Lancashire Teaching Hospitals NHS
NHS Foundation Trust

TRUST POLICY/PROCEDURE/STRATEGY AMENDMENT SHEET

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10 April 2019	All	Review date extended to 30 April 2020. Extension form number 222.

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

DISCHARGE POLICY AND PROCEDURE

POLICY AND PROCEDURE TO ENSURE THAT EFFICIENT AND APPROPRIATE ARRANGEMENTS ARE MADE FOR THE DISCHARGE OF ALL PATIENTS FROM LANCASHIRE TEACHING HOSPITALS NHS TRUST

AUTHOR.	AUTHORISED BY	DATE AUTH	POLICY REFERENCE NUMBER
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SIGNATURE **CLINICAL LEAD FOR THE INTEGRATED DISCHARGE SERVICE – DIVISION OF DIAGNOSTICS AND CLINICIAL SUPPORT**	SIGNATURE **CHIEF EXECUTIVE**	REVIEW DATE 30 April 2020	

TRUST POLICY

This Policy has general application throughout the undertaking of Lancashire Teaching Hospitals NHS Foundation Trust. It represents the governing principles outlined within the document and which are fully supported in every respect by the Board of Directors.

All members of staff are required to adhere to the principles involved as outlined within this document, together with any related procedures, which are enabled by this Policy document.

This Policy was produced in consultation with:	
Divisional Directors, Lancashire Teaching Hospitals NHS Foundation Trust	Heads of Nursing, Lancashire Teaching Hospitals NHS Foundation Trust

Other Trust Policies/Procedures associated with this document include:
Communications and Escalation Policy
Discharge Nursing Competency
Mental Capacity Act Policy and Procedure
Prisoners in Hospital Procedure
Deprivation of Liberty Procedure
Safeguarding Adults Procedure
Medications Policy
Discharge Policy for Babies, Children and Young People
NNU Discharge Policy
Discharge Policy for Maternity
Discharge Policy Neonatal Unit

Lancashire Teaching Hospitals NHS Foundation Trust Impact Assessment Screening

Policy Title: Discharge Policy			Policy Author: Colette Barnes
1.	**Does the policy/strategy affect one group more or less favourably than another on the basis of:**	**Yes/No**	**Evidence in support of either positive or negative impacts, including references to research and national documents must be provided for the sections below**
	1. Race	No	This policy promotes equality for minority groups because it encourages the assessment of all patients and meet their individual needs. The Trust faces some resource constraints, such as limited specialist residential and nursing home provision but access to Trust services and assessments is the same for all groups and this policy does not discriminate according to race, disability, gender, sexual orientation, religion or belief, age, culture, or gender.
	2. Disability	No	
	3. Gender	No	
	4. Sexual Orientation	No	
	5. Religion or Belief	No	
	6. Age	No	
	7. Marriage and Civil Partnership	No	
	8. Gender reassignment	No	
	9. Pregnancy and Maternity	No	
2.	Is there any evidence some groups will be affected differently?	No	This policy does not discriminate according to race, disability, gender, sexual orientation, religion or belief, age, culture, or gender.
3.	If potential discrimination has been identified is this justifiable (you must explain why)?	N/a	
4.	What methods of consultation have you used and with whom please describe?		This is a renewal of an existing Policy and as such has been ratified through Divisional Governance Committee and PDRG
5(a)	Is the impact identified likely to have a negative impact on the Policy/Strategy?	N/a	
5(b)	Can the impact be avoided?	N/a	
5(c)	Are there alternative ways of achieving the aims of the Policy/Strategy to remove the impact?	N/a	
5(d)	Can measure be put in place to reduce the impact?	N/a	
Comments			**Action to be taken (or not applicable)** None.

Name and designation of person completing this form Colette Barnes. (If anyone reading this form identifies any potential discriminatory impact that has not been identified on this form, please contact the Policy Author named above, along with suggestions how the impact can be eliminated or reduced.)

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1. INTRODUCTION

Demand for acute inpatient care is high and in order to meet this demand it is important that patients are discharged in a timely manner once medically fit for discharge (MFFD).

This policy has been developed to establish a standard approach to the management of patient discharges from hospital. It is designed to promote and facilitate a multi-disciplinary approach to the assessment, planning and monitoring of all discharges. Planning for discharge must start on admission and the identification of an Expected Discharge Date (EDD) must be documented by the admitting clinician in the patients' health records and updated by the ward team (as necessary) to support the discharge planning process.

Available bed capacity for emergency admission relies on a continuous discharge of patients and therefore consideration should be given to the transfer of the patients care back to primary care when physiologically stable with an anticipated recovery plan where community colleagues can support (District Nurses, General Practitioners and Community Matrons).

This policy applies to all staff at Lancashire Teaching Hospitals NHS Foundation Trust who are involved in the assessment, planning and monitoring of patients' discharges.

However, the discharges of certain groups of patients such as children thought to be in need of protection and vulnerable adults, such as those with dementia, learning disabilities or lacking mental capacity, raise some important and specific issues that are subject to specific and separate guidelines. The principles in this document still apply to these groups but should be considered along-with the recommendations in the other policies.

This policy is produced to reflect all aspects of the discharge process in line with the recommendations outlined in:

- The policy is based on guidance given in HC (89) 5/LAC(89)7
- The Care Act 2014
- Department of Health The Dignity Challenge (2006)
- DOH Discharge from Hospital 2003 : pathway, process and practice
- National Service Framework for Older People (2001)
- No Secrets in Lancashire joint strategy 2001
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DOLS)
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2007)
- Achieving Timely Simple Discharge from Hospital. A toolkit for the multi-disciplinary team (10 Step Plan) 2004, DoH.
- Department of Health, 2003 Getting the right start: National Service Framework for Children Standard for Hospital Services
- Department of Health, 2010, Ready to go?
- LTHT Policy for Supporting Patients Choice 2016

It is essential that all patients benefit from a ward completed Discharge Checklist prior to leaving the ward. As a Trust our preference is that the discharge lounge forms part of the patient discharge pathway and as such all patients who transfer to the Discharge Lounge must have a completed Discharge Checklist included in the clinical handover to the Discharge Lounge nurses. The Discharge Checklist is available on page 34 Appendix D.

2. POLICY AIM

The policy is designed to ensure that every patient discharged from the care of Lancashire Teaching Hospitals NHS Trust is discharged safely to the community with appropriate arrangements made for their ongoing care, involving all the appropriate agencies at the correct stage.

It aims to ensure that discharge preparation is timely and patient focussed, with patients/families/carers and advocates encouraged to be involved at all levels within the discharge planning process. It aims to ensure that relevant staff are aware of their responsibilities for preparing patients for discharge and that discharge planning itself is viewed as part of the process of good patient care rather than an isolated event.

In doing so it:

- recognises the responsibility held by Social Services to assess all people who require publicly funded community care services, including residential or nursing home care;
- sets out the Trust's responsibilities with regard to the reimbursement process and its associated timescale. This is referenced in Appendix B;
- sets out the broad principles within which all discharges should be planned; and
- outlines the audit processes to maintain the quality and effectiveness of the discharge arrangements.

3. DEFINITIONS

The term '*discharge*' is used to describe the discharge from a hospital care facility of an inpatient or day case to his/her home, to intermediate care or to residential or nursing home care. It also includes the discharge of patients from Accident and Emergency departments and speciality assessment areas e.g. Medical Assessment Unit.

Discharges are grouped as follows:

- **Simple** - Where there is minimal disturbance to the patient's activities of daily living which does not prevent or hamper their return to their usual place of residence. They do not require input from the Integrated Hospital Discharge Service. The Ward Manager is responsible for the discharge of patients in this group, and will ensure adequate provision of information to the patient and appropriate liaison with primary care Colleagues where necessary.

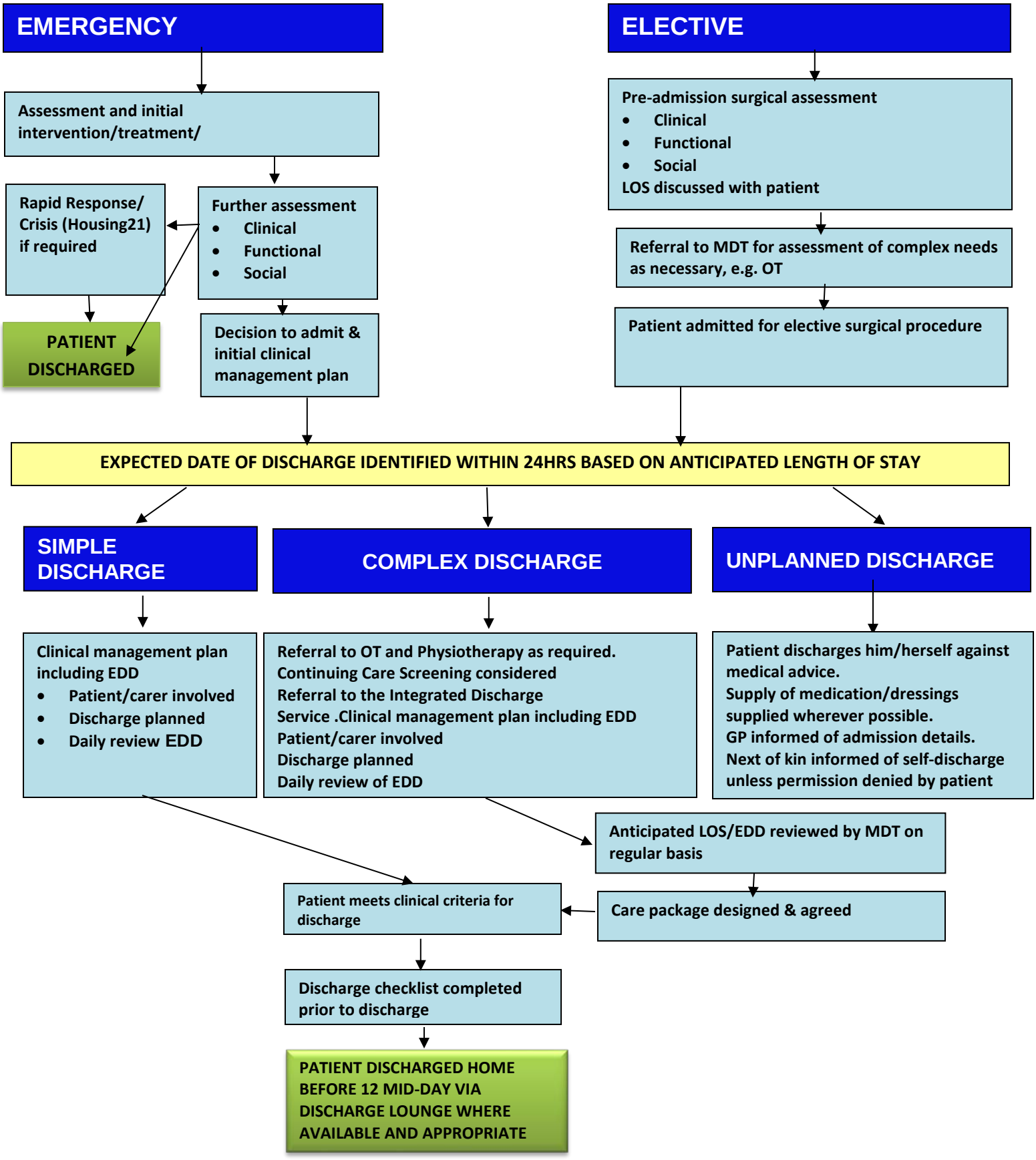
- **Complex -** When the patients' needs may have changed or they may require the restart of a package of care involving primary care, mental health services and /or social services. The patient does require input from the Integrated Hospital Discharge Service and all potential complex discharges should be referred to the Integrated discharge Team .

- **Unplanned discharges –** Where a patient discharges his/herself against medical advice.

Abbreviations used in Discharge Pathway

LOS: Length of stay
EDD: Expected date of discharge
MDT: Multi-Disciplinary Team
CLD: Criteria Led Discharge
CHC Continuing Health Care
IDS Integrated Discharge Service

ADMISSION TO DISCHARGE PATHWAY



4. RESPONSIBILITY FOR DISCHARGE

Consultant

A safe discharge is reliant upon the assessments made by a multidisciplinary team, the responsibility for which rests with the Consultant under whose care the patient is registered. The consultant is responsible for ensuring his team set an EDD within 48hrs of admission.

Ward Manager/ Nursing staff

The Ward Manager or her nominated deputy is responsible at all times for the co-ordinating of the assessment process. Members of ward staff are responsible for all simple discharges and for referring all complex cases to the Integrated Discharge Service .

The patients Registered Nurse is bound by the Code of Conduct to work in an open and co-operative manner with patients and their carers / families and should act to foster the patient's independence, recognising the importance of the patient/carer involvement in the planning and delivery of post discharge care.

The Registered Nurse discharging the patient either complex or simple cases must be confident that the arrangements made for on-going care are suitable before discharging the patient all relevant documentation is complete.

A patient may not be discharged from hospital without the authority of the doctor who has medical responsibility for that patient as highlighted in the discharge plan algorithm. This document is included in this policy as **Appendix D**. This authority may be designated by the doctor through Criteria Led Discharge described clearly within the medical notes.

The nurse ensures that the criteria described by the doctor have been met but in such cases a written procedure should be adhered to, so that the extent of that delegation is clearly understood by all concerned.

The Ward Manger or deputy is responsible for ensuring daily board meetings are implemented and monitored and ensure that all patients have an estimated date of discharge (EDD) within 48hrs of admission.

The Integrated Discharge Service (IDS)

The Integrated Discharge Service is an umbrella term for all disciplines that facilitate complex discharges and includes community district nurses, voluntary services, social workers and therapist.

The Integrated Discharge Service will assist ward staff to identify those patients who may have complex needs and who require referral to the Integrated Discharge Service.

The Integrated Discharge Service will be responsible for coordinating and monitoring the complex cases discharge process and taking appropriate action where problems or delays occur.
A member of the IDS will be identified for each complex patient and they will explain the discharge planning process to the patient.

The IDS will ensure that there is consistent, accurate and effective communication with all personnel of the health and social care system, in both primary and secondary sectors and the voluntary sector to ensure a safe and timely discharge.

The Integrated Discharge Service should keep patients, relatives and carers involved and informed to empower them in making decisions about their care; they will support staff in dealing with complex discharge issues at every stage and take a lead with the CHC process and choice patients.

The IDS are responsible for the collection of statutory information relating to delays in discharge, collecting audit data and preparing internal reports concerning the performance and adherence to the discharge policy.

The Integrated Discharge Service will ensure that any carer(s) of the patient are identified and supported through the discharge process. This includes providing information on Carer's Assessments and support services and/or referrals to the relevant support services. Ensuring the carer has adequate support in place will reduce the risk of unnecessary readmission of the patient.

6. DISCHARGE PLANNING FOR PATIENTS WHO LACK MENTAL CAPACITY

All patients who require complex discharge planning must be referred to the Integrated Discharge Team
All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA"). This means:

- Presume that adults from 16 are mentally capable of making their own decisions;
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success;
- Do not consider someone to lack capacity because they make a decision we consider to be unwise;
- When the patient is assessed to lack capacity we must act in their best interests;
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having capacity to consent to or refuse the treatment they have had as an inpatient may lack capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt capacity for a particular decision, it must be specifically assessed, in accordance with the MCA, the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as a providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision,
- Retain the information long enough to make a decision,
- Use and weigh the information as part of the decision making process and
- Communicate the decision they want to make.

In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available, with the person being given concrete information to consider, not starting with a blank sheet approach.

Options which are not available (e.g. placements which are not available, care which is not considered clinically appropriate, or care which will not be funded) should not be considered in either capacity assessments or in best interest decision-making. A patient with capacity cannot insist on staying in hospital after they are medically fit for discharge and so neither is it an option for a patient who lacks capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks capacity for discharge decisions, the decision must be made in their best interests'

It is important to identify who the decision maker is as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these are appointed then it will be the health or care professional who needs to make the decision in question. The wishes and feelings of the patient are paramount must be taken into consideration.

"Best interests" is interpreted widely, and goes beyond medical risk and benefit to include social, psychological and emotional factors. Before making a best interests decision, it should be tested by asking whether the patient's best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient is entitled to an Independent Mental Capacity Advocate (IMCA) where it is proposed that an NHS body or a local authority provides accommodation in a care home for 8 weeks or longer unless there is someone to consult about their best interests other than a paid professional

For patients who do not have full mental capacity to make a decision regarding discharge the patient's family /carers or friends (or an IMCA) must be involved in the decision making process along with the MDT regarding discharge and a Best Interest Meeting may be required.

There needs to be thorough documentation regarding how the patient's wishes were considered and how the decision about discharge was made in the patient's best interest.

Where the patient has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act 2005 Code of Practice..

Patients may also have a court appointed deputy or an attorney appointed under a Lasting Power of Attorney (previously known as Enduring power of attorney). Where this is not the case, and where the person may have to make potentially life-changing decisions, the Mental Capacity Act directs that an Independent Mental capacity Advocate (IMCA) should support and represent them and this service has been available in England since April 2007. An IMCA is an advocate that may need to be involved if the person does not have an alternative appointee to assist with decision-making, and should be involved as early as possible to prevent delays in discharge. The IMCA will not be the decision-maker, but the decision-maker will have a duty to take into account the information supplied by the IMCA.

An IMCA will only be involved if:

- The decision is about a serious medical treatment provided by the NHS
- It is proposed that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home.
- A long-term move (8 weeks or more) to different accommodation is being considered (e.g. to a different hospital or care home).

In England, local authorities and the NHS have been given powers to extend the IMCA service to specific situations if they are satisfied that an IMCA would provide particular benefit. These are:

- Care reviews about accommodation or changes to accommodation
- Adult protection cases (even if the person who lacks capacity has family or friends)

The duties of an IMCA are to:

- Support the person who lacks capacity and represent their views and interests to the decision-maker
- Obtain and evaluate information – an IMCA can talk to the patient in private and examine and where appropriate, take copies of health and social care records such as clinical records, care plans and/or social care documents.
- As far as possible, ascertain the person's wishes and feelings, beliefs and values.
- Ascertain alternative courses of action.
- Obtain a further medical opinion if necessary.
- Prepare a report for the person who instructed them.

If an IMCA disagrees with the decision made they can also challenge the decision-maker.
It is the duty of the decision-maker within the NHS to instruct an IMCA before making a decision, apart from in emergency situations.

Where a patient lacks mental capacity and where residential or nursing care is being considered, as part of the discharge planning process consideration should be given to the Deprivation of Liberty Safeguards.
Click here for the Trust's Deprivation of Liberty (DoLs) Procedure

For further guidance please see the Trusts Mental Capacity Act Policy and Procedure or contact the Trusts Clinical Risk Department for further information and/or legal advice.
Click here for the Trust's Mental Capacity Policy and Procedure.

7. DISCHARGE OF PATIENTS REQUIRING MENTAL HEALTH ASSESSMENT AND/OR FOLLOW-UP

Patients who require a Mental Health Assessment should be considered as having complex needs and should be referred to the Complex Case Managers as early as possible.

A Mental Health assessment is seen as part of the MDT assessment and as such, where necessary, a patient would not be discharged until the assessment had taken place.

Where a patient is detained under any of the various sections of the Mental Health Act, thus preventing their discharge or legally allowing discharge to go ahead, arrangements will be made to liaise with mental health providers to facilitate the patient transfer to appropriate accommodation.

If the patient requires a mental health assessment in the Accident and Emergency Department, the same principles set out above will apply to patient transfer on completion of treatment.

There is currently a Mental Health Liaison Service within Lancashire Teaching Hospitals. **Appendix H** demonstrates the care pathway for patients within the Trust who are over 65 years of age and are in need of a mental health assessment and/or input.

8. DISCHARGE POLICIES FOR BABIES, CHILDREN AND YOUNG ADULTS (INCLUDING NNU DISCHARGE)

Click here for the Trust's Discharge Policy for Babies, Children and Young Adults.

Click Here for the Neonatal Unit (NNU) Discharge Procedure.

9. DISCHARGE TO COMMUNITY CARE

Under the Care Act 2014 there are obligations for NHS and social care partners in England relating to hospital discharge arrangements.

The Trust has a statutory duty to notify Social Services of a patient's *likely need* for community care services in order to be safely discharged. This is referred to as an assessment notification (formally known as Section 2 notification). The assessment notification should be submitted as soon as possible after admission to hospital when it is deemed that their needs or requirements upon discharge are unlikely to change. The assessment notification will also contain an anticipated discharge date.

Following an assessment notification Social Services have a minimum of 48hours in which to assess the patient **and** arrange services before a reimbursement charge (under certain circumstances) may be liable. **See Appendix B.**

Following assessment and multidisciplinary agreement to proceed with discharge, a discharge notification (formally known as section 5) gives notice on which it is proposed that the patient will be discharged and should be issued **at least** 24 hours prior to discharge to ensure that Social Services receive "fair warning of the intention to discharge".

A reimbursement charge may be requested by the Trust from Social Services if Social Services have not met their obligations to **assess or provide** social care services as set out in Appendix B. However, the payment is made only if the sole reason for delay in discharge is due to a delay in providing social services. If any element of the delay is related to NHS areas of responsibility, then reimbursement does not apply. (Delays in children's services are excluded because children i.e. under the age of 18 do not receive community care services under the Act).-

The Integrated Discharge Team manages this process and monitors activity and delays. All patients who require Social Services support must be referred to the t IDS

10. DELAYED DISCHARGES

When a patient is medically stable and deemed by the MDT as safe to transfer from acute care but is unable to transfer due to waits for provision of services, equipment or suitable accommodation then this patient is determined as a delayed discharge.

Under national SitRep guidance, a discharge may only be defined as delayed when all three criteria listed below have been met and the patient has not left the acute care setting.

a) The patient has been declared medically fit for discharge.

b) A multidisciplinary team assessment that includes social services, where appropriate, has been completed.

c) It is safe for patient to be discharged.

11. AUDIT

CQC risk management standards outline a number of minimum requirements and processes that need to be in place to promote safety and quality of a care in Acute Trusts in relation to managing the risks associated with the discharge of patients and the Trust must demonstrate the process for monitoring compliance with all of these requirements.

In accordance with CQC Risk Management Standards audits of compliance with key stages in the discharge process will be undertaken twice yearly.

The audit will cover three themes outlines below:

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
The Discharge requirements for all patients:					
Time of discharge	Sample will be 25 discharges from all Specialist Business Units across both Medicine and Surgical Divisions	Clinical Lead for the Integrated Discharge Service	Twice yearly ideally during Quarters 1 and 4	The results of the audit will be collated and presented to the Integrated Governance Committee for Diagnostics and Clinical Support for initial presentation and approval	
Transport arrangements					
TTOs (given and explained)					
Removal of all medical equipment					
Training and/or support for patients leaving with appropriate medical equipment					
Any patient information given					
Any ongoing care arrangements for the patient					
The information to be given to the receiving healthcare professional:					
A discharge summary	Sample will be 25 discharges from all Specialist Business Units across both Medicine and Surgical Divisions	Clinical Lead for the Integrated Discharge Service	Twice yearly ideally during Quarters 1 and 4	The results of the audit will be collated and presented to the Integrated Governance Committee for Diagnostics and Clinical Support for initial presentation and approval	
A Transfer of Care Summary for 24/7 Placements					
Infection Control information (if applicable					
The information to be given to the patient on discharge:					
A copy of the discharge summary	Sample will be 25 discharges from all	Clinical Lead for the Integrated Discharge	Twice yearly ideally during Quarters 1	The results of the audit will be collated and presented to the	
Patient information (new diagnosis					

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
only) Contact details for supporting professionals (if applicable)	Specialist Business Units across both Medicine and Surgical Divisions	Service	and 4	Integrated Governance Committee for Diagnostics and Clinical Support for initial presentation and approval	
Application of the Home of Choice Policy	Sample will be 25 discharges from all Specialist Business Units across both Medicine and Surgical Divisions requiring 24/7 placement	Clinical Lead for the Integrated Discharge Service	Twice yearly ideally during Quarters 1 and 4	The results of the audit will be collated and presented to the Integrated Governance Committee for Diagnostics and Clinical Support for initial presentation and approval	

12. COMMUNITY REHABILITATION SERVICES

If a patient requires on-going rehabilitation on discharge from Lancashire Teaching Hospitals, a referral should be made to either:

- The Rehabilitation Therapy Team, which is a single point of access for three community teams: Intermediate care, Community Domiciliary Rehabilitation, Physiotherapy and Community Falls teams or:
- The Community Neurological Rehabilitation Team for Stroke and Acquired Brain Injury patients.
-

Multidisciplinary assessments in hospital should provide community rehabilitation teams with the necessary information to commence the service and for the seamless transfer of services from the Acute to community sectors.

Patients must be medically fit for discharge to be considered for these services and *ready for transfer home or* to placement *with* the appropriate services aligned to these teams.

12.1 Intermediate Care Services

The Intermediate Care Rehabilitation Service is a partnership between *Lancashire Care Foundation Trust*, *Clinical Commissioning Group* and Lancashire Social Services Directorate and is provided for adult patients over the age of 18.

The aims of the service are:

- To prevent inappropriate admission to hospital and residential care
- To facilitate early discharge from hospital.
- To enable the client to reach their maximum potential and return to their own home.

12.2 Discharge to Intermediate Care services

Intermediate Care services are provided in residential units and / or in the clients' own home and are provided for an initial assessment period of 14 days, there after further rehabilitation up to 42 days, in some circumstances,. Therapists can refer directly to the Intermediate Care Teams by completion of the **Discharge to Assess referral form.**

The principles for discharge to assess to a patient's own home, or a residential unit are the same as for all patients being discharged.

- All patients being discharged to Intermediate Care should have a Discharge Checklist completed.
- Patients discharged to Intermediate Care must have discharge medication and a copy of the discharge letter to take with them as per usual for all patients.
- Equipment for mobilising **must** be transferred with the patient.
- Any equipment needed to care for the patient, such as pressure relieving equipment will need to be ordered in advance.
- All Patients should be discharged with 14 days of medication.
- All transfers to residential rehabilitation units should occur prior to 20.00hrs.

12.3 Community Neurological Rehabilitation Team

This team cover specialist areas of Stroke care and Acquired Brain Injury. They do not cover other neurological conditions, which need to be referred through the above rehabilitation services.
Involvement of the team in discharge planning should occur at the moment there is MDT consideration for discharge.

13. PROCEDURE FOR DISCHARGE OF PATIENTS

This procedure is for the guidance of hospital staff to ensure that prior to discharge proper arrangements are made to ensure the safety of patients returning to their own home or to an alternative care setting.

13.1 Discharge Planning Principles

- The aim is to encourage and restore independence in the home whenever possible or to facilitate the smooth transfer of the patient where this has been agreed, to alternative care in the community.

- All patients will be considered as to their eligibility for fully funded Continuing Health Care as per local policy.

- Patients may not be discharged from hospital without authority of the doctor holding medical responsibility for that patient unless this authority has been delegated to a nurse. In such cases a written procedure should be adhered to, so that the extent of that delegation is clearly understood by all concerned.

- Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with those others with the patient's consent.

- Where it is identified that the patient requires a needs assessment under the Care Act 2014, but would have substantial difficulty in engaging in the assessment and care planning process, the local authority must consider whether there is anyone appropriate who can support the individual to be fully involved. If there is not then the local authority must arrange for an independent Care Act advocate

- Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether or not to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care.

- Carers must be offered the information, training and support they need to provide care following discharge[1], including a carer's assessment.

- Where hospital staff are aware that a patient has on-going support in the community from a health or social care professional such as a District Nurse, this professional should be involved in discussions to support appropriate discharge arrangements.

- Documentation must be fully completed to ensure a permanent record of the discussions and arrangements made for the patients discharge and these should be recorded in the patient's notes.

- All patients will be given an Estimated Date of Discharge (EDD) within 24hrs of admission by a consultant or senior clinician. Regular review and discussion about the EDD as part of 'board rounds' will ensure all parties understand when support will be required to facilitate discharge. The EDD must be communicated to the patient (or family where appropriate)so they are able to make appropriate arrangements. In all circumstances referrals to appropriate departments (e.g. Social Services, O.T, Community Discharge planning team) should be made as soon as possible. This will enable departments to be able to assess the patient's needs and plan any necessary services/equipment by the discharge date.

- If the patient is in receipt of social care services or is thought likely to need such services, referral should be made as soon as possible to the Integrated Discharge Team using the Assessment Notice to Social Services Form (Appendix L).

- If the patient is a resident in an area, which has a community hospital e.g. Longridge, the patient will be assessed on admission or at pre-op assessment as to his / her need to access this facility upon discharge from hospital. Referrals can be made by phone directly to Longridge Hospital and they will advise if they can accept the patient before transfer can occur.

- A multidisciplinary approach to discharge planning is essential, allowing continued assessment of patients' nursing and social needs in order to identify any necessary on-going arrangements prior to discharge.

- The designated Registered Nurse is responsible for checking that the necessary action has been taken prior to discharge in respect of any services to be organised or personnel to be informed. Where appropriate the nurse discharging the patient should complete the Discharge Checklist, starting 24-48 hours before discharge with final checks to be made on the day of discharge. If necessary the designated nurse should delay discharge until arrangements are satisfactory.

[1] Care Act 2014 s10

- All patients must have a discharge checklist Click here for Discharge Checklist MS091 fully completed prior to discharge.

- Should the discharge be cancelled or postponed the nurse in charge must inform the next of kin/carer / all concerned parties and record this in the notes

- Special consideration will be given prior to discharge to ensure that all appropriate action has been taken where the patient may be considered to be at risk. The Safeguarding Adults Procedure or Policy and Procedure for Safeguarding Children should be utilised as necessary and appropriate.

13.2 Discharge Planning – Assessing the Patient's Needs

Pre-Admission

Ideally for elective admissions discussion between appropriate health professionals and patient and/or carers will outline the likely outcome, length of stay and potential difficulties for the patient on discharge, this will assist patients /families to make appropriate arrangements in a timely manner and/or identify a possible need for more complex discharge planning.

Community nursing staff and social services staff already in contact with the patient will be able to provide information regarding the patients' nursing and care needs.

In the case of Day Surgery (day case) patients, discussion and assessment should be made to identify the requirements for on-going care and transport on discharge prior to their operation/treatment.

Inpatients will be routinely notified that, unless there are exceptional circumstances, they will be discharged before 12 mid-day on the day of discharge, and will be transferred to the discharge lounge wherever possible.

Following Admission

The designated nurse will commence discharge planning on admission involving the patient and relatives / carers and ensure they are aware of the expected day of discharge (EDD) and make appropriate referrals to the relevant members of the multidisciplinary team where appropriate, to assess the patient's needs and determine if the patient is likely to require help on discharge. If the patient is already receiving social care within the community, is from a care home or is likely to require help on discharge they must be referred with the patients consent to the Integrated Discharge Team.

When a referral is made a member of the Integrated Discharge Service will make visits to the ward to complete an assessment and to discuss with the medical team, designated nurse, MDT and the patient and relatives, any support required.

Referrals to all professionals and other agencies must be documented on the multidisciplinary communication sheet and patient care plan and filed in the patient's case notes.

Assessment Process

This process requires health professionals – both hospital and community staff and other external agencies, to provide detailed information to support the individual assessment as part of the single assessment process.

The purpose of the assessment is to establish the persons' health and social care needs and their eligibility for services

To support the decision that a discharge is 'safe', an assessment by the multidisciplinary team of the patients' home circumstances and support available may be necessary and this will be completed as early as possible.

A home visit may be deemed to be necessary by therapists and community nursing staff so that appropriate aids, equipment or alternative accommodation is available upon discharge.

Home visits will be timetabled to ensure that assessment is made when the patients' optimum potential is known. For certain cases the discharge date will be dependent upon the services being available.

14. THE PATIENT'S HOME CIRCUMSTANCES

Following assessment by the appropriate personnel, any necessary adaptations to the accommodation should be undertaken to coincide with the planned discharge date.

If there is a delay in the long term adaptations being put into place, temporary arrangements should be initiated where possible in order to facilitate an appropriate place of care until the adaptations are available.

Issues concerning alternative accommodation should be referred to the Integrated Discharge Service including patients who are homeless or likely to become homeless (See Section 26.)

Arrangements for discharge must be made with reference to the estimated discharge date and ideally will be agreed with the patient and relatives / carers.

For adult patients with complex needs the Integrated Discharge Service will co-ordinate a range of assessment processes to meet the following circumstances: -

Where appropriate, aftercare support services will be arranged at home for people who are living alone, and / or who are frail and / or elderly, or live with an elderly carer, even if resident in sheltered / warden controlled accommodation where emergency cover is available.

Where an elderly and / or frail person living alone is returning to an empty house arrangements will be made to ensure that the house is fit for occupation, e.g. the house is warm and food is available.

15. THE PATIENTS' VIEW

The relevant health professionals will discuss with the patient and relatives / carers as soon as possible the expected date of discharge and any follow up arrangements and record these discussions within the patient's records.

Before they are finalised, arrangements for services will be discussed with members of the multidisciplinary team involved in the patients care, with the patient and relatives / carers.

Our patients' comments on their experience of our care and services are wholly valued by the Trust and patient experience feedback helps to shape our care delivery. Patients (or their advocates) being discharged from our care should be reminded by our staff of the opportunity to complete the Friends and Family Test and the current methods by which this is achieved.

For all discharges due regard must be taken of the cultural, religious and communication needs of the patient and carers.

16. DESIGNATED NURSE RESPONSIBILITIES

48hrs prior to discharge

Where appropriate 24- 48 hours prior to discharge the following should occur:

- All arrangements for discharge must be recorded within the patient's records.
- The nurse will inform the patient, relatives, carers or Nursing /Residential home of the date of discharge.
- The designated nurse will confirm the date and approximate time of discharge and any other relevant information with the patients and their relatives/carers and will ask them to ensure that the patient's outdoor clothes are brought in for the journey home.
- Unless there are exceptional circumstances, morning discharge should be arranged to occur prior to 12 midday and patients should be transferred to the Discharge Lounge where appropriate.
- The nurse will ensure the patient has the means to access their address.
- Transport arrangements should be identified and confirmed with Next of Kin / Carers.
- If ambulance transport is deemed medically necessary (see appendix G) then this will be booked giving as much notice as possible. Advance arrangements will need to be made for any special equipment to accompany the patient.
- The ambulance service must be informed if a relative or friend is to receive any patient who needs supervision.
- The nurse will ensure medication has been prescribed.

Day of Discharge

- Prior to discharge it should be confirmed that the patient is medically stable to be discharged.
- A check must be made to ensure that any medical equipment is removed if appropriate ie cannula
- A copy of the IHDI must be available for the patient to take home with them.
- The discharging nurse is responsible for ensuring the patient is referred to the District Nursing Team if required and the patient /carers are aware of when they have been asked to attend and for what purpose.
- A minimum of 7 days' supply of dressings /catheters bags etc. must be provided.
- From Monday to Friday 9 - 5pm medication counselling may be provided by the ward pharmacist prior to discharge. A check should be made and a record kept, that the patient understands the instructions and those relating to other on-going care arrangements (for out of hours see point 25).
- The designated nurse will ensure that take home medications, and a copy of the IHDI, are supplied to the patient. After care instructions, medication prescription forms (for example for the administration of insulin) should be given to the patient.
- When an outpatient appointment is necessary this will be organised by the hospital and the designated nurse will again ensure that patient receives the relevant details or is aware that an appointment is to be sent to them.
- The nurse must ensure that all arrangements for complex cases are in place to support the patient at home and the patient /carer understands these.
- The designated nurse will ensure that all patients' property is returned to the patient or relative / carer before discharge, including safe deposits or valuables and the relevant receipts retained.

- The designated nurse will ensure that where necessary the patient has the relevant medical certification signed to enable the patient to apply for social security benefits.
- The discharging nurse must ensure that the patient is given information (when appropriate) relating to:
- Contact details in the event of emerging symptoms which may require further clinical management.-
- Follow up arrangements for further investigations, if required.
- Follow up arrangements for reporting of any test results.
- Their expected recovery process.
- Any written information relating to their condition
- Any information either verbally or written information given to the patient /carer should be recorded within the patient's records
- If the patient is to be discharged late in the day, at the weekend or on a Bank Holiday, the designated nurse will ensure that arrangements are complete and, where required, support services are available in order that it is safe for the patient to be discharged.

17. DISCHARGE DOCUMENTATION

- The designated nurse will confirm the date and approximate time of discharge and any other relevant information with the patients and their relatives/carers (except prisoners; see section 18) and record within the patients records.
- The relevant member of the MDT will ensure that any referrals to other services are completed on discharge, using the approved referral documentation i.e. Macmillan Nurse, Diabetes Team, Physiotherapy etc, and will also ensure that this is recorded in the patient's medical records.
- A discharge summary (IHDI) will be given to all inpatients detailing all of the above points (as well as information relating to medication a copy of which will be kept in the case notes and a copy e-mailed to the patients' General Practitioner within 48 hours following discharge. **See Appendix E**
- The nurse discharging the patient will ensure that any extra written condition specific information will be given to the patient where indicated (e.g. care of a plaster cast) and this should be documented on the Discharge Checklist. Any verbal advice given should be recorded within the patient's medical records.
- A Discharge Checklist must be fully completed and signed by the nurse who has discharged the patient and stored within the medical records.
- For patients being discharged to a care home a 'Transfer to a Care Home' Form must be completed and sent with the patient. (See Appendix I and Section 19).

18. DISCHARGING PRISONERS

Click here for the Trust's Prisoners in Hospital Procedure.

In order to protect the personal working in hospitals and the patients attending it is important that the prisoner and family of the prisoner are **not** made aware of any admission, discharge or appointment times. It is vital that clinical staff link with the Prison Services who will act on the behalf of the patient.

When a prisoner is provided with an appointment or a letter for admission this should not be sent to the prisoner, but care of the appropriate prison health care systems.

Most prisoners will access the hospital and not have any on-going health needs and can return to the prison setting. A Discharge Checklist should be completed and medication / discharge letter arranged as for all patients but the Discharge letter should be given to accompanying personnel

from the Prison Service or sent to the prison. Under **no** circumstances should information be given to relatives or the patient concerning transfer dates or future appointment dates.

If the patient is a prisoner and has complex needs information relating to their on-going needs must be discussed with the health care centre at the prison. There is a Prison Liaison Nurse who can be contacted via the appropriate prison to discuss the patient's needs with.

All prisoners with complex needs must be referred to the Integrated Discharge Service who will help co-ordinate the discharge.

19. DISCHARGING PATIENTS TO NURSING OR RESIDENTIAL HOMES

Where the assessment process indicates the person is unable to return home with an appropriate package of care, or does not meet the criteria for Residential Intermediate Care and this is agreed with the patient and the family, then a Social Worker will assess whether a patient is eligible to be cared for in a residential or nursing home.

The Mental Capacity Act Deprivation of Liberty Safeguards introduce a standard process that hospitals must follow before they deprive a person of their liberty, or discharge a person to a care home that will constitute the deprivation of person's liberty. Please refer to the Joint Mental Capacity Policy and Procedure (found on the Trust intranet site) and the Mental Capacity Act and Deprivation of Liberty Safeguards Code(s) of Practice.

Where care is arranged in private residential or nursing homes the Social Worker will ensure that the patient, and where appropriate, their relatives or carers will be fully aware of the nature, purpose and likely consequences of the arrangement and that a health needs assessment is completed by the Community Discharge Planning Team to indicate whether the patient is eligible for NHS fully funded nursing care.

Under no circumstances should the nurse discharge a patient back to residential care without checking and documenting that further arrangements (including the agreement of Social Services funding where appropriate) are in place for the patient, and it is negligent to return a patient to a facility that does not meet the patients assessed care needs**.**

Even if the patient has previously been a resident in a care home or it is a new placement, in line with CQC requirements, the home manager should be invited to come into assess the patient to ensure they can still safely and effectively meet the patient's needs.

For all patients being discharged to care home placements the principles of discharge remain the same (See section 13). Patients should be encouraged to be discharged in their own clothes.

Care homes may stipulate that they are unable to accept patients after a specific time and consideration must be given to this if transport is required.

Under normal circumstances, patients should not be transferred to care homes after 9pm. However, under exceptional circumstances, such as severe capacity pressures, this may be unavoidable. If there is a need to discharge after 9pm, this should be discussed with the hospital site manager.

Patient's family/Next of Kin/Carers must be informed of the expected date of discharge prior to transfer and this should be recorded in the medical records.

Where a patient is discharged to a nursing home or residential, home they will be contacted by telephone by the designated nurse to confirm the suitability of the discharge and transfer arrangements. A Transfer to A Care Home Form will be sent with the patient giving information on

diagnosis, medication and care requirements including any condition specific information and arrangements if any for follow up. **See Appendix I.**

In the case of patients returning to residential homes or a rest home bed within a dual registered home who require nursing care, they must be referred to the Community Nursing Service by completing a District Nurse Referral Form see **Appendix K**

20. APPLYING ELIGIBILITY CRITERIA FOR CONTINUING HEALTH CARE

A Continuing Health Care Checklist should be completed in line with local protocol agreed by MLCSU LCC LTHT and LCFT for patients as follows :

- When a patient has been admitted from a care or nursing home - where their needs have changed
- When a patient is being newly transferred to a care or nursing home
- Where a patient's needs have changed & require support where existing services are unable to meet their needs
- Where a patient's relatives/carers request a checklist
- Where a patient's care needs indicate to the case manager or Social Worker that a checklist is required
- Where a patient is 'new' to services & care needs indicate to the case manager that a checklist is required.

Consent must be gained and the responsible nurse must explain to the patient/relatives that the process of check listing a patient does not automatically lead to eligibility for funding.
All patients who trigger for a full continuing health care multi-disciplinary meeting (CHC MDT) must be referred to the IDS.

21. NON EMERGENCY PATIENT TRANSPORT (PTS)

Ward staff are responsible for booking transport on behalf of patients who are eligibile. Transport must be only authorised on the basis of medical need. Before booking please:

- Avoid raising the patient's expectations – not everyone is eligible for PTS (see flowchart at Appendix G)
- Determine whether the patient has a medical or clinical need for transport
- Prior to making a booking, make sure you have the patient's details to hand
- Consider if the patient can use alternative transport i.e. family member or taxi
- Inform the patient when the transport has been booked and the estimated waiting times

North West Ambulance Service NHS Trust is responsible for acting on hospital transport bookings. Bookings can be made by telephoning NWAS directly on **0800 0323 240**

Or can be made using the NWAS On Line facility (if you do not have access to an on-line booking system but wish to make an enquiry about setting up this facility, please email NWAS at Pts.onlinereferrals@nwas.nhs.uk who will arrange this for you).

Liaison should occur between the designated nurse or delegated other and North West Ambulance Service. Any delay should be reported to the designated nurse who in turn will inform the relevant personnel and the patients' relatives / carers.

PTS discharges can be **pre-booked for collection between 8am and 8pm Monday to Friday and between 10am and 6pm Weekends and Bank Holidays.**

On the day PTS booking cut off times are 7.00pm Monday to Friday and **5pm at the Weekends and Bank Holidays –** Bookings should be planned well in advance of these times otherwise transport deadlines may be missed. Click here for more information around the NWAS booking guidelines for Lancashire

For patients in the Discharge Lounge, members of staff have the responsibility to contact the relatives prior to the patient getting into the ambulance to ensure that they are at home to receive the patient if this is appropriate.

If there are to be any charges for transport, e.g. of a private patient to a private care home, then the patient and / or relatives / carers will be informed as early as possible by those arranging the ambulance.

All patients awaiting discharge transport must be sent to the discharge lounge at the earliest opportunity on the day of discharge to maintain effective use of Trust capacity and to ensure that beds are available for new admissions. Children can be discharged via the discharge lounge if accompanied by an adult. The discharge lounge enables convenient access for private and ambulance transport.

Discharged patients who will be travelling by public or private transport, and who are in receipt of Income Support or Working Family Tax Credit, may be eligible for help with travel costs. These patients should be directed to the Hospital's General Office from where they will be advised where funding can be obtained. Financial support may also be available for adults accompanying minors.

22. COMMUNICATION DIFFICULTIES

Patients and their relatives/carers must be at the centre of the discharge planning process. Every effort should be made to ensure that arrangements are understood and documentation should reflect the discussions which have taken place and the efforts made to ensure the patient has been involved in the arrangements being made.

Any difficulties in communication due to impaired vision, hearing or language differences, and patients with memory problems etc. must be overcome where possible by using interpreters, specialist communicators or therapists. In these circumstances support can be sought from Language Line, whose contact details can be found in the Information for Patient Policy. Click here for the Information for Patients Procedure.

In these cases instructions or information will be given the patient on discharge in both verbal and written format. If other arrangements are necessary, access by the patient to the relevant information must be ensured.

23. DISCHARGE FROM ACCIDENT AND EMERGENCY DEPARTMENT, MEDICAL & SURGICAL ASSESSMENT UNITS

There must be recognition that a speedy assessment process will be required for people treated in the Accident and Emergency Department and on the assessment units.

Where patients do not require admission to hospital, but require therapy and/or social care support to enable a safe and supported discharge, they can be referred directly to the following services:

'Crisis Care' (Housing 21)
This is a service for patients in Preston, Chorley, South Ribble and West Lancashire that can provide immediate social care support for up to 72 consecutive hours. Verbal referrals can be

made via telephone (**0303 123 1161**). Housing 21 will make an onward referral to substantive social care services if required and referral to Rapid Assessment Service where appropriate.

Rapid Assessment Service

This is a service for patients with therapy (e.g. physiotherapy; occupational therapy) needs. The rapid assessment team will refer to Housing 21 if social support is also required.

5 days' supply of any necessary medication and/or 3 days' supply of any necessary dressings will be provided from the Accident and Emergency Department, surgical and medical assessment units. A discharge summary letter will be sent to the GP within 24hrs.

24. ASSESSMENT PROCESS FOR PATIENTS ADMITTED FROM ADDRESSES OUTSIDE LANCASHIRE

Where patients are not resident within the Lancashire County Council area, and ward staff identify that the patient may require support once discharged a referral can be made to the Integrated Discharge Service as for in area patients.

25. PROCEDURE FOR DISCHARGE OF PATIENTS OUT OF HOURS

Discharges facilitated outside of normal working hours should still adhere to all the principles of the discharge policy and procedure. The only exception to this would be in relation to the dispensing of medication. If there is sufficient and correct medication available on the ward (as indicated by the IHDI) 2 qualified nurses can check the prescription against the medication and discharge the patient. For further information please refer to the Trust Medication Policy. Click here for the Trust's Medicines Management Policy.

26.HOMELESSNESS AND HOUSING ADVICE SERVICES

If a patient is homeless or threatened with homelessness it is important that contact is made with the relevant authority as soon as possible. It may be possible to prevent homelessness arising by early intervention. If a patient is to be discharged and has no home to go to the Local Authority MAY owe a duty under the homelessness legislation

The Local Authority needs to be aware of the patients' homelessness as soon as possible in order that an assessment can be undertaken and the Local Authority can commence trying to find suitable temporary or permanent accommodation. The Local Authority often relies upon medical evidence when assessing whether or not a duty is owed. It would therefore be helpful if confirmation of a person's medical problem could be made available for them either to bring along to an interview, or give to a visiting officer if a visit is done while they are still in hospital. The patient must give his/her permission for this information to be divulged.

Homelessness and Housing Advice Contact Numbers

Preston City Council Housing Advice	01772 906412 / 906414 (Out of Hours 01772 904014)
Preston City Council Housing Benefits	01772 906900
Chorley Homelessness Officer	01257 515151 Out of Hours 515142
South Ribble Housing Needs Officers	01772 625371/625374 Out of Hours 01772 436 756
Independent Housing Advisor On admission	08000 3895810

On admission, ward staff should ask every patient for their address and whether this is the address they expect to return to

Ward staff should seek to ascertain if, prior to admission, the patient was:

- Staying in a hostel
- Staying in supported housing
- Staying in bed-and-breakfast accommodation
- Staying in accommodation secured under immigration legislation
- Staying with friends/relatives
- Sleeping rough
- Sofa surfing
- Threatened with homelessness within 28days

If the patient had accommodation prior to admission, ward staff should check whether the accommodation is at risk of being lost whilst the person is in hospital, and that the accommodation will still be appropriate on discharge.

If the patient is concerned about how their rent will be paid during their stay you can contact the Housing Benefit Department, each Local Authority will have their own. Contact details for Preston, Chorley & South Ribble are above.

If the patient will be unable to return to their accommodation or was homeless prior to admission, ward staff should first obtain the patient's consent to share information and then refer the patient the Complex Case Management Service.

The Complex Case Manager will need to contact the Housing Advice Service in the district in which the patient was living prior to admission by telephoning the local authority housing advice service.

Ward staff must notify the IDS of any patients who are homeless, likely to become homeless or who need advice regarding housing as early as possible.

NB. The local authority housing advice service will, in all cases, offer options to patients to prevent homelessness. It will provide temporary accommodation only in certain circumstances and only for certain groups of people who are deemed to be 'in priority need'. The housing advice service is not a landlord and cannot provide permanent accommodation

The local authority housing advice service will want to know:

- The patient's name and date of birth
- The reason for them being in hospital
- The admission date
- The proposed discharge date
- If any other agencies are involved such as:
    - District Nurse
    - Occupational Therapy
    - Adult Social Care

The local authority will also need to speak to the patient directly to confirm:

- Their status under homeless legislation
- Whether any prevention options are possible

The local authority housing advice service will inform the patient, the Ward Manager and Complex Case Manager of its decisions.

Homeless patients with care needs

Patients with social care needs should be referred to Adult Social Services for the appropriate assessment and referred to the Community Discharge Planning Team if they have any ongoing nursing needs.

Unplanned early discharges

If a potentially homeless patient self-discharges, the ward manager should inform the relevant local authority housing advice service by telephone at the earliest opportunity if they have reason to believe that the patient intends to present to the housing advice service. Relevant telephone numbers are detailed above.

Refusal of Accommodation

If after assessment by housing advice the patient refuses the offer of accommodation made then no further duty will be owed & the patient will have to make their own arrangements.

27. SELF- DISCHARGE/REFUSAL OF SERVICES

Adult patients have a right to refuse all or part of their proposed treatment and to discharge themselves from hospital with the exception of those patients who are detained under an appropriate section of the Mental Health Act 2007.

Following discharge, they also have the right to refuse to accept care.

Where a patient takes their own discharge against medical advice, or refuses services, this action must be recorded on the medical and nursing notes. It is important to document that any risks caused by self-discharge or refusal of services have been discussed and witnessed and this can be countersigned by the patient or, if the patient is not willing, another member of staff. **See Appendix J**

The designated nurse will ensure that all necessary discharge and follow up arrangements are in place as the patient permits.

- The patient's next of kin should be informed unless the patient does not give permission.
- The standard amount of discharge medication should be supplied if patient will wait for dispensing
- 7 days' supply of dressings/catheter bags etc. should be given to the patient from a ward
- The GP must be informed, and discharge summary completed as normal.
- Community Nursing Service informed if appropriate.
- If the patient is in receipt of Social Services they need to be informed.
- All discussions and arrangements must be documented in the patient's records.

The hospital will not provide transport for patients who discharge themselves against medical advice.

28. MAJOR INCIDENT

Hasty discharge may occur in the event of a major incident. Lancashire Teaching Hospitals NHS Foundation Trust will make every effort to ensure that the patient continues to receive appropriate supported care by contacting the patients GP and, if appropriate, community nurses and Social Services, to advise them of the discharge.

29. DISCHARGE INCIDENTS/PROBLEMS/COMPLAINTS/ADVERSE INCIDENTS/REFUSING DISCHARGE

It must always be the intention in the first instance to endeavour to resolve differences of opinion between professionals, agencies or with the patient/carer, at ward/departmental level; and that the referral upwards will only be made if the parameters of authority at the levels involved have been exhausted.

Levels of referrals are as follows: -

Stage 1	Sister / Charge Nurse +/- Discharge Assessment Nurse
Stage 2	Clinical Lead for the Integrated Discharge Service / Social Services Manager
Stage 3	General Manager / Social Services Manager
Stage 4	Chief Executive / Medical / Nursing Director / Director of Social Services

Complaints

The Trust, CCG, Ambulance Service and the Social Services Department each have their own formal complaints procedure, which must be applied, in the cases of persons wishing to make a formal complaint.

There may be occasions when a patient or relative has concerns regarding the discharge process which cant or isn't being resolved by the Integrated Discharge service , in which case they should be referred to the Patient Advise and Liaison Service (PALS) on 01772 522972 (Preston)/01257 247280 (Chorley) or by e-mail: PALS-preston@lthr.nhs.uk in the first instance. The office is also available to visit between the hours of 9am to 12.30pm and 1pm to 4pm Monday to Friday.

If the patient or relative wishes to appeal or make a formal complaint about any aspect of the discharge process, they should be directed to the Trust's Customer Care Department on 01772 522521 (Monday to Friday 9am to 5pm) e-mail customer.care@lthtr.nhs.uk

Adverse Incidents

In the event of an adverse incident, staff must follow the guidance outlined in the Trust's Reporting of Adverse Incidents Policy.

Refusing Discharge

If a patient is medically fit for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes.

Patients do not have the right to remain in hospital longer than required[2].

If a patient's preferred care placement or package of care on discharge is not available when they become medically fit for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

Please refer to the Policy for Supporting Patients' Choices to Avoid Delayed Discharge.

If the patient declines NHS treatment and a care or support package, they may be discharged from hospital In those circumstances they will be advised in advance of any discharge on the further NHS or social care support they may be able to access in the community and warned of the risks if they refuse such support

WOMEN'S HEALTH DIRECTORATE - TRANSFER PROCEDURE AFTER DELIVERY

Click here for Transfer of All Patients Common Core document (including Adult and Women's Health)

ASSESSMENT NOTIFICATION AND MINIMUM INTERVAL FOR PROVISION OF COMMUNITY CARE SERVICES (ADULT PATIENTS)

On receiving an assessment notice, the local authority must carry out a needs assessment of the patient and (where applicable) a carer's assessment so as to determine, in the first place, whether it considers that the patient and where applicable, carer has needs. If so, the local authority must then determine whether any of these identified needs meet the eligibility criteria and if so, then how it proposes to meet any (if at all) of those needs which meet the eligibility criteria. The local authority must inform the NHS of the outcome of its assessment and decisions.

The local authority must carry out a needs assessment and put in place any arrangements for meeting such needs that it proposes to meet in relation to a patient and, where applicable, carer, before "the relevant day". The relevant day is either the date upon which the NHS proposes to discharge the patient (as contained in the discharge notice – see below) or the minimum period, whichever is the later.

1. The minimum period by which the local authority must carry out its assessments and put in place any arrangements to meet care and support and carer's needs is 2 days after it has received an assessment notice.

2. Any assessment notice which is given after 2pm on any day is treated as being given on the following day.

3. Examples of these timescales are set out below:

- The NHS issue an assessment notice to the local authority at 1pm on Monday. The assessment notice must specify the date of the proposed discharge date. The earliest date which would be permitted is 2 days after the date the assessment notice is given (although a later proposed discharge date could be set out in the discharge notice.) This means that Wednesday would be the earliest day by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carer's services that it proposes to meet.
- The NHS issue an assessment notice to the local authority at 3pm on Monday. The assessment notice is treated as having been given on the following day, Tuesday. This would mean that Thursday would be the earliest day by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carer's services that it proposes to meet. Again, the assessment notice and later the discharge notice (see below) could set out a proposed discharge date after Thursday, in which case this would be the actual deadline by which the local authority would be required to have carried out the assessment and put in place any care and support and carer's service that is proposes to meet.

4. Timing of discharge notice

To ensure that a local authority receives fair advance warning of the discharge, the NHS body must issue a discharge notice indicating the date of the patient's proposed discharge. The minimum discharge notification allowed is at least one day before the proposed discharge date. Again, where the discharge notice is issued after 2pm, it will not be treated as having been served until the next day.

Taking the examples above:

- The NHS issue an assessment notice to the local authority at 1pm on Monday. The assessment notice must specify the date of the proposed discharge date. The earliest date which would be permitted is 2 days after the date the assessment notice is given (although the proposed discharge date can be later than this) i.e. Wednesday. This means the discharge notice must be issued no later than Tuesday.

- The NHS issue an assessment notice to the local authority at 3pm on Monday. The assessment notice is treated as having been given on the following day, Tuesday. This would mean that Thursday would be the earliest date by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carer's services that it proposes to meet. So, this means the discharge notice must be issued no later than Wednesday.

5. The NHS body can issue the discharge notification with a much longer period of advance warning if appropriate and it should continue to seek to provide the local authority with as much notice of the proposed discharge date as possible. However, it will need to consider the likelihood of such a date being inaccurate and then the potential need to withdraw and reissue the discharge notification in the event the patient's condition changes in the meantime.

6. The NHS body is required to inform the local authority, by way of a withdrawal notice withdrawing the discharge notice, when it considers that it is no longer likely to be safe to discharge the patient on the proposed discharge date for any reason other than the fact that it would be likely to be unsafe to discharge the patient because the local authority has not taken the require steps. So, for example, the NHS must inform the local authority of changes in circumstances affecting the discharge date, for instance if the patient's medical condition changes or the patient dies.

7. The NHS should also take into account the appropriateness of issuing the assessment and discharge notices too closely together, as this may result in extremely short time frames for local authorities to put in place what may be complex and comprehensive packages of care, which will also need to be subject to discussion with the patient and/or their carer.

Immediate Hospital Discharge Summary

Immediate Hospital Discharge Summary

Please turn over for drug treatment summary

Lancashire Teaching Hospitals NHS Foundation Trust

Copies: 1. Pharmacy		2. GP by fax then put in casenotes		3. Patient	
Chorley & South Ribble Hospital Chorley Tel No: 01257 261222	☐	Royal Preston Hospital Preston Tel No: 01772 716565		☒	

Clinical Speciality: **med**

Title:		Pharmacy check by:			Date:	
First name:		DOB:	Gender	Male ☐	Female ☐	
Patient surname:		NHS No:				
Previous surname:		Consultant:				
Patient address:		Ward:				
		Date of Admission:				
Post code:		Date of Discharge:				
Tel (daytime):		Type of admission:				
Tel (evening):		Emergency ☐	Elective ☐	Domiciliary ☐		
Mobile:		Via: GP ☐	Home ☐	A&E /Assess Unit ☐	OP ☐	
GP Name:		Transfer from:		Date :		
GP Address:		Services arranged and start dates				
		Care package	District nurse/HV			
GP Post Code:		Practice nurse	Treatment room			
GP Tel No:		Physio	Other			
GP Fax No:		Outpatient appointment	Weight:			

Diagnosis, Operations / Procedures (with dates):

Is patient aware of diagnosis: yes / no **y** Comments:

Treatment / inpatient management:

Outcomes / adverse reactions: Further advice to GP:

Pathology tests:			
Arranged investigations and dates		Dates:	
Signature:	Name	Grade:	Date

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Immediate Hospital Discharge Medication Summary

Title:	Discharge date:	Ward:
First name:		Consultant:
Patient surname:		Directorate: med
Patients Address:		Postcode
NHS No:	Pharmacy Signature:	

Allergies

Drug treatment (approved name)	Dose	Directions	Comments/Special Insts/ duration of treatment etc	Quantity Supplied	Date Supplied	Dispensed	Checked

Signature:	Name (Print):	Bleep:	Designation:	Date:	Chkd

Medicines discontinued or altered during hospital inpatient stay

Follow-Up Plan / Multidisciplinary Team Summary Information

Is an Emergency First Appointment required ?	**Yes** ☐	**No** ☐
If Yes has the definitive treatment been given already ?	**Yes** ☐	**No** ☐

DISCHARGE CHECKLIST to be completed at the point of discharge

NB: THIS COMPLETED FORM MUST BE STORED IN PATIENTS CASE NOTES

Patient Name: **Date of Birth:** **NHS (or hospital) Number:**	**Discharging Ward:**

Patient has been considered for the Discharge Lounge?	**Yes**	**No**	**Transferring to Discharge Lounge**
			☐

	Yes	No	N/A
If discharged to a residential/nursing home/Hospice has the Discharge Assessment Nurse (DAN) completed a Transfer of Care form?	☐	☐	☐

	Yes	No	N/A
Have arrangements for follow up care been confirmed with patient / family / carer and they are aware patient is being discharged?	☐	☐	☐
Specialist equipment in place (i.e. commode/pressure relieving equipment)?	☐	☐	☐
House keys / access to home available?	☐	☐	☐
Heating on and food available? (*any concerns refer to case management team)* *Discharge Lounge: Order snack box if required*	☐	☐	☐
Patient's valuables returned	☐	☐	☐
Patient changed into own clothes	☐	☐	☐
FIT note given	☐	☐	☐
Transport arranged? Please state type:	☐	☐	☐
Discharged on Quadramed	☐	☐	☐
Copy of GP letter / IHDI given to patient and copy in notes?	☐	☐	☐
GP letter sent to GP by: email / fax / post *(circle as necessary)*	☐	☐	☐
14 day supply of medications given & explained to the patient and/or carer?	☐	☐	☐
District Nurses / Practice Nurse form completed / sent / faxed? *(circle as necessary)*	☐	☐	☐
Any medication to be given by District Nurses needs an IHD1 form signed by the Doctor	☐	☐	☐
Insulin authorisation form completed	☐	☐	☐
Where required: Anticoagulant form completed / emailed as per protocol?	☐	☐	☐
Where required: Anticoagulant appointment made?	☐	☐	☐
Patient / carers given the opportunity to ask final questions?	☐	☐	☐
Prompt Friends & Family Test completion post discharge?	☐	☐	☐
Out-patient appointment **given / or to be sent** to the patient? (circle as appropriate)	☐	☐	☐
Are Ted stockings to be worn on discharge? (prescription given / duration advised ___days)	☐	☐	☐
Patients with NG / PEG feeds issued with community feedback booklet and 7 day supply of Feed / Syringes / Giving sets / PH Strips?	☐	☐	☐
Patients with wounds/catheter issued with 7 day supply of dressing/tape/catheter bags	☐	☐	☐
Dressings removed and wounds checked			
Check all cannulas have been removed	☐	☐	☐
'Critical care follow up clinic', informed of discharge (only for patients in Critical Care for 4 days or more)?	☐	☐	☐

Discharge Lounge leaflet given to patient? Yes / No
State any other written or verbal information given:

Discharging Nurse on Ward (please print name): Date: / /

Discharging Nurse – Discharge Lounge (please print name): Date: / /

DISCHARGE CHECKLIST **APPENDIX D**

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

DISCHARGE CHECKLIST to be completed at the point of discharge
NB: THIS COMPLETED FORM MUST BE STORED IN PATIENTS CASE NOTES

Patient Name: **Date of Birth:** **NHS (or hospital) Number:**	**Discharging Ward:**

Patient has been considered for the Discharge Lounge?	**Yes**	**No**	**Transferring to Discharge Lounge**
			☐

	Yes	No	N/A
If discharged to a residential/nursing home/Hospice has the Discharge Assessment Nurse (DAN) completed a Transfer of Care form?	☐	☐	☐

	Yes	No	N/A
Have arrangements for follow up care been confirmed with patient / family / carer and they are aware patient is being discharged?	☐	☐	☐
Specialist equipment in place (i.e. commode/pressure relieving equipment)?	☐	☐	☐
House keys / access to home available?	☐	☐	☐
Heating on and food available? (*any concerns refer to case management team)* *Discharge Lounge: Order snack box if required*	☐	☐	☐
Patient's valuables returned	☐	☐	☐
Patient changed into own clothes	☐	☐	☐
FIT note given	☐	☐	☐
Transport arranged? Please state type:	☐	☐	☐
Discharged on Quadramed	☐	☐	☐
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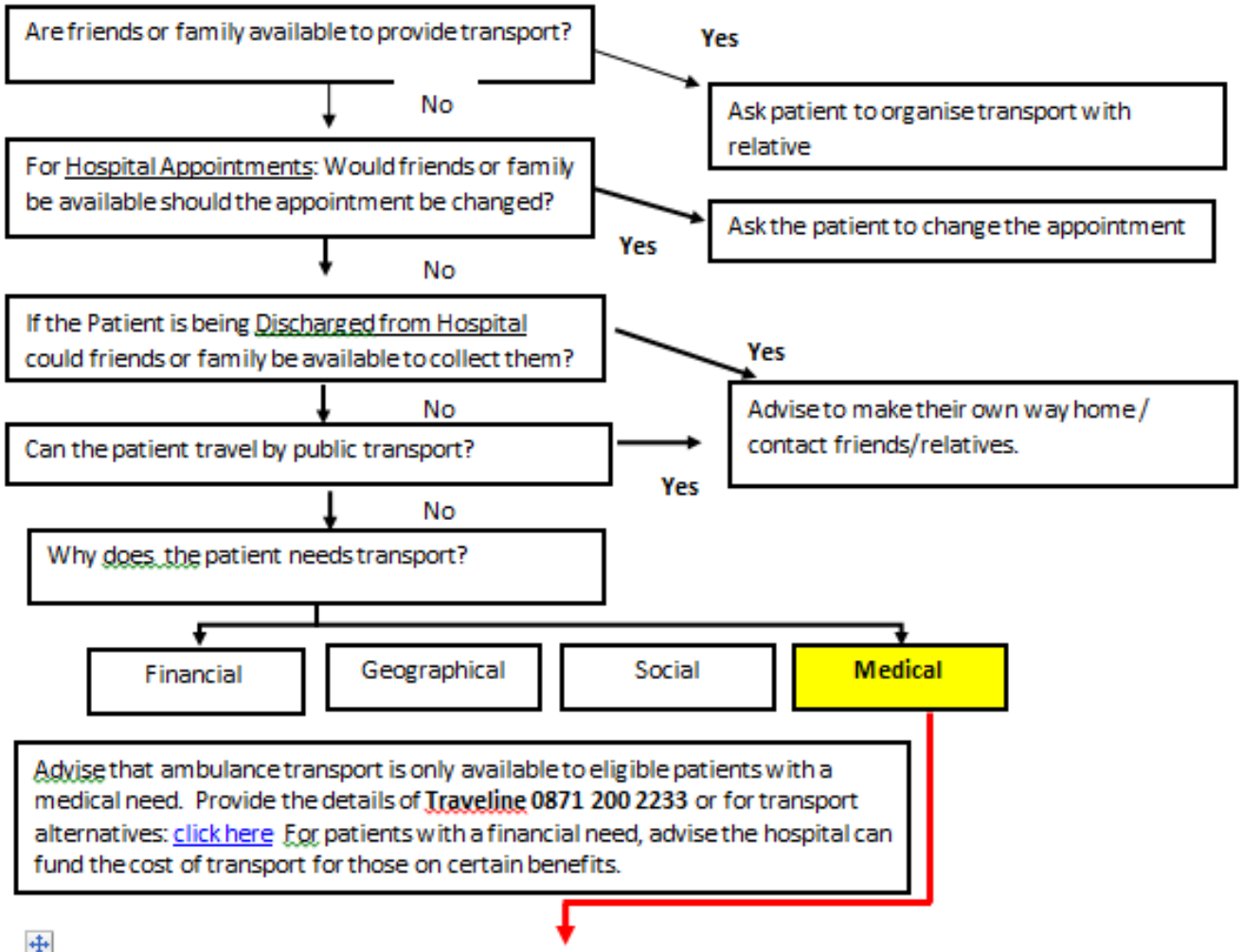
GP letter sent to GP by: email / fax / post *(circle as necessary)*	☐	☐	☐
14 day supply of medications given & explained to the patient and/or carer?	☐	☐	☐
District Nurses / Practice Nurse form completed / sent / faxed? *(circle as necessary)*	☐	☐	☐
Any medication to be given by District Nurses needs an IHD1 form signed by the Doctor	☐	☐	☐
Insulin authorisation form completed	☐	☐	☐
Where required: Anticoagulant form completed / emailed as per protocol?	☐	☐	☐
Where required: Anticoagulant appointment made?	☐	☐	☐
Patient / carers given the opportunity to ask final questions?	☐	☐	☐
Prompt Friends & Family Test completion post discharge?	☐	☐	☐
Out-patient appointment **given / or to be sent** to the patient? (circle as appropriate)	☐	☐	☐
Are Ted stockings to be worn on discharge? (prescription given / duration advised ___days)	☐	☐	☐
Patients with NG / PEG feeds issued with community feedback booklet and 7 day supply of Feed / Syringes / Giving sets / PH Strips?	☐	☐	☐
Patients with wounds/catheter issued with 7 day supply of dressing/tape/catheter bags	☐	☐	☐
Dressings removed and wounds checked			
Check all cannulas have been removed	☐	☐	☐
'Critical care follow up clinic', informed of discharge (only for patients in Critical Care for 4 days or more)?	☐	☐	☐

Discharge Lounge leaflet given to patient? Yes / No
State any other written or verbal information given:

Discharging Nurse on Ward (please print name): Date: / /

APPENDIX E

NON-EMERGENCY TRANSPORT ELIGIBILITY ASSESSMENT FLOW CHART



Assessment	Score	Description	Score
Mobility	0	Fully mobile	
	1	Partially mobile	
	2	Not mobile Requires oxygen therapy Making own way will affect condition Stretcher Mental Health / Learning Disability	
Side effects	0	No expected treatment or side effects	
	1	Minimal side effects, still able to use public transport	
	2	Major side effects, unable to use public transport or drive	
Escort		**Eligible for specific medical reasons only, e.g. patient confused, 24 hour care, travelling from a nursing home, under 16 or has learning difficulties.**	
TOTAL	**Score of 2 or above = Approve Request for Transport**		

APPENDIX F

PATHWAY FOR PATIENTS OVER THE AGE OF 65 WHO HAVE COMPLEX MENTAL HEALTH NEEDS

Central Lancs Older Adult Mental Health Hospital Liaison Service

RPH Monday-Sunday 8am-6pm

CDH Monday-Friday 8am-4pm

(RPH will cover CDH after 4pm, Weekends & BH's)

Central Lancs Older Adult Mental Health Hospital Liaison Service covers **Wards at RPH & CDH**

We **do not assess** patients in **A&E or EDU or Urgent Care** at RPH or CDH.

The A&E/Adult Liaison Team are commissioned and can be contacted by Bleep via switchboard

Has the Patient got a Mental Health need (Functional or Organic) that requires Assessment or is Presenting with Challenging Behaviour?

Or

Completion of CHC Domains 1-4 & Advice on Placement

Contact Mental Health Liaison Team for Advice:

RPH 523360 Mobile 07507853646

CDH 247292 Mobile 07507847336

Complete Referral Form

Intranet location: -information>manage stationary>printable forms>Mental Health referral for over 65

Please Complete **ALL** sections as fully as possible

Email to: Central.oamhl@lancashirecare.nhs.uk

Referral will be triaged by MHLT who will contact Referrer for further Information if necessary, gather collateral information from Mental Health Records & GP.

Referral will then be triaged by MHLT as either:

Urgent seen within 24 Hours

Routine seen within 72 Hours

Click here **for Transfer Form for Patients being Discharge to a Care Home.**

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

SELF DISCHARGE FORM

THIS FORM MUST BE COMPLETED EVEN IF THE PATIENT REFUSES TO SIGN

PART ONE (Staff)

I have discussed with the above patient/guardian the consequence of them taking their own discharge against medical advice and that it may place their health at serious risk.	Patient Label Name NHS Number
These risks may include the following:	

Name (Block Capitals):			
Title/Designation:			
Signed:		**Date:**	

PART TWO (Patient)

I, the undersigned, declare that I am taking my discharge at my own request and against medical advice.			
Name (Block Capitals):			
Signed:		**Date:**	

PART THREE (Witness)

I am witness to the above consultation.			
Name (Block Capitals):			
Signed:		**Date:**	

Any member of staff who may have concerns regarding the effect that this self-discharge has on this patient must contact a senior clinician and the consultant responsible for the patient at the earliest practicable opportunity.

Consent to Self Discharge CNST Standards 20.2.04

DISTRICT NURSE REFERRAL FORM - MANAGED STATIONERY REF MS115

Click here for District Nurse Referral form

APPENDIX J

Lancashire Teaching Hospitals
NHS Foundation Trust

Assessment Notice

Version 5.0	* indicates a required field
If the following apply – do not submit this form. • **Referral has been made to Community Therapy Services** • **Fast Track** • **CHC MDT to be arranged.***	
Does the patient require assistance with activities of daily living / personal /circumstantial difficulties, which are having a significant impact on well-being whilst on the ward? * **If no please do not submit a form**	
Hospital & Ward *	
Patient Name & address *	
Lives in own home, sheltered, or care home?*	
Date of Birth*	
NHS Number *	
G.P. Name and address*	
Referrer's name *	
Referrer's job title *	
Any Safeguarding concerns? *	

Reason for referral*	Eg/ Restart? Increased package of care, new placement? Please specify
Please provide a brief description of current needs *	Eg. Washing, dressing, toileting, mobility, overnight needs.
Is the patient in receipt of any existing services *	
Is this person known to Palliative Care team, oncology or renal? State which.*	
First language Is an interpreter required? *	
Are there any other communication issues? Please specify*	
Does the patient live alone? *	
Name and address of main carer if applicable.	(in case of emergency contact)
Does the patient have any caring responsibilities? *	
Date of admission *	
Consultant *	
Reason for admission *	
Diagnosis/Prognosis *	
Mental/physical health conditions or disabilities which have led to referral *	
Has this referral been discussed with the patient?*	
Have you contacted the preferred contact/NOK? *	Name and contact number of NOK
EDD (Expected Date of Discharge)*	

Patient considered for Continuing Health Care? *	

Please send this completed referral to IDS.referrals@lthtr.nhs.uk