St George's Healthcare NHS
NHS Trust

Discharge of patients from

St George's Healthcare NHS Trust

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences and the results are shown in Appendix I

Policy Profile			
Policy Reference:	Clin.5.3 (Pat. 7)		
Version:	5.3		
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Executive sponsor:	Alison Robertson, Chief Nurse & Director of Operations		
Executive sponsor sign off:	July 2013		
Target audience:	All Trust staff		
Date issued:	24 July 2013		
Review date:	16 August 2015		
Consultation			
Key individuals and committees consulted during drafting	Service Manager Bed/Site Management,	**Dates**	July/Aug 2012
	Paediatric Nurse Consultant Leads for individual services.	**Dates**	July 2012
	Divisional Director of Nursing & Governance, Community	**Dates**	July/Aug 2012
	Risk Assurance Manager		Aug 2012
	Interim Corporate Risk & Assurance Manager		June/July 2012
	EMT and Cross divisional meeting		June/July 2013
Ratification			
Ratification Committee:	Policy Ratification Group (Chair's action)		
Date:	23 July 2013		

Document History			
Version	**Date**	**Review date**	**Reason for change**
5.1	12th Sept 2011	12th September 2014	Policy ratified
5.2	16 August 2012	16 August 2015	Policy amended in light of new NHSLA manual. Policy ratified
5.3	24 July 2013	16 August 2015	Inclusion of follow up process for test results.

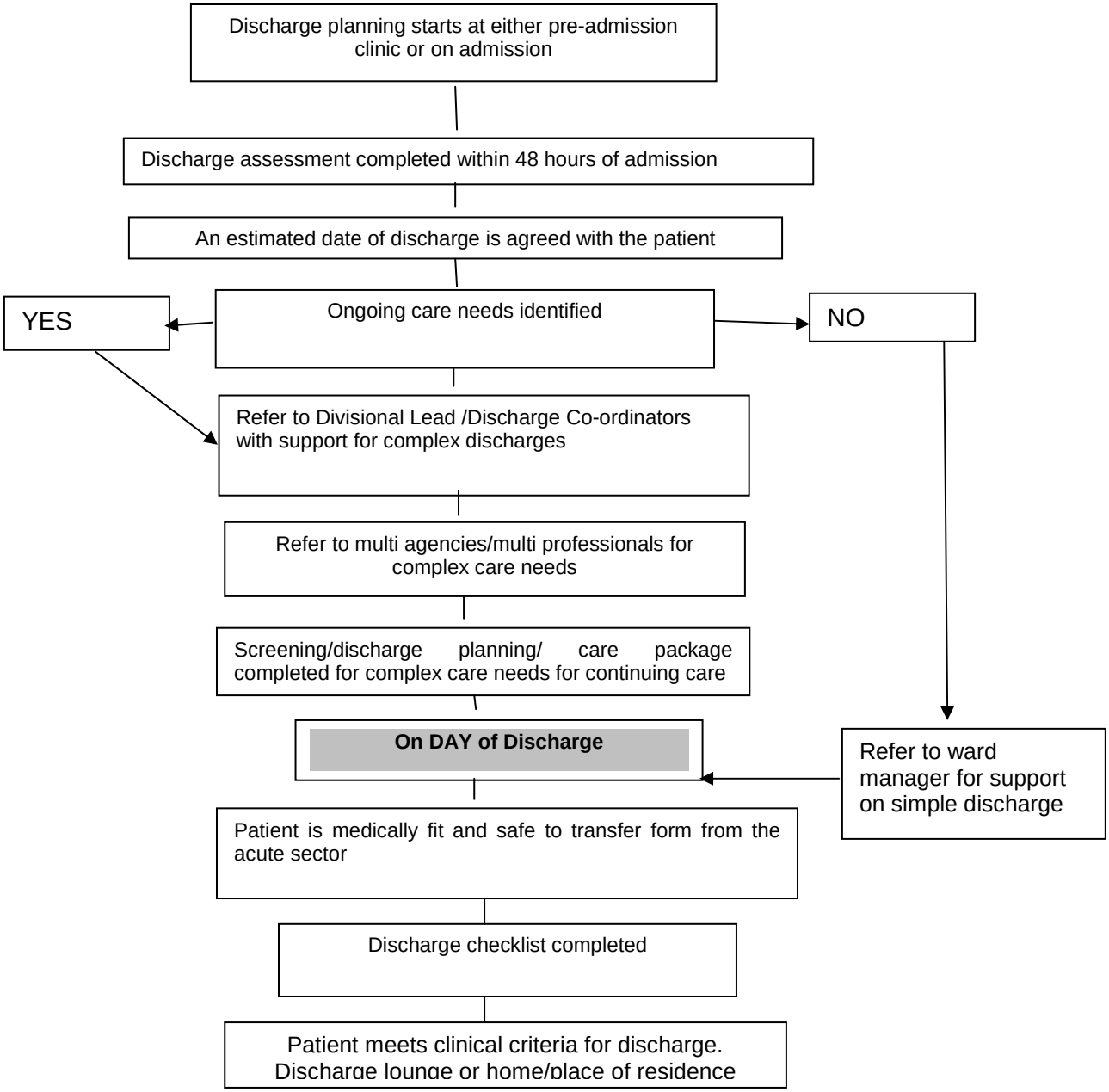
Contents

Executive Summary

St George's Healthcare NHS Trust is committed to ensuring the safe and timely discharge of all patients admitted to the hospital/community settings and caseloads, including Offender Healthcare within HMP Wandsworth.

Discharge is one of the most important but variable aspects of patient's experience and this policy draws on the fundamental importance of partnership between patients, carers and health care professionals and partnership agencies when planning safe and timely discharge.

This policy ensures that every patient is treated as an individual and that independence is promoted. More information can be located on the Trust Discharge Planning Homepage on the Intranet.



1. Introduction

St. George's Healthcare NHS Trust's approach to discharge aims to meet each patient's needs and recognises that to facilitate a smooth transition of care from hospital to community setting, the discharge plan must be well defined, prepared and agreed with each individual patient.

Every patient discharged from St. Georges Healthcare NHS Trust, either to their own home or to another health or social care facility, will have where appropriate joint working multi-disciplinary assessment of their ongoing health and social care needs in line with the Children's Act 1989 (Children only) or where appropriate, under the National Framework for Continuing Healthcare and NHS-funded nursing care which came into practice from 1st Oct 2007.

To allow sufficient time for suitable and safe arrangements to be made, discharge planning should begin on admission, or at pre-admission appointments/clinics, with a predicted date of discharge being identified within 48 hours of admission. The patient and / or their main carer will be fully involved at all stages and kept fully informed by regular reviews and updates of the care plan in the discharge planning process. All identified ongoing health and/or social needs will be co-ordinated and communicated by the patients key discharge lead to those individuals/agencies responsible for meeting the needs. Identifying and reducing these risks will assist in maintaining and supporting the safety of the patient and provide continuity of the right care in the right place and prevent patients being unprepared for their discharge. This will help reduce the patients' protracted length of stay in hospital or readmission, resulting in the inappropriate use of hospital resources.

2. Purpose

The purpose of this policy is to set out the process requirements and staff responsibilities to support well organised, safe and timely discharge or "transfer of care" for patients from hospital for all patients which promotes a positive patient and /or carer experience

It aims to identify and reduce risks by fully involving patients and their carers /relatives in the discharge process and ensuring high quality and appropriate assessment, planning / discharge procedures and documentation / record keeping, together with clear and consistent communication with all parties are maintained about their discharge and after care.

3. Definitions

Simple discharge: a simple discharge or transfer to a setting within community is one that:

- Normally means returning to the patient's own home or usual place of residence with little or no input from external agencies e.g. social services, community nurses

Complex discharge: a discharge process that deviates from the normal discharge pathway and requires:

- Discharge to own home or usual place of residence but require significant input from external agencies e.g. social services, community nurses, etc to enable safe discharge.

Self-discharge:

- Patients wishing to discharge themselves against medical advice

To Take Out Medicines (TTO): medicines which the patients take away when they leave the hospital.

Estimated discharge date: a target discharge date to which all agencies can work whilst recognising that the date may change according to the patient's needs.

Out of Hours Discharge: a discharge that takes place between 22.00 – 08.00 hours

4. Scope

Patient discharge must be seen as a multidisciplinary and/or inter agency process requiring collaborative working and good communication between external agencies / multi professionals.

This policy applies to all permanent, locum, agency and bank staff of St George's Healthcare NHS Trust in all locations registered with the Care Quality Commission. This also includes volunteers, contractors, students and/or trainees. This policy has been reviewed in partnership with Wandsworth PCT, Merton & Sutton PCT, Wandsworth Social Services, Merton Social Services and Lambeth Social Services.

The principles outlined in this document are common to all patients (children and adults) being discharged (or transferred from hospital to community home based settings) and reflects equality and diversity to the communities it serves. However relevant guidelines should also be consulted where specialist care is indicated. This policy will describe the overall referral, assessment, care planning and review framework.

Children and family community services, in particular health visiting, school nursing and children's therapy services, will not have a defined 'discharge date' as cases remain open on the caseload until transition age of 19 years or when the children benefit no longer from the therapeutic intervention. At which point, unless required to do so prior to this stage, the closure of the case, or transfer to another agency will follow the same principles of simple or complex discharge depending on the health and social needs of the child, young adult and family.

Offender Healthcare services discharge arrangements will depend on the release or transfer date of the offender. Until such time the offender will remain as an open case within the healthcare service provision. On release or transfer the 'discharge arrangements will follow the same principles of simple or complex discharge, depending on the health and social needs of the offender.

5. Roles and Responsibilities

5.1 Chief Executive

The Chief Executive has ultimate accountability for the strategic and operational management of the Trust, including ensuring there are safe processes in place for the safe discharge of patients. The Chief Executive delegates this responsibility through the Chief Nurse and Director of Operations.

5.2 Chief Nurse and Director of Operations

The Chief Nurse and Director of Operations has executive responsibilities for ensuring the policy is implemented across the Trust and that patients are discharged from hospital in a safe, and timely manner.

5.3 Divisional Director of Operations/Divisional Director of Nursing & Governance

The Divisional Directors of Operations and Divisional Directors of Nursing & Governance are responsible for implementing the policy within their Directorate / Divisions and for monitoring compliance.

5.4 General Manager Bed /Site Management

The General Manager has overall responsibility for ensuring that effective systems and processes are in place for the day-to-day safe discharge of patients and monitoring of this policy.

5.5 Responsible Consultant

For in-patient services, the Consultant is responsible for the patients' clinical care and has the final decision on when a patient is medically stable /fit for discharge. Once the decision has been made to discharge the patient it must be clearly documented in the patient's medical notes along with any follow up requirements. Some patients may require further support to reach maximum rehabilitation potential and the discharge date may require multi professional negotiation and agreement which may be sometime after the medical decision.

5.6 Divisional Discharge Lead

The Divisional Discharge Lead/Clinical Team Leaders have a responsibility to provide senior nursing support and expertise to colleagues, medical staff, patient /carers particularly where complex discharge arrangements are required through liaison and facilitation with health professionals. The Trust Discharge Team will continue to monitor the discharge planning process and identify key areas that require review in order that discharge planning remains in line with best practice.

5.7 Discharge Coordinators

The Discharge Coordinator/Care coordinator for complex discharge (community) has the responsibility for commencing the planning process to ensure a safe and timely discharge of their patients. Where Discharge Coordinators are not in post it is the responsibility of the Sister / Nurse in Charge/identified lead professional

5.8 Matrons/Ward Managers

The Matron / Ward Managers/Clinical Team Leaders are responsible for ensuring systems and processes are followed to facilitate a safe and timely discharge of their patients. This includes good verbal and written communication and the involvement of the Patient/Carers. They are responsible for ensuring lessons on poor discharge planning/coordination are learnt across their divisions, by representing at the Matron's forum and Divisional Governance Meetings.

5.9 Multidisciplinary Team

The Multidisciplinary Team have a responsibility to ensure that once involved in the planning process any necessary arrangements to facilitate discharge are identified and implemented. This team may comprise of one or more of the following group (in the least):

- Nurse
- Occupational Therapist
- Physiotherapist
- Social Worker
- Speech and Language Therapist
- Pharmacist
- Dietician
- Podiatrist
- GP / hospital based medical team

5.10 Registered Nurse Facilitated Discharges

Registered nurses are trained to facilitate and lead the discharges process. Registered nurses assess the patient, liaising with the multi-disciplinary team and plan timely discharge based on an agreed clinical protocol management plan.

5.11 All Clinical Staff

All clinical staff are required to comply with this policy and to report any discharge or "transfer" related issues to their line manager and for completing an adverse incident reporting form in line with the Trust policy.

5.12 Ward Clerk

Ward Clerks are responsible for photocopying any documents, the booking of transport and any other required administrative duties to support safe patient discharge or "transfer" from hospital.

5.13 Divisional Governance Committee

It is the responsibility of the Divisional Governance Committees to monitor adverse incidents, near misses at their meetings, to identify any emerging trends relating to the safe and timely discharge or "transfer" of patients home. The team will also support the implementation of any associated action plans and ensure cross organisational learning as necessary.

5.14 Patient Safety Committee

The Patient Safety Committee is overall responsible for ensuring systems and processes are robust and working across the Trust for the safe and timely discharge of all patients. Where deficiencies have been identified action plans are drawn up and changes made to reduce the risks.

6. Discharge Process

6.1 On Admission

On admission, or at a pre–operative assessment clinic, all patients will have an appropriate baseline assessment undertaken in order to identify and plan for any additional needs required on discharge to ensure the hospital stay/admission to caseload is kept as short as necessary. (Clinical Guideline-Management of the Confused Patient)

Pre-assessment of children must be performed by healthcare professionals trained in the pre-assessment of children. Registered nurses must have a recognised paediatric nursing and/or service specific qualification, for example health visiting, school nursing, and paediatric speech and language therapist.

The assessment should include a systematic assessment of the individuals' recent functional ability, providing the patient's condition allows this. Assessment of the home environment and support networks currently in place must also be explored and documented when appropriate. Consideration needs to be given to external environment and how this may impact on the needs of the patient returning home e.g. extreme weather conditions.

The individuals' views on how they are coping with activities of daily living should be considered and advice given on how to prepare for discharge from hospital/caseload. If appropriate, the carer's worries and concerns about the individual should be taken into account. Any further issues about the home environment should be identified. Ability to understand and manage any prescribed medication also requires assessment

The assessment process needs to be risk assessed to consider all factors in the patient's ability to manage their own care. This must be central to any decision making about future care planning. Where additional needs are identified, these must be documented and the discharge coordinator, where applicable, for the anticipated admission ward should be informed to enable prompt referral to appropriate services as soon as possible prior to discharge e.g. Occupational therapists, social services, physiotherapists, primary care and intermediate care teams and district nurses.

Information leaflets (**Appendix A**) should be given, which describe the admission, the procedure to be undergone and the discharge process for inpatient services. These must be explained to and understood by the patient and where necessary their carers.

If further medical intervention or extended rehabilitation may be required or anticipated, transfer to another NHS setting may be appropriate. This will depend on assessment by the hospital team/clinical team and the appropriate patient information should be given (**Appendix B**).

A member of the medical team, with the multi professional team where appropriate, will predict the possible date of discharge and discuss details and support required after discharge with patients and/or carers at the earliest opportunity ideally, within 48 hours of admission, if the patient's medical condition permits.

The expected date of discharge should be reviewed on a daily basis and in particular when there are changes to the patient condition.

For patients admitted for day treatment, the predicted date of discharge will be given as the same day unless the patient's post procedure condition requires admission, which could not have been identified pre-procedure.

6.2 Planning for discharge

The patient's Consultant/ward manager/key individual within the multi professional team will be the nominated individual with responsibility for co-ordinating the discharge process or "transfer" into the community home based services. The Trust Discharge planning documentation must be used to record the discharge plans.

The patient, relative/family or carer must be involved in the discharge planning process. It is important that the nurse caring for the patient provides relevant information on discharge planning, including as a minimum:

- Adequate notice of the predicted date of discharge
- Given the opportunity to discuss and agree the decision to discharge
- Have agreed the patient's discharge destination and clarified the address
- Patient Information Leaflet/ discharge booklet as appropriate
- Copy of the Merlin Discharge Letter, written copy of their medication, Nursing transfer letter/Discharge Form if applicable
- Copy of the discharge summary, complete with any information regarding post-discharge care and services
- Out-patients appointment if applicable
- Have access to an interpreter as required

6.2.1 All medications to take out (TTO) will be prescribed as far in advance as possible, but at least 24 hours before discharge. All medicines should be written on the discharge prescription even if the patient has their own supplies, as this is a record of what the patient is taking home for the GP. It is also good practice to indicate to the GP if medicines have been stopped or modified in hospital and the duration stated where appropriate.

For patients needing a monitored dosage device dispensed, more than 24 hours notice (weekdays only) is needed (NB adherence problems should ideally be highlighted to the pharmacist well in advance of discharge). Monitored dosage devices will only be filled once the pharmacist has established continuation of supply in the community.

A minimum of fourteen days will be supplied unless on discussion with the Community Pharmacist the patients can reuse their own supply or unless a shorter supply is appropriate.

Once dispensed by the Pharmacy, nursing staff must ensure that all medication given to the patient matches that written on the discharge prescription sheet. They should then sign the prescription sheet once the medicines have been given to the patient. The patient/carer should feel confident with the medication given and when to take it and be made aware of any side effects or cautions.

Further guidance on medications on discharge; Medicine management policy

6.3 Once decision for discharge made

The nurse caring for the patient will co-ordinate all arrangements required to ensure:

- A member of the medical team/GP has completed the discharge summary for the patient and their General Practitioner and/or community based services if required
- Tablets to take out (TTOs) have been prescribed and dispensed and are available in the ward at time /day of discharge
- Any other requirements e.g. continence products, dressings, equipment, appropriate packages of care are available and adaptations to the home in place for the date of discharge
- Referrals to appropriate therapists /services are arranged and confirmed; and they are made aware of the patient's imminent discharge and/or time of transportation if required
- Confirm that any health and/or social care equipment has been ordered and /or delivered and that the patient is familiar with its use and safety requirements

6.4 Information given to all patients on discharge

- Discharge summary (copy should be sent to the patients GP within 24 hours and/or other hospital/institution/community home based service to which the patient is discharged)

- Written information on TTO(medicines management policy)

- Follow up appointments as appropriate
- Written information on all medical instructions as appropriate
- Written details and contact numbers on any community/social services arranged (**Appendix C,D,E,F.G**)

6.5 Simple Discharge (including information given to the receiving healthcare professional)

The ward manager/matron/caseload manager/clinical team leader must be involved with the provision of advice and support related to simple discharges. The patient and/or carers must agree the discharge plan. This must be documented in the multi disciplinary notes.

If the patient requires hospital transport, this should be booked at least 24 hours in advance. The ward manager is responsible for liaising with departments and for making the necessary arrangements.

The patient must be provided with all the medications that have been prescribed to take with them. Discharge medication will be prescribed as far in advance as possible, but at least 24 hours before discharge.

The patient must be informed if an outpatient appointment is necessary, the time scale in which the appointment is needed and how they will be notified of the appointment date and time.

The nurse coordinating the discharge must ensure:

- All valuables held in the ward/department office are returned and signed for before discharge. All other personal property must also accompany the patient. If the patient is travelling on booked transport they must be forewarned that the transport can only carry a minimum of luggage
- How the patient will gain access to the property and ensure any keys are sent with the patient
- The patient is adequately clothed before discharge
- Confirm that any health and/or social care equipment has been ordered and/or delivered and that the patient is familiar with its use and safety requirements
- Discharge checklist completed

6.5.1 Following up on test results

Each clinical area should have a system to ensure that the responsibility for following up on blood (and other test) results is clear following discharge. The person ordering the investigation is responsible for chasing the result unless explicitly handed over and documented. There will be some instances where care groups /divisions will need to consider how best to follow up and document results:

- Where the junior doctor rotas make it important that the incoming shift follows up on the ordered tests of preceding shifts
- Where the patient is being transferred internally, the person to follow up should be clearly communicated and agreed at handover. If handover of tests is not documented, it is the responsibility of the individual ordering the test to chase the result and manage appropriately.

- Clinical teams should be clear how they review outstanding results following discharge. Where the patient is being discharged, the discharge letters and other documentation should make it clear what test results are being followed up by the department and advice for further follow up by the receiving organisation/practice.

6.5.2 Equipment Provision

It is the duty of the Occupational Therapist involved in a patients care to ensure that any Activities of Daily Living equipment that is seen as essential for discharge will be delivered and/or installed prior to discharge and the discharge date should take this into consideration. This excludes hospital beds, pressure care mattresses and cushions which are ordered via nursing staff.

For non essential items such as bathing equipment, information can be provided to the patient for private purchase.

For complex discharges including hoist discharges, an Environmental Visit will need to be carried out by the Occupational Therapist prior to discharge.
For hoist discharges a demonstration visit with the patients carers will be carried out as quickly as possible, this is usually the morning after discharge. Please note that this is a demonstration visit only and the Occupational Therapist is not responsible for providing hoist training to carers.
The ordering and installation of equipment may vary according to the source of equipment provider and processes for doing so will vary from borough to borough.

6.6 Complex Discharge (including information given to the receiving healthcare professional)

The health professional coordinating the discharge must ensure all points relating to simple discharges have been considered and/or completed in relation to functional independence, timely discharges and advice on the appropriate pathway of care, including community services provision.

Where additional health needs are identified, these must be documented. The discharge co-ordinator for the anticipated admission ward should be informed to enable prompt referral to appropriate services on admission e.g. Occupational therapists, social services, physiotherapists, primary care and intermediate care teams and district nurses.

The Discharge Team (STAR team for A&E) must be involved for the provision of expert advice to the ward/department managers and staff to:

- Assist ward staff in the identification of patients with on-going carer needs
- Support staff in ongoing assessment of patient discharge needs and assist where alternative discharge plans may be required
- Advise staff about reimbursement process and the relevant forms to complete (**Appendix D)**
- Advice staff about patient eligibility for continuing health care/social care packages/ offender healthcare and provide ongoing programme of education for ward/department staff

Further consideration must be given to;

- Any case of suspected Vulnerable Adult/child, the senior nurse and the Lead Nurse for Vulnerable Adults/Children must be alerted as soon as possible. In cases of suspected abuse patients must not be discharged to their normal addresses until social services have assessed the situation and agreed that a safe discharge can be made Adult Safeguarding Policy and/or the Child Protection Policy

- If the patient is deemed not to have a capacity following a capacity assessment (refer to the Mental Capacity Act 2005 or Consent policy) a referral to an Independent Mental Capacity Advocate (IMCA) should be considered before making and discharge plans

- For Patients Not for Resus (DNAR) including palliative care patients for transfer home or hospices should wait in the transport lounge or wait in day rooms unsupervised. Prior notice should be given to the PTS Provider and a confirmation letter signed by a member of the patients' medical team should be given to the ambulance crew on arrival at the ward. These patients can be transported with the statutory London Ambulance Service,

- An integrated approach will be taken with Health Professionals when considering if a patient is eligible for continuing NHS health care funding using the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care.

- For elderly patients who have fallen- refer to the Slips, Trips and Falls policy

- For patients requiring home oxygen therapy; a referral needs to be made to the Respiratory Nurse Specialists and for Paediatric and Neonatal orders please contact the child's local community Paediatric Nurses (see admin section on the Trust's child health intranet site for details of local paediatric community nursing teams). Community referrals

- For Patients Requiring Anticoagulant therapy on Discharge, refer to the Venous Thromboembolism Policy

- For patients admitted with dementia, refer to the Clinical Guideline for the Management of patients with established or suspected dementia or delirium.

- Minimizing Delays - Choice of Accommodation Protocol (**Appendix H**).

6.7 Discharges to other Hospital

- Please refer to Transfer & Escort of Patients Policy

6.8 Self Discharge (including information given to the receiving healthcare professional)

Patients may decide to discharge themselves from the hospital and/or healthcare treatment against clinical advice. If a patient wishes to self discharge or cease access to healthcare treatment:

- Staff must advice the patient why it is in their best interest to remain in hospital/be in receipt of treatment and care. This must be documented clearly in the nursing records

- Doctor on duty, or in charge of the patient treatment e.g. GP must be informed as soon as reasonably possible

- Where necessary, the doctor on duty must inform their consultant as soon as possible

- Any medication required on discharge must be provided. If the patient refuses to wait for their medication then reasonable steps should be taken to ensure that the patient is able to receives them e.g. coming back to ward to pick up at later date or GP;

- Relatives/social services must be contacted if relevant

- The GP must be contacted at the time the patient leaves the hospital

- A discharge summary must be sent as soon as possible following the patient leaving the hospital.

- Discharge for children should be discouraged and the on-call Paediatric Registrar requested to see the family.

- Discharge against advice should always be considered as a safeguarding issue, and medical and nursing staff together will need to decide if there is any need for formalise safeguarding issues. The consultant must be informed of any situation that occurs

- Ongoing referral made to community nursing if appropriate to support the patient at home

- All actions and discussions must be recorded, dated, timed and signed in the patients' health record and discharge documentation

6.9 Out of hours discharge

An out of hours discharge is a discharge that occurs between 22.00 and 08.00 hours

Out of hours discharges should only occur through patient choice or if there is absolutely no other option. Out of hours discharge, will be managed by the Bed Management Team/ on call manager (community services-site dependent).

Where possible, and in particular complex discharges, all agencies (including GPs and District Nurses), relatives and carers should be contacted during working hours to inform them of the discharge plan. If this is not possible, then this should be completed during normal working hours by the discharging nurse.

7. Training on Discharge Planning

Bespoke training on discharge planning processes is provided locally by the Sister and/or Discharge Co-ordinators.

The Divisional Discharge Leads chair monthly discharge meetings to discuss relevant issues and provide relevant training and development for staff.

8. Dissemination and implementation

8.1 Dissemination

The policy will be uploaded to the Trust intranet with the most recent version visible to all staff with its publication noted in eGazette as per usual Trust procedure. In addition; it will be disseminated to all Discharge Co-ordinators, Matrons/Ward Managers and discussed at the nursing forum. This document will replace the previous discharge /bed management policy and archived into the contensis folder by the Corporate Affairs Manager.

8.2 Implementation

Implementation of this policy will be overseen by the Discharge co-ordinators and/or caseload managers, where applicable and will be monitored by the Governance Directorate meetings.

Training will be provided on an on-going basis by the Discharge Co-ordinators and Discharge Leads.

9. Monitoring compliance

The Table One outlines the process for monitoring compliance with this document.

Table One: Monitoring compliance and effectiveness					
Element/ Activity being monitored	**Lead/role**	**Methodology to be used for monitoring**	**Frequency of monitoring and Reporting arrangements**	**Acting on recommendations and Leads**	**Change in practice and lessons to be shared**
Discharge requirements specific to patient groups	Divisional Discharge Lead & Discharge coordinators Directorate Governance Meeting	- on going checks of completed discharge checklist - snap shot audit of 10-15 notes per ward every quarter using the Discharge policy audit proforma (Appendix I)	Quarterly audit findings to be presented to the Patient Safety Committee who is expected to read and interrogate the report to identify deficiencies in the system and act upon them. Any significant issues escalated to the Divisional Governance meetings	The required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/wards.
Documentation accompanying the patient upon discharge	Divisional Discharge Lead & Discharge coordinators Directorate Governance Meeting	- on going checks of completed discharge checklist - snap shot audit of 10-15 notes per ward every quarter using the Discharge policy audit proforma (Appendix I) - annual audit of documentation on discharge by the Clinical Audit Team	Quarterly audit findings to be presented to the Patient Safety Committee who is expected to read and interrogate the report to identify deficiencies in the system and act upon them. Any significant issues escalated to the Divisional Governance	The required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate.

			meetings		Lessons will be shared with all the relevant staff/wards.
Information given to receiving healthcare professionals	Divisional Discharge Lead & Discharge coordinators Directorate Governance Meeting	on going checks of completed discharge checklist - snap shot audit of 10-15 notes per ward every quarter using the Discharge policy audit proforma (Appendix I) - annual audit of information on discharge by the Clinical Audit Team	Quarterly audit findings presented to the Patient Safety Committee who will read and interrogate the report to identify deficiencies in the system and act upon them. Any significant issues escalated to the Divisional Governance meetings	The required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Information given to patients on discharge	Divisional Discharge Lead & Discharge coordinators Directorate Governance Meeting	- on going checks of completed discharge checklist - snap shot audit of 10-15 notes per ward every quarter using the Discharge policy audit proforma (Appendix I) - annual audit of information on discharge by the Clinical Audit Team	Quarterly audit findings to be presented to the Patient Safety Committee who is expected to read and interrogate the report to identify deficiencies in the system and act upon them. Any significant issues escalated to the Divisional Governance meetings	The required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

Patient's medicines are managed on discharge	Divisional Discharge Lead & Discharge coordinators Directorate Governance Meeting	- on going checks of completed discharge checklist - snap shot audit of 10-15 notes per ward every quarter using the Discharge policy audit proforma (Appendix I) - annual audit of information on discharge by the Clinical Audit Team	Quarterly audit findings presented to the Patient Safety Committee who is expected to read and interrogate the report to identify deficiencies in the system and act upon them. Any significant issues escalated to the Divisional Governance meetings	The required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Process for Discharge out of hours	Divisional Discharge Lead & Discharge coordinators Directorate Governance Meeting	- on going checks of completed discharge checklist - snap shot audit of 10-15 notes per ward every quarter using the Discharge policy audit proforma (Appendix I)	Quarterly audit findings to be presented to the Patient Safety Committee who is expected to read and interrogate the report to identify deficiencies in the system and act upon them. Any significant issues escalated to the Divisional Governance meetings	The required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

10. Associated documentation

- Admission Policy (Clin.5.28)
- Referral to Treatment Access Policy (Clin 5.17)
- Transfer & Escort of Patient Policy (Clin.5.27)
- Safeguarding Adults (Clin.5.21)
- Safeguarding Children and Young People (Clin.5.8)
- Adverse Incident Reporting Policy and Procedures (Org.2.7)
- Serious Incident Policy (Org.2.10)
- DNAR policy
- Medicine Management policy
- Clinical Guideline-Management of the Confused Patient

11. References

- Department of Health. (2003). Discharge from Hospital: Pathway Process and Practice. London: Department of Health

- Department of Health. (2004). Active Timely “Simple” Discharge from Hospital: A Toolkit for the Multidisciplinary Team. London: Department of Health

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

- National Institute for Clinical Excellence (NICE). (2004). Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. London: NICE

- Royal Pharmaceutical Society of Great Britain, the Guild of Hospital pharmacists, the Pharmaceutical Services Negotiating Committee, the Primary Care Pharmacists’ Association. (2006). Moving patients, Moving medicines, Moving safely: Guidance on Discharge and Transfer Planning: London.

- Royal Pharmaceutical Society (2011). Keeping patients safe when they transfer between care providers – getting medicines right

- Pharmaceutical services Negotiating Committee (2008) Moving medicines, Moving safely: Guidance on Discharge and transfer Planning

St George's Healthcare NHS
NHS Trust

APPENDIX A

Patient Information (Adult)

Leaving Hospital: Information about your discharge from hospital

This information is for patients who are leaving hospital, which is called "being discharged". It explains what you need to know about leaving hospital and the arrangements that need to be made.

When do we start planning your discharge?

Discharge planning may start before you come into hospital either in the Outpatients Department or at a pre-assessment clinic. It will be confirmed on the first day of your stay. We usually arrange for patients to vacate their bed by 10.00 hours on the day of discharge. This helps us to make sure you have everything you need to leave hospital and to get things ready for the next patient.

Why do we start planning so early?

We start planning to make sure all arrangements are in place as soon as possible. This helps to minimise delays once you are ready to leave hospital. We will always try to discharge you as quickly as possible once you are medically fit to leave.

Who will be planning your discharge with you?

We will talk to you about any arrangements that we make. With your permission, we will also talk to your next of kin and/or your carers. Your nurse on the ward will oversee your care, including your discharge, whilst you are in hospital.

We also have a **Discharge Nurse** who is here to help you make arrangements for going home. If you have any concerns at all about leaving hospital, please ask to speak to her.

Other members of the team who might be involved in planning your discharge include:

- the Occupational Therapist who aims to help you to be as independent as possible. They can arrange equipment and home adaptations to help with this.
- the Social Worker who can arrange services such as homecare and Meals on Wheels if you need them.

What sort of arrangements need to be made?

When you are ready to leave hospital, we will make the following arrangements with you:

- Tablets or medicines – we will give you a minimum of fourteen days' supply of medication. A record of your medication will be sent to your GP where you should arrange further supplies **before** the hospital supply has run out. You will also be given a list of your medication to take to your local pharmacy.
- Outpatient appointments – we will make any appointments necessary and explain that you may be sent an appointment direct to your home.
- Your property - please make sure you take all of your property with you. If any money or valuables are being stored, we will return this to you before you go home.

- Transport arrangements – please arrange for a friend or relative to collect you. If your medical condition meets the criteria for hospital transport to take you home, your nurse will arrange this for you.

You might also find it useful to ask yourself the following questions, when thinking about leaving hospital:

- Do I have house keys?
- Do I have food at home?
- Do I need any equipment or dressings?
- Will I have clean clothes and suitable footwear when I leave hospital?

What if you are not able to return home?

If you think that you will have difficulties returning home, please talk to your healthcare team. We might need to make alternative arrangements for you for a number of reasons on either a short or long term basis. It might be that you need to move to sheltered accommodation, a residential home or nursing home. This is a complex decision to make so we will do everything we can to support you and give you the information you need.

You might want to go to a specific residential or nursing home and we will do what we can to support your choice. If there is not a vacancy in your chosen home, your name will be put on the waiting list. So that you do not have to stay in hospital once you are medically fit, we will make arrangements for you to move to another home as an interim placement.

What happens on the day that you leave?

We will ask you to be ready to leave your bed by 10.00hours. You will then be asked to wait in the day room. This is very important as this allows us to make arrangements for the next patient.

What if I have any questions or worries?

If you have any worries or concerns about leaving hospital, please ask your nurse or the Discharge Nurse as soon as possible.

Once you have left hospital, you can call your ward so you might find it useful to keep a note of the name and number of the ward. The telephone number for St George's Healthcare NHS Trust switchboard is 020 8672 1255.

Further information

You might also find it useful to contact:

- your GP
- NHS Direct on telephone 0845 4647 (website: www.nhsdirect.nhs.uk)

August 2007

APPENDIX B

St George's Healthcare NHS
NHS Trust

Patient Information

Leaving hospital to go to a care home: the Direction on Choice

This information is for people who may need to go to a care home when they leave hospital. You may be considering sheltered accommodation, a residential home or nursing home. This is a complex decision to make so we will do everything we can to support you and give you the information you need.

What is the Direction on Choice?

If you are moving to a care home with the support of health and social services, you are able to choose a home. This is part of a government plan called the **Direction on Choice of Accommodation**. These directions are currently being reviewed because new legislation (law).

The Direction on choice explains a patient can choose where to go providing:

- the accommodation is suitable in relation to the individual's assessed needs;
- it would cost the local authority no more than it would usually expect to pay for someone with the individual's assessed needs;
- the accommodation is available;
- the person in charge of the accommodation is willing to provide accommodation (subject to the local authority's usual terms and conditions for such accommodation).

What happens if there are no places in my chosen care home?

Sometimes finding a permanent place in a care home can take a long time. In these instances, you will need to consider a **transition** or **interim** placement. This will involve moving from hospital to a temporary place in a care home until a permanent (or alternative) choice becomes available. The transitional or interim placement must be able to meet the patient's care needs.

Why can't I stay in hospital until a place in my chosen care home is available?

Once you are medically ready to leave hospital, it is no longer the best place for your recovery. There are many reasons for this, which we can discuss with you individually. Additionally, we need to make sure that our hospital beds are available to those patients who medically need them the most.

We will inform patients and carers about the possibility of an interim placement as soon as possible. It is important that people understand why it is not appropriate to remain on an acute ward indefinitely while they are waiting for admission to a care home.

What happens when I move from my transition or interim placement to my permanent care home?

You will receive help to move on to the home of their choice when a place is available. There will be support (such as an independent advisory service) for you and your carers to make any important decisions.

Any questions?

If you have any questions or worries about leaving hospital, please talk to a member of your health care team. Don't forget the Discharge Nurse specialises in support patients who are leaving hospital.

Further information

You might also find it useful to contact

- your GP
- NHS Direct on telephone 0845 4647 (website: www.nhsdirect.nhs.uk)

We have another patient information sheet "Leaving Hospital: Information about your discharge from hospital" that you might find useful.

6 NHS Funded Nursing Care in Nursing Homes

1. From October 2001, the Government introduced important changes in the way that nursing care in nursing homes is arranged.
2. The Free Nursing Care Policy was developed as a response to the Royal Commission Recommendations that the NHS should contribute towards the cost of nursing care provided in Nursing Homes. The NHS plan also set out that registered nursing care should be free of charge to the recipient in all settings.
3. Anyone entering a nursing home should have their nursing needs reviewed, usually within 3 months and again after 12 months.
4. If you have been assessed as requiring some other form of care – whether residential, intermediate or care at home or at a day centre – but you or your family decide that you nevertheless prefer to go into a nursing home, you will need to meet all of your costs yourself.
5. A Department of Health booklet can be obtained free of charge from Department of Health, PO Box 777, London SE1 6XH or you could call the NHS Response Line on: 08701 555 455.

APPENDIX C

St George's Healthcare NHS
NHS Trust

Information about leaving hospital for relatives and carers

Giving you information about going home

When we make arrangements for your relative or friend to leave hospital, we will discuss this with you. Leaving hospital (called being "discharged") is a complex process. We might need to give the patient and their relative / carer lots of information about:

- medication (how to take them and any side effects)
- how to look after wounds
- any services or equipment that we might have arranged
- how to keep mobile and increase activity
- what do if you have any problems
- future treatment and any appointments
- sources of further information.

We will either tell you about these things or give you written information.

What about information in different formats and languages?

Please tell us about any particular needs that you have and how we can help. We will try to arrange support for:

- people with sensory impairments or disabilities, including:
  - information in different formats (such as large print)
  - signers.
- people who do not speak English as a first language, including:
  - interpreters (either in person or on the telephone) to explain procedures and arrangements
  - translation of written information.

What about support for you?

There are a number of different services available to support and advise patients and their relatives / carers. Please talk to a member of your healthcare team if you have any questions or worries.

If you are in the hospital, you might find it useful to contact the Patient Advice and Liaison Service. The PALS team can tell you about services, listen to your experiences and help to resolve any problems you may have had in hospital. You can contact them by:

- telephone: 020 8725 2453
- email: pals@stgeorges.nhs.uk
- dropping into the PALS office in the main entrance, Grosvenor Wing.

If you have any questions or worries once you are at home, you might find it useful to contact NHS

Direct. It is a 24 hour service about health, treatments and local services:

- telephone: 0845 46 47
- website: www.nhsdirect.nhs.uk

St George's Healthcare NHS
NHS Trust

APPENDIX D

Choice of Accommodation Protocol

CHOICE OF ACCOMMODATION PROTOCOL

1. Agreed principles

Wherever possible, the multidisciplinary team will seek the permission of the patient to allow full involvement of relatives, carers or advocates in the discharge planning process. Where patients are unable, for whatever reason, to speak for themselves or present their own views, the wishes and views of the relatives, carers or advocates will be taken into account. All involved in planning discharges will base the ultimate decision on patients' best interests.

- All patients are treated fairly and without discrimination
- The patient should be fully involved from the beginning during the discharge planning process
- The patient will continue to receive an appropriate standard of care during the assessment process, and the appropriateness of placement in a nursing home or a residential care home will be kept under review. **Whenever possible the option of returning home, with support package if necessary, should be explored first**
- The agreed assessment shows that the patient is ready for transfer of care from hospital, needs a placement in a nursing home or residential care home and this will be funded by either the patient (self-funded), Social Services and/or the NHS
- Where a patient has been assessed as lacking capacity to make a decision on accommodation needs, the provisions of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards must be given careful consideration. An Independent Mental Capacity Advocate (IMCA) must be appointed to represent a patient where he/she lacks the capacity to make a decision on accommodation needs and does not have any friends or family with whom the discharge team can consult.
- If a Safeguarding vulnerable adults investigation is being undertaken, the recommendations of the investigating officer, based on assessed risks, should take priority.
- If there is a view expressed that the continuing care eligibility criteria have not been applied correctly, this protocol does not affect the right of the patient to appeal against the decision in these cases. Interim Placements chosen would be based on the higher level of care wherever possible.
- The expectation is the patient will be discharged from hospital within **2 working days** when medically fit for discharge and completion of all appropriate assessments.
- If a particular home is identified, but does not have a current vacancy, an alternative must be found for either long term or an interim placement to meet the 2 working day deadline.
- Formal discussions with the patient and records of all decisions will be recorded in the patient's medical and/or social records and will be signed and dated

2. Minimising delays

This protocol should be followed for any patients that meet some of the criteria listed below:

- The patient has identified a preferred home and is unwilling for transfer to take place until a placement in a preferred home is available
- The patient is unwilling to be discharged from hospital into any other setting
- The patient's family are unavailable or unwilling to make a timely decision
- The patient's own home needs extensive repairs/adaptation and the patient is unwilling to move to a suitable interim placement or alternative care arrangements that meet the patient's assessed care needs
- The patient or patient representative are challenging the decision to discharge from hospital.
- The patient is awaiting re-housing and is unwilling to consider an interim placement.

3. 'Choice of Accommodation' Directions

These Directions will apply where the patient or family is unable to identify a suitable accommodation vacancy.
For the discharge or transfer of patients from an acute setting to a registered care home, all relevant Health and Social Services organisations* have agreed this protocol in relation to the 'Choice of Accommodation' Directions[1]. A summary of the requirements are:
1.1 If after an assessment of need it is identified and agreed that residential/nursing care placement is appropriate then the placement will be made on the individual's behalf in suitable accommodation.

1.2 If the individual concerned expresses a preference for a particular accommodation within the UK, the Trust will request social services to assist and identify a suitable placement, provided:

- The accommodation is suitable in relation to the individual's assessed needs
- It would not cost the authority more than it would expect to pay for accommodation for someone with the individual's assessed needs
- The accommodation is available
- The person in charge of the accommodation is willing to provide accommodation subject to the authority's usual terms and conditions for such accommodation.

1.3 If the individual requests it, the authority must also arrange for care in accommodation more expensive than it would normally fund, provided there is a third party willing and able to pay the difference between the costs the authority would usually expect to pay and the actual cost of the accommodation.

1.4 Where a place is not available in the individual's preferred care home, the guidance makes it clear that remaining in an acute setting once the patient is medically fit and safe to transfer is undesirable for the patient's welfare. There are particular risks of increasing dependency and acquiring infections. In addition, the acute provision is needed for other patients with acute care needs.

1.5 The Directions make it clear that, as long as an interim placement meets the needs of an individual, it is acceptable for a person to move from an acute setting to an interim placement until a permanent/alternative choice becomes available.
1.6 The general principles outlined also apply to patients who are self-funders who should be encouraged to find suitable interim care if their first choice home is not available.

1.7 Specific guidance around interim care was given in August 2000, as an addition to the 'Choice of Accommodation' Directions.

'The use of Interim or (transitional) care is consistent with the Choice of Accommodation Directions and the other guidance on the transfer of people from one care setting to another. Where a discharge is likely to mean placing people in intermediate care settings or care homes temporarily, patients and carers should be fully informed, interviewed and involved in good time. This process should be factored into the standard agreements so that it is not a source of delay in discharge'.

*Wandsworth Adult Social Services, Sutton Social Services, Merton Social Services, Lambeth Social Services, Wandsworth PCT, Sutton & Merton PCT, Lambeth PCT

[1] National Assistance Act 1948 (Choice of Accommodation) directions 1992, LAC (92)27.

This protocol builds on the need to follow standard procedures relating to patient consent and confidentiality. Where the protocol refers to carers, family or the patient's representative, those providing information, advice or letters of confirmation must make sure that patient consent and confidentiality rules are followed.

4. Protocol process - Steps to discharge/transfer

NOTE: To achieve a successful transfer of care, patients, carers and relatives must be kept fully informed and involved in the process.

4.1 Information regarding the Trust's discharge process will have been routinely provided on admission to all patients, carers and relatives (See patient information leaflet - Leaving hospital to go to a Care Home).

4.2 It is recognised that discharge planning should commence on admission followed by daily reviews of the patient's discharge plan, so that information can be provided early to the patient, carers and relatives.

4.3 In all cases, individuals must be assessed against the NHS Continuing Health Care Criteria, in case they are eligible for fully funded NHS care (although not all cases will need to go to Panel).

4.4 In all cases, all stages described in the attached discharge planning process ('see flow chart') need to be adhered to with particular emphasis on information (to include written letters and explanations) to patients at all times.

4.5 All health or social care professionals who come into contact with the patient, carer or relative will need to provide consistent messages about the discharge process.

4.6 The multidisciplinary decisions about future care needs will be conveyed to the patient, carers, or relatives and in all cases a member of the multidisciplinary team will discuss an expected date of discharge with them.

4.7 The patient, carers or relatives will proactively be supported during this process and will be offered continual advice and support.

4.8 If an interim care arrangement that meets the patient's identified needs can be found and has been agreed, the patient will be transferred to the interim placement

4.9 When a patient is transferred to an interim placement, either a social worker or the relevant PCT continuing care Team/family will maintain regular contact with the patient and will make sure that when a place becomes available in the preferred home and where funding permits, arrangements will be made to transfer the patient to that home.

4.10 Concerns may be expressed about the possibility of having to move twice. In all cases the patient's best interests will guide the decision making process.

4.11 In all cases, the process followed should be fully documented in the patient's records.

5. Interim Arrangements for Local Authority and NHS funded clients

All interim care arrangements are made on a temporary basis and should be for **no longer than six weeks**

6. Interim placements and charging Policy

Funding arrangements for interim placement will be the same as for permanent placement.

7. Complaints Procedure

St Georges Healthcare Trust Complaints Information leaflet will be provided to patients on request. Continuing Care placements appeals/complaints should be directed through the Continuing Care Panel.

8. Review of Protocol

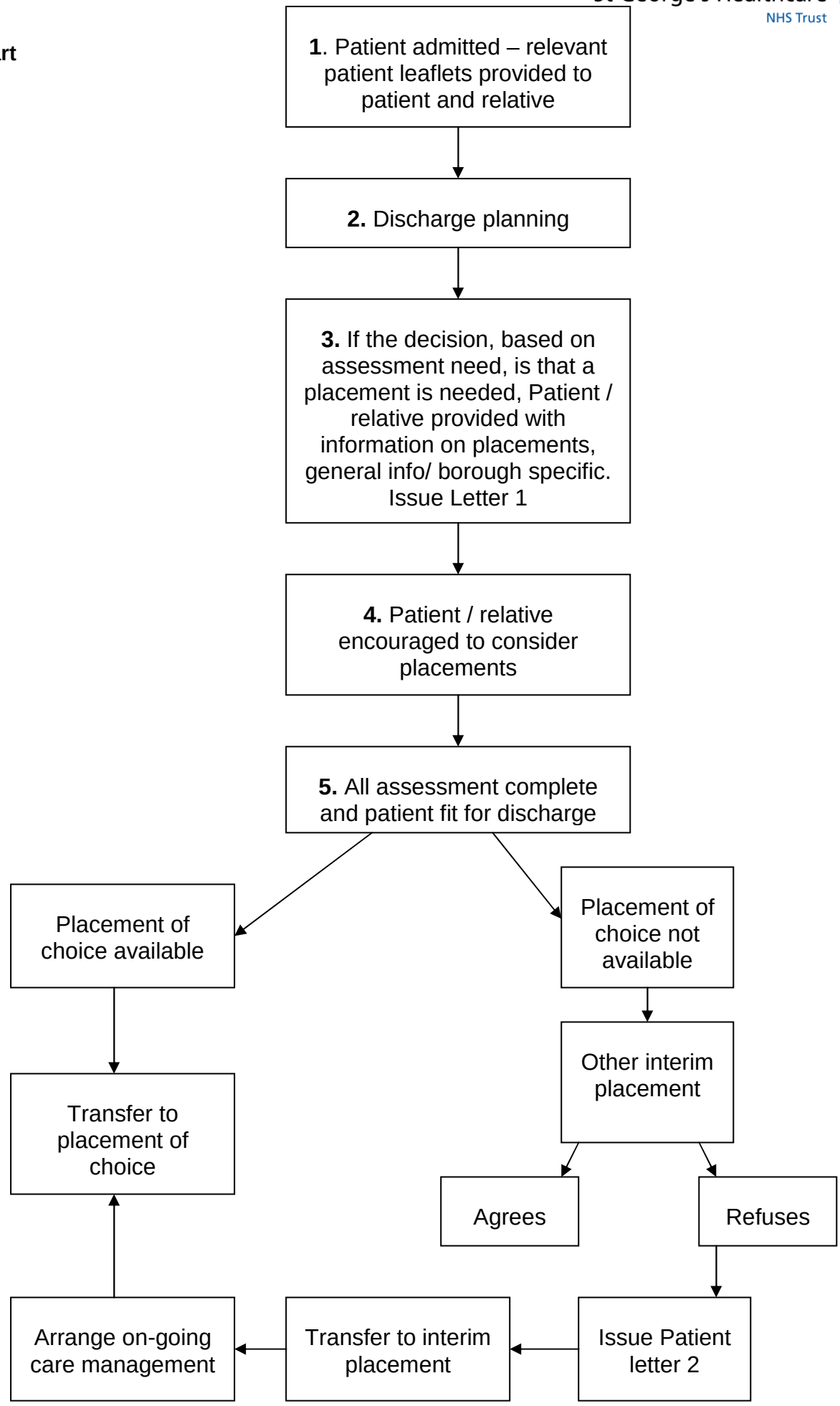
This protocol is intended to assist the partner organisations to reduce delayed transfers of care and strengthen joint working. A multi agency evaluation will take place 6 months after implementation.

It is expected that the effect on patient outcomes will be evaluated as an integral part of service development by each partner organisation.

A full review of the implementation and operation of the protocol will be carried out after the

first year of operation.

Flow Chart


1. Patient admitted – relevant patient leaflets provided to patient and relative
2. Discharge planning
3. If the decision, based on assessment need, is that a placement is needed, Patient / relative provided with information on placements, general info/ borough specific. Issue Letter 1
4. Patient / relative encouraged to consider placements
5. All assessment complete and patient fit for discharge
Placement of choice available
Placement of choice not available
Other interim placement
Agrees
Refuses
Transfer to placement of choice
Arrange on-going care management
Transfer to interim placement
Issue Patient letter 2

St George's Healthcare NHS
NHS Trust

Room 33, Grosvenor Wing Level 1

St George's Hospital

Blackshaw Road

London

Date:

Dear

Re: Discharge from hospital to a nursing/residential home

I understand that a decision has been made for you to move into a nursing / residential home and that this move is about to happen soon. The doctors, nurses and therapists will have discussed with you about your future care needs and wishes and referred you to a social worker who will be working with you and your family to find the best residence for you.

Your social worker will provide details about vacancies in suitable nursing/residential homes in the local area. All the nursing/residential homes have been inspected by the Care Quality Commission to ensure that national standards of care and quality are maintained.

However, there are often very few places available at any one time and you are urged to seriously consider the options presented to you.

You may decide that you would like to move to a nursing/residential home away from the local area to be nearer to friends or relatives. You may also find a nursing/residential home that you like but that does not have a vacancy at the time you are ready to leave hospital. In these circumstances we ask that you move to another available nursing/residential home as a *temporary* measure until the home of your choice becomes available. Your social worker will advise you further on what temporary places are available and will work with the nursing staff to co ordinate the completion of the necessary assessments and paperwork. Once your doctors and the team looking after you have said that you are ready to leave hospital, we estimate that an appropriate place will be available within two working days.

Many people are concerned about how they will be able to afford the costs of nursing/residential accommodation. Your social worker, with your permission, will be able to help by carrying out an assessment of your finances with you. The social worker will then be able to advise you how much you will be expected to pay towards your nursing/residential care.

Thank you for working with us to help plan appropriate ongoing support for your needs and in ensuring hospital beds are available for the next patient. We wish you all the best for the future in your new home.

Yours sincerely

Alison Robertson

Chief Nurse and Director of Operations

LETTER 2

St George's Healthcare NHS
NHS Trust

Room 33, Grosvenor Wing Level 1

St George's Hospital

Blackshaw Road

London

Date:

Dear

Re: Temporary residency in a Nursing/Residential home

I am sorry to learn that you have been unable to find a vacancy at the nursing/residential home of your choice. I understand that this is an important decision and one that you will not want to rush, therefore until a permanent place, that you would like to live in, can be found it is now necessary for you to move to a temporary residence.

Your doctors and the multi-disciplinary team consider you to be medically fit and ready to leave hospital and that an acute ward is no longer an appropriate place for you to be to continue your recovery and rehabilitation. Additionally, it is important that acute hospital beds are available to other patients who medically need them most.

I understand that you might be disappointed about having to move to a temporary residence, however I would like to reassure you that whilst you are in this temporary home, your relative or representative and your social worker will continue to look for another home which is more suitable for you. Your social worker or nurse will talk more to you about this arrangement.

A temporary residence has been organised for you at:

Name of this nursing/residential home:

St George's Healthcare NHS
NHS Trust

Address:

Your medical team have advised that you are ready to leave hospital and we will organise your transfer on:

Date: Time:

Thank you for working with us to help plan appropriate ongoing support for your needs. We wish you all the best for the future in your new home.

Yours sincerely

Alison Robertson

Chief Nurse and Director of Operations

Appendix E

REIMBURSEMENT

Reimbursement will not be triggered for:

- Self-funder's who have been assessed by social services, but are making their own arrangements and funding their own care. (LA's are only liable if the assessment has not been completed and is the sole cause of the delay).
- Self-funders who want no social services involvement and are making their own arrangements and funding their own care.
- Patients who are receiving direct payments from social services to arrange their own care.
- (However, LA's will be liable if the direct payments process is the cause of delay)
- Patients who have not been officially referred, but have received social services intervention in an informal advisory capacity.
- Patients who were admitted with no fixed abode and are awaiting accommodation from the relevant councils housing department, and who are **not** eligible for community care services. (Housing does not form part of community care services
- Patients who are receiving private acute medical care through an insurance scheme or paying directly, as they do not fall into the scope of the Act. (However private patients can elect to become NHS patients whilst receiving acute medical care).
- Patients awaiting a Registered Nursing Care Contribution assessment (RNNC), admission to a nursing home or multi-disciplinary panel agreement, as it is not the sole responsibility of social services.
- Overseas Patients - who have no automatic rights to social care in accordance with The Nationality, immigration and Asylum Act 2002, section 54, schedule 3.
- Patients who have been assessed and have refused the services offered.
- Patients who have refused the offer of reasonable interim placements, whilst waiting for a placement within a residential/nursing home of their own choosing.
- Patients in excess of the referral ceiling
- Reimbursement will not be triggered by waiting for health OT demonstrations on the use of equipment. However, where suppliers fail to deliver equipment within a reasonable time frame set by the OT (not less than 48hours), social services are liable to reimbursement.

APPENDIX` F

Social Services

Wandsworth

Based at St Georges Hospital, 2nd Floor Grosvenor Wing

Monday – Friday 09.00 – 17.00 hours

Tel: 0208 725 1443/1446

Out of hours: Monday to Friday, Weekends and Bank Holidays

Tel: 0208 871 7406

Merton

Based at St Georges, 2nd Floor Grosvenor Wing

Monday to Friday 09.00 - 17.00 hours

Tel: 0208 725 3006

Out of hours: Monday to Friday, Weekends and Bank Holidays

Tel: 0208 770 5000

Home Care is via Crisis Care: 0208 2886465

Lambeth

Based at Hopton House, Ground Floor, 243A Streatham High Road, London SW16 6EY

Monday to Friday 09.00 – 17.00 hours

Tel: 0207 926 5854

Out of Hours Monday to Friday, Weekends and Bank Holidays

Tel: 0207 926 1000

Appendix G

St George's Healthcare NHS
NHS Trust

Nurse Transfer/Discharge Form - (ADULT)

-

Name: **Address**: **Telephone number**:	**GP's Name**: **Address**: **Telephone number**:
DOB: **Gender**: **Ethnicity**: **Hospital Number**: **Religion or Belief**: **Language/How communicates**:	**Next of Kin**: **Relationship**: **Telephone Number**: **Informed of transfer/discharge**: YES NO
Current Patient Location: **Telephone Number**: **Consultant**:	**Date of Admission**: **Date of Discharge**:
Reason for Admission:	

Relevant Medical History:

Any Disabilities e.g. sensory, learning, physical, mental health issues: YES/NO

If yes how does this affect patient?

Is there a safeguarding alert for this patient:

Vital Signs	**B/P**:	**Temp**:	**Pulse**:
	Resps:	**BM:**	

Neurological assessment

Neurological status:

Glasgow coma scale:

Reason(s) for Referral: (Please Highlight below)

Wound Dressing(s)	Removal of Sutures/Clips	Continence Issues
Urinary Catheter Care	Medication Dispensing	Venepuncture
Dosset Box	Regular Injections	Blood Sugar Monitoring
Insulin Administration	Warfarin Control/Dosing	Respiratory Care:

Description of Care Required:

Condition of Pressure Areas:

Body map enclosed: YES NO **Waterlow score**:

Bruises/marks on body:

What are the possible causes:

Urinary catheter type:

Date due for change:

Reason for insertion:

Date of Last Bowel Action:

Patients Mobility Status:

Mobility Aids used:

Physiotherapist:

Bleep Number:

Patients dietary status/M.U.S.T. score:

Patients mental status (Please Highlight)

Alert ☐ Orientated ☐ Confused ☐

Patients self-care status:

Occupational Therapist:

Bleep Number:

Social Support/interaction & Home care arrangements:

Known to Social Services: YES NO

Name of social worker: (if known)

Contact Number:

Outpatient Appointment: YES NO

Date if known:

Inter – health care infection control transfer form which must be completed for every patient transfer in accordance with Dept. of Health guidelines.

Is patient an Infection Risk:

(Please highlight most appropriate box and give confirmed or suspected organism)

☐ Confirmed Risk Organism: _____

☐ Confirmed Risk Organism: _____

☐ Suspected Risk Organism: _____

If Patient had Diarrhoeal illness, *please indicate bowel history for last week*:

(based on Bristol Stool form scale)

Is the diarrhoea thought to be of an infectious nature?

YES NO

Relevant specimen results (including admission screens – MRSA, glycopeptides-resistant enterococcus SPP, *C. difficile*, multi-resistant *Acinetobacter* SPP)and treatment information, including antimicrobial therapy:

Specimen:				
Date:				
Result:				

Treatment Information:

Other Information:

Is the patient aware of their diagnosis/risk of infection? YES / NO

Does the patient require isolation? YES NO

Items with patient:

Doctors letter:	YES/NO/NA	**Wound chart**:	Yes/No/NA
X-Rays:	YES/NO/NA	**Drug chart/TTO form**:	Yes/No/NA
Medical Notes:	YES/NO/NA	**Diabetic chart**:	Yes/No/NA
Blood results:	YES/NO/NA	**Warfarin chart**:	Yes/No/NA
Physio report:	YES/NO/NA		

When referring to Community Nurses please also fax copy of TTO form

Additional Information
Signature: **Date**:
Printed name: **Status**:

St George's Healthcare NHS
NHS Trust

Nurse Transfer/Discharge Form (Paediatrics)

Name: **Address**: **Postcode:** **Ward name and contact details:**	**Parents / Carers (Full Name):** **Work:** **Mobile:** **Email:** **Religion:**
GP: **Address:** **Telephone:** **Community Paediatrician:** **Telephone:**	**School Nurse / Health Visitor:** **Name:** **Contact Details:** **Community Children's Nurse:**
Date of Admission: **Date of Discharge**:	**School / Nursery** **Address:**
Reason for Admission:	

Relevant Medical History:			
Social / Safeguarding History			
Current Medication:			
Out Patient Follow-up: Yes / No **Has appointment with:**			
Vital Signs	**B/P**:	**Temp**:	**Pulse**:
	Resps:	**BM:**	**Pain Score:** (Enclose a copy of the pain tool)
	PEWS Score: (Enclose a copy of the PEWS tool)	**Glasgow Coma Scale:**	

Reason(s) for Referral:

Description of Care Required:

(Use Ropers Activity of Daily Living – consider sending a copy of the child's care plan)

Parent /Carer Competencies Completed: **Yes / No**

List competencies and enclose a copy of competency assessment:

Other agencies involved:

Social Worker:

Physiotherapist:

O/T:

Speech and language therapist:

Dietician:

Psychologist:

Respite / Continuing Care:

Other:

Inter – health care infection control transfer form which must be completed for every patient transfer in accordance with Dept. of Health guidelines.

Is patient an Infection Risk:

(Please highlight most appropriate box and give confirmed or suspected organism)

☐ Confirmed Risk Organism: _____

☐ Confirmed Risk Organism: _____

☐ Suspected Risk Organism: _____

☐ No known Risk

Relevant specimen and blood results

Specimen:				
Date:				
Result:				

Treatment Information:

Other Information:

Does the patient require isolation? YES / NO

Items with patient:

Doctors letter: YES/NO/NA **Wound chart**: Yes/No/NA

X-Rays: YES/NO/NA **Drug chart/TTO form**: Yes/No/NA

Medical Notes: YES/NO/NA **Diabetic chart**: Yes/No/NA

Blood results: YES/NO/NA **Warfarin chart**: Yes/No/NA

Physio report: YES/NO/NA

Additional Information:

Signature:	**Date**:
Printed name:	**Status**:

Appendix H

Nurse Transfer/Discharge Form - (Child)

Name: **Address**: **Postcode:** **Hospital No:** **Consultant:** **Ward name and contact details:**	**Parents / Carers (Full Name):** **Work:** **Mobile:** **Email:** **Religion:**
GP: **Address:** **Telephone:** **Fax:** **Community Paediatrician:** **Telephone:**	**School Nurse / Health Visitor:** **Name:** **Contact Details:** **Community Children's Nurse:**
Date of Admission: **Date of Discharge**:	**School / Nursery** **Address:** **Telephone:**
Reason for Admission:	
Relevant Medical History:	
Social / Safeguarding History	

Current Medication

Immunisations up to date: Yes/No

Current Weight: **Date:**

Out Patient Follow-up: Yes / No

Has appointment with:

Vital Signs	**B/P**:	**Temp**:	**Pulse**:
	Resps:	**BM:**	**Pain Score:**
	PEWS Score: (Enclose a copy of the PEWS tool)	**Glasgow Coma Scale:**	(Enclose a copy of the pain tool)

Reason(s) for Referral:

Description of Care Required:

(Use Ropers Activity of Daily Living – consider sending a copy of the child's care plan)

Parent /Carer Competencies Completed: **Yes / No**

List competencies and enclose a copy of competency assessment:

Other agencies involved:

Social Worker:

Physiotherapist:

O/T:

Speech and language therapist:

Dietician:

Psychologist:

Respite / Continuing Care:

Other:

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Inter – health care infection control transfer form which must be completed for every patient transfer in accordance with Dept. of Health guidelines.

Is patient an Infection Risk:

(Please highlight most appropriate box and give confirmed or suspected organism)

Confirmed Risk Organism:

Confirmed Risk Organism:

Suspected Risk Organism:

Relevant specimen and blood results

Specimen:				
Date:				
Result:				

Treatment Information:

Other Information:

Does the patient require isolation? YES / NO

Items with patient:

Doctors letter: YES/NO/NA **Wound chart**: Yes/No/NA

X-Rays: YES/NO/NA **Drug chart/TTO form**: Yes/No/NA

Medical Notes: YES/NO/NA **Diabetic chart**: Yes/No/NA

Blood results: YES/NO/NA **Warfarin chart**: Yes/No/NA

Physio report: YES/NO/NA

Additional Information:

Signature: **Date**:

Printed name: **Status**:

Appendix I - DISCHARGE POLICY AUDIT

St George's Healthcare NHS Trust

1 A: Admission Details

1	Date of Birth	…… / …… / ……
2	Date of admission	…… / …… / ……
3	Method of admission	elective ☐ emergency ☐ transfer ☐
4	Admission ward	……..
5	Specialty on admission	……..

2 B: Discharge Planning

6	Was the date of discharge anticipated on admission?	Yes ☐ No ☐
7	If Yes to Q6 give anticipated date of discharge	…… / …… / ……
8	Is there evidence of discharge planning?	Yes ☐ No ☐
9	If emergency or transfer (Q3) did discharge planning begin on admission?	Yes ☐ No ☐
10	Does the discharge planning include assessment of whether the patient is likely to have continuing health &/or social needs?	Yes ☐ No ☐

3 C: Referrals

11 Which services/agencies were involved with discharge? (tick all that apply)

Physio ☐	OT ☐	SLT ☐
Dietitian ☐	Psych Liaison ☐	DALT ☐

Social Services	☐	District Nurse	☐	ICT	☐
Red Cross	☐	Other (state)	☐	……	

4 D: Medication

12	When was the discharge prescription written?	Date …. / …. / ….	Time …….
13	When was the discharge prescription dispensed?	Date …. / …. / ….	Time …….

5 E: Transport ☐ ☐

14	Did the patient require transport on discharge?	Yes Go to Q16	No Go to Q19
15	When was the need for transport identified?	Date …. / …. / ….	
16	When was the booking made?	Date …. / …. / ….	Time …….
17	When was transport booked for?	Date …. / …. / ….	Time …….

5.1

6 F: Information/Communication – all questions relate to patient and carers

18	Documented that pt/carer given info on reason for admission and treatment?	Yes ☐	No ☐
19	Documented that patient/carer given info regarding discharge?	Yes ☐	No ☐
20	Documented that pt/carer was given info regarding the following post-discharge concerns?		
21a	Danger signs to look for	Yes ☐	No ☐
21b	Who to contact with concerns or queries	Yes ☐	No ☐

21	Documented TTOs fully explained	Yes ☐	No ☐
22	Is it documented that appropriate health education literature was given?	Yes ☐	No ☐

G: Discharge Details

23 Who declared the patient medically fit for discharge?

Consultant ☐ Junior doctor ☐ Nurse ☐ Therapist ☐

SpR ☐ Doctor u/k grade ☐ Other ……

24 Date and time declared medically fit for discharge Date …. / …. / …. Time ……

25 Date and time discharged Date …. / …. / …. Time ……

26 Ward discharged from ……..

27 Care group discharged from ……..

28 Where was patient discharged to?

Home ☐ Res. home ☐ Nursing Home ☐ Other hospital ☐ ICT ☐

Hospice ☐ Other ……

29 Was this the same place the patient was admitted from? Yes ☐ No ☐

7 H: Documentation

30	Is "Discharge Arrangements + Other Social Details completed (or discharge assessment at admission doc)?	Fully ☐	Partially ☐	No ☐	☐
31	Is the nursing "Discharge checklist/plan" or local nursing discharge checklist documentation completed?	Fully ☐	Partially ☐	No ☐	NA ☐

32	Type of discharge communication in the notes	Discharge Summary written in the notes by nursing staff	☐ Merlin	☐

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Appendix J

EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
	Trust-wide		Existing	

1.1 Who is responsible for this service / function / policy?

All multi professional staff working in St George's Healthcare NHS Trust

1.2 Describe the purpose of the service / function / policy?

The purpose of this policy is to set out the process requirements and staff responsibilities to supporting well-organised, safe and timely discharge for all patients.

1.3 Are there any associated objectives?

To meet NHSLA Risk Management Standards for the safe and timely discharge of patients.

1.4 What factors contribute or detract from achieving intended outcomes?

None

1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?

None

1.6 If yes, please describe current or planned activities to address the impact.

N/A

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service

1.9 Equality Impact Rating [low, medium, high]- see guidance notes 3.1 above

Low

2.0. Please give you reasons for this rating

If you have rated the policy, service or function as having a high impact for any of these equality dimensions, it is necessary to carry out a detailed assessment and then complete section 2 of this form

Appendix K

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document submitted to the Policy Approval Group for ratification.

	Title of document being reviewed	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	The policy has been reviewed and updated by the individuals responsible for providing that part of the service. Eg PCTs, Social Services, CNS, Bed management team.
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	

	Title of document being reviewed	Yes/No/ Unsure	Comments
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have human resources/staff side committees (or equivalent) approved the document?	Yes	

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7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	