

Policy for Patient Discharge

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1. Introduction

Effective and early discharge planning ensures patients and on-going care providers are prepared for the patient returning home, enabling practical and emotional needs to be met and resulting in a better experience for the patient as well as an improved use of hospital resources.

This policy has been designed to give a broad overview of the principles of discharge planning for the multi-professional team within the hospital setting.

Effective discharge planning is evident when members of the multi-professional team work together, value each other's contribution to discharge planning and keep the patient at the centre of the process.

2. Purpose and Scope

This policy aims to provide direction and guidance to all King's staff on how to achieve the safe and timely discharge of patients from hospital to an appropriate setting in the community, whether that is their home, to a care home or a rehabilitation setting. This policy applies to all patients (both adult and children) who have their discharge arranged from wards and departments at King's College Hospital.

3. Definition of Discharge and Transfer of Care

In the context of this policy the term 'discharge' applies to all patients discharged from the provision of acute care in the hospital setting. The term 'transfer of care' applies to a discharge from hospital to a community setting where the patient will receive ongoing social or nursing care. 'Discharge and transfer of care' does not apply to outpatient services located in the hospital setting or satellite settings. It also does not include the transfer of care from this acute hospital setting to another acute hospital setting. Hospital transfers are addressed within a separate policy titled 'Policy & procedure for the Safe Transfer of Patients'.

4. Patient Groups

The patient groups that the policy applies to are:

- Adult in-patients
- Paediatric in-patients
- Postnatal care patients.

5. Communication and Documentation

All King's College Hospital NHS Foundation Trust patients must have a documented discharge plan ensuring that they leave hospital with minimal risk. Every discharge decision and significant discharge planning action completed by members of the multi-professional team must be recorded on the Electronic Patient Record system (EPR) or, if EPR unavailable in the medical notes, providing a unified record of patient discharge management. Every member of the team is accountable for ensuring clear and timely

communication and documentation with the rest of the multi-professional team and with the patient and their carers. This is inclusive of referral documentation to internal members of the multi-professional team and external agencies (refer appendices for details). Where external agencies are involved, information regarding the level of their involvement on discharge and transfer of care must be documented in the unified patient record.

All patients will receive basic information regarding discharge planning specifically the use of Expected Discharge Dates to manage discussions. This will be recorded in the patient notes. Patients who will be requiring more complex support on discharge will receive information as appropriate.

Every patient will receive a copy of their discharge summary on the day of discharge. This provides written information regarding the care and treatment they have received in hospital. It will detail any follow-up appointments planned and guidance for further intervention (if required) by the patient's general practitioner, practice or district nurse or social services.

Every patient will receive written information regarding their medication and will be fully informed of any potential side effects that are common for the medication they are taking, prior to being discharged from hospital. In addition they will receive information on who to call for advice re medication once they are discharged.

6. Roles and Responsibilities

6.1 Chief Executive

The Chief Executive has overall and ultimate responsibility for ensuring that the Policy for Patient Discharge is implemented fully within the Trust. It is expected that this responsibility will be appropriately delegated to the Director of Operations, Director of Nursing & Midwifery and Medical Director. They will hold a shared responsibility to ensure that the policy is adhered to by all members of the multi-professional team.

6.2 Clinical Consultant and Teams

The named consultant is accountable for the overall medical management of the patient from admission through to discharge. Every patient must have an expected date of discharge (EDD) which will be identified within the first twenty-four hours of admission and reviewed during every ward round thereafter. Clinical exceptions can be made and recorded in the EPR system. A clear plan for the care and treatment of the patient must be appropriately documented and communicated to the wider multi-professional team.

All medical staff have a responsibility to ensure that they answer any questions the patient, family members or carers may have regarding investigations and procedures that contribute to the care process.

6.3 Matron

The role of matron is to lead the nursing teams and ensure that the quality of care and the patient experience is of the highest standard. The matron will monitor the quality of the discharge planning process and facilitate effective communication and documentation across the multi-professional team.

6.4 Ward Manager

The ward manager is accountable for ensuring that each patient is discharged safely from their ward. To facilitate this, the ward manager sets appropriate standards for communication and nursing documentation and ensures they are maintained. This will include standards for the quality of the nursing assessment, timely referrals to members of the multi-professional team (hospital and the community) and accurate documentation in the EPR.

6.5 Discharge Co-ordinator

The role of the discharge co-ordinator is to provide a specialist and expert service to facilitate timely, effective and safe discharge for the adult patient with complex needs. It is their responsibility to co-ordinate complex assessments and discharge plans in partnership with multi-professional teams in the hospital and the community. Accurate reporting of delays in discharge experienced by patients is an important aspect of performance monitoring that is undertaken by the discharge co-ordinator.

6.6 Multi-Professional Team

The multi-professional team (also referred to as the multi-disciplinary team) is a generic term to represent the varied and many disciplines involved in the care of a patient in hospital. For the purpose of this policy the main disciplines referred to are those that are ward based or allocated to specific wards or specialities, and which have a significant role to play in discharge planning for both adults and children. The disciplines included are:

- Physiotherapy
- Occupational therapy
- Pharmacy
- Dietetics
- Speech and language therapy
- Palliative care
- Clinical nurse specialists.

The role of the multi-professional team is to individually, and collectively, contribute to identifying the expected date of discharge. Clear and consistent communication between members of the multi-professional team will promote a joined-up approach and will prevent potential delays in the patient discharge.

6.7 Role of Social Services (Hospital Discharge Team)

The role of social services is to ensure adult patients requiring social care on discharge from hospital have an appropriate and timely assessment and social care arrangements in place prior to discharge.

7. Discharge Requirements

7.1 Adults: Simple Discharge Planning

A simple adult discharge starts as a patient who presents with a simple medical or surgical problem. This person will usually be independent or have minimal restrictions to their normal level of functioning. Discharge requirements for the simple discharge will remain minimal, usually requiring only GP services and possible outpatient follow-up from the hospital (DH, 2004).

Twenty four hours prior to the expected date of discharge the nursing team will start the discharge checklist. This will identify the individual person's requirements for a safe transition of care from hospital to community. This will include:

- Transport arrangements and time of discharge
- House keys
- Own clothes.

Any safeguarding concerns will be managed in accordance with the Trust Safeguarding Policy.

7.2 Adults: Complex Discharge Planning

The complex adult, in relation to discharge planning, may be defined as a person with one or more of the following:

- Multiple co-morbidities, requiring intervention by varying medical teams and specialities during their hospital stay
- An existing impaired level of function (physical and or cognitive) on admission and, due to the complexities of their medical condition, will likely have a further decrease in their functional and or cognitive status.
- An acute illness that has resulted in impaired physical and or cognitive ability (younger or older person)
 - Palliative care needs
 - Complicated social circumstances

Complex discharge planning for adults follows all the requirements for simple discharge planning but has additional elements in relation to the assessment and planning involved. Attention needs to be paid to the involvement of the individual person and their families or carers in all aspects of planning and decision-making, facilitating a person-centred approach to care and discharge planning.

The expected date of discharge will be reviewed at regular intervals and will be dependent on the discharge destination. The regular intervals will be during ward rounds, multi-disciplinary meetings (MDT) or multi-disciplinary reviews (MDR). The majority of complex discharges will be case managed by either a discharge co-ordinator or a senior nurse or practitioner. The case manager will be clearly identified to facilitate good communication between all members of the team and ensure best practice.

Any concerns with a family's eligibility for recourse to public funds or issues around leave to remain in the UK to be identified as soon as possible and discussed with the Trust overseas team.

Any safeguarding concerns will be managed in accordance with the Trust Safeguarding Policy.

7.3 Paediatrics: Simple Discharge Planning

To follow the principles outlined in Section 7.1 plus:

- Any safeguarding concerns managed in accordance with the Trust Safeguarding Policy
- Any referrals to the Children's Community Nursing Team to be made as soon as identified as being required and at least two days before discharge
- Notification to Health Visitor for all children under 5
- Child Health discharge checklist to be started the day before discharge

7.4 Paediatrics: Complex Discharge Planning

To follow the principles outlined in Section 7.2 plus:

- Any complex safeguarding concerns to be immediately discussed with the safeguarding team
- Any baby, child or young person with complex clinical needs who may require an ongoing care package to be immediately referred to the relevant community continuing care team
- Where an ongoing care package is required, the suitability of housing must be assessed by the community occupational therapists

7.5 Postnatal: Simple Discharge Planning

To follow the principles outlined in Section 7.1 plus:

The majority of discharges from postnatal care are referred to as simple. Women who have a vaginal birth with no complications will be discharged from hospital in less than six hours. Women who have a planned or emergency caesarean section may require up to seventy-two hours in hospital.

7.6 Postnatal: Complex Discharge Planning

To follow the principles outlined in Section 7.2 plus:

Mothers and families who are considered potentially high risk with social concerns will be referred to the Children and Families Social Services, this may also be a continuation from a referral that was made during the antenatal period. This will include families deemed to have coping problems or experiencing major life crisis, children in need of protection and the mothers of sick neonates who have received special/intensive care.

Women who have their baby admitted to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU), will normally be expected to leave the hospital when they themselves are fit for transfer to the care of the Community Midwives.

The Postnatal Guidelines 2nd Edition 2008 provide detailed and specific guidance on the transfer of care/discharge to the Community Midwifery and Health Visiting service.

Any safeguarding concerns will be managed in accordance with the Trust Safeguarding Policy.

7.7 Discharge and Transfer of Care Options

It is vital to involve the patient and their carers / guardians (where appropriate) to ensure the right care options to meet their needs. The care options include:

- Home
- NHS continuing care
- Placement - nursing or residential
- Intermediate care (person's own home or residential setting)
- A package of care in the patient's home provided jointly or separately by the NHS and social services
- A package of care for the carer in the patient's home
- Hospice.

Consideration must always be given to undertake a 'best interest' meeting where appropriate to support a safe discharge. Risk must be considered by all professionals, with patients and their carers as part of the discharge planning process.

8. Information to be given to the Patient whilst in Hospital to Support Discharge Planning

8.1 Adults and Children

During their stay in hospital a patient and their carers should be provided with information which will include the following:

- Expected discharge date (EDD) and when this is reviewed the patient should be kept informed
- Relevant Patient information leaflet to support discharge planning
- If required information about options other than home e.g. placement
- Information regarding their medication and any changes to their existing medication both during their stay and in preparation for discharge
- Outcomes of multi-disciplinary assessment(s) and discussions that will affect the patient and their carers and discharge planning.

8.2 Postnatal

Women will be given a significant amount of information during the prenatal stage. Once postnatal the mother will be given relevant information in both a written and verbal form. This information will be tailored to the individual and will therefore vary.

9. Documentation to Accompany Patients on Discharge

The following documentation should accompany the patient on discharge:

- Instructions regarding management and administration of their medication
- A copy of their discharge summary detailing the care and treatment received and follow-up management plan
- Any appointments for follow-up
- Relevant leaflets and information packs regarding their condition (where appropriate)
- Nursing transfer letter and wound care plan for the district nurse or care home if required
- Nursing letter for all Children returned to the community nursing team, midwife or health visitor

10. Information to be Given to the Receiving Healthcare Professional

On discharge, a copy of the EPR (or paper) discharge summary will be sent to the patient's General Practitioner or relevant other healthcare professional, outlining:

- Instructions regarding management and administration of any medication
- Details of the care and treatment the patient received and follow-up management plan
- Any appointments for follow-up
- A nursing transfer letter and wound care plan for the district nurse or care home, if required
- Any safeguarding concerns noted
- Required level of involvement of external agencies.

11. Patient Transport

On discharge from hospital, patients (in the case of children, their guardians) are expected to make their own arrangements for transport home. Patients and guardians must be informed of this expectation when the discharge date and time has been arranged.

Patients will be provided transport if they meet certain criteria:

- Frail, older patients with impaired mobility or functional status
- Patients with chronic conditions resulting in reduced functional status
- Palliative care patients
- All patients being transferred to a care home

12. Discharge Out of Hours

Medical and nursing staff are expected to arrange discharge for the earliest point in the day. Afternoon discharges are to be avoided where possible particularly for older or vulnerable patients.

Discharge 'out of hours' would be deemed to be after 1800hrs when access to support services is limited. However, discharges do occur during the afternoon period (adults and children) and are still deemed safe and appropriate. Discharges after 1800hrs should be avoided; should these occur then it is the responsibility of the ward staff to ensure that patient is cognitively and functionally aware and able to manage the discharge. Discharges after 2100hrs should not occur, unless this is down to patient choice.

Children should not be discharged after 21.00 hours unless this is the choice of the parent and transport arrangements have been confirmed.

13. Self-Discharge

The medical team in charge of the patient must be informed of anyone requesting to take their own, or their child's discharge from hospital. Efforts must be made to persuade the patient to stay to complete the course of recommended treatment. If a patient takes their own discharge from hospital it is both the medical and nursing staffs' responsibility to ensure

that the Discharge against Medical Advice form is completed and all parties involved in their care are informed. Medical and nursing must be mindful of the fact that all patients have the right to self-discharge if they have the capacity to do so.

14. Patient or Carers Refusing Discharge

Involvement of senior practitioners with the right level of expertise is essential to ensure best practice and safe transition of care. In these cases the following members of the multi-professional team should be involved in facilitating a safe discharge:

- Discharge co-ordinator
- Matron
- Medical / Surgical Consultant
- Legal Team (if appropriate)
- Social Services (if appropriate)
- Safeguarding issues may become apparent and so the Safeguarding Co-ordinator should be contacted for advice and support

15. Monitoring the Discharge Process and Reimbursements

Reimbursement is the process of claiming back funds from local authorities for agreed adult social care delays. It is monitored two ways

- Daily - review of all complex cases occurs attended by discharge co-ordinators and management. Complex cases are reviewed and closely monitored to ensure EDD's are being met. A daily SITREP report is generated from this 1:30 board review and sent to Primary Care, Social Care and KCH.
- Weekly - delayed discharge meeting hosted by the trust and attended by the local authorities. All delays are discussed and agreement for the category of the delay is established, the daily SITREP reports are often utilised within this meeting. Reimbursement takes place for any agreed social care delays.

16. Monitoring Compliance

Measurable policy objectives i.e. what will be monitored	Criteria	Monitoring/ audit method and frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to groups/committees, inc responsibility for action plans
Information to be given to the receiving healthcare professional	On discharge, a copy of the EPR (or paper) discharge summary will be sent to the patient's General Practitioner, outlining: <ul style="list-style-type: none"> • Instructions regarding management and administration of any medication • Details of the care and treatment the patient received and follow-up management plan • Any appointments for follow-up • Required level of involvement of external agencies. 	Annual audit	Discharge Coordination Manager	Nursing Board Operational Safety Committee

Measurable policy objectives i.e. what will be monitored	Criteria	Monitoring/ audit method and frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to groups/committees, inc responsibility for action plans
	<ul style="list-style-type: none"> A nursing transfer letter and wound care plan for the district nurse or care home, if required Any safeguarding concerns noted 	Quality alerts and AI's Monthly review of cases	Safeguarding Lead	
Information to be given to the patient when they are discharged	<p>All patients will receive :</p> <ol style="list-style-type: none"> Instructions regarding management and administration of their medication. A copy of their discharge summary detailing the care and treatment received and follow-up management plan. Any appointments for follow-up where appropriate Relevant leaflets and information packs regarding their condition (where appropriate) Nursing transfer letter and wound care plan for the district nurse or care home if required. Child – copy of the discharge checklist 			
How King's records the information given to the receiving healthcare professional and the patient	Discharge decisions and significant actions will be recorded on EPR (or paper records where EPR not available) for all in-patients			

17. Associated Documents

1. Section 2 Notification/Discharge Checklist
2. Discharge Checklist
3. Nursing Transfer Letter/Community Nursing Referral
4. Patient Information booklet
5. Patient Flow Chart
6. Section 5 Discharge Notification
7. Patient Transport System booking form
8. Quality Alert form
9. Mental Capacity Tool
10. Best Interests Assessment Tool
11. Early Transfer of Care to Community Midwifery Service.

The Discharge Policy is the primary document to refer to, when planning a patient's discharge, but the following may also help inform staff in the process:

- Patient Transfer Policy
- Patient Leave Policy
- Patient Transport Policy
- Medicines Management Policy
- Infection Control Policy
- Operational Policy for Oncology Patients
- Policies on Safeguarding adults and children
- Self-discharge Policy.

18. References

Department of Health (2003) Discharge from Hospital: Pathway, Process & Practice. DH: London

Department of Health (2004) Achieving Timely 'Simple' Discharge from Hospital. DH: London

Department of Health (2010) Ready to Go? DH: London

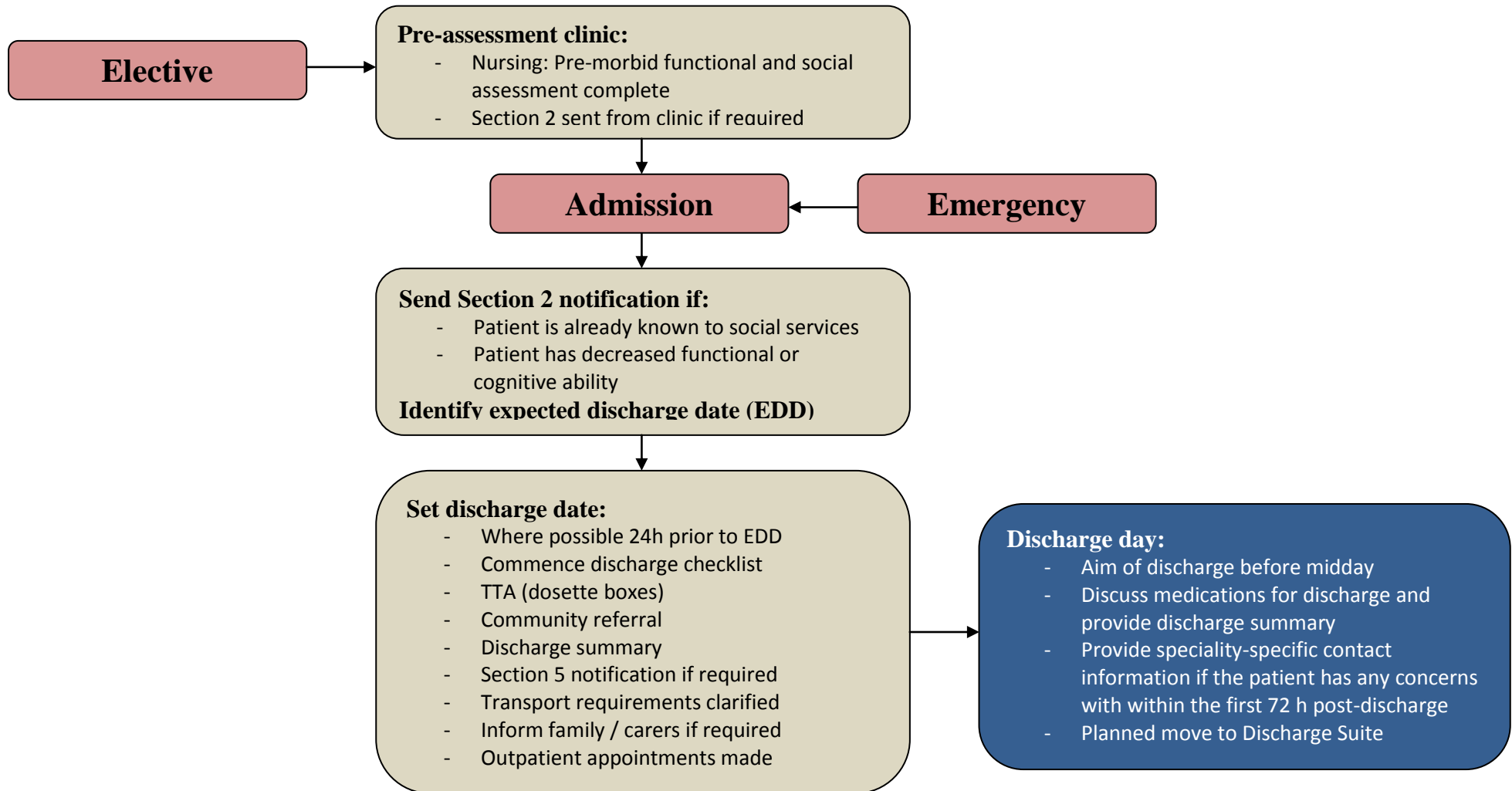
19. Glossary

Assessment	A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated
Case Management	A process whereby an individual's needs are assessed and evaluated, eligibility for services determined, care plans drafted and implemented. The needs are monitored and reassessed
Case Manager	A practitioner, who undertakes care management of complex discharge planning, usually a discharge co-ordinator, Senior Nurse, Therapist, Social Worker or Community Matron.
Carer	A person, often a relative or friend, who looks after or provides regular unpaid help to a named individual. This includes parents of children with disabilities. Children or young people who undertake caring responsibilities are referred to as 'young carers'
Carer's assessment	An assessment of the carer's needs; physical, social and emotional. This assessment is carried out at the request of the Carer to determine: <ul style="list-style-type: none"> • Whether the carer is eligible for support • The support needs of the carer • If these needs can be met by social or other services
Community health services	Local based services including GP, district nursing, community matrons, health visiting, practice nurses, therapy, psychiatric nursing, dentistry, chiropody and others.
Continuing care	This is a generic term that describes the care that people need over an extended period of time, as a result of disability, accident or illness. It can be provided in care homes, hospices,

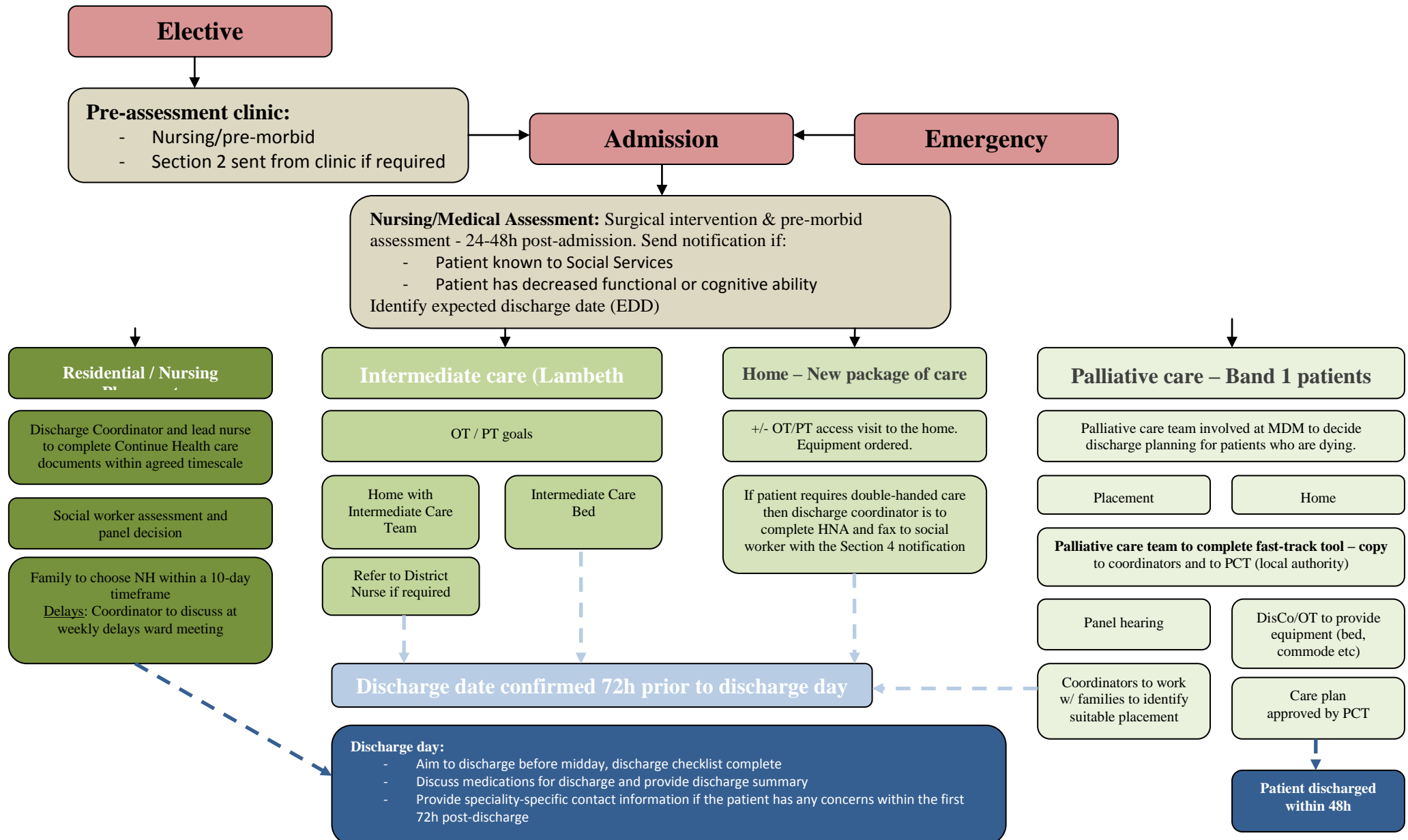
	or the individuals' own home.
Decision Support Tool checklist	An assessment which is completed in conjunction with the Health Needs Assessment which can indicate a need to further examine a patient against the full National Framework for NHS-funded Continuing Healthcare.
Decision Support Tool	This is an assessment process to support Practitioners in the application of the National Framework for NHS-funded continuing healthcare and NHS-funded nursing contribution.
'Delayed discharge' or 'delayed transfer of care'	A 'delayed discharge' is defined as a consensually agreed decision that a patient in an 'acute' hospital bed no longer requires the intensity of treatment, care and/or rehabilitation provided by with the intervention of a consultant. The patient should be deemed clinically fit and safe for discharge by the MDT, including social work and have an agreed discharge plan.
Discharge – Simple	Simple discharges are defined as patients who can “be discharged to their own home, including residential and nursing home settings if this is their usual residence, and have simple ongoing health needs which can be met without complex planning”. Department of Health 2004.
Discharge - Complex	A complex discharge is defined as anyone who requires a full assessment by the hospital multi-disciplinary team and referral to appropriate services to manage their needs either at home or in a care facility that is able to meet their needs.
Discharge Co-ordinators	Senior staff that 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
Domiciliary care	This term refers to care or services which are usually arranged funded and delivered through social services but can apply to a combination of services from a variety of community agencies designed to meet the needs of the individual at home.
Health Needs Assessment	A multi-disciplinary assessment which is completed as part of the process for long-term care.
Intermediate care	Services offered to people who do not need care or rehabilitation in hospital but require a higher level of support for time-limited period. They can be provided in the patient's home or in residential care settings.
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)	The MDT is a group of professionals provide a range of interventions to an individual patient.
NHS-funded Continuing Healthcare	A process whereby an assessment is made against set criteria to consider eligibility for funding long-term care against the National Service Framework for NHS Continuing Healthcare. Each patient is entitled to have consideration of part of this process to assess for eligibility and funding especially if transferring into long-term residential care or has high needs

	which can be managed at home. Patients whose primary need is health will be agreed for NHS funding.
NHS-funded Nursing contribution.	A process whereby an assessment is made for the nursing component of a patient's long-term care is funded by the NHS.
Re-Enablement.	A process of care provision and rehabilitation within a person's own home aimed to encourage independence which is reviewed within 6 weeks.
Rehabilitation	These are services offered to patients to enable them to regain, in part or in full previous independence which has been impaired by illness or injury, giving them back as far as is possible control over their own lives. It is usually time-limited and may involve a range of health and social intervention.
Single assessment process	A single approach to assessing health and social care needs, where the assessment is proportional to needs. All agencies will contribute, ensuring the views of the older person and carer are central
Vulnerable adult	<p>Any adult patient with recognised difficulty communicating their needs; this may be due to a physical, psychological or learning disability.</p> <p>'Vulnerable adult' is defined by the Law Commission as "someone of 16 years or over who:</p> <ul style="list-style-type: none"> • Is or may be in need of community care services by reasons of mental or other disability, age, or illness; and who • Is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation". <p><i>Making Decisions. Lord Chancellor's Department 1999.</i></p>

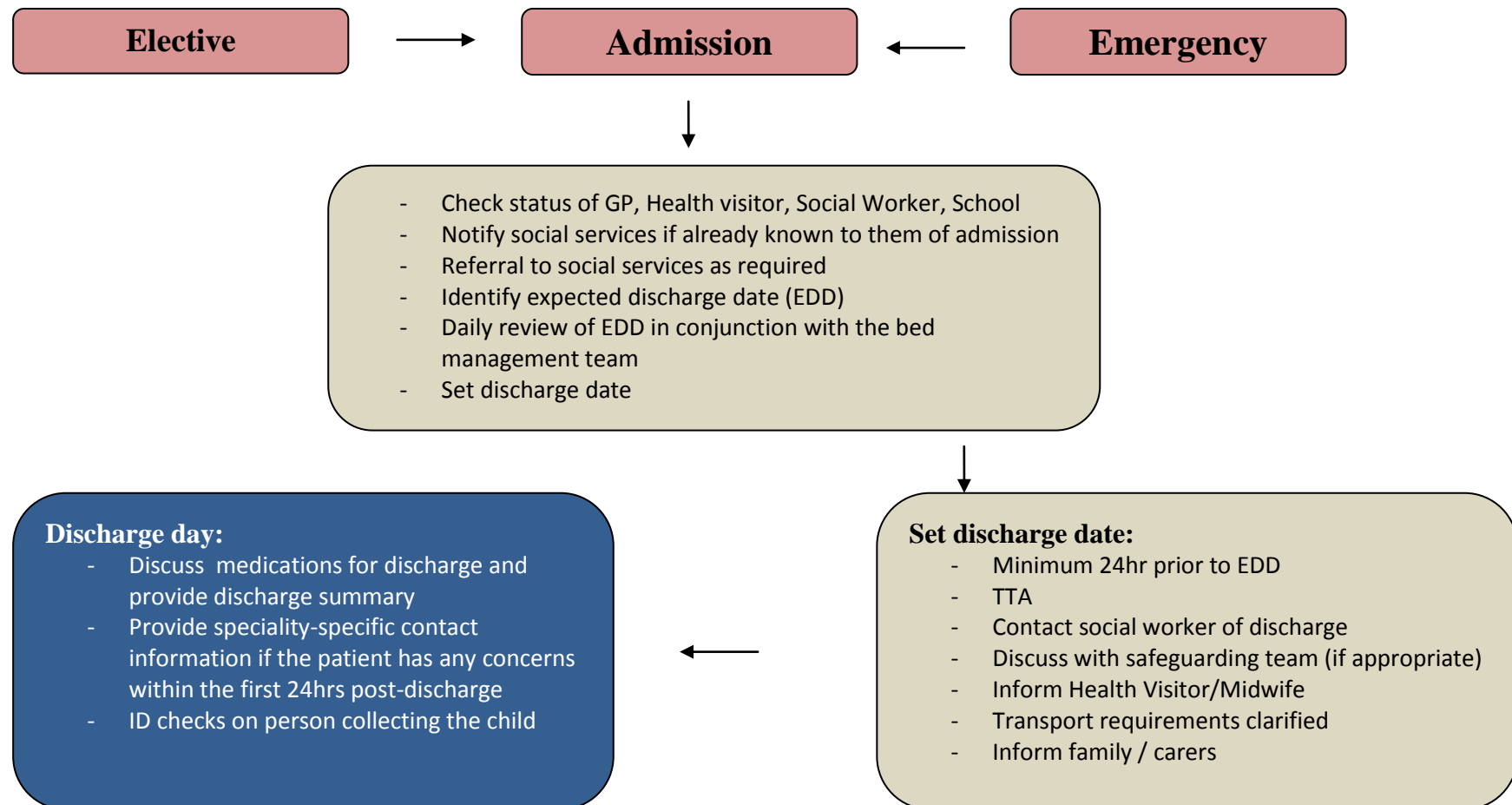
Appendix 1: Discharge Process for Adult Patients: Simple



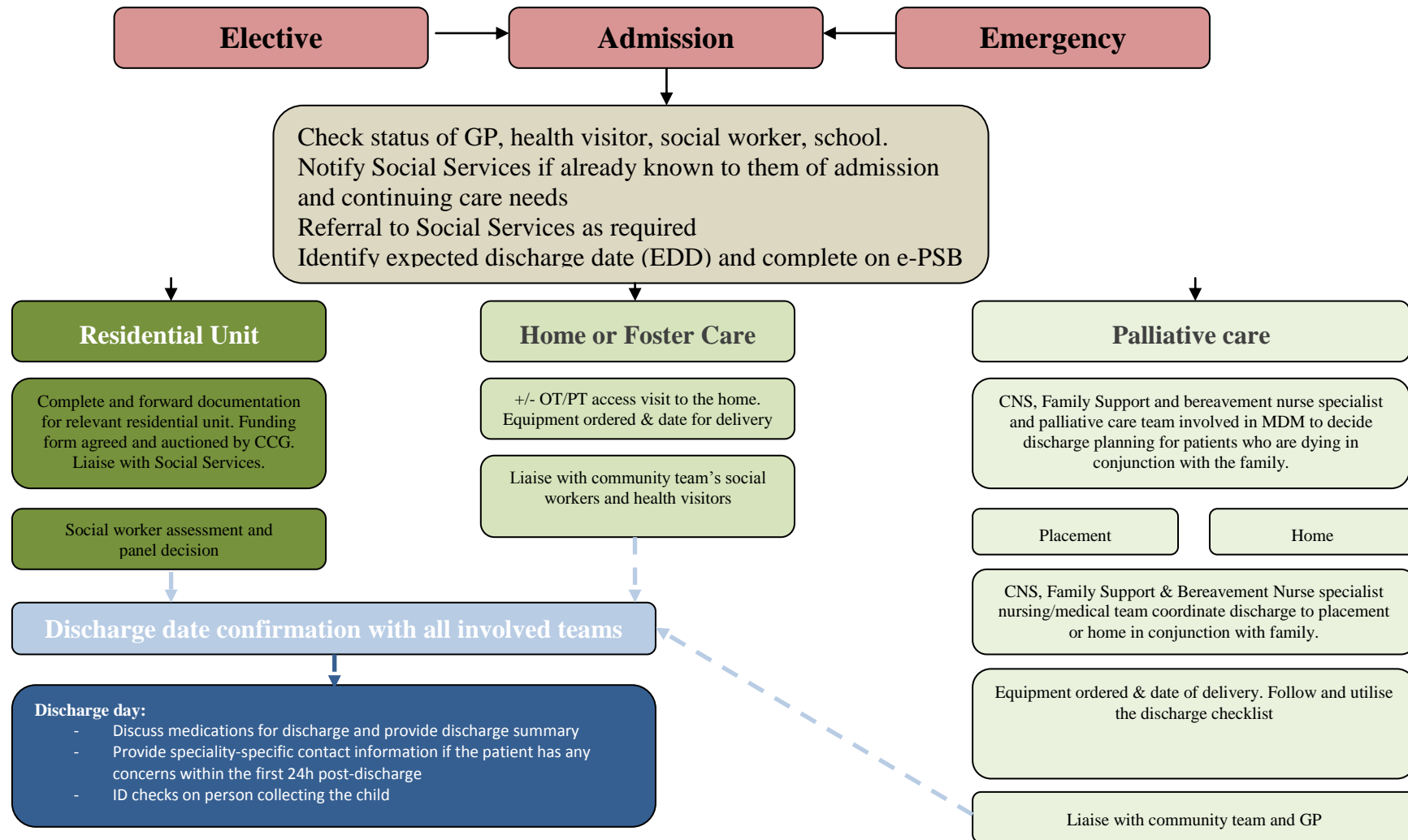
Appendix 2: Discharge Process for Adult Patients: Complex



Appendix 3: Discharge Process for Paediatric Patients: Simple



Appendix 4: Discharge Process for Paediatric Patients: Complex



Appendix 5: Discharge Process for Post-Natal Women: Simple and Complex Pathways

