Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Discharge of Patients From Hospital Policy

This procedural document supersedes: PAT/PA 3 v.4 - Discharge of Patients from Hospital Policy.

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	David Purdue
Author/reviewer: (this version)	Laura Di Ciacca
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Target audience:	Trust-wide

Policy Amendment Form

Please record brief details of the changes made alongside the next version number.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	2 August 2019	• Full review and updated in line with the Trust policy format • Amendments made throughout document	Laura Di Ciacca
Version 4	September 2011	▪ DNACPR added to 1.3 Definitions ▪ Addition of section 3.12 to reflect patients who are discharged from the Trust with an active DNACPR order in place. ▪ The associated documents now listed under 'Associated Trust Procedural Documents' and PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) added to the list.	Pat Johnson
Version 3	May 2010	▪ Title change ▪ Several additions to Section 1.3 – Definitions ▪ Additions of new roles to section 1.5 – Roles & Responsibilities ▪ Changes to section 2.5 to reflect changes in documentation ▪ Changes to section 3 to reflect different processes across different sites. ▪ Addition to section 3 to include deprivation of Liberty ▪ Change to section 3.4 to reflect fast track process	Pat Johnson/ Callum Nile
Version 2	September 2007	Significant changes throughout. The policy will need to be read in full	P Johnson L Jones

Contents

1 INTRODUCTION

Effective hospital discharge can only be achieved when there is cohesive joint working between all organisations, including hospital, primary care, social care, housing departments, independent and voluntary sector. These working arrangements must be effective not only in supporting individual discharges, but also in commissioning and delivery of services.

This policy is intended to assist all staff, working across all sites within the Trust, who are involved in the discharge process.

Although planned discharges are between 8am and 9pm, there are occasions when discharge will occur outside these times. This policy is to be followed out of the stated hours also.

During the development of this policy, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has reviewed previous discharge policies and consulted with partner organisations in the Health and Social care community.

Although applying equally to patients of either sex, for simplicity, throughout the policy, the patient will be referred to as male.

2 POLICY STATEMENT

Discharge planning is a process, not an isolated event, which will start at the point of admission for patients undergoing unplanned care, or before for those undergoing elective care. It will be a systematic and integrated process resulting in a safe and timely discharge.

A plan will be developed and agreed with each patient and carer to ensure a smooth transition from hospital care to care in the community.

Continuity of care will be maintained when a patient transfers from one care setting to another.

3 AIMS OF THE POLICY

- The discharge process will provide an optimal care experience for patients and families
- The patient and where appropriate, their relatives/carers will be fully involved at all stages of the discharge process
- Patients and their carers will be provided with information on what to expect and what their own contribution to the process will be, with particular reference to the Estimated Date of Discharge (EDD). They will be updated in the event of any change to the plan
- Patients will be provided with details of arrangements, including contact details and any relevant information regarding their continuing care or treatment.

- Professionals and organisations will be aware of their responsibilities within the discharge planning process

- Discharge planning will be clearly documented using relevant documentation

- Risk assessment processes will be integral to assessment and care planning

- Effective communication will take place between multi-disciplinary team members and community based staff including escalation of any issues related to discharge

- Discharges are planned to take place between the hours of 8am and 9pm with as many discharges as possible before 10am. Out of hours discharge may occur and the same process is followed as during the day.

4 ROLES AND RESPONSIBILITIES

- **Trust Board** – The Chief Operating Officer has overall responsibility for ensuring that effective systems are in place to support the safe, timely discharge of patients. The Director of Nursing, Midwifery and Allied Health Professionals is responsible for the clinical governance and professional issues relating to the policy

- **Medical Staff** – the decision that a patient is medically fit for discharge is made by the patient's Consultant, or someone to whom the Consultant has delegated responsibility or other doctor responsible for the care of the patient. Documentation of the decision must be clear, concise and accessible to all members of the multi-disciplinary team (MDT). Medical staff should consider proactive prescribing of discharge medications, for patients approaching their discharge date

- **Heads of Nursing/Services and Matrons** – responsible for ensuring that the policy is implemented within their area of management

- **Ward Managers** – responsible for ensuring that systems and procedures are in place to facilitate safe and timely discharge in line with this policy. This includes clear communication with the patient and his relatives/ carers about the discharge process, utilising the EDD.

- **Ward Nurses** - responsible for the commencement of early discharge planning, using the EDD as guidance**,** on or before admission. They should use the systems and procedures in place to co-ordinate the process effectively, to enable the patient to leave hospital in a safe and timely manner. In order to facilitate this process, the nurse should consider proactive prescribing of discharge medications, for patients approaching their discharge date. All discharges should, where possible, be planned to take place before 10am making optimal use of the Discharge Lounge

- **Multi-Disciplinary Team (MDT)** – all members of the MDT should be aware of the EDD and have the responsibility to ensure that they contribute effectively to the discharge planning process. They will contribute to the decision to discharge and identify and implement any

arrangements required to facilitate that discharge. Communication with patients and relatives/carers must be consistent. The MDT is the team of staff involved in the care of the patient. It will include some, or all, of the following: Nursing Team, Medical Team, Physiotherapist, Occupational Therapist, Speech and Language Therapist, Social Worker and/or Assessment Officer, Community Nursing team, Specialist Nurse, and other Allied Health Professionals

- **Ward Discharge Co-ordinators (WDC) –** support the ward managers to ensure that all patients have a planned and timely discharge as per their EDD. The WDC works with the ward staff to co-ordinate all aspects of the patient's discharge pathway and works with the multi-disciplinary team to make sure the discharge plan is set up and managed in a timely way in order to reduce delays in discharge and to ensure that safe and effective discharges take place

- **Patient Flow Team –** responsible for the oversight and co-ordination of activity related to discharge and patient movement throughout the system and identifying potential flow/pressure points which may affect bed capacity management

- **Integrated Discharge Team (IDT)** – the multi-disciplinary, multi-agency team responsible for receiving referrals for complex discharge planning and ensuring a Fact Find assessment is completed in a timely manner to identify the most appropriate pathway to facilitate the safe transfer/discharge of an identified caseload of patients. The IDT is responsible for actively seeking solutions to complex discharge problems and pursuing all options for effective discharge. The team is also responsible for accurately identifying and reporting local and national Delayed Transfers of Care (DTOC).
  The team is comprised of Discharge Nurse Specialists, Social Care staff, Community Nursing Staff, Older People's Mental Health staff and Therapists.

5 OPERATIONAL PROCEDURES

5.1 Starting the Discharge Planning

The discharge planning process should begin at the point of admission or before for all episodes of care.

When starting to plan for a patient's discharge, the following factors must be considered.

- Complexity, stability and predictability of the patient's physical and mental condition
- Environmental considerations – will the patient be able to return to his home, taking into consideration any changes in ability or dependency he may have undergone
- Level of support prior to admission and required on discharge – has the patient's care needs changed; if so are carers/relatives still able to give appropriate amount of support. Has the patient had care support at home; if so, by whom/details of care workers

- Ward staff should identify if a Monitored Dosage System (NOMAD) will be required on discharge.

Every patient should be given a Trust 'Patient and Carer Discharge Passport' (Appendix 1) which outlines the patient/carer's responsibility in the discharge planning process including informing ward staff if they have support at home which will need to be in place for a safe discharge eg. care needs, identified community workers, NOMADs. Discharge planning information is also included in the DBTH Bedside Information booklet.

For patients with non-complex discharge or transfer needs, the ward staff will facilitate discharge /transfer with the support of the Ward Discharge Co-ordinator.

If the patient requires care support at home and has not had a package of care at home before, the ward staff should refer for a short term enablement programme on discharge.
For Doncaster patients, this will be through the Community Single Point of Access to access the Short Term Enablement Pathway (STEPs).
For Bassetlaw patients, this will be through the Integrated Discharge Team to access the Short Term Assessment and Reablement Team (START).

If the patient is assessed to have more complex discharge needs, a referral should be made to the Integrated Discharge Team when the patient is medically fit for assessment for discharge or transfer planning.

The Integrated Discharge Team will allocate a Trusted Assessor from either health or social care to complete a Fact Find Assessment, which is a comprehensive assessment tool which considers the patient's health and social care needs. The patient will then be supported by the most appropriate member of the Integrated Discharge Team through their discharge planning to the most appropriate discharge or transfer pathway.

If the patient is not a Doncaster or Bassetlaw resident and has complex health and social care needs ie. an out of area patient, referrals should be made using Assessment and Discharge Notifications as per the relevant Local Authority arrangements and refer to the Integrated Discharge Team who, will not lead the discharge planning process, but support the relevant area authority to drive the safe discharge/transfer of the patient. If ward staff are unaware of the local arrangements, they should contact their Ward Discharge Co-ordinator or the Integrated Discharge Team.

Further details regarding Assessment and Discharge Notifications are outlined in Section 7.2.

If a patient has complex discharge planning needs and does not wish to be referred to the Integrated Discharge Team, the MDT will need to consider their capacity to make this decision and whether this patient will be safe to discharge without additional support. The MDT should then establish that the patient's family or carer is able and willing to provide any support required. If it is deemed that discharge will not be safe, they will need to explain their concerns further to the patient and family which must be documented. A referral may be made to the Integrated Discharge Team to discuss and determine options or for further capacity and best interest assessment.

When starting the discharge planning process, transport arrangements should be considered. The patient should be asked to make his own arrangements wherever possible. This should be determined when discharge plans are first discussed with the patient.

The Trust will only provide transport if there is a clinical need to do so.

Refer to Non-Emergency Trust Funded Transport Policy - CORP/FAC 2.

5.2 Communication

Communication is integral to a safe, effective and quality discharge.

It is the responsibility of all individuals involved in the patient's care to maintain effective and consistent communication channels with:

- the patient and/or carer
- relevant members of the MDT involved in the patients care
- other relevant departments within the Trust and
- other agencies and organisations.

All communication should be documented in the patient's clinical record.

The person assessing the patient on admission will assume responsibility for ensuring that all relevant information is given to him or, where appropriate, his carer, in a timely manner which will include the following;

- Proposed length of stay and Estimated Date of Discharge (EDD) should be discussed with all patients and/or carer
- All patients should be given a copy of the Trust's Patient and Carer Discharge Passport
- If a patient has complex requirements, discuss the need for a referral to the Integrated Discharge Team
- A case conference/goal setting meeting may be required to support discharge planning. The patient and carer should be present wherever possible.
  If arranging a case conference, all professionals involved in the patient's care should be invited, including a representative from the Integrated Discharge Team and a record of the meeting kept
- The patient is to be kept informed at all stages of care planning, e.g if referrals made to other disciplines
- For those patients who are unable to communicate in English, translators are available and can be booked through the Doncaster Interpretation and Translation Unit
- For those patients who use British Sign Language and do not have their own communicator present, ward staff can arrange for a 'signer' through the RNID.

This is not an exhaustive list and additional information will be provided in different specialist areas.

If a patient is unhappy with the outcome of their assessment or care plan, they should have access to the appropriate complaints procedures (depending on which services are causing concern).

5.3 Preparing for discharge

When the EDD has been confirmed, the nurse caring for the patient has responsibility for informing all professionals and agencies involved and co-ordinating the appropriate services and documentation.

The most up-to-date, relevant Discharge Checklist for the clinical area should be used to support the safe discharge of patients from hospital and should be commenced as part of the discharge planning process. It may include the following key aspects of discharge planning:

To Take Out Medication (Discharge Medications)

As soon as the decision to discharge is made, the discharge medications should be prescribed in accordance with the current Medicines policy; Policy for the safe and secure handling of Medicines. (PAT/MM 1)

- If the patient requires a Monitored Dosage System on discharge, Pharmacy should be made aware at least 48 hrs prior to the discharge date in order for them to liaise with the patients nominated Community Pharmacy
- Pharmacy has a current standard time of 90 minutes for dispensing discharge medicines (not including delivery to the ward). This should be taken into consideration when planning discharges. Where possible the patient and their carer should be given an approximate time that the medications will be available.

Community Referrals including Nursing

Where appropriate, community staff should be involved at an early stage of discharge planning and included in any MDT meetings, case conferences and Best Interest Meetings.

Referral is through the relevant Community Single Point of Access/Contact. In addition, there is a Community Nursing Team based within the Integrated Discharge Team who will support patients transfer back into the community.

If the patient is able to visit his GP for the continuation of nursing needs, he should be asked to contact the practice nurse on discharge and make an appointment. A patient discharge/transfer summary should be completed for these patients with relevant information for the practice nurse. The patient should be given this summary to take to the appointment.

Equipment

It may be may be necessary to arrange for equipment or minor adaptations to be provided prior to discharge, to ensure that patient can manage independently or can be cared for safely at home. This should be in place prior to discharge or plans in place to deliver in a timely manner.

Transport

If, after assessment of the patient's clinical needs, it is decided that they will need transport on discharge, follow the Trust Policy - Non-Emergency Trust Funded Transport (Internal Transportation) Policy (CORP/FAC 2).

Access to Property

Staff should ensure that the patient has the key to the accommodation they will be discharged to or that there will be someone at the accommodation to allow access. Where appropriate, check with the patient/relative/carer that the heating will be turned on and that there are basic supplies available at the time of discharge ie. bread, milk etc.

Patient's property

Where possible, relatives or carers should be asked to take excess property home prior to discharge, especially if the patient will be using hospital transport. Patients are only able to take one bag with them on hospital transport, due to space constraints.

Any property handed in for safe keeping should be returned to the patient in accordance with the Trust Policy for Patients' Property and Valuables (PAT/PA 12).

5.4 Completing the Discharge

On the day of discharge, it is the responsibility of the nurse caring for the patient to co-ordinate the discharge, thereby ensuring a smooth and seamless discharge and transfer of care where appropriate. The relevant Discharge Checklist should be completed on the day of discharge.

Once the patient has been medically and clinically discharged, they may transfer to the Discharge Lounge whilst awaiting final arrangements to be made e.g. transport or medications to take home. The Discharge Lounge is a specified area within the hospital to facilitate timely discharge from the wards. Use of the Discharge Lounge will enable more timely admissions, as beds can be made available earlier. The Discharge Lounge is staffed by qualified nursing staff who can continue the care of the patient. For further guidance, please refer to the Trust's Discharge Lounge Operational Policy.

Other considerations for discharge are as follows;

The **next of kin or relatives should be informed**, if appropriate and the patient has given his consent, if able.

Discharge Medications

- The Discharge Medications should be available at the time of discharge from the ward or Discharge Lounge where appropriate
- Discharge medication will be checked against the discharge prescription and inpatient medication record in accordance with Pat MM1 the Policy for the Safe and Secure Handling of Medicines
- The nurse discharging the patient will ensure that he and/or his carer understands his medication regime, how and when to take his medications and any possible side effects, prior to handing them over.
- The discharging nurse will ensure that the patient and his relatives know how to access further supplies of his medication as appropriate after his discharge.

Medical Fit Notes

- A Statement of Fitness for Work certificate may have been issued to the patient to cover the inpatient period. This can be issued by a Doctor or a Registered Nurse
- If a further certificate is required after discharge, **this can only be issued by a Doctor,** who will take into account the amount of time the patient should refrain from work
- The certificate should be completed and available to the patient on discharge.

Out Patient appointment

If an outpatient appointment is required after discharge, the nurse or ward clerk should contact the Appointments Clerk for the appropriate speciality providing the following details:

- Name of Consultant
- Number of weeks before appointment is required
- Patient's name and hospital number.

This should be documented on the patient's Discharge Summary. Ensure that the patient is aware of the date and time of the appointment and that he knows where the appointment will be held

If the details of the appointment are not available at the time of discharge, they will be posted to the patient's discharge address

If an ambulance is required for the appointment, this should be booked in accordance with the Trust's Non-Emergency Trust Funded Transport (Internal Transportation) Policy (CORP/FAC 2).

Dressings / Continence products

- Supplies of dressings and continence products should be given to the patient on discharge, if still required, as community nurses do not hold stocks of products
- Patients should be given 3 days supply of wound management products, and any other item available on prescription eg. catheters

- The Community Nursing Team should be given details of any product being used, to enable further supplies to be prescribed
- Patients should be given a 7 day supply of items not available on prescription, e.g. pads and pants
- All patients using wound care / continence products should be referred prior to discharge, for supply of a clinical waste bin, to ensure safe, hygienic disposal of used products
- Any queries with regard to the supply of these products should be referred to the Community Nurse Liaison Team or the Continence Advisory Service.

5.5 Discharge Documentation

All discharge planning will be clearly documented in the clinical records.

The Summary Care Record/ discharge letter, completed by the doctor, will be sent to the General Practitioner by the ward clerk within 24 hours of the discharge.

Other documentation that may be required is as follows:

Patient Information Leaflets

- Patient information leaflets will be given to the patient as appropriate and will be specific to that individual patient
- These may be information about his diagnosis or condition, eg leaflets about heart disease, diabetes etc
- There may be instructions for continued management, eg physiotherapy exercises
- If a patient is to undergo further investigations or tests, he may be given information to explain the procedure
- For patients who lack capacity or have other special needs regarding communication, staff should ensure information is provided in an appropriate format and given to the appropriate carers.

- **Fact Find Assessment** – for some discharge pathways eg. intermediate care bed-based unit, social care assessment unit, the Fact Find assessment can be used as the referral document and will be updated by the appropriate member of the IDT on the day of discharge and sent to the relevant receiving unit. Depending on the receiving unit's requirements, additional documentation will also be sent eg. Venous Thrombo-embolism (VTE) assessment.

6 GUIDELINES FOR SPECIFIC DISCHARGES

Whilst the operational procedures apply to all discharges, in addition, the guidance in this section will apply to specific discharges from, or to, various settings and for specific groups of patients.

When planning discharge, staff should consider whether the patient has appropriate resources in place to facilitate a safe discharge.

6.1 Transfers to other Hospitals/Trusts

As well as following the operational procedures in Section 5, the nurse co-ordinating the discharge has added responsibilities in respect of transfers to other Trusts, or other sites within the Trust. The nurse is responsible for ensuring a safe transfer in accordance with the Trust Policy for the Transfer of Patients and their Records (PAT/PA 24)**.**

6.2 Management of Patients wishing to Self-discharge

On occasion, and for a variety of reasons, a patient may wish to be discharged against medical advice.

The patient should be assessed with regard to his Mental Capacity, as per the Trust policy *Mental Capacity Act 2005 – Policy for Staff (PAT/PA 19)*

- If the patient is assessed as having capacity, he has the right to make what others may see as an unwise decision (as stated in principle 3 of the Mental Capacity Act, section 4 of the policy)
- If the patient is assessed as lacking capacity to make a decision, he can be refused discharge if it can be demonstrated that staff are acting in his best interests (see section 9 of the policy)

If capacity has been determined, the nurse caring for the patient is responsible for ensuring that a safe discharge process is in place. She may wish to contact a Senior Nurse or Matron for advice and support.

The nurse should try to establish the patient's reason for wishing to self-discharge and address any issues that can be resolved at this point

A member of the medical team should talk to the patient and explain the reasons for and the benefits of the patient remaining in hospital.

The patient should be provided with all the relevant and appropriate information, in order for him to make an informed decision.

If the patient still wishes to self-discharge, it may be appropriate to involve friends or family, who may help to dissuade the patient against this course of action. This must only be done with consent of the patient.

If the patient still insists on self discharge, the discharge process should then be followed, as for any other discharge.

The patient should be asked to complete form 'WPR10390A - Release from responsibility for discharge', which will then be filed in the patient's health care records.

All details of the incident should be documented in the patient's clinical records.

Staff must ensure that they do not put themselves at risk from violence or aggression from a patient whilst managing this situation.

6.3 Discharge of Patients into the Prison Service

Patients admitted from the local prison service will have prison staff in attendance at all times, in accordance with the Trust Policy for the Care of Prisoners and Patients from High secure Hospitals PAT/PA 10.

Prisoners will be discharged using the operational procedures within this policy, whilst taking into consideration the following:

- Communication about the patient should always be directed through the prison service staff. No information should be passed to friends or family. Any enquiries about the patient from an outside source should be directed to the escorting staff, as per the above policy.
- At the time of discharge, all items of property belonging to the patient, including any equipment or medications issued by the Trust, will be handed to the escorting staff and not the patient.

6.4 Discharge of Fast Track /Rapid Discharge Patients

6.4.1 Fast Track

For those patients having been assessed by their Consultant as likely to have a rapidly deteriorating condition, which may be in a terminal phase and increasing level of dependency, the **Fast Track** discharge process will be initiated.

- Once the assessment decision has been made, the Consultant/responsible medical doctor in charge of the patient's care or a member of the Specialist Palliative Care Team will complete a NHS Continuing Healthcare Fast Track Tool
- A referral will be made to the Integrated Discharge Team and a Discharge Nurse Specialist will be allocated to ensure the documentation to support the fast track pathway is complete and a care needs assessment will be completed with the patient and relevant family/carers
- The patient and his relatives, where appropriate, will identify their preferred place of care eg. home with no support, home with an appropriate care package and equipment or nursing home placement
- Depending on the patient's medical condition, it may be appropriate for him to remain in hospital in order to be given the appropriate care. In these instances the patient will be cared for using the Trust's End of Life care records
- All fast track referrals/discharges will be treated as a priority
- Referrals will be made to relevant agencies/disciplines to support the discharge process eg. community nursing, occupational therapist
- All disciplines and agencies involved with the patient's transfer of care should be informed of the progress of the discharge planning

- Ensure that the patient's GP is informed of the discharge and any subsequent arrangements made for the transfer of care
- It is important that all communication is accurate and timely, in order to facilitate a safe, timely, discharge and therefore a positive outcome for the patient and his family.

6.4.2 Rapid Discharge

For those patients having been assessed by their Consultant as likely to have a rapidly deteriorating condition, which may be in the last hours/days of life and the patient's wish is to return home, the **Rapid Discharge** process will be initiated. These patients should be discharged within hours of referral

- A referral will be made to the Palliative Care Team and the Integrated Discharge Team
- A Discharge Nurse Specialist will be allocated to work with the Palliative Care Team and the patient and relevant family members/carers to facilitate the timely discharge home to the patient's preferred place for end of life care
- Referrals will be made to relevant agencies/disciplines to support the discharge process eg. occupational therapist
- For those patients who require ongoing care, a referral will be made to the Unplanned Care Team

For any delays associated with fast track discharges, these will be escalated appropriately via the Integrated Discharge Team.

6.5 Discharges to Care Homes

6.5.1 First Time Placements

Assessments for transfer to care homes should only be undertaken once the patient has realised their full potential for rehabilitation.

Where possible, assessment for permanent placement will not be completed in an acute hospital bed. Patients will be transferred to an alternative care setting where appropriate assessment can be completed out of a hospital environment.

All patients will be referred to the Integrated Discharge Team where a Fact Find assessment will be completed to identify the most appropriate pathway to maximise the potential for the patient to return home.

This may be in a social care assessment unit or a Discharge to Assess/Short Term Nursing Care bed.

If however, the patient is unable to be managed in one of the allocated pathways, assessment for long term needs will be completed by a complex social worker within the Integrated Discharge Team.

Where a patient is self-funding, he may choose not to undergo assessment, but it is in his best interests to consult with a member of the Social Care Team within the Integrated Discharge Team.

Where Local Authority funding is required, the patient should not be discharged until it has been confirmed in writing by the admissions panel that funding has been released.

Where Local Authority funding is not appropriate and the patient is self-funding, the MDT will continue to manage the discharge process so that transfer arrangements can be made in a timely manner. This request will be authorised by the admissions panel after a social and financial assessment.

Once placement has been confirmed, the nurse co-ordinating the discharge will check if the patient will be transferring to the care of a different GP; if so, copies of all relevant documentation will be sent to the new GP as well as the existing GP. Care should be taken to ensure that the correct discharge address is used in all communication.

6.5.2 Patients already in Residential Care

If the condition of a patient admitted from a residential care home has not deteriorated, he will be able to return to the home without re-assessment.

For those patients whose condition has deteriorated and the care home may be unable to cope with their additional needs, re-assessment may be indicated. The manager from the residential care home should be contacted as soon as the discharge process is started and arrangements made for the reassessment to take place as soon as possible.

For those patients who will need reassessment and are unable to return to their care home, a referral should also be made to the Integrated Discharge Team where a Fact Find assessment will be completed and discharge planning can be commenced to the most appropriate pathway.

6.6 Discharge from Emergency Department, Unplanned Care and Clinical Decision Unit, Acute Medical Unit and the Minor Injuries Unit

Patients attending these units must undergo a full risk assessment including an assessment of their social circumstances and the impact of their present condition on their ability to manage safely, when deciding to discharge back to the community.

- Referrals to community services should be made after consultation with the patient and his family where appropriate
- Referral to the Rapid Assessment Programme Team (RAPT) at Doncaster and Rapid Response Teams at Bassetlaw should be made where it is felt admission avoidance intervention may be appropriate for the patient
- Consideration should be given to delaying discharge until appropriate arrangements can be confirmed

- Consideration should be given when discharge is planned for late evening or during the night and in circumstances that might cause hardship to the patient. i.e. vulnerable people being discharged to an unheated property in the winter
- Medication, equipment and dressings will be supplied as appropriate. The discharging nurse should ensure that the patient and/or relative understand instructions as to the use of supplies
- If the patient is unable to work due to his condition, a member of the medical team should issue a medical certificate for the appropriate length of time
- A letter will be sent to the GP, detailing the reason for attendance, the diagnosis and relevant treatment given
- Details of any follow up arrangements should be given to the patient ensuring that he fully understands these.
- Transport should be arranged only if there is a clinical need, in accordance with the Trust transport policy and procedures
- Ensure any property is returned to the patient prior to discharge.

6.7 Discharges from Maternity Services

Planning for transfer to community services starts in the antenatal period. Any issues relating to discharge should be discussed with the woman by the community midwife.

The length of time the woman stays in hospital is not prescriptive but will depend on a number of factors :

- The type of birth
- Condition of the mother after the birth
- Condition of the baby after the birth and
- Level of support available at home.

If a woman feels well and there are no complications, she may go home from hospital as early as 2 hours after the birth. In this case, the woman can be transferred home from the Central Delivery Suite/Labour Ward following the advice provided by maternity staff.

For those women who are admitted to the postnatal ward, planning for transfer to community maternity services should begin as soon as is reasonable after admission. The midwife should discuss with the woman and, if appropriate, her family when she intends going home and this, along with professional advice on length of stay should be recorded in the midwifery record. The midwife should document the proposed date of discharge in to the care plan.

All babies need to have the first examination of the newborn performed. Where possible, this will be performed on the ward by an appropriately qualified midwife or a paediatrician. Where this is not possible, e.g. if the mother wishes to go home before this can be arranged, if the baby appears well, then this examination can be performed in the community by an appropriate midwife. Alternatively, an appointment can be made for this to take place on the maternity ward. Clear documentation must show this examination has not taken place and to advise the community midwife and the GP that the baby has not had the examination.

The ward midwife, as lead professional in the post natal period for women who have had an uneventful labour and a vaginal birth, will arrange transfer home. However, all women who have had a Caesarean Section, or a third degree tear, must be seen by a doctor before transfer. The documentation of all postnatal care must be completed prior to leaving the ward.

The ward midwife should ensure that the woman's correct address is recorded in the written and the computer record.

On the day of transfer, the woman's details should be rechecked, i.e. that she is still fit to go home and the accuracy of the address to which she is going. The Community midwife is informed via the discharge book and receives a copy of the discharge letter. The GP is informed via a copy of the discharge letter, which at the Bassetlaw Hospital site is faxed.

6.8 Discharging Children and Babies

6.8.1 Hospital Discharge for Children where there are child protection concerns:

Where risk of significant harm has been identified the child should not be discharged without a clear plan to address these concerns in partnership with other agencies including childrens social care.

These may be new concerns identified by the hospital or children who already have a child protection plan in place. If these are new child protection concerns they should have already been reported to childrens social care (see Safeguarding Children Policy). Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and where appropriate provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews (HMG, 2015).

Discussions with other professionals including external agencies or other services within the Hospital Trust should take place. These may take place by telephone or it may be more conducive to hold a multi-agency discharge planning meeting. It is important that all professionals who will be supporting the child and their family when they return home attend the meeting.

6.8.2 Hospital Discharge for Children who Require Further Support in the Community

Even if there are no child protection concerns but a child is being discharged into the community and requires further support, there may still be a need to hold a discharge planning meeting. This may be a child with complex needs or ongoing health needs. Those skilled practitioners are in the best position to use their professional judgement about when to share information with colleagues working within the same organisation, as well as with those working within other organisations, in order to provide effective early help and to keep children safe from harm.

There are local procedures in place on the children's ward:-

- Children's ward discharge policy; (Children's/Clinical Guidelines/Wards/no 22.)
- Neonatal Services discharge policy ; (Children's/C/NNN/Neonatal/gen/no3)

6.9 Discharge of Homeless Patients

The law requires the Local Authority to provide housing only for some people who are homeless.

In order to qualify for housing, a person must fit all of the following criteria:

- they must be homeless
- they must be in priority need
- they must be unintentionally homeless
- they must have a local connection to the borough in which they are applying.

The only way to establish whether a person fits these criteria is for them to be assessed by a social worker.

For those patients who do not have ongoing care needs and have capacity, they will be advised to present to their local Housing Association.

It may help to have a letter from the hospital saying when and why they were admitted and if they have any continuing problems with their health.

For those patients with care needs and do not have capacity, they will be referred to the Integrated Discharge Team where they will have a Fact Find assessment and be allocated to a complex social worker who will liaise with the Housing Association.

6.10 Discharge of patients with Safeguarding Adult Issues

If a patient is the subject of a Safeguarding Adults referral/investigation, or it is felt that discharging the patient may put him at risk, the Social Care Team within the Integrated Discharge Team will be notified by the Community Safeguarding Team and will agree how they will support discharge arrangements in the best interests of the patient.

If there is a Social Worker or Assessment Officer involved with the patient, he or she should be kept informed at each stage of the planning process.

It may not be appropriate for the patient to remain in an acute hospital setting, therefore a transfer to intermediate care, or a non-acute area, may be considered. Short term or temporary placement in a care home may also be considered until the Safeguarding Adult procedures are resolved.

All actions in respect of Safeguarding Adults should be in accordance with the Care Act.

6.11 Discharge of patients who are being deprived of their liberty

Deprivation of Liberty Safeguards - Provision, under the Mental Capacity Act 2005, to protect those individuals who, for their own safety and their best interest, need to be accommodated to undergo treatment and/or care. This accommodation may have the effect of depriving them of their liberty, whilst they lack the capacity to consent.

In accordance with the Deprivation of Liberty Code of Practice, it is possible for a patient to be discharged from hospital, even if he is being deprived of his liberty whilst he is in hospital. This is irrespective of whether discharge is either to his home address, or another hospital or a care home.

As soon as a discharge date is established, a request for a review by the managing authority should be completed and sent to the Deprivation of Liberty Administration office, informing them of the intention to discharge. This can be done in liaison with the Trust's Lead for Safeguarding Adults.

If the patient is being discharged to another hospital or a care home, they should be informed of the Deprivation of Liberty order.

6.12 Discharge of patients who lack capacity

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Trust Intranet.

There is no single definition of Best Interest. Best Interest is determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Refer to Section 5 of the MCA code of practice for further information.

For patients who lack capacity or have other special needs regarding communication, staff should ensure that patients are discharged home or to a place where there are relatives/carers with sufficient knowledge and skill to look after them and meet their needs. Staff should also ensure that any information required to support discharge or ongoing care or treatment is provided in an appropriate format and given to the appropriate relatives/carers.

6.13 Discharge of patients with a DNACPR order in place

If a patient has an active DNACPR order in place, the decision will still be applicable when the patient is transferred to another care setting, or discharged home unless it is revoked at time of discharge following an appropriate review.

It is important that on transfer/discharge, the decision is reviewed, and the DNACPR order updated if appropriate and clearly documented.

Whenever a patient is transferred between care settings, or discharged home, it is imperative that DNACPR decisions are communicated to the patients GP, and any other service involved in the patient's ongoing care, including the ambulance service and the receiving organisation/team.

Refer to Trust policy PAT/EC 8 – Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) policy for full policy information.

7 DELAYED DISCHARGE

7.1 Guidance for patients refusing discharge

Occasionally situations occur where a patient refuses to be discharged or unreasonably prolongs the discharge planning process. If a patient is refusing to be discharged and is not eligible for review of their case under the continuing care criteria, consideration must be given to each individual case.

The Matron will ensure that the patient has been referred to the Integrated Discharge Team. If the Integrated Discharge Team has exhausted all options and approaches for discharge or transfer with all relevant agencies and organisations, including the responsible Clinical Commissioning Group, the case will be escalated to the Chief Operating Officer/ Director of Nursing, Midwifery and Allied Health Professionals and legal advice sought if appropriate, especially in cases where eviction may be required.

It is important that staff identify these cases as early as possible and that they are managed firmly but with a consistent and sensitive approach. Any risk management or patient safety issues will be managed and addressed as per the Trust's Risk Management Policy.

7.2 Reimbursement

The Care and Support (Discharge of Hospital Patients) Regulations 2014 sets out that :

The NHS is required to notify relevant local authorities of a patient's likely need for care and support and (where appropriate) carer's support, where the patient is unlikely to be safely discharged from hospital without arrangements for such support being put in place first - an

Assessment notification. The NHS also has to give at least 24 hours' notice of when it intends to discharge the patient - a Discharge notification.

A defined timescale for the Local Authority to complete assessments and provide services is set (a minimum of 2 days from an Assessment notification and 1 day from a Discharge notification).

From 1 April 2015, if a local authority had not carried out an assessment or put in place care and support or (where applicable) carer's support, and that is the sole reason for the patient not being safely discharged, the NHS body has a discretion as to whether to seek reimbursement from the relevant local authority for each day an acute patient's discharge is delayed.

For patients within Doncaster and Bassetlaw, there is agreement in place between the Trust and Doncaster Metropolitan Borough Council and North Nottinghamshire Council respectively, that the referral to the Integrated Discharge Team and subsequent Fact Find assessment will act as the Assessment Notification with agreement within the Integrated Discharge Team regarding the date and time of the Discharge Notification.

For out of area patients, the requirement for Assessment and Discharge Notifications remains, unless the local Trust agreement has been agreed and adopted.

Withdrawing Notifications – there may be occasions when the Assessment or Discharge notification should be withdrawn or cease to have effect, because of a change in the patient's needs or condition. A Withdrawal Notification will then be completed. This is to ensure that no one continues unnecessarily to arrange a care package which is no longer needed or to work to dates which have changed.

8 MONITORING DELAYS

8.1 Delayed Transfers of Care

Information regarding delayed transfers of care is collected for acute and non-acute (including community and mental health) patients on a Monthly Delayed Transfers SitRep return. The focus of this return is to identify patients who are in the wrong care setting for their current level of need and it includes patients in all NHS settings irrespective of who is responsible for the delay.

The Monthly Delayed Transfers SitRep return has been amended to reflect changes made by the provisions of the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 in relation to the reimbursement regime for delayed discharge of hospital patients with care and support needs and is required on a monthly basis.

Daily monitoring also takes place at a local and national level in order to inform pressures and waits/delays within the systems and record the number of delayed days each month for the SitRep.

Delayed Transfers of Care occur when a patient is ready for discharge, or transfer to another service but is still occupying a hospital bed.

A patient becomes a SitRep delayed discharge/transfer when he is ready to depart from acute care and is still occupying a bed.

A patient is ready for transfer when:
a. A clinical decision has been made that patient is ready for transfer AND
b. A multi-disciplinary team decision has been made that patient is ready for transfer AND
c. The patient is safe to discharge/transfer.

The multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient.

The Monthly Delayed Transfers Of Care SitReps: Definitions and Guidance document sets out guidance for reporting. All delays should be agreed by representatives from both health and social care.

Data is also collected locally to inform daily pressures and the need for escalation.

8.2 Length of Stay meetings (LOS)

Length of Stay meetings are held weekly at Bassetlaw Hospital and monthly at Doncaster Royal Infirmary and Mexborough Montagu Hospital with Matrons/Ward Managers, key representatives from partner organisations including Clinical Commissioning Groups and the Integrated Discharge Teams to review patients with a length of stay of 7 days or over, identify obstacles to discharge and support staff to ensure a seamless transition to the most appropriate pathway for discharge or transfer.

Any actions are escalated to the appropriate teams/organisations and if necessary, with clinical commissioning colleagues.

8.3 Surge and Escalation/Urgent Care Operational meetings

Surge and Escalation meetings chaired by the Doncaster Clinical Commissioning Group take place weekly with representation from all agencies and organisations across the systems and discharge pathways to identify obstacle and potential solutions within the pathways from front door services to discharge.

Urgent Care Operational meetings chaired by the Bassetlaw Clinical Commissioning Group take place monthly with representation from all agencies and organisations across the systems and discharge pathways with the same objectives.

9 TRAINING/SUPPORT

Discharge planning is part of the nursing and allied health professional preceptorship programmes.

Discharge Events organised by the Integrated Discharge Team take place on both the Doncaster Royal Infirmary and Bassetlaw Hospital sites at least twice a year. Updates to discharge/transfer planning including discharge/transfer pathways are provided at these events with internal and partner organisations invited to contribute. Other relevant training is provided outside of these events as required to relevant staff groups eg. changes to continuing health care processes etc.

The community nursing teams deliver an education programme to ward staff on an annual basis with feedback and learning shared from community services regarding quality of patient discharges into the community.

10 MONITORING EFFECTIVENESS OF THE POLICY

The effectiveness of the policy will be monitored by:

- Delayed Transfers of Care – local and national (DTOCs)
- Datix including patient experience
- Length of Stay and readmission rates.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Delayed Transfers of Care	Internal IDT CCG NHSE	Monthly SITREP Daily Pressures	Uploaded through NHS England portal
Complaints regarding patient pathways/discharge processes	Care Group Representative	As required	Through DATIX
Length of Stay and readmission rates	Head of Performance	Monthly	LOS monitoring LOS Steering group

11 DEFINITIONS

Clinical Nurse Specialist (CNS) a senior nurse who specialises in a particular area of nursing, caring for patients suffering from specific illnesses. A CNS provides direct care, as well as providing support and education to the patient, and where appropriate, their family or carers, around the management of their illness. A CSN will support the patient during admission and following discharge.

Clinical Site Manager - A team of senior Nurses managing DRI out of hours and BDGH over a 24hr period offering clinical support to junior nursing and medical staff, ensuring the safety of patients, staff and the environment. Manages patient flow from the point of admission to the appropriate speciality. An advocate for the senior manager out of hours.

Continuing Healthcare and NHS funded nursing care – the term NHS continuing care means fully funded care for people who do not require care in an NHS acute hospital, but require a high degree of ongoing health care. Anybody can qualify for NHS continuing care funding if their needs satisfy eligibility criteria.

An individual who needs continuing care may require services from NHS bodies and/ or local authorities. If a person does not qualify for NHS continuing healthcare, the NHS may still have responsibility to contribute to that person's health needs. A joint package of continuing care may be required.

The Discharge Lead Nurse and Discharge Nurse Specialist can advise on issues relating to continuing care.

Complex Care Practitioner – a senior nurse who will take on a caseload of patients in the community with long term conditions. The patient will be managed at home, or in a residential home. The Complex care practitioner will support the patient and their family and co-ordinate their health and social care needs, thereby facilitating discharge or preventing admission or readmission. To meet the criteria for the Complex Care Practitioner Service the patient must have:

- Two or more long term conditions
- Two or more unplanned hospital admissions within the last 12 months
- Polypharmacy: i.e. six or more prescribed medications
- A high volume of input by ED, Out of Hours Service, Primary or Social Care Services
- A prolonged stay in an acute hospital bed.

Any queries related to the service, or for patients who may benefit from the input of a Complex Care Practitioner, but who do not fulfil all the above criteria, please contact any of the Complex Care Practitioners directly. An information leaflet and contact numbers can be found on the wards.

Delayed Discharge/Delayed Transfer of Care (DTOC) – occurs when a patient is ready for discharge, or transfer to another service, but is still occupying a hospital bed. A patient becomes a delayed discharge/transfer when:

- A clinical decision has been made that he is ready for discharge
- A Multi Disciplinary decision has been made that he is ready for discharge
- He is safe for discharge or transfer

The patient may be unable to be discharged because he is waiting for:

- assessment by any member of the MDT
- a Community Care Package to commence
- funding for placement into Residential/Nursing care
- a vacancy in Residential/Nursing care.

Deprivation of Liberty Safeguards. Provision, under the Mental Capacity Act 2005, to protect those individuals who, for their own safety, & their best interest, need to be accommodated to undergo treatment and/or care. This accommodation may have the effect of depriving them of their liberty, whilst they lack the capacity to consent.

Discharge Lounge – is a specified area within the hospital to facilitate timely discharge from the wards. If a patient has been medically and clinically discharged, they will transfer to the discharge lounge whilst awaiting final arrangements to be made e.g. transport, or medications to take home. The facility will enable more timely admissions, as beds can be made available earlier. The discharge lounge is staffed by qualified nursing staff who can continue the care of the patient. For further guidance, please refer to the Trust's Discharge Lounge Operational Policy.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - A clinical decision not to commence cardio pulmonary resuscitation to restart a patient's heart, and breathing in the event of a cardiac or respiratory arrest. [Previously Do Not Attempt Resuscitation – (DNAR)]

Fast Track Discharge – for those patients having been assessed by their Consultant as having a rapidly deteriorating condition, which may be in a terminal phase and increasing level of dependency. These patients and their carers are given a choice as to where their care may take place; i.e. at home, or in a Care home.

For those patients being discharged home, or into a Care Home, the discharge will be treated as a priority. The discharge will be arranged in accordance with the Fast Track Flow Chart, using the Healthcare fast track tool. These can be found on the ward or by contacting the case facilitator.

Rapid Discharge when in the Final Stages of Life:

- Rapid discharge was one of the 5 key enablers for route to success in acute hospitals. In some wards or departments, staff at all levels may lack the knowledge, skills and attitude to deliver high quality end of life care. There can also be a failure to recognise when continuation of treatment is not in the person's best interest. In other cases, inadequate planning or lack of discharge coordination, means that individuals are denied the chance to die at home even if they express the wish to do so.

- For these patients "home" might mean a care home. These problems can be remedied by senior clinical decision making, close to the patient. A decision that the patient is dying and their care is to be supported by an individualised plan of care for the dying patient, incorporating the five priorities of care, should be taken by a senior clinician with appropriate training in end of life care and use of the care plan. The decision should be taken after discussion with the patient (where possible) and their loved ones and they should continue to be involved in decision making. Relatives and carers should be informed of likely changes as the patient approaches death. If the care planning and rapid discharge arrangements are discussed early enough then a patient can often be discharged to die at home with the support that will prevent unnecessary distressing and expensive emergency readmission (The route to success in end of life care – achieving quality in acute hospitals 2010).

- Patients can remain in hospital for the appropriate care to be given if it is the patients and or families wishes.

Integrated Discharge Team (IDT)

IDT is a multi-agency team based at DRI which receive referrals for complex discharge planning, restarts and increases of exiting care packages. The team accepts referrals from DRI, Mexborough Montagu, and Magnolia Lodge, Intermediate care beds on the Tickhill Road site and also out of area referrals via notifications of discharge. The team manage the Discharge to Assess (D2A) pathways that can be accessed through this team.

It is made up of staff from social care, Social Workers and Assessment Officers, Discharge Nurse Specialists from DBH, therapy staff from DBH and also Nurses from intermediate care in RDASH. In addition a Housing officer is now based within the team to deal with all housing issues.

Intermediate Care (IC) – a range of Intermediate care services that have been developed in order to promote active recovery and rehabilitation and to prevent unnecessary loss of independence for older people and other care groups. Local service developments are mainly targeted at people who would otherwise face unnecessarily prolonged hospital stays, inappropriate admissions to acute in-patient care or long term residential care.

The eligibility criteria and referral procedures for these schemes are available from the discharge co-ordinators.

The discharge co-ordinators or the social work team can also advise on local interim care arrangements available for people whose acute treatment is completed but where, for various reasons, their discharge is delayed.

Mental Capacity – the ability of a patient to make an informed decision based on the ability to receive, retain and understand information relevant to the decision being made. From April 2007, all adult patients should be assessed for Mental Capacity in accordance with the Mental Capacity Act 2005. (Please refer to the Trust Policy, *Mental Capacity Ref: PAT/PA 19)*
Individuals should be assessed *only* on their capacity to make the decision required.

Multi-Disciplinary Team (MDT) – the team of staff involved in the care of the patient. It will include some, or all, of the following: Nursing Team, Medical Team, Physiotherapist, Occupational Therapist, Speech and Language Therapist, Social Worker and/or Assessment Officer, Community Nursing team, Specialist Nurse, and other Allied Health Professionals.

Estimated Date of Discharge (EDD) Also known as Predicted Date of Discharge or Expected Date of Discharge – an estimated date for the patient to be discharged is determined within 24 hours of admission, or before admission for those patients undergoing elective treatment. It is based on an anticipated Length of Stay in hospital needed to ensure that all diagnostic tests are completed and that the patient has responded to treatment and is clinically stable. The MDT must be confident that the patient's actual Length of Stay is determined by clinical need. It is important to note that this is an estimated date, and can/will be reviewed by MDT. It is a date that is shared with both patient and relatives to ensure seamless process. Sharing the

Estimated Discharge Date with the patient, relatives and members of the MDT can facilitate and ensure seamless care and improve patient flow through the healthcare process.

Self-Discharge – If a patient insists on being discharged before being assessed as fit for discharge, and against medical advice, he will be taking Self-discharge. The process for co-ordinating a Self-Discharge is described in section 3.4.

Pre-Emptive Medications - these are medications that are prescribed on an as required basis for symptoms that may develop in the last hours or days of life. Prescribing these medications will ensure there is no delay in responding to a symptom if it occurs.

Individualised Plan of Care (IPOC) for the last hours/ days of life -this is a care plan that is used when the person is approaching the end of their lives it ensures that each person is treated as an individual and an individual care plan is used in accordance to their care needs, the plan should be discussed openly with the person and those important to them.

12 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 2).

13 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Patients' Property and Valuables (PAT/PA 12)
- Safe and Secure Handing of Medicines Management Policy (PAT/MM 1)
- Policy for the Care of Prisoners and Patients from High Secure Hospitals (PAT/PA 10)
- Mental Capacity Act 2005 - Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) (PAT/PA 19)
- Non-Emergency Trust Funded Transport (Internal Transportation) (CORP/FAC 2)
- Transfer of Patients and their Records (PAT/PA 24)
- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) policy (PAT/EC 8)
- Trust's Discharge Lounge Operational Policy
- Fair Treatment for All Policy (CORP/EMP 4)
- Equality Analysis Policy (CORP/EMP 27).

14 REFERENCES

Department of Health
Achieving timely simple discharge from hospital: A toolkit for the multidisciplinary team 2004 www.dh.gov.uk

South Yorkshire's Adult Protection Procedures
Safeguarding Adults - Practice Guidance for Doncaster 2017

Deprivation of Liberty Code of Practice
Achieving Timely Simple Discharges from Hospital DOH 2004

Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 NHS Improvement

Monthly Delayed Transfers Of Care SitReps: Definitions and Guidance

National Priorities for acute hospitals July 2017
Good practice guide :Focus on improving patient flow

Mental Capacity Act 2005 - Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) (PAT/PA 19)
Add Mental Capacity Act etc.

The Care and Support (Discharge of Hospital Patients) Regulations 2014

APPENDIX 1 – TRUST 'PATIENT AND CARER DISCHARGE PASSPORT'

Appendix 1

Trust 'Patient and Carer Discharge Passport'

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT/PA 3 v.5 – Discharge of Patients from Hospital Policy	Performance	Laura Di Ciacca	Existing Policy	12 October 2017

1) Who is responsible for this policy? Chief Operating Officer

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? All patients being discharged from hospital

3) Are there any associated objectives? Legislation, targets national expectation, standards - Delayed Transfers of Care

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] None required

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	utcome 2	Outcome 3	Outcoe 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: October 2020

Checked by: R Bruce **Date: October 2017**