PATIENT DISCHARGE POLICY

Version:	V1.2
Ratifying Committee:	Healthcare Governance Committee
Date ratified:	January 2016
Name of originator/author/job title:	Karen Hatch– Patient Flow Manager
Name of responsible committee/individual:	Health Care Governance
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EQUALITY IMPACT

University Hospital of South Manchester NHS Foundation Trust ('UHSM') strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care UHSM aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed by the Healthcare Governance Committee to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Tool at Appendix B.

University Hospital of South Manchester NHS Foundation Trust

VERSION CONTROL SCHEDULE

Version number	Issue Date	Revisions from previous issue	Date of Ratification by Committee
1	August 2012	Previously part of the Admissions and Discharge Policy. Discharge element separated out for NHSLA purposes. Admissions element of original policy still applies.	19/07/12
1.1	September 2013	Section 4.3.1 now contains a recommendation with regards to patient clothing Patient information – for new diagnosis only (pages 13,17,19) Medical equipment now to include the documentation of any equipment and training / support required to go home with the patient (pages 14,19) Issue of Med 3 certificate is no longer a must do (pages 14,19) Contacting the bereavement officer is now advisable and not a must do (pages 14,19) Case notes for audit reduced to 25 (page 19)	23/09/13
1.2	December 2015	Section 3.11 – Discharge Check list now required for all discharges. Section 2 Directory of Service link Section 4.3 Discharge Lounge Guidlines	January 2015

DOCUMENT CONTROL

Summary of consultation process	Initial consultation has been with the Heads of Nursing for each Directorate (which would cover senior nurses and support service managers / leads) and with external partners through the Patient Flow Manager. In line with Trust policy, a 3 week consultation period has been undertaken using the Trust intranet.
Control arrangements	Minimum requirement to be monitored *The process for monitoring this policy will be in the form of an annual audit* *The Patient Flow Manager will be responsible for communicating that the audit needs to be undertaken. The Matrons for the relevant areas will be responsible for ensuring the audits are undertaken by the ward staff.* *The results will be reviewed by the Patient Flow Manager, the Heads of Nursing and the Healthcare Governance Committee* *The Matrons will be responsible for development of action plans to improve compliance in any areas that fall short* *The Patient Flow Manager and Heads of Nursing will be responsible for the monitoring of the action plans and the Healthcare Governance Committee will monitor the overall improvements from the action plans*
Associated documentation and references	The following references have been used to inform this policy: • Essence of Care Benchmark (2001), DOH • Department of Health (2001) National Service Framework for Older People • Department of Health (2006) The Dignity Challenge • Department of Health (2007) Privacy & Dignity report • Health Care Commission (2007) Caring for dignity national report • Department of Health (2010) Ready to go?

Contents

1. Introduction

Demand for acute inpatient care is high and in order to meet this demand it is important that patients are discharged in a timely manner once medically fit for discharge.

This policy has been developed to establish a standard approach to the management of patients' discharges from hospital. It is designed to promote and facilitate a multi disciplinary approach to the assessment, planning and monitoring of all discharges. Planning for discharge must start on admission and the identification of an Estimated Date of Discharge (EDD) must be documented by the admitting Clinician in the patients health records and updated by the ward team (as necessary) to support the discharge planning process.

Available bed capacity for emergency admissions relies on a continuous discharge of patients and therefore consideration should be given to the transfer of the patients care back to primary care when physiologically stable with an anticipated recovery course where community colleagues can support (District Nurses, General Practitioners and Community Matrons).

This policy applies to all staff within University Hospital of South Manchester who are involved in the assessment, planning and monitoring of patients' discharges. It also applies to staff from other health/social care organisations involved in the discharge process.

However, the discharges of certain groups of patients such as children thought to be in need of protection and vulnerable adults, such as those with dementia, learning disabilities, or lacking mental capacity, raise some important and specific issues, which are subject to specific and separate guidelines. The principles in this document still apply to these groups but should be considered along with the recommendations in the other policies. These can be found at the link below under the sub category – Clinical.

http://uhsm-intranet/policies/Pages/default.aspx

2. Purpose of the Document

The purpose of this document is to ensure that employees at UHSM deliver a safe and effective discharge process to all patients admitted to the University Hospital of South Manchester. Discharge or transfer of care is an essential part of care management in any setting. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home or transfer to another care setting following an acute hospital stay.

Directory of Services is available

http://uhsm-intranet/AZ/i/IntegratedHealthSocialCare/Documents/Community%20DOS%202014.pdf

The need for timely discharge and care transfer requires clinicians and others to plan, communicate, negotiate and ensure a smooth transition for individuals and their families. Staff involved in the discharge process have a duty of care to:

- Ensure early and effective communication with all individuals across all care settings to provide a well-planned discharge from hospital to all patients (GP's, District Nurses, Community Matrons etc)
- Consider discharge with primary care support when patients are physiologically stable with an anticipated recovery course
- Align services to ensure continuity of care and thereby provide the patients with the necessary support for a safe and effective discharge
- Ensure efficient systems and processes at ward level to support discharge arrangements and transfers of care
- To ensure that patients / carers and healthcare professionals in other settings are given the appropriate written and verbal information regarding future care management plans
- To ensure that the patient's dignity and wishes are recognised
- To ensure identification of an Expected Discharge Date (EDD) is determined on admission and recognised by the multi-disciplinary team

This policy outlines the roles and responsibilities of the health professionals involved in the patients discharge process and aims to ensure that the benefits of effective discharge planning are recognised for all those involved. It also identifies the overarching discharge requirements for all patients and the information that should routinely be given to patients and other healthcare professionals.

For the patient

- Their needs are met
- Able to maximise independence
- Feel part of the care process, an active partner and not disempowered
- Do not experience unnecessary gaps or duplication in effort
- Understand and sign up to their care plan
- Experience care as a coherent pathway and not a series of unrelated events
- Believe they have been supported to make the right decision about their future care

For the carer(s)

- Feel valued as partners in the discharge process
- Consider their knowledge has been used appropriately
- Are aware of their right to have their needs identified and met
- Feel confident of continued support in their caring role and get support before it becomes a problem
- Have the right advice and information to help them in their caring role
- Are given a choice about undertaking their caring role
- Understand what has happened and who to contact

For the staff

- Feel their expertise is recognised and used appropriately
- Receive key information in a timely manner
- Understand their part in the system
- Can develop new skills and roles
- Have opportunities to work in different ways
- Work within a 'whole system' which enables them to do so effectively

For the Organisation

- Resources are used to best effect

- Service is valued by the local community
- Fewer complaints
- Positive relationships with other local providers of health and social care
- Meet targets and can therefore concentrate on service delivery

3. Duties and Responsibilities

3.1 The Board of Directors

The Board of Directors are ultimately accountable for the effectiveness of the UHSM Discharge Policy.

3.2 The Chief Executive

The Chief Executive is responsible for ensuring that responsibility is delegated to an appropriate Executive Director for ensuring that systems are in place with regard to compliance with the principles outlines in this policy relating to patients discharge.

3.3 The Chief Operating Officer (COO)

As the delegated executive responsible for Patient Flow, the Chief Operating Officer is responsible for ensuring that there are systems in place for safe and effective discharge and that the Trust has up to date policies in place that reflect best practice. The Chief Operating Officer is also responsible for ensuring regular audit of the policy. This can be delegated to an appropriate person identified by the COO. This should be in compliance with the processes in place to promote safety and quality of care within the Trust.

The Medical Director

The Medical Director is responsible for ensuring all Consultant and Junior Medical staff are aware of and compliant with the safe and effective discharge of patients in accordance with this policy.

3.4 The Chief Nurse

As the delegated executive responsible for discharge, the Chief Nurse is responsible for ensuring that there are systems in place for admission, transfer and discharge and that the Trust has up to date policies in place that reflect best practice. The Chief Nurse is also responsible for ensuring regular audit of the policy. This can be delegated to an appropriate person / persons identified by the Chief Nurse. This must be in compliance with the processes in place to promote safety and quality of care within the Trust.

3.5 Patient Flow Manager

The Patient Flow Manager is responsible for ensuring that this policy is kept up to date, reflecting best practice and that it remains compliant with CQC standards. They are also responsible for ensuring that regular audits of the policy occur and outcomes reported back to the HealthCare Governance Committee with any associated action plan for monitoring improvements as appropriate.

3.6 All Medical Staff

Consultant medical staff and their medical teams are responsible for assessing the patients' medical fitness for discharge and for liaising with other members of the MDT and colleagues in primary care regarding arrangements for meeting the patients' care needs in the community. They are responsible for the decision to discharge a patient and ensuring that a detailed discharge plan and an Expected Date for Discharge (EDD) is clearly documented in the patients' health records to ensure an effective and safe discharge from hospital. Consultant medical staff are responsible for ensuring all information required for the ongoing management of the patient is communicated to the relevant personnel as part of the discharge planning arrangements either by themselves or though their medical teams. Changes in the EDD must be noted in the health records if for a clinical reason.

3.7Heads of Nursing

Heads of Nursing are responsible for ensuring all nursing staff are aware of the policy and that the Discharge requirements and principles are followed throughout their areas.

3.8 Matrons, Directorate Managers & Clinical Directors

Matrons, Directorate Managers and Clinical Directors are responsible for ensuring compliance with this policy, supporting audit, reviewing results and implementing change where appropriate. Delays in patients discharge must be monitored and improvements made to processes if the reason for failing to meet the EDD is due to non clinical reasons.

3.9 Ward Managers

Ward Managers are responsible for ensuring that there are systems in place to identify the patients' discharge needs and thereby facilitate a safe discharge from hospital for all patients under their care. Discharge must be coordinated through a multi disciplinary approach by the Ward Manager or nominated deputy. Discharge must be in line with the discharge plan documented by the Consultant and delivered to the EDD where possible.

The Ward Manager must ensure that all relevant Trust policies referenced in this policy in relation to patients discharge are adhered to. It is also the responsibility of the Ward Manager to make sure there are monitoring mechanisms in place to make certain all discharges are safe and effective. Ward Managers are responsible for ensuring that all relevant information is passed to the patient and other relevant personnel responsible for any ongoing care.

3.10 Ward Based Registered Nurses

Registered Nurses are responsible for ensuring that an initial assessment is completed when the patient is admitted and that any issues relating to discharge are documented in the management plan. The Registered Nurse must update the discharge plan following regular review with the MDT and thereby co-ordinate the discharge arrangements; making sure that all necessary assessments are completed in order to achieve a safe and effective discharge. The Registered Nurse will ensure patients relatives and carers are involved in the discharge planning as appropriate.

During the admission the Registered Nurse will identify who else needs be involved in the care / support of the patients' discharge and instigate and co-ordinate the referrals required

to other internal and external agencies. This must be undertaken promptly to ensure that there are no delays to discharge, impacting on the patient's length of stay and reviewed as necessary as their care and treatment progresses.

The Registered Nurse will be responsible for completing the discharge transfer forms and check list whilst ensuring detailed information relating to any ongoing care needs be clearly documented and communicated i.e. pressure ulcer management, nutritional requirement etc.

3.11 Members of the Integrated Hospital Discharge Team (which includes Discharge Nurses, Social Care Assessors, Social Workers & Primary Assessment Team)

All members of the Hospital Discharge Teams have a role to proactively support and manage the discharge of complex patients from hospital in conjunction with the Ward Manager and Registered Nurse. They provide support and education to ward teams in the preparation of discharge plans, especially those requiring complex discharge arrangements.

They are responsible for ensuring referrals to support services are sent in a timely manner and the completion of complex assessments for patients requiring intermediate care / continuing healthcare beds, acting as the mediator between wards and the relevant external agencies (including social services and Residential and Nursing Homes). They should establish contact with patients General Practitioner as early as possible following admission to establish the normal level of functioning for the patient and therefore support decision making with the multi-disciplinary team in relation to discharge arrangements. They should work in partnership with other disciplines such as the Bed Management Team, Matrons, and other relevant healthcare professionals.

Members of the Integrated Hospital Discharge Team are responsible for the ordering of any equipment necessary to support patients' at home and to confirm that equipment has been delivered / installed prior to the patient's discharge. Where equipment is identified as essential for discharge, the registered nurse must liaise with the Occupational Therapist.

The Integrated Hospital Discharge Team must endeavour to ensure that there is no negative effect on a patient's length of stay due to delays in discharge for those patients on their caseload.

Social Workers are responsible for working in accordance with the relevant legislation, policies and procedures appropriate to their professional group. They must provide timely assessment and / or services for a patient being discharged from the acute hospital bed.

3.12 Physiotherapists

The role of the physiotherapist in planning and facilitating a safe effective discharge is to:

- Assess the patient and, if indicated, rehabilitate to achieve an increased level of independence and function Provide a timely and effective holistic functional assessment of the patient and their environment often in conjunction with the Occupational Therapist to maximise their level of rehabilitative potential.
- Liaise with patients and carers and the Multi Disciplinary Team (MDT) regarding goals for discharge

- If clinically indicated, provide / order equipment in advance of the discharge date (if delivery to the patients home is identified and access to the home is not possible the physiotherapist must liaise with that patient or family / carers to arrange collection of equipment from the equipment stores)
- Where indicated the physiotherapist must ensure arrangements are made and communicated to the patient / carer regarding treatment post discharge

3.13 Occupational Therapists (OT)

The role of the occupational therapist is to provide a timely and effective functional assessment as part of the discharge planning process. The assessment must be patient centred and treatment must be given to obtain the optimal (occupational) performance from the patient within the acute hospital setting.

- Responding to referrals for assessment where there is a clearly identified need and outcome for OT intervention
- Providing a holistic assessment of the needs of the patient and carer
- Work with the patient and carers regarding the goals for discharge planning
- Liaise with relevant support agencies both internally and externally to meet the needs of the patient and carer
- Where appropriate, conduct pre discharge environmental visits in order to establish the patient's needs for a safe discharge
- Where required, prescribe and arrange for the provision / fitting of equipment to meet the needs of the patient

3.14 Pharmacist / Pharmacy Technician

The Pharmacist must provide the ward staff with advice and guidance in relation to the patient's medication on discharge. Either the Pharmacist or Technician should be contacted as soon as the prescriptions are written, which should be 24hrs prior to discharge. They will then process the prescription at ward level. It will take longer for prescriptions to be processed if you send them to the Pharmacy Department; always contact your pharmacist or technician first. If they know patients are due to be discharged they will remind the medical team to write the prescription.

3.15 The Ward Clerk

The Ward Clerk is responsible for ensuring all tasks delegated to them to support the patients discharge are carried out in a timely manner. They must ensure that discharge information is sent to the receiving healthcare professionals within the agreed timescale following the patients discharge from hospital.

4 Discharge requirements and principles for all patients

4.1 All patients must have a well-planned discharge from hospital. This must occur in consultation with the patient and / or their carers together with the relevant staff from a multi-disciplinary team; including, where relevant, GP's, staff from nursing and residential homes, community matrons and District Nurses involved with the patient's overall care and well-being.

This policy has been written on the basis of the assumption that patients have mental capacity to consent to arrangements which clinical staff may seek to put in place to facilitate their safe discharge. The discharge principles in this policy still apply to patients lacking mental capacity however, where it is identified that a patient does lack capacity, the Trust Mental Capacity Act Policy must also be followed and can be found via the following link under sub category 'general';

http://uhsm-intranet/policies/Pages/default.aspx

4.2 The key principles for effective discharge and transfer of care are:

- Unnecessary admissions are avoided and effective discharge is facilitated by a 'whole system approach' to assessment processes 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;
- Discharge is a process and not an isolated event. It must be planned for at the earliest opportunity across primary, 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 must be coordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'.
- Staff must work within a framework of integrated multidisciplinary and multi-agency team working, to manage all aspects of the discharge process;
- Effective use is made of transitional and intermediate care services, so that acute hospital capacity is used appropriately and individuals achieve their optimum outcome;
- The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make an informed decision about their future care;

4.3 A patient's discharge requirements will also be dictated by the complexity of their condition whilst in hospital and the care they will need following discharge.
The discharge needs and the principles for all discharges fall into 4 distinct groups.

- Simple
- Complex
- Self-discharge
- End of Life

The following groups of patients will also have additional needs to consider:

- Neonates
- Post-natal
- Homeless

The discharge planning process must take into account patients' physical, psychological, social, cultural, economic and environmental needs. Health and Social care service departments must work together with the patient, families, carers and the hospital MDT to plan and deliver a safe and effective discharge.

Patients, where suitable, must transfer to the discharge lounge to await collection. The Trust Discharge Lounge Guidelines can be found at:
http://uhsm-intranet/guidelines/clinical/Clinical%20Guidelines/Forms/Trustwide.aspx
This outlines the key inclusion and exclusion criteria.

A simple check that all elements have been achieved must be recorded in the patient's medical notes. As a minimum it must include
Appendix

4.3.1 Simple Discharge (including discharge from ED)

Simple discharges must include:

- An understanding of the circumstances the patient will be discharged to (possible temperature of accommodation, availability of food, darkness, home alone etc) and give support to ensure patients safety
- An awareness of the time of discharge and whether this is appropriate (patient in agreement, family / carer(s) / nursing or residential home aware etc)
- Assurance that the patient can enter accommodation at destination
- An awareness of the patients clothing for discharge. Where possible patients / families should be encouraged to bring outdoor clothes in for discharge, however patient choice will be honoured.
- Appropriate transport arrangements. Ambulance bookings should be in line with PTS eligibility criteria
- Medications to take home (TTO's) with full explanation
- The removal of any medical equipment (as appropriate) including cannula, Sutures and dressings as appropriate

- The documentation of any medical equipment to remain in situ or go home with the patient along with confirmation that relevant training / support is in place
- Reinforcement of any special instructions with written information where possible or an approved patient information booklet
- An electronic discharge summary – a copy of which should be given to the patient
- Sufficient dressings / appliances provided to the patient to cover the seven days post discharge (more if Bank Holiday or weekend discharge)
- The return of all the patient's property, including valuables must be given to them by the nursing staff prior to discharge
- Details of any outpatient appointments or other follow up appointments the patient needs to be aware of
- All medical and nursing personnel providing ongoing care / support to the patient made aware of any infection control issues

Medical Staff may issue a Med 3 Certificate at the patients' request as appropriate.

It is advisable that the Bereavement Officer is informed so that they can undertake the necessary communications to the patients General Practitioner and where appropriate the manager of a patient's nursing / residential home, within 24 hours of a patient's death, with the exception of Bank Holidays and weekends; when they will notify the General Practitioner and manager on the first working day following the Bank Holiday or weekend.

4.3.2 Complex Discharge

Complex discharges follow all the principles of the simple discharge plus the following additional criteria

- The early identification, planning and communication of any Continuing Health Care (CHC) needs in accordance with the eligibility criteria and appropriate referral to the Integrated Hospital Discharge Team for assessment. Details for CHC can be found via the link sub category Continuing Health Care:

  http://uhsm-intranet/AZ/d/Discharge/Pages/Discharge.aspx

- Early assessments from all health and social care partners involved to ensure planning happens in parallel with the patient's medical management to becoming medically stable to commence discharge planning before becoming suitable for discharge
- Early contact with the General Practitioner to establish the normal level of functioning for the patient to inform discharge planning
- The discharge from Physiotherapy and Occupational Therapy services and where required, referrals made on to community services with details being given to the patient / relative / carer
- Confirmation from Social Services that any care package or ongoing support is lined up to commence in an appropriate timeframe following the patients discharge
- Any referral for District Nurse, Community Therapy or Rehabilitation Services have been sent and details given to the patient / relative / carer of what to expect on return home / transfer to another care setting
- Any equipment that is required has been confirmed as being in place

- For patients requiring compliance aids on discharge nursing staff must speak to their pharmacist or technician in advance of the patient leaving the hospital. Requests must be made 24 hours prior to discharge as they take at least 4 hours to complete. Requests for compliance aids will not be accepted by pharmacy after 3pm or after 1pm at weekends, at the Pharmacists discretion
- Plan to access to patient's property has been discussed prior to them leaving the hospital
- All relevant relatives and carers are aware of the patient's discharge date and time
- All medical and nursing personnel providing ongoing care / support to the patient made aware of any infection control issues

4.3.3 Self Discharge

If a patient wishes to take their own discharge, the Ward Manager / Registered Nurse must contact either:

- A member of the medical team (in hours) or
- The Duty Manager (out of hours)

A member of the Hospital Discharge Team must be informed in hours who will then inform social services, if appropriate.

Patients wishing to take their own discharge must be advised by the medical and / or nursing staff to stay (if appropriate). The medical staff must encourage the patient to stay if they believe leaving hospital is not in the patient's best interest medically.

If the patient remains adamant that they wish to leave the nurse must ask the patient to sign the self discharge form which must be countersigned by a member of staff. This must then be placed in the patient's health records. If the patient refuses to sign the self discharge form this must be documented in the patient's health records and signed by two members of staff.

If it is felt that the patient requires a district nurse, this must be discussed with the patient to be established if the Trust must contact the DN service or if the patient wishes to make their own arrangements. If this is the case, the relevant contact number must be given to the patient. The decision and action must be documented in the patient's health records.

4.3.4 End of Life

The End of Life Care Strategy (DH 2008) requires that assessment is made of the patient's preferred place of care and where they wish to be cared for at the end of life. Every effort must be made to ensure that all practicable steps are taken to allow the patient's wishes to be carried out.

The Registered Nurse looking after any patient with a life limiting illness whose preferred priority of care is to be discharged from hospital to home / local hospice / community palliative care bed must contact the Integrated Hospital Discharge Team as soon as possible after the decision is made by the patient and / or family, carer. The Discharge Team will then arrange to fast track the patient to the Continuing Healthcare Team in the relevant Primary Care Trust.

For discharges home during normal working hours, the Discharge Team will then organise District Nurse support, any necessary equipment, take home prescriptions and transport to the preferred destination within the same day. Patients referred to the Discharge Team late in the day will be discharged to their preferred choice of care where available within 24 hours from the point of referral. Discharges outside of normal working hours will be facilitated by the Specialist Nurses for Palliative Care.

All supportive care and equipment necessary to support the dying patient in their preferred place of care will be arranged and facilitated through the Discharge Team to ensure a safe and effective discharge.

Discharges outside of normal working hours will be facilitated by the Specialist Nurses for Palliative Care. If medication is needed the Specialist Nurse should contact the on-call Pharmacist who will facilitate the supply of medication.

4.3.5 Neonates

Discharge arrangements from the neonatal unit must be followed as outlined in the local Admission – Discharge Policy for the Neonatal Unit via the following link; sub category guidelines and neonatal & paediatrics.

http://uhsm-intranet/policies/Pages/default.aspx

4.3.6 Post-natal

The transfer of post-natal care from hospital to home must follow the guidance set out in the Trust's Inpatient Postnatal Guidelines.

4.3.7 The Homeless

During the admission process all homeless people must be identified and contact established with the relevant agencies (Social Services for > 65's and a local homeless unit for < 65's). Timely referral and liaison with the agencies is essential to support the discharge of individuals who are homeless, ensure that they have access to primary care services who can oversee their clinical care following discharge and ensure acute facilities are not used inappropriately.

http://uhsm-intranet/policies/Trustwide%20policies%20operational%20policies%20and%20guidel/Prevention%20of%20homelessness%20protocol%20v1.1.pdf

4.5 Information to be given on discharge

On discharge information relating to the patients admission and ongoing care must be shared with other appropriate health care professional.

4.5.1 Discharge information to be given to the receiving healthcare professional

Actions must be taken to ensure a number of administrative procedures are completed on discharge of a patient from the acute hospital bed. These include: -

- The Consultant or his/her deputy will, on discharge, complete a discharge summary which must be either be sent electronically or posted to the patient's General Practitioner within one working day of the patient's discharge. This must contain the date of discharge, relevant diagnosis, details of medication, advice on patient management and follow-up arrangements
- A full discharge summary letter to the GP must be dictated by Medical staff, typed by the relevant secretary and sent to the GP within 14 days of the patients discharge from hospital
- Suitable, accurate information on any infections the patient has must also be clearly communicated to receiving healthcare professionals
- If a patient dies, the Bereavement Officer will inform the GP within 24 hours of the patients' death (by fax preferably or telephone). Weekends and Bank Holidays are the exception but the notification must occur on the first working day following the weekend or Bank Holiday

All actions taken and documentation given / sent must be noted within the patient's medical notes. As a minimum this must include;

- A discharge summary
- Infection Control Information given (if applicable)

4.5.2 Discharge Information to be given to the patient

All relevant information to support the patient on discharge must be given to the patient prior to leaving the hospital. This must include a copy of the IDS (discharge summary) and must also include relevant patient information leaflets for those patients leaving hospital with new diagnosis. Information must also include, as appropriate, the patient's ongoing management plan along with any contact details of professionals who can support the patient on their return home. Outpatient appointment details must also be given if known on the day of discharge. Any information given must either be documented as being given in the health records by the Registered Nurse. As a minimum this must include;

- A copy of the IDS Discharge Summary
- Patient Information (new diagnosis)
- Contact details for supporting professionals (if applicable)

4.6 Medicines on Discharge

Medicines management plays an important role in preparing patients and their carers for transfer / discharge, which has an impact on the recovery and / or maintenance of their condition following discharge.

Whilst a patient is in hospital it is possible that a familiar medication pattern will be changed. In order to take the changed medication as the prescriber intended the patient and / or their carer(s) must understand the rationale for the medication regime as well as be able to physically manage to take their medication. This explanation and assessment must be undertaken by the person responsible for the discharge.

The patients General Practitioner must also receive timely up to date information so that any revised prescription can be continued on discharge. This is covered on the IDS Discharge Summary.

Patients TTO's must be prepared to support an effective and efficient discharge and must not be a reason for any discharge being delayed or postponed.

4.7 The Out of Hours Discharge Process

It must not be usual practice for patients to be discharged during the 'out of hours' period between 22:00hrs and 07:00hrs. However, in some circumstances this will happen and staff must always ensure that this only occurs with the full agreement of the patient and their family and /or carer.

Staff must always ensure they fully understand the situation in which the patient will go home to (temperature, light, home alone etc) and ensure that the discharge arrangements are appropriate.

Simple Discharges: Staff facilitating a patients discharge 'out of hours' must clearly document in the patient's medical records the reason for the late discharge along with confirmation there was agreement with the patient, family and/or carers.

Complex Discharge: Patients with Complex discharge needs must not be discharged during the 'out of hours' period.

For patients remaining on the ward who are waiting transport (PTS) to transfer or discharge and this hasn't arrived by 22:00hrs then the patient must not be discharged and transport arrangements cancelled and re-booked for the following morning.

5 Monitoring Compliance and the Effectiveness of the Policy

The CQC Risk Management Standards outline a number of minimum requirements and processes that need to be in place to promote safety and quality of care in Acute Trusts in relation to managing the risks associated with the discharge of patients and the Trust must demonstrate the process for monitoring compliance with all of these requirements.

In accordance with CQC Risk Management Standards audits of compliance with key stages in the discharge process will be undertaken twice per year.

The audits will identify compliance with;

1) The Discharge requirements for all patients
    - Time of discharge
    - Transport arrangements
    - TTO's (given and explained)
    - Removal of all medical equipment
    - Training / support for patients leaving with appropriate medical equipment
    - Any patient information given
    - Any ongoing care arrangements for the patient
2) The information to be given to the receiving healthcare professional
    - A discharge summary
    - Infection Control Information given (if applicable)
3) The information to be given to the patient on discharge
    - A copy of the IDS Discharge Summary
    - Patient Information (new diagnosis only)
    - Contact details for supporting professionals (if applicable)

The sample will be 25 discharges from each Directorate. This will be audited by the Patient Flow Team. The results will be collated and presented at the Health Care Governance Committee along with any required action plan. The actions required for improvement will be discussed with the Directorate Matrons who will be responsible for ensuring improvements are made to ensure compliance.

Name……..…… RM. No…….

Patient Discharge Checklist		
Expected discharge date-	**Met- Initial**	**N/A- Initial**
Ward Contact Card provided		
Patient and family aware of discharge date-		
Pressure areas checked. State observation:		
District Nurse referral completed electronically and copy in notes Where appropriate wound assessment chart, photograph and vascular studies report (if patient has leg ulcers) to be sent Comments:		
Cannula removed		
Valuables returned		
Patient has own keys		
Patient changed into own clothes		
Discharge advice sheet given		
VTE information leaflet & anti embolic stockings given if required		
Medications given and explained		
Anti-coagulation appointment and booklet given		
Fit note given		
Transport booked		
GP discharge letter written and copy given to patient and copy in notes		
Feeding guidelines completed		
Dressing removed and wound checked		
Friends and Family Questionnaire card provided		
Relevant Follow up arranged. State details:		
If nursing/rest home, transfer form completed		
Transfer to Discharge Lounge arranged		
Discharged on Lorenzo system		
Relevant specialist teams aware of discharge. State details:		
Other- State:		

Date and Time Discharged ……..……

Signature & Print discharging Nurse …….

APPENDIX B

PLAN FOR DISSEMINATION

Title of document:	**Discharge Policy**		
Date finalised:		**Dissemination lead: Print name and contact details**	Karen Hatch Tel: 291 6475
Previous document already being used?	Yes		
If yes, in what format and where?	Trust wide Admission and Discharge Policy – Trust Intranet		
Proposed action to retrieve out-of-date copies of the document:	Remove current policy from Intranet and replace with revised policy.		
Describe the plans for dissemination of the document to specific people / groups in specified formats and if appropriate with relevant training All Trust Staff – Electronic format via e-mail communication to the Heads of Nursing for local dissemination Social Service Staff – Manchester and Trafford – Electronic Format via e-mail and through the Integrated Hospital Discharge Team Management Structure Community Services (via commissioners) – Manchester and Trafford - Electronic Format via e-mail and through the Integrated Hospital Discharge Team Management Structure			

Dissemination Record - to be used once document is ratified.

Date put on register / library of policy or procedural documents		**Date due to be reviewed**	

Notes

APPENDIX C

EQUALITY IMPACT ASSESSMENT – DISCHARGE POLICY

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay, bisexual and transgender people	No	
	• Age	No	
	• Disability	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to [N/A], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact the Corporate HR Manager