

In partnership with the Ministry of Defence

# PATIENT DISCHARGE POLICY

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## **Discharge Policy**

### **Executive Summary**

The purpose of this document sets out the key principles of good discharge planning which will ensure efficient use of beds, reduced waiting lists, reduced readmission rates and will lead to greater patient and carer satisfaction.

This Policy has been developed in conjunction with all relevant parties involved in discharge planning. The speed of recovery and quality of care of any patient during their hospitalisation is dependent upon the full co-operation and co-ordination of all the team members.

The Policy clarifies the roles and responsibilities of all staff involved in discharge planning, detailing statutory and organisational obligations for both health and social services.

The Policy recognises the importance of commencing the planning process at the earliest opportunity, identifying associated risks, involving the patient and their carers at all stages in the process.

The Trust, in conjunction with Social Services, will provide training for all staff involved in the planning of patient discharge.

.....  
**Andrew Morris**  
**Chief Executive**

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**Nicola Ranger**  
**Director of Nursing**

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**Edward Palfrey**  
**Medical Director**

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## **1.0 Introduction**

This Discharge Policy is an interagency policy, detailing statutory and organisational obligations for both the health and social services. This document has been drawn up in consultation with primary user members including commissioning Primary Care Trusts and Social Services departments.

Frimley Park Discharge Policy is to be used in conjunction with the Discharge from Hospital: pathway, process and practice guidance (DOH 2003), the Joint Protocol for the Transfer of Community Care (Delayed Discharge Act) 2003, The Carers (Recognition and Service) Act 1995; The Carers and Disabled Children Act 2000; The Carers (Equal Opportunities) Act 2004; Mental Capacity Act (2005), The Deprivation Of Liberty Safeguards (2009) and Ready To Go? (DOH 2010).

## **Equality and Diversity Statement**

Frimley Park Hospital NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat individual needs does not discriminate against individuals or groups on any grounds.

## **2.0 Policy Aims**

When planning for patient's discharge from acute care, we at Frimley Park Hospital, in conjunction with Social Services departments and Primary Care colleagues, aim to:

- Ensure the patient is always treated as an individual
- Involve the patient's next-of-kin and carers
- Provide continuity of care as patients transfer from one care setting to another
- Continue the assessment process where necessary, outside of Frimley Park Foundation NHS Trust, to ensure acute services are used only for the delivery of acute care.
- Discharge patients promptly when they are deemed 'medically stable' and safe for discharge, hence ensuring appropriate use of acute care facilities
- Identify and agree joint priorities for change.
- Ensure best practice

For the majority of patients, discharge from hospital is simple and uncomplicated. However for those patients whose needs are more complex, the discharge process ensures that discharge planning is straight forward, understood by all those involved and meets individual needs, as well as utilising acute services appropriately and responsibly.

### 3.0 Key Principles

Effective discharge planning will aim to avoid premature discharge or an increased length of stay, which can:

- Leave the patient with some unmet needs
- Poorly prepared for home
- Likelihood of re-admission
- Using inappropriate or more costly social care services (DOH 2010)
- Create difficulties for family members/carers

Similarly a protracted length of stay can:

- Increase the risk of infection, depression / low mood, boredom and frustration
- Increase the risk of loss of independence and confidence
- Allow NHS resources to be used inappropriately (DOH 2010)

The key principles therefore need to ensure that:

- Patients, next of kin and carers are central to the planning of care and the successful discharge. Ensuring their involvement and empowerment in all decision making.
- Discharge is a process and should be planned for at the earliest opportunity. The preparation for discharge should start prior to admission for elective cases and soon after admission for emergencies.
- Risks associated with discharge will be promptly identified by discussions with the patient, next-of-kin, carers and other health or social workers involved in the patient's care, whether in hospital or in the community prior to admission. If during this process it is identified that there may be concerns regarding the patient's ability to return to their previous accommodation, then it will be necessary to ensure the patient is referred to Social Services and all other relevant multi-disciplinary team members including Ward Matron and Discharge Team. The multi-disciplinary team can therefore in conjunction with the patient and/or family decide whether the patient may need rehabilitation, care at home, long- term placement or re-housing.
- These referrals to relevant multi-disciplinary team members must be made in a timely manner and recorded on the Jonah System.
- Paediatric referrals to relevant multi-disciplinary team members are recorded in the nursing care plan.
- The responsibility for the process of discharge planning should be co-ordinated by the Team Leader who co-ordinates all stages of the patients journey.
- The co-ordination of training for the ward staff re discharge planning is the responsibility of the Practice Development Nurse.
- A Predicted Date of Discharge (PDD) should be identified within 24-48 hours of admission and reviewed daily. This PDD should be communicated on all referrals to the multi-disciplinary team members and to the patient and/or family. Any issues resulting in an unnecessary delay in reaching this PDD must be recorded and documented on ADT, paediatric care plan and where necessary escalated to, either the Matron, Head of Department or the Discharge Team, to ensure any delay is minimised.

- Effective use is made of health and social step up and step down rehabilitation / assessment units and intermediate care services, aiding patients to achieve their optimal outcome and using acute hospital services appropriately.

See Glossary of terms for this policy (Appendix 1)

## **4.0 Roles and Responsibilities**

### **Executive Lead, Director of Nursing**

- To notify the board of directors of any significant incidents that arise from the discharge process.
- To chair the “Top 20” delayed patients, weekly meeting, with Matrons, Head of Social Services Department Teams, Senior Occupational Therapists and the Discharge Team, when complex discharges can be discussed and subsequent plans agreed.
- To chair the Multi-agency Meetings, with Senior Managers in both Health (acute and community) and Social Care and also relevant hospital allied health professionals, when recurrent themes and issues regarding discharge can be raised and discussed at a strategic level.

### **Discharge Team**

- To provide assistance and guidance to the multi-disciplinary team with potentially complicated discharges.
- To ensure patients / relatives and carers are proactively involved in their discharge and independent advocates involved when necessary.
- To provide support to the ward staff in the discharge process.
- To ensure appropriate patients are screened against the eligibility criteria for NHS fully funded Continuing Health Care. For those patients requiring subsequent assessment the discharge team will either complete the Decision Support Tool Assessments and/or refer the patient and carers to the correct authority for further assessments.

### **The Patient**

#### **Will be asked to:**

- Provide the nurses with details of any current care support and packages, giving details of the name and contact number for their Care Manager prior to/on admission.
- Voice any concerns about their ability to continue in their current setting with no changes in the support they receive.
- Actively participate in own care and discharge planning.

#### **The patient can expect to be:**

- Involved actively in all discussions regarding their acute and ongoing care.
- Consulted and referred by the NHS to Social Services for assessment if additional community care needs are anticipated.
- Promptly assessed by Social Services (after referral) for his/her care needs and those of the carer. Patient's choice is paramount in all decisions about discharge.
- Able to maximise independence.
- Given written information when pertinent, including the Leaving Hospital leaflet
- The recipient of a coherent care pathway.

### **The Relatives &/or Carer**

#### **Will be asked to:**

- Provide information to nurses about current issues/needs of the patient or themselves.
- Actively participate in care and discharge planning.
- Discuss with the relevant professionals if and how much they would like to be directly involved in the provision of care for the patient on discharge.

**The identified relative  
&/or Carer can expect to:**

- Be involved actively in all discussions regarding the patient's acute and ongoing care
- Be informed who, at ward level, is coordinating their patient's discharge arrangements.
- Be consulted and referred for assessment (carer) to determine their role in the care of the patient and any additional community care needs.
- Be promptly assessed by Social Services (after referral) for his/her care needs as a carer.
- Be offered a copy of the Carers Discharge Leaflet (Appendix 2) soon after the admission of the patient.
- Where patients have undergone a surgical procedure, they will be given written/verbal information which must include post-discharge advice.

**Nursing and Medical Teams role:**

- To assess the patient promptly on admission, identifying and involving patient and relative/carer and initiating referrals to relevant disciplinary team members, including community nursing teams where necessary.
- To ensure the patient and relative/carer are involved in the care and discharge planning.
- To ensure that the patients understand what medication has been prescribed, how to take it and what side effects to look out for.
- In the event of a complex discharge, the nursing team will involve the Discharge Team to support and co-ordinate the agencies concerned. The nursing team and the discharge team will then agree a plan of action with the patient and carers.
- To complete a Section 2 (Admission Assessment) Notification (via Patient Centre) as soon as possible after admission, having assessed that there may be a need for social services on discharge including details of the Predicted Date of Discharge.
- To complete a Section 5 (Discharge) Notification (via fax) following multi-disciplinary agreement that the patient has had all relevant assessments, and is medically stable and safe for discharge. This notification is jointly owned and signed by health and Social Care partners. To relay this to the correct authority at least one day in advance of the proposed discharge date.
- To complete the Discharge Assessment and Discharge Checklist documentation (Appendix 3)

**Social Services Role:**

- Social Services have a duty of care to patients who have a social need for carers.
- Community care is planned, co-ordinated and managed by a named care manager for patients who have social care needs when they are discharged.
- The care manager will keep the team leader (care coordinator) informed of the progress and outcome of the care planning process. The Care Manager will offer an assessment under the NHS & Community Care Act to any patient referred to Social Services by way of a Section 2 assessment notification if they meet the eligibility criteria.
- The patient will be assessed for suitability for further social rehabilitation / assessment either within their own home environment or in a "step down" facility prior to making any long-term decisions on care provision.
- Proper recognition must be given to carers (The Carers [Recognition and Service] Act 1995 and the Carers Equal Opportunity Act 2004. The team leader (care coordinator) will be responsible for referring carers to social services by way of a Section 2 assessment notification. A Care Manager will then offer all carers who provide, or intend to provide substantial care an assessment of their needs to identify any support/services they may require in order to continue to fulfil their caring role, where they choose to do so.
- Carer's assessments may also be started within the hospital but may be completed after the patient is discharged. The Care Manager must undertake a risk assessment before



discharging a patient where the Carers Assessment has not been completed to ensure that a carers employment, health and other responsibilities are not placed at risk.

- Young carers must also be identified and referred to the Social Care Team, as they are equally entitled to an assessment and support.
- Referrals from A&E will be dealt with by a Duty Care Manager from the hospital Social Care Team or referred to the locality social care team to complete a full community care assessment following discharge or complete one prior to discharge from A&E depending on the Counties local protocols and procedure.
- Social Services will be liable to pay Reimbursement fines for delayed transfers of care as stated in the Delayed Discharge Legislation. Please refer to the FPH Trust Reimbursement Policy and Procedures guidelines. Details of reimbursement liability and timings (Appendix 4).
- A Common Assessment Form (CAF) is completed for children and young people and referred to the children in need team prior to discharge to ensure the needs of the child are met.

### **Occupational Therapy Staff's Role:**

- On receipt of a referral the Occupational Therapy team (OT) will respond as soon as possible, the maximum wait times are :-
  - ◆ A&E - within 30 minutes of referral (Mon – Fri)
  - ◆ MAU - within 3 hours of referral (Mon – Fri)
- ◆ Other Ward areas – within 24 hours working days of referral (Mon-Fri) and within 48 hours of referral at weekends.

The Occupational Therapist will prioritise their workload taking into account the expected date of discharge of the patient – which must be stated at the time of the referral. (See Appendix 5 for OT referral guidelines).

- To carry out an assessment of the patient's abilities and needs for discharge, making decisions as to whether equipment, services are required. OT staff will involve the patient, relevant personnel and relative/carer as required. .
- Home visits, where necessary, will occur within 4 working days from the time the decision is made that a home assessment is needed as time is needed to co-ordinate all relevant parties. The OT will liaise with the patient, relevant personnel and relative/carer to organise this.

Where it is determined that a patient's ability to cope at home will be aided by the fitting of appropriate equipment or minor home adaptations, the patient and their carer will be involved in understand its purpose, and be trained in its use. The Occupational Therapists directly arrange for the fitting of, essential for discharge, home aids for patients living in Surrey and Hampshire. For those patients in outside of Surrey and Hampshire, and provision of none essential equipment and adaptations, Occupational Therapists refer directly to the relevant Social Services department.

### **Physiotherapy Staff's Role:**

- To assess patients according to clinical need (generally, urgent referrals will be seen within the same working day & non-urgent referrals will be assessed within 24 hours).
- If mobility aids/compressors are required for short-term loan for the patient to use after their discharge, the Physiotherapists will ensure that the patient and relative/carer are aware of the correct usage of the device. Training must consider use of the equipment in the individual's home setting.
- On transfer to another hospital or intermediate care scheme, the Physiotherapist will complete a transfer summary.
- If an out-patient appointment is required, the Physiotherapist will give the details to the patient.
- In more complex cases, direct liaison may be appropriate.

(Refer to each speciality within physiotherapy department for discharge information for patients in their area)

### **Hospital In Reach Matron's Role (Hampshire and Surrey):**

- To receive referrals for all patients with a complex nursing or intermediate care need, via the Patient Centre IT system (DNL) and specify that they are a 'special' referral. Staff will clearly indicate on the referral the reason the patient requires support on discharge and when the predicted discharge date is.
- Complex nursing needs include:
  - IV therapy (including community drug chart)
  - End of life support
  - Complex discharges
  - Intermediate Care support
- To receive referrals for patients requiring equipment on discharge when the Occupational Therapists have not been involved due to the patient's dependency level.
- The In Reach Matrons will, alongside Social Services and the Discharge Team to support ward staff, patients and carers/families with complex discharges, ensuring a smooth transition from acute care to the community
- Work in partnership with our community and social care colleagues to prevent unnecessary hospital admissions

### **Community Nurses / District Nurses Role's**

- To receive referrals for all patients with a routine nursing need via the Patient Centre IT system (DNL) and specify that they are a 'routine' referral. This referral should then be printed out automatically at the local printer and faxed to the relevant district nursing team. Staff will clearly indicate on the referral the reason the patient requires support on discharge and when the predicted discharge date is. All referrals should be followed up with a telephone call from the ward nursing teams to ensure a complete and thorough plan is agreed with the district nurses, prior to discharge.
- Routine nursing needs include:
  - Continence management
  - Wound management
  - Enteral feeding
  - Diabetic management
  - Acute/chronic illness management
  - To promote teaching and self management

### **Intermediate Care Referrals:**

- Patients can be referred for intermediate care via the Intermediate Care Service, by completing a “special” DNL referral via Patient Centre IT system and the relevant referral paperwork for Surrey patients, by completing a “special” DNL referral via Patient Centre IT system and telephone call for Hampshire patients and a Section 2 and relevant referral paperwork for Berkshire patients.
- Referrals may be for patients to receive rehabilitation in their own home or in any of the ‘step up – step down’ units within the community. Rehabilitation may be for up to

6 weeks, depending on the patient’s requirement and the service offered in different areas. Patients identified as requiring intermediate care will require rehabilitation goals from OT’s and/ or Physio’s following their assessment.

Patients are identified as needing further rehabilitation or support either on the wards at the multi-disciplinary meetings, or in the Medical Assessment Unit (MAU) and in the Accident & Emergency departments (A&E). After the assessment, the patient’s discharge is coordinated by the Intermediate Care Team.

Paediatric patients are referred to the children’s community nurse (CNN) team by telephone and completion of a child health referral form is sent within 24 hours.

### **Dietetics Role:**

- To action Patient Centre IT system referrals within 1, 2 or 4 working days, according to Dietetic department guidelines (Appendix 6).
- To ensure the patient is aware of any necessary changes to their diet as part of their treatment and has received adequate information to implement these changes at home.
- To contact the GP and/or Nursing Home to organise special feeds or supplementary sip feeds that are required.
- To organise provision of 3-days supply of Enteral feeding equipment and feeds for patients discharged on nasogastric or gastrostomy feeding and set up further supplies in the community. Relatives/Carers will be informed about these feeds and be educated as appropriate.

(A minimum of 48 hours notice prior to discharge is needed, otherwise where appropriate patients will be followed up as an out-patient)

### **Pharmacists/Pharmacy Technician’s Role:**

- To assist patients with potential medication problems within 24 hours of referral (via Ward Pharmacist/technician), involving the relatives/carers if pertinent
- To ensure the patient’s capability to manage medicines at home is assessed.
- To communicate with primary care staff to ensure patients at risk of non-compliance are followed-up.
- Relatives / Carers will be informed about the medication and advised / educated as appropriate.
- To provide a minimum of 14 days supply of all medication where the patient does not already have supplies in hospital / at home. Where possible this should be done in advance of the patients discharge.

### **Speech and Language Therapist Role:**

- To write to GP on discharge with outline of intervention for dysphagia and requesting on-going prescription for thickening product if necessary (ward to discharge with a 7 day supply)
- Prior to discharge, to provide verbal and written information for patient/carer/nursing/residential home with regard to need for any on-going food/fluid modification requirement.
- To liaise directly with community/specialist unit speech and language therapy department when patient transferred with on-going rehabilitation needs.

## **5.0 PATIENT CATEGORIES**

Discharge planning should start at the point of admission, involving the patient in conjunction with carers and relatives when appropriate. Predicted date of discharge will be set by the multidisciplinary team and recorded on the ADT system.

The discharge process will fall into two major categories, complex and routine.

### **A routine discharge**

If a Patient's level of functioning is unchanged from their pre-admission state and they do not require extra community support in order to return to their previous residence. The discharge requirement for this patient group is set out on the discharge checklist in appendix 4.

### **A complex discharge**

This may involve both health and social care working together in a timely manner to ensure health and social care needs can be met in a suitable environment. The discharge requirement for this patient group is set out on the discharge checklist in appendix 4. Examples of what constitutes a complex discharge are listed below, this is not an exhaustive list and further examples can be found in section 9.0 of this policy.

- NHS Continuing Care
- Health needs assessment
- Intermediate care in the patient's own home
- Hospice
- Care home provision
- Ongoing specialist rehabilitation

The discharge process for Surrey, Hampshire and Berkshire can be found in Appendix 7

## **6.0 OUT OF HOURS DISCHARGE**

This policy seeks to ensure that all patients are discharged safely in a planned and timely manner.

Patients who are being discharged in a routine nature should not do so after 22.00 hours or before 08.00 hours, with the exception of Accident & Emergency, Clinical Decisions Unit, Medical Assessment Unit, Paediatric Assessment Unit and Surgical Assessment Unit.

The appropriateness of discharge after 22.00 is the responsibility of the nurse in charge and the patient to be discharged. Any concerns about the suitability of the discharge must be raised with the site manager.

Elderly patients living alone who chose to be discharged in the evening, the following consideration must be taken:-

- Transport home
- Arriving to an empty home
- Keys to their home
- Availability of essential supplies
- Heating at home

Patients who require a complex discharge should be discharged at a time agreed by the external agencies delivering their care. Should transport have not arrived at the agreed time, those involved in the ongoing care, for example Social Services, Residential/Nursing homes, Families and carers should be immediately contacted and alternative times agreed. If there are still issues regarding re-arranging the transport time, then this should be escalated to the Nurse In Charge and accordingly with the Bed Managers if out of hours provision needs to be made. Only if no safe alternative can be arranged should the discharge be cancelled and re-arranged for the following day. Staff should complete an incident form if this occurs.

## **7.0 DISCHARGE CARE PLANNING PRIOR TO ADMISSION**

### **Pre-elective admission clinics**

- At pre-elective admission clinics, patients are screened for potential risk factors which could lead to discharge delay. Prompt referral is made by the lead professional to the appropriate therapist or department in advance of admission. Assessments should include whether the patient is receiving help/support from:
  - Community services
  - Social care
  - Meal-on-wheels
  - Private care workers or agencies.
  - Family and/or friends
  - Carers
  - Community specialist palliative care
  - That the patient and/or carer are satisfied with the level of support they are receiving.
  - That the carer is able to continue their role.

Appropriate referrals should then be made to the following if patients meet any of the risk criteria:

|                             |                        |
|-----------------------------|------------------------|
| • Anaesthetic department    | • Occupational Therapy |
| • Physiotherapy             | • Speech Therapy       |
| • Community Social Services | • Dietetics            |
| • Pharmacy                  | • Community Team       |
| • Intermediate Care         | • GP                   |
| • Psychiatric liaison team  | • Discharge Team       |

- In this assessment, the nurse must also identify the nominated next-of-kin and, if applicable, carer.

Patients and relatives should be informed about the use of the Discharge Lounge (if appropriate) and that a morning discharge will be arranged where possible.

Each patient will be admitted using the admission assessment book which includes the discharge checklist. This information will be used, with the patient's permission, in collecting demographic, medical and social facts which will populate the relevant systems, including Patient Centre and ADT and also any assessments.

### **Discharge of patients from Accident and Emergency (A&E)**

- Not all patients attending A&E will require admission. Any patient who is considered suitable for discharge, but may need care or support within the Community should be referred promptly to the appropriate member of the multi-disciplinary team:
  - *Hampshire- Frimley Park (PFH) Occupational therapy (OT) / In Reach Matron / Rapid Response.*
  - *Surrey – FPH OT / In-Reach Team*
  - *Berkshire- FPH OT*
  - *Specialist Palliative Care Team.*

Following discharge from the Emergency Department the medical staff will be responsible for notifying the GP. The In Reach Matrons and OT will be responsible for referring on to the appropriate community services. In their absence or out of hours the nursing staff will refer to the community folder and make the appropriate referrals.

- When patients are seen, treated and discharged from A&E, especially after a fall, the GP must be promptly notified and the patient assessed using the falls Proforma and referred to the appropriate falls service.

### **Discharge of children from Accident and Emergency**

- All Children and Young people 0-19 are referred to the public health team, health visitor, school nurse, safeguarding leads by the specialist paediatric liaison team using the information sharing/safeguarding alert form (SAF).
- The Frimley Park Hospital safeguarding team meet weekly to review the SAF forms and attendance record on symphony to ensure required intervention have been actioned to facilitate the safe discharge of a child/Young person.
- If the child has a named social worker, the nursing staff notify them by telephone of the child's attendance.
- Referrals to Social Services are made by nursing/medical staff using the multi-agency referral form.

### **Discharge of the elderly and those with special needs from Accident and Emergency**

- In Reach Matrons attend A & E on a daily basis (Including weekends) and on request to assess patients for discharge.
- Occupational Therapy attend A&E on a daily basis and complete assessments for those identified as requiring intervention to facilitate discharge. They liaise with the in reach service for Hampshire and Surrey for provision of community support services – community services are limited at weekends. Out of hours patients who have presented with a fall will receive a follow up telephone call from OT.

## **Discharge/referral of psychiatric patients**

- Those patients requiring psychiatric assessment are referred to the relevant psychiatric liaison team.

### **The Carer:**

- If any patients have a Carer, it is imperative that this person is involved in the discharge process.
- It needs to be indicated to the Carer that he/she is entitled to a Carer's Assessment ([www.carersnet.org.uk](http://www.carersnet.org.uk)) and a carers leaflet given if required (Appendix 3)

## **8.0 DISCHARGE CARE PLANNING AT TIME OF ADMISSION**

- Discharge planning is initiated by the admitting nurse during an admission for a patient who has been admitted as an emergency. In this assessment, the nurse must identify the nominated next-of-kin and, if applicable, carer.
- It is essential that discharge care planning continues immediately after a patient's admission. The starting point for this process being the completion of **all** sections of the admission assessment book (discharge checklist in Appendix 4). This should also include whether the patient is receiving help/support from various services, as listed above in the pre-elective admissions.
- After consultation with the patient and carer, the nurse will inform all relevant community services of the patient admission to hospital and Social Services/Adult Services by way of a section 2 informing the care manager of the predicted date of discharge.
- Early identification of each individual patient's requirements and referral to the appropriate team will optimise the use of resources; ensuring discharge can be made without delay. Including referral to pharmacy especially if compliance aids are used.
- It is the responsibility of the Team Leader to ensure that each patient's discharge is appropriately planned in conjunction with the patient, their next-of-kin and/or carer.
- All trained nurses are responsible and accountable for ensuring all information necessary to plan and manage their patients discharge is gathered, recorded and communicated. The Team Leader is responsible for co-ordinating any assessments, treatment and support necessary to expedite a discharge without delay.

## **9.0 DISCHARGE PLANNING DURING THE IN-PATIENT CARE EPISODE**

For both complex and routine discharges, the ward staff will complete the discharge checklist when all health and/or social care services are in place and the patient has been assessed as medically fit for discharge. Where appropriate, the ward staff should also ensure the patient is discharged in the morning and when possible the patient waits in the discharge lounge for outstanding discharge letters, medication and transport.

### **Complex discharge**

There are many care options that need to be considered in the assessment of need and risk associated with discharge planning. The Discharge Co-ordinators and In Reach Matrons should be involved, in order to support staff and facilitate complex discharges as appropriate. It is vital to also involve the patient and relative/carer to find the right care options to meet their needs.

The care options include:

- NHS continuing care
- Health Needs Assessment
- Intermediate care in the patient's own home/residential setting
- Interim care
- A care package for the patient provided jointly or separately by the NHS and Social Services, or privately.
- A care package for the carer
- Care home provision
- Hospice



This is not an exhaustive list, and staff need to be aware what is available in the patient's locality.

- A Health Needs Assessment (HNA) is completed for all Patients who are recommended for Placement or who will require a complex package of care. A NHS Continuing Health Care checklist is attached to each HNA. This identifies those patients that need a full assessment of eligibility for NHS Continuing Health Care. All referrals for HNA and NHS Continuing Care should be via the discharge team and HNA's should be completed within 48 hours.
- Risk must be considered by all professionals, with their patients and relative/carers as part of the discharge planning process. A shared understanding of what is an acceptable risk will reduce conflict at all stages of the discharge process, and lead to a more positive experience for the patient/relative/carer. ([www.npsa.nhs.uk](http://www.npsa.nhs.uk))
- For those patients requiring a Nursing, Residential or Specialist Care Home, the care manager will support the patient or staff in finding a suitable placement. If a home of choice is not available then a plan to transfer to an interim placement will be made, until the preferred choice becomes available. This is applicable for both self and local authority funded patients.
- If a patient is unable to return home with their current level of needs, but long-term placement may not be necessary either, then alternative options can be considered including rehabilitation or appropriate step down assessment units. Housing authorities would also be involved if rehabilitation or a step down unit is not appropriate, or the patient does not require 24 hour placement, but their own home would not be suitable any longer for their care needs.
- For all transfers of care, where appropriate, the multidisciplinary team will ensure that the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) are adhered to and followed.
- The team leader must consider a Section 5 and if felt appropriate discuss this with the Discharge Team. Once agreed necessary, this notification will be relayed to the correct authority at least 1 day in advance of the proposed discharge date (via fax) and needs to be jointly agreed by both health and social care.
- If the multi-disciplinary team fail to elicit a discharge plan or date, or if patient/family/carers dispute the discharge arrangements, then despite using daily buffer meetings, multidisciplinary team meetings or via case conferences, the discharge team should be informed if not already involved. If necessary the case will then be discussed at the Jonah "top 20" meeting with the Director of Nursing and Heads of Departments.
- The patient and/or family should be informed at all stages of the agreed discharge date.

## **Safeguarding Adults and the Discharge Process (Complex Discharge)**

It is important that all staff are aware and alert to the fact that on admission patients may present with safeguarding issues, which may be new or ongoing. It is essential that staff are aware of the hospitals safeguarding procedures and liaise closely with the relevant multi-disciplinary workers:

- Relevant social services departments via a safeguarding Section 2
- Hospital Lead Nurse for Safeguarding Adults
- Nurse Specialist for the Older Person
- Out of hours night site manager / ward manager

Factors indicating the need to pursue adult safeguarding procedures may be:

- A patient has made an allegation of abuse / neglect
- A carer has made an allegation of abuse / neglect
- Staff are concerned that abuse / neglect has taken place or may take place in the future

The person whom the safeguarding concerns are related to, should not be discharged until the relevant social services department / Lead Nurse for Safeguarding have made a decision as to where the person can be discharged to, pending any further investigations.

Please refer to The Safeguarding Adult Policy for further information.

## **Safeguarding children & young people and the discharge process**

Staff may encounter child protection concerns. The concern may be brought to the attention by the child or young person themselves, alleged by others or direct observation. It is essential that staff are aware of the hospitals safeguarding procedures and liaise closely with the relevant multi-disciplinary workers:

- Line manager
- Named Nurse /Midwife or Doctor for safeguarding children & Young people.
- Relevant social services contact centre or out of hours emergency duty team.

The concern might relate to:

- Child/Young person who is at risk of Child/young person who are at risk from Domestic abuse
- Non-attendance at outpatients appointment
- A child subject to a protection plan
- Behaviour of a member of staff, relative, child or young person.
- Alcohol or substance misuse
- Parent/carers with mental health or learning disability. A referral must be made if parent carer express delusional beliefs involving their child and/or if parent/carers might harm their child as part of a suicide plan.

Ensure the child or young person is not discharged until the Consultant Paediatrician is assured that there is an agreed plan in place that will safeguard the children's welfare. For more information please refer to the Safeguarding Children Policy on the Intranet.

## **Adults with Learning Difficulties (Complex Discharge)**

Any patient with learning difficulties that may require support during admission and with discharge planning and therefore should be referred to the Nurse Specialist for Learning Difficulties.

## **Patients Taking Their Own Discharge (Complex Discharge)**

There will be occasions when patients may wish to discharge themselves against medical advice. However the following issues should be considered

- when the patient is regarded as an adult
- any mental health disorders
- when there is a dispute between agencies (e.g. Social Services, health professionals, carers and/or relatives)
- when the decision involves complicated assessments of capacity or best interests or there are immediate or serious risks to the health of the patient or others

This area is particularly difficult so consider advice from the senior nurse/ site manager who will help with these issues.

Consideration will be given to the elements surrounding the Mental Capacity Act (2005) which require an assessment of the persons ability to understand the information given, is able to retain it long enough to make an informed decision, can weigh up the implications of the information and apply that in relation to the decision (Appendix 8) Finally, they are able to communicate their decision. The Deprivation of Liberty Safeguards (2009) must also be

considered in this assessment, as prohibiting a patient from leaving could be seen as depriving them of their liberty and freedom, if not done in their best interests.

Where consideration needs to be given to using the Mental Health Act (1983) then the doctor in charge of the patient's care, where the relevant criteria are met, can authorise detention of an in-patient on a general ward for up to 72 hours to allow arrangements to be made.

Therefore establishing a patient's capacity to understand the implications of leaving and an ability to weigh up the consequences is imperative.

**For patients deemed as having capacity** to make this decision, then they are entitled to consent or to refuse treatment, even if a refusal could lead to their death.

In this situation the ward staff should:

- Attempt to establish the reasons for this intention, and attempt to resolve any of the issues raised, where issues cannot be resolved, record reasons given by patient for self-discharge
- Explain to the patient the need for discussion with a member of the medical staff before leaving hospital
- Immediately inform a member of the medical staff
- Provide the duty doctor with the Self-discharge Against Medical Advice form
- Inform the Senior Nurse on duty for the hospital (i.e. Matron during hours and Site Manager, out of hours) and in discussion decide whether he/she needs to attend to support ward staff in the self-discharge process.

- In the absence of a Senior Nurse or Site Manager, witness the discussion between the patient and the doctor, and ensure that the self discharge form is completed fully.
- Ensure that the top copy of the completed self discharge form is faxed to the patient's GP (with the hard copy to be sent in the post); the second copy should be given to the patient and the third copy filed in the patient's records
- ensure that appropriate follow-up arrangements are in place (e.g. out-patients appointment, community nursing) and that where applicable the patient's next of kin and/or carer have been notified (unless forbidden by the patient)
- Complete an IR1 indicating that the patient has self-discharged against medical advice
- If they are not willing to wait for medical advice, nursing staff will be required to assess capacity and complete the appropriate paperwork

**For patients deemed to have capacity but are suffering from a mental disorder** then it may be necessary to detain them under the Mental Health Act (1983). This can justify detention and treatment in certain circumstances where detention is necessary in the interests of the health and safety of the patient or the protection of others.

Under section 5(2) of the Mental Health Act 2007, the doctor in charge of the patient's care can authorise detention of the patient on a general ward for up to 72 hours to allow assessment of their mental health. Although the patient does not need to be receiving psychiatric treatment for this power to be exercisable, the patient must be an inpatient. The duty doctor must seek guidance from the Liaison Psychiatry team or site manager on invoking section 5(2), as specific paperwork needs to be completed. In addition the mental health leads must be informed of this decision.

Invoking section 5(2) allows time for arrangements to be made for an assessment under the Mental Health Act. This will include an assessment by a Section 12(2) approved doctor, and another doctor and an approved mental health professional (AMHP). Immediate contact should be made with a Consultant Psychiatrist and an approved social worker/AMHP.

This would also be the case if detention were being considered other than under section 5(2) of the act.

The patient cannot be detained past 72 hours during that period of time the patient must be reassessed and the 5(2) should be rescinded or the patient detained under another section of the mental health act. A section 5(2) cannot be allowed to lapse, as this would be an illegal detention.

Should a patient be detained under Section 5(2) of the Mental Health Act then the Clinician in charge of the case (or his/her nominated deputy) has a duty to ensure that the patient has been given, and understands, specific information in relation to their rights as soon as practicable after the commencement of their detention and/or as soon as their detention is changed from being under one section to another section of the Act. In practice this will mean that the patient will have to be told immediately of their rights if they are to be detained for 72 hours or less. Staff should be as helpful as possible and try to explain any point the patient does not appear to understand. This should be undertaken under the guidance of staff from Liaison Psychiatry.

The power to detain the patient will end when:

- The patient is discharged from the 5(2)
- Following assessment, a decision is reached not to make an application for a section under the act and as such they are discharged from the section.
-

If a patient is being detained under the Mental Health Act on a general ward in the Trust then there must be appropriate liaison between acute and psychiatric services.

**For patients deemed as not having capacity to make this decision** as recorded by a completed capacity assessment, relevant to their decision making on leaving hospital then the health care professionals have a duty to provide treatment in the “best interests” of the patient. The best interest decision should be informed by good practice and should involve documented consultation with all relevant parties including the patient themselves.

If treatment is not given there could potentially be civil and criminal consequences. It could also constitute a breach of human rights.

Under these circumstances the Mental Capacity Act (2005) allows for “reasonable force” to be used to enable treatment to be given (Mental Capacity Act, Code of Practice section 5).

Decisions made about what is in the patients “best interests” can be difficult. The consultation should be co-ordinated by the responsible Consultant or nominated deputy (an appropriate multidisciplinary team member). In difficult cases where, for example, there are serious consequences to the patient or others; where there is a dispute or doubt as to the patient’s “best interests”; where the procedure involved is unusual or where there are other complicating factors, then advice should be sought as soon as possible from Liaison Psychiatry and the Risk Management Department (Out of hour’s consideration should be given to contacting the 24 hour legal advice line – the contact number should be available in the on-call manager’s briefcase).

Where the Mental Capacity Act (2005) is used to detain a patient in hospital it is essential that the following are taken into account:

- that anyone exercising the power is aware of the need to justify its use and that this is appropriately recorded
- that the use of the power of detention is always proportionate to its aim
- that where force is used, this is no more than the minimum reasonable amount of force
- that the involvement of other agencies (Police, Social Services etc.) should be by way of prior agreement with clarification of their roles in advance
- that any health and safety issues are addressed prior to exercising such a power and if control and restraint of the patient needs to be carried out then this should only be carried out by staff who have been trained in control and restraint techniques (e.g. Security) or by the Police.

The Lead for Safeguarding must also be informed as a Deprivation Of Liberty application may need to be made, in line with the Deprivation Of Liberty Safeguards (2009).

In certain circumstances there may be a dispute between health professionals and family and/or carers. This could happen, for example, where relatives attempt to remove an incompetent adult from hospital and health professionals believe the patient needs to stay in hospital to receive treatment. In these circumstances it may be necessary to involve other agencies e.g. the Police or Social Services. In this situation, where a patient is being placed at risk by a family member, the situation should be regarded as an urgent Safeguarding case. If necessary, advice should be sought from the senior nurse in charge

## **Advocacy Services**

Advocacy services can be used in certain situations when the person lacks capacity and is facing serious treatment or life changing decisions, including moving into long term placement. In these circumstances then an Independent Mental Capacity Advocate (IMCA) must be involved in the “best interest” decision making.

## **Deprivation of Liberty Safeguards (2009)**

The Mental Capacity Act (2005) Deprivation of Liberty Safeguards (MCA DOLS) protects patients who are unable to make decisions regarding their care or treatment which may need to be given in a restrictive way. Therefore if a patient does require their liberty to be deprived in order to care for them in their best interests, by adhering to the MCA DOLS principles the hospital will be working within the legal framework.

Any patient who is requiring a “special,” a one to one carer, then the Safeguarding Lead must be notified in order to assess whether a DOLS application needs to be made.

Please refer to the Safeguarding Adults Policy for further guidance or contact the Safeguarding Lead for the Trust.

## **Rapid discharge of terminally ill palliative care patients from all wards (Complex Discharge)**

- Refer to palliative care team if not already known.
- Health Needs Assessment to be requested from the discharge team and completed within one working day by appropriate health professionals, in order to determine eligibility for NHS Continuing Healthcare.
- Refer to In Reach Matrons
- If needed follow Trust procedure for ordering home oxygen.
- Order TTO's and end of life PRN medication.
- Liaise with palliative care team to arrange transport as soon as discharge date confirmed.
- Ensure patient discharged home with original DO Not Attempt CPR Order.
- Ensure all procedures re Carers involvement; risk assessment and support have been carried out.
- If transfer to hospice confirm transfer time is acceptable. Any transfers are preferable and transfer after 3.30 is not accepted by the hospice.

## **Discharging a patient with Dementia**

- Discharge should be an actively managed process which begins within 24 hours of admission
- Discharge should take place during the day and not after 8pm at night.
- Relatives and carers should be informed and updated about perspective discharge dates
- Information about discharge and support should be available to patients, relatives and carers.

## **10.0 DISCHARGING MILITARY PATIENTS**

- Military patients should be subject to all the same considerations as civilians and may require special care if their families are not nearby.
- If a military patient is being discharged inform the Inpatient Ward Master who can be contacted in the Military Administration Centre (MPAC) on Ext 4059 or on bleep 592 during working hours. The documentation used for planned elective day cases is carried out at the front desk in the main entrance by the Military Duty NCO or contact Ext 6205, Bleep 688 or Mobile 077887651670
- For unplanned discharges out of hours the Duty NCO is to be contacted via their mobile to complete discharge paperwork and assist with transport arrangements for military patients. This is only relevant for those patients requiring transport to the MRS. Duty NCO can only assist an individual with contacting their unit; they have no authority for the provision of individual unit transport.
- Military patients will be given the same supply of medication as civilian patients.
- All Military patient discharges out of hours should be notified to their Duty NCO, but this discharge does not become the responsibility of the Duty NCO but remains with the discharging ward/dept.
- Military patients undergoing a procedure under general anaesthetic or sedation who live further than 50 miles drive from Frimley Park Hospital or live in a military accommodation block / Mess will be transferred to Medical Reception Station (MRS) following day procedures or when discharged from a ward the same day as the procedure.
- Military patients discharged from Day Surgery to the MRS must meet the same clinical discharge criteria that apply to civilian patients being discharged to their home.
- On discharge, all Service patients are to be instructed to report to their Medical Centre on the same day or the next working day if out of hours, with a copy of their discharge paperwork. In order to confirm their sick leave with the Unit Medical Officer and gain authority to proceed on sick leave.
- If Military patients are a planned admission and prior sick leave has been granted before admission, it is the discharging wards responsibility to ensure that a copy of the discharge paperwork be sent or faxed to the patients medical centre at the earliest opportunity.
- All under 18 years olds on discharge must contact the units Duty Office to report the hospitals discharge details and then report directly to their Unit Medical Officer at the earliest opportunity. This is not required if the patient is to be discharged to an MRS.
- Support and advice is available for the relatives of military patients from the Defence Medical Welfare Service Officers who can be contacted via FPH Switchboard.
- Clinical advice regarding appropriate discharge procedures can be given by a military Consultant or senior ST for the relevant speciality if required.

## **11.0 DISCHARGE/ TRANSFER TO ANOTHER HEALTHCARE FACILITY OF A PERSON WITH AN INFECTION.**

Guidance pertaining to patients who are for discharge who have suffered or are suffering with an infection is detailed in the 'IPC 10 - Transfer of Infectious Patients' (FPH 2010) and should be followed closely.

Discharge/ Transfer to Another Healthcare Facility (As cited in the aforementioned policy).

- The sending healthcare provider must ensure that it provides suitable and sufficient information on each patients' infection status whenever arranging for a patient to be moved from the care of one organisation to another. This will ensure that any risk to the patient and others from infection may be minimised (DOH 2009, 2008 & 2006).
- There should be joint planning between the Infection Prevention & Control Team and the Patient Flow Managers for planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities. Where necessary, Ambulance Trusts may need to be involved in such planning (DOH 2009, 2008 & 2006).
- When patients are receiving treatment for a healthcare associated infection, such as MRSA decolonisation or antibiotic treatment, it is vital to communicate what treatment and follow-up is needed. This will ensure that treatment regimes can be completed and the outcome for the patient is optimised (DOH 2007).
- Infectious patients should not be transferred to another hospital or care home unless appropriate facilities and care have been confirmed with the receiving hospital or care home (DOH 1996). Seek advice from the Infection prevention & Control Team if required.
- Ward/ department staff should inform transport staff of any additional infection prevention and control precautions they need to take while the patient is in their care.

### **Discharge Home**

- When patients are receiving treatment for a healthcare associated infection, such as MRSA decolonisation or antibiotic treatment, it is vital to communicate to the patient and carers, any treatment protocol and what follow-up is needed. This will ensure that treatment regimes can be completed and the outcome for the patient is optimised (DOH 2007, FPH 2010).
- Identified relative/ carer should be informed of any specific infection prevention and control precautions they may need to take and identify any relatives / carers who might be at risk of infection e.g. immune compromised. ( It must not be assumed that relatives / carers will be able or want to provide care in these circumstances)
- If follow-up is required by District Nurses or GP surgery, detail of relevant infection, treatment and follow-up should be provided in any referrals made.
- Details of any new diagnosis of infection (such as MRSA or C.Difficile) should be included in the GP letter (DH 2009, 2008 & 2006, FPH 2010).



### **12.0 Discharge to local community Hospital – Farnham & Fleet Hospital (Adults Only)**

All transfers of patients to Farnham will be co-ordinated by Specialist Nurse for Older Persons (Bleep 251) and to Fleet co-ordinated by Hampshire In reach Matron on bleep 124 to ensure they meet relevant admission criteria. Transfer must be discussed with patients and relatives and the patient's medical condition must be stable on transfer. Transport will be provided by the hospital's own transportation service and an escort will only go with the patient when required.

Medical notes need to be coded prior to transfer and the following must accompany the patient:-

- *Medical Notes*
- *Drug Chart*
- *Nursing Documentation*
- *Original copy of any Do Not Attempt CPR form.*
- *Transfer Letter*
- *Patients property*
- *Medications*
- *A copy of the hospital discharge letter and medication prescription sheet*
- *Details of any new diagnosis of infection (such as MRSA and C.difficile) should be included in the GP letter (DH 2008 & 2006).*
- *Discharge Checklist (Appendix3)*

### **13.0 DISCHARGE DOCUMENTATION / INFORMATION**

#### **Medication on discharge:**

- Patients will receive a minimum of 14 days' supply of medication unless they already have sufficient supplies at home.
- Where possible the patients own drugs, if brought into hospital will be returned
- Patient admitted with a monitored dosage system, will have this re-stocked in preparation for discharge, providing there is a continuing need as assessed by pharmacy staff.
- Where possible, Pharmacists/Pharmacy Technicians will identify patients (and relatives/carers) who are in need of counselling about their medication and carry this out at ward level.
- Patients and/or carers will be advised of the importance of continuing with medication and obtaining further supplies from their GP as necessary.
- The tablets to take out (TTO) will be explained to the patient by the discharge nurse at the time of discharge.
- Where necessary, patients likely to experience difficulties taking medication, will be given the opportunity to self administer their medication during admission according to the self administration policy.

#### **Supplies:**

- Patients being discharged will be given enough dressings and/or supplies, i.e. drainage bags, pads, catheters, O2 therapy etc., to last at least three days to ensure seamless transfer of care into the community.
- Where it has been identified that equipment is needed, this will be in place/available on the discharge date. The patient/carer will be shown how to use the equipment prior to their discharge, and will have a contact name/number in event of questions about the equipment.
- Please ensure that Patient's Medical Devices Checklist (MD3) is completed and signed. (Appendix 9).

### **Documentation and Information given to patient, GP and Nursing/Residential Home**

- The discharging doctor will complete a discharge summary which will be sent to pharmacy, these will subsequently be:
  - sent to GP
  - placed in the Patients medical records
  - given to the patient to take home on discharge
- Patients will take home a copy of their discharge summary. The discharge includes:
  - Discharge medication
  - Diagnosis
  - Important Clinical findings & Management
  - Hospital Follow up
  - GP recommendations
- Hand held notes for maternity patients.
- Patients being transferred to either a nursing or residential home will have a hospital transfer form (Appendix 11) completed by the nursing staff.
- Ward responsible to ensure the patient is discharged with a 7 day supply of thickener when required and to ensure the discharge destination is aware of the need for food/Fluid Modification
- Discharging patients with ongoing Do Not Attempt Resuscitation (DNACPR) forms should be discharged with the original signed DNAR form as described in appendix
- Referral to the Community Nurses and/or Community Matrons where necessary.
- Where patients have undergone a surgical procedure, they will be given written/verbal information which must include post-discharge advice.
- A trust wide carer's discharge leaflet is available to all patients (Appendix 2).

All information above is documented as completed on the hospital discharge checklist with the exception of handheld maternity notes and DNACPR form. (Appendix 10). The checklist identifies discharge requirements for all discharges.

### **Discharge Lounge**

- The Discharge Lounge is designed to enable patients who are medically fit, and who no longer require nursing care in the acute setting to wait in a safe environment whilst awaiting completion of their discharge arrangements from FPH.
- When planning a patient's discharge. Each member of the multi-disciplinary team leading a patient's discharge must adhere to the principles of facilitating morning discharge.

Patients, medically fit for discharge will be relocated to a Discharge Lounge who are:

- Awaiting ambulance, or other forms of transport to take them to their discharge destination.
- Awaiting carers/family/friends to collect them and take them to their discharge destination.
- Awaiting their Take Home Drugs (TTOs) to be delivered prior to discharge.

- Require assistance with basic care of a low dependency, e.g., assistance to the toilet and mobilisation with aids.
- Must have suitable clothing. Nightwear is not acceptable.

Use of the Discharge Lounge is part of the patient flow process which will in turn facilitate early availability of hospital beds for acutely unwell patients in the ED or for planned admissions.

- Some patient groups would not be appropriate to transfer to the lounge i.e. the patient suffering from dementia, these individual cases should be discussed with the Ward manager or Head of Nursing in order to ensure they remain in the appropriate environment prior to discharge.

## Transport

All patients should where possible be encouraged to make their own transport arrangements.

However if a patient fulfills the following criteria then transport can be requested and should be booked as soon as the confirmed discharge date and time is arranged:

- Need to travel lying down
- Require Continuous Oxygen or other medical gases

Transport will be considered for the below criteria

- Need to travel in a wheelchair
- Have a mental health problem, learning disability, speech, sight or hearing difficulties which prevents from using hospital transport
- Have a medical condition that would compromise your dignity or cause public concern if public transport was used
- Experience side effects as a result of your medical treatment or condition

Ambulances will **not**;

- Be provided on the ground of social/financial reasons.
- Be provided for patients whose medical condition does not prevent them from traveling by other means.

Morning discharge should be arranged where possible and all medications/supplies/letters should be ready for when the patient is collected. At the time of booking the transport, there needs to be careful consideration of whether the patient requires a wheelchair, stretcher or an escort and what if any infection control issues there are.

- If late discharge is necessary and transport is needed then the bed managers can access their own transport services between the hours of 17.00-19.00 Monday to Friday. Any patients requiring this type of transport and are receiving oxygen therapy will need a nurse escort. (Not for stretched patients that are going home to own home)
- Patients who are approaching end of life and are being discharged, may require appropriate transport and this can be arranged by contacting the palliative care team.

## 14.0 MONITORING OF THE POLICY

This policy will be monitored through a six monthly trust wide mixed specialty respective audit every March by the Head of Nursing for Practice Development and Education and will be presented to the Clinical Risk Committee.

The audit data that will monitor compliance of the guideline:

- When discharge planning commenced
- Documentary evidence of involvement in discharge planning with patients, next of kin and carer's.
- Documentary evidence of information given to patients
- Were appropriate referrals made for discharge *i.e district nurse*.
- Patients transferred to Nursing Homes sent with transfer letter.
- Completion of the discharge checklist
- Discharge summary in the medical notes.
- Out of hours discharge
- Was the patient readmitted within 30 days and was the original discharge unsafe.

The audit report will also include:

- A report will be produced by the Specialist nurse for Older People and In Reach Matron to monitor compliance with patient transfer to community hospital.
- A review of incidents for the 12 month reporting period.
- A review of complaints for the 12 months reporting period.

Following the audit being undertaken, an action plan will be developed and monitored at the Clinical Risk Committee until all actions have been completed.

## 15.0 CONTACT DETAILS

- **In Reach Matrons**

Referrals are accepted from MDT, patients, carers and/or relatives.

**Surrey**

Tel: 01276 604604 bleep 325, 326 and 078

Fax: 01276 62824

**Hampshire**

Tel: 01276 604604 bleep 082 or 124 and ext.4337 (in hours)

Fax: 01276 604072

Tel. 01256 810683 (23 hour contact) via Single Point Of Access

- **Social Services**

**Surrey**

Tel. 01276 604604 ext.4206

Fax: 01276 62824

**Hampshire**

Tel. 01276 604604 ext. 4002

Fax: 01276 526774

Tel. 01256 810683 (23 hour contact) via Single Point Of Access

**Bracknell**

Tel. 01344 351500

**Wokingham**

Tel. 01189 746800

**Windsor and Maidenhead**

Tel. 01344 877601

**Discharge Team – 01276 604604**

**Christine House** – Bleep 571

**Richelle Marcelo** – Bleep 357

**Tina Shoon** – Bleep 641

**Sharon Wilkinson** – Bleep 489

**Danielle Bridport** – Bleep 840

**Lisa Barbier** (Nurse Specialist for the Older Person) – 01276 604387 / bleep 251

## 16.0 REFERENCES

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Sort out all appendices and use Katie's new flow chart

## 16.0 APPENDICES

### Appendix 1 – Glossary of terms

|                                   |   |
|-----------------------------------|---|
| Assessment                        | A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated  |
| Care Coordinator                  | The nurse/practitioner in the ward/department who is named and responsible for coordinating all stages of the 'patients journey' during one admission episode to hospital   |
| Care Manager                      | The practitioner, usually a Social Worker, who undertakes care management   |
| Care Package                      | A combination of services designed to meet a person's assessed needs  |
| Carer                             | A person, often a relative or friend, who looks after or provides unpaid help to an individual who is ill, frail or has a disability.   |
| Young Carer                       | A child or person under the age of 18 who provides regular and ongoing care and/or emotional support to a family member who is physically or mentally ill, disabled, frail or misuses substances.<br><a href="http://www.carersnet.org.uk">www.carersnet.org.uk</a>   |
| Carer's assessment                | An assessment of the carer's needs, physical, practical and emotional. This assessment is carried out at the request of the Carer to determine: <ul style="list-style-type: none"> <li>- whether the carer is eligible for Local Authority support</li> <li>- the support needs of the carer</li> <li>- if these needs can be met by social or other services</li> </ul>  |
| Careseekers                       | An independent agency that support families of private funders in sourcing a suitable placement.  |
| Continuing Health Care (CHC)      | NHS Continuing Health Care is the provision of care for a patient that is funded by the NHS, due to their primary care need being a health need.  |
| Discharge Team                    | Senior nurses who assist the multi-disciplinary team with potentially complicated discharges, ensuring the patient/relatives/carers are proactively involved. They also support ward teams in the discharge process   |
| Health action plan (HAP)          | A personal plan detailing the actions needed to maintain and improve the health of an individual and any help needed to achieve this<br>(Ref: <a href="http://www.doh.gov.uk/learningdisabilities">www.doh.gov.uk/learningdisabilities</a> )  |
| Jonah                             | Jonah is a computer programme which works on The Theory of Constraints (TOC) by the MDT identifying a Predicated Date Of Discharge (PDD) and tasks required to achieve this. If for any reason the PDD is not achieved the delay reasons for each patient will collectively highlight possible restraints in the discharge pathway either internally or externally.   |
| Multi-disciplinary assessment     | An assessment of an individual's needs that has actively involved professionals (inter-disciplinary working) from different disciplines in collecting and evaluating this information   |
| Multi-disciplinary team (MDT)     | A team of members from various specialist areas for example: Dietician, Discharge team, Intermediate Care Team, MacMillan Team, Occupational Therapist, Physiotherapist, Care Manager Social Services, Speech & Language Therapist, Ward Manager / Team Leader, Pharmacist/Pharmacy Technician, Community In-reach team, Consultant / Medical team  |
| Predicted Date of Discharge (PDD) | A date that is recorded on the Jonah system and communicated to all MDT members of when a patient should be medically stable to leave the acute environment of the hospital.  |
| Safeguarding adult                | Any adult patient with recognised difficulty communicating their needs; this may be due to a physical, psychological or learning disability<br>'Vulnerable adult' is defined by the Law Commission as:<br>"Someone of 16 years or over who: <ul style="list-style-type: none"> <li>• Is or may be in need of community care services by reasons of mental or other disability, age, or illness; and who</li> <li>• Is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation".</li> </ul> <i>Making Decisions. Lord Chancellor's Department 1999.</i> |

## Appendix 3

# LOOKING AFTER SOMEONE?

## Going Home From Hospital And Carers Assessments

### Are you a Carer?

You are a **carer** if you look after a relative, partner or friend who needs help because they are ill, frail or have a disability.

This Leaflet is to guide you through the time when the person you care for is in hospital and when they go home. Going into hospital is an anxious time for patients, relatives and friends. You may already provide support and care or you may be considering taking this on for the first time.

Hospital based staff will involve you in discussions and you should be able to expect:

- To be identified as a carer
- To be involved in all stages of planning for the return home including discussion about the discharge date
- To be asked about the home setting, your knowledge of the patient and your caring role
- To know who the person is on the ward responsible for speaking to you
- To be involved in discussions about any help the patient will need when discharged
- A recognition of the impact on any children or young people in the household
- To have a choice about caring and information about help to juggle caring with other responsibilities such as employment, child care or your own education
- To have a separate discussion about your own needs through a "carers assessment"

### What your assessment is for

A carers assessment is your opportunity to talk about your own needs and things that could make caring easier for you. Carers Assessments are undertaken by Berkshire, Hampshire and Surrey County Council but can look at the support available from a range of organisations.

### Some things you may want to think about

- Do you get enough sleep?
- Is your health affected in other ways?
- Are you able to get out and about?
- Do you get any time for yourself?
- Are your other relationships affected?
- Do you want information about benefits?
- Are you worried you may have to give up work?
- Are you interested in Training or Adult Education for yourself?
- Is the person you care for getting enough help?

### Services that might help you

- Services that give you a break or time for yourself
- Direct Payments for a service to support you as a carer
- Emotional support from other carers or people who understand provided through a Carers Support Scheme
- Help with caring tasks
- Help with household tasks
- Advice about juggling work and caring
- Benefits advice
- Activities for the person you care for
- Back Care advice

### Carers Support

#### • Carers Together

**01794 519495**

Carers Together provides a range of services for carers and has a large resource of useful information for carers and professionals

**[www.carerstogether.org.uk](http://www.carerstogether.org.uk)**

#### • Hampshire County Council

**0845 600 45 55**



For more information about the local authority and other services that may be available to help you and your family call Hampshire County Council or go to **www.hants.gov.uk**.

• **Action for Carers (Surrey)**

**01483 302748**

For details of local Carers Support and an information pack - also see the Surrey website for Carers **www.carersnet.org.uk**

• **Surrey County Council**

For more information about the local authority and other services that may be available to help you and your family call the Surrey County Council Contact Centre on **08456 009009** or go to **www.surreycc.gov.uk**.

**Useful Contacts**

|                                |              |
|--------------------------------|--------------|
| Patient Advice Liaison Service | 01276 526530 |
| Hampshire Social Services      | 01276 604002 |
| Surrey Social Services         | 01276 604206 |
| Berkshire Social Services      | 01344 424642 |
| Discharge Facilitators         | 01276 604835 |

**DESIGNED BY PROJECT 18 01932**

## APPENDIX 4 Reimbursement Liability and Timings.

Reimbursement occurs when local authorities must pay NHS acute trusts back if they are responsible for a delayed hospital discharge - for example through delayed social care assessments or services. This is a new obligation under the Community Care (Delayed Discharges) Act (2003). In addition, acute trusts must tell social services departments about inpatients that are likely to need community care services.

Within the Delayed Transfers of Care: Planning for the implementation of reimbursement and improving hospital discharge practice (2003) all NHS bodies will be required to make two notifications to Social Services Departments (SSDs).

### Section 2

The first is known as an **Assessment Notification (section 2)** of the Act) which gives notice of the patient's possible need for services on discharge. Following this notification, SSDs have a minimum of three days to carry out an assessment and arrange care.

A section 2 is completed by sending a request to social services via Patient Centre/PAS and includes an expected date of discharge.

### Section 5

The second, a **Discharge Notification (Section 5)**, gives notice of the day on which it is proposed that the patient will be discharged. Reimbursement liability commences on the day after the minimum period (the third day after an Assessment Notification - Section 2) or the day after the proposed discharge date, whichever is the later. A notification after 2pm is counted from the next day. See below for precise timings for reimbursement:

#### Precise timings:

- Assessment notification before 2pm – starts the 3 day period from the *same day*
- Assessment notification after 2pm – starts 3 day period from the *next day*
- Discharge notification after 5pm – treated as having been given the *following day*
- Pre-11am discharge of patient = equivalent to *previous day*

A section 5 is a paper copy (which can be found in the Discharge Folder on each ward).

Please liaise with the discharge team when completing a Section 5.

| Discharge Checklist   |               |  |  |  |                   |  |               |
|---|---------------|--|--|--|-------------------|--|---------------|
| Name and Hospital number  |               |  |  |  | Date of Discharge |  |               |
| If care package required, confirm it has been re-started  |               |  |  | Yes / No / Na  |                   | Sign   | Date Time     |
| Discharge destination (check patient centre up to date)   |               |  | Can family provide transport home? (refer to going home from hospital leaflet) |  |                   | If 'No' does patient require hospital transport? |               |
| Home <input type="checkbox"/> Care Home <input type="checkbox"/>  |               | Res Home <input type="checkbox"/> Different address <input type="checkbox"/> |  | Yes / No / Na  |                   | Yes / No / Na                                    |               |
| Checked patient has house keys?   |               |  | Patient valuables returned?  |  |                   | IV access removed?                               |               |
| Yes / No / Na   |               |  | Yes / No / Na  |  |                   | Yes / No / Na                                    |               |
| All drugs removed from patient lockers/CD cupboard/fridge?  |               | Yes / No / Na  |  | Medications, including side effects and danger signals explained to patient? |                   | Yes / No / Na                                    |               |
|   |               |  |  |  |                   | Sign Date Time                                   |               |
| Have TTO's been obtained?   |               | Yes / No / Na  |  | Copy of TTO letter given to patient?   |                   | Yes No   |               |
| Any drugs to be given in community are prescribed on community drug chart   |               | Yes / No / Na  |  | Patient has been given 7 day supply of thickener (when required)             |                   | Yes / No / Na                                    |               |
| Nebuliser/compressor provided?  |               | Yes / No / Na  |  | Home oxygen in situ?   |                   | Yes / No / Na                                    |               |
|   |               |  |  | Special aids or equipment in place?  |                   | Yes / No / Na                                    |               |
| If patient has a catheter on discharge, refer to District Nurse.<br><br>Include additional information re how much a person can manage.                                       |               | Does patient require District Nurse Referral?                                |  | Yes No   |                   | Sign Date Time                                   |               |
|   |               | Date of insertion  |  |  |                   |  |               |
|   |               | Date for catheter change   |  |  |                   |  |               |
|   |               | 3 day supply of dressings and bags provided?                                 |  | Yes No   |                   |  |               |
|   |               | How much can patient self-manage?  |  |  |                   |  |               |
| If the patient is being transferred to a nursing/residential home – send with the patient copies of:  |               |  |  |  |                   |  |               |
| TTO letter  |               | Yes / No / Na  |  | DNAR form  |                   | Yes / No / Na                                    |               |
| Transfer letter   |               | Yes / No / Na  |  | Sign Date Time   |                   |  |               |
| External transfer letter.   |               | Completed copy filed in medical notes  |  | Correct MRSA/C diff status identified on transfer letter.                    |                   |  |               |
| Yes / No / Na   |               | Yes / No / Na  |  | Yes / No / Na  |                   |  |               |
| Sign Date Time  |               |  |  |  |                   |  |               |
| Medical device discharge checklist completed *available in Medical Devices Policy/Discharge Policy. To be used for patients being discharged with high-cost/high risk devices |               |  |  |  |                   |  |               |
| Yes / No / Na   |               | Sign   |  | Date   |                   | Time   |               |
| Family and Friends Questionnaire completed?   |               |  |  | Yes No   |                   |  |               |
| 'Preparing for going home from hospital' leaflet provided?  |               |  |  | Yes No   |                   |  |               |
| Notification of discharge given to:   |               |  |  | Further appointments   |                   |  |               |
| Patient   | Yes           | No   |  | Outpatient follow up or arrangements discussed?                              |                   |  | Yes / No / Na |
| NOK   | Yes           | No   |  |  |                   |  |               |
| Carer (carers leaflet given?)   | Yes / No / Na |  |  | Anti-coagulation booklet and appointment made?                               |                   |  | Yes / No / Na |
| Matron  | Yes / No / Na |  |  |  |                   |  |               |
| Warden  | Yes / No / Na |  |  |  |                   |  |               |
| MDT members currently involved  | Yes No        |  |  |  |                   |  |               |
| Discharge from Ward   |               | Ward nurse signature   |  |  | Date              |  | Time          |
| Discharged from Discharge Lounge  |               | Ward nurse signature   |  |  | Date              |  | Time          |
| Patient signature   |               | Signature  |  |  | Date              |  | Time          |

## APPENDIX 5 Referral

### Guidelines for in- patients requiring Occupational Therapy (OT) at Frimley park Hospital

#### Nursing Handover to discuss

- *Why patient in hospital (Not past medical history)*
- *Does patient have Package of Care or help from family with personal care or domestic tasks.*

| Refer to OT if:-  | Yes        | No        |
|---|------------|-----------|
| Patient has consented to OT referral  |            |           |
| 1. Patient has been admitted with a stroke or suffered a stroke since admission – consent will be gained by OT.   |            |           |
| 2. Medically stable and beginning to mobilise<br><b>(plus at least one of the following)</b>  |            |           |
| a) Recent change in function which is affecting independence mobility; i.e. activities of daily living ability has changed.   |            |           |
| b) Recent change in mobility, i.e. was independent, now being provided with stick/frame or being hoisted.   |            |           |
| c) Family / patient / carer identified specific functional concerns about how they were managing at home prior to admission.  |            |           |
| d) Patient is the main carer at home and their function has deteriorated.   |            |           |
| e) Patient may be at risk if discharged without support and /or equipment.  |            |           |
| 3. Exception to being medically stable is made for patients in ICU, New amputees, Head injuries, splint requests and patients going home with a hoist for the first time. |            |           |
| <b>DO NOT Refer to Occupational Therapy :-</b>  | <b>Yes</b> | <b>No</b> |
| Based upon age alone  |            |           |
| If medically unstable e.g. BP unstable, UTI, acutely confused.  |            |           |
| Patient is independently mobile (unless there are concerns about cognition or function)   |            |           |
| Patient is from a nursing home (unless they have specific functional needs e.g. a splint.   |            |           |
| Patient is at their pre-admission functional level and they are usually assisted in all ADL.  |            |           |
| Patient is at their pre-admission functional level and they were coping at home / have no concerns about discharge.   |            |           |
| Patient is independent except needing meals on wheels or domestic help (refer directly to Social services).   |            |           |
| If patient is going home to be nursed in bed (not getting out).   |            |           |

**If nurses are unsure as to whether a referral is appropriate they must discuss it with the O.T covering their ward area.**

## APPENDIX 6

### Dietetics Department Prioritising In-Patients Assessment

**Urgent:** See within 1 working day/24 hours

- Paediatric referrals
- TPN
- NG/ PEG/ jejunostomy feeds
- Renal impairment
- Hepatic impairment
- Food allergy (newly diagnosed)
- Coeliac disease (newly diagnosed)
- Low residue (new)

**Soon:** See within 2 working days/ 48 hours

- fortified diet/high protein drinks
- newly diagnosed insulin dependent diabetes
- newly diagnosed non-insulin dependent diabetes
- GI disturbances, e.g. Crohns, ulcerative colitis
- Coeliac (known)
- Food allergy (known)
- Cystic fibrosis (unless PEG fed, then seen as urgent)

**Routine:** see within 4 working days/ 96 hours

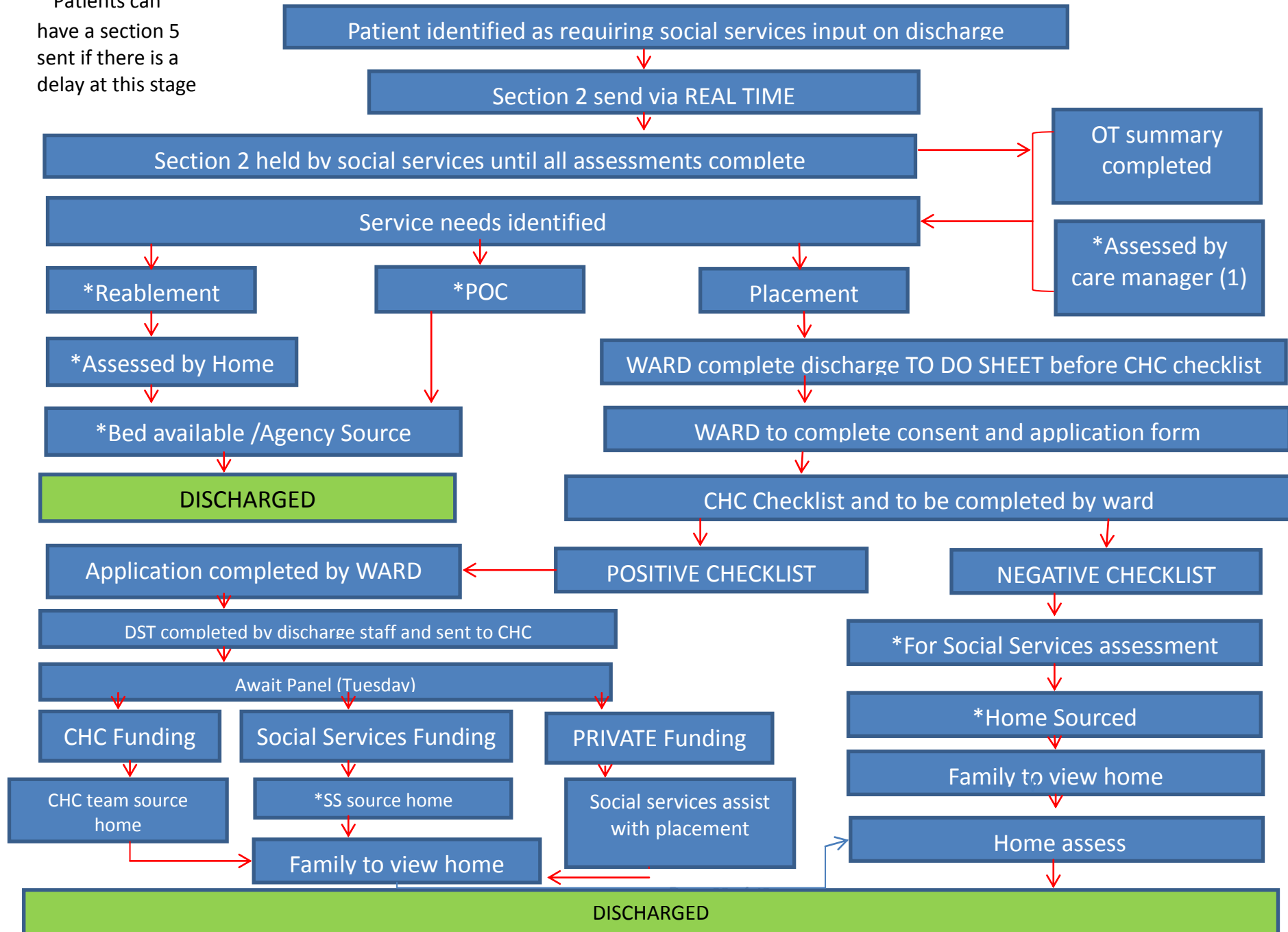
- weight reduction
- insulin dependent diabetes review
- non-insulin dependent diabetes review
- lipid modification

(Dietetics Dept, FPH. 2003)

# HAMPSHIRE DISCHARGE PROCESS

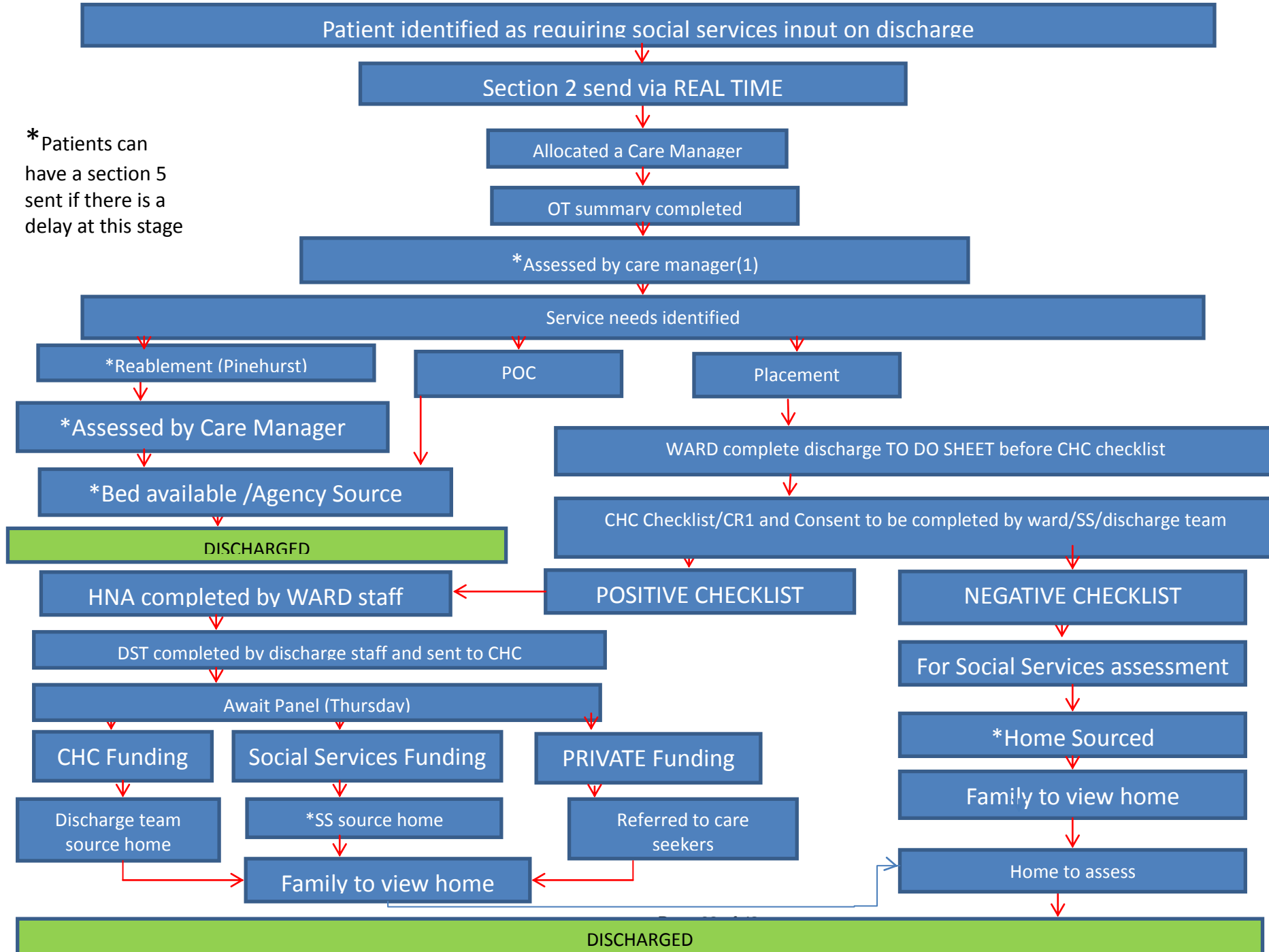
Appendix 7

\*Patients can have a section 5 sent if there is a delay at this stage



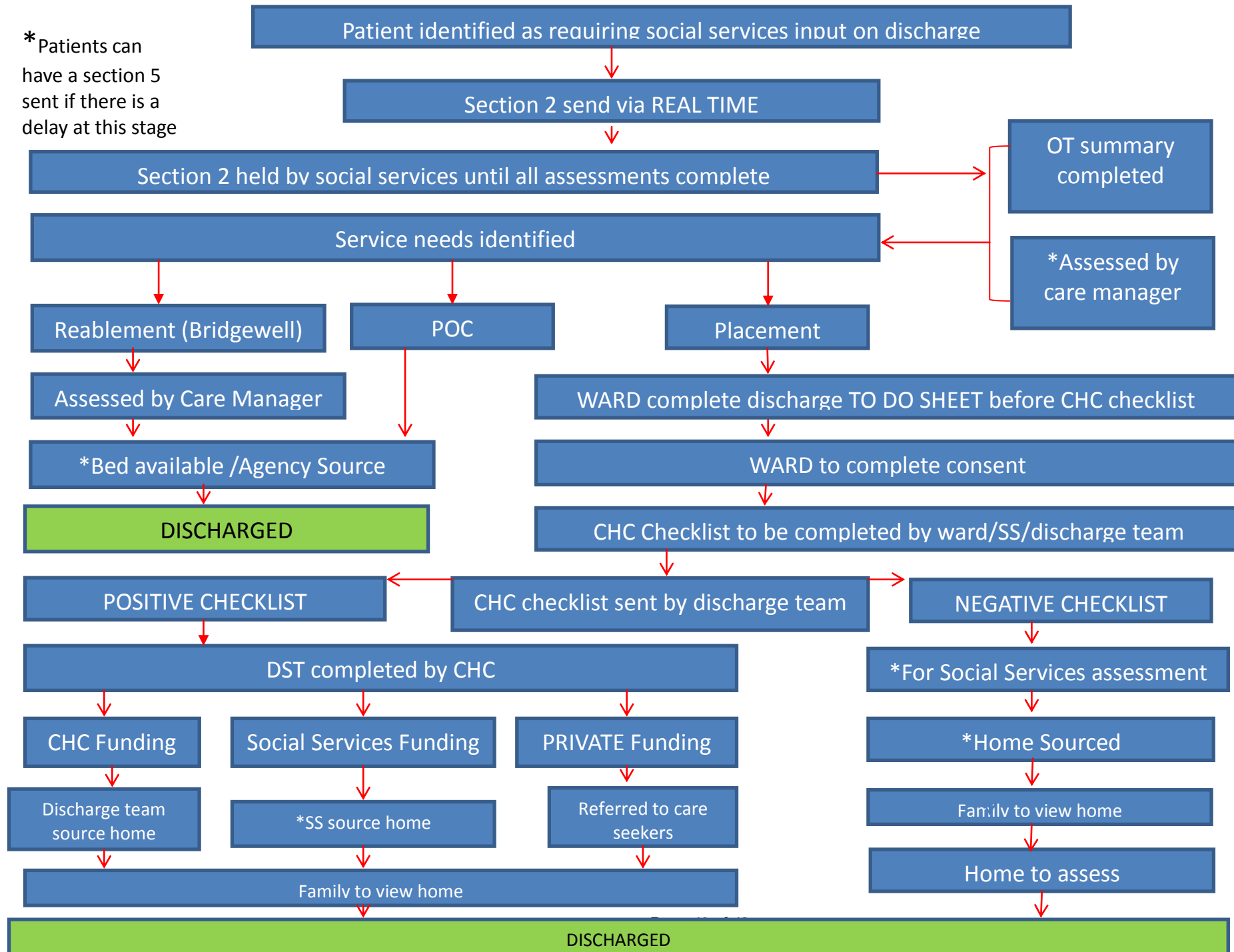
# SURREY DISCHARGE PROCESS

Appendix 7



# BERKSHIRE DISCHARGE PROCESS


\*Patients can have a section 5 sent if there is a delay at this stage







## APPENIDX 8 Mental Capacity Checklist

|   |  |
|---|--|
| <b>Mental Capacity Act 2005 (MCA)</b><br><b>Assessing Mental Capacity – A Checklist</b> | <b>Frimley Park Hospital</b> <br>NHS Foundation Trust<br><i>In partnership with the Ministry of Defence</i> |
|---|--|

Name of person being assessed \_\_\_\_\_

Date of Birth \_\_\_\_\_ PAS Number \_\_\_\_\_

Assessing Mental Capacity is always decision specific and therefore capacity has to be assessed for each decision or type of decision at the time the decision has to be made. It is important to record clearly why you are making a particular decision or judgement. Please record clearly in the patients' records or on this form for answering any of the questions below. This form must be placed in the confidential section of the patients' notes.

What is the question/issue being considered? \_\_\_\_\_

| <b>STAGE 1</b>  |   |   |
|---|---|---|
| Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? eg. learning disabilities, dementia, acquired brain injury, drug/alcohol misuse, mental illness or other cognitive impairment.                       | <b>YES</b><br>Impairment is present.<br><br>If YES, please record what the impairment is and what information you used to support this judgement then please go to STAGE 2.   | <b>NO</b><br>Impairment is not present<br><br>If NO, the person is deemed capable and the assessment is ended |
| <b>STAGE 2</b>  |   |   |
| <b>A.</b><br>With all possible help given, is the person able to understand the information relevant to the decision, eg. What is your understanding of the question? Can you tell me why you think the decision needs to be made? What do you think the consequences of your decision will be? | <b>YES</b><br>Able to understand information. Record views/evidence to show they understood it.   | <b>NO</b><br>Unable to retain information, record any help given and advice.                                  |
| <b>B.</b><br>Are they able to retain the information long enough to make the decision?  | <b>YES</b><br>Able to retain information.   | <b>NO</b><br>Unable to retain information   |
| <b>C.</b><br>Are they able to weigh the information as part of the decision making process?   | <b>YES</b><br>Able to weigh information   | <b>NO</b><br>Unable to weigh information  |
| <b>D.</b><br>Are they able to communicate the decision?   | <b>YES</b><br>Able to communicate   | <b>NO</b><br>Unable to communicate  |
| <b>CONCLUSION</b> – If the answer to STAGE 1 is YES and the answer to any of STAGE 2 a-d is NO then the person lacks capacity under the Mental Capacity Act 2005<br><br><b>ASSESSOR</b> _____<br>Please print name  | <b>FLUCTUATING CAPACITY</b> : Always consider whether the person has fluctuating capacity and whether the decision can wait until capacity returns. If this is the case, explain and enter reassessment date in outcome below<br><br><b>OUTCOME</b> : |   |

**Mental Capacity Act 2005 (MCA)**  
**Best Interests – A Checklist for undertaking**  
**wider consultation**

**Frimley Park Hospital**   
 NHS Foundation Trust  
*In partnership with the Ministry of Defence*

Decision/action being consulted upon:

In relation to \_\_\_\_\_ (person deemed to lack capacity)

| Checklist   | Date consultations were undertaken/comment |
|---|--|
| All relevant circumstances, eg. diagnosis/best clinical view  |  |
| Will the person have capacity sometime in the future in relation to the matter, if so, when   |  |
| The persons reasonably ascertainable past and presents wishes/statement   |  |
| The persons beliefs and values  |  |
| Consult others, if practicable and appropriate;<br><br>1) Anyone named by the person lacking capacity as someone to be consulted (specify person/s). 2) Anyone engaged in caring for the person or interested in their welfare (specify person/s). 3) Any attorney appointed under an Lasting Power of Attorney (LPA) (specify person/s). 4) Any Deputy appointed by the Court of Protection.<br>In cases where the person lacking capacity has nobody in the above 4 categories other than paid carers and faces a decision about serious medical treatment or a change of residence, you will need to consult an Independent Mental Capacity Advocate (IMCA).<br><b>To consult an IMCA;</b><br><b>Change of residence - contact Social Services</b><br><b>Serious medical treatment – contact the Risk Office</b> |  |
| Other factors the person would consider if able to do so  |  |
| Must encourage and permit the person concerned to participate   |  |
| Consider the least restrictive option   |  |
| Do not base the 'best interests' decision on age, appearance, behaviour or condition  |  |
| If the decision is about life sustaining treatment, do not be motivated by a desire to bring about the persons death  |  |

Record of Decision:

**Appendix 9 Medical  
Devices Discharge Checklist (MD3)**  
**Section 1 Patient Details**

|                          |  |
|--------------------------|--|
| Patient Name:            |  |
| Hospital No:             |  |
| Expected Discharge Date: |  |
| Date of Discharge:       |  |

**Section 2 Equipment Details**

|               |  |
|---------------|--|
| Manufacturer: |  |
| Make:         |  |
| Model:        |  |
| Serial No:    |  |
| Asset No:     |  |

**Section 3 General Considerations**

|   | Please tick          |    |    |
|---|----------------------|----|----|
|   | YES                  | NO | NA |
| Is the device suitable for home use?                                |                      |    |    |
| Who is the person responsible for using the device?                 | Nurse/Patient/Carer* |    |    |
| Has the device been fully tested prior to release (PAT & function)? |                      |    |    |
| Is the maintenance schedule compatible with the loan?               |                      |    |    |
| Is the device indwelling i.e. catheter?                             |                      |    |    |
| If indwelling, has District Nurse Liaison been contacted?           |                      |    |    |

**Section 4 Patient/Carer Instructions**

|   |  |  |  |
|---|--|--|--|
| Does the patient/carers know the name of the device?                            |  |  |  |
| Does the patient/carers know how to setup the device?                           |  |  |  |
| Has the patient/carers been trained in the use and functions of the device?     |  |  |  |
| Has the patient/carers been provided with written instructions?                 |  |  |  |
| Is the patient/carers aware of fail-safe procedures i.e. alarm, auto shut-off?  |  |  |  |
| Has the patient/carers been trained in the care of the device?                  |  |  |  |
| Will the patient/carers require any accessories i.e. consumables, sharps bin?   |  |  |  |
| If so, have they been issued?   |  |  |  |
| Is maintenance required?  |  |  |  |
| If so, is the patient/carers aware of how this will be achieved?                |  |  |  |
| Does the patient have a point of contact within the Trust regarding the device? |  |  |  |

**Section 5 Return**

|                                       |
|---------------------------------------|
| When is the device to be returned?    |
| Where will the device be returned to? |
| Who is the device to be returned to?  |

**Section 6 Other Comments**

|  |
|--|
|  |
|--|

**Section 7 Signatures**

|                                   |       |
|-----------------------------------|-------|
| Patient/carers signature:         | Date: |
| Discharge Nurse signature:        | Date: |
| Discharge Lounge Nurse signature: | Date: |

## **Appendix 9 – Discharge patient with ongoing Do Not Attempt (DNACPR) Resuscitation Decisions.**

Patients being discharged to the following ongoing managed care environments should be discharged home with the ORIGINAL Do Not Attempt CPR form (this will be the red bordered DNACPR for) unless the admitting consultant specifically requests that the DNACPR order is reviewed. The grey carbonised form will remain in the patients notes as a record of the DNACPR decision.

Ongoing managed care areas

- nursing homes
- residential homes
- community hospitals
- hospices
- with terminally ill patients who have expressed the wish to die at home

In selected patients based on a patient too patient bases who are not included in the listed 'managed care areas' the ORIGINAL DNACPR can be discharged home with the patient. This will only occur when:

- patient requests that the DNACPR form is life long
- on the instruction of the admitting consultant
- on request from a GP or community matron
- following case review

When Discharging patients to there home address with an ongoing DNACPR form it is vital that

- the patient and next of kin are aware of the existence of the DNACPR form (please note permission from next of kin is not required to make a DNACPR decision but its best practise to ensure early/effective communication)
- The GP is informed in the discharge letter
- The community services are informed

## Appendix 11 Transfer Form

|  |   |  |
|--|---|--|
| Patient identity label   | <b>From</b>   |  |
|  | <b>Tel: no.</b>   |  |
|  | <b>GP</b>   |  |
|  | <b>Consultant</b>   |  |
| <b>NEXT OF KIN DETAILS</b>   | <b>Paperwork with patient</b>   |  |
| Tel:   | Property list Yes / No<br>Discharge Letter Yes / No<br>NOK informed Yes / No<br>Date.....Time.....<br>By whom? .....<br>If 'no', state reason:  |  |
| <b>Infection control status</b><br><br><b>MRSA Status Positive/Negative</b><br><br><b>Other Infection:</b> | <b>DNACPR decision made Yes / No</b><br><b>DNACPR form present for discharge Yes / No</b><br><b>MET Score &gt;6 last recorded observation in last 2 hours Yes (review refer to Outreach/ need escort for transfer. ) Current MET Score:</b> |  |

|                          |                                      |
|--------------------------|--------------------------------------|
| <b>PRESENT DIAGNOSIS</b> | <b>RELEVANT PAST MEDICAL HISTORY</b> |
|                          |                                      |
| <b>ALLERGIES</b>         |                                      |

|                         |          |          |
|-------------------------|----------|----------|
| <b>SAFETY</b>           | Yes / No | Comments |
| Orientated?             |          |          |
| Maintaining own safety? |          |          |
| Confused?               |          |          |

|                    |          |          |
|--------------------|----------|----------|
| <b>MOBILITY</b>    | Yes / No | Comments |
| Walking            |          |          |
| Aids / no:of staff |          |          |
| Bed / chair bound  |          |          |

|                           |          |                                |
|---------------------------|----------|--------------------------------|
| <b>ANY PROBLEMS WITH:</b> | Yes / No | Comments:                      |
| Cardiovascular status     |          |                                |
| Respiratory status        |          | FiO2                      SpO2 |

|                              |          |  |               |               |          |
|------------------------------|----------|--|---------------|---------------|----------|
| <b>COMMUNICATION</b>         |          | Comments   |               |               |          |
| Speech problems              | Yes / No |  |               |               |          |
| Visual problems              | Yes / No | Glasses:   | Yes / No      | With patient? | Yes / No |
|                              |          | Comments:  |               |               |          |
| Hearing problems             | Yes / No | Hearing aids:  | Yes / No      | Left / Right  |          |
|                              |          |  | With patient? | Yes / No      |          |
|                              |          | Comments:  |               |               |          |
| Dentures                     | Yes / No | Top  | Yes / No      | Bottom        | Yes / No |
|                              |          | With patient?  | Yes / No      |               |          |
| Emotional / Spiritual needs? | Yes / No | Special needs? Yes / No<br>Copy of hospital passport attached: Yes / No / NA<br>If pt has dementia copy of 'This is Me' leaflet: Yes / No / NA |               |               |          |

|                   |  |  |                    |  |  |
|-------------------|--|--|--------------------|--|--|
| History of Falls? |  |  | Transfers          |  |  |
| Wanderer          |  |  | Aids / No:of staff |  |  |

|                              |          |          |                        |          |        |
|------------------------------|----------|----------|------------------------|----------|--------|
| <b>EATING &amp; DRINKING</b> | Yes / No | Comments | <b>SKIN CONDITION</b>  | Comments |        |
| Swallowing problems?         |          |          | Waterlow Score         |          |        |
| SALT involved?               |          |          | Pressure Sores         | Yes / No | Grade: |
| Dietician involved?          |          |          | Treatment /Dressing    |          |        |
|                              |          |          | Compression bandaging: |          |        |
|                              |          |          | ABPI:                  |          |        |
| Special Diet?                |          |          | Wound Type             |          |        |
| PEG tube                     |          | Date:    | Wound Closure          |          |        |
| NG tube                      |          | Date:    | Date of removal?       |          |        |

|  |                    |            |  |             |
|--|--------------------|------------|--|-------------|
| <b>CONTINENCE</b>                        | Continent of urine | Day/ Night | Continent of faeces  | Day / Night |
| Promotion of continence                  |                    |            |  |             |
| Management of incontinence               |                    |            |  |             |
| Incontinence pads                        | Size               |            |  |             |
| Sheath                                   | Size               |            |  |             |
| Catheter                                 | Size               |            | Date inserted  |             |
|  |                    |            | <b>Date to be changed:</b>   |             |
| Catheter safe to be changed in community | Yes<br>No          |            | <i>Catheter to be changed in hospital</i><br>Appointment for change :              |             |
| Feeding regime<br>Copy of regime         |                    |            | <b>Photocopy Tissue Viability Assessment Sheet if applicable to send with form</b> |             |

Please draw on the body map in black ink, using the following key to indicate the different types of injury (shading or alphabetic code), and provide brief details for each injury, e.g. grade of pressure ulcer, colour of bruise, etc



**A - pressure ulcers**  
(not broken down)



B - bruising



C - cuts, wounds



**D - excoriation, red areas**



E - scalds, burns

F other (specify)

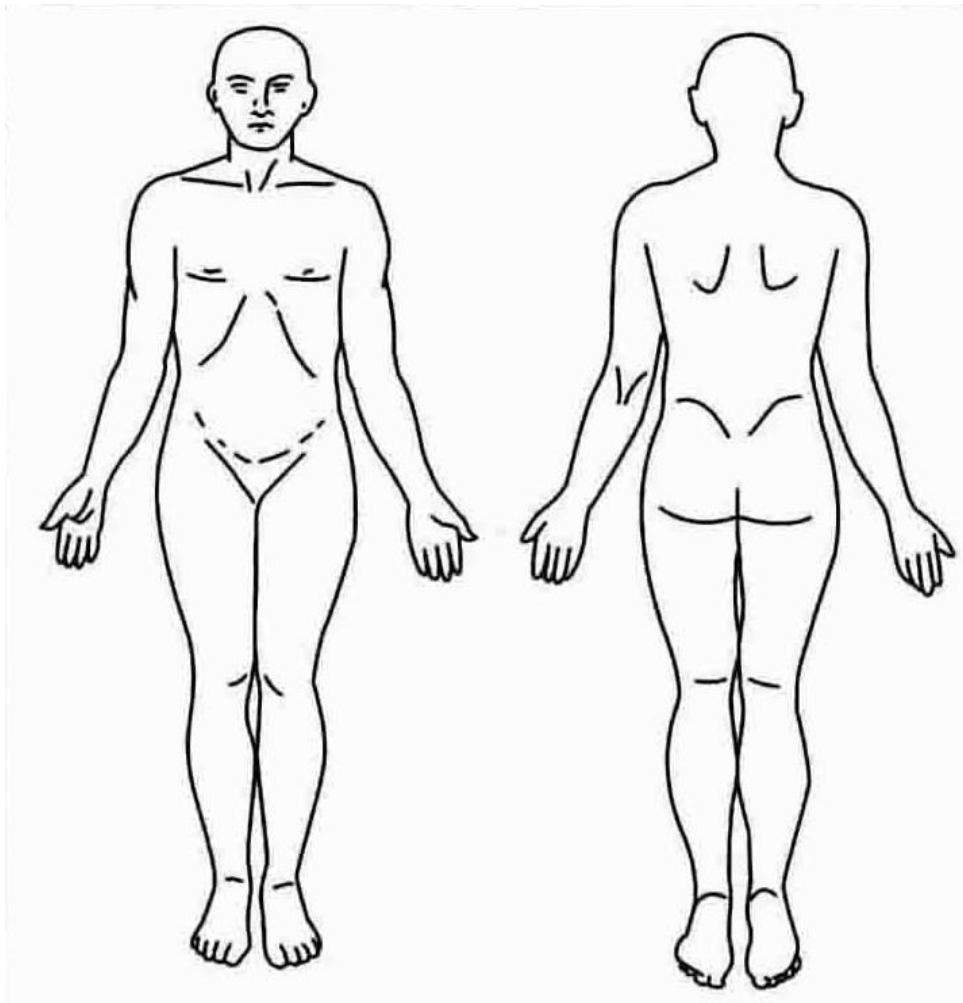


**Body Map notes:**

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|      |                 |
|------|-----------------|
| PAIN | Acute / Chronic |
|      |                 |

|                |
|----------------|
| SLEEPING       |
| Usual Pattern: |
| Medication     |
| Other remedies |

|            |                 |
|------------|-----------------|
| Hygiene    | Ability to wash |
| Upper body |                 |
| Lower body |                 |
| Aids       |                 |

|                  |  |
|------------------|--|
| Ability to dress |  |
| Upper body       |  |
| Lower body       |  |
| Aids             |  |

Nurse's signature

|                            |
|----------------------------|
| OTHER RELEVANT INFORMATION |
|                            |

|                     |
|---------------------|
| PRINT<br>NAME/STAMP |
|                     |

Date  
and  
Time of  
transfer

**TRANSFER LETTER MUST BE FILED IN MEDICAL NOTES**