional Nurse for Medicine and Surgery
- To escalate any discharge that is extraordinary that carries a high risk to the patient or to the Trust
- To escalate all ‘safe guarding vulnerable adults’ cases to the relevant General Managers or Divisional/ Directorate Nurses to ensure that the right team member is allocated to the case
- To audit the use of discharge tools provided by the team to the Trust, including the contact assessment
- To manage the discharge lounge
- To provide biweekly reports to community partners outlining complex, delayed or statutory delayed discharges (Appendix three contains the definitions of statutory delays)

7.8 Consultants
• Ensure the participation of patients and significant others in discharge planning

• Are responsible for planning the discharge of their patients including the allocation of a predicted date of discharge ‘PDD’ at the point of admission and evaluating this through the patient’s journey to ensure proactive discharge management

• To lead their teams providing a positive role model with regards to discharge planning

• To work as part of the multi disciplinary team to ensure that the patients and their best interests remains at the centre of all plans

• Ensure timely completion of referrals to other agencies and assessments required to secure funding/ placements

7.9 Other Medical Staff

• Are responsible for producing discharge summaries that accurately reflect the episode of care which are sent to the patients G.P. within 24 hours of discharge

• To work as part of the multi disciplinary team to ensure that the patients and their best interests remains at the centre of all plans

• To produce ‘to take home’ (TTO’s) medicine prescriptions or ensure that a suitably qualified person has completed the task where possible 24 hours in advance of the proposed discharge date

• Ensure the participation of patients and significant others in discharge planning

• Ensure timely completion of reports and assessments required to secure funding/ placements

7.10 General Managers/ Divisional/ Directorate Nurses

• Resources are provided (including time allowance for staff taking on additional roles) to comply with this policy

• The policy is distributed within their directorate and implemented and staff are aware of its contents and their duties

• Staff are provided with written information, instruction and supervision

• Competent persons are identified to perform root cause analysis of any incidents related to out of hours discharge

• Their managers provide written risk assessments with a view to implementing suitable control measures to reduce or remove the risk

• Immediate action is taken when shortcomings in control measures have been identified

• Work with the Clinical Site Management team to mitigate any risks relating to our of hours discharge

• To establish a culture where discharge of patients is an integral part of care planning

• To work as part of the multi disciplinary team to ensure that the patients and their best interests remains at the centre of all plans
• To lead their teams providing a positive role model with regards to discharge planning

7.11 Matrons

• Ensure the participation of patients and significant others in discharge planning

• To have oversight over all patients within their case load and provide leadership and hands on intervention where required to expedite timely discharge. This includes the active management of patients whose length of stay exceeds 10 days

• To performance manage the wards and units to ensure that there is compliance with this policy.

• Are responsible for ensuring all patients have been allocated a predicted date of discharge ‘PDD’ at the point of admission and that this is evaluated through the patient’s journey to ensure proactive discharge management

• Responsible for ensuring that all patients (adults) have an electronic discharge assessment in place within 48 hours of admission.

• Responsible for ensuring discharges occur before 11:00 where possible.

7.12 Ward and Department Managers

• Ensure the participation of patients and significant others in discharge planning

• Ensure timely completion of reports and assessments required to secure funding/ placements

• This policy and the accompanying procedures are fully implemented in their area and staff are aware of its contents and their duties

• Any patients who are for discharge out of hours are identified; an assessment of risks is carried out and escalated immediately to the Clinical Site Management team if required.

• All attempts are made to discharge patients in hours.

• Staff receive adequate information, instruction and advice relevant to managing safe patient discharge

• To lead the ward discharge process with the consultant and allied health professionals

• To ensure that all patients have a PDD documented in Last Word and that this is updated to reflect discharge plans.

• To ensure that all adult inpatients have a discharge assessment within 48 hours of admission and that it is updated according to any changes in the patient’s condition or discharge plans.

• To ensure that discharges occur, where possible before 11:00am

• To ensure that each patient is given a ‘leaving hospital’ booklet

• To work as part of the multi disciplinary team to ensure that the patients and their best interests remains at the centre of all plans.

7.13 All staff/ Multi-Disciplinary Team ‘MDT’

(Includes those members outside the organisation and those already mentioned above)
- Ensure the participation of patients and significant others in discharge planning
- Ensure timely completion of reports and assessments required to secure funding/placements
- To assess, plan and implement safe discharge plans to ensure that patients spend no more time in hospital that is clinically required.
- To work together to affect safe discharge and in the best interests/wishes of the patient
- To execute the duties of their profession and extended scopes to expedite and facilitate safe and timely discharge
- Comply with Trust guidance contained in this Policy
- Bring to the attention of their manager any risks within their work area they believe to be non-compliant with safe patient discharge
- Take steps to reduce the risks to safe discharge practice
- Participate in any training as identified in the training needs analysis
- Ensure that patients are provided with information relating to discharge and available support.

8. DISCHARGE REQUIREMENTS

Discharge planning is a multi-agency, multidisciplinary activity in which all professions have a contribution to make. It is acknowledged that whilst the majority of patients in secondary care will not require a lengthy and in-depth discharge planning process it should be assumed that the discharge will be complex until proven otherwise. All inpatients should have a robust assessment undertaken in order to identify the patient’s current home situation and any requirements that will be needed on discharge to support a safe discharge. For adult inpatients, the discharge assessment should be recorded within the appropriate assessment tool found on Lastword and any communication relating to discharge should be noted within the electronic communication record found on Lastword.

For paediatric patients, please refer to the discharge flowchart for complex/long term children/young people in Appendix 6. Information given to patients/carers should be recorded on the E-communication notes on Last word. The information to be given is as listed in the discharge checklist (appendix 7). For paediatric patients who do not require complex discharge planning support, the discharge checklist should be completed and filed on discharge within the patient’s medical records (Appendix 7). For Maternity, information should be recorded in the mother and baby’s records.

8.1 Discharge Requirements of Specific Patient groups

At Chelsea and Westminster Hospital we divide patients’ discharges into four groups:

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<tr>
<th>Groups</th>
<th>Specific Discharge Requirements</th>
<th>Staff responsible</th>
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<tr>
<td>Simple</td>
<td>• No involvement of other agencies other than District Nurses, GPs or community therapy</td>
<td>Ward Staff</td>
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<tr>
<td></td>
<td>• Able to understand medicines regime</td>
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<td></td>
<td>• In most cases will be able to independently leave the hospital by their own means</td>
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<tr>
<td></td>
<td>• Involvement of social services or private care providers</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Responsible Party</td>
</tr>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>Standard</td>
<td>• No escalation of care levels required</td>
<td>Ward Staff</td>
</tr>
<tr>
<td></td>
<td>• In most cases will be able to understand medicines regime but may need compliance aids</td>
<td></td>
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<tr>
<td>Complex</td>
<td>• Involvement of several agencies</td>
<td>Discharge Team</td>
</tr>
<tr>
<td></td>
<td>• Escalation of care levels required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May need compliance aids with medicines or District Nurse administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New admissions to another care environment</td>
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<tr>
<td></td>
<td>• Continuing care process will need to be followed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May involve Safeguarding adult procedures</td>
<td></td>
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<tr>
<td>Extraordinary</td>
<td>This area is difficult to define but may involve several agencies and will often be characterised by several interdependencies e.g. immigration status, housing status, medical condition, safeguarding procedures, capacity</td>
<td>Discharge Team/ Divisional Nurse, Medicine and Surgery/ Divisional Director of Operations</td>
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9. GP REAL TIME INFORMATION (CQUIN)

9.1 Discharge Summaries

The discharge summary should accurately reflect the episode of care for the patient. It should be completed and sent to the patient's G.P. within 24 hours of discharge. This is recorded automatically within the electronic patient record system – Lastword.

A copy of the discharge summary should also be given to the patient/ relative on discharge from the Trust. This should then be recorded within the discharge assessment checklist found on the Electronic Patient record ‘Lastword’.

The content of the discharge summary is as per the discharge template on the Electronic Patient Record (EPR) system which is part of Lastword.

The discharge summaries are posted on a portal between the Trust and GP surgeries review these. This allows GPs to directly access information. This is recorded on Lastword.

9.2 Predicted Discharge Dates (PDD)

The Provisional Discharge date is an estimated date of discharge for the patient set by the multi-disciplinary team. All patients should be allocated a predicted date of discharge ‘PDD’ at the point of admission and this should be evaluated throughout the patient’s journey to ensure proactive discharge management is undertaken.

The predicted discharge dates are posted on a portal between the Trust and local GP surgeries. This allows GPs to directly access information on a patients discharge and support safe discharge.

10. OUT OF HOURS DISCHARGES

It is understood that all members of staff should already be prioritising the early discharge of patients. It is our aim to ensure all at-risk patients discharged should be actively planned to occur during daylight hours. Our aim is to ensure that each patient discharged out of hours is evaluated by a senior member of nursing staff. By doing this we, as the Trust, will ensure that each patient will be discharged out of hours safely and appropriately whilst respecting the patient’s own wishes. In all cases where staff are concerned regarding a patient discharge out of hours, the Clinical Site
Manager should be contacted immediately to discuss the patient. (N.B. For paediatric patients, the paediatric senior nurse/ bleep holder should be informed)

The safety of our patients is of paramount importance and this policy will provide Trust staff with guidance around ensuring we are considering risk factors in association with patient discharge. It will ensure all patients discharged out of hours are highlighted to the most senior nurse / manager on site (CSM) or paediatric/ neonatal co-ordinator/ bleep holder in order to ensure that an evaluation is made ensuring that the discharge is appropriate. It also ensures that each patient is discharged out of hours to a safe environment.

The most common areas where discharges of care occur out of hours are:

- The Emergency Department
- The Acute Assessment Unit
- The Treatment Centre
- Day Surgery Beds
- Paediatrics

In cases where there is a significant reason why it is in the patient’s best interests to be discharged out of hours this must be clearly documented in the communication notes on the last word system. Due to the reduced primary and social care infrastructures available out of hours it is important that these patients have adequate information and resources to ensure self-care until the next working day. It is the responsibility of the discharging nurse and Doctor to ensure this.

In all cases, without exclusion, any concerns, issues or complications relating to a patient’s discharge out of hours should be escalated immediately to the CSM. A sensible and balanced view of the potential discharge should be made ensuring that the patient and his or her safety remain at the heart of any discharge process. It is appreciated that all cases are individual and, as such, the CSM should be able to exercise fair judgement as to whether the discharge should go ahead.

N.B. For paediatric patients, the paediatric senior nurse/ bleep holder should be informed

10.1 Procedure of discharging a patient out of hours

Once a decision to discharge out of hours has been reached, the member of staff in charge of the patient’s care (usually this would be the nurse/ midwife caring for the patient) should ensure that the normal procedures for discharge have been followed. This would include (but is not limited to):

- The patient’s team have declared the patient medically/ team fit and safe for discharge OR has the capacity to be able to take their own discharge (or parents wish to self-discharge their child) if this is their preference (self-discharging patients should always be escalated to the nurse in charge who may choose to involve the CSM)
- The patient’s wishes are being respected and where ever possible being adhered to
- As a hospital, we are satisfied the patient is returning to a safe environment which they can access (e.g. keys are present, carer is at the residence etc.) and that previous or recommended care provision has been set up

Appendix 1 outlines the process to be followed for discharges out of hours.

10.2 Additions to this procedure out of hours
In addition to 10.2, in the event the patient has to be discharged out of hour’s period AND if the member of staff has any other concerns not named already then the following extra practices should be employed before the patient is physically discharged:

- The member of staff in charge of the patient’s care OR the member of staff in charge of the area should contact the CSM and state they have a potential out of hours discharge and that they have concerns regarding the discharge (N.B. For paediatric patients, the paediatric senior nurse/ bleep holder should be informed)

- The member of staff should have all the information in relation to 6.2 so the CSM/ paediatric senior nurse is able to make an appropriate valued decision in regards to whether the discharge should proceed at that time

- Where concern is raised, a patient should not be discharged out of hours without a discussion having first taken place with the CSM/ Paediatric senior nurse OR if the patient has capacity and wishes to leave immediately. The rights of the patient must be respected.

- Ensure that patients who are deemed at risk and have capacity to self-discharge have appropriate follow up in the community.

10.3 Specific Documentation out of hours

Documentation within the patient’s written or electronic notes should reflect that the processes in 10.1 and 10.2 have been followed. In all cases out of hours, the member of staff looking after the patient should document the following:

- Whether the patient was happy to be discharged
- What was decided/ organised/ actioned in order to ensure the patient was safe to leave
- Who and Where the patient was being discharged to and with what support
- The time the Clinical Site Manager (CSM)/ Paediatric senior nurse was called (if at all) and the advice provided

The CSM/ Paediatric senior nurse should ensure that an entry has been made into the patient’s electronic notes or medical notes which reflect that these three points have been considered.

11. MEDICATION INFORMATION TO BE GIVEN TO PATIENTS/CARERS WHEN THEY ARE DISCHARGED BY THE MDT (WHICH WILL BE LOCATED IN THE MEDICATIONS PACK (TTO))

Please refer to the Trust’s Medicines policy.

12. INFORMATION TO BE GIVEN TO PATIENTS/ CARERS WHEN THEY ARE DISCHARGED HOME BY THE MDT

When adult patients are discharged from the Trust, they (or their carers) should be offered relevant information relating to their condition and carers should be reminded of any specific information advised by clinicians and be provided with support and understanding to reduce their anxieties.

There is some information that should be given to all patients/ carers on discharge and these include:

- A discharge summary (ensure a copy is also sent to the GP as referred to in section 9)
Any follow up information (for example, outpatient appointment or diagnostic test appointment) (this should be documented on the discharge checklist within the discharge assessment found on the Electronic Patient record ‘Lastword’).

A ‘Planning for your hospital discharge’ Leaflet (this should be documented on the discharge checklist within the discharge assessment found on the Electronic Patient record ‘Lastword’).

Advice should be given to patients on discharge regarding the ability to locate condition specific information (Trust website). This should be documented on the discharge checklist within the discharge assessment found on the Electronic Patient record ‘Lastword’

‘Are you at risk of blood clots?’ venous thromboembolism patient information leaflet - this should be documented on the discharge checklist within the discharge assessment found on the Electronic Patient record ‘Lastword’.

Wound care plan and/ or District Nurse referral if required for on-going healthcare treatment at home (for example, dressings, incontinence support) (this should be documented on the discharge checklist within the discharge assessment found on the Electronic Patient record ‘Lastword’).

For paediatric patients, the information to be given is as listed in the discharge checklist (appendix 7). For complex discharges further information should be recorded in the electronic communication notes.

13. INFORMATION TO BE GIVEN (BY THE NURSING/MEDICAL TEAM) TO THE HEALTH OR SOCIAL CARE PROFESSIONAL WHEN PATIENTS ARE DISCHARGED FROM THE TRUST TO ANOTHER HEALTH OR SOCIAL CARE FACILITY

A) General practitioner (GP):
   • A discharge summary (ensure a copy is also sent to the GP as referred to in section 9)

B) Other, for example care home (which will be sent via the patient)
   • Any follow up information (for example, outpatient appointment or diagnostic test appointment) – this is recorded on the discharge summary and documented as being sent with the patient on the e-communication notes found on the Electronic Patient record ‘Lastword’).

   • Handover letters outlining any pertinent information regarding the patient being discharged (this is recorded on the discharge summary and documented as being sent with the patient on the e-communication notes found on the Electronic Patient record ‘Lastword’). N.B: The RN should also telephone care facilities if faxing information to confirm its receipt.

   • Wound care plans for any existing wounds/ skin damage that require on-going wound management (this should be documented as being sent with the patient on the e-communication notes found on the Electronic Patient record ‘Lastword’).

14. DELAYED DISCHARGES

14.1 Internal delays

(This includes anything that delays patient moving on to next stage of pathway/ Journey from the Trust)
An internal delayed discharge is defined as when a patient has been deemed team fit for discharge and there are no external delays but the patients is still occupying a bed. This may be due to medications to take home not being ready or transport not organised.

The categories for internal delays are found in Appendix 2.

14.2 External delays

(Delayed Discharges)

A delayed discharge is defined as when a patient is ready for discharge from acute care, but is still occupying an acute bed. A patient is ready for discharge:

- A clinical decision has been made that patient is medically fit for discharge
- A multi-disciplinary team decision has been made that patient is medically fit for discharge
- The patient is safe to discharge

- The categories of delay are found in Appendix 3. The Discharge team are responsible for collating any information for patients deemed to be delayed discharges and compiling a biweekly situation report (Appendix 5) which is then sent to community partners, the Divisional Director of Operations and the Divisional Nurse for Medicine and Surgery.

14.3 Escalation of Delays

Once the patient is team fit and discharge delays (whether internal or external) occur the following actions should be undertaken:

- Internal delays should be escalated to the relevant matron who would then be expected to address any bottlenecks with the clinical team or relevant individuals.
- Delayed discharges over 72 hours should be escalated to the relevant senior nurse for action.
- Delayed discharges over 5 working days should be escalated to the Divisional Director of Operations for action.
- Reportable delayed discharges over 24 hours should be escalated to the Divisional Director of Operations. They will in turn liaise with the relevant community partners to support a timely solution to any delays.

15. DISSEMINATION

- The policy will be disseminated via divisional boards.
- Each directorate is expected to ensure that all persons who the policy affects are aware of its ratification and the need to read this document in conjunction with the Trust
- The policy will be held on the Trust Intranet.

16. MONITORING IMPLEMENTATION AND EFFECTIVENESS OF THE POLICY

The Divisional Boards will be the main monitoring committees for this policy.

The monitoring responsibilities and process followed to report compliance with the Discharge policy and develop any subsequent actions can be found in appendix 4.
The adult Safeguarding committee will also monitor any incidents relating to discharge with the expectation that divisional representatives will communicate any emerging themes or recommendations to their divisional board.
Appendix 1

Discharging any patient out of hours

SUMMARY OF ACTIONS

In the event that a patient is about to be discharged out of hours (8pm to 8am), the most senior nurse or midwife working should be made aware before the patient is actually discharged

The senior nurse / midwife should then risk assess whether they deem it appropriate that the patient should be discharged at this time. They should specifically consider the patient's wishes, how the patient is to get home safely and if they have a place of safety to go to (with appropriate care in place – previous or new) and contact the next of kin.

If the senior nurse or midwife is satisfied the discharge is appropriate and they have no concerns then the discharge should go ahead.

If there is any doubt or concerns regarding this process then the senior nurse or midwife should contact the Clinical Site Manager (CSM) on duty expressing their concerns. The CSM will then make a decision as to whether the discharge should go ahead at that time.

All decisions should be clearly documented.
## APPENDIX 2
Guidance on what constitutes a delay?

<table>
<thead>
<tr>
<th>CODE</th>
<th>REASON FOR DELAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>Transport</td>
</tr>
<tr>
<td>N2</td>
<td>TTOs</td>
</tr>
<tr>
<td>N3</td>
<td>Awaiting medical team to set date</td>
</tr>
<tr>
<td>N4</td>
<td>Awaiting scheduled ward round</td>
</tr>
<tr>
<td>N5</td>
<td>Awaiting for MDT reports</td>
</tr>
<tr>
<td>N6</td>
<td>Awaiting community bed</td>
</tr>
<tr>
<td>N7</td>
<td>Awaiting social services</td>
</tr>
<tr>
<td>N8</td>
<td>Awaiting delivery OT/Physio equip/external assess</td>
</tr>
<tr>
<td>N9</td>
<td>Awaiting diagnostic at C&amp;W</td>
</tr>
<tr>
<td>N10</td>
<td>Awaiting external diagnostic</td>
</tr>
<tr>
<td>N11</td>
<td>Awaiting inter-hospital transfer</td>
</tr>
<tr>
<td>N12</td>
<td>Awaiting SGA outcomes</td>
</tr>
<tr>
<td>N13</td>
<td>Delay to booked procedure</td>
</tr>
<tr>
<td>N14</td>
<td>Awaiting continuing care assessment</td>
</tr>
<tr>
<td>N15</td>
<td>Patient/ Family choice</td>
</tr>
<tr>
<td>N16</td>
<td>Awaiting panel</td>
</tr>
</tbody>
</table>
Appendix 3
Guidance on what constitutes a Reportable delay?

**Category 1: Awaiting Assessment** this applies to patient who are awaiting assessment by an external agency. i.e. IMCA, Health funded rehabilitation service etc. A period of 48 hours is permitted before it is counted as a delay. Counting would begin on Day 3.

**Category 2: Awaiting Public Funding** applies when there is a discrepancy relating to health funding for a patient’s treatment following discharge from hospital. This may include rehab where the patient does not have a GP (i.e. homeless, unable to indentify patient etc). Cases such as these should always be escalated to the Head of Patient Flow.

**Category 3: Awaiting non-acute NHS funded care** refers to those patients awaiting beds at NHS funded rehab units or Continuing Care placements. A period of 48 hours is permitted before it is counted as a delay. Day 3 would count as one day.

**Category 4a: Awaiting Residential Care Home Placement** applies to those patients awaiting placement in a care home directly from hospital. Hospital Discharge Policy allows for five working days from the point that patient is declared fit for discharge by both medical and therapy staff and ALL necessary reports have been provided to social services. The five-working day policy applies to permanent placements only, not temporary respite or step down placements.

**Category 4b: Awaiting Nursing Care Home Placement** applies to those patients awaiting placement in a nursing care home directly from hospital. Hospital Discharge Policy allows for five working days from the point that a decision regarding funding is reached by the Continuing Care Panel. This category is used for those patients that are funded by social services.

**Category 5: Awaiting Domiciliary Care Package** applies to patients who are going home with a package of care and there is a delay in providing that care. This can include a delay with the Care Agency in starting the care plan, awaiting a blitz clean arranged by social services or any other service provided by social services which is not completed and ready within 48 hours of the patient being fit for discharge. (A Section 5 must have been sent)

**Category 6: Awaiting Community Equipment** refers to those patients waiting equipment in the community such as hospital bed, hoists or wheel chair etc and can be from any source. A period of 48 hours from referral is permitted before it is counted as a delay.

**Category 7: Patient or Family Choice** refers to those instances where it is the patient or the patient’s family/NOK that are being obstructive with the discharge plan AND the patient is deemed fit for discharge. This can include instances where social services have made adequate offers of care homes that the family have rejected. This category is also used where a patient is fully moving to a self funded placement where there is no assistance from Social Services. The Hospital Choice Policy should be consulted and implemented if necessary.

**Category 8: Disputes** refers to those rare instances where there is an issue relating to a discharge plan. These are usually awaiting negotiation by Senior Management. This code should not be used without guidance from the Head of Patient Flow.

**Category 9: Housing Issues** refers to those patients who are delayed due to housing issues that do not allow for discharge to the Homeless Persons Unit.
### Appendix 4: Monitoring Responsibilities

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Method/ Tool</th>
<th>Frequency</th>
<th>Reporting Arrangements</th>
<th>Recommendations and Lead(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. GP Real Time Information:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Discharge Summaries to be completed and available to GP within 24 hours for all inpatients (A, P)</td>
<td>Information Team/ General managers</td>
<td>Report from Last word</td>
<td>Weekly</td>
<td>Report to Trust Board monthly who will agree actions if targets are not being met.</td>
<td>Progress on the actions will be monitored by the Board.</td>
</tr>
<tr>
<td>For a Predicted Discharge Date to be set (and available for patients over 75 years to GP) within 24 hours of patient admission (A)</td>
<td>Information Team/ Divisional/ Directorate Nurses</td>
<td>Report from Last word/ Clikview</td>
<td>Daily</td>
<td>Report to Trust Board monthly who will agree actions if targets are not being met.</td>
<td>Progress on the actions will be monitored by the Board.</td>
</tr>
<tr>
<td><strong>2. Information given to patients/ carers/ Healthcare professionals on discharge:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All inpatients have an Electronic Discharge Assessment completed (checklist only for patients with a LOS of less than 72 hours) (A)</td>
<td>Divisional Nurse, medicine and Surgery</td>
<td>Audit</td>
<td>Weekly</td>
<td>Report to weekly discharge meeting who will agree actions if targets not being met.</td>
<td>Progress on the recommendations will be monitored at the bi-weekly discharge transformation committee.</td>
</tr>
<tr>
<td>For all patients to be given ‘Are you at risk of blood clots?’ venous thromboembolism patient information leaflets on discharge (A, M)</td>
<td>Specialist Anticoagulation Pharmacist</td>
<td>Audit</td>
<td>Bi-Annual</td>
<td>Report to the Thrombosis and Thromboprophylaxis Committee who will agree actions and timescales which are documented in the minutes.</td>
<td>Progress on the recommendations will be monitored at the Quality Committee</td>
</tr>
<tr>
<td>Other information given to all patients: (A) Discharge Summary Any follow up information e.g. outpatient appointment Planning for your hospital discharge Leaflet Advice re: location of condition specific leaflets Handover Letters (if applicable) Wound Care plan/district nurse referrals (if applicable) Are you at risk of blood clots?’ leaflet (and see above)</td>
<td>Divisional Nurse, Medicine and Surgery</td>
<td>Audit of completion of these specific elements in the LastWord Discharge Assessment Checklist – spot check audit</td>
<td>Annual (starting 6 months post implementation of LastWord Discharge Assessment checklist)</td>
<td>Report to Senior Nursing and Midwifery Committee who will agree actions and timescales</td>
<td>Progress on the recommendations will be monitored at the Senior Nursing and Midwifery Committee</td>
</tr>
<tr>
<td>Medication side effect leaflet *</td>
<td>*Pharmacy</td>
<td>*Spot check audit</td>
<td>*Annual</td>
<td>*Report to Pharmacy Board who will agree actions and timescales</td>
<td>Progress on the recommendations will be monitored at the Pharmacy Board</td>
</tr>
<tr>
<td>Information to be given to the health or social care professional when patients are discharged to another health or social care facility.</td>
<td>Divisional Nurse, Medicine and Surgery</td>
<td>Audit of completion of these specific elements in LastWord Communication notes – annual spot check</td>
<td>Report to Senior Nursing and Midwifery Committee who will agree actions and timescales</td>
<td>Progress on the recommendations will be monitored at the Senior Nursing and Midwifery Committee</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>Handover letters outlining any pertinent information regarding the patient being discharged</td>
<td>Wound care plans for any existing wounds/skin damage that require ongoing wound management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(P) Other information given to all patients: paediatrics</td>
<td>Divisional Nurse, Paediatrics</td>
<td>Spot check audit of discharge checklist filed in notes and electronic communication records if relevant</td>
<td>Annual</td>
<td>Report to Senior Nursing and Midwifery Committee who will agree actions and timescales</td>
<td>Progress on the recommendations will be monitored at the Senior Nursing and Midwifery Committee</td>
</tr>
</tbody>
</table>

### 3. Delayed Discharges:

<table>
<thead>
<tr>
<th>Delayed Discharges:</th>
<th>Healthcare and Transport Services</th>
<th>Regular monitoring against key performance indicators</th>
<th>Monthly</th>
<th>Report to PEAT Operational Management Group who will agree actions and timescales which are documented in the minutes</th>
<th>Progress on the recommendations will be monitored at the PEAT Operational Management Group and reported to the Facilities Committee via minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all transport delays for patients being discharged from the Trust to be monitored (A,P,M)</td>
<td>Divisional/ Directorate Nurses</td>
<td>Review of incidents for learning</td>
<td>Weekly report from Clinical Governance</td>
<td>Results of incidents reviews are discussed in multiple forums e.g. at Divisional Boards documented in the minutes</td>
<td>Using the Incident review register and Quarterly Quality reports (where applicable) the Divisional Boards</td>
</tr>
<tr>
<td>For all Incidents related to patient discharge to be monitored – used to monitor variance (A,P,M,N)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A=Adults**  **P=Paediatrics**  **M=Maternity**  **N=Neonates**
Appendix 5: Delayed Transfer of Care Situation Report Template

**Patients needing Care Home bed (Team fit and Continuing care assessment completed)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**DAYS DELAYED:** Trust/Tm Fit Date, External:PDD

**TOTAL CONTINUING CARE BEDS NEEDED:** 2

**Patients needing Residential Care (Team fit)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**TOTAL LOCAL AUTHORITY BEDS NEEDED:** 1

**Patients needing Rehabilitation beds (Team fit)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**TOTAL RESIDENTIAL HOME BEDS NEEDED:**

**Patients needing Interim Bed (Team fit)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**TOTAL INTERIM BEDS NEEDED:** 0

**Complex Team fit patients (e.g. needing POC, equipment and SGA)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**Patients needing Continuing Care Assessment (Team fit)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**Patients with complex discharge needs who are not yet Team fit**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Locality</th>
<th>Patient</th>
<th>Hosp. No</th>
<th>Sex</th>
<th>D.O.B</th>
<th>FY/Date</th>
<th>Admitted</th>
<th>Team Sec Date</th>
<th>Date for assessment</th>
<th>Panel Date</th>
<th>Trust days</th>
<th>Delayed</th>
<th>Comments</th>
</tr>
</thead>
</table>

**External Categories**

- 1. Awaiting Assessment
- 2. Awaiting Public Funding
- 3. Awaiting further (non acute) MDS Care
- 4a. Waiting Residential Home Placement
- 4b. Waiting Nursing Home Placement
- 5. Awaiting Domiciliary Package
- 6. Awaiting Community Equipment
- 7. Patient / Family Choice
- 8. Disputes
- 9. Housing Issues

- 10. Report incomplete in 2 or more areas
Appendix 6

Discharge Flowchart for complex/long term children/young people

Admitted to Paediatric Unit

Children can be admitted from – Paediatric Emergency Department; Elective Waiting Lists; Children’s Outpatients; PICU; Transfers from other Healthcare Providers; Direct Access; NICU

Admission completed including Social History-confirmed G.P and School details

Establish Medical Plan

Discharge Planning starts

If child under 1 yr or long term patient (over 1/12) refer to Health Visitor on admission
Adolescents to be referred to School Nurse

If child has a named Social Worker, inform them of admission and also inform Named Nurse for Child Protection

Any child that you have concerns about refer to Named Nurse for Child Protection, if out of hours contact Senior Paediatric Nurse (bleep 0113)

If child has been admitted with any of these conditions, consider a Discharge Planning Meeting:

- Multiple professional involvement, both hospital and community
- The child/young person has been out of school for a protracted period e.g. 1month+
- Complex family issues and/or concerns re parental mental health/parenting capacity
- Concerns re treatment adherence
- Social Services involvement
- Gastro/home PN children

If organising a Discharge Planning Meeting, remember to book room and sort out date and time that will be agreeable to most members of the MDT. Use Discharge Planning folder for information and meeting structure available on Paediatric Wards. Give family/carers information sheet. Remember to invite:

Ward Nurse/Ward Manager/Leader; Consultant/Medical Rep; School Teacher – from C&W and local school; Community Nurse; G.P.; Physiotherapy; Psychology; Specialist Nurse; Social Services; Named Nurse for Child Protection; Health Visitor/Liaison Health Visitor; Dietician; Pharmacist; Play Specialist; SALT; Parents/Main Carers/Young Person;

Remember to forward minutes to those unable to attend and file a copy in the medical notes and a summary to be typed in the Communication notes.

When Discharge agreed, inform all members of MDT, order TTO’s and ensure any parental teaching with pharmacist, include transport and ensure parents/main carers are aware of plan

Discharge letter and minutes from the discharge planning meeting sent to all concerned, including GP/HV, school nurse and community nurse

Safe Discharge……
## APPENDIX 7

### Discharge Checklist

Predicted Date of Discharge and entered on computer (DISPEN)..........................

<table>
<thead>
<tr>
<th>Observation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations within normal limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerated diet and fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childs/young person's pain is controlled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person is alert and orientated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV cannula removed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TTO’s Dispensed and location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TTO’s given to family and explained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice given</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Summary given to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPA follow up (If required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Nurse/Health Visitor referral and date contacted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport arrangements agreed/booked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child discharged from LastWord in real time.</td>
<td></td>
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</tr>
</tbody>
</table>

**Discharge Information/Referrals/Contact Numbers**