The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Ref: FOI-072023-000194

Date: 11/7/23

Address / Email:

Dear

Request Under Freedom of Information Act 2000

Thank you for requesting information under the Freedom of Information Act 2000.

Request

My nan is currently an inpatient at Russell's Hall. She is soon to be discharged. Would it be possible to get a copy of the hospitals discharge policy please.

Response

Please find attached copy of discharge policy as requested.
Please note names have been redacted and where there are links to other Trust documents these with only work internally at the hospital and not outside of the hospital.

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ
Email: dgft.dpo@nhs.net

Should you disagree with the contents of our response to your appeal, you have the right to appeal to the Information Commissioners Office at.

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
www.ico.org.uk

If you require further clarification, please do not hesitate to contact us.

Yours sincerely

Freedom of Information Team
The Dudley Group NHS Foundation Trust

The Dudley Group
NHS Foundation Trust

DISCHARGE OF PATIENTS POLICY	DOCUMENT TITLE:	DISCHARGE OF PATIENTS POLICY
	Name of Originator/Author /Designation & Specialty:	[redacted] – Head of Patient Access and Discharge
	Director Lead:	Chief Operating Officer
	Target Audience:	All staff employed by the Trust involved in the process discharging and transferring patients.
	Version:	7.0
	Date of Final Ratification:	February 2022
	Name of Ratifying Director Lead/Sponsor:	[redacted] Operating Officer
	Review Date:	February 2025
	Registration Requirements Outcome Number(s) (CQC)	Safe; Caring; Effective; Well Led
	Relevant Documents /Legislation/Standards	Care Act 2014 Hospital Discharge and Community Support: Policy and Operating Model, HM Government 2021
	Contributors: ***Individuals involved in developing the document*.**	**Designation:** Deputy Head of Patient Access and Discharge General Manager ED, EAU and Capacity Assistant General Manager Acute Medicine Emergency Planning and Capacity Manager Deputy Divisional Chief Nurse, SWC Division
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
1	January 2005	New policy
2	December 2007	Minor amendments
3	October 2010	Minor amendments
4	October 2012	Reviewed to meet revised procedural presentation requirements and changes in reporting arrangements
5	April 2016	Amendments,& Appendix 5 & 6 added
6	December 2016	Full Review
6.1	February 2017	Amendments & Appendix 7, 8 & 9 added
7.0	January 2022	Full review and transfer to new template

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

1 Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

DISCHARGE OF PATIENTS POLICY

1 INTRODUCTION

The Dudley Group NHS Foundation Trust (DGNHSFT) recognises the need to facilitate a safe and seamless discharge from hospital to home or alternative care facilities. This policy provides a framework for Trust staff to enable the safe discharge of patients and is to be used in conjunction with the 2021 National Discharge document: Hospital Discharge and Community Support: Policy and Operating Model, which contains Hospital Discharge and Community Support: Staff Action Cards for the following staff roles:

- Medical Staff (Doctors)
- Matron, Ward Manager (Nurse-in-Charge)
- Acute Therapy Teams
- Bedded Rehabilitation (Therapies)
- Adult Social Care Team
- Local System Commissioners
- Managers of the Discharge Team
- Members of the Discharge Team
- Single Co-ordinators
- Case Managers
- Transfer of Care Hub

The policy is written in accordance with the Care Act 2014.

2 STATEMENT OF INTENT and /PURPOSE

The purpose of this policy is to set out the process and responsibilities of staff to support well-organised, safe and timely discharge for all patients. It aims to involve patients and their carers in the discharge process, and ensure that patients receive appropriate assessment, planning, and information about their discharge.

The intention of this policy is to:

- Avoid delays in the discharge or transfer of medically stable patients not requiring acute care.
- Involve the patient and family in the planning and implementation of discharge plans, taking into account the specific needs of the patient.
- Establish and maintain effective communication with patients, relatives and partner organisations.
- Work within the Adult and Children Safeguarding Policies and Guidance.
- Monitor the effectiveness of the discharge process, taking action to address shortfalls as required.

- Work in partnership with outside agencies i.e. community services, social services and independent providers to ensure timely and effective discharge.

The Trust has separate guidelines for Maternity, Neonatal and Emergency Paediatric discharges. These are specialty specific and are not outlined in this policy (refer to Maternity Unit Discharge Guideline and Discharge Management from the Neonatal Unit Guideline and Paediatric Advice, Admission and Discharge Emergency Department Guideline)

This policy applies to all staff employed by The Dudley Group NHS Foundation Trust involved in the process of discharging patients.

3 DEFINITIONS

ADT: Admission, Discharge, Transfer (electronic)

Complex Discharge: Relates to patients who have complex ongoing health and social care needs which require detailed assessment, planning, and delivery by the MDT and other multi-agency working, and whose length of stay in hospital is more difficult to predict.

Discharge Lounge: Is a comfortable unit for patients to wait for transport home or TTOs. The Discharge Lounge is open from 0800-2030 Monday to Friday.

EDD (Estimated Discharge Date): A target discharge date to which all agencies can work to whilst recognising that the date may change according to the patient's condition/medical status.

MDT (Multidisciplinary Team): includes nurses, medical staff, occupational therapy professionals, physiotherapists, social workers, discharge co-ordinators, speech and language therapists, and dietetics.

Out of Hours Discharge: A discharge that takes place after 18:00 hours and before 08:00 hours Monday to Sunday.

Patient (Adult): A patient who is 18 years of age or older

Patient (Child): A patient who is less than 18 years of age

SAP: Single Assessment Process-Transfer of Care Document

Simple Discharge: Patients who will usually be discharged to their own home and have simple on-going care needs which do not require complex planning and delivery.

TTOs: Tablets to Take Out

4 DUTIES (RESPONSIBILITIES)

4.1 The Trust Board

The Trust Board is responsible for ensuring there is a policy, which ensures the Trust meets their statutory obligations in respect of discharging patients from hospital.

4.2 Chief Executive Officer

The Chief Executive Officer is responsible for ensuring that appropriate arrangements are in place for discharge of patients from hospital.

4.3 Director Lead

The Director Lead is responsible for advising the Chief Executive and Trust Board on matters of Policy and trust performance in relation to this policy.

4.4 Line Managers

Line Managers (including Senior Managers) are responsible for implementing this policy in their areas and monitoring its compliance, ensuring all staff are aware of their roles and responsibilities.

4.5 Lead Nurses

Lead nurses are responsible for compliance with this policy and the initiation of discharge planning from admission and throughout the patient care pathway. They are responsible to ensure effective communication; make timely referrals in the Multidisciplinary Team to support the discharge process; identifying patients who can be discharged in time to be 'Home for Lunch' that day.

4.6 Multidisciplinary Team

The Multidisciplinary Team (including Occupational Therapists, Physiotherapists, Social Workers, Pharmacists, Dieticians) are responsible for implementing this policy, and to provide a seamless service though effective communication and team working in order to facilitate a safe discharge.

4.7 Medical Staff

Medical staff are responsible to comply with this policy, review patients regularly, and inform ward staff when a patient is medically fit for discharge; complete TTOs 24 hours prior to discharge where discharge is anticipated the next day.

4.8 Discharge Co-ordinator Team

The Discharge Co-ordinator Team are responsible to provide specialist advice and support to wards and the MDT team on complex hospital discharges.

4.9 Ward clerk

The ward clerk will review the discharge summary and patient notes on discharge to ensure any diagnostics or appointments have been arranged after discharge.

5 PROCESS

Effective discharge planning and the avoidance of delays or errors in discharge must be a priority for all staff. As soon as the acute phase of care is completed, the

patient is medically stable and functionally optimised. Patients, including those whose period of rehabilitation is completed, or can be provided elsewhere, should be discharged from acute hospital beds in a timely and safe manner to their interim/other or final destination.

Further guidance on the right to reside in an NHS Trust can be found in the Hospital Discharge and Community Support: Policy and Operating Model, Annex A: Criteria to Reside - Maintaining good decision making in acute setting (page 35)

If a discharge / transfer of care cannot be achieved for whatever reason the patient will be offered a placement in an interim setting which the Multi-Disciplinary Team deem appropriate to meet the needs of the patient from the time of discharge until the permanent destination is ready.

The following provides an over view of the discharge process. **Appendix 2** outlines the role specific responsibilities for this process.

5.1 ON ADMISSION

5.1.1 Discharge planning must start on admission (or pre-assessment) - at the first patient contact.

5.1.2 On admission or at pre-assessment clinic all patients will require a base-line assessment of their physical and social circumstances, providing their condition allows. This is reviewed throughout the patient's episode of care.

5.1.3 The nursing staff will ensure the Trust 'Patient Welcome and Discharge booklet' or a copy of the NHS discharge letter is given to a patient. In this letter is a section regarding discharge planning which encourages patients and their relatives to highlight as early as possible in their stay any actual or anticipated problems regarding discharge from hospital.

5.1.4 A member of the medical team/senior nurse will estimate a discharge date and discuss details and support required after discharge with the patient and/or carers at the earliest opportunity.

5.1.5 The patient, family and carers will be made aware of the discharge protocol from admission. The MDT will ensure that good communication and involvement is maintained throughout the process of discharge planning.

5.1.6 For patients admitted for day surgery/treatment, the predicted date of discharge will be given as the same day unless the patients post procedure condition requires an inpatient stay.

5.2 DISCHARGE PLANNING

5.2.1 To support discharge planning, the involvement of appropriate agencies, for example interpreting and advocacy services, is integral (if required). This will be facilitated through the nurse responsible for the discharge.

5.2.2 Registered Nurses will complete the assessment, planning and implementation of the uncomplicated discharge of patients not requiring the involvement of multi-agency services/MDT. Please refer to **Appendix 2** for more detail of a Registered Nurses role in discharge planning

5.2.3 If the patient is a complex discharge the registered nurse will refer the patient to the Discharge Co-ordinator Team.

5.2.4 The registered nurse will initiate referrals to members of the MDT for further specialised assessments as indicated by the medical condition/treatment or base line assessment of discharge needs.
Patients must give permission before referrals to other agencies are made e.g. social services. Patients have a right to refuse referral.

Please note: if a referral is made to Social Services they must be informed of the estimated discharge date. If the patient is known to social services and has an existing care package they must be informed when services need to be reinstated.

5.2.5 All assessments will be reviewed daily and updated as necessary.

5.2.6 Whiteboard meetings will be held daily to discuss the patient's progress and to review the patients' future care needs. Patient Goal Planning will be agreed and involve all relevant disciplines and agencies. The Patient Status at a Glance white board will be up-dated accordingly.

5.2.7 TTOs will be prescribed and ordered the day before discharge. For same day discharges the TTOs will be prioritised and identified as 'ring when ready – for discharge'. This will assist pharmacy with order of work load.

5.2.8 A member of the medical team will complete a discharge summary for the patient and GP including details of the in-patient episode, on-going treatment, medication and out-patient follow-ups.

5.2.9 Procedures relating to the safe-guarding of adults and children will be followed (refer to the Safeguarding Children Policy). If a patient has been referred for assessment within the terms of these policies, procedures for the protection of the patient will take precedent.

5.3 HOME FOR LUNCH

5.3.1 This scheme focuses efforts to plan a safe and effective patient discharge that will increase the number of patients discharged before noon.

5.3.2 Staff will plan a patient's discharge as soon as the patient is admitted (discharge on admission).

5.3.3 Ward staff will identify suitable patients as 'Home for Lunch' discharges on the ward the day before as part of the daily whiteboard patient review.

5.3.4 Medical staff will complete TTO requests the day before discharge.

5.3.5 Ward clerks will book ambulance transport the day before the expected date of discharge.

5.3.6 Patients identified as 'Home for Lunch' discharges will be transferred to the Discharge Lounge on morning of discharge.

5.3.7 Unless a new, acute problem arises, Medical staff will refrain from requesting unnecessary or last minute tests. If tests are necessary but non-urgent, these will be requested to be done at an out-patient appointment.

5.4 DISCHARGE REQUIREMENTS FOR ALL PATIENTS

5.4.1 The discharge of vulnerable patients will be discussed with community nursing services, and social services prior to discharge in order to ensure that services are/will be in place.

5.4.2 Transport arrangements will be made as soon as the discharge date is agreed ensuring relative/carers are informed. Suitable provision must be made to transport the patient to their discharge destination, taking into account of the patient's current mobility needs.
Hospital transport will only be provided when other options are deemed inappropriate and the patient is eligible for hospital transport (refer to **Appendix 4** for eligibility criteria and **Appendix 5** for transport process).

If the patient is being collected by a relative/carer the arrangements will be confirmed with the collector and the date and time confirmed.

5.4.3 Ensure suitable clothing is available for discharge.

5.4.4 TTOs will be given to the patient/carer. Please refer to section 10 for further information on how a patient's medicines are managed on discharge.

5.4.5 Any valuables which have been stored in the hospital safe are returned prior to discharge in accordance with Trust policy.

5.4.6 A written discharge letter, and condition specific patient discharge information (if applicable), in addition to a verbal explanation will be given to the patient. These will outline their medical condition/treatment, follow-up care and recuperation. Refer to section 5.6 for further guidance. Outpatient diagnostics will be booked by the doctors requesting the investigation. Ward clerks will review the discharge summary and patient notes on discharge to book appointments. If there

is any investigation suggested that has not yet been booked the ward clerk will email the Consultants secretary to ensure it is booked and the patient informed.

5.4.7 Staff must ensure that information about infections and any particular care needs relating to those infections and their control are communicated when a patient is discharged home or moves to another care setting e.g. community nurse, GP, nursing home, social services.

5.4.8 All adult patients awaiting discharge will be transferred to the Discharge Lounge to await discharge or transfer. The exceptions are patients with infection control issues confused or nursed in bed.

5.5 DISCHARGE FROM CHILDREN'S IN-PATIENT AREAS

5.5.1 Discharge planning must begin on admission with a multi-professional and family involvement focus, to ensure all needs are met. The focus of discharge planning is always that the safety and developmental needs of the child are maintained on discharge, supported by and giving support to those with whom they live.

5.5.2 The general processes of the Trust apply equally to children as adults. However, specific community services exist for the on-going support of children requiring on-going care. These include:

- Community children's services – medical and development
- Peripatetic and school based educational services
- Child and adolescent mental health services (CAMHS)
- Health visiting
- Community children's nursing/dental teams
- Social Services children's team

5.5.3 Communication with all relevant services must be documented.

5.5.4 Discharge can only be facilitated once there is agreement of the MDT that the child is medically fit for discharge and that their on-going health needs can be met in the community.

5.5.5 Children for whom there are safeguarding concerns (see Safeguarding Children Policy) can only be discharged by the paediatric consultant or registrar in charge of the child's episode of care. A decision to discharge the child must be documented in the medical and nursing notes along with any plan for follow-up after discharge. The discharge must also include input from any other services (internal and external) that are involved in the care of the child.

5.5.6 When children are discharged it is essential that the parents/carers are fully aware and informed of what they can expect when the child gets home. The parents/carers will be informed if a referral to the Children's Ward Community Team

for follow up has been made. Available and applicable advice leaflets will be given to the child or parent/carer at the time of discharge.

5.5.7 If TTOs are required, then advice must be given to parents/carers on the duration, frequency and possible side effects of the medication.

A discharge summary letter will be produced and a copy must be given to the parent/carer prior to discharge. A further copy will be sent to the child's GP to advise them of the admission.

5.6 INFORMATION TO BE GIVEN TO PATIENTS, AND/OR CARERS FOR DISCHARGE

The patient and carer/s are central to discharge planning and must be kept involved and informed at all stages of the discharge process; the following information will be given prior to and on discharge:

- Written information on medications (TTOs) required on discharge and their side effects. This information will also be provided verbally.
- Information, both verbal and written (Patient information leaflet/letter), about the patient's recovery at home in relation to their procedure/condition, signs and symptoms to observe for. The patient/carers level of understanding must be checked.
- Information on life-style and diet (if appropriate) to medical condition/treatment.
- How to access on-going advice, support and help-line numbers.
- A copy of the electronic discharge summary.
- Information including the date, time and any special requirements for any follow-up appointments.
- The Transfer of Care Document (SAP) is to be completed (with copy retained in notes) and given to all patients who:
    - Require Community/ Practice or District Nurse input,
    - Currently hold a SAP, document Require an over 70s observation visit (patients with Dudley GP only)
    - Already receive a Social Service package of care
    - Already receive a community therapy input (including specialist therapy)
    - Are assessed as being vulnerable adults
    - Attend Day Centres or receive Meals on Wheels
    - Require referral to Community Infection Control Team

5.7 INFORMATION TO BE GIVEN TO THE RECEIVING HEALTHCARE PROFESSIONAL ON DISCHARGE

- An electronic copy of the discharge summary, and medications provided will be automatically sent through to the patients General Practitioner.
- The community nursing team (if applicable) will receive the SAP document detailing the patient's care requirements.
- If the patient is being discharged to a nursing or residential home a discharge letter will be provided.
- Verbal and written information of any medication they are being discharged with including the reason for taking the medication, dose/frequency to take and side effects
- A record must be made in the patient's medical records of discharge information given this will include:
  - A copy of the electronic discharge letter
  - A copy of any transfer letters
- Documentation in nursing/medical records - Medical and nursing staff must clearly document any verbal or written advice that has been given to the patient on discharge in relation to their care, treatment and medication.

5.8 MEDICINES MANAGEMENT FOR A PATIENT DISCHARGE

Refer to Medicines Management Policy

5.8.1 Medical staff will:

- Ensure that the patient's medication is updated and ordered through the electronic prescribing system.

- Ensure take home medication (TTOs) will be prescribed at least 24 hours prior to the planned discharge date

- Ensure the supply of TTOs is for a minimum of 10 days (normally 28 days' supply will be issued). Surgical Dressings and dietetic supplies will be supplied for 7 days.

- Ensure TTOs are not prescribed when a patient has a supply of their medicine (with no dose changes) at home – this will be documented on the discharge letter.

- When the patient is discharged, record details of the inpatient episode and ongoing treatment in the electronic discharge and prescription letter.

5.8.2 Nursing staff will:

- Check the TTOs against the discharge prescription; this may be done by either the ward nurse or Discharge Lounge nurse. This will be repeated as the patient is discharged. Information about these medications including dosage and storage instructions will be discussed with the patient. (refer to Checking Medicines to Take Home by Nursing Staff SOP)

- Return any medication brought into hospital by the patient.

- TTOs will be explained to the patient or carer, and must not be sent by taxi.

5.9 DISCHARGE OUT OF HOURS

It is safe practice to discharge patients as early as possible during daylight hours. However, at times this is not possible due to late decision making, late treatment/procedures being undertaken or patient choice, the process for discharge is the same as outlined above with the same responsibilities and requirements.

- Where possible all agencies (including GP's and District Nurses), relatives and carers will be contacted during working hours to inform them of discharge plans. If this is not possible, then this should be completed as soon as normal hours resume.

- If an agency/carer cannot be contacted to inform of the late discharge the safety of the patient if the discharge goes ahead must be reviewed by the lead nurse/medical team. If there is any doubt as to the safety of the discharge then it must be delayed until the following day or contact can be made. It is the responsibility of the nurse in charge to ensure this occurs.

5.10 ADDITIONAL DISCHARGE CONSIDERATIONS

5.10.1 Self Discharge (Adults/Children)

In the event that patients or parents/carers of children decide to leave hospital despite being advised that continued admission to hospital is recommended, the following documents provide guidance for staff of the actions to be taken.

- Discharge against medical advice (Adults) (DAMA) policy.
- Discharge against medical advice (Paediatrics and Neonates) policy.
- Safeguarding Children Policy.

5.10.2 Delayed Discharge

A patient may be considered fit for discharge but awaiting further input from agencies; there are a number of reasons a patient may be declared a delayed discharge. These patients are monitored by the Discharge Co-ordinator Team and daily intervention is required and reported via Capacity Meetings.

In the event that a patient's delayed discharge is due to refusal of advised care, Lead Nurses and Discharge Co-ordinators will make every effort to explain the reasons behind the planned care option. In the event that the patient refuses to accept the planned discharge or transfer, the Matron will talk to the patient and issue the Final Discharge Patient Letter.

5.10.3 Infection Control

The discharge of any patient with known or suspected communicable diseases will be co-ordinated with advice from the Infection Control Team. All relevant information will be documented accurately on Transfer of Care Document within the Transfer and handover of patient care policy.

5.10.4 Patients under the Mental Health Act

Mental Health Act support and advice, via telephone, regarding use of the Act can be gained from:

- The Mental Health Act Administrator at Bushy Fields Hospital (during working hours via switchboard)
- The Trust Older People Mental Health team between 08:00hrs – 16:00hrs via bleep 8959
- The Senior Nurse at Bushy Fields Hospital can advise at any other time via switchboard.

5.10.5 Discharge on ADT system

Admissions, discharges or transfers should be updated on ADT within 30 minutes of a move. Discharges from ward areas will be within 30 minutes of leaving the ward unless they go to the discharge lounge. Patients going home from the lounge will not be discharged until they leave this area.
Patients sat out to use the bed for an acute admission will not be discharged on ADT until the patient leaves the ward.

5.10.6 Capacity planning

Capacity meetings are carried out at 09:00hrs, 12:00hrs, 15:00hrs, 17:00hrs & 21:00hrs. These meetings are attended by senior staff in the Trust who will plan for the day (and night ahead) using current activity within the Trust, bed availability and definite and potential discharges, alongside the action cards appropriate to their role to ensure every required intervention/action has been taken.

The capacity manager and the matron for the Directorate, alongside the Clinical Site Coordinator will review the potential discharges to ensure that they are only added if they are assessed as very likely to go. Any weak potential discharges will be followed up by the directorate matron but not relied upon for the plan. The Clinical Site manager will review all definite and potential discharges after the 12:00hrs

meeting to escalate any problems that can be dealt with to ensure these patients are discharged.

The Clinical Site Manager will check that staff have completed the actions detailed in the action cards at each meeting, escalating to the capacity manager and matron for the directorate where outstanding actions exist.

Where compliance with action cards continues, this will be escalated to the Deputy Chief Operating Officer/ Chief Operating Officer.

5.11 OUTLIERS

Whilst it is accepted that the placing of patients in beds appropriate to their clinical condition is the ideal way to manage care, there will inevitably be times when this cannot happen because of excessive capacity pressures.

5.11.1 At such times it is essential that clinical teams work together to identify the most appropriate patients who can be out lied to ensure that acutely ill patients can be nursed within suitable clinical areas. In the main this will affect the outlying of medical and trauma patients to surgical wards.

5.11.2 Patients who have been assessed as medically fit will automatically be identified as suitable to be transferred out of their host ward; and in the event that the outlying of patients becomes necessary, these patients will be moved into empty beds (usually on surgical wards). In addition it is the responsibility of Medical staff to ensure that:

- Appropriate patients within medical and trauma wards are identified as suitable for outlying in the event that acutely ill patients from ED or EAU need to be accommodated into specialist areas.

- Patients who are not suitable for outlying have this clearly documented in the medical records, together with the reason, so that in the event that this situation has to be reassessed in response to more critical capacity pressures, all staff understand the issues associated with the assessment of individual patients.

- All patients not deemed as medically fit are assessed on a daily basis by a senior doctor at Registrar level or above.

- In response to critical capacity pressures, patients are re-assessed to identify patients suitable for discharge or for outlying in line with the Medical Outliers Management Policy.

6 TRAINING/SUPPORT

All graduate nurses appointed to the Trust attend training on discharge planning during the Graduate Nurse Induction Programme. This encompasses theory taught

in the classroom setting competency assessment in the work place of their ability to discharge.

In addition for individuals who require additional training, or a refresher 1:1 training, advice and support is offered by the Discharge Co-ordinator Team and the Intermediate Care Team.

7 PROCESS FOR MONITORING COMPLIANCE

Monitoring of Compliance Chart

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Duties of key staff	Line Managers	Undertaken through the appraisal process	Annually	Through the appraisal process and documentation.	Line managers Clinical Directors	Through staff meeting Individual discussions with staff involved in the discharge planning process.
Compliance to • Discharge requirements • Documentation to accompany the patients discharge • Information given to the patient • Process for out of hours discharge	Matron/ Lead Nurse	Electronic Incident Database (DATIX)	Monthly	Monthly review at Directorate risk Management Meetings if identified as a trend or area of concern from incidents reported	Consider, challenge and monitor areas of poor compliance Identifying leads to take actions forward.	Feed back to department by the Matron and Lead Nurse
Process for out of hours discharge	Complaints Team	Complaint handling and resolution.	On-going	Trends identified. Raised at Directorate Risk Management Meeting.	Consider, challenge and monitor areas of poor compliance Identifying leads to take actions forward	Issues identified will be communicated via Quality and Risk Management meetings
Discharge requirements	Information Department	Information Department	Monthly	Joint DGNHS FT/PCT quality meeting	Consider, challenge and monitor areas of poor compliance Identifying leads to take actions forward	Issues identified will be communicated via the Quality meeting
Documentation to accompany the patient on discharge	Information Department	Information Department	Monthly	Joint DGNHS FT/PCT quality meeting	Consider, challenge and monitor areas of poor compliance Identifying leads to take actions forward	Issues identified will be communicated via the Quality meeting by Matrons and Line Managers

8 EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

9 REFERENCES

Care Act 2014. London: HMSO https://www.legislation.gov.uk/ukpga/2014/23/contents [Accessed 7 December 2021]

HM Government. (2021) Hospital Discharge and Community Support. Policy and Operating Model. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1026672/hospital-discharge-and-community-support-policy-and-operating-model-oct-2021.pdf [Accessed 25/11/2021]

10 APPENDICES

Appendix 1

The Trust bases its operational discharge procedures on the following national document:

Hospital Discharge and Community Support: Policy and Operating Model.

Click the link above to review the most up to date version.

Appendix 2

DISCHARGE REQUIREMENTS SPECIFIC TO EACH PATIENT GROUP

Action cards for individual staff groups should be used in conjunction with these requirements

1. ADULT PATIENTS

1.1 Medical Staff

- Will inform both the patient and ward nursing staff when the patient is medically fit for discharge and will record this information clearly in the patient record.
- Will, when the patient is discharged, record details of the inpatient episode and ongoing treatment in the electronic discharge and prescription letter.
- Will ensure that patients are reviewed on the day of discharge unless a discharge plan has been agreed and the Consultant has delegated the responsibility of discharge to nursing staff.
- Will document Infection control risks and precautions on the discharge letter. The Infection Control Team will be actively involved with the discharge of these patients. Further advice is available from the Infection Control Team.
- Will request any outpatient diagnostic tests and specify when follow up is required.

1.2 Ward Nurse and Nurse in Charge

- Will commence a discharge plan and then co-ordinate the referral to and assessment by the multidisciplinary team, if appropriate. To oversee the updating and review of the document.
- Will ensure The Patient Welcome and Discharge booklet is handed to patients on admission by the admitting nurse. There is a section regarding discharge planning and it encourages patients and their relatives to highlight as early as possible in their stay if they think there may be problems regarding discharge from hospital.
- Will ensure patient discharges are facilitated as quickly as possible reflecting clinical need
- Will be responsible for ensuring the electronic Admission Discharge Transfer (ADT) is updated within 30 minutes of any patient admission, discharge or transfer
- A discharge will not be added to capacity meetings until ADT is up to date. If a patient has sat out to release the bed but is not moved to the Discharge lounge, the discharge is not added.
- Discharges in the Discharge lounge are not added to the ward they were discharged from until they leave the Trust and are on ADT as a discharge.
- Will ensure white boards display accurate and up to date patient information
- Will be responsible for informing the capacity team immediately that a bed is available, once the discharge of a patient has been agreed.
- Will ensure that empty beds and surrounding areas are appropriately cleaned and prepared in a timely manner in preparation for the next patient
- Will ensure that outliers are repatriated as appropriate to their host ward as quickly as possible

- Will ensure that patients within Medical and Trauma wards are identified as suitable outliers, in the event that patients need to be moved in the interests of more acutely ill patients.
- Will be responsible for facilitating the ongoing involvement of the patient, carer and family in the discharge planning process.
- Will inform Social Services of the anticipated date of discharge and when reinstatement services will be required; if a patient is admitted with an established care package.
- Will ensure suitable provision is made to transport the patient to their discharge destination, taking into account the patient's assessed mobility needs and eligibility. Transport arrangements will be made as soon as the discharge date is agreed ensuring relative/carers are informed. Transport will only be provided when other options are deemed inappropriate or unavailable.
- Occasionally patients go home by taxi because the transport provider is unable to transport on the day required. Patient safety must be considered to ensure this mode of transport is appropriate.
- Patients will not be provided with a taxi funded by the Trust unless they are eligible for free transport (see **Appendix 4**) Approval for a funded taxi must be via matron, capacity matron or the manager on call (See **Appendix 5**)
- Will ensure the discharge of vulnerable patients is discussed with community nursing services and social services prior to discharge.
- Will ensure that patients have suitable clothing for discharge and that blankets are provided to maintain comfort and dignity during the journey from hospital, if necessary.
- Will ensure that the any valuables, which have been stored in the hospital safe, are returned prior to discharge in accordance with the Trust policy.
- Will, prior to discharge, make arrangements for Community Nurse input when necessary following the agreed Trust referral procedure
- Will ensure that provision for continence and catheter care has been organised prior to discharge and this to be documented in the discharge plan and given to the patient.
- Will inform the medical staff if the patient's condition deteriorates in the interval between the discharge decision and the patient leaving the ward.
- Will highlight and arrange to transfer suitable patients to the Discharge Lounge.
- Will be responsible for checking that patients and or carers discharged with medical devices state they have the skills and information to safely use them in the care setting.
- Will ensure that timely referrals to the Discharge Co-ordinator Team are made in response to patients being identified as having complex needs.
- Will complete the Discharge Goal Plan, which is incorporated in the patient admission documentation.
- Will check TTOs against the discharge prescription in accordance with Pharmacy policies.

1.3 Medical and Nursing Staff

Medical and Nursing Staff will ensure that a referral to therapy services is undertaken when required. They will ensure that an assessment is made if patients require intermediate care, taking access criteria and availability of beds into consideration.

1.4 Ward clerk

The ward clerk will review the discharge summary and patient notes to ensure any follow up appointments or diagnostic procedures have been booked. The ward clerk will email the Consultants secretary if the diagnostics were not requested or if a clinic is full. The secretary will speak to the Consultant to arrange a later date or force book onto a full clinic.

2. CHILDREN AND YOUNG PEOPLE

2.1 Medical Staff

- Will inform both the patient, parent/carer and ward nursing staff when the patient is medically fit for discharge and will record this information clearly in the patient record.
- Will, when the patient is discharged, record details of the inpatient episode and ongoing treatment in the electronic discharge and prescription letter.
- Will ensure that the patient's medication is updated and ordered through the electronic prescribing system. Take home medication (TTOs) should be prescribed at least 24 hours prior to the planned discharge date
- Will include a supply of TTOs drugs for a minimum of 10 days (normally 28 days' supply will be issued).
- Surgical dressings and dietetic supplies to be supplied for 7 days
- Will note that if a patient has an adequate supply of their medicine (with no dose changes) at home a TTO is not required.
- Will ensure that patients are reviewed on the day of discharge unless a discharge plan has been agreed and the Consultant has delegated the responsibility of discharge to nursing staff.
- Will document Infection control risks and precautions on the discharge letter. The Infection Control Team will be actively involved with the discharge of these patients. Further advice is available from the Infection Control Team.

2.2 Ward Nurse and Nurse in Charge

- Will commence a discharge plan and then co-ordinate the referral to and assessment by the multidisciplinary team, if appropriate. To oversee the updating and review of the document.
- Will ensure the Patient Welcome and Discharge letter are handed to patients on admission by the admitting nurse. There is a section regarding discharge planning and it encourages patients and their relatives to highlight as early as possible in their stay if they think there may be problems regarding discharge from hospital.
- Will ensure patient discharges are facilitated as quickly as possible reflecting clinical need
- Will be responsible for ensuring the electronic Admission Discharge Transfer (ADT) is updated within 30 minutes of any patient admission, discharge or transfer.

- Will be responsible for informing the capacity team immediately that a bed is available, once the discharge of a patient has been agreed.
- Will ensure that empty beds and surrounding areas are appropriately cleaned and prepared in a timely manner in preparation for the next patient.
- Will be responsible for facilitating the ongoing involvement of the patient, parent/carer in the discharge planning process.
- Will inform Social Services and Health Visitor/School Health Advisor of the anticipated date of discharge if necessary.
- Will ensure suitable provision is made to transport the patient to their discharge destination with parents/carers if necessary. Ambulance transport will only be provided when other options are deemed inappropriate or unavailable.
- Will ensure that patients have suitable clothing for discharge and that blankets are provided to maintain comfort and dignity during the journey from hospital, if necessary.
- Will ensure that the any valuables, which have been stored in the hospital safe, are returned prior to discharge in accordance with the Trust policy.
- Will, prior to discharge, make arrangements for Community Nurse Input when necessary following the agreed Trust referral procedure.

3. The Discharge Co-ordinator Team

The Discharge Co-ordinator Team responsibility is to:

- Provide the following information
- Database of all patients on their caseload
- Trust wide delays on a daily basis.
- Delayed discharge report SITREP (Situation Reporting) on a weekly basis
- Government's Snapshot report on delayed discharges on a quarterly basis
- Make all necessary referrals to the relevant Social Services Department.
- Maintain and lead on the joint discharge data base
- Recommencement of existing Social Service package of care when a patient's abilities are at the same level as they were prior to admission.
- Section 2 notification when a Social Service assessment of need is required for a safe discharge
- Section 5 notification when the patient's delay is solely attributable to Social Services.
- Any referral to social services will need to highlight the potential need for a mental capacity assessment.
- The discharge team is the link between the acute Trust and the CCG Intermediate Care Step down Schemes.
- Specialist Dementia beds are available at Hollybush House, Vicarage Road, Stourbridge- any patients who may be appropriate for this home will require an assessment by the Intermediate Care Team.

4. Therapy Services

- Nursing or medical staff may request Therapy Services as appropriate. This is completed either by a referral process or some services operate a 'blanket' referral process.

- Will be responsible for assessing referred patients, agreeing a discharge focussed treatment plan, documenting in the patient record and liaising with other professionals, patients and carers as appropriate.
- Will communicate with other members of the multi-disciplinary team about the progress and status of the patient in relation to discharge planning.
- Will be responsible for assessing, recommending and arranging delivery and fitting of equipment to the patient's home or interim setting prior to or following discharge as appropriate to the patient's need and safety.
- Will be responsible for instructing patient/family/carers in the correct and safe use of any equipment.
- Will ensure that follow up appointments are arranged as required, liaising with patient, carers, relatives and ward staff and documented in the discharge plan.
- Will be responsible for referral to appropriate community based services.

5. Capacity Management Team

All Ward Nursing Staff will communicate with the Capacity Management Team in relation to actual and potential patient discharges. It is the responsibility of the Capacity Team to:

- Monitor the supply and demand for beds
- Place patients wherever possible in beds appropriate to the their clinical condition
- Ensure the 98% target (patients seen, assessed and discharged from Ed within 4 hours of attendance) for patient throughput within ED is met and maintained
- Apply the Surge and Escalation Policy Level as appropriate
- Cascade this information appropriately; highlighting concerns and problems to senior staff in a timely manner
- Facilitate patient movement to optimise the number of patients placed in or moved to beds appropriate to their clinical condition

6. Capacity meetings

The meeting times are:-
09:00hrs, 12:00hrs, 15:00hrs, 17:00hrs and 21:00hrs
Discharge information and escalation issues should be emailed to dgft.site.operations@nhs.net

These meetings are chaired by the Clinical Site Manager alongside the Clinical Site Coordinator. The purpose of these meetings is to:-

- Front door position and triggers – current position and actions
- Operational oversight and management of whole hospital constraints
- Challenge patient plans and pathway
- Understand actions required and agree accountability
- Site plans, escalation and report

Appendix 3

Non-Emergency Patient Transport

Consideration should be given to transport arrangements for patients discharge as soon as possible after admission. Transport bookings should only be made when there is a clinical need. It is inevitable that same day discharge requests will be required however advanced notice is preferable as this allows the patient transport provider to plan their work allocation more proactively to facilitate all journeys and to assist with certain restrictions placed on them e.g. Transfers by certain times such as to meet Manual Handling Teams, support services, nursing home cut off times.

It is the lead nurses responsibility to ensure that the following is addressed prior to, or at the time of booking

- Where possible, transport bookings should be planned in advance and an AM or PM time slot requested. Please state the ward to be collected from and if booked in advance whether the patient will be transferred to the discharge lounge to wait for collection.

- The patient classification should be clearly stated e.g. 2 man; 4 man; stretcher; scoop stretcher. The transport liaison officer based in main reception on ext. 3424 (or the WMAS discharge co-ordinator on ext. 2816, Mon – Fri 08:00 – 16:00 hours) will assess the patient's needs if advice is required.

- The transport provider will require information prior to discharge of any patients, whose transfer may pose a risk in terms to the patient and / or crew due to the patient's weight; physical capabilities or access to the property. The contractor may wish to conduct a Health and Safety checks at the patients property to establish the most appropriate mode of transfer.

- The discharge address has been confirmed– there may be a charge if a destination is considered to be out of area or if the transfer is at the request of the family and not for clinical needs. Please ensure that if the destination is a residential/ nursing home or step-down facility, sufficient notice and appropriate time is given to ensure that the journey can be completed within the 'acceptance time' for that particular residence.

- Patients are aware that ambulance crews will not accommodate visits to care homes prior to selecting their home of choice

- The patient is appropriately dressed e.g. Coat and shoes in cold wet weather. Staff to ensure blankets are available, if required.

- The patient has access to their property e.g. house key is available or relative / carer waiting to greet patient.

Appendix 4

Wolverhampton and Dudley CCG

Patient Transport Service

Eligibility Criteria

Medical Need, Disability or condition questions

- Q1. Do you/Does the patient believe there is a medical need for transport?
- Q2. Do you/Does the patient have a disability or condition that would make it difficult to travel by alternative transport? E.g. Wheelchair
- Q3. Do you/Does the patient need to travel lying down due to medical need?
- Q4. Do you/Does the patient require oxygen or other medical gases while being transported?
- Q5. Do you/Does the patient require intravenous support while being transported?
- Q6. Do you/Does the patient have a physical dependency, learning or mental health condition?
- Q7. Do you/Does the patient require skilled assistance or a support aid to transfer to and from a vehicle?
- Q8. Do you/Does the patient have a condition that could lead to an episode during transportation that requires skilled assistance?
- Q9. Do you/Does the patient have a condition that would comprise their dignity, or cause public concern, if they used alternative transport?
- Q10.Do you/ Does the patient experience side effects as a result of treatment that would prevent the use of alternative transport?
- Q11. Please confirm that you/the patient does <u>not</u> receive financial support** or have a vehicle provided - this would make the patient ineligible for transport

  ***Disability Living Allowance Mobility component or equivalent*

For patients that are not eligible, discuss these factors

- Q12. How does the patient travel around on a day to day basis?
- Q13. Does the patient have their own transport or a friend/relative that could drive them?
- Q14. Would changing the appointment time help?
- Q15. Has the patient considered public transport?

Q16. Escort Assessment - Friends/Relatives are welcome to meet you/the patient at your/their destination point. Escorts must only be conveyed if:

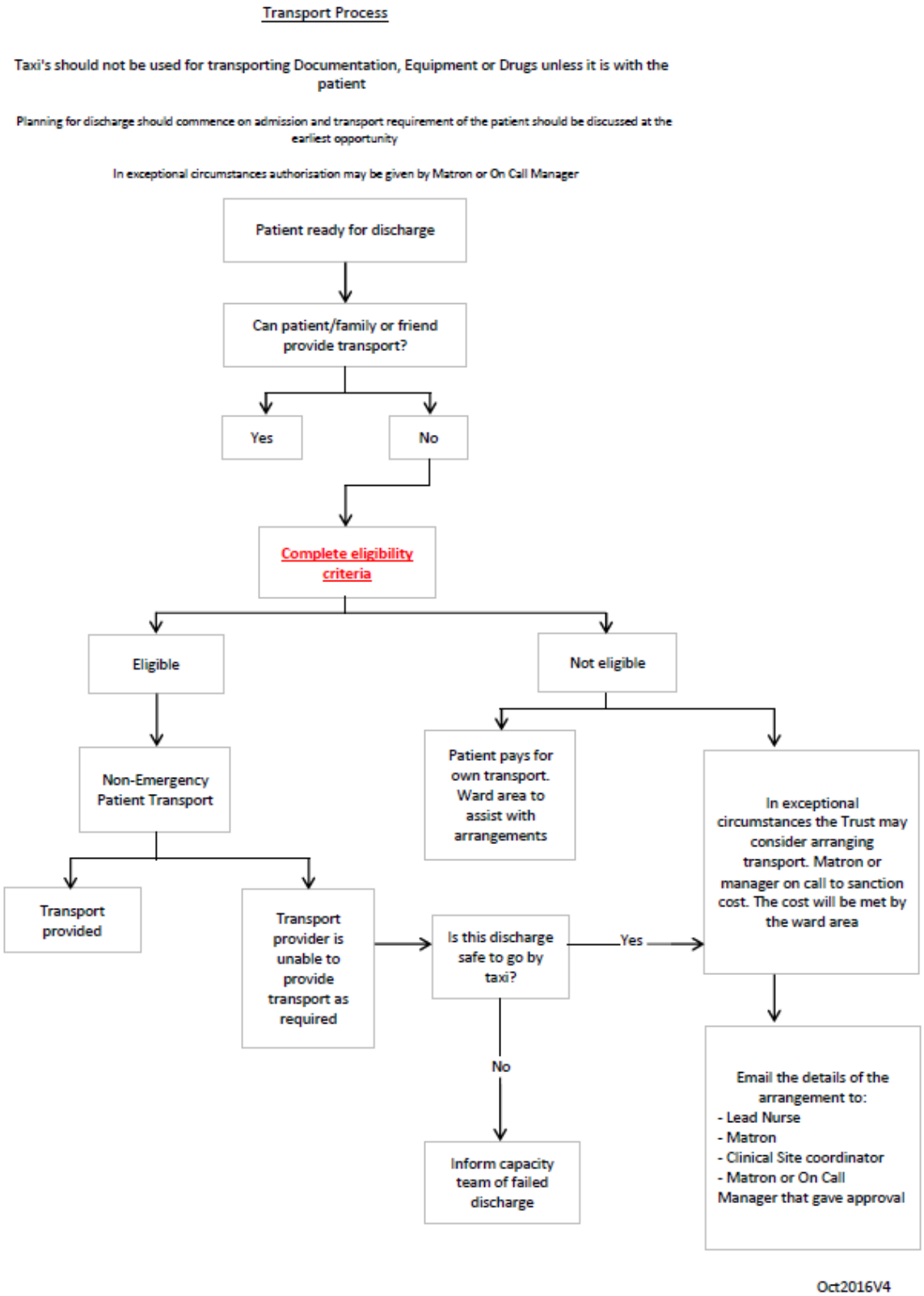
a. Patient is under 16 years of age

b. There is a medical need i.e. physical dependency, communication, learning or mental health problem

c. The patient resides in a residential care establishment due to a medical condition

d. Escort is not required – patients choice

Appendix 5


Transport Process
Taxi's should not be used for transporting Documentation, Equipment or Drugs unless it is with the patient
Planning for discharge should commence on admission and transport requirement of the patient should be discussed at the earliest opportunity
In exceptional circumstances authorisation may be given by Matron or On Call Manager
Patient ready for discharge
Can patient/family or friend provide transport?
Yes
No
Complete eligibility criteria
Eligible
Not eligible
Non-Emergency Patient Transport
Patient pays for own transport. Ward area to assist with arrangements
In exceptional circumstances the Trust may consider arranging transport. Matron or manager on call to sanction cost. The cost will be met by the ward area
Transport provided
Transport provider is unable to provide transport as required
Is this discharge safe to go by taxi?
Yes
No
Email the details of the arrangement to:
- Lead Nurse
- Matron
- Clinical Site coordinator
- Matron or On Call Manager that gave approval
Inform capacity team of failed discharge
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