Livewell Southwest and
Plymouth Hospitals NHS Trust

Discharge and Transfer of Patients from Hospital Policy – Joint Guidance

Version No. 2.1
Review: December 2018

Notice to staff using a paper copy of this guidance.

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Asset Number: **105**

Reader Information

Title	Discharge and Transfer of Patients from Hospital Policy – Joint Guidance. V.2.1
Asset number	105
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document purpose/summary	Operational standards of patients' discharge and transfer from hospital.
Author	Integrated Hospital Discharge Team Operational Lead and Community Urgent Care Services Manager
Ratification date and group	16th September 2015. Policy Ratification Group
Publication date	20th July 2016
Review Date and Frequency (one, two or three years based on risk assessment)	Three years after publication or earlier if minor changes are required.
Disposal date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Discharge Team Operational Lead and Community Urgent Care Services Manager.
Target audience	All clinical and administrative staff in inpatient units and discharge team staff.
Circulation	Electronic: LSW intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☏ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation process	Developed in consultation with Integrated Hospital Discharge Team, In-patient Medical, Nursing and Therapy staff, Modern Matrons, Patient Flow Group (reporting to Urgent Care Partnership), Professional Practice.
Equality analysis checklist completed	Yes
References/sources of information	• Department of Health (2003) – Discharge from hospital: pathway, process & practice • Department of Health (2004) – Achieving timely 'simple' discharge from hospital • University College Hospital (2005) – Hospital Discharge policy • Department of Health (2006) – Hospital admission and

	discharge: people who are homeless or living in temporary or insecure accommodation. • Department of Health (Mar 2010) Ready to go. Planning the discharge and the transfer of patients from hospital and intermediate care. • Plymouth Hospitals NHS Trust Policy for the Admission, Transfer & Discharge of the Infected Patient (See Intranet for latest version) • Livewell Southwest Infection Prevention and Control Policy (See Intranet for latest version) • National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care; Nov 2012 (Revised Guidance) • National Assistance Act 1948 (Choice of Accommodation) Directions 1992, LAC(92)27 • Guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1992, LAC (2004)20 • The Community Care (Delayed Discharges etc.) Act 2003: Guidance for Implementation (para 52) • The Community Care (Delayed Discharges etc.) Act 2003: Guidance for Implementation (para 100) • The Mental Capacity Act 2005; Code of Practice • Adult protection / Safeguarding Adults Multi Agency Policy and Procedure (See Intranet for latest version) • Deprivation of Liberty Safeguards Guidance • Continuing Healthcare NHS Disputes Resolution Procedure **NHS Northern, Eastern & Western Devon and Plymouth City Council** (See Intranet for latest version) • The Care Act, 2014
Associated documentation	N/A
Supersedes document	All previous versions.
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New format – updating	6th November 2008	Deputy Director of Nursing	Modified to policy framework to reflect PCT needs
0.2	Updated	29th January 2009	Deputy Director of Nursing	Updated to include pathway/checklist
0.3	updated	15th May	Deputy Director of Nursing	Updated to include discharge summary
0.4	Updated	22.6.09	Deputy Director of Nursing	Updated to include pharmacy additions
1	Updated	02.06.10	Assistant Director of Community and Rehab	Updated to include new DoH guidance and PHNT patient information leaflet
1:1	Reviewed	26/07/12	PRG	Review date extended, no other changes made.
1.2	Extended	March 2013	D Slater	Extended, no other changes.
1.3	Extended	September 2013	K Elgood	Extended, no other changes.
1.4	Extended	April 2014	K Elgood	Extended, no other changes.
1.5	Updated	August 2014	S Pearce	
1.6	Extended	March 2015	Interim Locality Manager	Extended, no other changes.
1.7	Full review	July 2015	S Pearce, S Goodman, R Burns, N Johnson	Full rewrite
2	Ratified	September 2015	Policy Ratification Group	Ratified
2.1	Updated	20/07/2016	SystmOne Helpdesk	Addition to Appendix B - Consultant/GP to reflect the SHWD Hospitals who only have GP's.

Discharge and Transfer of Patients from Hospital Policy

1 Introduction

1.1 This policy sets out agreed operational procedures and standards for the discharge and transfer of patients from hospital.

1.2 Discharge planning is a patient centred process that requires the collective contributions of various agencies and professional disciplines. It should be a planned, coordinated and systematic process with effective communication throughout. Individuals concerned and their carer(s) should be involved at all stages and regular reviews and updates should take place to keep them fully informed.

2 Purpose

2.1 This policy aims to ensure that all agencies involved in the provision of health and social care of patients transferring from hospital work together to deliver an effective, timely and well-co-ordinated transfer of patients from hospital, which meets the needs of patients, carers and families and all National/Local Frameworks and Legislation, e.g. Care Act, NHS Framework for CHC.

2.2 Appropriate and timely discharge planning will promote efficient patient flow within the hospital setting, to reduce the risks to patients of hospital admission and ensure that hospital facilities are used appropriately.

3 Definitions

- IHDT: Integrated Hospital Discharge Team
- MDT: Multi-Disciplinary Team
- DToC: Delayed Transfers of Care
- SITREP: Situation Reporting
- EOL: End-of life
- EDD: Estimated date of discharge
- IMCA: Independent Mental Capacity Advocate
- LA: Local Authority
- CCG: Clinical Commissioning Group
- SW: Social worker or Community Care Worker Adult Services

4 Duties and Responsibilities

4.1 The **Board and Senior Management Team** of each organisation will ensure that appropriate management arrangements are in place and monitored to comply with the requirements of this policy.

4.2 **The IHDT Operational Lead, Modern Matrons, Advanced Practitioners and Clinical Team Leaders** will ensure that all clinical and non-clinical staff understand their roles and responsibilities with respect to patient discharge and patient flow throughout the organisation – this includes assessment of patient need, negotiation of appropriate onward care services, communication with the patient and carers onward care services and provision of appropriate services, equipment and supplies for discharge.

5 Delayed Transfers of Care

5.1 A delayed transfer of care occurs when a patient is ready for transfer from NHS care, but is still occupying a bed designated for such care. A patient is ready for transfer when:

- A clinical decision has been made that patient is ready for transfer **and**
- A multi-disciplinary team decision has been made that patient is ready for transfer **and**
- The patient is safe to discharge/transfer.

6 Situation Reporting (SITREP)

6.1 SITREP returns are required on a weekly basis. Organisations need to monitor the following:

- Number of delayed transfers of care, on Thursday of the reporting period, by name of Local Authority
- Number of patients whose discharge is delayed
- Number of delayed days during the week
- Agency responsible for the delay (NHS, social services, or both)
- Reason for delay using STEIS (Strategic Executive Information System) codes (Appendix A)

6.2 Local arrangements to be in place to agree reasons for delay across organisations.

7 Principles of Discharge Planning

7.1 Planning for a patient's discharge will commence on or before a patient's admission. It will be an on-going process that will involve the patient and the carer as well as the multidisciplinary team.

7.2 Individuals and their carer(s) will be actively involved in the planning of discharge and be central to plans, assessment processes and decisions.

Individuals and their carer(s) will receive advice and information to enable them to make informed decisions about their future care.

7.3 Individuals will be encouraged to organise their onward transport home from hospital by the MDT.

7.4 When the patient is a child, all discharge planning will be undertaken in partnership with the child and parent or carer/legal guardian.

7.5 The multi-disciplinary clinical team will review all patients and set estimated date of discharge (EDD) on admission and confirm at 1st MDT Meeting following admission. The EDD should be recorded on electronic patient information system and in the Patient record.

7.6 The Mental Capacity Act:

- It is recognised that most patients have the capacity to participate in making choices relating to planning their discharge from hospital.

- If the patient appears to be unable to make choices regarding discharge, despite efforts to help them communicate their wishes, the MDT will consult advocates, e.g. family or an Independent Mental Capacity Advocate (IMCA), in line with the Mental Capacity Act (2005), and make a Best Interest Decision as appropriate.

- Staff will be mindful of the obligation to seek the least restrictive option for the patient's discharge and should follow their Organisation's policies and procedures relating to Mental Capacity, Best Interest and Deprivation of Liberty Safeguards.

7.7 Detained Patients:

Patients detained under the Mental Health Act 1983 (amended in 2007) receiving care in the acute general hospital setting should be transferred to a mental health unit when their physical health permits safe transfer. This must be done in collaboration between the acute and mental health services, under the direction of the Responsible clinician. All statutory paper work needs to be completed in line with the Mental Health Act Code of Practice (DOH, 2008).

7.8 For adult patients receiving care from the Learning Disabilities Service admitted to General Services in PHT the Acute Services Learning Disability Unit should be made aware of admission and involved in the early planning for discharge.

7.9 Discharge planning staff should interrogate systems to ascertain if patients are known to community services as part of discharge planning and involve the community teams in this.

7.10 Rehabilitation and interim services should be considered before a decision is made to transfer to a long term placement.

7.11 An agreement will be made, and recorded in the patient record, that the individual is ready for discharge, following the criteria outlined in section 5.1.

7.12 All wards and departments will ensure that a discharge checklist is complete, with a clear signature (may be electronic) and date of completion, **prior to the patient leaving the ward** /department. This checklist will be kept in the patient record. Each Organisation will have their own checklist either in paper or electronic format.

7.13 Delays in discharge will be monitored daily by the Unit/Ward Manager or Deputy, and the IHDT. A formal validation of delays will be undertaken between PHT, LSW and Social Services weekly in line with the community care (Delayed Discharges Act 2003) and Department of Health SITREP guidance. Actions will be agreed between agencies to address any delays in discharge; these will be monitored daily by Matrons, Ward Managers and the IHDT.

8 Safe and Effective Discharge

8.1 In order to ensure safe and timely discharge, the following standards must be adhered to in the discharge planning process:

- A full assessment of individual needs will inform the discharge plan. Where indicated this will include an initial screening against criteria for NHS funded Continuing Healthcare.

- Planned discharges from the wards will aim to be completed by 13:00 hours in most cases.

- Written information will be given to patients on discharge, to include a copy of discharge summary, customer plan, medication, and any other relevant information (each organisation will have documents in paper or electronic format).

- It is the IHDT and the MDT responsibility to ensure that full communication regarding the patient's discharge and ongoing referral to relevant agencies, services and individuals has been made and recorded.

- Referrals to community services should be made by the ward team using identified referral pathways.

- Whilst it is acknowledged that discharge planning is a multidisciplinary activity, it

is the responsibility of the Registered Nurse at ward level who is discharging the patient to ensure that all arrangements are in place on the day of discharge, before the patient leaves the ward. Completion of the checklist on day of discharge is essential (see 7.11).

- Ward pharmacists, with the assistance of Pharmacy Technicians will (where available) assess patients' medication needs during their inpatient stay and plan for discharge medication. The ward pharmacist will screen TTAs and authorise on day of discharge.

- If the patient was in receipt of a medical homecare package prior to admission e.g. medicines delivery and/or administration, home oxygen therapy, the ward nurse should liaise with the community pharmacist and/or GP about re-establishing the homecare service at least 48 hours prior to planned discharge date.

- The medical team must ensure that discharge medicines (TTAs) are prescribed at least 24 hours prior to discharge (i.e. before 12 noon the day prior to discharge). TTA's for compliance aids must be written by 12 noon, a minimum of 48 hours prior to discharge, and be accompanied by a completed compliance aid request form (Appendix 7).

- As part of discharge planning medications are discussed in detail with the patient, relative or carer by the Registered Nurse.

- Patients requiring administration of medicines by community teams should have this medication prescribed on a Community prescription card, which should be sent home with the patient's medication.

- If the patient is employed they may require a sickness certificate. A MED10 certificate stating that the patient has been an inpatient can be completed by nursing staff. The MED3 certificate must be completed by a member of the medical/surgical team if the patient will require time off work following their hospital admission.

- A copy of the patients' ward discharge summary must be sent to the GP within 24 hours for all patients. (This may be electronically sent or faxed, depending on discharging ward systems). If the patient is discharged at the weekend or a bank holiday, notification must be given to the G.P. on the next available working day.

- Where a patient has commenced oral anticoagulation or had oral anticoagulation medication changed during their hospital stay the **"**Oral Anticoagulant Discharge Information Provider Services Wards / Units" form must be completed by the ward doctor and faxed to the GP as per fax policy.

- A copy of the discharge summary and/or care plan should be given to all relevant community services involved in patient's onward care.

- Where there is a Treatment Escalation Plan and/or Do Not Attempt Resuscitation order agreed for a patient, the original needs to be sent with the patient; a copy is kept in patient record.

9 End-of life (EOL) care on discharge

9.1 It is the MDT responsibility to identify patients entering the terminal phase and refer to the IHDT (for Derriford site).

9.2 Patients requiring packages of care or placement should be referred to the End of Life (Pearn) Coordination centre by the IHDT or ward team.

9.3 All standards outlined in section 8 apply to EOL discharges.

10 Discharge/transfer to another hospital/ care setting

10.1 Where patients are transferred to another NHS provider or to a Care Home or Private hospital, the following arrangements are needed:

- Best practice is to ensure that discharge is within normal working hours (9-5) to enable medical staff and medication to be readily available and for a patient to be orientated to their surroundings before staffing levels reduce at night.
- Standards set out in section 6 to be adhered to.
- The Registered Nurse on the ward should discuss the patient's needs with relevant staff of the care setting e.g. Registered Nurse, Matron. It is now a Care Quality Commission requirement and best practice for care homes to assess the patient's suitability for their care setting. (Exceptions to this are step-down and discharge to assess beds).

11 Transfer of Infected Patients to another care setting

11.1 It is the responsibility of the ward/unit staff to inform the new care setting and ambulance/transport staff of the patient's infection status and the medical staff to inform the receiving doctors, General Practitioners and community teams if appropriate. This should include actual and potential risks of infections and any clinical practice required to control or prevent infection.

11.2 Specific care required should be recorded on the discharge summary.

12 Self Discharge

12.1 If a patient who has mental capacity to make a decision on future care wishes to

leave hospital despite explanation and encouragement from the clinical team, family, carers etc. then they should be allowed to leave; such a discharge still should be made as safe as possible.

12.2 As part of self-discharge ensure the following actions taken are recorded:

- Discuss the recommended course of treatment and available alternatives;
- Go over the specific risks of that patient refusing treatment;
- Ask the patient to explain their diagnosis;
- Have the patient describe the consequences to them of leaving AMA;
- Evaluate the patient's rationale for leaving AMA;
- Discuss follow-up care and the patient's option to return to the ED;
- Notify the patient's primary physician and their family or friend;
- Document the discussion in the medical record.

12.3 Having discussed the above, if the patient still insists on leaving, he/she should be asked to sign a “Discharge Against Advice” form (See Appendix B). In addition, the health care professional present should also document the patient’s decision and action in the patient record.

12.4 The patient and ward should be advised to contact their G.P. practice as they may need services or treatment in the community. The doctor should contact the G.P. by phone if they have any immediate concerns.

12.5 The Registered Nurse on the ward should contact Health and Social Care Services within the community where a patient taking self-discharge has identified continuing needs.

12.6 Unless there is an expressed recorded decision, the registered nurse should contact the patient’s family or next-of-kin to advise that the patient is taking self-discharge and that this is against medical/MDT advice. No details of the patient’s clinical condition should be disclosed – merely notification that they are no longer in hospital. A record of this communication should be made in the patient record.

13 Discharge of those who are Homeless or with Insecure Accommodation

13.1 This includes those patients whose lifestyle involves rough sleeping, those living in hostels, night shelters or in temporary bed & breakfast accommodation.

13.2 All patients who are homeless or with insecure accommodation should be referred to the homeless team.

13.3 Ward staff should be aware that those who live in hostels or night shelters may lose their place in the establishment if they do not report in on a daily basis –

therefore contact with the hostel or shelter within 12 hours of admission is important, to notify that the person is in hospital.

13.4 Referral to Plymouth City Council Homeless team will be necessary for liaison with hostel or shelter staff, contact with outreach providers and where appropriate application for housing assistance.

14 Direction on Choice of Accommodation and Reluctant Discharge Process

14.1 This framework is relevant to all inpatients who are required to choose a destination and/or care provider on discharge from hospital. The process applies equally to all patients irrespective of funding arrangements for on-going care. (The formal stages of 4 and 5 apply to those patients where appropriate choices have been refused).

14.2 This process ensures that Choice is manage fairly throughout the discharge planning process, and that the process is a continuum across organisations to reduce the length of super spells. This requires consistent and timely MDT intervention across all bed based settings. Where choice has become a barrier to discharge and appropriate options have been refused, the organisations will follow the formal stages 4 and 5.

14.3 The Choice process ensures that:

- Hospital beds will be used appropriately and efficiently for those requiring bed based care.
- When patients no longer need bed based care they will not remain in hospital if the preferred options are unavailable.
- Planning for effective transfer of care, in collaboration with the patient, their representatives and all members so the MDT will begin at or before admission but no later than 24 hours after admission.
- The process for offering choice of care provider and/or discharge destination will be followed in a fair and consistent way throughout the acute and community provider. The will be an audit trail of choices offered to the patient.
- Where a patient is unable to express a preference, an advocate will be consulted on their behalf.

14.4 Managing Choice:

The consequences of a patient who is ready for discharge remaining in a hospital bed are that:

- The patient is exposed to an unnecessary risk of hospital-acquired infection.
- Frustration and distress may be caused to patients and/or their relatives

whilst waiting for a preferred discharge destination to become available.

- The needs of the person can be more appropriately met in a lower-acuity setting, including a non-hospital environment.
- Decreased level of patient independence, as a bed based environment is not designed to meet the needs of people who are medically well.
- Increased pressure within the Health care system due to the unnecessary use of hospital beds.

14.5 The organisation will acknowledge and offer support with any concerns, whether financial or otherwise, whilst reinforcing the message that each member of the MDT will work towards discharge, at the end of the period of care, to a safe destination. This destination may not be the patient's preferred destination of choice. At the point at which a patient is ready for discharge or transfer of care as decided by the MDT they cannot continue to occupy a hospital bed.

14.6 If the patient preferred choice is not available they will be required to accept an alternative location or care provider whilst they await availability of their preferred choice.

14.7 People who are self-funding their care will be provided with the same advice, guidance and assistance on choice as those fully or partly funded by the Local Authority. If such patients decline to accept advice, guidance and assistance, a risk assessment will be completed and arrangements will be made for their onward care on discharge from hospital. Once a patient is clinically fit for transfer to their usual place of residence of a less acute setting they will be subject to the Choice process.

14.8 Where people make an interim move into a care home, their case will be transferred to a Locality Team to review the interim placement and where possible support a move to the preferred choice care home. If a patient indicates he/she would prefer to stay in the interim care home, either when offered a place in one of the preferred care homes originally chosen or during the waiting process, this can be agreed at the point of review of the Interim placement.

14.9 The MDT must ensure that discussion between the patient and their representatives has been undertaken prior to initiating the Choice process. Emphasis should be placed on accessing available support, clarification of the process and the possible need to transfer to an interim placement if the preferred option is not available.

The problem remains we are aware of support services that are available but barriers remain e.g. funding disagreements/process of accessing support.

15 The Choice Process (described in Appendix C)

15.1 Stages 1 to 3 apply to every patient in order to provide support and prevent the

need for further escalation.

15.2 **Stage 1** – Provision of information to patient

As part of discharge planning, once the patient pathway is agreed and the patient is medically well the 'You are ready to leave hospital – what happens now?" patient information letter is issued by the ward staff and documented in the patient record (Appendix D).

15.3 **Stage 2** – Daily patient review

If barriers are identified to effective discharge planning, a case conference will be arranged by the ward, led by the senior Nurse to include the patient and their representative within 5 working days. The Choice Process will be clearly explained within this case conference. The case conference will clarify the expectations of the patient, family or carer with regards to discharge planning and a further 5 working days will be afforded to engage in the process and prepare for discharge.

The decision should be documented in the medical notes and a reminder for the stage 2 letter to be issued after the next MDT.

If appropriate care arrangements are unavailable due to a lack of vacancies in health or social care organisations, the MDT will discuss with the patient and give the stage 2 letter.

If the offered care arrangements are declined, the MDT will arrange a meeting within 3 working days to explore the reasons.

At this meeting the patient will be given another 3 working days to arrange an alternative (Appendix E and F).

15.4 **Stage 3 –** Preparing for discharge to include;

Identification of onward care options, identification of two or more appropriate and available discharge destinations, provision of any outstanding documentation. The destination(s) may not always be the patient or representative's preference (Appendix G and H).

15.5 **Stages 4 and 5**- represent the Formal Choice process:

Stage 4 –Formal letters; A Transfer of Care letter is sent to the family, carer or patient within 48 hours of failure to comply with the agreed timescales as outlined within stage 2. A list of available onward care options are provided and a request to provide the ward with a decision of 2 options within 10 days. The letter will be prepared and signed by the Integrated Hospital Team Operational

Manager, Locality Manager or Deputy Service Line Manager (Appendix I and J).

15.6 **Stage 5 –** Formal planned discharge process; If after 10 days there has been no information regarding discharge provided by the patient/ family/carer, a second letter will be issued with either the name of an available care home or care provider that is able to meet the patient's care needs and a confirmed date for discharge. The patient will be discharged in accordance with this letter. The letter will be signed by the Director of Operations or Chief Operating Officer.

16 Training Implications

16.1 Training will be completed as part of local induction on this policy by the senior nurse.

17 Monitoring Compliance and Effectiveness

17.1 The discharge process and this policy will be monitored, audited and compared with Local and National standards – through the Patient Flow meeting (sub group of the Urgent Care Partnership.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 1st December 2015

Appendix A STEIS Codes

Description	
NMF. Not Medically Fit	
A. Awaiting Completion of Assessment	
A1. Awaiting Social Services Assessment (after section 2)	Social
A2. Awaiting Social Services Completion of Assessment (after section 2)	Social
A3. Awaiting OT Assessment	Could be either - to check
A4. Awaiting Physio Assessment	Health
A5. Awaiting Discharge Assessment by Nurse / Facilitator in Hospital **(HEALTH)**	Health
A6. Awaiting Community Care Coordinator **(HEALTH)**	Health
A7i. Awaiting CPN (Over 65)	Health
A7ii. Awaiting CPN (under 65)	Health
A8. Awaiting Consultant Psychiatrist	Health
A9. Awaiting Rehab Clinician	Health
A10. Awaiting Nurse Specialist **(HEALTH)**	Health
A11i. Awaiting PLN (Over 65)	Health
A11ii. Awaiting PLN (Under 65)	Health
A12. Other - Specify **(Joint Health and Social assessment)**	Joint
B. Awaiting Public Funding	
B1. Awaiting Domiciliary Care Package **(Social following section 5)**	Social
B2. Awaiting Nursing Home Funding **(Social following section 5)**	Social
B3. Awaiting Residential Home Funding **(Social following section 5)**	Social
B4. Awaiting Domiciliary Care Package **(Health)**	Health
B5. Awaiting Nursing Home Funding **(Health)**	Health
B6. Awaiting Residential Home Funding **(Health)**	Health
B7. Awaiting NHS Funded Continuing Healthcare	Health
B8. Other - Specify (following section 5)	Social
C. Awaiting Further (non -acute) NHS Care (inc Intermediate Care, Rehab Services etc)	
C1. Awaiting Community Hospital	Health
C2. Awaiting Hospice Bed	Health
C3. Awaiting Inpatient Rehab	Health
C4. Awaiting Specialist Inpatient Rehab	Health
C5. Awaiting Reablement	Joint
C6. Awaiting Intermediate Dom Care	Joint
C7. Awaiting Interim Care	Joint
C8. Awaiting Intermediate Care	Joint
C9. Awaiting Palliative Care in Community	Health
C10. Awaiting Fully Funded NHS Care	Health
C11. Awaiting Acute NHS Facility	Health
C12. Awaiting Mental Health NHS Facility	Health
C13. Awaiting Specialist Facility	Health
C14. Other - Specify	
Di. Awaiting Residential Home Placement or availability	

Dii. Awaiting Nursing Home Placement or availability	
D1a Awaiting General Residential **(HEALTH)**	Health
D1b Awaiting General Residential **(SOCIAL)**	Social
D2. Awaiting Mental Health Residential	Social
D3. Awaiting Mental Health Nursing	Health
D4. Awaiting General Nursing	Health
D5. Other - Specify	
E. Awaiting Care Package in own Home	
E1. Awaiting Care Package Provision in own Home (after section 5)	Social
E2. Other - Specify **(HEALTH Package of care)**	Health
F. Awaiting Community Equipment or Adaptations	
F1. Awaiting Equipment **(Social following section 5)**	Social
F2. Awaiting Adaptations **(Social following section 5)**	Social
F3. Other - Specify **(Health Equipment)**	Health
G. Patient or Family Choice	
G1a Awaiting General Residential Home of Choice **(Health)**	Health
G1b. Awaiting General Residential Home of Choice **(Social)**	Social
G2. Awaiting Mental Health Residential Home of Choice	Social
G3. Awaiting Mental Health Nursing Home of Choice	Health
G4. Awaiting General Nursing Home of Choice	Health
G5a. Awaiting Family Action **(Health)**	Health
G5b. Awaiting Family Action **(Social)**	Social
G6a. Awaiting Care home Action **(Health)**	Health
G6b. Awaiting Care home Action **(Social)**	Social
G7 IMCA	Could be either - to check
H. Disputes	
H1. Disputes Whether Ready for Discharge	
H2. Disputes over Appropriateness of Care Package	
I. Housing	
I1. Patients Not Covered by NHS and Community Care Act	

Appendix B
Discharge against Advice

Patient's Name:	
Hospital No:	
Date of Birth:	
NHS No.	
Consultant/GP:	
Named Nurse/Keyworker:	
Date:	

This is to confirm I am leaving this Hospital at my own request, at my own risk and on my own responsibility and against the advice of the Clinical Team.

Signed: (Patient)	
Address:	
Date:	

Signed: (Staff Member)	
Designation:	
Date:	

To be filed in Patient record.

Copy sent to:	

Appendix C: Discharge and Choice Process

Stage 1: Provision of information

- You should have been given your Estimated Date of Discharge within 24 hours of admission and confirmed at the MDT meeting.
- A multi-disciplinary team meeting on the ward agrees the date at which you no longer need to stay in a hospital bed.
- We will then discuss this with you and offer an appropriate future care plan to meet your assessed onward care needs as quickly as possible.(Appendix D)

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Stage 2: Daily review

- If your appropriate care arrangements are unavailable due to a lack of vacancies in health or social care organisations, we will discuss and give you a letter explaining this.(Appendix E)
- If you decline the offered care arrangements, we will arrange to meet with you within 3 working days to explore your reasons.
- At this meeting you will be given another 3 working days to arrange an alternative.

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Stage 3: Prepare for discharge

- Alternative discharge arrangements are agreed with you (this may not be your preferred choice)
- Your discharge is arranged
- Where an agreement cannot be reached, the formal Stage 4 and 5 process will commence.

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Stage 4: Formal Letters

- If you cannot arrange an alternative within the timescales identified in Stage 3, you will be given a Stage 4 choice letter with a list of vacancies
- You will be asked to choose 2 options from this list and inform us of your decision within 5 days so we can arrange your discharge

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Stage 5: Formal planned discharge

- If after 3 days you have not provided us with any information regarding discharge, we will give you a final letter 'Formal stage 5' providing the name of an available care home or provider that is able to meet your needs with a confirmed date for discharge.
- We will plan to discharge you as described in this letter.

Appendix D: Stage 1 letter

Insert letter head – organisational logo etc.

Date: ……

Choice Letter (Stage 1)

Dear ……..

Your Ward Sister / Charge Nurse is: …….

"You Are Ready to Leave Hospital – What Happens Now?"

During your time in hospital your Care Team has made regular assessments of your abilities and needs. We have assessed the help and support you need now with you and have decided you are medically fit to leave the acute hospital.

Now you are at this stage, there are good reasons why you shouldn't stay in hospital:

- A hospital ward is not the best place to continue your recovery once your acute illness/ treatment is over
- Staying in hospital too long can make you lose confidence
- Staying in hospital may increase your risk of acquiring an infection
- Other people are in need of this acute bed, we have a responsibility to make sure beds are vacated promptly to free them up for other sick patients.

What happens next?

Your team will work with you and/or your family to find an appropriate on going care depending on your needs **[Care Package at Home Agency, Residential Home / Nursing Home, Community Hospital]** that has a vacancy.

We will make every effort to meet your preferences, according to your needs, in your next steps along the discharge pathway.
Options are:

- If you are waiting for a package of care to support you at home and we cannot identify an agency to support you within 3 days, we will ask you to move to a paid for care home to wait for the package of care to become available.
- If you are waiting for a Residential or Nursing Care Home, and the chosen Care Home has no vacancy within 3 days, or the choice becomes a longer process as planned, you will be asked to move to a suitable alternative until your first choice becomes available or you can decide on your final choice.
- If you need a Community Hospital for rehabilitation, we will transfer you to the first available bed, in order to maximise your therapy and rehabilitation

opportunities. If this is not in your local Community Hospital, it is possible for you to move to the next available bed nearer to your home when a bed becomes available.

Support will be available throughout the discharge process and you should speak to me if you have any questions or concerns. Most people are able to move once the team have agreed you are medically fit. There may be disagreements about the timing of transfer or the care required and we will work with you to resolve these.
We are all here to help and recognise that discharge from hospital can be a difficult and stressful time for patients, families and carers.

Yours sincerely,

Add in Authorised Signatory and Consultant

Appendix E: Stage 2 Letter (Package of Care)

Insert letter head – organisational logo etc.

Date: ……

Choice Letter (Stage 2) Package of Care

Dear ……..

Your Ward Sister / Charge Nurse is: …….

Your Discharge Key Worker is: ……

You have been a patient hospital since …../…../……. and we are pleased that you are now ready to leave the hospital. We have completed all the assessments and have agreed with you (and your family) that your care needs can be best met with a supportive **[Local Adult Social Care / National Health Service]** funded Package of Care back at home.

We have not forgotten about you but unfortunately we have not yet been able to find an agency to provide a Package of Care that can meet your needs. We are continuing to check for availability every day and will tell you as soon as an agency is available.

We appreciate that this is a difficult time for you and we recognise your needs no longer require a hospital bed. Therefore, the medical team and discharge key worker have agreed with you (and your family) that it is in your best interests to move to a temporary Care Home placement where you can be in a more settled environment, awaiting the Package of Care to come available. This will be a <u>temporary arrangement only</u> and will be funded by the National Health Service - there will be no charge to you or your family.

We will now give you a choice of two available Care Homes and would like you tell us your preference as soon as possible, to arrange your move within the next 3 days.

Care Home Name	Care Home Address and Contact Number

We would like to proceed with the move as soon as possible and ask you for you cooperation.

We are happy to discuss any concerns you have.

Yours Sincerely

Insert Authorised Signatory and Consultant Signatures

Appendix F: Stage 2 Letter (Placement)

Insert letter head and Organisation logo

Choice letter (Stage 2) Care Home (NHS/Social Care funded)

Date: ……..

Dear: ……

Your Ward Sister / Charge Nurse is: ……

Your Discharge Key Worker is: ……

You have been a patient hospital since …../…../……. and we are pleased that you are now ready to leave the hospital. We have completed all the assessments and have agreed with you (and your family) that your care needs can be best met in a **[Residential Care / Nursing Care]** Home.

We have not forgotten about you but unfortunately we have not yet been able to find a Care Home of your choice, with a vacancy that can meet your needs. We are continuing to check for availability every day and will tell you as soon as the Care Home is available.

We appreciate that this is a difficult time for you and we recognise your needs no longer require a hospital bed. Therefore, the medical team and discharge key worker have agreed with you (and your family) that it is in your best interests to move to a temporary Care Home placement where you can be in a more settled environment, awaiting your chosen permanent Care Home to come available. This will be a <u>temporary arrangement only</u> and will be funded by the National Health Service - there will be no charge to you or your family. We would like to proceed with the move as soon as possible and ask you for you cooperation.
Who checks provider availability? Clinical staff or depending on funder? SW/CHC

We are happy to discuss any concerns you have.

Yours Sincerely

Insert Authorised Signatory and Consultant Signatures

Appendix G: Stage 3 Letter (Care Home)

Insert letter head and Organisation logo

Choice Letter Stage 3 Care Home

Date: ……..

Dear: ……..

Your Ward Sister/ Charge Nurse is: ……

Your Discharge Key Worker is: ……

You have now been a patient in Hospital since …../…../……. and we are pleased that you are ready to leave. We have completed all the assessments and have agreed with you (and your family) that your care needs can be best met in a Care Home.
On …../…../……. you were awarded **[Social Services / National Health Service]** funding and we immediately asked you to identify a suitable Care Home and gave you information regarding the homes which will accept the awarded funding. Unfortunately as yet, you have not told us your decision, so we attach a list of homes with current vacancies. Please be aware that these vacancies may change due to demand for beds. We ask you to identify at least 2 homes from this list as soon as possible, so that the home can make an assessment of you in order for you to move from hospital quickly.

On the (date of stage 2 letter) …../…../……. we wrote to you stating that while you are still waiting for your chosen Care Home to become available, we wanted you to move to a temporary Care Home, at no cost to you or your family. However, you have as yet not agreed to this move and we kindly ask you again to accept our offer and let us move you to the identified care home within the next 3 days. We believe this option is in your best interest, as by remaining in the hospital is not good for your longer-term health and well-being. Moreover, we have an urgent need to move patients through the hospital and make beds available for those more medically unwell than you.

We are happy to discuss any concerns you have but please be aware if you decline the move during the time frame stated above, we will have to take further action. Please address any questions or concerns you may have with your Ward Sister/Charge Nurse in the first instance.

Yours Sincerely

Insert Authorised Signatory and Consultant Signatures

Appendix H: Stage 3 Letter (Package of Care)

Insert letter head and Organisation logo

Date:……..

Choice Letter Stage 3 Package of Care

Dear: ……..

Your ward Sister/ Charge Nurse is: ……

Your discharge key worker is: ……

You have now been a patient in Hospital since (date)……. and we are pleased that you are now ready to leave the acute hospital. We have completed all the assessments and agreed that your care needs can be best met with care support at home, with a package of care.

On the (date of stage 2 letter) …../…../……. we wrote to you stating that while you are still waiting for your Package of Care to become available, we wanted you to move to a temporary Care Home, at no cost to you or your family. However, you have as yet not agreed to this move and we kindly ask you again to accept our offer and let us move you to the identified care home within the next 3 days. We believe this option is in your best interest, as by remaining in the hospital is not good for your longer-term health and well-being. Moreover, we have an urgent need to move patients through the hospital and make beds available for those more medically unwell than you.

We are happy to discuss any concerns you have but please be aware if you decline the move during the time frame stated above, we will have to take further action. Please address any questions or concerns you may have with your Ward Sister/Charge Nurse in the first instance.

Yours Sincerely

Insert Authorised Signatory and Consultant Signatures

Appendix I: Stage 4 Letter (Package of Care)

Insert letter head and Organisation logo
Date:……..

Choice Letter Stage 4 Package of Care

Dear: ……..

Your ward sister is: ……

Your discharge key worker is: ……

You have been a patient in hospital since …../…../……. and you have been medically fit to leave the hospital since …../…../…….

We have asked you in the Choice Letter Stage 2 and Choice Letter Stage 3 to wait for the availability for a Package of Care at home, in a Care Home we have asked you to choose form that will be paid for by the National Health Service.

It has been agreed by the medical team, your discharge key worker and discussed with you that this option is in your best interest, as by remaining in the hospital is not good for your longer-term health and well-being. Moreover, we have an urgent need to move patients through the hospital and make beds available for those more medically unwell than you.

However, to date you still have not agreed to the move and we are asking you again, to please understand and let us move you to one of the two chosen care homes as soon as you can.

Care Home Name	Care Home Address and Contact Number

If, within the next 5 days we have still not confirmed an agency for your Package of Care at home, we will give you a final letter providing you with the name and address of an available Care Home that can meet your needs and your date for discharge from the hospital.

If you wish to discuss this further please contact your ward Sister/ Charge Nurse in the first instance.

Yours Sincerely
Insert Authorised Signatory and Consultant Signatures

Appendix J: Stage 4 Letter (Placement)
Insert letter head and Organisation logo
Date:……..

Choice Letter Stage 4 – Care Home

Dear: ……..

Your ward sister is: ……

Your discharge key worker is: ……

You have been a patient in Hospital since …../…../……. and you have been medically fit to leave the acute setting since …../…../…….
Unfortunately, we / you have still not been able to identify a suitable Care Home of your choice that can meet your needs. We continue to check for availability every day and we will tell you as soon as one is available.

We have asked you earlier in Choice Letters Stage 2 and Choice Letter Stage 3 to reside in a Care Home we have chosen until the Care Home of your choice becomes available. This temporary arrangement will be paid for by the National Health Service.

It has been agreed by the medical team, your discharge key worker and discussed with you that this option is in your best interest, as by remaining in the hospital is not good for your longer-term health and well-being. Moreover, we have an urgent need to move patients through the hospital and make beds available for those more medically unwell than you.

However, to date you still have not agreed to the move and we are asking you again, to please understand the situation and let us move you to one of these two Care Homes as soon as possible, we need to arrange your discharge:

Care Home Name	Care Home Address and Contact Number

If, within the next 5 working days we have still not confirmed a Care Home for you or you have not provide us with any information regarding your discharge, we will give you a final letter providing you with the name and address of an available Care Home that can meet your needs and your date for discharge from the hospital.

If you wish to discuss this further please contact your Ward Sister/Charge Nurse, in the first instance.
Yours Sincerely
Insert Authorised Signatory and Consultant Signatures

Appendix K: Stage 5 Letter

Insert letter head and Organisation logo
Date:……..

Choice Formal Letter Stage 5

Dear: ……..

Your ward Sister/ Charge Nurse is: ……..

Your Discharge Key Worker is: ……

You have been a patient in hospital since …../…../……. your treatment has been completed and you have been medically fit to leave the acute setting since …../…../…….

We have asked you in the Choice Letter Stage 2, Choice Letter Stage 3 and Choice Letter Stage 4 to wait in a Care Home we have chosen, until the Care Home of your choice becomes available. We have said this temporary arrangement will be paid for by the National Health Service. However, to date you still have not agreed to move.

The Organisation will now arrange for you to transfer to:

Care Home Name	Care Home Address and Contact Number

Your date of discharge will be …../…../……. unless you have made private arrangements within this time.

All members of the ward team are available to answer any questions you may have. Alternatively, if you would like to discuss this decision with a Senior Manager, please do not hesitate to get your Ward Sister/Charge Nurse to contact me I will arrange for a Senior Manager to meet with you.

Yours sincerely

Director of Operations or Chief Operating Officer

Appendix L:

Staff distribution signature sheet for approved & ratified LSW policies and procedural documents

Training requirements must be communicated to staff on dissemination.

Name of Policy:

Policy No:

Statement: I have read the above approved and ratified document and understand its contents. If there are any difficulties regarding implementation or any training needs, I have raised and resolved these with my line manager.

I agree to implement the content of the above approved and ratified document.

Staff Name (please print)	Signature	Date

On completion of this record, this sheet will be kept by the line manager and become part of the training record.