Brighton and Sussex University Hospitals NHS Trust

Discharge Policy for Adults and Children

Version:	1.3
Category and Number	C010
Approved by:	Clinical Policies Steering Group
Date approved:	8 May 2012
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Name of responsible committee/individual:	Clinical Policies Steering Group
Date issued:	May 2012
Review date:	May 2015
Target audience:	BSUH Management Board, all Clinical Divisions and Corporate Directorates, Divisional Management Boards, all staff
Accessibility	This document is available in electronic format only (read only).

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Appendices

1. Introduction

1.1 Appropriate, timely discharge planning is fundamental to the provision of effective health care. Poor discharge planning leads to the inefficient use of beds, increases in waiting lists, higher re-admission rates, patient and carer distress as well as increased workloads for acute trusts and our colleagues in the community and social care.

1.2 Discharge planning is a process and not an isolated event. This process needs to be actively managed 7 days a week and fully involve patients, relatives and carers. It needs to start from the day of admission for emergency patients and from pre-operative assessment for elective patients.

1.3 Children should only remain in Hospital until their needs can be equally well met in the Community.

1.4 It outlines all matters pertaining to the process of patient discharge and follows guidance in 'Ready to Go?' DH Feb 2010.

1.5 In this policy:

- People in hospital are referred to as patients.
- The word 'carers' will be used as the generic term for carers/relatives/parents.
- Discharge is used generically to describe discharge from hospital with or without transfer of care to health or social care organisations/agencies in the community

1.6 Where a ward manager is referred to this implies the ward manager or their nominated deputy.

2. Purpose

Operating Principles

2.1 The purpose of this document is to guide individual and multidisciplinary team activity throughout the Trust, providing reference for staff involved in discharge planning so that that they may understand individual and team responsibility.

2.1.1 Input from multidisciplinary/multi agency teams at the earliest opportunity where they work together to provide information, medication, organisation or equipment and specialist input to enable optimum independence for the patient / carer / parent

2.1.2 All patients to have a discharge care plan which is kept in the nursing notes.

This plan to be updated as necessary.

3. Definitions

AAR - After Action Review

CAF – Continual Assessment Framework for Children

CCNT – Children's Community Nursing Team

Child / Young Person – Any Patient aged from birth to 18 Years

CYP – Children or Young Person

DOLS - Deprivation of Liberties

MDM – Multi-disciplinary Meeting

MDT - Management Discharge Team

NSF – National Service Framework

Patients – Any member of public treated as a patient or under the care of a hospital professional.

POD – Patients Own Drugs

Safeguarding Team – Nurse Consultant Safeguarding, Band 6 Sister, Lead Consultant Paediatrician for Safeguarding, Lead Midwife, Lead Community Midwife and Nurse Consultant Safeguarding Children

SAP - Single Assessment Process

Staff - An Employee of Brighton & Sussex University Hospitals

The Discharge Team – Any member of staff involved in the discharge of a patient

TTO – Tablet to Take Out

4. Responsibilities, Accountabilities and Duties

4.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that effective systems are in place for safe and timely patient discharge.

4.2 Medical Director

The Medical Director has responsibility to ensure that all medical teams are planning for safe and early discharge and setting realistic and achievable estimated dates of discharge within 24 hours of admission.

4.3 Chief Nurse

Has overall responsibility for ensuring that all nursing requirements to facilitate safe and timely discharge are delivered at all times across both wards and departments.

4.4 **The Divisional Safety and Quality Committees** have responsibility for monitoring any trends within the divisions relating to unsafe discharge and ensuring actions are taken to prevent re-occurrence of such practice.

4.6 **The Trust's Drug and Therapeutics Committee & Hospital Management Board** have responsibility for ensuring correct medication and electronic discharge summaries accompany patients on discharge from hospital and that a copy is sent to the patients' GP.

4.8 **The Discharge Team** work with patients with complex discharge needs and support the coordination of the discharge plan. Daily communication takes place between the discharge coordinator and the ward so that complex discharge issues are discussed and action and accountability agreed. The Discharge Coordinators attend the ward MDM where actions and accountabilities are discussed and agreed. Other professional teams such as the Learning Disability Liaison Team will be contacted for additional guidance and support as required.

4.9 All Staff and Ward Managers

4.9.1 Staff from all disciplines will adhere to the discharge planning policy and processes as described in this policy without exception. Members of the multi disciplinary team will work in such a manner as to ensure joint assessment and planning as per the application of the SAP / CAF by:

- Health and adult social care / child and young persons social care working collaboratively
- Sharing skills and information
- Ensuring effective communication both written and verbal within themselves and with patients/carers
- Ensuring the trust documentation is accurate and contemporaneous
- To agreed levels of risk and how risks can be managed
- Ultimate responsibility for the discharge rests with the ward manager, this is a delegated responsibility to the MDT and if applicable the discharge coordinator.

5 Policy

5.1 The following principles apply in ensuring that the discharge or transfer of care of patient once they leave acute care meets the needs of patients / parents / carers and supports safe and timely discharge.

5.1.2 Ensure engagement and active participation of all patients and carers as equal partners so that individuals are able to make informed choice about how their on going needs are going to be met once discharged from hospital

5.1.3 The needs, wishes, and rights of the patient and carer will remain central to all discharge planning and the discharge plan must be implemented in such a way as to provide continuity of care across health and social care settings.

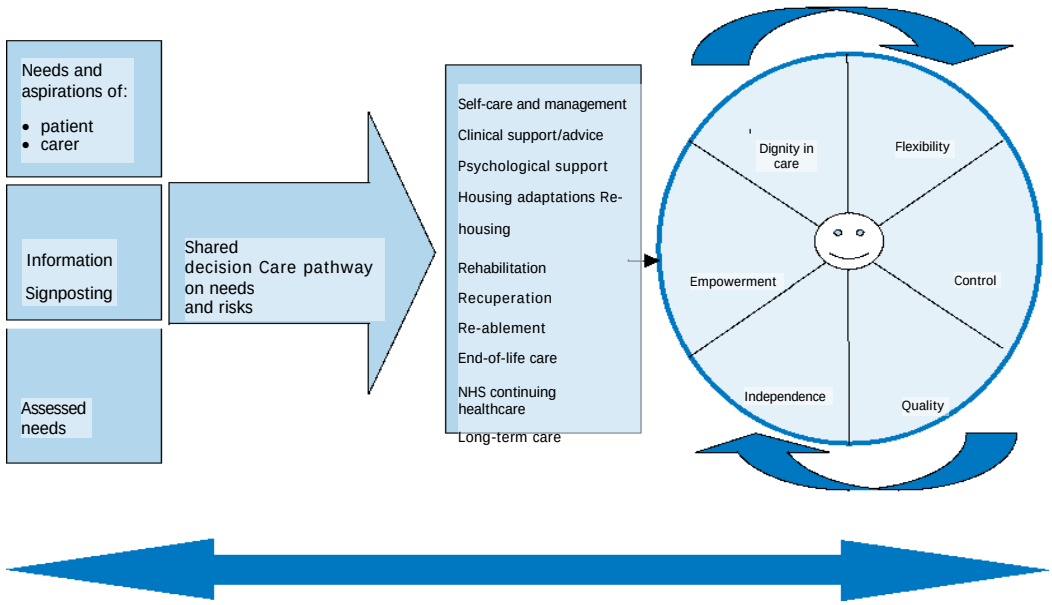
5.1.4 Ensure that patients remain in the acute Trusts in patient facilities only as long as they require an acute hospital bed. All investigations, treatment or therapy need to be done as an outpatient wherever possible and patients will be expected to follow a pathway where appropriate to meet their needs.

5.1.5 Achieve a uniform, standardised approach and practice in discharge planning across all the Trust with coordination of discharge planning undertaken by a named member of the multidisciplinary team

5.1.6 Assessment, prior to admission whenever possible and in consideration of the patient's health within 24 hours of admission for all other cases. This assessment should ensure screening for risk (potential/actual) related to discharge planning but be mindful that discharge planning is a continuous process and should be considered at all time during the patient's journey.

5.1.7 The patient's journey and standards applied to discharge outlined in this policy should be adhered to regardless of the discharge being planned and taking place in or out of hours.

5.1.8 Figure 2. Personalised care planning in hospital discharge



5.2 Safeguarding the safety of adults and children who may be affected by the discharge plan

5.2.1 Where the patient is a carer, or where the patient is being discharged to a residence where there are children resident and their discharge may present a risk to the safety of that child; the discharge plan should be assessed with the Parents Safeguarding Team. For children please refer to Appendix 8 Children and Young Person Discharge Letter.

5.2.2 Patients currently having a safeguarding issue investigated or an issue has been raised should not be discharged until a plan has been agreed with relevant partner organisations.

5.2.3 Ward staff need to ensure that time is built into a patients daily care regime to ensure that those with additional communication requirements have their needs met, for example deaf, blind, British sign language, overseas languages, learning disabilities, other sensory losses i.e. sight, hearing or dyslexia.

5.2.4 Where a patient's mental capacity may be doubted it is essential that the Mental Capacity Act (MCA) is considered. In some cases capacity may be permanently affected due to a form of dementia, a learning disability or have sustained a brain injury. It may also be the case that capacity is only affected for a temporary period due to confusion, unconsciousness or as a result of illness or treatment for illness. Please also consider if the patient requires an Independent Mental Capacity Advocate (IMCA).

5.3. Information for Parents, Patients and Carers

5.3.1 It is essential that parents, patients and carers be given all the necessary information in a format that they can understand at all stages of the discharge planning process. Time must be made to ask questions about the information given and any other queries that they should have regarding their ongoing care.

5.3.2 The patient/carer should be consulted and kept informed of progress at all stages of the discharge pathway.

5.3.3 Patients and carers should be given as much notice as possible of their estimated discharge date and be involved in agreeing this date. If the discharge is likely to happen with little notice the patient/carer should be advised that this might be likely.

5.3.4 If the child / young patient are being discharged home and going to be receiving on going care i.e. CCNT, Package of Care, Intermediate Care input, the contact details of the provider should be given to the parent / patient / carer.

5.3.5 In particular the following points should be covered for adult patients:

- The Discharge Information booklet should be given to the patient at pre-admission assessment or at the earliest appropriate time, taking into account to the patient's clinical condition. It should be documented in the purple planner that this information has been given.
- As part of the pre-admission assessment or at the earliest appropriate time the patient/carer should be informed that:
- On the day of discharge, the patient will vacate their bed by 10.00am where possible and be transferred to the discharge lounge. If for any reason i.e. waiting for transport or medication they are not able to leave directly for their discharge destination.
- Transport home is not provided unless it the patients is assessed as needing specialist transport for clinical needs.

- Patients will be assessed as per the transfer criteria available from the ward manager or discharge lounge.
- The leaflet 'Planning your discharge from hospital' can be made available to patients in other languages. This will need to be made available by the department on a case-by-case basis.

5.3.6 On discharging a child, the Discharge Information leaflet should be given to the patient or carer at pre-admission assessment, or at the earliest appropriate time, taking into account the patient's clinical condition. It should be documented in the nursing notes that this information has been given.

5.3.7 Ensure that everyone involved in the patient's care is aware of the anticipated timing and works towards the discharge deadline.

5.3.8 Ward staff or members of the discharge team will provide individuals with learning disabilities or other communication needs with the appropriate information about their discharge. This may include pictorial or verbal explanation.

5.4 Factors to consider when agreeing and setting an estimated date for discharging children and adults

5.4.1 For a paediatric patient to be ready for discharge or their care to be transferred to a community or social setting, the estimated date of discharge or transfer is agreed by the multidisciplinary team. Once they have taken into account the factors in 5.2 MDT and the patient/carer can be assured that the patient's wishes and needs have been considered in the assessment, planning and implementation of the discharge plan.

5.4.2 Patients need to be clinically (physiologically) safe to move from acute care and this assessment takes into account the following:

- Where possible the review of the patients condition can be shared or taken over by the GP including adjustments to medication
- That there should be no further tests or procedures related to this in patient stay or another care pathway that are planned and must to be undertaken while the patient is an in patient for this episode
- Additional tests and interventions can be carried out as an out-patient, in an ambulatory care setting or as a separate in patient admission.

5.4.3 That the MDT, parent / patient / carer agree that services or a setting able to meet the person's on-going needs is in place. Ongoing general, nursing, or rehabilitation in another setting can be met at home or through primary / community / intermediate or social care.

5.4.4 That there are no safeguarding issues that have been overlooked and been risk managed as part of the discharge plan.

5.4.5 The parent / patient / carer is not disputing the discharge plan under the steps in the Choice on Transfer of Care Policy TCP 212

5.4.6 Figure 2. The START technique is used for planning discharge of adults

S Set	Set the EDD according to the patient's condition and diagnosis.
T Test	Tests and investigations base the EDD on the anticipated results of tests and investigations, and only change the EDD if the results are not as expected.
A Achievable	Achievable but challenging; base the EDD on how long it should take to get results and assessments, not on how long it actually takes in practice (this enables organizations to identify any constraints).
R Routine	The MDT must set the EDD as part of the routine admissions assessment for every patent, and must regularly review it.
T Timely	The EDD must be set within 48 hours of admission, or at a pre-admission assessment and within 4 days of community settings

5.4.7 If the patient is being discharged home and going to be receiving on going care, the contact details of the provider should be given to the patient/carer.

5.5 Provision for parents / patients / carers with communication difficulties

5.5.1 Non English Speaking people
This Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English. If there are concerns about the extent of understanding of, and the ability to communicate in English by the patient or their carer the ward manager must ensure that a professional interpreter is identified who is trained in interpreting in the languages required.

Various interpreting services are available for all patients' communication needs, as listed in Appendix 1.
For further information, see the Trust's policy Translating and Interpreting Medical Information in a Foreign Language (Trust Clinical Policies, ref.C0103, available on the Trust Intranet).

5.5.2 People with Learning Disabilities / Sensory Impairment
Where a patient / parent of a patient has learning disabilities and / or sensory impairment the patient, and all relevant others e.g. family members, advocate, support provider, and relevant key worker/social worker must be involved in all issues related to discharge planning and transfer of care.

Information about the patient's discharge and transfer of should be conveyed to the patient in a way that is most appropriate to their individual communication needs, e.g. written information in an easy read format. The Learning Disabilities Liaison team should be involved, where necessary, in

the patients discharge planning and transfer of care. They can be contacted on: 01273 696955 ext 4375 Bleep 8514

For further information (for adult patients only), see the Trust's policy on Caring for Adults with Learning Disabilities in Acute Trusts

5.6 Factors to consider when agreeing and setting an estimated date for discharge

5.6.1 Acute hospitals provides diagnosis, care and intervention for patients who require a period in hospital to have their acute (physiological) needs met. It is generally agreed that the estimated date of discharge based on physiological needs alone can be estimated or predicted on admission. For many elective patients the expected length of stay and therefore the expected data of discharge can be identified at pre-assessment.

5.6.2 At the multi disciplinary meetings, individual patients' ongoing needs will be assessed and planned for with appropriate support for ongoing safe transfer.

5.6.3 Therefore for a patient to be ready for discharge or their care to be transferred to a community or social setting the estimated date of discharge or transfer is agreed by the multidisciplinary team once they have taken into account the factors in 5.2 so that the MDT and the patient/carer can be assured that the patients:

- Health and social needs have been considered in the assessment, planning and implementation of the discharge plan.
- Are clinically (physiologically) safe to move from acute care
- Where possible the review of the patients condition can be shared or taken over by the GP including adjustments to medication
- That there should be no further tests or procedures related to this patients' stay or another care pathway must to be undertaken while the patient is an in-patient for this episode
- Additional tests and interventions can be carried out as an out-patient, in an ambulatory care setting or as a separate in patient admission.
- That the MDT, parent / patient / carer agrees that services or a setting that is able to meet the persons on going needs is in place.
- Ongoing general, nursing, or rehabilitation needs can be met in another setting at home or through primary / community / intermediate or social care
- That all safeguarding issues have been considered and been risk managed as part of the discharge plan.
- The parent / patient / carer are not disputing the discharge plan under the steps in the Choice on Transfer of Care Policy TCP 212.

5.7 Single Assessment Process

5.7.1 The Single Assessment Process (SAP) came about as a result of recognition that many people have wide-ranging welfare needs and that organisations /

agencies need to work together to ensure that assessment and subsequent care planning is effective and coordinated; care should be holistic and involve service users.

5.7.2 Initially this was outlined in the National Service Framework for older people but the principles that SAP outlines are applicable to all adults and present a practical lever to achieving person centred care and integrated service delivery of that care.

5.7.3 The National Service Framework (NSF) for Children Young People and Maternity Services is the standard on maternity services, which forms part of the National Service Framework for Children, Young People and Maternity Services.

5.7.4 By applying the SAP and CAF models, BSUH are supporting the principle that the scale and depth of assessment is in proportion to all peoples needs; that agencies do not duplicate each other's assessments; and professionals contribute to assessments in the most effective way.

5.8 Documentation of discharge plan

5.8.1 Progress reports relating to the discharge plan should be documented in the purple discharge planner for adults / in-patient notes for children used by the whole local health economy. All members of the MDT must use the purple planner / patient notes for children as a central and contemporaneous record of the discharge plan regardless of their individual professional or organizational requirements for record keeping.

5.8.2 The agreed care plan is to be given to parents, patients, carers and any ongoing care providers along with any transfer letters and post discharge advice that may be required.

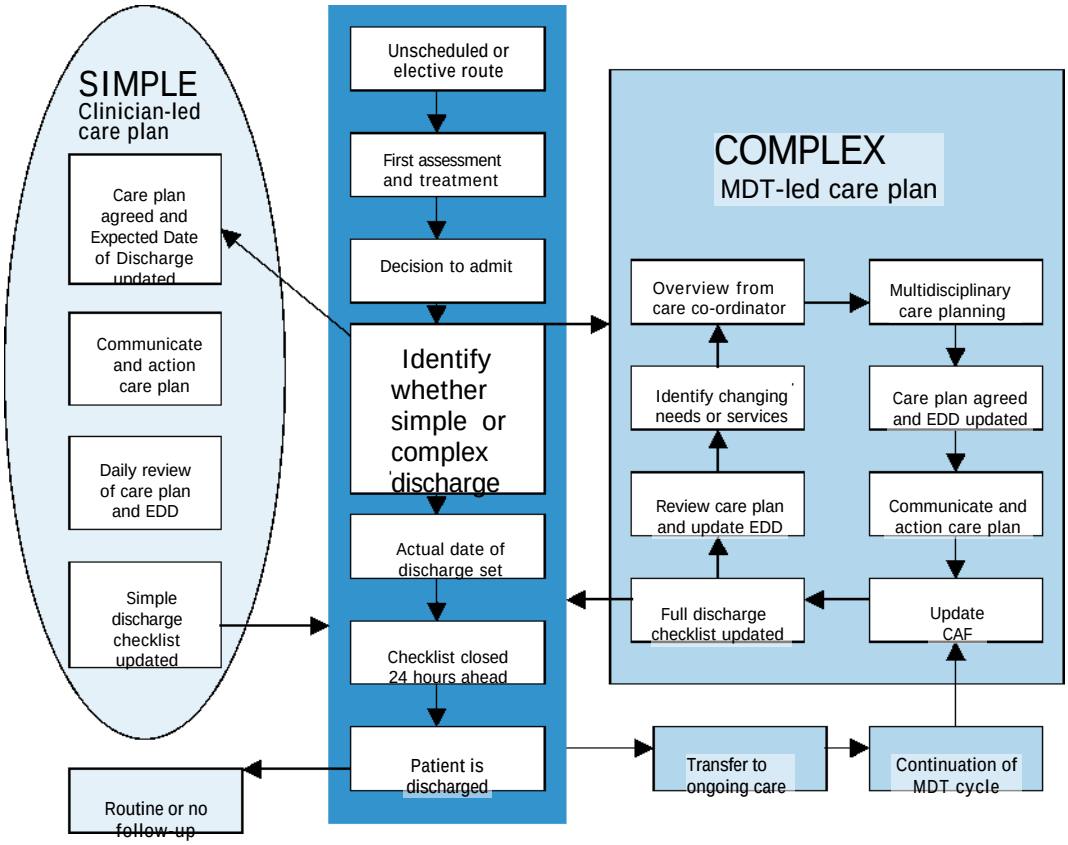
5.8.3 On discharge the parent / patient / carer should be given a copy of their discharge summary and agreed discharge care plan which the multi disciplinary team, patients and carers have had input into agreeing, and a copy of these is to be sent direct to the patients GP and care worker where appropriate.

5.9 Meeting the discharge requirements specific to patient needs

5.9.1 There are two discharge-planning pathways that the trust uses to describe the patient's needs; these are described as simple and complex. Patients will fall within these groups regardless of whether they are admitted as an emergency or as a pre-planned elective patient.

5.9.2 Common themes that describe these patient's needs are listed in the table below.

5.9.3 **Figure 1. The discharge and transfer planning process for simple and complex discharges for Adults**



Simple Discharge for Adults
• Has minimal ongoing care needs • Is returning to their usual place of residence • Does not require a change in support offered to the patient or their carer when living at their usual place of residence
Complex Discharge for Adults
• Has ongoing health and social care needs • Lives alone and/or frail or elderly • Supported by a carer who may have difficulty meeting the individuals needs or is a main carer of another dependant person • Life expectancy is limited or the patient has a serious illness which may require frequent visits to hospital for further treatment • Has a physical disability or sensory impairment or recognized learning disability and a newly identified health or social care need or previous unmet need • Is to be discharged home with a complex package of care which requires

monitoring and on-going review

- Adults at risk from abuse and/or with safeguarding issues
- Has cognitive impairment with newly identified health or social care needs or previous unmet need
- Known to be homeless and or to misuse substances
- Patients whose first language is not English

Patients who are to be discharged with complex drug regimes or changes to drug therapy

Simple Discharge for Children:

- Has minimal ongoing care needs
- Are returning to their usual place of residence

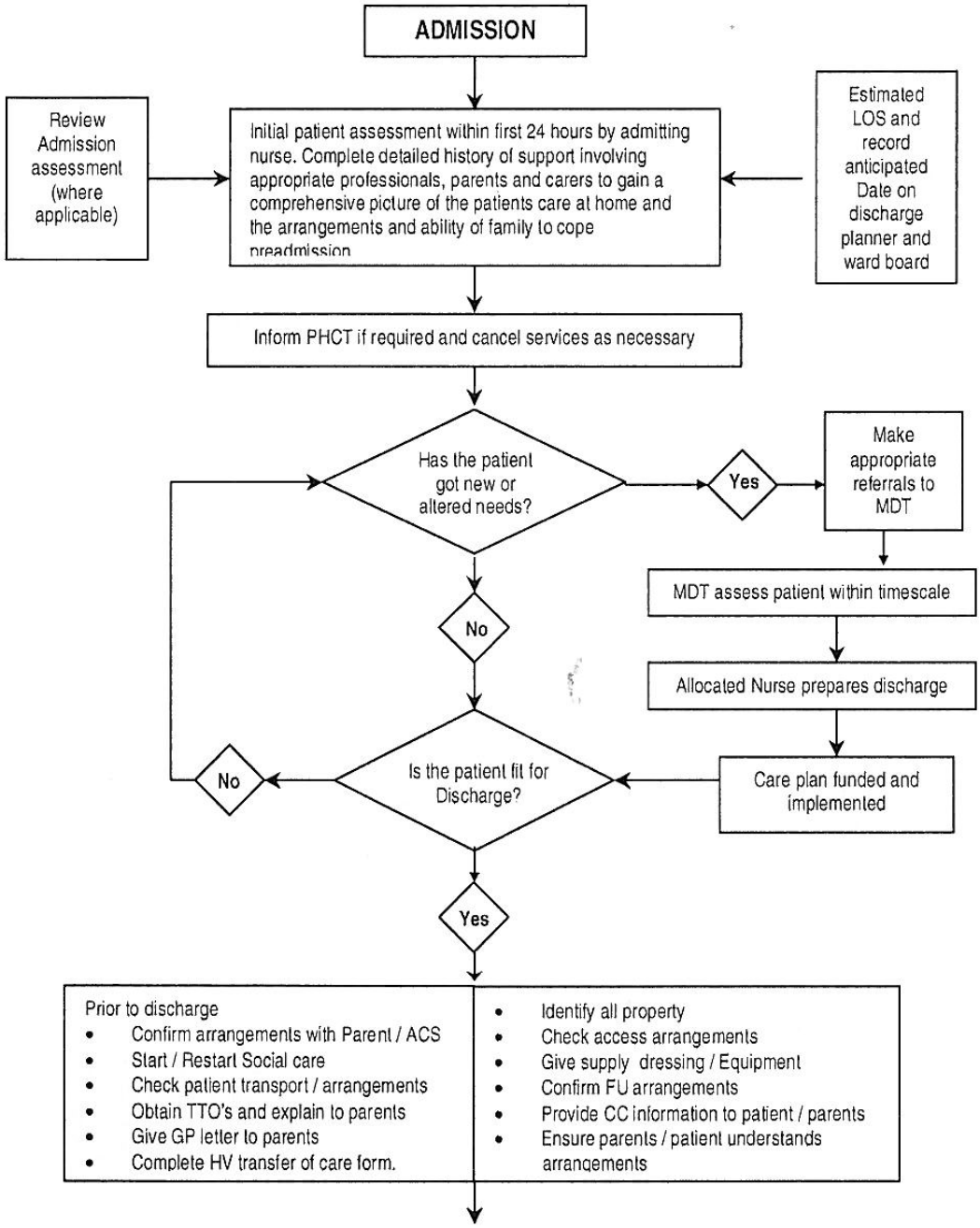
Does not require a change in support offered to the patient or their carer when living at their usual place of residence

- Has minimal ongoing care needs
- Are returning to their usual place of residence
- Does not require a change in support offered to the patient or their carer when living at their usual place of residence

Complex Discharge for Children

- Has ongoing health and social care needs
- Life expectancy is limited or the patient has a serious illness which may require frequent visits to hospital for further treatment
- Have a physical disability or sensory impairment or recognized learning disability or communication requirements and a newly identified health or social care need or previous unmet need
- Is to be discharged home with a complex package of care which requires monitoring and on going review
- Children at risk from abuse and/or with safeguarding issues (see appendix)
- Have cognitive impairment with newly identified health or social care needs or previous unmet need
- Known to be homeless and or to misuse substances
- Patients/carers whose first language is not English
- Patients who are to be discharged with complex drug regimes or changes to drug therapy
- Supported by a carer who may have difficulty meeting the individual has needs or is a main carer of another dependant person.

Figure 2. Summary of the discharge process for children



Legend of Abbreviations

MDT	-	Multidisciplinary team
PHCT	-	Primary health care team
CCNT	-	Children's Community Nursing Team
TTO's	-	To take out medication
LOS	-	Length of stay
ACS	-	Alternative Care Setting
FU	-	Follow up
CC	-	Continuing care

5.10 Discharge Planning Process

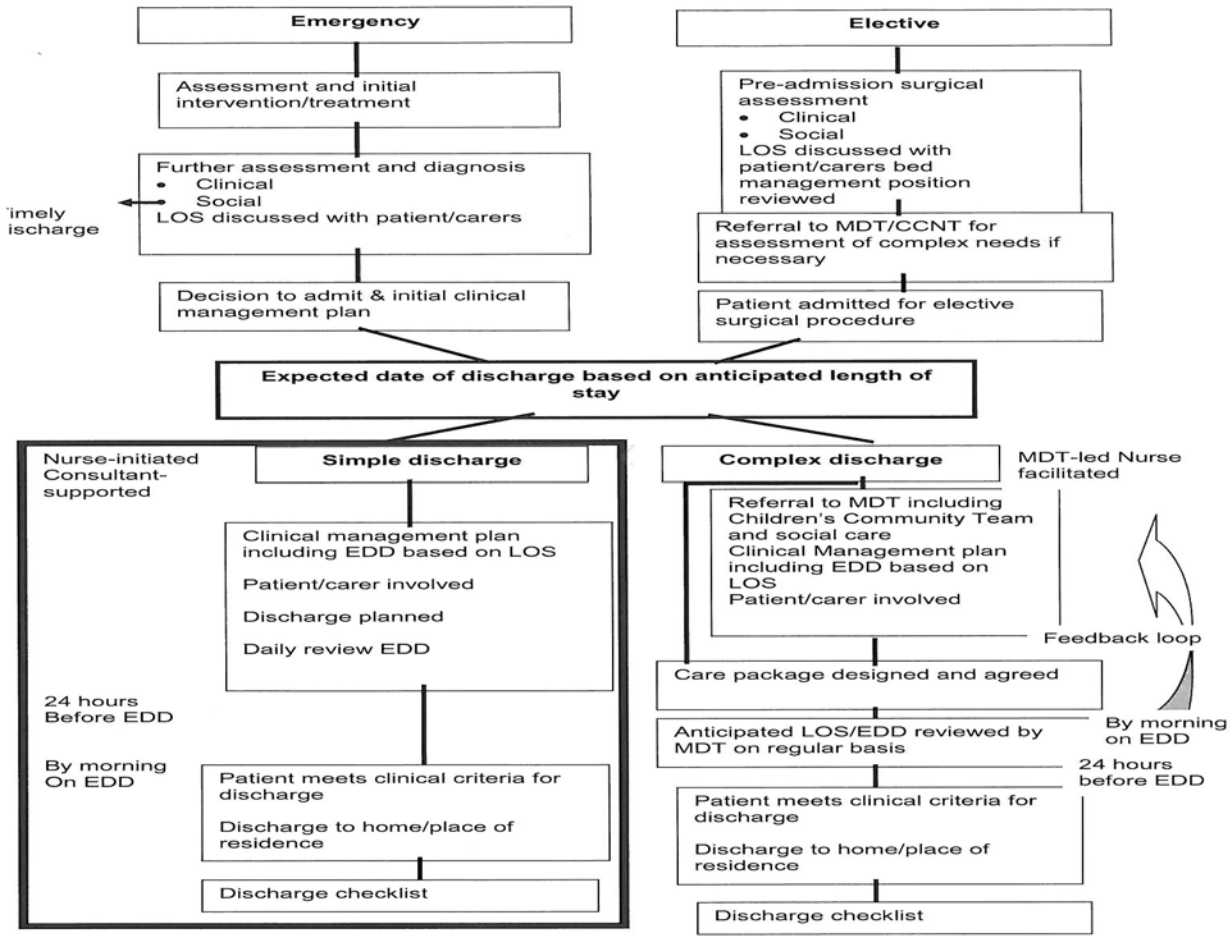
5.10.1 The discharge planning process must take account of the patients needs whether they are simple or complex (as outlined in section 5.7 above). As the patients journey moves through acute care there must be continuous monitoring of the discharge plan through the audit of the purple discharge planner / children's patient notes and through the 'High Impact Action' on hospital Discharge. The purpose of which is to identify the any change in the patients needs that may affect the discharge plan i.e. cross from simple to complex or visa versa, and if their needs have changed because of their reason for admission.

5.10.2 The discharge planning process comprises of three key stages

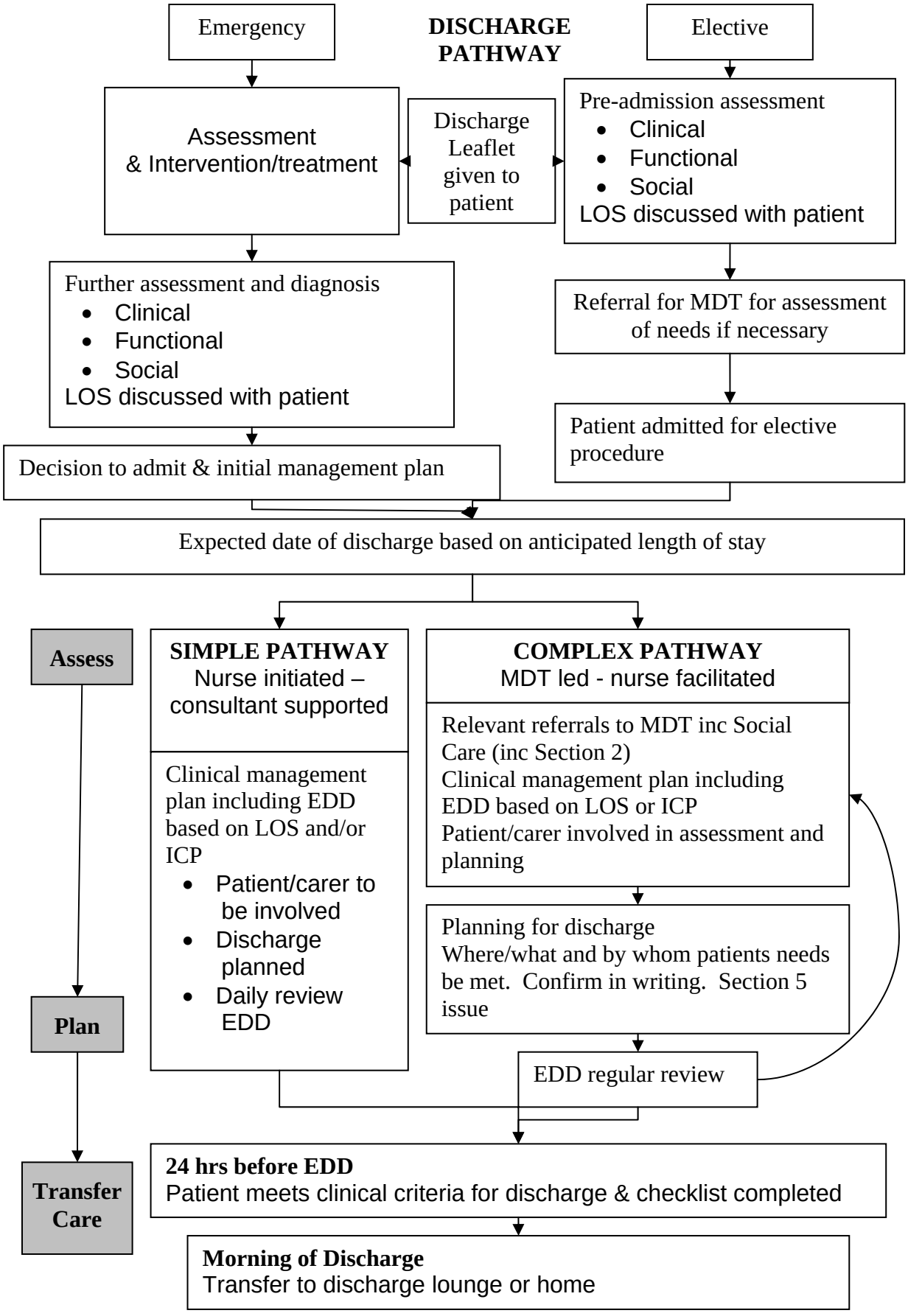
- Assessment (section 12)
- Planning (section 13)
- Discharge/transfer of care (section 14)

5.10.3The pathway is outlined in the discharge pathway flow charts as below.

5.10.4 Figure 3. Discharge process for children



5.10.5 Figure 4. Discharge Process for Adults



5.11 Assessment for Discharge

5.11.1 Assessment of the patients needs to support a timely and safe discharge will start either at pre admission assessment (elective patients) or on admission assessment for emergency patients.

5.11.2 Assessments should be undertaken in parallel, whenever possible. This means that the minimum amount of time is spent in the assessment phase and serial assessment is avoided thus, expediting formation of the discharge plan and ultimately the discharge.

5.11.3 The purpose of the assessment is for the multidisciplinary team to work within the Single Assessment Framework / Children's Assessment Framework (CAF) to:

- Undertake 'community triage' i.e. determines the pre admission input/ support that the patient was receiving from health (mainstream and mental health) and social care.
- Understand the needs of the patient and corresponding risks relating to how the patient can be safely discharged from acute care and what actions need to be undertaken to mitigate or plan for those risks.
- Determine whether the patient has any new, altered needs because of hospital admission.
- Include the parent / patient / carer with regard to the planning of ongoing care on discharge if it is necessary.
- Identify the likely length of stay and estimated discharge date on admission or at pre operative assessment. This needs to be updated on Oasis/PAS on a daily basis.
- Identify which assessments are needed so that all relevant information is available when moving to the planning phase. A comprehensive assessment will be supported by input from relevant members of the MDT, where referrals for assessment are needed these will be undertaken as per local policies and procedures. In the case of the discharge arrangements requiring input from adult social care referrals should be made as per section notification agreements in line with local procedures and national guidance for reimbursement
- Assessment to identify if the patient qualifies for Continuing Health Care funding.

5.11.4 For patients in the following circumstances the discharge plan should be assessed with the trust Nurse Consultant Safeguarding Children.

5.11.5 Where the patient is a carer or where the patient is being discharged to a residence where there are other children resident and their discharge may present a risk to the safety of other children

5.11.6 Once the outcome of the assessments is agreed, the nominated caseworker from the MDT will discuss with the parent / patient / carer and ward manager those services likely to be required. A verbal explanation by the nominated member of the MDT is given to the parent / patient / carer regarding the expectation around timescales and possible short term solutions. This conversation must be recorded in the discharge planner or child patient notes.

Plans about what support will be required from social services need to be agreed with the parent / patient / carer, particularly if the patient is self-funding.

5.12 Planning for Discharge

5.12.1 The discharge-planning phase requires the MDT to clarify and agree, in consultation and with input from the patient / carer, the elements needed for a safe and timely discharge from acute care. The plan should be put together in such a way that means that all the elements of the discharge plan comes together in parallel so that the length of time spent within acute care is kept to the minimum.

5.12.2 The following are elements of the discharge planning process that need to be considered when putting in place a discharge plan:

- Start planning for discharge or transfer before or on admission.
- Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
- Develop a clinical management plan for every patient within 24 hours of admission.
- Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
- Set an expected date of discharge or transfer within 24-48 hours of admission and discuss with the parent / patient / carer.
- Review the clinical management plan each day, take any necessary action and update progress towards the discharge or transfer date.
- Involve parents / patients / careers so that they can make informed decisions and choices that deliver a personalized care pathway and maximize their independence.
- Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
- Use a discharge checklist 24-48 hours prior to transfer.
- Make decisions to discharge and transfer patients each day.

5.12.3 The following are elements of the discharge planning process that need to be considered for *children* when putting in place a discharge plan:

- Where and by whom the patients needs will be met
- The family/informal care provision that is proposed any risks associated with this provision and how they need to be mitigated
- Competency assessments need to be undertaken for all carers who will be giving complex care at home e.g. feeding, tracheostomy care, medications etc. these must be reviewed at each admission.
- What services and equipment are required
- When the services and equipment are required
- Who is responsible for putting in place the services/equipment

- When the services need to be started or when the setting will be available

5.12.4 Once the plan is agreed by the MDT and patient / carer, the agreed arrangements need to be made thus ensuring the transfer of care is seamless. Referrals should be made to the required services in line with local procedures.

Where the patient ongoing care is going to be met by local authority provision where possible available settings within 48hrs and this will usually be two options. It is important that the patient/carer is aware that:

- This will only be possible where appropriate settings are available to meet the patient needs
- It may sometimes be necessary to accept a short term placement prior to a long term placement being found, as outlined in letter one. Any options discussed must be recorded in the discharge planner
- If a first option is agreed by the patient/carer and meets the patients needs further options will not necessarily be sought

If the patient/carer **agrees** to one of the option(s), for either short or long term placement, arrangements are then made for discharge in the usual way. Confirmation is made in writing, **letter 2a (short term placement) 2b (package of care) 2c (long term placement) Appendix 2**. This is recorded in the discharge planner, a copy of the letter is filed in the patient's medical record and arrangements to complete the discharge are made.

5.12.5 In some instances it is helpful to convene a discharge planning meeting. This should be an inclusive meeting the aim of which is to enable transparency in planning and understanding of the issues that need to be addressed to put in place a safe and timely discharge plan.

Examples of where this may be helpful are:

- The ongoing plan is extremely complex and requires multi-agency coordination and/or there is difficulty in getting agreement regarding the plan.
- There are concerns that it has not be possible to ensure that the patient/ carers wishes have been included/can be included in the discharge planning

5.12.6 Invitees should include relevant members of the MDT, representatives from outside agencies i.e. care provider, community matron, district nurse, and the patient and/or carer.

5.12.7 Clear actions and accountability for actions should be made at the meeting and these should be recorded in the discharge planner. If necessary a follow-up meeting should be planned.

5.13 Discharge / Transfer of Care Documents Given to Patients Carers and Healthcare Professionals

5.13.1 The final arrangements should be clearly communicated to the parent / patient / carer ensuring that they understand the arrangements that have been made.

5.13.2 Once the discharge plan is agreed by the MDT and parent / patient / carer the estimated date of discharge should be revised and documented in the notes and on the required patient administration systems.

5.13.3 On discharge from the Trust, it is standard that patients should be supported in being able to leave in daywear and that leaving hospital in nightclothes as a norm is not acceptable. If it is not possible for the patient to access their own clothes and if they find it acceptable; a store of clothes are available by contacting the discharge lounge, for them to wear.

5.13.4 Where the patients needs require an ongoing transfer of care to community/social care services the actual discharge should be carried out so that the transfer of care happens smoothly and the patient's needs are met at all times.

5.13.4 On-going medical equipment supplies - Where necessary this will include a minimum of 3 days of supplies such as drainage bags, pads, catheters etc. There may be exceptions to this where more than 3 days supply will be needed are where patients are being discharged at bank holiday weekend or where there are particular pathways such as the wound VAC pathway.

5.13.5 Follow-up appointment - Where needed the follow-up appointments should be arranged and the appointment card given to the patient/ carer.

5.13.6 Transport arrangements - Transport can only be arranged where there is a clinical need. If there is not a clinical need then the patient/ carer should be asked to make their own transport arrangements. If transport for the appointment is needed then this should be booked and the patient/ carer informed.

5.13.7 A transfer of care form must be completed for every child discharged and forwarded to the Liaison Health Visitor service; Health visitors and school nurses will require this.

5.13.8 Discharges that occur out of standard working hours i.e. not within Monday to Friday 9.00am – 5.00pm will be managed and information provided as it is in normal working hours. Exceptions to this will be as listed below:

- If a specific department is unavailable to book outpatient or follow up appointments. Patients will be given a specific timeframe within which an appointment will be made for their follow up treatment.
- If the pharmacy department is unavailable medications may be given from ward stock in pre-prepared dispensing packs and/ or a prescription will be given to the patient for supplies when pharmacy services resume.

5.13.9 On discharge, the patient/ carer / healthcare professionals should be given the relevant information as appropriate to the individual patient needs as listed below and referred to in 5.12 – 5.13

Document	**Sent to / used by:**
For all Adult and Child patients:	
Copy of electronic discharge summary – detailing the episode of admission	GP and Patient A copy kept in Patient notes
Medicines TTOs with information about medication from pharmacy or enclosed with the medication from the drugs company. This should be recorded in the purple discharge planner and on the electronic discharge summary.	Patient / Carer
Health promotion leaflets	Patient / Carer
Information on follow-up e.g. outpatient appointments, treatments or review. Including details of any additional language or communication needs	GP Patient / Carer Healthcare professional if ongoing care is required
Ongoing care arrangements, as necessary on the electronic discharge summary if not already given in writing as part of the discharge planning process. Community referral forms vary for different locations provided by the location of discharge.	Patient / Carer GP Patient notes Discharge planner
If the patient requires ongoing care from other Healthcare / Social Services, they will need a Transfer letter regarding ongoing care needs, Wound Care plans and Dietetic Information.	Patient Healthcare Professionals
For Adults Patients Only:	
After Hospital Care Plan See Appendix 9	Patients & Healthcare Professionals
Appendix 2 Letter 1a - Confirmation of assessed need in Care Home	Patient / Carer
Appendix 3 Letter 1b – Confirmation of assessed need supporting Package of Care	Patient / Carer
Appendix 4 Letter 2a – Confirmation of transfer to Short Term Care Home	Patient / Carer
Appendix 5 Letter 2b – Confirmation of transfer home supported by a package of care	Care Agency / Home and Patient / Carer
Appendix 6 Letter 2c – Confirmation of transfer of care to a long term Care Home	Long Term Care Provider Patient / Carer
For Child Patients Only:	
Appendix 7 Children and young persons	Pharmacy

discharge letter	GP Patient / Carer Internal
Appendix 8 – Children's Transfer of Care form for Health Visitor / School Nurse	Nurse only
Appendix 9 - Community Children's Nursing Team – Referral Form	Internal only
Appendix 10 Royal Alexandra Children's Hospital Theatre & Recovery Integrated Care Pathway – 'Discharge Criteria'	On the ward / internal only
Appendix 11 - Children and Young Person Day Surgery Care Pathway – section on 'Discharge'	On the ward / internally

5.14 Self Discharge or Discharge against medical advice

5.14.1 Where a patient is self-discharging or taking their discharge against medical advice the following actions need to be taken:

- The parent / patient understands the risk they are taking in discharging themselves or their child
- Is not competent to understand the risks they are taking in discharging themselves either due to medical or mental health issues affecting their judgment.

5.14.2 Where patients wish to take their own discharge but their decision-making is affected by medical or mental health or a lack of capacity then the clinical teams involved in the care of the patient should consider applying for the patient to be detained under the Mental Health Act or Deprivation of Liberty.

5.14.3 Parents / patients who choose to discharge their child / themselves against clinical advice must sign a disclaimer form. This should be filed in the patients notes and a brief description of the events documented in the patients notes.

5.15 Choice on transfer of care for adults

5.15.1 Where a patient/carer does not agree with the assessment plan regarding the outcome of the assessment and options offered the *Choice on Transfer of Care Policy* should be implemented.

5.16 Discharge of care for patients not resident in the UK

5.16.1 Patients who are visiting the UK will be treated in an equal and humane manor to UK residents and discharged into a suitable, safe environment.

5.16.2 Patients being treated who are not UK residents will need to have funding clarified by the overseas team. This is equally the case where a patient is referred from another NHS body. The relevant NHS body receiving the patient should assess for eligibility, make, and recover charges as appropriate.

5.16.3 BSUH will not refuse to accept and treat a patient with acute health needs because they are a chargeable overseas visitor. If clinicians refer a patient to

another relevant NHS body then that NHS body should treat the patient and apply the charging regime as in point 6.15.1.

5.16.4 At the point of discharge, if the patient requires non-critical immediately necessary care to be ongoing and they are not able to return to their country of origin, ongoing care will be provided by Sussex Community NHS Trust as they would as a UK citizen. On discharge, the care responsibility will be transferred to the next provider.

5.17 Management of medicines

5.17.1 All patients who require medication on discharge should have a TTO prescription chart written 24 hours prior to discharge.

5.17.2 Patients will be provided with the appropriate supply of medication for up to 4 weeks after discharge. Included in the discharge summary to the GP will be details of the medications provided and any review required.

5.17.3 Medications provided to patients on discharge should be given in accordance with policy on 'Safe and Secure Handing of Medicines MM0026' and if appropriate the 'Guidelines for the use of the Patients own Drugs MM0108'.

5.17.4 Pharmacy Supplies - Requests for medication on discharge (TTO's) should be planned well in advance of the discharge date and the POD algorithm should be adhered to. Where blister packs are assessed as being needed 24 hours notice is required.

5.17.5 Where patients are discharged, as part of a ward round then a 'one stop' round should be done and the TTO's written on the round.

5.17.6 It is the responsibility of the registered nurse looking after the patient to ensure that they, their parent / carer has received education about their medication and a registered nurse must check that the medication that the patient is taking away matches the medications on the TTO's list.

5.18 Treatment of property on discharge

5.18.1 On discharge, patients should take with them all their own property, managed in accordance with the 'SQ001 Claims Management Policy'

5.18.2 Management of the patient's health record will be managed in accordance with the policy 'IKM001 - An Organisation-wide Policy for Managing the Quality of Health Records'.

6. Training Implications

6.1 Training for all newly qualified nurses on discharge planning

6.2 Monthly ward based training sessions for all allied health professionals in adult settings

7 Monitoring Arrangements

Measurable Policy Objective	**Monitoring / Audit Method**	**Frequency**	**Responsibility for performing monitoring**	**Where is monitoring reported and which groups / committees will be responsible for progressing and reviewing action plans**
Monthly feedback of improvement log from community services with joint review and actions recorded. This includes any concerns which need to be raised with regards to out of hours discharges. **Adult only**	Monthly Meetings with all stakeholders. Systems group meetings with Brighton & Hove local health economy.	Bi-Monthly Weekly Fortnightly meetings with Mid Sussex Urgent Care Task Force.	Head of Nursing Discharge and Partnerships & The Discharge Team Manager	Through IR1 Meetings
Review of DOLS applications, lessons learned **Adult only**	Through strategy meetings	Monthly	Associate Director of Quality	Adult social care and BSUH lead for safeguarding vulnerable adults
Real time patient surveys **Adult only**	Patient Experience Panel	Monthly	Chief Nurse	Patience Experience Panel meetings
BSUH Internal Audit on Ready To Go High Impact Action and discharge ward audit **Adult and Child**	Audit of ward purple discharge planner as part of the monthly nursing metrics completed by	Monthly	Head of Nursing Discharge and Partnerships And Patient Safety Team.	Ward managers report to the WWW (Working Ward Wednesdays) chief nurse meetings.

	the Ward Managers. and Audit of staff education			
Documentation to accompany patient on discharge - Review of issues regarding discharge raised through LINKs **Adult only**	Recorded meetings	Quarterly	Head of Nursing Discharge & Partnerships	At LINKs meetings reporting to Patient experience Forum/Chief Nurse.
Documentation to accompany patient on discharge - Audit of Discharge Care Plan **Adult and Child**	Transfer of Care for Health Visitors form.	Annually	Monitored by Nurse Consultant Safeguarding	ALEX Senior Nurses Team Meeting/ Chief Nurse

8. Equality Impact Assessment Screening

Please refer to Appendix 1

9. Links to other Trust policies

Choice on Transfer of Care Policy

Translating and Interpreting Policy

Caring for Adults with Learning Disabilities in Acute Trusts

Major Incident and Bomb Threat Plan

Mental Capacity Act Policy

Policy and procedures for the Correct Identification of Patients

Missing Patient Policy

Safe and Secure Handing of Medicines

Guidelines for the use of the Patients own Drugs

Policy on Management of Patients' Property

An Organisation-wide Policy for Managing the Quality of Health Records

10. Associated documentation

Discharge Resource folder, available on every ward for all staff

11. References

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Noyes J & Lewis M. Care pathway for the discharge and support of children requiring long-term ventilation in the community: National Service Framework for Children, Young People and Maternity Services. Department of Health, 2005.

Appendix 1 Equality Impact Assessment

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	Yes	Some religious groups have access to religious support networks.
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Yes	Alter information as required liaise with learning disabilities, RNIB, RNID
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	No	
6.	**What alternative is there to achieving the document/guidance without the impact?**	No	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?**	No	

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality and Human Rights Adviser, together with any suggestions as to the action required to avoid/reduce this impact.

Communication Services Available for BSUH Patients

Overseas Language Interpretation:

Sussex Interpreting Services (SIS)

The Trust has a core contract with SIS to provide interpreters to meet the language needs for all patients being treated by BSUH.
Non emergency – 01273 702005
Emergency – 07811 459315
Online booking form (elective procedures) www.sussexinterpreting.org.uk

Vandu Language Services (VLS)
Telephone – 01273 473986
Mobile – 07989 023460
Online booking form (elective procedures) www.vlslanguages.com

Communication Support/Interpretation:

Neals Communication Agency Limited
Provide British Sign Language, Lip-speaking and Deafblind interpretation.
Interpreters can be booked by contacting:
Telephone: 0845 6048345
Online booking form (elective procedures) www.neal.uk.com

Deafblind UK
Provide free and confidential communication and guiding support for all medical appointments in Brighton and Hove for people with sight and hearing loss. Deafblind UK can also provide Deafblind interpreters (which is chargeable)
Advice Line: 0800 132 320

Blatchington Court Trust
Can provide translation of small documents (in plain text) into Braille, for larger documents Blatchington Court Trust can provide advice on alternative suppliers.
Please email Word documents to: alison@blatchingtoncourt.org.uk

Sources of Support within BSUH

Learning Disability Liaison Team
The team can be contacted on 01273 696955 ext. 4975, and are available Monday to Friday, from 8.30am - 4.30pm. The team will support healthcare professionals and patient, service users and their carers or family during admission or attendance at our hospitals.

The Learning Disabilities Liaison Team aims to provide active support, education and advice for professionals, acute hospital staff, the patient and their family and carers.

Portable Induction Loops
These can be hired by contacting the Estates helpdesks:
PRH – ext. 5929

All patient letters can be made available in other languages and other formats as required to assist in communication for patients with learning difficulties or communication needs**.**

Appendix 2

Patient Letters

A copy of **letter 1a (care home) or 1b (package of care) Appendix 1** outlining the outcome of the assessment is given to the patient/carer by the discharge coordinator within 24 hours of the plan being agreed and this is recorded in the discharge planner. A copy of the letter is filed in the patient's notes and also sent to the Adult Social Care team.

If the patient/carer has a preference for a particular care home it should be explained by a nominated member of the MDT that in the instance of the home being funded by the local authority, that they can only arrange accommodation in that home subject to the following conditions being met (Age Concern, 2008):

- The home is suitable to meet the individuals assessed needs
- It doesn't cost more than the council would normally pay to arrange accommodation for someone of those assessed needs
- There is accommodation available in the home
- The provider is willing to enter into a contract on the councils usual terms

Appendix 3 - Letter 1a
Confirmation of assessed need in Care Home

TO BE SENT IN SIZE 12 FONT OR LARGER IF THE PATIENT/CARER HAS VISUAL IMPAIRMENT

[Name of Patient]
[NHS/PAS Number]

[Date]

Dear [Patient Name]

To help those involved in planning your care, and to support your safe discharge, your health and social care assessment has been completed and the team has discussed and agreed with you where your needs will best be met. It is thought that this would be *[insert what and where here].* A nominated caseworker and other ward staff will do all they can to help identify a suitable place quickly so that you are able to leave hospital as a soon as possible. The person co-ordinating your discharge will be *[insert named coordinator]*

It is in your best interests for you to leave hospital as soon as an appropriate place that meets your needs has been identified. Staying in hospital longer than necessary can increase the chance of your health deteriorating and can lead to a loss of independence. In addition, we are sure you will understand that hospital beds are in great demand and that we need to ensure that they are available for patients who need acute in-patient care.

Once a care home that is suitable to meet your need has been identified, you or your carer will be asked to visit the home as soon as possible. We would hope that within 2 days of that visit you should be able to be discharged from hospital. Your caseworker will agree with you the timescales for this.

In the unlikely event that none of the place(s) offered to you are of your preference, but they are identified as meeting your immediate needs, then you will be asked to accept an alternative placement in the short term to enable you to leave hospital by your proposed discharge date. A short-term placement can also aid further recovery or help you regain your independence before making a final decision about your longer-term needs.

If you do have to move to the short-term placement, you will be helped to move to a more permanent home when a vacancy that takes into account your wishes and needs has been identified. Whilst you are at the short-term placement, you will be contacted by a social care worker to have a review of your needs at between 4-6 weeks, and again at 12 weeks if you have not already moved into a longer-term placement or returned home.

If you, or your carer wish to talk things through with someone who can help and support you in your discharge, please contact *[insert who here]*, who will arrange this.

Yours sincerely
Signed on behalf of:
Brighton and Sussex University Hospitals NHS Trust
cc: Family/Representative with patient’s permission

Appendix 4 - Letter 1b
Confirmation of assessed need supporting Package of Care

TO BE SENT IN SIZE 12 FONT OR LARGER IF THE PATIENT/CARER HAS VISUAL IMPAIRMENT

[Name of Patient]
[NHS/PAS Number]

[Date]

Dear [Patient Name]

To help those involved in planning your care and support your safe discharge your health and social care assessment has been completed and the team has discussed and agreed with you where your needs will best be met. It is thought that this would be with a supporting package of care at home. A nominated case worker and other ward staff will do all they can to help to put the care package in place quickly so that you are able to leave hospital as a soon as possible. The person co-ordinating your discharge will be *[insert named coordinator]*

It is in your best interests for you to leave hospital as soon as the appropriate service that meets your needs has been identified. Staying in hospital longer than necessary can increase the chance of your health deteriorating and can lead to a loss of independence. Also we are sure you will understand that hospital beds are in great demand and that we need to ensure that they are available for patients who need acute in-patient care.

Once everything is in place for you to return home safely with this support we would hope that within 1 day you should be able to be discharged from hospital. Your case worker will agree with you the timescales for this.

In the unlikely event that the package of care is not of your preference, but is identified as meeting your immediate needs, then you will be asked to accept the package of care in the short term to enable you to leave hospital by your proposed discharge date.

If you, or your carer wish to talk things through with someone who can help and support you in your discharge, please contact *[insert who here]*, who will arrange this.

Yours sincerely

Signed on behalf of:
Brighton and Sussex University Hospitals NHS Trust

cc: Family/Representative with patient's permission

Appendix 5 - Letter 2a
Confirmation of transfer to Short term Care Home

TO BE SENT IN SIZE 12 FONT OR LARGER IF THE PATIENT/CARER HAS VISUAL IMPAIRMENT

[Patient Name]
[NHS/PAS number]

[Date]

Dear [Patient Name]

I am pleased to inform you that you are now well enough to leave hospital. A place has been arranged for you at …..... and arrangements have been made for you to leave hospital on ……

Whilst you are staying at the short term care home you and/or your carer will be able to continue to view other care homes to identify another place that meets your needs. A named social worker will be identified to assist you with this.

We hope you will be happy in this care home and thank you for your co-operation.

Yours sincerely.

Insert appropriate LHC organisations e.g.
Brighton and Sussex University Hospitals NHS Trust

cc: Family/Representative with patient's permission

Appendix 6 - Letter 2b
Confirmation of transfer home supported by a Package of Care

TO BE SENT IN SIZE 12 FONT OR LARGER IF THE PATIENT/CARER HAS VISUAL IMPAIRMENT

[Patient Name]
[NHS/PAS number]

[Date]

Dear [Patient Name]

I am pleased to inform you that you are now well enough to leave hospital. Your package of care has been arranged for you which is as follows ….... and arrangements have been made for you to leave hospital on …….

We hope you will be happy with this service and thank you for your co-operation.

Yours sincerely.

Insert appropriate LHC organisations e.g.

Brighton and Sussex University Hospitals NHS Trust

cc: Family/Representative with patient's permission

Appendix 7 - Letter 2c
Confirmation of transfer of care to a long term Care Home

TO BE SENT IN SIZE 12 FONT OR LARGER IF THE PATIENT/CARER HAS VISUAL IMPAIRMENT

[Patient Name]
[NHS/PAS number]

[Date]

Dear [Patient Name]

I am pleased to inform you that you are now well enough to leave hospital. It has been arranged for you to transfer to ……..and arrangements have been made for you to leave hospital on ……..

We hope you will be happy in this care home and would like to thank you for your co-operation.

Yours sincerely.

Insert appropriate LHC organisations e.g.
Brighton and Sussex University Hospitals NHS Trust

cc: Family/Representative with patient's permission

Appendix 8 – Children and Young Persons discharge letter

Brighton and Sussex University Hospitals NHS Trust

DISCHARGE NOTE & PRESCRIPTION

PATIENT DETAILS

Mr/Mrs/Miss..... Unit No: K .....

Forename(s)..... DoB:...../...../.....

Address .....

Date: _____ /_____ /_____

Please complete in ballpoint pen legibly and without the use of specialist abbreviations.

Please ensure legibility of ALL copies.

Dear Dr _____

Your patient was admitted electively/as emergency on _____/_____/_____ to _____ ward in_____ hospital under _____consultant, and was subsequently transferred on _____/_____/_____ to _____ ward in _____ hospital under _____ consultant.

PRESENTING PROBLEM was: _____

PAST HISTORY included: _____

INVESTIGATIONS included: _____

and OGD/Sigmoidoscopy/Colonoscopy/Ultrasound/CT/IVU/Isotopes/MRI (tick as appropriate for coding)

PRINCIPAL DIAGNOSIS was: _____

Diagnosis notified to: Patient ☐ Relative ☐ Relative's details _____

MAIN TREATMENT/OPERATION was: _____

_____

_____ and this was carried out on _____ /_____ /_____

Complications, secondary problems were: _____

Managed by: _____

Discharge Date: _____ /_____ /_____

Discharged to: Patient's home ☐ Discharge notified to: Social Services ☐

Nursing/Rest Home ☐ District Nursing ☐

Further details (including address of nursing/rest home) _____

Outpatient Appointment at: _____ Hospital in _____ weeks

Drugs on discharge, from Pharmacy or patient's own stock

DRUG	DOSE	DIRECTIONS	QUANTITY/ DURATION	CONTINUE AFTER COMPLETION (Y/N)	OWN DRUGS	PHARMACY

Yours sincerely

Dr _____ _____ Bleep _____ SHO/HS/HP

Signature (PLEASE PRINT YOUR NAME)

White Copy Pharmacy Pink Copy By Hand to Patient

Yellow Copy Post to GP Blue Copy Front of Notes

WGN 500120 CSP Ltd.

Appendix 9 – Children's Transfer of Care form for Health Visitor / School Nurse
Page 1.

Brighton and Sussex University Hospitals NHS Trust

Transfer of Care Form For Health Visitor/School Nurse	The Royal Alexandra Children's Hospital Eastern Road Brighton and Sussex University Hospitals East Sussex BN2 5BE Tel: 01273 696955
Affix patient Address label or enter details: **Trust ID No.:** **Surname (BLOCK LETTERS):** **First name:** **Address** **D.O.B.:**	*Address on discharge if Different* *Post Code*
ADMISSION DATE	*Discharge Date*

PRIMARY HEALTH CARE / EDUCATION			
GP Dr.			Address Tel No;
Health Visitor			
Known to Seaside View - *tick appropriate box*	Yes	No	Department / Key worker
Social Worker			Patch
School, Nursery, Child Minder			

WARD	CONSULTANT

REASON FOR ADMISSION / DIAGNOSIS / TREATMENT
State mechanism of injury for an accident.

ASSESSMENT as *appropriate*	
WEIGHT Admission KG	Discharge KG
HEAD CIRCUMFERENCE CMS	LENGTH CMS
FEEDING REGIME *Babies under 1 year or Special diets*	
SPECIAL EQUIPMENT e.g. home O_2, Gastrostomy	

Appendix 9 – Children's Transfer of Care form for Health Visitor / School Nurse
Page 2.

Brighton and Sussex University Hospitals NHS Trust

DISCHARGE		YES	NO
1	Parents have had the opportunity to talk with the surgeon following theatre and discussed the outcome Name of Surgeon:		
2	Is fully conscious and orientated		
3	Can breath comfortably and exhibits no sign of respiratory distress		
4	Has had cardiovascular observations, PEWS taken and recorded ½ hourly or as indicated		
5	Has eaten and drunk and is not nauseated		
6	Cannula sited in has been removed by		
7	Can walk unaided or mobilise as usual.		
8	Has passed urine (where relevant)		
9	The wound site has been checked prior to discharge		
10	Has had post-operative medications and TTO's (if required) Given times of when next medications are due:		
11	Has been given post-operative instructions and guidance, verbal and written if possible		
12	Parents / Child understand the effect of a caudal to lower limbs. Numbness, tingling sensation, pins & needle, Advised about mobility		
13	Teaching programmes completed for new equipment		
14	Does the patient need to stay overnight? If Yes		
	Ward: | Bed Space Number: | Bleep holder informed:		
15	Does the Patient need a referral to another service? Which one? Has a Health Visitor referral form been completed?		
Nurse Signature	Date		

SIGNATURE LIST OF ALL NURSES WHO HAVE DOCUMENTED CARE FOR THIS CHILD			
DATE	NAME (Please Print)	SIGNATURE	INITIALS

Appendix 9 – Children's Transfer of Care form for Health Visitor / School Nurse
Page 3.

Brighton and Sussex University Hospitals NHS

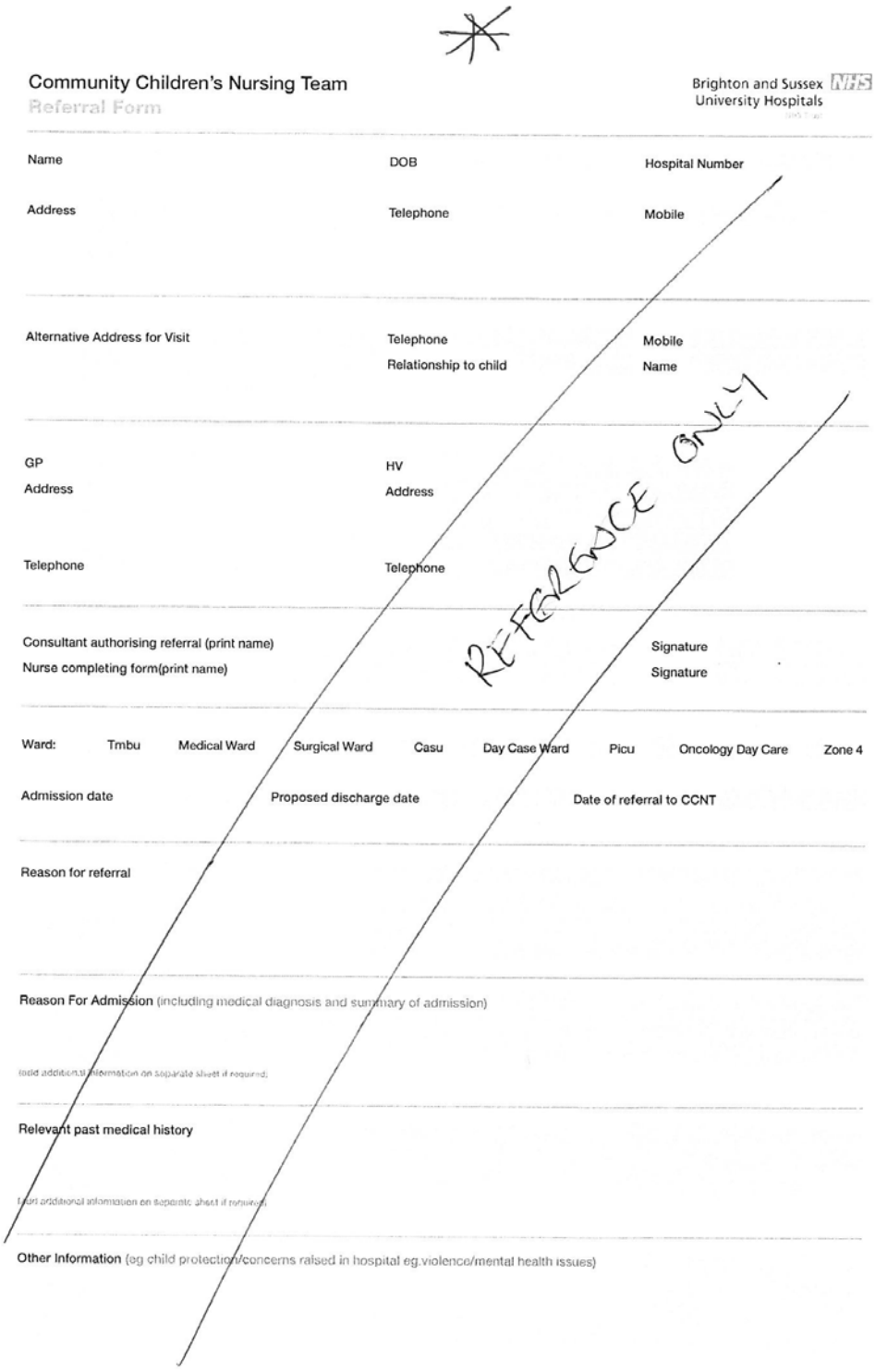
MEDICATIONS TO TAKE HOME	YES / NO

FOLLOW UP APPOINTMENT	YES / NO
Date	Venue

OTHER PROFESSIONALS INVOLVED IN CARE	*Tick those whose involvement will continue in the Community*
CHILDREN'S COMMUNITY NURSES	RESPIRATORY NURSE
DIETICIAN	PRACTICE NURSE
PSYCHOLOGIST	

ANY OTHER COMMENTS *Mothers health, Social concerns, etc*

Appendix 10 – Community Children's Nursing Team Referral Form Page 1



Community Children's Nursing Team
Referral Form

Brighton and Sussex University Hospitals NHS

Name | DOB | Hospital Number

Address | Telephone | Mobile

Alternative Address for Visit | Telephone | Mobile
Relationship to child | Name

GP | HV
Address | Address

Telephone | Telephone

Consultant authorising referral (print name) | Signature
Nurse completing form(print name) | Signature

Ward: Tmbu | Medical Ward | Surgical Ward | Casu | Day Case Ward | Picu | Oncology Day Care | Zone 4

Admission date | Proposed discharge date | Date of referral to CCNT

Reason for referral

Reason For Admission (including medical diagnosis and summary of admission)

(add additional information on separate sheet if required)

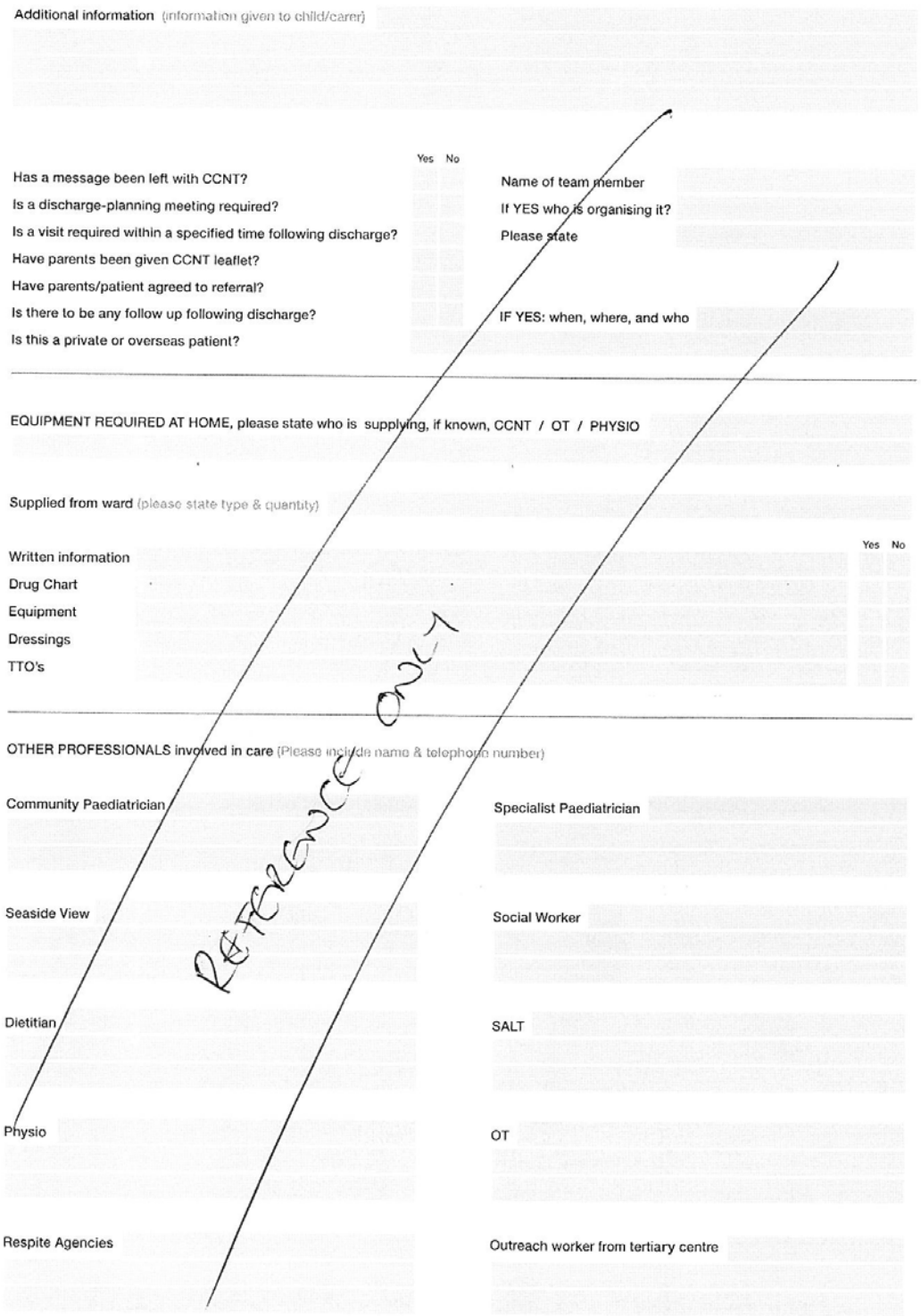
Relevant past medical history

(add additional information on separate sheet if required)

Other Information (eg child protection/concerns raised in hospital eg.violence/mental health issues)

REFERENCE ONLY

Appendix 10 – Community Children's Nursing Team Referral Form Page 2



Additional information (information given to child/carer)

	Yes	No
Has a message been left with CCNT?		
Is a discharge-planning meeting required?		
Is a visit required within a specified time following discharge?		
Have parents been given CCNT leaflet?		
Have parents/patient agreed to referral?		
Is there to be any follow up following discharge?		
Is this a private or overseas patient?		

Name of team member
If YES who is organising it?
Please state

IF YES: when, where, and who

EQUIPMENT REQUIRED AT HOME, please state who is supplying, if known, CCNT / OT / PHYSIO

Supplied from ward (please state type & quantity)

	Yes	No
Written information		
Drug Chart		
Equipment		
Dressings		
TTO's		

REFERENCE ONLY

OTHER PROFESSIONALS involved in care (Please include name & telephone number)

Community Paediatrician

Specialist Paediatrician

Seaside View

Social Worker

Dietitian

SALT

Physio

OT

Respite Agencies

Outreach worker from tertiary centre

Appendix 11 RACH Theatre and Recovery Integrated Care Pathway Page 1

Brighton and Sussex University Hospitals NHS Trust

Addressograph:

Surname: ..... Trust ID No: .....
Forename: REFERENCE ONLY NHS No. .....
Mr/Mrs/Ms/Miss: ..... DoB: ...../...../.....
Address: .....

Royal Alexandra Children's Hospital
Theatre & Recovery Integrated Care Pathway

This document is to be filed in the notes with Surgical and Anaesthetic notes

Date: **Ward:**

Pulse_____ **Temp.**_____**°C** **Pre Anaesthetic State**_____

Respiration_____ **Patient likes to be called**_____

Blood Pressure_____ **Bloods need to be taken** Yes ☐ No ☐

Temperature_____ **Broselow**_____ **Pre-op Temp.**_____**°C**

Weight (kgs)_____

Accompanied to Theatre by Parent ☐ Legal Guardian ☐ Carer ☐

Medication administered pre-operatively
(Pain relief / Antibiotics / Premed) Yes ☐ No ☐ N/A ☐

Allergies_____

List of accepted abbreviations

A.F.	Atrial Fibrillation	F.L.A.C.C.	Behavioural Pain Assessment Score	Numeric	Self Report Pain Assessment Score
B.P.	Blood Pressure	C.V.P.	Central Venous Pressure	C.X.R.	Chest X-Ray
D.P.	Dorsalis Pedis	E.C.G.	Electrocardiograph	E.U.A.	Examination Under Anaesthetic
G.A.	General Anaesthetic	I.V.	Intra Venous	L.A.	Local Anaesthetic
L.M.A.	Laryngeal Mask Airway	M.U.A.	Manipulation Under Anaesthetic	N.I.B.P.	Non Invasive Blood Pressure
P.C.A.	Patient Controlled Analgesia	P.R.	Per Rectum	P.T.	Posterior Tibial
P.U.	Passed Urine	P.V.	Per Vagina	P.E.W.S	Paediatric Early Warning Score
↑	Increase	↓	Decrease	I/C	With

Name of Anaesthetist: .....

Name of Surgeon: .....

Theatre Number: .....

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WGN 500423

Appendix 11 RACH Theatre and Recovery Integrated Care Pathway Page 2

Patient's Name:_____ Trust ID No.:_____

Discharge Criteria

Time patient met RAH Theatre criteria: (score 14>) _____

Vital Signs at Discharge

B.P:_____ Pulse:_____ Respiration:_____

Temperature:_____°C SaO_2_____% On O_2 ❑ O_2 flowrate_____L

PACLAT Score_____ PEWS: _____ Pain score: Numeric _____

FLACC_____

Discharge Criteria =

1. Post anaesthetic conscious level assessment tool (PACLAT): Minimum score of 14
2. Pain (Numeric): Score should be <5
3. FLACC (Behavioural): Score should be 0-1

NURSING NOTES

Datix Form: ☐ **Ref No:**_____	
Time patient left Recovery _____	
Recovery Nurse Signatures: 1.	2.
Name: 1.	2.
Ward Nurse's Signature	
Name:	

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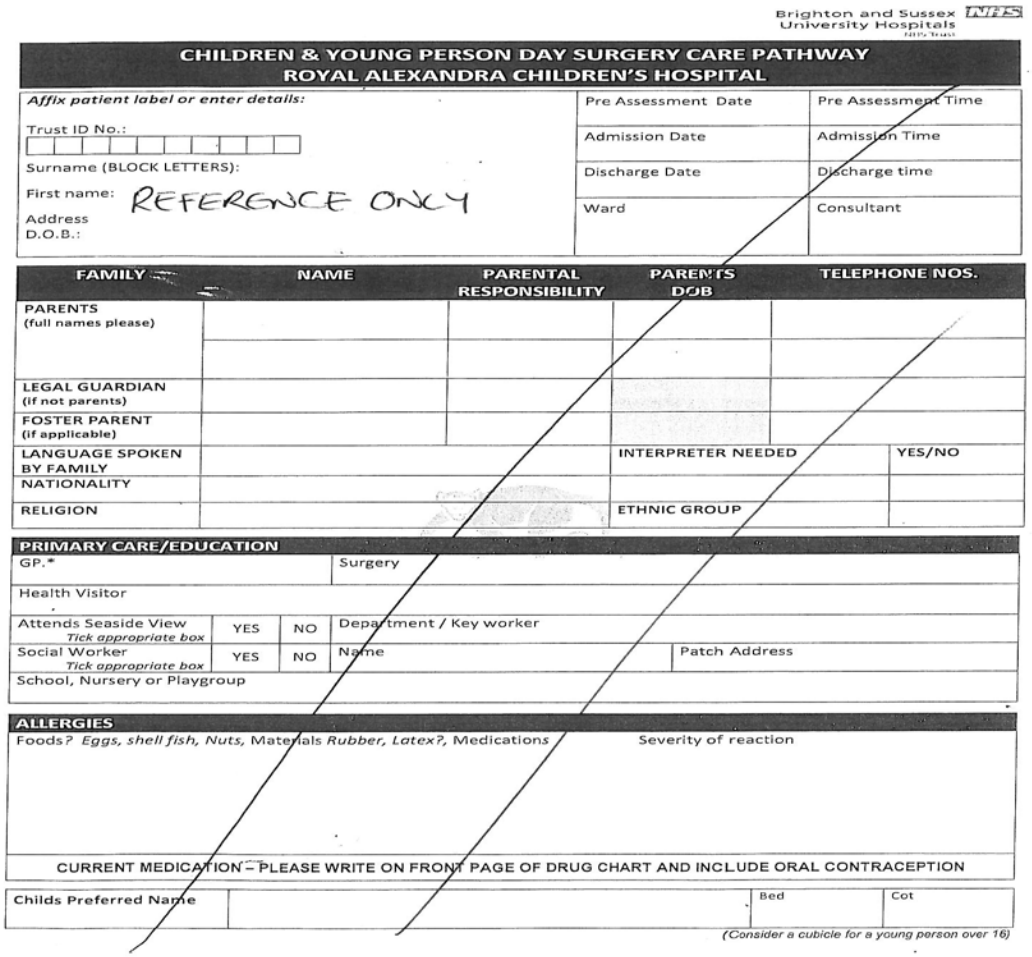
Appendix 12 Children and Young Person Day Surgery Care Pathway Page 1



Brighton and Sussex University Hospitals NHS Trust

CHILDREN & YOUNG PERSON DAY SURGERY CARE PATHWAY
ROYAL ALEXANDRA CHILDREN'S HOSPITAL

Affix patient label or enter details:	Pre Assessment Date	Pre Assessment Time
Trust ID No.:	Admission Date	Admission Time
Surname (BLOCK LETTERS):	Discharge Date	Discharge time
First name: REFERENCE ONLY	Ward	Consultant
Address D.O.B.:		

FAMILY	NAME	PARENTAL RESPONSIBILITY	PARENTS DOB	TELEPHONE NOS.
PARENTS (full names please)				
LEGAL GUARDIAN (if not parents)				
FOSTER PARENT (if applicable)				

LANGUAGE SPOKEN BY FAMILY		INTERPRETER NEEDED	YES/NO
NATIONALITY			
RELIGION		ETHNIC GROUP	

PRIMARY CARE/EDUCATION

GP.*			Surgery	
Health Visitor				
Attends Seaside View *Tick appropriate box*	YES	NO	Department / Key worker	
Social Worker *Tick appropriate box*	YES	NO	Name	Patch Address
School, Nursery or Playgroup				

ALLERGIES

Foods? *Eggs, shell fish, Nuts,* Materials *Rubber, Latex?,* Medications	Severity of reaction

CURRENT MEDICATION – PLEASE WRITE ON FRONT PAGE OF DRUG CHART AND INCLUDE ORAL CONTRACEPTION

Childs Preferred Name		Bed	Cot

(Consider a cubicle for a young person over 16)

Appendix 12 Children and Young Person Day Surgery Care Pathway Page 2

REFERENCE ONLY

Brighton and Sussex University Hospitals NHS Trust

DISCHARGE

		YES	NO
1	Parents have had the opportunity to talk with the surgeon following theatre and discussed the outcome Name of Surgeon:		
2	Is fully conscious and orientated		
3	Can breath comfortably and exhibits no sign of respiratory distress		
4	Has had cardiovascular observations, PEWS taken and recorded ½ hourly or as indicated		
5	Has eaten and drunk and is not nauseated		
6	Cannula sited in has been removed by		
7	Can walk unaided or mobilise as usual.		
8	Has passed urine (where relevant)		
9	The wound site has been checked prior to discharge		
10	Has had post-operative medications and TTO's (if required) Given times of when next medications are due:		
11	Has been given post-operative instructions and guidance, verbal and written if possible		
12	Parents / Child understand the effect of a caudal to lower limbs. Numbness, tingling sensation, pins & needle, Advised about mobility		
13	Teaching programmes completed for new equipment		
14	Does the patient need to stay overnight? If Yes Ward: | Bed Space Number: | Bleep holder informed:		
15	Does the Patient need a referral to another service? Which one? Has a Health Visitor referral form been completed?		

Nurse Signature	Date

SIGNATURE LIST OF ALL NURSES WHO HAVE DOCUMENTED CARE FOR THIS CHILD

DATE	NAME (Please Print)	SIGNATURE	INITIALS