DOCUMENT CONTROL PAGE	
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Contents

1. Introduction

Being admitted to hospital can be frightening. In addition to the physical ill-health or trauma that triggered the admission, hospital environments can be daunting and confusing, and particularly for people who are ill, frail or vulnerable. Discharge from hospital to an appropriate setting requires clinicians and others to plan, inform and negotiate to ensure a smooth transition for patients and their families. Underpinning this is the need for early identification of discharge/transfer dates including pre-admission planning, effective communication between and across settings, good clinical management plans and the alignment of services to ensure continuity of care.

Central Manchester University Hospital Foundation Trust (CMFT) recognises that the planning of patient discharge should be delivered as "a process and not an isolated event" and therefore hospital discharge plans should be established at the earliest opportunity in order to identify factors that may impact on efficient discharge (DH 2010). To ensure a safe hospital discharge to an appropriate setting, a discharge plan should be well defined, comprehensive and agreed by the patient or carer(s).

Good and effective communication should occur at every stage of the discharge process between the multidisciplinary teams and the patient or carer(s) identifying factors that may impact on their discharge and guarantee that each review and update has been discussed and conveyed to all associated parties.

This policy has been written in accordance with the best practice identified from the following publications:

- *Department of Health Publication 'Ready to go? - Planning the discharge and the transfer of patients from hospital and intermediate care' (March 2010).*
- *General Medical Council – Good Medical Practice (March 2013).*
- *Royal College of Nursing – Discharge Planning (2010)*

2. Purpose

2.1 The purpose of this policy is to provide guiding principles to support a well organised, safe and timely discharge for all adult patients within CMFT.

Key principles are:-

- To achieve a standardised approach and practice towards discharge planning across the Trust.
- To ensure that discharge planning commences at the earliest opportunity and involves patients and their relatives/carers.
- Discharge planning process is 'person centred' ensuring respect and dignity of the patient.
- To ensure patients and relatives are able to make informed choices about their onward care.
- To ensure that all risks relating to the discharge of a patient are identified and discussed so that appropriate management plans can be put into place.
- To ensure the patient experience when planning discharge is not compromised by bed pressures in hospital.

- To ensure that patients are treated in the most appropriate setting to meet their needs recognising that as needs change so may the setting.
- To reduce unnecessary delays in the discharge process and enhance patient flow from hospital to alternative care settings minimising inappropriate length of stay.
- To support the provision of continuity of care through effective communication between hospital and community professionals.
- To reduce the risk of re-admission following inappropriate discharge.
- To reduce delays in discharge and support optimal bed management.

The policy aims to ensure that patients and carer(s) have access to clear information, guidance and instructions prior to discharge. Where continuing health and social care is organised patients understand the continuum of health and social care services, their rights and receive advice and information to enable them to make informed decisions about their future care.

2.2 Scope

This policy applies to all staff, departments and local stakeholders involved in the discharge of adult patients within CMFT.

The patient discharges covered by this policy are from any adult ward or department within CMFT and will engage with patients and their families/representative to ensure they are informed and consulted at each step of the process.

The policy does not include the discharge of patients from Children's or Obstetric services

2.3 Definitions

Simple Discharge

Patients with simple discharge needs make up approximately 80% of all discharges. They are defined as patients who:

- Will usually be discharged to their own home and have minimal on-going care needs which do not require complex planning and delivery.
- Many of these patients will be discharged from medical assessment units, short stay wards, or even ED itself as well as medical and surgical wards.
- Time in hospital does not determine whether a patient has simple discharge needs. The key criterion is the level of on-going care required and therefore the complexity/simplicity of the discharge arrangements.

Complex Discharge

The remaining patients in hospital who have more complex needs require referral for assessment by other members of the multidisciplinary team and will need support from the Hospital Discharge Service.

Complex discharges relate to patients:

- Who will be discharged home, to a carer's home, or to intermediate care, or to a nursing or residential care home, and/or who have complex on-going health and

social care needs which require detailed assessment, planning, and delivery by the multi-disciplinary team (MDT) and multi-agency working, and whose length of stay in hospital is more difficult to predict.

See Appendix 1 for patient groups associated with complex discharge.

Section 2 Assessment Notification (Community Care Act 2003)

Is a trigger for assessment and care planning of patients likely to need community care services after discharge.

Section 5 Discharge Notification (Community Care Act 2003)

Notifies social services of the proposed date of the patient's discharge once it has been confirmed.

3. Roles & Responsibilities

Board of Directors

The Trust Board has overall accountability through the Chief Executive to ensure that adequate structures, governance and control mechanisms are in place to promote good practice by all staff and ensuring that appropriate resources are available to deliver the policy in full.

Chief Operating Officer

The Chief Operating Officer is the executive director with responsibility for ensuring that safe and effective patient discharges occur from the Trust in-patient facilities.

Directors of Nursing/Deputy Directors of Nursing

The Directors of Nursing/Deputy Directors of Nursing will be responsible for ensuring the implementation of the policy through the nursing workforce.

Divisional Directors/Directorate Managers/Heads of Nursing

The Divisional Directors, Directorate Managers and Heads of Nursing will be responsible for ensuring that arrangements and processes are in place to support the implementation of the policy via their operational structures and local policies, across all clinical areas within the Divisions.

Lead Nurses and Matrons

The Lead Nurses and Matrons will be responsible for the monitoring of compliance within the policy and appropriate actions as required.

Consultant

The **responsible Consultant** is accountable for all medical aspects of the patient's pathway (including the discharge or transfer of care). S/he may delegate to appropriately competent medical or other staff.

Hospital Discharge Service

The Hospital Discharge Service will be responsible for supporting wards in the discharge process of patients who require special considerations or who may have complex support needs on discharge (see Appendix A) and assist the ward staff to plan and identify the supporting needs of the patient for discharge (see section 5.3.5).

Medical staff

Medical staff must :

- Assess, review, record (in the medical record) and communicate as soon as practicable to patients, relatives and MDT members the likely outcome of the admission, planned discharge date, and level of support likely to be needed on discharge, based on a diagnostic formulation, and consideration of the impact of recuperation and rehabilitation.
- Ensure the patient's EDD (expected discharge date) is set within 24 hours of admission and communicated to the patient and MDT ward team. Ensure any change to the EDD (after 24hrs of admission or transfer to ward area) is communicated to the ward team and updated and recorded as the Planned Discharge Date (PDD).
- Attend morning MDT board rounds identify patients ready for discharge to the nurse in charge and reviewing EDDs and PDDs.
- Undertake daily morning senior medical reviews and second reviews later for appropriate patients. Patients potentially ready for discharge should be reviewed as early in the day as is consistent with clinical priorities (i.e. at the beginning of ward rounds wherever possible).
- Make timely referrals to other specialist teams or services necessary to formulate comprehensive diagnostic, treatment (including rehabilitation) and discharge plans.
- Maintain written records of decisions made at MDT meetings (principally on the diagnostic, treatment and discharge plans).
- Ensure that prescriptions for discharge are written at least 24 hours before a predicted discharge, and as soon as practicable when discharge is confirmed with less than 24 hour notice
- Ensure that appropriate and adequate written information is available for dispatch to the GP at the time of discharge.

Ward Managers

The Ward Manager must:- ·

- Ensure that an effective discharge planning process operates in the ward.
- Ensure that processes are in place for commencing planning for discharge on admission or soon after (e.g. referrals to MDT, Social Care, planned discharge dates).
- Ensure the patient's EDD (expected discharge date) is set within 24 hours of admission and communicated to the patient and multi-professional ward team. Ensure any change to the EDD (after 24hrs of admission or transfer to ward area) is updated and recorded as the Planned Discharge Date (PDD).
- Ensure appropriate communication and information sharing with patients and relatives/carers by all involved nursing staff. This will include providing a copy of information about medicines upon discharge, treatment received during admission,

follow up plans and information of who to contact if patients have any fears and worries.
- Attend length of stay meetings identify the number of predicted discharges and discussing any discharge issues.
- Inform the ward matron of any issues which are impacting on the effective discharge from their ward.

Registered Ward Nurses

Registered ward nurses will :

- Help plan a safe and timely discharge for their patients.
- Start discharge planning at preadmission or within 24 hours of admission.
- For elective admissions/planned admissions a pre-admission assessment should examine an existing care plan, services and home environment and highlight any potential problems at discharge.
- Ensure timely referrals as necessary for discharge.
- Ensure SBAR handover sheets, care plans, safety huddles and discharge planning documents are completed and updated ensuring patients discharge plans are accurately documented and communicated.
- Communicate with the patient, relatives/carers, MDT and other agencies about agreeing and planning discharge.
- Inform the ward manager or matron of any issues which are impacting on effective discharge from their ward.

4. Detail of Procedural Document

4.1 Key Principles of Discharge Planning and Implementation

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

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

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

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

The discharge planning process must be co-ordinated effectively to dovetail processes with the MDT working collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharge.

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

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

Patients who do not have capacity to make decisions are not disadvantaged and are cared for safely under the Mental Capacity Act 2005 (*see CMFT Mental Capacity Act Policy, DOLs and Patient Consent Policy)*.

The role of the patient's carer must not be underestimated. It must be recognised that often carers have different needs and therefore carers must be offered an assessment to identify services they may need to support them in their caring role if appropriate.

4.2 Estimated Date of Discharge (EDD)

The Estimated Date of Discharge (EDD) is based on the expected time required for tests and interventions to be completed, the integrated care pathway and the time it is likely to take for the patient to be clinically stable and fit for discharge (DH 2010).

The EDD should be set within 24 hours of admission, based on the predicted length of stay and this should be communicated with the patient and/or carer and all relevant staff within 24-48 hours of admission.

Patients who are transferred from an admissions/assessment area to a ward may be given a new EDD within 24 hours.

The EDD must be recorded on the electronic Bedman system and displayed on the electronic Patient Status at Glance Board (PSAG).

It is recognised that in cases of complex discharge or a deterioration of the patient's condition, the EDD may need to be revised. Any change to the EDD (after 24hrs of admission or transfer to ward area) must be recorded as the Planned Discharge Date (PDD).

If a patient is likely to be discharged earlier than their EDD a PDD can be set.

4.3 Process of Discharge Planning – Key Stages

4.3.1 On Admission to Hospital

Following admission, a clinical management plan should be developed in conjunction with the patient and/or their carer within 24 hours. This will identify the main goals for the patient and should include:

- Identification of the problem.
- Goals for treatment activities to achieve outcomes.
- Methods for achieving these goals.
- Estimated time to meet the goals.

The clinical management plan should identify whether the patient has simple or complex discharge requirements (see Appendix 1). Patients must be involved in the decision making relating to their future care requirement. Where a patient is deemed to lack mental capacity see section 4.9 (*see CMFT Mental Capacity Act Policy, DOLs and Patient Consent Policy)*.

The patient must be given a '*Preparing for your discharge from hospital'* leaflet which details the Trusts expectation of the discharge process and the related steps that will occur during their stay this leaflet must be issued to the patient (relative or carer if patient lacks mental capacity) following transfer to an admission ward (not on AMU, OMU or surgical receiving beds).

During the patients stay in hospital it may be necessary for the patient to move to a different ward or wards within the Trust. This may include transfer to/from Trafford Hospital. This must be explained to the patient when issuing the '*Preparing for your discharge from hospital'* leaflet.

For planned admissions, a pre-admission assessment should examine an existing care plan, services and home environment which may highlight potential problems when planning discharge and be brought to the attention of appropriate agencies.

On admission the admitting nurse is responsible for checking the patient's details and ensuring any changes are updated on The Patient Admission System (PAS) and their medical records.

Where a patients is an elective admission discharge planning should begin prior to admission as part of their pre-operative/pre-admission assessment.

4.3.2 Patient Assessment

Fundamental to effective discharge is understanding patients in their normal situations and establishing the patient's baseline. Through assessment, their individual needs and priorities can be identified, along with the treatment, advice and services that could offer the most effective support.

Good communication is essential when assessing the patients care needs. Using terminology familiar to the patient is important and that the right questions are asked so that details of the patient's lifestyle leading up to his/her hospital admission are clear.

The patient (where able) has the right to be involved in the choice of their transfer or discharge destination. Where there are concerns that a patient lacks mental capacity to decide where to be discharged to (i.e. whether to go to their own home or a care home), an assessment of mental capacity should be undertaken (see section 4.9).

The admitting nurse is responsible for establishing and documenting the patients home and social circumstances. This should include as a minimum:-

- Next of kin contact details.
- Sheltered accommodation warden contact details.
- Community Social Worker/Primary Assessment Officer and input received.
- Community District Nurse and input received.

- Community Active Case Manager/Community Matron.
- Other health care professionals. Example: Occupational Therapist, Physiotherapist etc.
- Home care service provider and input received including meals on wheels and day care.
- Details of the patients accommodation e.g. stairs and access, location of toilet facilities, if local authority, housing association or owner occupied.
- Mode of access and entry to their home i.e. key holder, key safe or carer.

Where it is evident or suspected that the patient has a learning disability consent should be sought for flagging on PAS and Bedman, and an assessment for reasonable adjustments should be undertaken and implemented:

If the patient ordinarily lives in a nursing or residential home a baseline and any concerns must be identified which may delay discharge.

The admitting nurse must establish if the patient has any dependants living with them or fulfil a role of carer for any resident or non-resident relative. The nurse must notify social services if they believe the patient supports someone with essential daily living needs that will not be met because of their hospitalisation. This should be done by telephone to the Social Services Contact Centre (see CMFT Staffnet).

Consideration should be given to the care of unattended pets. The nurse must notify the Social Services Contact Centre if they believe the patient has left an unattended pet at home.

The delegated nurse must commence the discharge checklist within 24 hours of admission (appendix 2).

The admitting nurse must complete a Section 2 with the patient's consent where possible, if the patient requires assessment due to on-going complex health or social care support.

Patients requiring assessment from allied health professionals to assist with discharge planning should have referrals made at the earliest opportunity and identified as part of the daily MDT board round.

Determine if there are any safeguarding concerns and if so initiate appropriate referrals to safeguard the patient.

The admitting nurse must check with the patient or carers arrangements to gain access to their home on discharge i.e. someone to open the door, availability of keys.

4.3.3 Daily Review and Coordination of Discharge Planning

Discharge planning must be coordinated (on a daily basis) by a named person (usually a nurse) who has responsibility of leading the care planning process and effective liaison with other relevant health and social care teams involved in the patient discharge plan.

The nurse in charge must coordinate the MDT board round every day and include medical and MDT feedback and progress, discharge planning and completing/updating patients EDD/PDD.

The board round must have representation from a senior doctor who is authorised to discharge when appropriate and in the absence of the patient's named consultant.

The ward SBAR handover document must be updated each shift and include the appropriate up to date discharge planning information.

The clinical management plan should be reviewed with the patient and / or their carer on a daily basis so there is a personalised pathway that can be amended with the necessary actions to progress towards the discharge or transfer date.

4.3.4 Planning Discharge

Discharge planning should be delivered over seven days to deliver continuity of care for the patient with a discharge checklist being completed 24-48 hours prior to discharge (see appendix 2).

The patient must agree the discharge plan. This must be documented in the patient's record.

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

If an existing care package needs to be restarted, the nurse responsible for the patients care must contact the relevant care provider (when not referred to discharge team). If weekend or out of working hours call the Social Services Contact Centre (see CMFT Staffnet).

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

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

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

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

- MRSA status and whether the patent is currently receiving decolonisation treatment and the date of the next MRSA screen.
- Contact with other patients with known or suspected infections.
- Any recent history of diarrhoea and/vomiting.
- Clostridium difficile.

- CPE status.
- Tuberculosis.

4.3.5 Referral to the Hospital Discharge Service (see section 2.3)

All patients with complex discharge needs (see Appendix 1) must be referred to The Hospital Discharge Service who can provide expert advice and assessment to:

- Identify patients with on-going care needs.
- Support ward staff in assessment of patient discharge needs and assist ward staff in making alternative discharge plans, as appropriate.
- Consider patients eligibility and process for accessing Continuing Health Care (CHC) funding.
- Support and lead if required on Best Interest Meetings and CHC Meetings.
- Provide access to Intermediate Care.
- Assess on-going health and social care needs of the patients referred to the service.

4.3.6 Complex Discharge Procedure

Complex discharge will apply when a patient has been identified as requiring support upon discharge as described in appendix 1.

On admission to the ward/ department, the delegated nurse must establish where possible the patient's baseline, current care requirements and future arrangements for discharge.

A referral to the Hospital Discharge Service must be made by the delegated nurse within 24 hours of initial assessment of the patient. Where required the referral will be made using the Section 2 referral process on the Clinical Work Station (CWS) (central site) EPR (Trafford Hospital).

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

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

4.3.7 Discharge Medication

Patients requiring discharge medication must have a discharge prescription completed and sent to pharmacy *at least 24 hours prior to discharge* to ensure it is available for the time of discharge.

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

Prior to discharge the patient / carer must be educated about their medication by the nurse or pharmacist and given the opportunity to ask questions, advise regarding any

potential adverse reactions or side effects and provided with the contact details of whom to contact if they have any fears or worries about their medication.

If a District Nurse is required to administer a patient medication an authorised discharge prescription must be sent home with the patients discharge medication.

Patients who are discharged to Intermediate Care must be discharged with 7 days supply of medication (Manchester IC patients) or 2 weeks supply of medication in a blister-pack (Trafford IC patients).

4.3.8 Patient Transport

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

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

Where a patient requires hospital transport / ambulance the booking must be made through electronic booking system (central site), telephone booking system (Trafford) giving at least 24 hours' notice and requesting an appropriate time at which the patient will be known to be ready and which may need to be considered to fit with their discharge circumstances.

Where a patient is discharged out of working hours or weekend and requires hospital transport the ward staff must contact the Patient Pathway Coordinators to arrange transport (central site only) or arrange through the telephone booking system (Trafford site).

Ambulances may be booked on the day of discharge however a specific time cannot be requested for same day discharges and therefore the patient and their family **must** be informed of such.

Where patients are likely to be discharged later in the day/evening they must be risk assessed and consideration must be given to their safety especially if they live alone. Frail/elderly patients should not be discharged after 20.00 hours.

4.3.9 District Nurse Referral

The District Nursing Service operates an open referral system; this includes referrals from GPs, hospital, social services, carers and self referrals. All referrals will be treated as a new episode and therefore a referral must include all relevant patient details.
The District Nurse referral must be completed via CWS (central site) and EPR (Trafford Hospital). For urgent referrals/ issues the appropriate District Nurse team can be contacted directly.

The Night Nursing service can be contacted via the Radio Room on 701-5155 (Central site) or telephone number 03003 230303 for Trafford Hospital

There are three categories of referral:

Urgent- requiring contact within 4 hours e.g. blocked catheter or patients within the last 48 hours of life.

Non Urgent- Contact within 24 hours and a visit on date agreed.

Routine- Contact within 48 hours and visit on date agreed. Patients in need of emergency treatment should be referred to the appropriate emergency services.

Each referral should include:

- Patients name.
- Address.
- Contact details.
- Date of birth.
- GP details.
- Reason for referral.
- Whether patient is considered to be housebound.

The patient/ carer should consent to the referral and be aware that a referral has been made.

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

If a District Nurse is required to administer a patient medication an authorised discharge prescription must be sent home with the patients discharge medication.

4.3.10 Day of Discharge

The nurse must complete the discharge checklist (Appendix 2).

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

- Out-patient appointments.
- Date the first visit requested by the district nurses and telephone number if there is any change in situation. Patients should be informed that they will be contacted by District Nurses prior to the date requested to confirm visit and at this time the date of visit may be changed.
- Date and time of 1st visit from local authority / private provider home care service.

Patients who require a District Nurse referral for on-going wound care or treatment – see section 4.3.9.

Patients discharged on anticoagulant therapy and require blood tests must be given the date/time of their first appointment with details of the appropriate clinic/GP surgery.

All valuables held in the ward safe or cashiers department must be returned to the patient and signed for before discharge.

All other personal property must also accompany the patient. If the patient is travelling on 'patient transport' they and their relatives must be forewarned that the transport can only carry a minimum of luggage.

The patient must be fully clothed on discharge if possible and not discharged in their night clothes unless the patient declines the offer of clothes, or alternative clothing is not available.

4.4 Patient Discharge Summary

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

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

Copies of the discharge summary must be filed in the patient's notes within 24 hours. A copy of the discharge summary can be found on EPR for patients discharged from Trafford Hospital.

If the patient is employed they may require a sick certificate. A MED10 certificate stating the patient has been an inpatient may be completed by the nursing staff coordinating the discharge. A MED3 certificate should be completed if the patient requires time off after their hospital admission.

4.5 Transfer to the Hospital Discharge Lounge (Central Site only)

The purpose of the discharge lounge is to transfer patients on their day of discharge from their ward areas to create early morning bed capacity and facilitate transfers from A&E, AMU and ESTU.

The Discharge Lounge is open:-

Monday – Friday 08.00-20.00 hrs (accepting first patient at 08.30hrs).
Saturday – Sunday 09.30 -16.30 hrs.

Prior to transfer to the Discharge Lounge all ward areas must ensure that the following are in place:

- Where it is known that a patient is being transferred on the following day this information should be passed to the Discharge Lounge and relevant patient pathway coordinators team the day before discharge.
- Discharge prescriptions must be written in advance of patients transferring.
- Patients who are being discharged via ambulance must have their transport booked the day before and advising that the patient will require pick-up from the discharge lounge.

- A Transfer of Care form should be completed prior to transfer (see *CMFT Trust Transfer Policy, Staffnet).*
- All patients' notes and discharge medication must be transferred with the patient from the ward that they are being transferred from.
- Patients must have a set of observations done within one hour prior to transfer and a print out of the last 24 hours of observations must be sent with the patient.

The following patients will not be transferred to the Discharge Lounge:

- Patients with CPE.
- Patients with increased confusion and known to wander.
- Stretcher patients who have not had their transport booked before 3.00pm on the day of discharge.
- Patients who require end of life care.
- Transfers to other hospitals (as these would be deemed as not medically fit).

Patients with MRSA and other infections must be discussed separately with the Infection Control team prior to transfer to the Discharge Lounge

4.5 Discharge of Patients Back to Residential or Nursing Homes.

The nursing/residential home must be contacted weekly to report on the patient's progress.

The ward must contact the nursing/residential home at the earliest opportunity to inform them of the intention to discharge the patient.

When a patient's condition has altered from their pre admission state the nursing/residential home must be invited to come and assess the patient to confirm that they are still able to meet the needs of the patient and arrange an appropriate date of discharge.

Diligence should be applied if the patient's ability to swallow has changed and a different type of diet is needed. This should be clearly communicated and documented to the carer/ care home provider. The Speech and Language Therapist (SALT) must be included in discharge planning and confirm the patient is safe to be discharged from their service. The relevant guidelines and nutrition regime must be sent with the patient.

Do not discharge a patient to a NEW nursing or residential home without first discussing this with the Hospital Discharge Service, social services and the home to which the patient is being discharged to.

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

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

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

4.7 Discharge of Patients from Emergency Department (ED)

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

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

4.8 Delayed Patient Discharge

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

If the discharge process is delayed due to lack of availability of a nursing/residential care home or package of care a section 5 referral must be completed by the ward manager/nurse in charge via CWS (Central site) and EPR (Trafford site).

4.9 Patients Who Lack Mental Capacity

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

Where there are concerns that a patient lacks mental capacity to decide where to be discharged to (i.e. whether to go to their own home or a care home), an assessment of mental capacity should be undertaken. If the assessment identifies that the patient does currently lack the capacity to make that decision, a Best Interest Meeting will be required to identify the type of placement that can most appropriately meet the patient's needs. A referral to an Independent Mental Capacity Advocate (IMCA) should also be considered (*see CMFT Mental Capacity Act Policy, DOLs and Patient Consent Policy).*

Any concerns regarding a patient with mental health needs or learning disabilities must be taken into account and the discharge planning process must involve the appropriate specialists to ensure the discharge is safe and appropriate for their on-going care needs (*see CMFT Mental Capacity Act Policy, DOLs and Patient Consent Policy).*

4.10 Discharges to Intermediate Care

Following a discharge assessment by the MDT and Hospital Discharge Service some patients will be identified as suitable for Intermediate Care (IC) to provide further clinical support to maximise their independence.

Following agreement with the patient and their relatives/representative the patient will be given a copy of the 'admission to intermediate care bed from hospital' letter (Appendix 3).

Patients transferred to an intermediate care facility must be transferred as per section 4.3 together with a copy of their medical notes.

Patients who will be discharged with a wound(s) or require on-going treatment must be referred to the District Nurse Service and be given a copy of their wound care plan, discharge summary and a supply of dressings/treatment and when necessary urinary night bags, stoma bags (a minimum of 3 day supply must be provided and 5 day supply if

the patient is discharged before or during a weekend/bank holiday period to allow sufficient time to obtain a prescription).

Patients who are discharged to the IC Home Pathway must be assessed for administering their medication. If required, discharge medication must be provided in a blister pack.

4.11 Homeless Patients / No Fixed Abode

Patients identified as homeless or with no fixed abode on discharge must be referred to both the MPATH Team on admission and the Hospital Discharge Service (see CMFT Homelessness Policy, CMFT Staffnet).

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

If a patient and/or family/carer express the wish to die at home and they are approaching the last few hours to days of their life the Rapid Discharge Pathway is available to coordinate discharge safely and should be used to expedite this request (see CMFT Satffnet *Rapid Discharge Guidelines for EoL Care*).

Staff must ensure that the completed unified DNACPR form is included with the discharge documentation.

4.13 Repatriation to an Other Hospital/Health Care Provider

If the patient is not registered with a Manchester or Trafford GP and no longer requires specialist treatment within CMFT, they should be discharged back to their local hospital or care provider. A consultant to consultant referral must be made to the referring hospital and the transfer arranged by the Divisional Patient Pathway Coordinators Team.

4.14 When Patient Refuses Discharge

Where patients have been assessed as not requiring NHS continuing inpatient care, they do not have the right to occupy indefinitely an NHS bed. When the patient refuses discharge the patient's medical and nursing team must discuss the discharge options with the patient and understand the underlying reasons for refusal. Where there are concerns that a patient lacks mental capacity to decide where to be discharged to (i.e. whether to go to their own home or a care home), an assessment of mental capacity should be undertaken (see section 4.9).

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

The management of patients who refuse to leave hospital must be managed on a case by case basis. Every attempt must be made to achieve an outcome that is in the patient's best interest. Escalation and management of such cases should follow the same approach described in Section 5.

If the patient has been transferred to a different ward in a different Division but remains under the care of the transferring Consultant specialty the original Division retains accountability for the patients care. If the ward manager/staff cannot progress the

discharge, than this must be escalated to the Head of Nursing and Divisional Director for the accountable Division.

4.15 Management of Patients Who Wish to Self Discharge Against Medical Advice

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

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

If the patient appears to be missing from the ward see *Missing Patient Policy, CMFT Staffnet.*

Where the patient lacks the mental capacity or staff have any doubt about the patient's ability to make the decision to self discharge the patient must be reviewed by the medical team, see section 4.9 (*see CMFT Mental Capacity Act Policy, DOLs Policy).*

5 Transfer to 24 hour Care

5.1 Patients who are Unable to Return Home

Most people return home after a period of acute care, some after a period of intermediate care. Increasingly, in line with the policy of supporting independent living, those who are unable to return to their previous accommodation are re-housed in more appropriate extra care housing or other provision.

For a minority of patients transfer directly from an acute setting to a nursing/residential home may be the plan agreed with the patient. It should however be recognised that when a transfer to a registered care home is the agreed outcome, the opportunity for maximum rehabilitation has occurred.

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

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

Where a place is not available in the individuals preferred care home, remaining in an acute hospital setting is undesirable for the welfare of the patient. There are particular risks of increasing dependency, acquiring infections and harm i.e. falls. In addition the acute care provision is needed for patients with acute care needs.

5.2 Home of Choice

5.2.1 Process for Patients Waiting in a Hospital Bed for Care Home Placement

See flow chart (Appendix 4)

The guidance in sections 5.2 should be followed where an MDT assessment of the patient indicates that the patient is close to being fit for discharge and not requiring further acute inpatient care. all members of the MDT should be satisfied that the patient's condition cannot be further improved by inpatient rehabilitation or intermediate care and that placement in a residential or nursing home is the most appropriate option to meet the patient's needs.

A nursing and social care needs assessment must be completed by the Hospital Discharge Service to establish the on-going health and social care needs of the patient.

The patient and their family/representative must be involved in all stages of the assessment process.

The patient and their family/representative must be informed of the outcome following the assessments including agreed funding arrangements if required. It is essential that families are also informed about Top-up funding arrangements where they apply.

5.2.2 Stage 1

Once all assessmentsand meetings are complete the patient and/or family/representative will receive written confirmation of discharge plans requiring the family/representative to identify a suitable home within 7 days of receipt of the letter (Appendix 5). The date and to whom the letter was given must be documented in the patients records by the issuer. Where possible, this must be given directly to the patient and/or relative by the Hospital Discharge Service or delegated nurse.

In the case of a patient requiring a nursing/residential home placement, a shortlist of appropriate establishments with vacancies (social care need to provide a list with vacancies) will be provided along with the preferred provider list for the relevant local authority. Patients, families/carers must be made aware that the list provided is non-exhaustive and a full list can be found at www.cqc.org.uk.

All further information and support required by the patient's family/representative is to be provided by the Hospital Discharge Service to facilitate a safe and efficient discharge to the appropriate destination.

The patient's family/representative will be contacted by the Hospital Discharge Service following the 7 days if not contacted by the family/representative to discuss progress in identify a suitable vacancy in a residential/nursing home.

If the family cannot be contacted following receipt of the initial confirmation, the patients discharge /transfer plans will still continue to ensure that their best interests of the patient are being addressed by hospital staff.

5.2.3 Stage 2:

If after 7 days a suitable vacancy within a care home has not been identified a member of the Hospital Discharge Service must ensure that all the necessary information and support has been given to the patient, family/representative. A stage 2a letter (appendix 6) must

be given to the patient or family/representative notifying them that a review meeting will be required after 14 days if a suitable care home has not been identified.

If a care home has been identified as the home of choice by the patient or family/representative however a vacancy is not available a stage 2b letter (appendix 9) must be given to the patient or family/representative asking them to consider alternative placements or accepting a temporary placement elsewhere until their preferred choice becomes available.

If a temporary placement is agreed with the patient, family/representative a *discharge from hospital to temporary placement letter* (appendix 9) must be given to the patient, family/representative.

The patient/relatives/representative must be provided with the contact details of the Hospital Discharge Service who can advise and assist them with any problems or concerns they may have.

A review meeting will be required after 14 days if a suitable care home has not been identified.

5.2.4 If a care home has not been identified within 14 days

After 14 days, if a care home has not been identified, or the patient relatives/representative are refusing transfer until a vacancy in the care home of their choice becomes available, the Discharge Service Manager is required to take the following action:

- Confirm that the delay in discharge is not due to a requirement for any assessment of altered needs.
- Arrange a review meeting with the patient, family/representative within 3 working days (see 5.2.5).
- Provide the patient and/or relatives with a leaflet informing them of the role of the Patient Advice and Liaison Service (PALS), including contact details.

5.2.5 1st Review Meeting

The first review meeting should be chaired by the Directorate Manager with support from the ward Matron and a member of the Discharge team together with a member of the patient's medical team who knows the patient. The meeting is to be documented in the patient's record and an invitational letter will be issued to the patient's family/representative.

The chair of the meeting will advise the patient and their relatives/representative that a hospital bed is no longer required and that alternative arrangements should be made for transfer or discharge of care.

The following points will be confirmed at the meeting:

- That the patient remains medically well enough for discharge to take place.
- That remaining in a hospital environment is not in the patients best interest for their care needs and may also be detrimental to the patient's health and well-being.

- That the patient family/representative has had 14 days in which to select a care home. This period commenced when written notification was given identifying the need for a care home placement to meet the patient's needs (letter - appendix 5).

The chair of the meeting must ensure that:

- The patient and/or their family/representative have received all necessary information and are in possession of any appropriate contact numbers for seeking further support or advice.
- The patient and their relatives understand they have up to 7 days from the date of this meeting during which time an appropriate selection should be made and communicated to the case manager.
- A provisional date for the 2nd review meeting should be agreed during this meeting (see section 5.2.6).
- The patient and/or relative should receive written confirmation of the discussions from this meeting. A copy of the appropriate letter should also be retained in the patient's notes, and a further copy retained by the Discharge Team.
- If the patient/relatives choose to engage in selecting a care home and request more time to support them to find a care home, the Directorate Manager can exercise judgement as to the timing of moving onto stage 3.

5.2.6 In the event that a care home has not been selected within 21 days

Stage 3

After 21 days If the patient family/representative choose not to engage in selecting a care home or a placement has still not been identified a stage 3 letter (Appendix 10) should be given/sent, requesting that they attend a further meeting to be arranged for seven days after the 'First Review' meeting. The Stage 3 letter will also contain information on how to contact the PALS team if required.

2nd Review Meeting

The Hospital Discharge Service case manager must arrange and confirm the date of the '2nd review meeting' with the patient family/representative. The meeting must be chaired by the Directorate Manager and attended by the ward matron, the discharge team case manager and a senior member of the patient's medical team.

If, during the '2nd Review' meeting it is apparent that the patient and/or their family/representative do not intend to find an appropriate placement within the next 7 days, the Directorate Manager must ensure that it is made clear in the meeting (and confirmed in writing) that action will be taken in line with NHS guidance due to the absence of any agreement to find or accept a placement in a care home with a vacancy.

5.2.7 In the event that a care home has not been selected within 28 days

Stage 4

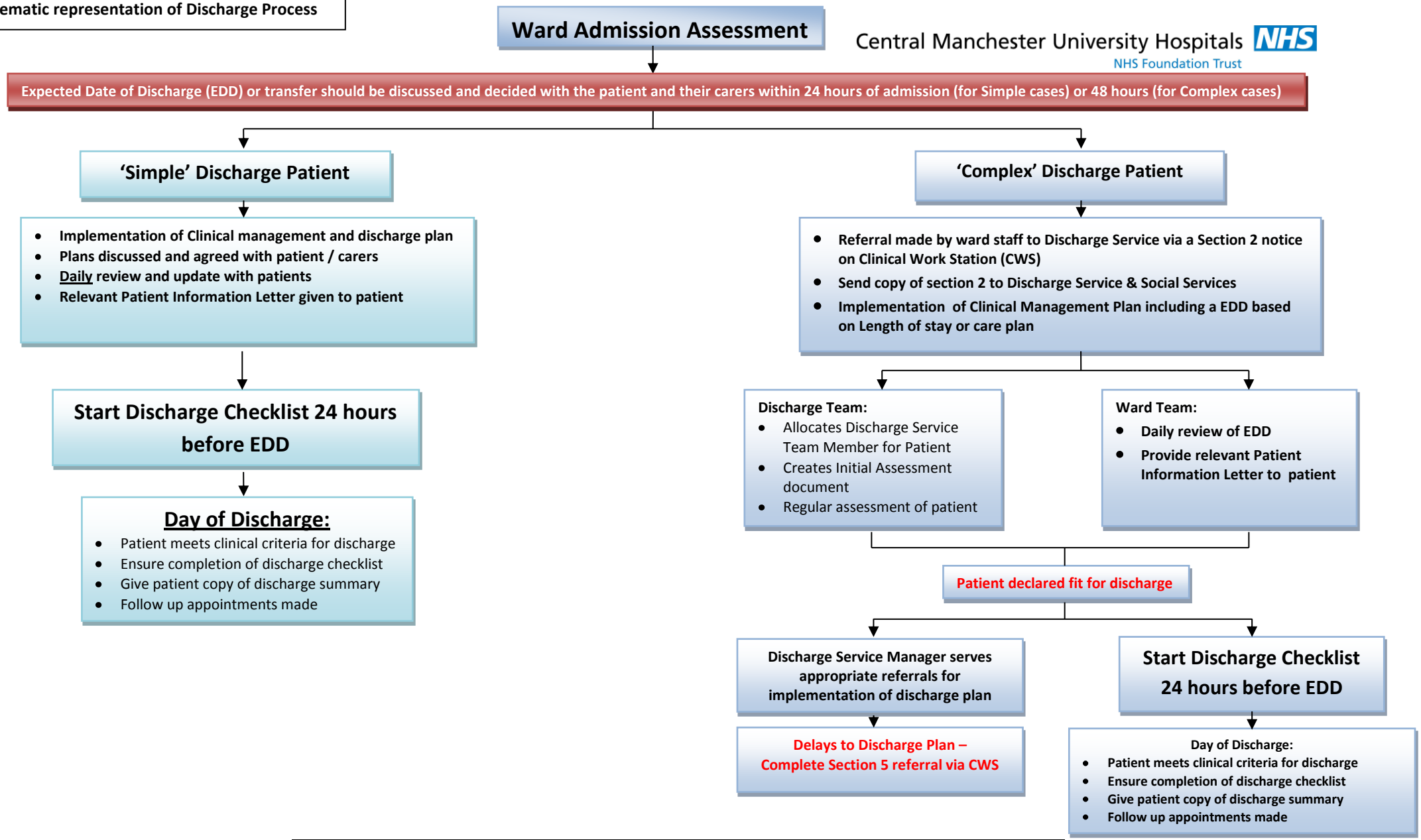
After 28 days a stage 4 letter (appendix 10) must be given/sent to the patient family/representative advising the patient and/or their relatives that a further meeting will need to be convened chaired by the Divisional Director, and include the Head of Nursing,

Ward Matron, patients medical consultant and a member of the Discharge team within 48 hours from expiry of the 7 day period.

This meeting will determine the next course of action, likely to result in commencement of legal proceedings to ensure that the patient is transferred or discharged from hospital in order to safeguard their health and well-being, and to ensure that the occupied bed is made available for appropriate patients. By this time, the patient will have had 28 days (14+7+7) to find a suitable placement.

Following the meeting details of the meeting must be sent to the patient and their family/representative, Divisional Director, Chief Operating Officer, Head of Nursing and the patient's consultant. A copy should also be retained in the patient's notes.

Schematic representation of Discharge Process



7. Equality Impact Assessment.

7.1 The Trust is committed to promoting Equality, Diversity and Human Rights in all areas of its activities.

7.2 It is important to address, through consultation, the diverse needs of our community, patients, their carers and our staff. This will be achieved by working to the values and principles set out in the Trust's Equality, Diversity and Human Rights Strategic Framework.

7.3 To enable the Trust to meet its legislative duties and regulatory guidance, all new and revised procedural documents, services and functions are to undertake an equalities impact assessment to ensure that everyone has equality of access, opportunity and outcomes regarding the activities. Contact the Service Equality Team (SET) on **Ext 66897** for support to complete an initial assessment. Upon completion of the assessment, SET will assign a unique EqIA Registration Number.

7.4 The Trust undertakes Equality Impact Assessments to ensure that its activities do not discriminate on the grounds of:

Religion or belief	Age
Disability	Race or ethnicity
Sex or gender	Sexual orientation
Human Rights	Socio economic

8. Consultation, Approval and Ratification Process

The policy will be consulted on widely throughout the Trust and include all senior Divisional teams, senior nurses, member of the Hospital Discharge Service, social services and Transformation Leads.

The policy has been ratified by Nursing and midwifery Professional Forum in January 2015

The policy will be tabled at Operational Management Group (OMG) and Clinical Effectiveness Committee in February 2015

9. Dissemination and Implementation

The Divisional Heads of Nursing will be responsible for disseminating this policy within their clinical Division. The HON together with the senior Divisional Team will be responsible for agreeing an implementation plan

10. Monitoring Compliance of Discharge Policy

10.1 Process for Monitoring Compliance and Effectiveness

10.2 The Discharge Service is responsible for monitoring compliance with the Discharge Policy (adults) at Divisional level and escalating to the Divisional senior team when problems are identified.

10.3 The following will be monitored for compliance:

- Discharge requirements specific to simple discharges.
- Discharge requirements specific to complex discharges.
- Documentation to accompany patient on Discharge.

10.4 In addition reports on number of incidents related to discharge will be reported to operational risk management group on an annual basis.

10.5 Any shortfalls identified will have an action plan put in place to address which will have timescales included for re-audit / monitoring.

11. Standards and Key Performance Indicators 'KPIs'

11.1 The policy will be reviewed every 3 years or when there are significant changes to the document.

11.2 Delayed discharge will be monitored as a key performance indicator and reported on in Divisional weekly length of stay meetings.

11.3 Discharges into intermediate care will be monitored as a key performance indicator and reported in Divisional weekly length of stay meetings.

12. References and Bibliography

Department of Health Publication 'Ready to go? - Planning the discharge and the transfer of patients from hospital and intermediate care' (March 2010).

General Medical Council – Good Medical Practice (March 2013).

Royal College of Nursing – Discharge Planning (2010).

13. Associated Trust Documents

Refer to the Trust Intranet Site for latest version

Discharge Service Operational Policy, Version: 1, Reference Number: CL – DS002

Adult Safeguarding Policy, Version 6, Reference Number: OC10-2408

'*Preparing for your discharge from hospital' leaflet* – **order number CM16243**

14. Appendices

Appendix 1 – *Complex Discharge – Identifiable Patient Groups Requiring Special Consideration.*

Appendix 2 – *Discharge Checklist.*

Appendix 3 – *'Admission To An Intermediate Care Home'* Letter.

Appendix 4 – Process Flow Chart For Patients Waiting For Care Home Placement.

Appendix 5 – *'Discharge From Hospital To Care Home'* Letter.

Appendix 6 – Stage 2 Letter – *'No Care Home Identified'* Letter.

Appendix 7 – Stage 2 Letter – *'Care Home Identified But No Bed Available'* Letter.

Appendix 8 – *'Discharge From Hospital To A Temporary Care Home Placement'* Letter.

Appendix 9 – Stage 3 Letter – *'Home Of Choice'* Letter.

Appendix 10 – Stage 4 Letter – *'Home Of Choice'* Letter.

Appendix 11 – Stage 1 Letter – (Carer/Relative Letter) *' Patient Who Lacks Capacity'*

Appendix 12 – Stage 2 Letter – (Carer/Relative Letter) *' Patient Who Lacks Capacity'*

Appendix 1.

Complex Discharge – Identifiable Patient Groups Requiring Special Consideration

Patients who require support to be arranged prior to discharge would be described as 'Complex' discharge. Examples of the type of patient that this would include are found below:

- Patients who live with a carer.
- Patients who themselves have a caring responsibility.
- Patients who have serious on-going health conditions which may result in regular return visits to hospital.
- Patients who have had an extended period of hospitalisation.
- Patients who have sustained injuries which prevent them from meeting their own essential daily living needs in the short term or long term terminally ill patients.
- Patients who are, or may be eligible for Continuing Health Care.
- Patients who already receive a community health or social care service.
- Patients who are admitted from a nursing or residential care home.
- Patients who may require Intermediate care (Acute and Community).
- Patients with Chronic diseases.
- Patients with communication difficulties that affect their ability to meet their essential daily living needs.
- Patients with or suspected to have a learning disability.
- Patients who wish to die at home and be cared for on the Rapid Discharge Pathway.
- Mental Health issues that affect their ability to meet their essential daily living needs.
- Patients who have a disability that affects their ability to meet their essential daily living needs.
- Patients who are homeless.
- Patients who are known to have substance misuse problems.
- Patients where adult abuse is suspected or known to have occurred
- Patients who are refugees
- Patients who are Asylum Seekers
- Patients with no recourse to public funds

Appendix 2

Discharge Checklist

Part 1 – To be Completed on Admission

All questions to be asked on admission.	Added information/Actions	Outcome	Actions	sign
Estimated date of discharge given to patient and family.	Explain that this is an estimate and will depend on medical condition.			
Establish the patients home situation (Lives alone, with family, nursing home, residential home etc.). ***Are you coping at home?***	Check if the patient is a Central Manchester/Trafford resident or not.			
Does the patient have a package of care? Is the patient happy with this package of care?	Check what the package of care is. Complete section 2.			
Does patient have/ require own social worker?	Social worker contact details or section 2.			
What is the patient's baseline (health status, level of independence)? ***Is the patient at base line?***	If no, the patient requires referral to Physiotherapist and Occupational Therapist.			
Is the patient known to the District Nursing team/community services?	If yes what for? Contact details.			
Does the patient have home oxygen or any other medical services? e.g. home nebulisers.	Referral required to PFT or COPD team?			
Does the patient have an Active Case Manager?	Confirm details.			
Does the patient have access to his/her home? **How will access be gained on discharge?**	Check if they have keys/keypad/key safe.			

All questions to be asked on admission.	Added information/Actions	Outcome	Actions	sign
Does the patient have stairs in the property?	Patient may require stairs assessment prior to discharge.			
Will the patient require hospital transport on discharge?	Check if family will be able to collect or type of transport required.			
TTO's – does the patient administer their own medications? **Will the patient require a blister pack?**	Does the patient require district nurse for LMW Heparin, insulin injections.			
Will the patients family need to be available on day of discharge?	Confirm with family any potential discharge delays.			
Does the patient or family have any concerns/worries or fears regarding discharge?	Identify any potential delays.			

Discharge Planning/Best Interest Meetings	Outcome	Actions

Part 2

To be completed by: NURSE and Discharge Team (if involved)
TO BE COMPLETED 24hours prior to discharge

Actions	Name	Date
1. Patient considered fit for home within next 24 hrs.		
• Discuss discharge arrangements with NOK/Carers. • Finalise package of care / re-ablement /meals on wheels/ Care alarm/ 'Key Safe' with patient / NOK.		
2. Transport		
• Arrange transport home with NOK or hospital transport (Arriva). • Consider other equipment/frame. • Oxygen required in transit?		
3. Confirm Essentials Organised		
Keys ……. heating…… food……. belongings (sent home)…….		
4. Medication		
• Discharge prescription completed -Prescribed on Medisec. • Is blister pack required?…… • 7 days supply of ALL medication. 'Thick and easy' and supplements to be prescribed on TTO.		
5. Equipment		
• Order and check if the correct mattress and other ordered equipment has been delivered prior to discharge.		
6. Oxygen		
• Confirm oxygen is in place before discharge. • Confirm COPD team to fax HOOF to Intermediate care.		
7. Anticoagulation Therapy		
If on anticoagulants please arrange clinic appointment. • Dose until next appointment and document in Yellow book. • Supply enough drug until next clinic appointment.		
8. Nebulisers		

Actions	Name	Date
• If the patient is new to nebulisers please contact the Pulmonary Function Team to supply a nebuliser on discharge. • If the patient is going to intermediate care and has a nebuliser at home, please ask the patient if someone can take it to I C.		
9. Walking Aids		
• **if required** Please send any walking aids e.g. sticks, crutches, zimmer frames etc. with patient (ensure ambulance aware).		
10. Care Products		
• If required please supply 7 days supply of dressings, stoma bags, catheter bags/catheter home pack, incontinence pads. • If discharge to intermediate care also indicate frequency/last change of dressing. …….. • Type/size/change of catheter……. • Order and check if the correct mattress and other ordered equipment has been delivered prior to discharge (including ICT).		
11. District Nurses		
• Referral completed…….. • Drug Administration Authorisation Form to be completed if needs eye drops, insulin, LMW Heparin or other injection. • 3 days supply of dressings, bags, stoma care (5 days if weekend or bank holiday).		
12. Nutritional Needs		
• Ensure dietary requirements and SALT recommendations are sent. • with the patient following SALT review as appropriate. • Also discuss with carers/ residential/nursing home prior to • discharge. • 7 days supply of feeds e.g. PEG feeds or oral dietary supplements e.g.fortisip.		
13. Intermediate Care		
• Inform patient of the discharge to Intermediate care on confirmation with intermediate care. • Inform carer/relative of the discharge to Intermediate care. • Send Medical notes with patient (Manchester IC bed base only). • For patient being transferred to Intermediate Care bed please send the Nursing Care Plan for the first 72 hours of care, a contact assessment, and a therapy discharge summary.		
14. Sharing Information		
• Send yellow notes with the patient (Manchester Patients)		
15. Discharge to Nursing/Residential Care Home		
• Send copy of discharge summary. • Send copy of nursing care plan and wound plan.		

Actions	Name	Date
• Ensure SALT recommendations are sent. • 3 days supply of dressings, bags, stoma care (5 days if weekend or bank holiday).		
Medical Discharge |Summary Completed		

Signed by:	**Print Name**
Designation	Date

Central Manchester University Hospitals NHS
NHS Foundation Trust

PART 3

Day of Discharge Information

Actions	Name	Date
1.Discharge confirmed with patient and family-discuss any worries/fears around discharge.		
2. Removal of cannula.		
3. Arriva transport confirmed (90 mins before) *Inform ambulance crew of dietary restrictions on transfer*.		
4. Belongings/valuables given back to patient.		
5. Confirm reason for admission and diagnosis with the patient.		
6.Copy of discharge summary for patient.		
7.Check medication is labelled correctly for right patient.		
8. Advice given regarding changes in medication and current medication to be taken home - what are they for/ Dosage and frequency. **Check patient is able to open packaging/bottles.**	**Pharmacist/nurse**	
9. What to do with previous medications that you already have at home.		
10. Advice re storage of medications.		
11. Potential side effects and what to look out for.		
12. How long to continue to take medication and how to obtain further supply.		
13. Use of inhalers/insulin pens.		
14. Anticoagulants such as Warfarin, have doses recorded in yellow book until next appointment and appropriate sections completed. **1st appointment for blood test**		
15. Pharmacy help line is on the advice card with your medications if you need further advice regarding your medication.		

Actions	Name	Date
16 Friend and Family questionnaire/electronic device offered.		
17. Follow-up appointments are /for: **Health care professionals to visit are:**		
18. If you have any concerns please contact …… (ward) Tel: 0161…… or your own GP.		

Appendix 3 *'Admission to an Intermediate Care Bed from Hospital'* letter

Dear

RE: Transfer from Hospital to Intermediate Care

Your discharge assessment has now been completed and it has been identified that you require further clinical support in order to maximise your independence. In order to provide this care and support you in your recovery we will be transferring you to an Intermediate Care Facility.

How long will I be in Intermediate Care?

During your time in intermediate care the team in charge of your care will make every effort to keep you fully informed of your progress and ensure that you are ready to leave the intermediate care service as soon as you are assessed as fit to do so.

How do we prepare for discharge?

The team will undertake an assessment of your needs and discuss these along with the potential options available to you, with your permission, we are also happy to discuss these options with close family members, friends or representatives who may support you at home.

Returning home from Intermediate Care?

When you are ready to return home you may require some support from the Intermediate Care Home Pathway Team and social care support. The Intermediate Care Team will discuss with you and your family/representative prior to discharge what support you may need.

What happens if I need long term care?

If returning home immediately is not possible then the Intermediate Care Team will discuss with you and your family/representative the option of whether short term residential/ nursing care will help you to regain more independence.

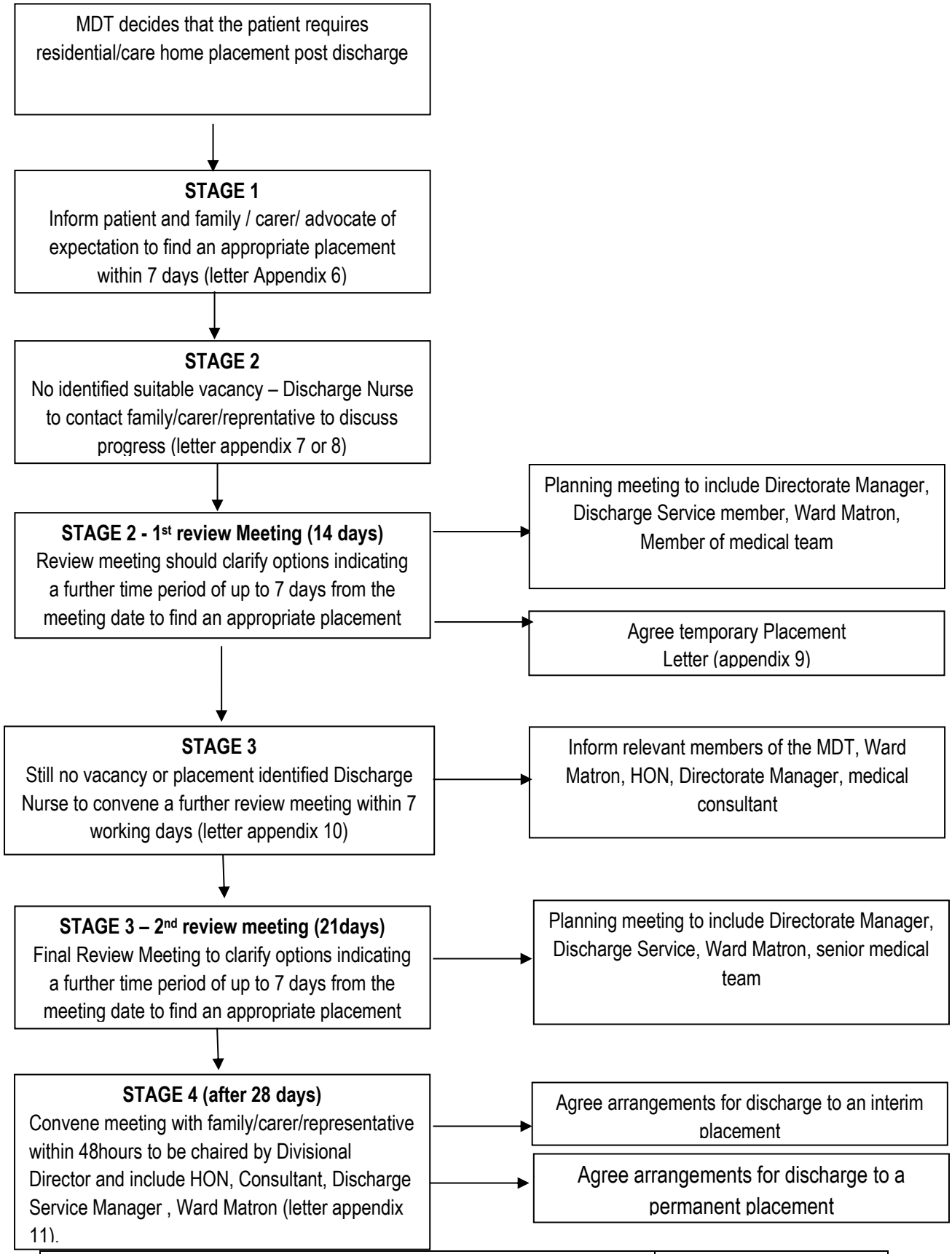
Some patients will be assessed as needing support in a 24 hour care environment. In this situation the Intermediate Care Team will discuss options available and provide information in respect of the services available to you, so that an informed decision in respect of were you wish to be cared for can be made.

Who can I speak to if I have any concerns?

If you have any questions regarding this letter then please speak to a member of staff currently looking after you. We are also happy with your consent to speak to friends/ family or another representative whom you would like to be involved.

Yours sincerely

Appendix 4 Process Flow Chart for Patients waiting for Care Home Placement



Appendix 5 *'Discharge from Hospital to a Care Home'* letter

Dear

RE: Discharge from Hospital to a Care Home

Your discharge assessment has now been completed and you are now well enough to leave our hospital care.

Your future care needs have been discussed with you and your care team. Where appropriate, they may also have been discussed with your family/ representative. During these discussions we/you agreed that your future care needs would be best met in a suitable care home.

What support is available?

Whilst we do not wish to cause you any anxiety or distress, an extended stay in hospital for longer than is medically necessary is not beneficial to your health and wellbeing, and therefore it is important to support you to ensure a timely discharge from hospital. The Discharge Team will provide you with information to support you and your family/representative in finding a suitable care home

The choice of care home will be determined by:

- The level of care you need
- The availability of a suitable care home to meet those needs
- And (for residential care/ funded nursing care) the completion of a financial assessment
-

It is advisable that you and your family/ representative make your choice based on the options made available to you by the hospital Discharge Team as these will have been carefully considered based on your individual needs.

Following the formal decision in respect of finances and funding being given to you we normally expect the process for choosing a suitable home to take no more than one week

What happens if there is a delay in finding a suitable home?

If there is a delay in finalising your choice of home then we may arrange for you to be discharged to a temporary care home. The funding of this home would be in line with the outcome of your assessment. Please be assured that where we need to take this approach we will ensure that you and your family/ representative are kept fully informed.

Who can I speak to if I have any concerns?

If you have any questions regarding this letter then please speak to a member of staff currently looking after you. Alternatively, you can also ask for a member of the discharge team who will arrange to visit you on the ward to discuss things further. We are also happy to speak to friends/ family or another representative whom you would like to be involved.

Yours sincerely

Appendix 6 Stage 2 letter – '*No Care Home Identified*' letter

Dear

Further to our letter dated …….

I understand that you have not yet advised us of you/your relatives preferred place of residence following discharge.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment. It is therefore important that those who have been assessed as medically fit to be discharged from hospital move to a more suitable placement promptly. It is also not in a patient's best interests to remain in hospital once they are fit for discharge.

It would therefore be extremely helpful if you would give serious consideration to alternative placements, which could satisfactorily meet you/your relative's needs, as your preferred choice is not available. Otherwise, we would ask that you consider accepting a temporary placement elsewhere until your preferred choice becomes available.

Please will you confirm your preferences for accommodation by contacting [**INSERT CONTACT DETAILS],** by the [**INSERT DATE – 7 days after the date on which the letter is sent]** so that we can arrange you/your relatives discharge safely and promptly? If, at this stage you have been unable to identify a suitable placement, I would like to meet with you in person to discuss how we can help you progress discharge arrangements.

If you have any queries or wish to discuss this further, please contact **[NAME OF CASE MANAGER]** the Case Management Team on **[INSERT CONTACT DETAILS]**.

Thank you for your co-operation.

Yours sincerely,

Appendix 7 Stage 2 letter – '*Care Home identified but no bed available'* letter

Dear

Further to our letter dated …….

I understand that your preferred place of residence following discharge is [INSERT NAME OF CHOSEN ESTABLISHMENT] but that they are not able to accommodate you/your relative at the present time.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment. It is therefore very important that those who have been assessed as medically fit for discharge move to a more suitable placement promptly. It is also not in a patient's best interests to remain in hospital once they are fit for discharge.

It would therefore be extremely helpful if you would give serious consideration to alternative placements that could satisfactorily meet you/your relative's needs, as your preferred choice is not available. Otherwise, we would ask that you consider accepting a temporary placement elsewhere until your preferred choice becomes available.

Please will you confirm your preferences for accommodation by contacting [**INSERT CONTACT DETAILS],** by the [**INSERT DATE – 7 days after the date on which the letter is sent]** so that we can arrange you/your relatives discharge safely and promptly? If, at this stage you have been unable to identify a suitable placement with vacancies, the Head of Case Management and I would like to meet with you in person to discuss how we can help you progress discharge arrangements.

If you have any queries or wish to discuss this further, please contact **[NAME OF CASE MANAGER]** the Case Management Team on **[INSERT CONTACT DETAILS]**.

Thank you for your co-operation.

Yours sincerely,

Appendix 8 *'Discharge from Hospital to a Temporary Care Home Placement'*

Dear

RE: Discharge from Hospital to a Care Home (Temporary Placement)

Your discharge assessment has been completed and, as you are no longer in need of hospital care, you are now ready to be discharged from our care. I understand that, despite the provision of support to assist you (and where applicable your family/ representative) with your discharge arrangements, it has not proved possible to complete the discharge arrangements to a care home of your choice within the expected timescales.

Given that there has been an unexpected delay in finalising your discharge to your selected care home, we have now arranged your discharge to a temporary care home placement on your behalf, the funding of which will be in line with the outcome of your assessment.

Following discussion with you (and where appropriate your family/ representative) I am now pleased to confirm that a temporary alternative placement has been arranged for you at …….and that this placement is available from ……..

Please be assured that whilst it has proved necessary to arrange a temporary placement for you at this time, we will continue to support you (and your family/ representative) with the arrangements involved in supporting your on-going transfer into your preferred care home as soon as your placement becomes available.

If it would be helpful for you (and/ or a member of your family/ friend) to talk things though with someone who can offer you further help and support then please don't hesitate to speak to a member of the team looking after you.

Yours sincerely

Appendix 9 Stage 3 *'Home of Choice'* Letter

Dear

I write further to the 'First Review' Meeting, held on [DATE] in relation to the discharge arrangements for you/your relative. During the meeting we requested that you advise us of your chosen care home within a further 7 days, and I am therefore keen to establish whether you have been able to find a permanent or temporary placement that will meet your/your relative's needs.

You have been provided with a list of suitable placements I would urge you to consider identifying and accepting one of these placements.

As your aware from my previous letter acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment. It is therefore important that those who have been assessed as medically fit to be discharged from hospital move to a more suitable placement promptly. It is also not in a patient's best interests to remain in hospital once they are fit for discharge.

I appreciate that this might be an unsettling time for you, but it is extremely important that your/your relatives discharge is now expedited, for the reasons explained.

I would therefore like to arrange a further meeting (Second Review Meeting) with you again on [DATE] to agree how to progress **your/your** relatives discharge arrangements promptly. If you identify a suitable placement before this date, please contact (**INSERT CONTACT DETAILS),** in which case it may not be necessary for us to meet.

If you feel that support from the Trusts Patient Advocacy Liaison Service (PALS) or the Hospital Discharge Service would be of benefit to you, please contact them on **[INSERT TELEPHONE NUMBER**

Yours sincerely

Appendix 10 Stage 4 '*Home of Choice'* letter

Dear

We write further to the 'Second Review' Meeting, held on [DATE] in relation to the discharge arrangements for you/your relative. During the meeting, we requested that you advise us of your chosen care home within a further 7 days, but we have not yet received confirmation that arrangements have been made for you/your relative's accommodation.

I would therefore like to arrange a further meeting with you again on **[DATE]** to agree how to progress **your/your** relatives discharge arrangements promptly. If you identify a suitable placement before this date, please contact (**INSERT CONTACT DETAILS),** in which case it may not be necessary for us to meet.

I must therefore inform you that if a suitable placement is not identified within the next 48 hours, it will be necessary for the Trust to discharge **your relative** to **[INSERT NAME OF PLACEMENT]** from **[INSERT SITE]** Hospital. This interim placement will be available for a period of 2 weeks, after which time you will become liable for funding your place in the care home. If however you have identified alternative accommodation please let us know and this interim placement will be cancelled.

We hope you will appreciate the importance of this discharge policy being enforced to ensure the most effective use of NHS resources. If you have any queries relating to the content of this letter, please do not hesitate to contact **xxxxxx Divisional Director {INSERT NAME]**

For the avoidance of doubt, we confirm that the hospital bed you/your relative are currently occupying will no longer be available to you as of **[INSERT TIME]** ON **[INSERT DATE**].

Yours sincerely

Appendix 11 - STAGE 1 LETTER – (Carer/Relative Letter) PATIENT WHO LACKS CAPACITY

Dear

I am writing to you regarding it being identified that (NAME OF PATIENT) will require a residential/care home placement following their discharge from hospital.

A Health and Social Services Assessment has been completed and (PATIENT'S NAME) care needs have been fully discussed with you and with (PATIENT'S NAME), as far as appropriate.

As you may be aware, (PATIENT'S NAME) has been assessed as lacking the mental capacity to make a valid decision concerning their living arrangements following discharge. Therefore, hospital staff are obliged to work with other professionals and with the family/carers/advocate(s) of (PATIENT'S NAME) to identify an appropriate placement for (PATIENTS NAME) in line with (his/her) "best interests".

…… Hospital Discharge Service have discussed this with you and we would be grateful if you could now inform us of your views regarding appropriate accommodation for (PATIENTS NAME) so that your preferences can be taken into account in reaching a decision, and to ensure that (PATIENTS NAME) can be discharged safely and promptly. It is hoped that professionals and family and friends will be agreed on their preference for an appropriate placement. We are asking you to inform of us your preferred care home within 7 days of the date on this letter.

If you have any queries or wish to discuss this further, please contact a member of the Hospital Discharge Service on (INSERT CONTACT NUMBER).

If you have any further questions please do not hesitate to contact any member of the staff.

Thank you for your co-operation.

Yours sincerely,

Appendix 12 STAGE 2 LETTER – (Carer/Relative Letter) PATIENT WHO LACKS CAPACITY

Dear

We are pleased to hear that the Consultant responsible for [_____'s] treatment in hospital has confirmed that (NAME OF PATIENT) is now medically fit to be discharged from hospital. A Health and Social Services Assessment has been completed and (PATIENT'S NAME)'s care needs have been fully discussed with you, and with [INSERT PATIENT'S NAME], as far as appropriate.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment and care. It is therefore important that those who have been assessed as medically fit for discharge move to a more suitable placement promptly. It is also rarely in a patient's best interests to remain in hospital once they are fit for discharge.

As you may be aware, [PATIENT'S NAME] has been assessed as lacking the mental capacity to make a valid decision concerning their living arrangements following discharge. Therefore, hospital staff are obliged to work with other professionals and with family and friends of (PATIENTS NAME) to identify an appropriate placement for (PATIENTS NAME) in line with his / her "best interests". We have discussed (PATIENTS NAME) with you and have taken into account your views about where he / she should now live.

[I understand that your preferred place of residence for [PATIENT'S NAME] following discharge is (NAME OF CHOSEN ESTABLISHMENT) but that they are not able to offer accommodation at the present time / it has been decided that they are not the most appropriate placement to meet (PATIENTS NAME) needs. (Delete as applicable)

We have considered what placements are available that can meet (NAME OF PATIENT)'s care needs, and have decided that [PATIENT'S NAME] should move to [NAME OF PLACEMENT]. [This is a temporary placement, until the chosen placement becomes available] – INSERT WHERE APPLICABLE.

[NAME OF PLACEMENT] has confirmed that a bed will be available for [PATIENT'S NAME] on [DATE]. We therefore intend to discharge [PATIENT'S NAME] from the hospital on that day. We would welcome your assistance with the transfer process, if possible. If you have any queries, or if you wish to discuss this further then please contact a member of the Team on (CONTACT NUMBER).

If you have any further questions please do not hesitate to contact any member of the staff.

Yours sincerely