Imperial College Healthcare NHS
NHS Trust

IMPERIAL COLLEGE HEALTHCARE NHS TRUST
ADULT INPATIENT DISCHARGE POLICY
FINAL

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Replacing:	**i) Adult Discharge Policy – Complex, Standard and Inter-hospital Transfer, June 2008 ii) Adult Choice Policy – Self-funding, Local Authority and PCT Funded Patients, June 2008 iii) Standard Operating Procedure – Estimated Date of Discharge (draft), August 2010 iv) Standard Operating Procedure – Inter-hospital Transfers (draft), October 2010 v) Discharge Planning/ Delayed Transfers of Care – Management, Escalation and Exception Reporting, August 2010 vi) Standard Operating Procedure – Patient Flow for Inter-Hospital Transfers, February 2009**

VERSION CONTROL

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0.1	Gabrielle Nicholson	02 November 2010	Initial drafting
1.0	Jill Anderson, Robert Conyers & Rebecca Campbell	26 November 2010	Re-written
1.1 – 1.4	Gavin MacDonald, Robert Conyers & Rebecca Campbell	2 December 2010	Further amendments
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3.5	Robert Conyers, Rebecca Campbell and Jill Anderson	29 March 2011	Final amendments
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5.5	Dr Andrew Hartle, Sarah Morton	8th September 2014	Further amendments
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1. INTRODUCTION

The Adult Inpatient Discharge Policy identifies the processes to be followed in discharging patients from Imperial College Healthcare NHS Trust. The Policy includes roles and responsibilities to ensure that discharge happens in accordance with best practice and to maximise the safety of patients.

This Policy replaces the following policies / processes:

i) Adult Discharge Policy – Complex, Standard and Inter-hospital Transfer, June 2008
ii) Adult Choice Policy – Self-funding, Local Authority and PCT Funded Patients, June 2008
iii) Standard Operating Procedure – Estimated Date of Discharge (draft), August 2010
iv) Standard Operating Procedure – Inter-hospital Transfers (draft), October 2010
v) Discharge Planning/ Delayed Transfers of Care – Management, Escalation and Exception Reporting, August 2010
vi) Standard Operating Procedure – Patient Flow for Inter-Hospital Transfers, February 2009

2. AIMS OF THE POLICY

The aims of this policy are to ensure:

i) All patients have a patient centred discharge experience.
ii) All patients/relatives/support networks are involved and kept informed about their discharge pathway by all members of the multidisciplinary team, to promote their patient experience.
iii) All patients, carers and families are involved in all stages of discharge planning and needs assessments through effective communication.
iv) All patients should have an appropriate, timely and effective discharge.
v) All patients follow a discharge pathway from their admission.
vi) All patients with anticipated complex discharge needs are referred to the Complex Discharge Team, and staff know how and when to do this.
vii) All patients have an Anticipated Date of Discharge.
viii) All patients are discharged by 09.00 hrs as the gold standard, where appropriate.
ix) All services discharge patients seven days a week.
x) All delayed discharges follow an appropriate escalation process once the patient is classified medically stable and or fit.

3. SCOPE OF THE POLICY

This policy covers all Adult Inpatients at ICHT with the exception of Day Cases. The ICHT Paediatric Services Discharge Policy should be referred to for the processes relating to the discharge of paediatric patients.

Whilst this policy aims to cover all potential discharge pathways for inpatients there will be a small number of patients that may not fit into the pathways described within the Policy. However, even for this group of patients the fundamental overarching principles can still be applied.

In the event that a patient does not fit into the pathways described in the policy the cases should be referred to the complex discharge team who can provide advice on how to case manage these discharges.

4. KEY STAKEHOLDERS IN IMPLEMENTING THE POLICY

The following are key ICHT stakeholders in the delivery of this policy:

Stakeholder Organisation	Organisational Responsibilities
Imperial College Healthcare NHS Trust	i) The Trust Board is responsible for providing assurance to patients and the public that the policy is in place. ii) The CEO/Principal, Executive Directors and Directors are responsible for ensuring that all staff are informed about the Policy and carrying out their roles and responsibilities as specified in the Policy. i) All staff are responsible for ensuring they carry out their individual responsibilities as specified in this policy.
Clinical Commissioning Groups	CCG's have an obligation to ensure that community healthcare is provided in a way that meets their population's needs.
Local Authorities	Local Authorities (LAs) have an obligation to ensure that community social care is provided in a way that meets their population's needs.

5. KEY DEFINITIONS USED IN THE POLICY

5.1 Medically Fit

Medically fit is defined as a patient who has no acute medical problems and is fit for discharge.

For the purposes of this policy a patient would become medically fit when all required acute intervention is complete for the associated hospital admission.

The decision as to a patient's medically fit status will be made by the medical team and consultant in charge, with input from the ward Nursing and MDT staff where required.

5.2 Routine Discharge

A routine discharge is defined where it is anticipated that the patient will not have any significant ongoing care or support needs once they are classified as medically fit.

If patients have high care needs that were previously being met by health and or social care providers, and these needs are unchanged, they will be classed as a routine discharge.

5.3 Complex Discharge

A complex discharge is defined as when a routine discharge cannot be completed due to a change in care needs. Patients undergoing complex discharge will require relatively new high ongoing care or support needs following a discharge from hospital.

Input is required from at least 2 members of the MDT team and agencies outside ICHT.

Complex Discharge Criteria are detailed in Section 7.1.

5.4 Delayed Transfer of Care

A delayed transfer of care occurs when a patient is medically fit for discharge, but is still occupying an acute bed.

6. ROUTINE PATIENT DISCHARGE PATHWAYS

There are two pathways for routine discharge patients to complete:

i) Medically fit pathway for routine patients.
ii) Routine package of care pathway (if applicable).

Discharge plans should be discussed with the patients and their family/carer throughout their inpatient stay. If there are concerns over a patient's mental capacity an assessment may be required; please see Section 10.

6.1 Medically Fit Pathway

All patients on a routine care pathway require the medically fit actions to be completed.

STEPS	Medically Fit Actions	Responsibility
STEP 1	All patients should have a medical assessment by a Consultant (Named Consultant or Consultant of the Week) within 24 hours.	Clinical Programme Directors, Chief of Services and all ICHT Consultants.
STEP 2	All patients should have an Anticipated Date of Discharge (ADD) established as early in their patient pathway as possible at a clinically appropriate time (the appropriate timing should be agreed locally). **This should normally be set within 24 hours of admission and the patient/relative informed**	i) **Elective Patients:** Ward Sister / Charge Nurse / Ward nursing staff. ii) **Non Elective Patients:** Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 3	Once the ADD is established this should be communicated to the patient and their family / carer as soon as possible using the discharge ticket (included in Appendix 1).	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT. Therapy teams where they are involved in supporting discharge.
STEP 4	The ADD should be logged onto iWard within 2 hours of establishing **(and this date should only be amended if there is a significant change in the clinical pathway).**	Ward Sister / Charge Nurse, Deputy or Nurse with responsibility in caring for patient when ADD is established.
STEP 5* See Appendix 2	The Electronic Discharge Communication (EDC) should be commenced on admission and kept updated to reflect progress towards discharge as per Appendix 2.	Consultant Team representative. All other staff involved in the care to complete EDC as required.
STEP 6 + REPEAT STEP 3	Patients should have progress against their ADD monitored as part of the daily consultant inpatient review or consultant led inpatient board review.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 7	The patient should be referred to pharmacy if there are anticipated medication adherence issues, e.g. Dossett boxes, 24 hours prior to ADD.	Ward Nursing Staff.

STEP 8* See Appendix 2	Once the ADD is confirmed the To Take Away (TTA) Drugs should be prescribed and supplied in line with EDC/TTA protocol in Appendix 2.	Medical team responsible for the care of the patient or nominated representative of a covering team and members of the ward team.
STEP 9	If a District Nurse is required the referral should be completed within 24 hours before discharge and verification of referral completed. District Nurses should be informed of any equipment or supplies requirement as soon as possible.	Ward Nursing Staff.
STEP 10	If community rehabilitation services will be supporting discharge the referral must be completed 24 hours before discharge and verification of referral completed.	Ward Therapy Staff
STEP 11	Patient transport should be booked 24hours prior to discharge (if the patient meets the ICHT criteria for transport).	Ward Nursing Staff.
STEP 12	The patient is discharged and given a copy of the EDC. (An electronic copy is sent to the GP automatically unless specified not to by the patient).	Ward Nursing Staff.

Note; Additional guidance on completion of the EDC and supply of To Take Away (TTA) Drugs is included in the protocol in Appendix 2.

6.2 Routine Package of Care Pathway (If Applicable)

This pathway should be followed for all patients who require a new or restart of a routine package of care (social services) after they have been discharged.

Patients should be consulted and consent before any referral to Social Services is made; see Section 8.1.1 for more information.

STEPS	Routine Discharge Actions	Responsibility
STEP 1	The assessment of condition and care requirements is completed in accordance with the locally agreed care planning process.	Ward Nursing Staff.
STEP 2	If there is an identified need a Section 2* is completed within 24 hours of admission.	Ward Nursing Staff.
STEP 3	Social Services assessment or contact completed within 2 days of receipt of Section 2 or earlier for short stay patients	Social Services Team.
STEP 4	MDT Assessment completed.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and ward based MDT staff involved in the case.
STEP 5	Section 5* completed within minimum of 24 hours prior to being anticipated medically fit for discharge.	Ward Nursing Staff.
STEP 6	Patient discharged and package of care implemented	Social Services.

*Section notification templates in Appendix

7. IDENTIFICATION OF THE APPROPRIATE COMPLEX PATHWAY

7.1. Criteria for Activating a Complex Discharge Pathway.

Patients should be identified as having complex care needs on admission.
The below list identifies patients who are vulnerable and require robust discharge planning.

	Complex Discharge Criteria - Description of Category
1	Patients that are anticipated to require **specialist rehab** once the acute episode of care has been completed.
2	Patients that are anticipated to have **new or a change in housing / residential care needs** once the acute episode of care has been completed (including asylum seekers, homeless patients and overseas patients).
3	Patients that are anticipated to have **new or a change in health needs** once the acute episode of care has been completed (including asylum seekers, homeless patients and overseas patients).
4	Patients that are identified as requiring a mental capacity assessment and as a result require **referral to the Independent Mental Capacity Advocate** service regarding a discharge decision.
5	Patients who are not the responsibility of Primary Care Trust or Local Authority that are anticipated to require **spot purchase of care or a placement**.

The Complex Discharge Team will support ward staff to identify complex discharges through their daily validation process. This process takes place daily (Monday-Friday) with a member of the complex discharge team visiting clinical areas before 11am where possible.

7.2 Activating a Complex Discharge Pathway

This should take place in identifying patients that will require a complex discharge pathway in line with the above criteria.

Point in Pathway	Action	Lead Responsibility
Pre assessment	Inform the Complex Discharge Team that the patient is likely to require a Complex Discharge Pathway.	Doctor/ Nurse / Allied Health Professional carrying out the pre assessment screen.
Accident and Emergency	As above.	Accident & Emergency Nurses or other members of the A&E MDT.
Medical Assessment Unit	As above.	Nurse / Allied Health Professional supervising the care of / or providing the care in the Medical Assessment Unit.
Inpatient Wards	As above.	The Ward Sister / Charge Nurse or their shift deputy / Allied Health Professionals or other members of the MDT.
	Review on each ward of (i) all patients who have been referred to the Complex Discharge Team and (ii) identification of any additional patients for referral.	Complex Discharge Team

8. COMPLEX PATIENT DISCHARGE PATHWAYS

There are two pathways for complex discharge patients

i) Complex packages of care pathways.
ii) Medically fit pathway (for complex discharge patients).

8.1 Complex Packages of Care Pathways

There are five complex packages of care pathways:

1A: Patients that Require Residential Care Home or Supported Accommodation
1B: Patients that Require Nursing Home and Continuing Care
2: Patients that Require Inpatient Rehabilitation
3: Patients that are Fast-track Due to Rapidly Deteriorating Condition
4: Patients that are Out of Area and Require Repatriation

Note: Eligibility of NHS Continuing Care or NHS-Funded Nursing Care should be determined using the Trusts' Electronic Continuing Care Assessment (eCCA). This comprises of the following forms:

i) Continuing Healthcare Needs Checklist
ii) Health Needs Assessment
iii) Decision Support Tool
iv) Palliative Care for Fast Track Patients

For more information on these documents also refer to Appendix 3.

Assessment under the National Framework for NHS Continuing Care and NHS-Funded Nursing Care criteria (Reference 1) is coordinated by the Complex Discharge Team.

8.1.1 Obtaining Consent for Referral to Social Services

The Community Care (Delayed Discharge) Act (Reference 2) requires that patients are consulted and consent is sought before a referral to social services is made. If a patient does not consent to being referred to social services the following should be completed:

i) An assessment with the patient/ carers to ascertain if there is adequate support available outside social services.
ii) Advise patient/carers they will be responsible for arranging their own onward care.
iii) Send assessment notification to Social Services if patient/carer still does not consent to be referred to Social Services.
iv) Refer to the Escalation Process 4 (Disputes) if there are any delays regarding a discharge.

8.1.2 Complex Package of Care Pathway 1A: Patients that Require Residential Care Home or Supported (e.g. Sheltered) Accommodation

STEPS	Complex Package of Care Actions	Responsibility
STEP 1	MDT Assessment of condition and care requirements using the locally agreed care planning process.	Medical team/Ward Nursing Staff/appropriate members of MDT
STEP 2	If patient requires a Residential Care Home of Supported Accommodation, Section 2 to be completed within 24 hours of admission.	Ward Nursing Staff.
STEP 3	Social Services assessment or contact completed within 2 days of receipt of Section 2.	Social Services Team.
STEP 4	MDT identify needs and complete Complex Needs Assessment	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and appropriate other members of the MDT.
STEP 5	Section 5* completed within minimum of 24 hours prior to being anticipated medically fit for discharge.	Ward Nursing Staff.
STEP 6	Social Service to identify appropriate residential or Supported (e.g. Sheltered) care accommodation, and patient to be discharged.	Social Services.

8.1.3 Complex Package of Care Pathway 1B: Patients that Require Nursing Home and Continuing Care

STEPS	Complex Package of Care Actions	Responsibility
STEP 1	MDT Assessment of condition and care requirements using the locally agreed care planning process.	Medical team/Ward Nursing Staff/appropriate members of MDT
STEP 2	Referral to Complex Discharge Team	Ward Nursing Staff, any member of the MDT
STEP 3	If there is an identified need a Section 2 is completed within 24 hours of admission.	Ward Nursing Staff.
STEP 4	Social Services assessment or contact completed within 2 days of receipt of Section 2.	Social Services Team.
STEP 5	MDT to identify high care/health needs.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 6	Completion of Department of Health (DOH) Checklist and distribution of the Electronic HNA (part of eCCA) to all the appropriate MDT members.	Complex Discharge Team.
STEP 7	Completion of Health Need Assessment (HNA) within 48 hours of being confirmed as medically fit for discharge.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 8	HNA to be completed and returned to	Ward Sister / Charge Nurse or Deputy

	Complex Discharge Team within 48 hours.	in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 9	Decision Support Tool completed.	Complex Discharge Team
STEP 10	Joint meeting to determine responsibility for providing care (PCT or Local Authority) within 24 hours	Complex Discharge Team and Social Services.
STEP 11	Joint Assessment sent to panel for ratification.	Complex Discharge Team, Social Services and joint Primary Care Trust and Local Authority Panel.
STEP 12 A	For Fully Funded NHS Continuing Health Care a Continuing Care placement or home care package will be identified.	Complex Discharge Team / Primary Care Trust
STEP 12 B	If responsibility is to the Local Authority and not Fully Funded NHS Continuing Health Care, a Section 5 needs to be completed and sent.	Ward Nursing Staff.
STEP 12 C	Upon receiving the Section 5 Social Services will determine an appropriate placement or home.	Social Services
STEP 13	Home or Placement Assessment and patient to be discharged following successful completion of this.	Nursing Home or Placement Team, liaising with Complex Discharge Team.

8.1.4 Complex Package of Care Pathway 2: Patients that Require Inpatient Rehabilitation

STEPS	Complex Package of Care Task	Responsibility
STEP 1	MDT assessment of condition and care requirements using the locally agreed care planning process.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 2	If there is an identified need a Section 2 is completed within 24 hours of admission.	Ward Nursing Staff.
STEP 3	Social Services assessment completed within 2 days of receipt of Section 2.	Social Services Team.
STEP 4	Patient identified as medically fit but requiring inpatient rehabilitation.	Allied Health Professionals / Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 5 *	Establish the patient's CCG and Borough of responsibility.	Ward Nursing Staff/Therapy Staff
STEP 6*	Identify appropriate rehab bed based upon above data or if unable to do so (e.g. patient is out of area) inform Complex Discharge Team.	Ward Nursing Staff/Therapy Staff
STEP 7*	Inform Complex Discharge Team of all referrals, out of area requirements or specialist needs, e.g. Putney or Northwick Park Level 1 and 2	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 8	If patient requires a specialist rehab bed contact the commissioners to	Complex Discharge Team.

	agree funding (NHS England for Level 1 and CCG Level 2)	
STEP 9	Completion of appropriate rehab referral forms/ single assessment form.	Allied Health Professionals / Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 10	Discharge patient to a rehab bed.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.

*** These steps can be completed concurrently**

8.1.5 Complex Package of Care Pathway 3: Patients that Require Continuing Care Fast-Track (For Rapidly Deteriorating Condition)

STEPS	Complex Package of Care Actions	Responsibility
STEP 1	Patient on an existing discharge pathway is identified as requiring fast track discharge due to rapidly deteriorating condition.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week / AHP's and other members of the MDT.
STEP 2	Referral to an appropriate to specialist palliative care team or other appropriate specialist team, based on condition.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week / AHP's and other members of the MDT.
STEP 3	Fast Track assessment completed.	Specialist Team/Palliative Care Team.
STEP 4	Fast Track care plan to be completed.	Specialist Team/Palliative Care Team/AHP's/MDT/Nursing Staff.
STEP 5	Fast Track and Care Plan given to Complex Discharge Team	Specialist Team/Palliative Care Team/MDT/Nursing Staff.
STEP 6	Referral to the District Nursing Team, community specialist palliative care team and other services (e.g. hospice at home) prior to discharge.	Specialist Team/Palliative Care Team/MDT/Nursing Staff.
STEP 7	Contact CCG to agree funding.	Complex Discharge Team.
STEP 8	GP notification prior to discharge.	Specialist Team/Palliative Care Team/MDT/Nursing Staff.
STEP 9	If funding agreed patient transport booked and patient discharged into an appropriate palliative care setting.	Consultant / Consultant of the Week.

8.1.6 Complex Package of Care Pathway 4: Patients Out of Area that Require Repatriation

STEPS	Complex Package of Care Actions	Responsibility
STEP 1	On admission patient identified as out of area and requiring repatriation.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 2	Patient to be stabilised.	Ward Sister / Charge Nurse or Deputy in liaison with the Named Consultant / Consultant of the Week and other members of the MDT.
STEP 3	Refer patient to local hospital and confirm Consultant accepted for repatriation	Named Consultant/Consultant of the Week
STEP 4	Inform Site Operations Manager via online repatriation system on The Source	Ward Nursing staff
STEP 5	Patient repatriated within 24 hours.	Ward Nursing staff / Site Management Team.

8.1.7 Complex Package of Care Pathway 4: Escalation Process for Patients Out of Area Requiring Repatriation

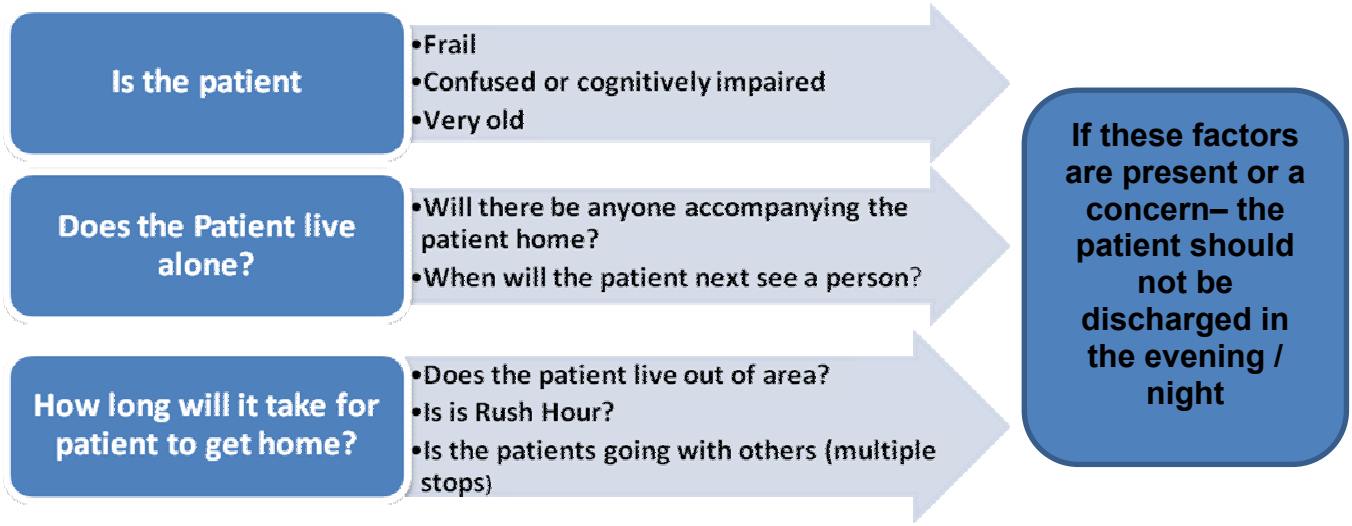
Where delays occur as a result of waiting for a bed in another Acute Trust the following escalation policy should be followed:

Time to Take Action	Escalation Action to be Taken	Responsibility
24 hours after the patient is classified as medically fit.	Inform the Site Operations Manager that the patient has not been repatriated to the host Trust.	Ward Sister / Charge Nurse or member of the Ward Nursing Staff.
Day 5 after the patient is classified as medically fit.	Inform the Head of Clinical Site Operations and Emergency Planning (or designated Deputy) that the patient has not been repatriated to the host Trust.	Site Operations Manager.
Day 7 after the patient is classified as medically fit.	Inform Director of Operational Performance that the patient has not been repatriated to the host Trust.	Head of Clinical Site Operations and Emergency Planning (or designated Deputy)

Note: Algorithms for all discharge pathways are included in Appendix 4.
Escalation process for other escalation categories can be found in Section 14.1.

8.2 Core Principles for discharging vulnerable patients from hospital

Patients who are vulnerable because of extreme age, cognitive impairment or frailty require additional support for discharge home. In particular, vulnerable patients should be discharged during the day up until early evening and **not** late in the evening or night time unless it is by prior agreement or for a particular reason (such as a family member meeting the patient after work)
Staff need to consider the questions below to ensure that patients are not discharged at an innapropriate time.

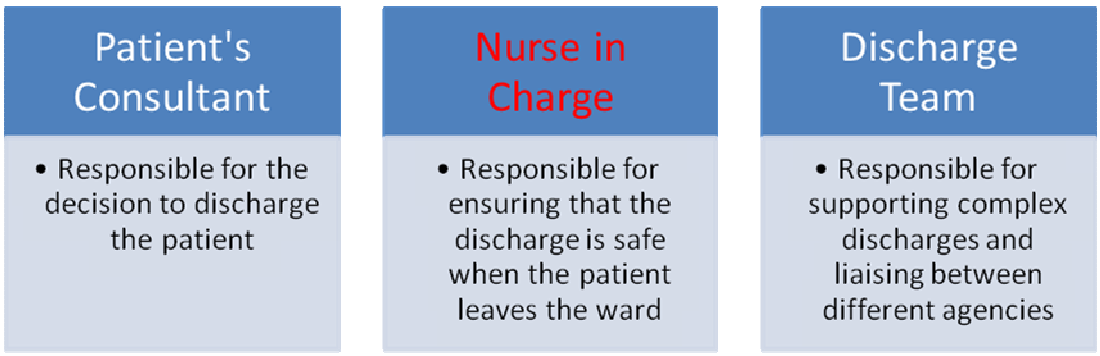


If a vulnerable patient with the above issues is discharged in the late evening or at night, it is less likely to be a safe discharge and also could cause significant distress to a patient. Patients with cognitive impairment should not be disturbed during the night as this leads to increased confusion and this will result in an increased probability of readmission to hospital.

Remember that these patients should have planned discharges and that the aim should always be to discharge as early as is practicable in the day as per the gold standard.

Responsibilities and Escalation

The key staff responsibilities for the person's discharge are shown below



If the nurse in charge has identified that a vulnerable patient is going to be discharged late / in the night and that there are no mitigating factors such as a relative waiting at home or a carer scheduled to arrive an hour later; the nurse in charge must act immediately to re-schedule the discharge to a safer time:

1. In office hours contact the Discharge Co-ordinator immediately to discuss an alternative
2. Out of hours contact the site team and inform them that the patient will need to stay in hospital
3. Ensure that the patient's medical team are also informed about the change of plan
4. Inform the patient and the patient's next of kin about the change of plan
5. Document decision and actions in the patient's notes.

8.3 Patient Choice

The National Health Service Act 1997 (Reference 3) and Trusts National Health Service and Community Care Act, 2003 (Reference 2) requires that all Health Authorities, PCTs and Trusts 'to meet all reasonable requirements for the after-care of illness to the extent considered necessary'.

In relation to this policy this covers the following:

ii) patient choice in relation to changes in accommodation that are required following admission
iii) patient choice of care home or alternative accommodation subject to availability

If Social Services are responsible for arranging a placement, the patient is entitled to move to a home of their own choice as defined in the National Assistance Act 1948 (Choice of Accommodation) Directions 1992 (Reference 4) on condition that:

i) A place is available.
ii) The accommodation is suitable to meet the needs assessed.
iii) It does not cost the Local Authority more than usual for the accommodation of someone with those needs.
iv) The home agrees to comply with the terms and conditions set by the Local Authority, i.e. agreed quality and standards.

If a placement in the home or the patients' choice is not available at the point at which the patient is ready for discharge an interim/alternative placement maybe arranged. If this occurs please see Escalation Process 3 (Patient Choice) for further guidance.

9. SELF DISCHARGE

Self – discharge is defined in section 5.4. The process for managing self–discharge is as follows:

STEP	Self – Discharge Process Actions	RESPONSIBILITY
STEP 1	Request for self discharge	Patient
STEP 2	The medical implications should be discussed with the patient.	Named Consultant / Consultant of the Week in liaison with the Ward Sister / Charge Nurse or Deputy and other members of the MDT.
STEP 3	The medical implications should be documented in the patient's health care record.	Nominated Medical Representative
STEP 4	A self discharge form should be	Ward Nursing Staff.

	completed and placed within the patient's health record.	
STEP 5	A copy of the discharge summary should be sent to the GP and where possible given to the patient.	Ward Nursing Staff.
STEP 6	Where necessary patient's GP and/or relevant health/social worker should be contacted to inform them of the patient's self discharge. This should be done in collaboration with the patient's carer/next of kin where necessary. Community rehabilitation referrals should be made where it has been identified that they could support the individual and they have given consent	Named Consultant / Consultant of the Week in liaison with the Ward Sister / Charge Nurse or Deputy and other members of the MDT. AHP's

If there are concerns regarding a patient's mental capacity please see section 10 of this policy and refer to the Mental Health Act policy and the Trust's Missing Person (Adult) policy and procedure (Reference 12).

All patients will have access to electronic discharge communication, to take home medication and details of any follow up appointments regardless of a decision to self-discharge. Staff should ensure that this is properly communicated to self-discharging patients and provide them with all the relevant information and medication for discharge.

Where a patient refuses to sign a self discharge form refer to section 4.3 of the Missing Person policy.

10. DISCHARGE OF PATIENTS WHERE THERE ARE CONCERNS / ISSUES ABOUT MENTAL CAPACITY

If the patient has a disorder which potentially affects their decision making ability, their mental capacity must be formally assessed. If there is concern that an individual may not have the mental capacity to give informed consent during any part of the discharge pathway, this should be determined in accordance with the Mental Capacity Act 2005 and the associated Code of Practice.

All efforts must be made to facilitate a person's decision making ability e.g. if there are communication problems you may need to refer to speech and language therapist.

The patient may be asked to make several different decisions relating to their discharge and each of these decisions must be assessed separately. If the patient is shown to lack capacity to make that decision, then a decision should be made on their behalf acting in their best interests and family or relatives need to be involved in this process. If the person is unbefriended they will need referral to an Independent Mental Capacity Advocate (IMCA).

Please refer to the Capacity Assessment and Best Interest Decision Pathways on The Source. These can be found on the following links:

Capacity Assessment
http://source/prdcont/groups/extranet/@clinical/@guidelines/documents/ppgs/id_035246.pdf
Best Interest Decision Pathways
http://source/prdcont/groups/extranet/@clinical/@guidelines/documents/ppgs/id_035247.pdf

11. DISCHARGE OF PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT

Patients subject to a section of the Mental Health Act can not be discharged home without the section being rescinded by the responsible clinician.

If a patient under section is near to being medically fit the mental health liaison team should be contacted prior to the Anticipated Date of Discharge to confirm the Care Programme approach prior to discharge. This should be done in conjunction with the appropriate psychiatric liaison team. Please refer to the Trust's Patients Detained under the Mental Health Act available at for more information. (Reference 7)
http://source/prdcont/groups/intranet/@corporate/@policies/documents/ppgs/id_024111.pdf

For patients with severe mental illness, or who self-harm, a 7 day follow up should be planned following discharge. Please see the Mental Capacity Act and Deprivation of Liberty Safeguards for more information.

12. VULNERABLE PATIENTS/LEARNING DISABILITIES

Vulnerable patients should be provided with additional information and communication support to their decision making ability and to help them in understanding the discharge process. Consideration must also be taken regarding time of discharge for vulnerable patients, particular instances where hospital transport is being provided and the time a patient will be at home on the day of discharge and pending start time of social care provision. Vulnerable patients should not be discharged home late in the day, consideration and communication must occur with the patient, carers/next of kin as appropriate and / or social care providers to ensure a safe and appropriate discharge.

Where patients are not discharged to their usual address, it is the responsibility of the team looking after the patient to ensure records are updated to ensure follow up appointments are communicated effectively to the appropriate address and community care providers informed of changes including GP's.

Additional information may include the following:

i) written or pictorial information
ii) referral to speech and language therapy
iii) telephone numbers of who can contacted following their discharge
iv) Trust's discharge ticket.

Specific information on this can be found in Appendix 6: Westminster Learning Disabilities Partnership, RBK&C Learning Disabilities Service & Imperial College Healthcare NHS Trust (ICHT) Discharge Pathway for People with Learning Disability

For further information on vulnerable groups please see the following Trust documents and policies or contact The Vulnerability Lead, Nursing Directorate.

i) Imperial College Healthcare Safeguarding Adults Policy and Procedure (Protection of Vulnerable Adults) (Reference 13)
ii) Imperial College Healthcare Learning Difficulties Policy (Draft 2011).
iii) Imperial College Healthcare Supporting patients with learning disabilities - Good practice guidelines (Reference 14)
iv) Caring for people with learning disability in a hospital setting (GAIN June 2010) (Reference 15)

13. TRANSFERRING PATIENTS UNDER DEPRIVATION OF LIBERTY SAFEGAURD (DOLS)

If a patient is under an authorisation (standard or urgent) for a DOLS and is required to be discharged to a another hospital Trust or care home, the managing authority of the new hospital or care home must request a new standard authorisation.

Please refer to Section 19 of the Mental Health Act and the Imperial College Healthcare NHS Trust's Transfer Policy (Reference 8) for guidance and terms outlining the appropriate transfer procedures and staff escort requirements.

Please refer to the Trust Deprivation of Liberty Safeguards Policy and Procedure and The Mental Capacity Act 2005 (Reference 5) for more information regarding (DOLS).

14. DELAYED TRANSFER OF CARE

A delayed transfer of care is defined as when a patient is ready for transfer from acute care, but is still occupying an acute bed. A patient is ready for transfer when all three points have been met:

i) A clinical decision has been made that patient is medically fit for transfer.
ii) A multi-disciplinary team decision has been made that patient is medically fit for transfer.
iii) The patient is safe to discharge/transfer.

14.1 Categories of Delay

The Department of Health classify a number of delays (Community Care (Delayed Discharges) Act - Reference 2) included in the table below. In addition a local category has also been classified:

Escalation Process No.	Classification of Delay	Category
1	Awaiting completion of assessment	A
1	Awaiting public funding	B
1	Awaiting community equipment and adaptations.	F
2	Awaiting further (non acute) NHS care (including intermediate care, rehabilitation services etc)	C
2	Awaiting residential home placement or availability	Di
2	Awaiting nursing home placement or availability	Dii
2	Awaiting domiciliary package.	E
3	Patient or Family Choice	G
4	Disputes.	H
See Section 8.1.7	Awaiting a bed in another Acute Trust	I

14.2 Escalation Processes for Delayed Discharges

Once the patient is medically fit and delayed transfers of care occur the following actions should be undertaken:

14.2.1 Escalation Process Number 1 (When delays occur when awaiting (A) Completion of Assessment, (B) Public Funding or (F) Community Equipment and Adaptations)

Time to Take Action	Action to be Taken	Responsibility
Day 1 from patient being medically fit.	Inform Complex Discharge Team Manager (site specific)	Ward Sister / Charge Nurse or member of the Ward Nursing Staff.
Day 1-3 from referral	Escalate the delay to the patients Borough and / or Primary Care Trust.	Head of Discharge and Intermediate Care / nominated representative.
Day 3	Complex Discharge Team Manager informs Service Manager Intermediate Care and Discharge escalates within Borough / CCG	Complex Discharge Manager

14.2.2 Escalation Process 2 – (When delays occur when awaiting (C) Further (Non Acute) NHS Care, (Di) Residential Home Placement, (Dii) Nursing Home Placement or (E) Availability of Domiciliary Package

Time to Take Action	Action to be Taken	Responsibility
3 days or more from patient being medically fit.	Inform the Complex Discharge Team, Team Manager	Ward Sister / Charge Nurse or member of the Ward Nursing Staff.
Immediately on escalation from the Ward Nursing Team	Escalate the delay to the patients Borough and / or Primary Care Trust.	Complex Discharge Team, Team Manager.
5 days or more from patient being medically fit.	Escalate to the Head of Discharge and Intermediate Care.	Complex Discharge Team, Team Manager.
Immediately on escalation from the Complex Discharge Team, Team Manager	Escalate the delay to the patients Borough and / or Primary Care Trust.	Head of Discharge and Intermediate Care / nominated representative.

14.2.3 Escalation Process 3 (To be used when delays occur as a result of (G) Patient Choice)

Time to Take Action	Action to be Taken	Responsibility
Home / Placement has been identified but there is no availability.	If patient is given a choice of 3 suitable placements but these placements do not have vacancy for the individual the CDT to be informed.	Social Services
Within 24 hours	Arrange discharge planning meeting held with patients/carers to discuss options.	Members of MDT
During discharge planning meeting	Advise patient/carer that patient can not remain in NHS hospital bed and needs an interim/alternative placement	Complex Discharge Team
7 days (from discharge planning meeting)	Find and agree on alternative/interim placement	Complex Discharge Team
Immediately after 7 day period has expired	If no suitable placement identified in timeframe or patient/carer rejects 2 suitable placements, inform Service Manager for Discharge and Intermediate Care.	Complex Discharge Team
Within 24 hours	Contact MDT and	Service Manager for

	patient/carer to inform them a suitable placement will be provided as an interim and a request to the Local Authority to provide this has been made. Confirm this decision in writing to the patient/carer.	Discharge and Intermediate Care
Within 2 days	Suitable interim placement identified by LA pr PCT and confirmed in writing to Head of Discharge and Intermediate Care.	PCT or Local Authority Service Manager
Immediately on escalation	Discharge arrangements to be put in place.	Specialist Discharge Nurse Coordinator
As soon as suitable placement and arrangements have been confirmed.	Implement discharge	Ward Sister / Charge Nurse or member of the Ward Nursing Staff.

14.2.4 Escalation Process 4 (To be used where delays occur as a result of (H) Disputes)

Time to Take Action	Action to be Taken	Responsibility
Within 24 hours	Inform the Head of Discharge and Intermediate Care.	Ward Sister / Charge Nurse or member of the Ward Nursing Staff.
Within 24 hours	Escalate the delay to the patients Consultant.	Head of Discharge and Intermediate Care / nominated representative.
Within 48 hours	Patient's consultant to identify a second Consultant to complete a review to confirm that the patient is medically fit.	Patients Consultant
Within 24 hours	Medically fit review process completed.	Patients Consultant and nominated second Consultant.
Within 2 hours	If medically fit patient is invited to leave the Trust premises.	ICHT Security Team

15 EQUALITY AND DIVERSITY IMPACT

The Trust is committed to supporting all forms of equality and recognises patient diversity. The Trust strives to provide a high quality, accessible and responsive discharge service which recognises and values patient diversity and promotes equality and respect to all patients.

The Trust will work towards the availability of robust equality statistical information, in relation to discharge and transfer, to assist with the Equality Impact Assessment process.

Please refer to the Trust's Single Equality Scheme for more information on the Trust's commitment and approach to all forms of equality

16 MONITORING OF THE DISCHARGE POLICY

The Trust's Divisions will monitor the implementation of the policy.

Any complaints, incidents or data relating to an unsatisfactory discharge will be root caused analysed.

An audit of the policy will include a sample of patients from each group within the Policy to review compliance with information provided to patient and information provided to receiving healthcare professional. This will be carried out annually.

16.1 Discharge Key Performance Indicators

No	KPI	Definition
1	% number of patients with an Anticipated Date of Discharge	N = Number of patients with an ADD D = Total number of patients
2	% number of patients discharged before 09.00hrs.	N = Number of patients discharged before noon. D = Total number of patients discharged.
3.	% number of patients discharged at the weekend.	N = Number of patients discharged on a Saturday and Sunday. D = Total number of patients discharged.
4.	% number of patients discharged to Anticipated Date of Discharge (first change).	N = Total number of patients discharged on the Anticipated Date of Discharge (first change). D = Total number of patients.

N = Numerator, D = Denominator

16.2 Delayed Discharge KPIs

No	KPI	Definition
1	% number of complex discharges identified by the Complex Discharge Team.	N = Number of complex discharges identified by the Complex Discharge Team. D = Total number of complex discharges.
2	Total number of bed days lost (by Site/CPG) for each category of delay A, B, C, Di, Dii, E, F, G, H, and I.	Absolute numbers.

17 REVIEW AND REVISION ARRANGEMENTS

The Policy will be reviewed after 2 years following publication in order that it can be further refined through monitoring of KPIs, audit and other lessons learned.

18 REFERENCES AND RELATED DOCUMENTATION

i) Department of Health (2009), The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, Department of Health: London. (Reference 1)

ii) Ministry of Justice (2003), Community Care (Delayed Discharges Etc.) Act, Office of Public Sector Information: London. (Reference 2).

iii) National Health Service Act (1997) (Reference 3)
iv) National Assistance Act 1948 (Choice of Accommodation) Directions 1992 (Reference 4)
v) Ministry of Justice (2005), Mental Capacity Act, Office of Public Sector Information: London. (Reference 5).
vi) Imperial College Healthcare NHS Trust Consent Policy (Reference 6).
vii) Imperial College Healthcare NHS Trust (2010), Patients Detained Under the Mental Health Act (Reference 7).
viii) Imperial College NHS Healthcare Trust Transfer Policy (2010 Draft) (Reference 8).
ix) Imperial College Healthcare NHS Trust Policy for Prescribing Medicines (2011) (Reference 9).
x) Imperial College Healthcare NHS Trust Medicines Reconciliation Policy (2009) (Reference 10).
xi) North West London Prescribing Policy (2009) (Reference 11).
xii) Imperial College Healthcare NHS Trust Missing Person (Adult) Policy and Procedure (2010) (Reference 12).
xiii) Imperial College Healthcare Safeguarding Adults Policy and Procedure (Protection of Vulnerable Adults) (2009) (Reference 13).
xiv) Imperial College Healthcare Supporting patients with learning disabilities - Good practice guidelines (Reference 14).
xv) Caring for people with learning disability in a hospital setting (GAIN June 2010) http://www.gain-ni.org/Library/Guidelines/Gain%20disability.pdf (Reference 15).

19 DISSEMINATION AND IMPLEMENTATION

To ensure that the Imperial College NHS Trust Staff are aware of, and understand the principles behind the discharge policy it will be incorporated into staff training.

This training, focusing on discharge, will be provided at induction for new staff members and regular intervals for substantive staff.

The training will focus on:

i) Pathways within the policy.
ii) Practical examples of routine and complex discharges.
iii) When to refer to the complex discharge team.
iv) How to use the Discharge Ticket.
v) Improving the discharge pathway.

An interactive approach to ensure a good level of understanding is achieved.

A training schedule will be available on the Trust's Source.

APPENDIX 1: PATIENT DISCHARGE TICKET

Discharge ticket

Imperial College Healthcare NHS
NHS Trust

Name of patient: *Jill Anderson*

Anticipated date of discharge*: *2nd Feb 2011*

Method for going home: *Family* Date: *2nd Feb* Time: *11am*

District nurse booked: Yes ☑ N/A ☐ Date: *9th Feb* Time: *9.30am*

Social services booked: Yes ☐ N/A ☑ Date: Time:

Any other arrangements:

If you have any queries relating to the recent care you received on the ward, please call: *020 3312 WXYZ*

* Anticipated date of discharge may be revised due to clinical need

Discharge ticket

Imperial College Healthcare NHS
NHS Trust

Questions to consider during your inpatient hospital stay:

- Do you know when you will be going home?
- Has your discharge medication been explained to you and do you understand the side effects?
- Have you discussed your arrangements for getting home?
- Have you been offered a patient survey device?
- Once you have left hospital do you know your community service arrangements for dressings, sutures or clips?
- Have all your questions been answered?
- Have you been told who to contact if you are worried about your condition or treatment after you leave hospital?

If the answer the any of the above questions is "no" please ask the nursing staff to clarify these for you

APPENDIX 2: ELECTRONIC DISCHARGE COMMUNICATION (EDC) & TTA PROTOCOL

STEPS	Actions	Time for Completion	Responsibility
STEP 8	**Providing Patients with their TTAs**		
STEP 8.1	TTAs to be completed within the following timescales:		
	Highly Predictable Discharge Drugs (HiPDD)	48 HRS prior to discharge	Registered Prescribers
	Moderately Predictable Discharge Drugs (MoPDD)	24 HRS prior to discharge.	
	Less than Predictable discharge drugs (LePDD) **Nursing or Medical staff to inform Pharmacy that aTTA is ready to be screened by Pharmacist**	≥ 4 HRS prior to discharge Prior to discharge	 Nursing and Medical staff
STEP 8.2	TTA to be received and screened against IP chart for completeness.	When received.	Pharmacy Staff
STEP 8.3	Availability of previously dispensed medication to be checked to see if it is already on the ward, or in the patients home	Prior to discharge.	Pharmacy or Ward Nursing Staff
STEP 8.4	Medication dispensed.	Prior to discharge.	Pharmacy Staff
STEP 8.5	Newly dispensed medication to be combined with medication already on the ward. Medication checked to ensure only medication prescribed on the TTA is supplied at discharge, and that the directions on the medication matches the TTA	Prior to discharge. Prior to discharge	Pharmacy or Ward Nursing Staff Pharmacy or ward Nursing Staff
STEP 8.6	Confirm with the patient they understand both use and likely side effects of medication.	Prior to discharge.	Pharmacy or Ward Nursing Staff
STEP 5	**Authorisation of the EDC**		
STEP 5.1	All relevant sections of the EDC (including Nursing and Allied Health Professionals) to be completed and authorised. Please refer to the EDC system for further information.	24 Hours prior to discharge	Medical, AHPs and Ward Nursing Staff
STEP 5.3	Provide patient with a copy of the EDC. (Electronic copy of EDC will be automatically sent to GP).	At point of discharge	Ward Nursing Staff

For further information regarding prescribing and medicine reconciliation please refer to the following: Imperial College Healthcare NHS Trust Policy for Prescribing Medicines (Reference 9), Imperial College Healthcare NHS Trust Medicines Reconciliation Policy (Reference 10), North West London Prescribing Policy (Reference 11).

Monitored Dosage Systems and other Compliance Aids
Hospital Trusts are encouraged to develop discharge planning arrangements for vulnerable patients. Where these include supply of monitored dosage or other similar systems there should be a policy in place for their use, including assessment of need and making appropriate arrangements for continuity after discharge (see ICHNT Guidance for Aiding Medicines Adherence). This arrangement should reflect guidance on support to people with disabilities, compliance with the Equalities Act 2010 (see www.primarycarecontracting.nhs.uk/98.php for a resource tool) and include community pharmacies, where appropriate.

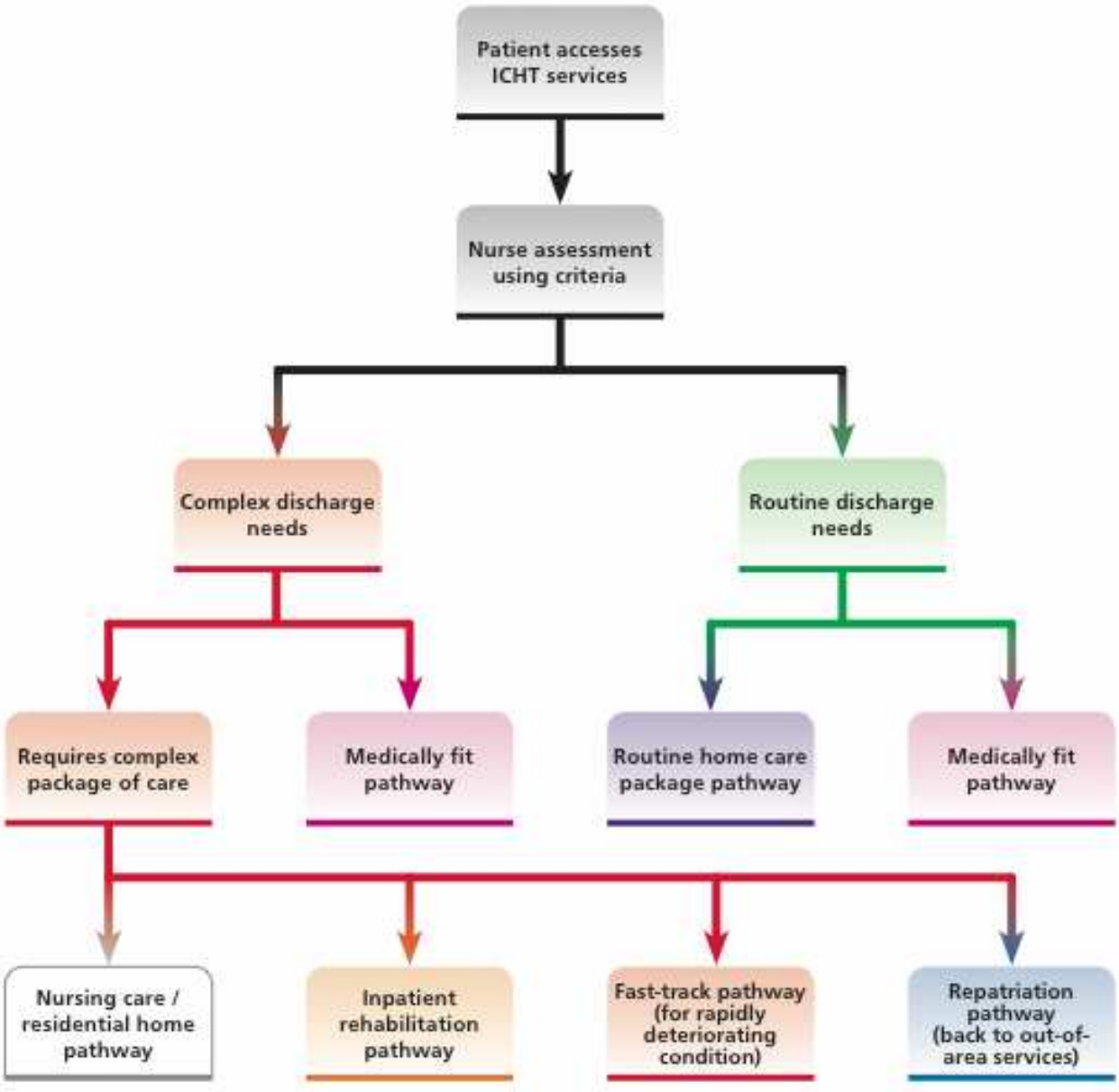
APPENDIX 3: DISCHARGE DOCUMENTATION MATRIX

Documentation	Why Required	Responsibility for Completion	When this Requires to be Completed	Timescales for Completion	To Be Sent To
Complex Needs Assessment	Assessment of complex needs	Nurses and other members of the MDT	For patients that require residential care home or Supported (e.g. Sheltered) accommodation.	As soon as possible.	Recorded in patient notes
Single Assessment Form	Assessment of condition and care requirements.	Nurses and other members of the MDT	On admission	On the day of admission	Recorded in patient notes
Decision Support Tool	To facilitate decision making on continuing care eligibility.	Complex Discharge Team	Following completion of the Health Needs Assessment.	As soon as possible	Complex Discharge Team
Health Needs Assessment	Part of Continuing Care Assessment	Complex Discharge Team	Prior to patient becoming medically fit.	2 Days	Complex Discharge Team
Section 2	Notification of Assessment	Ward Nursing Team	As soon as needs have been identified.	As soon as possible	Reimbursement Team
Section 5	Notification of Discharge to Social Services	Ward Nursing Team	At least 24 hours prior to patient being medically fit.	At least 24 hours prior to patient being medically fit.	Reimbursement Team

Appendix 4.1

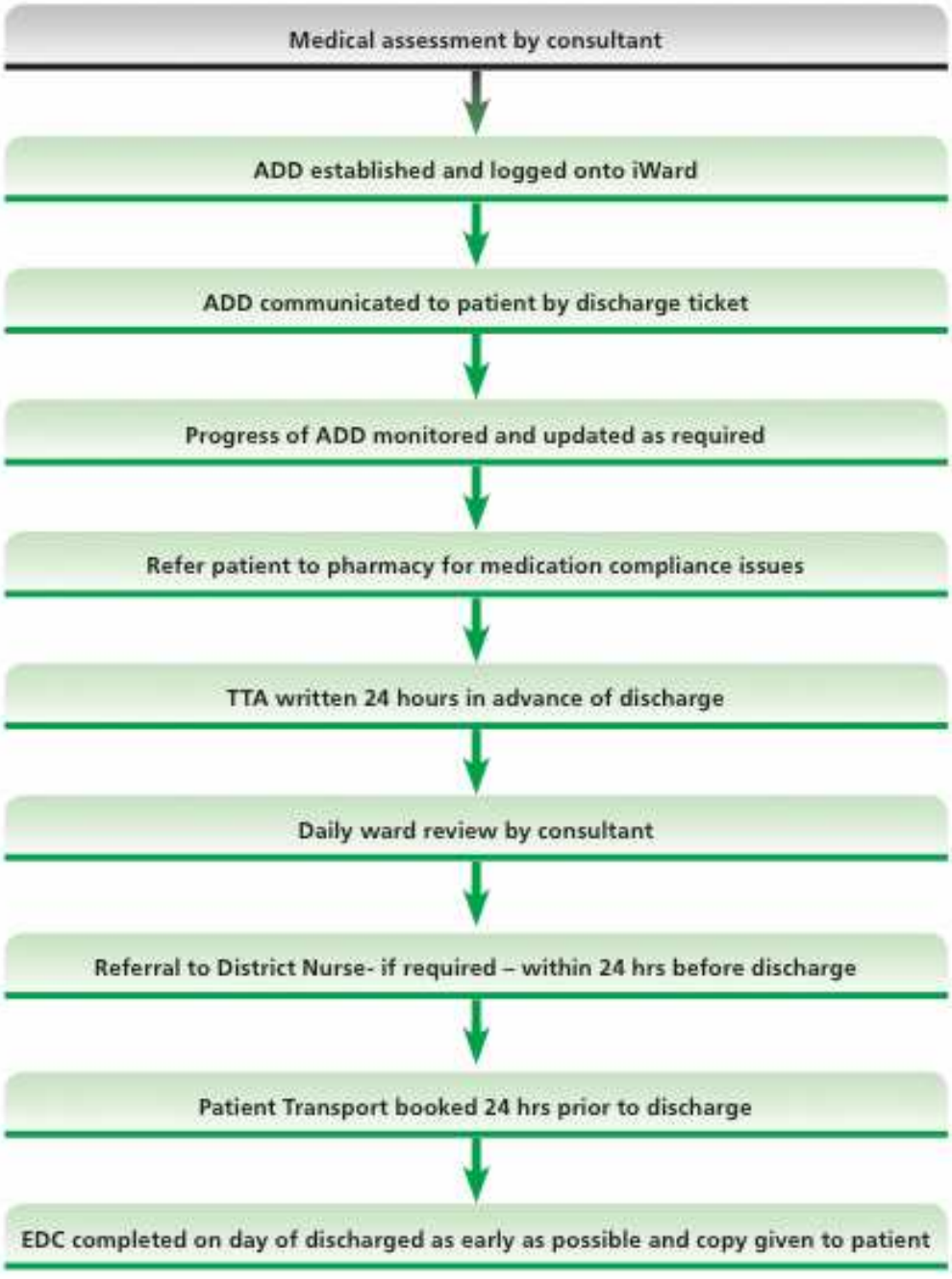
Summary of Discharge Policies

Imperial College Healthcare NHS Trust



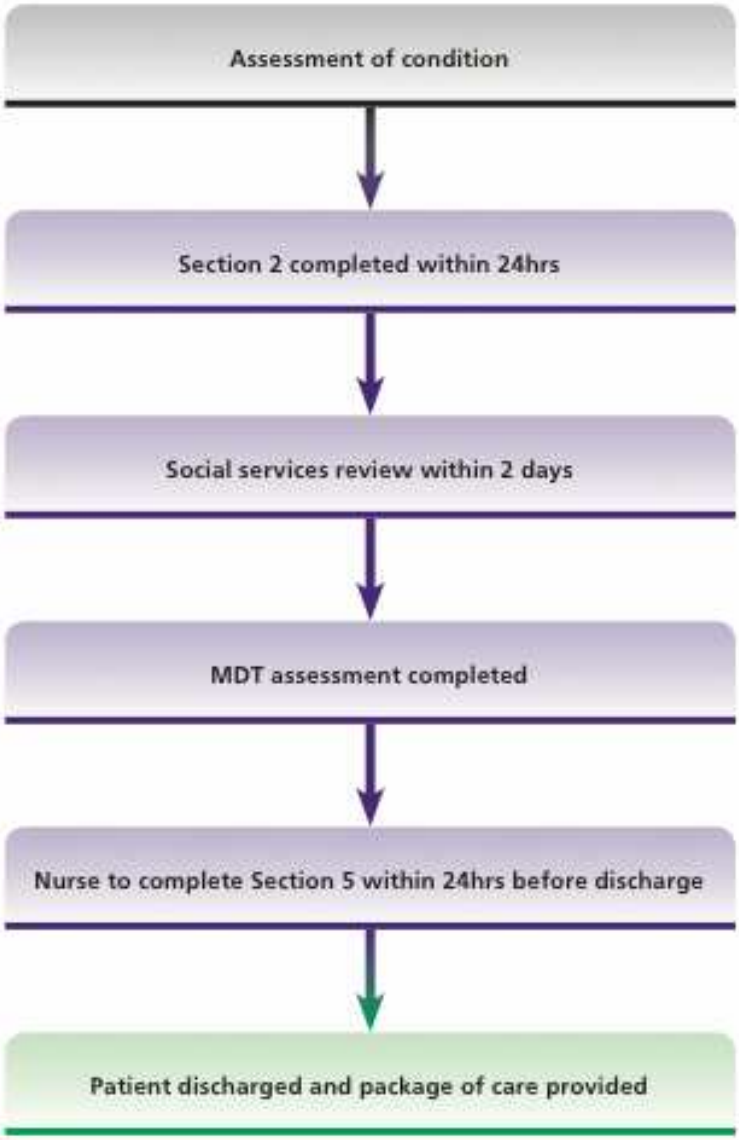
Appendix 4.2

Routine discharge patients: medically fit pathway



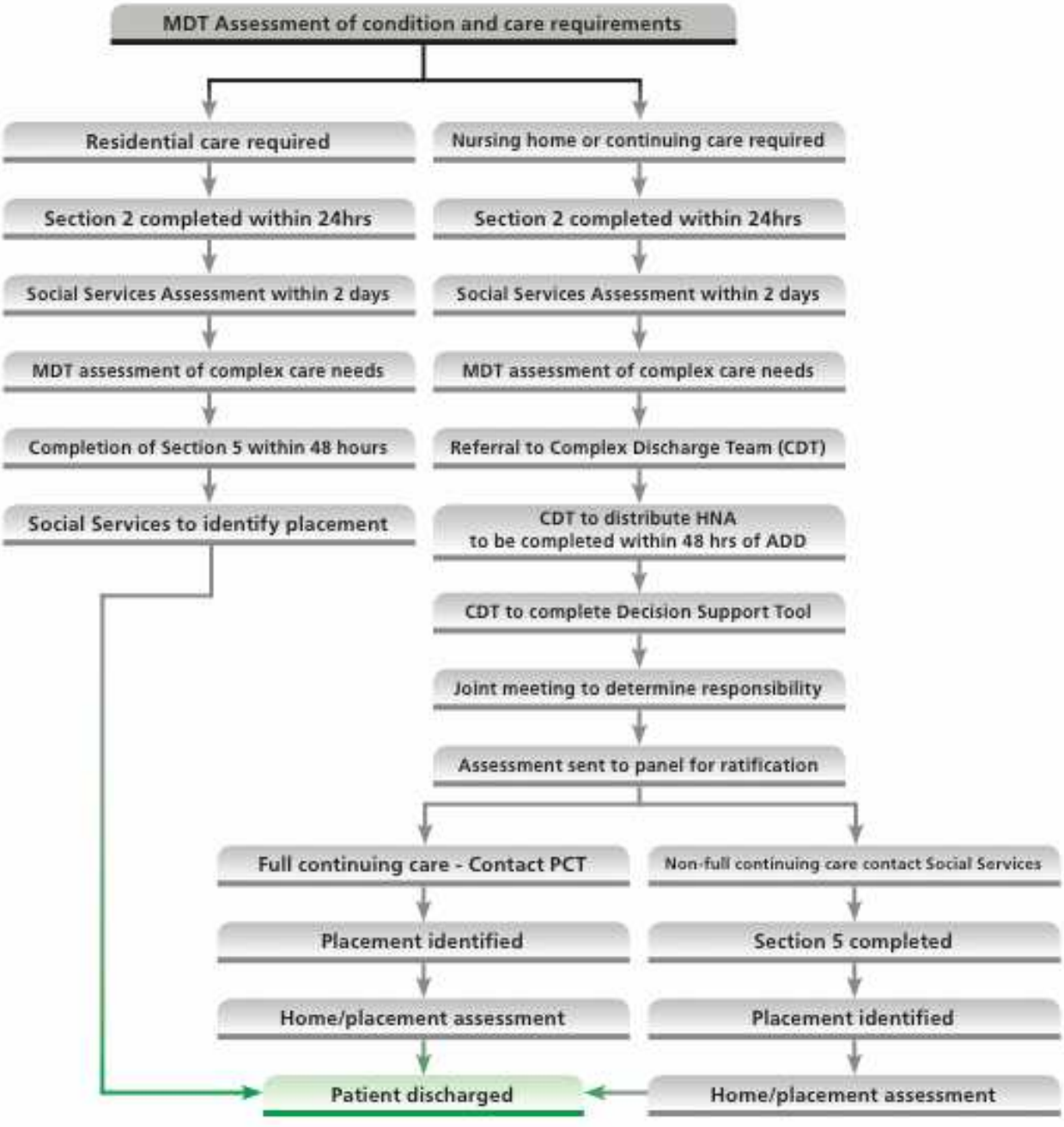
Appendix 4.3

Routine discharge patients: routine care package at home



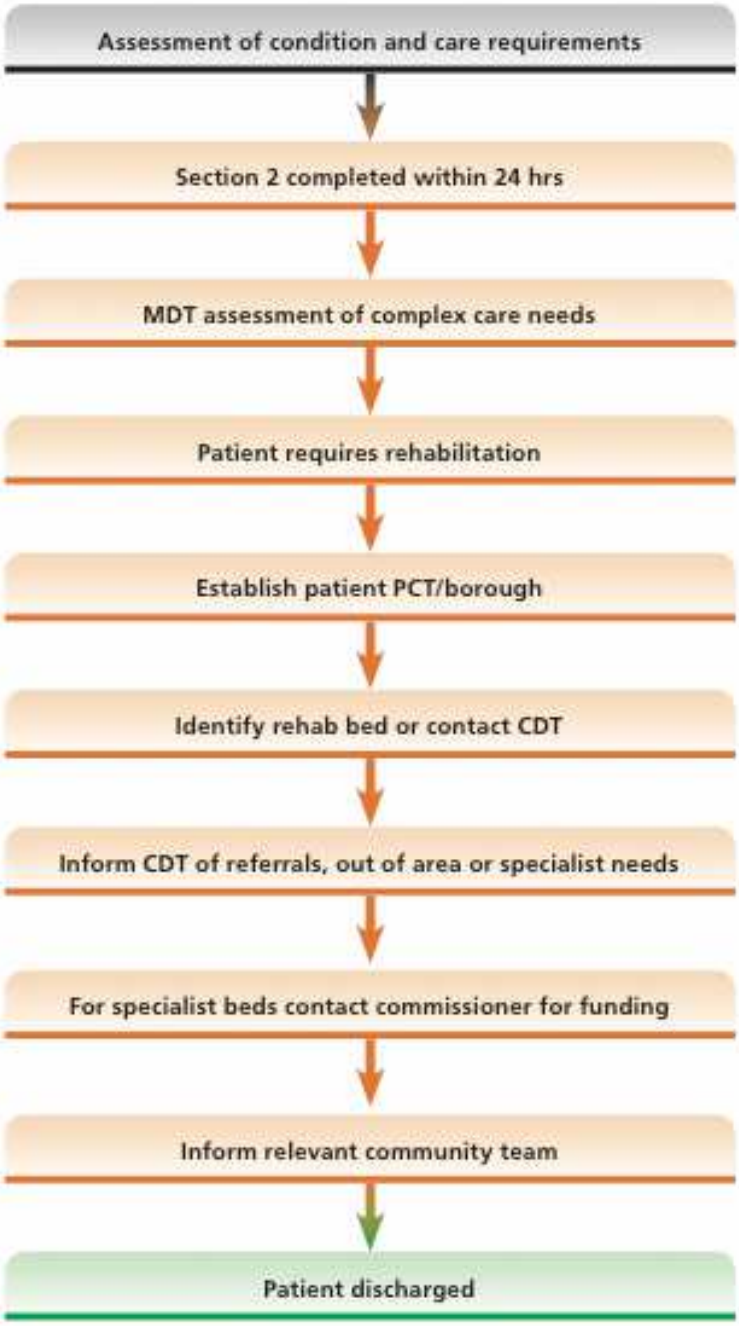
Appendix 4.4

Complex discharge patients (1A and 1B):
nursing home/continuing care/residential pathway



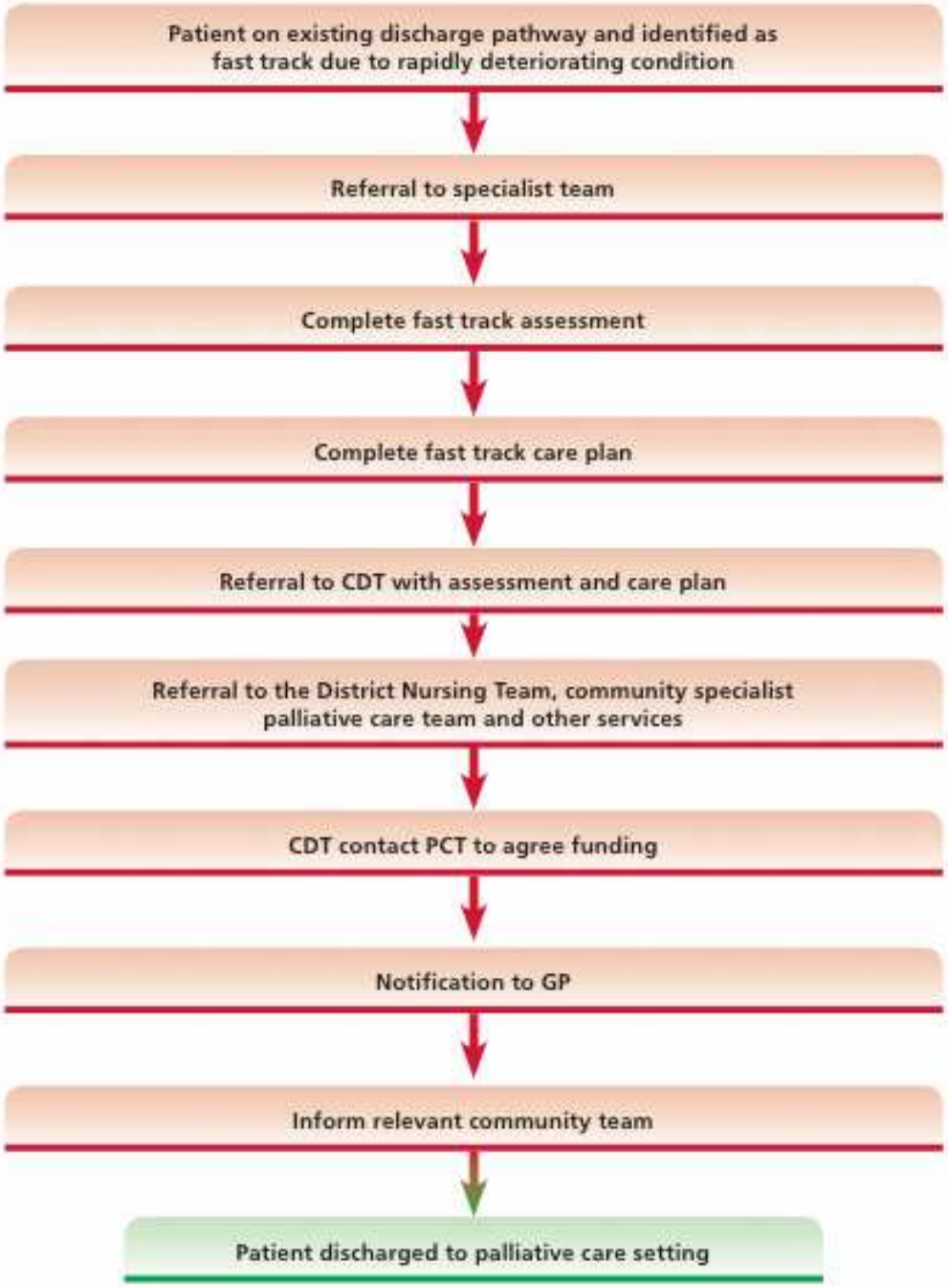
Appendix 4.5

Complex routine discharge patients (2): rehabilitation pathway



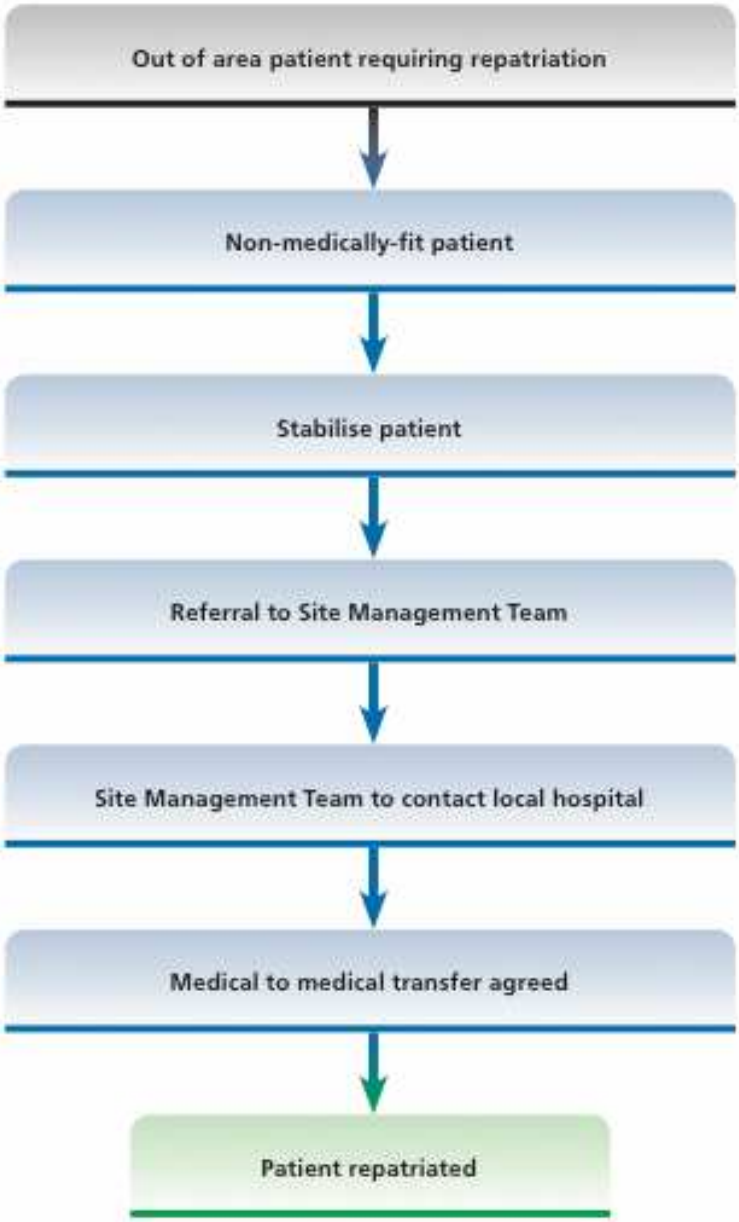
Appendix 4.6

Complex routine discharge patients (3): fast track pathway



Appendix 4.7

Routine discharge patients: out-of-area repatriation pathway



APPENDIX 5: THERAPY REPORTS / ONWARDS REFERRALS

5.1 GUIDELINES FOR WRITING OCCUPATIONAL THERAPY REPORTS

Introduction

This document has been developed to clarify expectations and facilitate consistency in the provision of Occupational Therapy (OT) reports across specialities and sites. It provides an overview of the information which will be provided by OT following assessment, together with the format in which this will be presented. This is linked to urgency of referral and the anticipated time of discharge, with examples provided.

Timescales

In line with the Trust's Documentation Policy, OT will aim to provide written OT reports within 24 hours of completion of a full OT assessment.

For some same day services, it is expected outside agencies will accept a verbal or electronic handover to ensure patients' discharges are not delayed.

For other services, OT will provide reports, in order for this to be completed in a timely manner, staff referring patients to OT must do this as early as possible to allow realistic timescales for discharging patients.

Generally, patients meeting OT acceptance criteria will be seen within 2 days of referral, providing there are no outstanding medical investigations / procedures likely to impact on function, and they have an imminent discharge of less than 5 days.

More complex patients requiring specialist equipment, full functional or environmental assessment, or complex care plans, are likely to take longer to assess, arrange necessary equipment or adaptations, and provide comprehensive recommendations.

Please note, some referrals are deemed inappropriate for OT intervention, and providing input for these patients hinders the assessment and provision of timely intervention for patients who would most benefit from OT services. In these circumstances the OT might signpost outside agencies to relevant MDT colleagues for additional input/advice.

Criteria for providing reports

Please refer to the following algorithm of priority for discharge to determine when reports will be written, and if so, the format in which they are to be provided.

5.2 COMMUNITY REHABILITATION REFERRALS – SLT/ OT / PT / Dietician

If for discharge support of community based rehabilitation services is required the therapy teams on the wards must complete the referrals 24 hours prior to discharge (unless self-discharge pathway and therefore as soon as possible) and ensure they are sent to the appropriate local teams. This requires updated assessments of physical and cognitive impairments to identify the needs and inform the community based therapy teams. All community based services require up to date therapy reports and referrals.

(Please see other related documents including Enteral Feeding Guidelines 2011)

OT Reports Guidance

Urgent - Same day service
Verbal or e-mail communication only will be provided, with the addition of any risk assessments, specialist care plans (eg. moving and handling / positioning or splinting) or specialist referrals

- Fast track patients with imminent risk of delayed discharge compromising preferred place of death
- Patients from A&E, OPAL, SAU and Day Surgery
- Patients to be discharged from HASU

High - Patients to be picked up within maximum 2 working days from referral
A template report will be provided following completion of a full OT assessment for patients with imminent discharge less than 5 days

- Patients experiencing new difficulties in the following areas which have not been addressed previously:
  - personal care such as washing and dressing, toileting, grooming or feeding
  - postural seating and transfers
  - managing within the home environment
  - memory / cognition / perception or sensation
- History of and/or risk of falls which has not already been addressed
- Newly diagnosed chronic conditions that impact on daily functional ability
- Following non-elective MSK or surgical interventions including spinal surgery
- Patients requiring re-ablement goals (providing OT previously involved)

Medium – Complex patients to be picked up within maximum 2 working day from referral
Report will measure complexity following completion of a full OT assessment for patients with anticipated discharge from medical care in the next 5 days

- Complex discharges (eg. double care patients, hoisting needs)
- Critical or substantial changes in function
- Significant cognitive dysfunction
- High level of dependency

Patients not meeting criteria for OT
A report will not be provided

- Conditions are longstanding and will not change within the acute care setting
- Needs can be met in the community (e.g. assessment for outdoor transit wheelchair, difficulties with bath or car transfers)
- Assessment / report requested by another agency with no clear reason for OT specific involvement
- Normally resident in a nursing home (exceptions: new stroke, new amputee, requires specialist seating assessment, trauma to upper limb or hand requiring instructions for carers)
- Awaiting transfer to hospice
- Stairs assessment
- Social needs only (eg. requests for rehousing, “blitz” clean)
- Pressure relief for bed and armchair only
- Wheelchair for occasional outdoor use only
- Domestic assistance only (eg. Meals on wheels, shopping, cleaning, laundry)
- Terminal discharge (eg. if nursed in bed)
- Patients who have been assessed in Orthopaedic Pre-Assessment clinic, identified as having no social care needs (eg. requiring equipment only, or assistance with medical appliances such as TED stockings)
- Temporary assistance with personal care due to post op hip precautions or loss of range following knee surgery
- MSK trauma patients with temporary non-weight-bearing status and inability to access full facilities (ie, mobility and social needs only)
- Restart of care package only
- Needs a new chair or bed
- Needs a commode for continence issues
- Needs assistance with stoma care
- Patients that have been provided with simple equipment only, and not requiring specialist instructions
- Self – referrals from family where the patient is independent on the ward and no concerns for safety have otherwise been raised

Imperial College Healthcare NHS Trust

APPENDIX 6: Westminster Learning Disabilities Partnership, RBK&C Learning Disabilities Service & Imperial College Healthcare NHS Trust (ICHT) Discharge Pathway for People with Learning Disability

Please Note: Each Team to follow the tasks described in their role

Admission of Patient with Learning Disabilities resident in Westminster or Royal Borough of Kensington and Chelsea to an ICHT Hospital

Community Learning Disability Team (CLDT) Role

If patient is allocated to a Case Manager:

1. CLDT Case Manager to inform the ICHT Discharge Team of any admission known to them
2. CLDT Case manager to provide information to ICHT Discharge Team on the patient's needs, e.g. Hospital passport, Health Action Plan, contact details of carers.
3. If appropriate or required for the Case manager to attend discharge planning meeting.
4. Case Manager to liaise with Learning Disabilities Multi Disciplinary Team (MDT) if informed by the ICHT team that support will be required from Community services once ICHT have safely discharged the patient.

If patient is not allocated to a Case Manager:

1. CLDT Duty Worker to inform the ICHT Discharge Team of any admission known to them
2. CLDT Duty worker to provide information to the ICHT Discharge Team on the patient's needs, e.g. Hospital passport, Health Action Plan, contact details of carers.
3. If appropriate or required for the WLDP Duty team to attend discharge planning meeting.
4. For the CLDT Duty team to liaise with Learning Disabilities MDT if informed by the ICHT team that support will be required from Community services once ICHT have safely discharged the patient.

Planned admission. Ward Staff Role

1. Ward staff to contact the CLDT Case manager or CLDT Duty worker to gather information on the patient to inform discharge plan.
2. Ward staff to inform Discharge Team of admission for support when required.
3. Discharge planning to begin as soon as possible including inviting CLDT Case manager or Duty worker to discharge planning meeting.
4. Ward staff to inform CLDT Case manager or CLDT Duty team if patient will require support from Community services once ICHT have safely discharged the patient.
5. Ward Staff to provide CLDT with a copy of Discharge report.

Unplanned admission. Ward Staff Role

1. Hospital staff ascertain that patient has a diagnosis of a Learning Disability by contacting CLDT Duty team, GP or, through Hospital passport,
2. Ward staff to contact the CLDT Case manager or CLDT Duty team to gather information on the patient to inform discharge plan.
3. Ward staff to inform Discharge Team of admission for support when required.
4. Discharge planning to begin as soon as possible including inviting CLDT Case manager or Duty worker to discharge planning meeting.
5. Ward staff to inform CLDT Case manager or CLDT Duty team if patient will require support from Community services once ICHT have safely discharged the patient.
6. Ward Staff to provide CLDT with a copy of Discharge report.

ICHT Discharge Team Role

1. If contacted by CLDT for the Discharge Team to inform the ward of details of patient, including contact details for the CLDT Case manager or Duty team.
2. Discharge Team to manage complex Learning Disabilities cases and support the ward with simple pathways.
3. Discharge Team when managing complex Learning Disabilities cases, to invite CLDT Case Manager or Duty Team to discharge planning meetings

Learning Disabilities Service Multi Disciplinary Team (MDT) Role

(Including OT, Nursing, Psychiatry, Psychology, Physiotherapy, SALT).

1. Via the CLDT Referral system the CLDT MDT to be informed by the Case manager or Duty worker that due to changes in the patient's circumstances further support is required following safe discharge by ICHT.
2. Case manager or Duty worker to provide information to the CLDT MDT on the supporting required from the ICHT discharge planning meeting.
3. Patient allocated to appropriate CLDT MDT e.g.; OT, Nursing, Psychiatry, Psychology, Physiotherapy, SALT
4. CLDT MDT provides support to patient following safe discharge in to the community from ICHT.

Imperial College Healthcare NHS Trust
St Mary's Hospital Discharge Team: 020 3312 1360.
Charing Cross Hospital Discharge Team: 020 3312 1432
Hammersmith Hospital Discharge Team 020 3313 4721.

Community Learning Disability Teams
Royal Borough of Kensington and Chelsea Learning Disability Service Reception: 020 7313 6880
Westminster Learning Disabilities Partnership Reception: 020 7641 7411.
Tri borough Learning Disabilities services work 9 am to 5 pm Monday to Friday - there is no Out of hours service