Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/CAD/ID 3113

Please reply to:
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Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
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Email: mtw-tr.foiadmin@nhs.net

01 February 2016

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Admissions and Discharge policies and Venous Thromboembolism (VTE) policy.

Under the Freedom of Information Act, please may you send me a copy of your Admissions Policy and Discharge Policy?

If held, please may you send me your policy on preventing and treating venous thromboembolism (VTE's).

Please see the attached policies.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Patient Admission Policy and Procedure

Requested/ Required by:	Clinical Operations & Delivery Committee to comply with national recommendations for good practice
Main author:	Associate Director of Nursing Planned Services **Contact Details:** 01622 225653
Document lead:	Chief Operating Officer **Contact Details:** 01622 226421
Directorate:	Planned Services
Specialty:	Admissions
Supersedes:	Patient Admission Policy and Procedure (Version 2.0: March 2011)
Approved by:	Standards Committee, 17th October 2014
Ratified by:	Trust Management Executive, 15th October 2014
Review date:	October 2015

Document history

Requirement for document:	• To reduce the incidents associated with unsafe transfer of patients, reduce risk of infection and loss of patient property.
Cross references:	•
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Patient Property Policy & Procedure* [RWF-OPPPCS-NC-NUR1] • Maidstone and Tunbridge Wells NHS Trust. *Patient handling assessment tool* [RWF-OPF-CS-NC-FH3] • Maidstone and Tunbridge Wells NHS Trust. *Infection Control Policy and Procedure* [RWF-OPPPCSS-C-PATH15] • Maidstone and Tunbridge Wells NHS Trust. *Medicines Policy and Procedure* [RWF-OPPPCSS-C-PHAR1] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Children Policy and Practice Guidelines* [RWF-OPPPCS-C-NUR6] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure* [RWF-OPPPCS-C-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *Discharge Policy and Procedure, Operational* [RWF-OPPPES-C-AEM6] • Maidstone and Tunbridge Wells NHS Trust. *Patient Transfer Policy and Procedure* [RWF-OPPPCS-C-TM3] • Maidstone and Tunbridge Wells NHS Trust. *Malnutrition Universal Screening Tool Policy* [RWF-OPPPCSS-C-THP2] • Maidstone and Tunbridge Wells NHS Trust. *Protected Mealtimes and Red Tray Policy and Procedure* [RWF-OPPPCS-C-NUR3] • Maidstone and Tunbridge Wells NHS Trust. *Patient Identification Policy and Procedure* [RWF-OPPPCS-C-NUR2] • Maidstone and Tunbridge Wells NHS Trust. *Diarrhoea, Policy and Procedure for the Assessment of Patients Presenting with* [RWF-OPPPCSS-C-PATH10] • Maidstone and Tunbridge Wells NHS Trust. *Isolation Policy and Procedure* [RWF-OPPPCSS-C-PATH16] • Maidstone and Tunbridge Wells NHS Trust. *MRSA - Control and Management of Meticillin Resistant Staphylococcus Aureus including Screening and De-colonisation* [RWF-OPPPCSS-C-PATH21] • Maidstone and Tunbridge Wells NHS Trust. *Clostridium difficile, Control and Management of* [RWF-OPPPCSS-C-PATH8] • Maidstone and Tunbridge Wells NHS Trust. *Maternity Guidelines* [see Women and Children's Q-Pulse database] • Maidstone and Tunbridge Wells NHS Trust. *Paediatric Unit Policies* [see Women and Children's Q-Pulse database] • Maidstone and Tunbridge Wells NHS Trust. *Multi-Resistant Organisms (excluding MRSA and CRE), Control and management of* [RWF-OPPPCSS-C-PATH23] • Maidstone and Tunbridge Wells NHS Trust. *Carbapenemase-producing Enterobacteriaceae (CPE) and carbapenemase-resistant Enterobacteriaceae (CRE), Control and Management of* [RWF-OPPPCSS-C-PATH41]

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	New guidelines	March 2009
2.0	Reviewed	March 2011
3.0	Reviewed	August 2014

Policy statement for

Patient Admission Policy

All patients admitted to Maidstone and Tunbridge Wells NHS Trust hospitals, either planned or emergency must receive equitable treatment and be provided with standard information to enable them to be safely orientated and made to feel secure in the environment.

At the point of admission the staff looking after the patient must record all information required to ensure the needs of the patient are fully met during their stay in hospital, and ensure that appropriate provisions can be made for discharge.

To enable us to prevent and reduce the spread of infection all patients will undergo assessment and /or screening, as detailed in the Infection Control policies. All appropriate cases will be discussed with the Infection Control Team. This may include placing the patient within a specific area in the Trust and taking infection control measures as necessary. The patient will be fully informed of their treatment and management whilst in the care of the Trust.

Particular care and consideration must be given to vulnerable adults, children and in particular patients with learning disabilities who require admission.

We aim to ensure that men and women do not have to share either sleeping accommodation or toilet facilities within our hospitals, except where it is clinically justified for each patient.

Maidstone and Tunbridge Wells NHS Trust is committed to providing quality services which ensure appropriate food, drink or specialised nutrition are made available within their hospitals. The Trust aims to provide all necessary help to ensure every individual is able to select and consume appropriate nutrition in a conducive environment to promote health.

The policy for patients being admitted into Maidstone and Tunbridge Wells NHS Trust has been drawn up to include aspects of care raised in the Essence of Care Document [Benchmarks for safety of clients with mental health needs in acute mental health and general hospital settings] (2003), to address aspects of orientation and assessment which if addressed on arrival in the Trust can result in a more safe and effective patient stay.

Patient Admission Procedure

Contents **Page**

1.0 Introduction and scope

Introduction

All patients admitted to Maidstone and Tunbridge Wells NHS Trust hospitals, either planned or emergency must receive equitable treatment and be provided with standard information to enable them to be safely orientated and made to feel secure in the environment. This policy aims to clarify each member of staff responsibility in relation to the admission of a patient and the information they should receive.

Scope

This document will apply to all healthcare staff working in the Trust, including managers, nurses, doctors and allied health professionals or whoever first makes contact with the patient and initiates assessment of their needs.

2.0 Definitions

No definitions are required at this time.

3.0 Duties

The member of staff meeting the patient for the first time is ultimately responsible for recording and imparting information, to ensure that their admission is safe and individual needs are met.

4.0 Training / competency requirements

There are no training / competency requirements at this time.

5.0 Procedures

5.1 Standard introduction

5.1.1 Each patient arriving in the Trust must be greeted by a member of staff who must introduce themselves by name and title e.g. doctor, nurse. An outline of the admission process and clinical assessment must be described. The name of the doctor under whom the patient has been admitted must be given and details of any routine procedures, i.e. taking of details, routine observations, blood test, must be explained.

5.1.2 The patient must be orientated to the local environment including toilets, washing facilities and nurse call bell system.

5.2 Admission to a procedure / assessment area

5.2.1 If the receiving area is not a ward, e.g. an assessment area, the location and assessment process must be explained, making clear that the area is not a designated ward, but an area for assessment and that following designated procedures a decision will be made regarding the need for admission or discharge. If admission is required a bed will be located appropriately.

5.2.2 Timely updates of the admission/assessment process must be given to the patient and any accompanying person.

5.3 Admission to a ward

5.3.1 On arrival to the allocated bed, it must be considered if it is appropriate to introduce the patient to others in the bay.

5.3.2 The ward routine must be explained. A copy of the generic hospital booklet 'Welcome to Maidstone and Tunbridge Wells NHS Trust' must be made available to the patient and in addition local information relevant to the ward area should be shared and supported with a local booklet detailing for example ward round times ,meal times and any other specific information .

5.3.3 Visiting times must be explained clearly, highlighting the reasons for restrictions and these details should be highlighted to any accompanying person.

5.3.4 The procedure to be followed in the unlikely event of the fire alarm sounding must also be explained, as should fire alarm test days and times.

5.4 Individual needs

5.4.1 The patient must be asked if they have any particular needs to be addressed during their hospital stay. At this point it is important to establish if the patient has any communication requirements

5.4.2 Assessing a patient's needs can be achieved by applying standard questions during the admission process including questions relating to previous access to health services.

For example:

'Have you ever been referred to any of the following services?'

- Diabetic Services,
- Social Services,
- District Nursing Services
- Mental Health Services,
- Others?'

5.4.3 Once identified these needs must be recorded in the relevant documentation and passed on to other appropriate persons, i.e. the catering dept. or the multidisciplinary team. Specialist nurses or others involved in the individual's care can be informed of the admission, and consulted on care requirements with the permission of the patient.

5.4.4 Assessment tools/care plans e.g. Infection Control, (see **Appendix 4**), MUST, VTE, Falls must be used to ensure a full assessment is completed on admission within an appropriate or designated time frame for that ward/area.

5.5 Transfers within the hospital Trust

5.5.1 The Medical and Surgical Acute Admissions Unit operates the policy of a 12 to 24 hour stay with a move to an appropriate ward if the patient needs to remain in hospital after that period. The length of stay in the admissions unit may vary according to bed availability and the number of emergency admissions. The unit is open 24 hours a day 7 days a week.

5.5.2 Wherever possible transfers within the hospital will be avoided but patients must be made aware that at times this becomes a necessity due to the number of emergency admissions or clinical need. Staff must try to ensure that transfers are made at appropriate times of the day to minimise disruptions to patients. Please refer to **Appendix 6**.

5.5.3 Patients must also be made aware that it is standard practice to transfer on from assessment units/wards to specialist wards/departments or hospital site if ongoing care needs have been identified.

5.6 Maternity Services

5.6.1 Patient admissions can be either by self referral or from another health professional. Telephone advice (from the delivery suite/antenatal ward) will be sought prior to admission into hospital.

5.6.2 Patients will be asked to attend either the antenatal ward, midwifery day unit or the delivery suite and, after initial assessment, may be transferred to another area of maternity which is more appropriate to their needs. Transfer to another area/ward will be conducted in a timely manner and relevant information regarding the patient will be transferred using the CHAPs handover tool – refer to handover (onsite) guideline.

5.6.3 If the maternity unit is on divert or closed, ambulances and patients will be advised which unit to attend – refer to maternity divert/closure guideline.

5.7 Paediatric Services

5.7.1 Every child admitted to a paediatric ward overnight is entitled to have one adult (18yrs and over) resident overnight. If this adult is not the parent / guardian (e.g. grandparent / carer) there must be clear evidence that there is parental / guardian consent for them to stay. Children / parent / guardian will be given a booklet explaining the ward routine and will be advised about facilities available regarding play and education as appropriate.

5.7.2 All inpatient children will have access to a Hospital Play Specialist.

5.7.3 On admission any safeguarding issues identified will be addressed following the *Safeguarding Children Policy and Practice Guidelines*.

5.8 Plan of care

5.8.1 On admission each patient must be made aware of the approximate length of time they can expect to stay in hospital.

5.8.2 For some conditions or procedures a standard length of stay can be predicted, in others this may be variable. All lengths of stay are approximate and may change due to the patient's condition.

5.8.3 The predicted discharge date will be documented in the notes to assist the multidisciplinary team plan and co-ordinate a safe and timely discharge.

5.8.4 Depending on the patient needs their care may be transferred to one of our partner organisations in the community.

5.8.5 Each patient must be involved in their plan of care and must be kept informed of their progress.

5.8.6 Relatives and/or next of kin should be given information about how to contact the ward and questions related to the plan of care should be answered where possible on admission.

5.9 Raising concerns

5.9.1 Each patient must be informed that if they wish to raise concerns or are unhappy with any aspect of their care, they may raise the matter with any member of staff so their problem can be resolved quickly.

5.9.2 The Matrons are available to support patients and carers and the patient must be informed of the Patient Advice and Liaison Service (PALS).

5.9.3 Patients must also be made aware of the complaints procedure and supported should they wish to make a formal complaint.

5.10 Wristbands

5.10.1 All patients admitted or under going treatments must have one wristband detailing the following:

- Full name
- Date of birth
- NHS number (NPSA, 2007a) or Patient Hospital number

5.10.2 The wrist bands must have a red border if the patient is reported to have an allergy. All details must be checked with the patient or accompanying person prior to application.

5.10.3 Newborn babies admitted to the wards must have two identification wrist bands with include specific details - refer to newborn security guideline.

5.10.4 Please refer to Patient Identification Policy and Procedure.

6.0 Monitoring and audit

Compliance with policy will be monitored on an ongoing basis by ward managers and directorate Matrons.

Ward Managers will undertake annually, an audit of Admission Documentation activity as part of the quality assurance framework audit work and the results reported and reviewed at Ward Sister's meetings.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- Updated policy to be shared via ward sisters' meeting to be managed by ADNS
- Circulation to all consultants via Medical Committee
- Hard copies will be distributed to wards
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

The policy will be reviewed at the Trust Management Executive yearly.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Patient Admission Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Associate Director Nursing Planned Services

By date: 30th Sept 2014

Name: Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Chief Executive	01/09/14			
Director of Infection Prevention & Control	01/09/14			
Chief Operating Officer	01/09/14			
Chief Nurse	01/09/14			
Medical Director	01/09/14			
Relevant Directors / ADO/ ADNS etc.	01/09/14			
Relevant GM's/ CD's/ Matrons etc.	01/09/14	03/09/14	Y	Y
Relevant risk leads/ governance leads etc.	01/09/14			
Infection Control representative	01/09/14	04/09/14	Y	Y
Estates and Facilities representatives	01/09/14			
Trust Competent Officers and advisors etc.	01/09/14			
	01/09/14			
Staff required to implement the policy	01/09/14			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Patient Admission Policy and Procedure
What are the aims of the policy or practice?	To ensure that all patients on admission are provided with standard information to enable them to be safely orientated and made to feel secure in the environment
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	Interpreters available
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not	

require a stage 2 assessment?	
When will you monitor and review your EqIA?	At the same time as this policy and procedure.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three of this policy and procedure on the Trust Intranet (Q-Pulse)

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Admissions: Infection control risk assessment	RWF-OPG-PS10
5	Internal / external patient transfer form	RWF-OWP-APP79
6	Patient transfer risk assessment flowchart	RWF-OWP-APP81

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Operational Discharge Policy and Procedure

Requested/ Required by:	Clinical Governance to comply with national recommendations for good practice
Main author:	Discharge Liaison Team **Contact Details:** ext. 24838/35723
Document lead:	Chief Operating Officer **Contact Details:** ext. 26427
Division:	Emergency Services
Specialty:	Discharge Liaison
Supersedes:	Discharge Policy, Version 3.0 (November 2007) Discharge Policy and Procedure, Version 4.0 (11th November 2009) Discharge Policy and Procedure, Version 4.1 (July 2011) Discharge Policy and Procedure, Version 4.2 (September 2011)
Approved by:	Divisional Operations, 18th April 2012 (Version 4.3)
Ratified on behalf of the Board by:	Divisional Operations, 18th April 2012 (Version 4.3)
Review date:	April 2015

Document History

Requirement for document	• To set out the responsibility of professional staff and support services in respect of Discharge Planning and transfers. • To outline key tasks which will be completed in order to effectively co-ordinate the process. • To ensure effective discharge planning in accordance with the Trust's Risk Management strategy. • NHSLA Risk Management Standards: Standard 4.10
Cross references:	• Mental Capacity Act, Policy and Procedure 2008 • Mental Capacity Act Code of Practice • DOLS Policy and Procedure • DOLS Code of Practice • SCIE Guide 25: Dignity in Care. Feb 2008 • National Framework for NHS funded Continuing Health Care, Oct 2007 • Community Care (Delayed Discharges etc.) *Act 2003. (c5),* London: Stationery Office. • Department of Health. (2004). *Making Partnership Work for Patients, Carers and Service Users A Strategic Agreement between the Department of Health, NHS and Voluntary and Community Sector.* London: Department of Health. • Department of Health. (2004). *Active Timely "Simple" Discharge from Hospital – A Toolkit for the Multidisciplinary-Team.* London: Department of Health. • Department of Health. (2010). *Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care.* London: Department of Health • Health and Social Care Joint Unit & Change Agents Team (Department of Health). (2003). *Discharge From Hospital: Pathway, Process and Practice.* London: Department of Health. • National Audit Office. (2003). *Ensuring the Effective Discharge of Older patients from NHS Acute Hospitals.* London: The Stationery Office. • National Institute for Clinical Excellence (NICE). (2004). *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* London: NICE. • Rapid Discharge Pathway for a Patient going home for end of Life Care (2012) • Royal Pharmaceutical Society of Great Britain, the Guild of Hospital pharmacists, the Pharmaceutical Services Negotiating Committee, the Primary Care Pharmacists' Association. (2006). *Moving patients, Moving medicines, Moving safely: Guidance on Discharge and Transfer Planning.* London. • *Joint Protocol for use of interim community placements for non-weight bearing patients.* September 2008.
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Care of the Dying Policy and Procedure* • Maidstone and Tunbridge Wells NHS Trust. *Reimbursement, Protocols for Delayed Transfer of Care* • Maidstone and Tunbridge Wells NHS Trust. *Care Home Discharge Policy and Procedure* • Maidstone and Tunbridge Wells NHS Trust. *Multi-Agency Adult Protection Policy Protocols and Guidance for Kent and Medway* • Maidstone and Tunbridge Wells NHS Trust. *Joint Protocol for use of interim community placements for non-weight bearing patients* • Maidstone and Tunbridge Wells NHS Trust. *Patient Transfer Policy and Procedure* • Maidstone and Tunbridge Wells NHS Trust. *Discharge Lounge Protocol* • Maidstone and Tunbridge Wells NHS Trust. *Patients Property Policy and Procedure*

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	Initial document	
2.0	Updated	2005
3.0	Updated	November 2007
4.0	Updated for NHSLA standards	November 2009
4.1	Minor amendments (NHSLA informal recommendations and EDN)	July 2011
4.2	Addition of Appendix 4	September 2011
4.3	Minor Amendments (4.3 approved in April 2012, but additional minor amendments were requested by the Director of Nursing so the version was only released in December 2012)	April 2012

Policy Statement for

Discharge Policy and Procedure

Maidstone and Tunbridge Wells NHS Trust is committed to providing patients with a safe, timely and efficient discharge service, whether an emergency or elective admission.

To ensure effective discharge planning in accordance with the Trust's Risk Management strategy, Maidstone and Tunbridge Wells NHS Trust has produced this Discharge Policy and Procedure which will be peer reviewed every two years. It sets out the responsibility of all agencies, professional staff and support services in respect of Discharge Planning and transfers and outlines key tasks which will be completed in order to effectively co-ordinate the process.

Discharge Procedure

CONTENTS **Page**

Further appendices **27**

Appendix	Title
4	Medical Admission Proforma
5	Admission and discharge sheet
6	Flow chart for referral to East Sussex Social Services
7	Rapid discharge pathway for a patient going home for end of life care
8	Transfer of care summary for patients discharged to Care Homes
9	Body map

1.0 Introduction and scope

1.1 Discharge should take place when there is no longer a need for ongoing acute inpatient care.

1.2 The ultimate responsibility for the patient's discharge rests with the Consultant, whilst the co-ordination of the discharge procedure is the responsibility of the patient's named nurse. Nurse led discharge can take place once the medical plan is completed and the patient is discharged from the Multi-disciplinary team.

1.3 Where patients have had access to community Health and Social Services prior to admission the named nurse, who should record the level of service currently/previously being provided, will initiate contact with these services, either directly or via the Patient Discharge Team or Care Management Team.

1.4 Multi-disciplinary assessments must be carried out and an Expected Date of Discharge (E.D.D) set within 24 hours of admission. The patient's progress must be monitored and discussed within the multi-disciplinary team on a regular basis.

1.5 Sufficient notice of the date of discharge must be given to enable the necessary arrangements for care in the community to be made. The time required to ensure the continuity of health/social care will vary according to the needs of the patient, their family and/or carers, and the resources required to meet those needs.

1.6 If a patient being discharged to a private residence is identified as having no mobility, i.e. bed bound, or requires a stretcher to travel, Patient Transport must be informed as soon as an E.D.D has been set, in order for a risk assessment of the property to be carried out, with regard to access.

1.7 The following document is intended to aid the professionals through the discharge procedure, ensuring safe, efficient and effective discharge of the patient into the community.

EFFECTIVE DISCHARGE PLANNING

- Facilitates a safe organised transfer that ensures that the relevant Health /Social/Voluntary Services are ready to receive and support the patient and carer.
- Ensures that patients are discharged to a safe and clinically appropriate environment in a speedy and timely manner.
- Provides information regarding medication, appropriate equipment /adaptations, relevant community and general information to enable the maximum possible independence for the patient and carer.

- Provides continuity of care through effective communication between hospital and community multi-disciplinary teams.
- Supports patients who wish to go “home at risk”, e.g. patients who wish to take their own discharge against medical advice (self discharge), any instance where there may be a dispute between professional groups regarding discharge plans/arrangements, any dispute between patient and family/carers, etc.
- With the consent of the patient, the family or carer (where appropriate) are kept fully informed of all aspects of their discharge plan and planned aftercare/ post-discharge services and arrangements.

2.0 Definitions

Discharge: To leave the acute hospital setting.

Multi-disciplinary team (MDT): Relating to input from other disciplines related to health e.g. Therapists, Social Services, and Specialist Nurses.

Functional Assessment: Assessment of activities of daily living, independence and rehabilitation requirements.

Safe and clinically appropriate environment: To an environment which will meet the patients assessed needs.

Discharged at risk: Patients’ who have capacity, may decide to ignore advice from professionals allied to health regarding safety issues when discharged to their home e.g. a patient may self neglect or be at risk of falls.

Lifestyle change advice: Information regarding any adjustments to activities of daily living which need to be made due to a medical condition.

EDD: Estimated Date of Discharge.

3.0 Duties

3.1 Executive Responsibility

The Director of Operations will take overall responsibility for ensuring that effective discharge planning is in place. They are responsible for ensuring that audit of compliance with the policy is undertaken and that actions are taken to ensure a reduction of problems arising from discharge processes.

3.2 Medical Staff Responsibilities

3.2.1 Ultimate medical responsibility for the discharge of a patient lies with the Consultant in charge of the patient’s care.

3.2.2 All patients will have a Medical Admission Profoma (**Appendix 4**) completed, in order to facilitate efficient and safe early discharge. Appendix 4 will indicate medical criteria and parameters to trigger discharge without further medical review. All patients will be reviewed by the senior nurse on the day of discharge prior to leaving the ward; this enables patients to be discharged at the weekends when relevant teams are not on call.

3.2.3 Discussions with the patient and/or their next of kin/significant other/carers at the earliest opportunity regarding:

- Anticipated length of stay
- The expected date of discharge
- Expected outcome of proposed treatment
- Necessary follow-up arrangements

3.2.3 Contribute to and attend multi-disciplinary team meetings weekly.

3.2.4 Electronic Discharge Notification for patients for discharge are to be written by a member of the patient's medical team 24 hours prior to discharge.

3.2.5 Electronic Discharge Notification copy will be given to the patient and a copy put in the patients notes (This must be a final version and not a draft version). Electronic copy is automatically sent to the patient's GP on discharge when completed.

3.2.6 Medical Staff who complete the Electronic Discharge Notification will liaise with the GP when there is a need for them to be involved in the discharge planning process.

3.2.7 Medical Staff will forward any relevant abnormal results of investigations requiring specific action that arrives after the patient's discharge to the GP as soon as possible by telephone and fax and followed up by a letter with a copy of the results.

3.2.8 For patients where there are particular medical concerns, notify the patient's GP and, where appropriate the Discharge Liaison Team and, if necessary, attend any meeting/case conference. Depending on complexity this will be the Consultant or other members of designated medical team.

3.3 Nursing Staff Responsibilities

3.3.1 An Admission/Discharge sheet needs to be completed for every patient admitted (**Appendix 5**). Completion of the Admission sheet informs the patient's discharge plan and appropriate referrals to be made. This allows everyone to focus on a clear end point in the patient's care. It also reduces errors and unnecessary delays along the patient pathway. Discharge planning should involve the patient and the next of kin. The discharge planner must be completed on the patients discharge. The nurse in charge is responsible for the safe discharge of patients.

3.3.2 The patient's next of kin needs to be identified as soon as possible, and established by the patient who will receive and coordinate information for other family members. This 'main contact' is documented in the patient's notes.

3.3.3 A detailed 'body check' for pressure ulcers, bruising or marks should be documented on the body map (**Appendix 9**) on admission, a further body map should be supplied prior to discharge, and sent with the patient when being discharged to another healthcare provider.

3.3.4 The Expected Date of Discharge should be set within 24 hours of admission in conjunction with the MDT, and written on the discharge planner to be found on the reverse side of the admission sheet.

3.3.5 The designated nurse will identify whether the patient receives any community support or whether the patient is a carer and contact relevant Social Services personnel to confirm admission.

3.3.6 When the patient has an assessed identifiable need for social services care management, a referral should be made immediately with the patients

permission to a hospital based Case Manager, via the Patient Centre system. Notification to social services under the Community Care Act permits a minimum of 3 days to carry out an assessment and arrange services.

3.3.7 If a patient has been assessed as lacking the mental capacity to make specific decisions for themselves with regards to their discharge plans, staff need to establish if a Lasting Power of Attorney exists.
There are two types of Lasting Power of Attorney (LPA):

1. Property and Affairs LPA

2. Personal Welfare LPA

When arranging a Community Care Package or placement in a Care Home both LPA's will need to be consulted with (refer to MCA Policy and Procedure.)

All Attorneys have to abide by the five statutory principles of the Mental Capacity Act 2005 (refer to MCA Code of Practice).

If a patient has no-one appropriate to act on his/her behalf and lacks capacity to make a decision about a change in long term accommodation needs then an Independent Mental Capacity Advocate referral will need to be completed (refer to MCA Policy and Procedure).

3.3.7 Criteria led discharge (**Appendix 4**) to be completed in full by a senior staff nurse or above before an appropriately identified patient can be discharged without further review.

3.3.8 The patient and next of kin or identified 'main contact 'must be informed as soon as possible of the discharge date so that they can be involved in the discharge plan.

3.3.9 The ward manager is responsible for weekly attending Multi-disciplinary meetings or sending a deputy to attend on their behalf.

3.3.10 The ward manager or deputy is also responsible for attending the weekly LOS / SitRep meetings to ensure plans are in place for all patients with a LOS > 7 days. These plans will be regularly reviewed and updated with the ward managers by the divisional representatives on a daily basis.

3.4 Pharmacist Responsibilities

3.4.1 Ward Pharmacy teams will conduct medication histories on all patients where appropriate and ensure that any discrepancies with medication are sorted at the earliest opportunity.

3.4.2 Patients who are admitted on monitored dosage systems will be identified by Pharmacy who will endeavor to discharge the patient on the same monitored dosage system. Pharmacy will liaise with the patient's usual community pharmacy to ensure continuation of supplies. Monitored dosage systems are more time consuming to dispense and check, therefore a minimum of 4 working hours notice is required of discharge medication in such devices.

3.4.3 For potential medication compliance problems the patient should be referred to the ward Pharmacy team at least 24 hours prior to discharge. An assessment can then be made of the most appropriate compliance method e.g. large labels, medication record card, simplifying the medication or a monitored dosage system.

3.4.4 Before discharge, Pharmacists will check all discharge prescriptions to ensure that all items have been correctly prescribed according to the inpatient prescription chart and that quantities and duration of treatment are appropriate. The ward Pharmacist or Technician will check all medication in the patients POD locker, at the bedside or in the ward fridge to check that any medicines to take home have the correct instructions.

3.4.5 The ward Pharmacy team will aim to discuss medication with patients before their discharge. The discussion will include detail of what their medication is for, how best to take them and how to obtain further supplies.

3.4.6 All discharge prescriptions will be logged onto the Pharmacy TTO Tracker system so that the ward can keep up to date with the expected delivery times.

3.4.7 Pharmacy will liaise closely with the discharge lounge staff to ensure that the use of the discharge lounge is maximised and that medication is dispensed safely and timely.

3.4.8 Pharmacy will ensure that all discharge medication is dispensed with a manufacturer's patient information leaflet and a Trust Medication Helpline leaflet.

3.5 Therapy Responsibilities

3.5.1 Nutrition and Dietetics

- When the patient has an assessed identifiable need for Dietetic intervention, a referral should be made with the patient's permission immediately to the Department of Nutrition and Dietetics, via the Patient Centre system. In line with the Enteral Feeding Policy, 48 hour notice is required to organise discharge with Home Enteral Nutrition.
- The designated Dietician or feed company representative will provide advice and training on the use of the equipment etc required for ongoing nutritional support. If appropriate this can be arranged to be carried out once the patient is in the community (e.g. home).
- Communicate with the appropriate community team and complete a discharge summary that will be faxed or sent electronically on the day of discharge.
- Be responsible for informing the Community Dietician if patients with existing nutritional support in place on admission subsequently require a change to regime on discharge etc.
- Inform the patient's General Practitioner if an ongoing nutritional support prescription is required
- Patients referred for Lifestyle change advice may be offered an out patient appointment once discharged if deemed more appropriate by the designated Dietician.

3.5.2 Occupational Therapy

- Assessing ability to function in essential activities of daily living on discharge from hospital and providing rehabilitation or adaptive interventions to improve occupational function e.g. practice in self care, equipment provision and recommendations for care assistance required.

- Home visits are undertaken where required to complete occupational therapy assessments or interventions.
- Patients requiring occupational therapy should be referred as soon as possible via patient centre. The Occupational Therapy service aims to provide a response to referrals within 24 hours as resources allow.

3.5.3 **Physiotherapy**

- Physiotherapy staff will assess an individual's functional independence and rehabilitation requirements to optimise this.
- The physiotherapists will liaise with outpatient or community colleagues as required for onward referral on discharge.
- Patients requiring physiotherapy should be referred to the ward physiotherapist as soon as possible.

3.5.4 **Speech and Language Therapy**

- SLTs will have given communication and swallowing guidelines where necessary to nursing staff, whilst the patient is on the ward. On discharge, it is the responsibility of the nursing staff to ensure that these guidelines go with the patient.
- Patients requiring follow-up SLT in the community will be referred by the in-patient SLT team.
- The in-patient SLTs will contact residential or nursing homes when the patient is discharged, to ensure guidelines are in place.

3.6 Infection Control

3.6.1 Prior to planning suspected or confirmed infectious patients' discharge or interhealthcare transfer or re-admission the infection control nurse must be notified to ensure that the risks of cross infection are assessed and minimised.

3.6.2 A 'confirmed risk' patient is one who has been confirmed as being colonised or infected with Meticillin–Resistant Staphylococcus Aureus (MRSA), Glycopeptide-Resistant Enterococci (GRE), Extended Spectrum Beta Lactamase (ESBL), Pulmonary Tuberculosis (TB) and enteric infections (diarrhoea and/or vomiting) including Clostridium difficile, (see relevant policies for further information).

3.6.3 A 'suspected risk' patient includes one who is awaiting laboratory test results to identify infections/organisms or those who have been in recent contact/close proximity to an infected patient case.

3.6.4 When transferring patients in either of the above risk groups between wards and departments or to another healthcare setting it is essential to inform the infection control team at the receiving ward/unit of any infectious conditions, within working hours before the transfer is carried out and before arranging an appointment or ordering transport. A transfer form must also be completed for all transfers whether the patient presents an infection risk or not, (DH 2008). The guidelines should be read in conjunction with the Standard Infection Control Precautions Policy.

Discharges and Transfers to External Healthcare Facilities:

3.6.5 Detailed verbal and written information about the patient's current infection status or risk factors must be given to the receiving unit prior to transfer.

- General Practitioners should be informed in the Discharge Letter if an infectious patient is to be discharged home.
- If patients require continuing care and management of their infection e.g. MRSA in the community, then the District Nurses, Community Infection Control nurse and Community Psychiatric nurse should also be advised of their discharge as necessary.
- If treatment courses need to be continued following discharge from hospital a referral should be made to the district nurse to ensure that the course is completed. The patient should be given medication to take home as appropriate.
- For ambulance transportation, clinical staff must notify the Trust's Patient Transport department in advance. If the patient requires a trained or paramedic crew, Patient Transport will advise on the appropriate service, in accordance with the individual circumstances.
- Ensure that any leaking wounds are covered with an appropriate occlusive dressing.
- Patients with diarrhoea due to suspected or confirmed viral or bacterial infection should not be transferred (excluding transfer for emergency care or admission on clinical grounds) to a General Hospital. Diarrhoea is defined by an increased number (two or more) of loose, watery or liquefied stools (Bristol stool type 6 and 7 only) within a 24 hour period. Refer to the Diarrhoea, Norovirus and Clostridium difficile policies for further guidance. Use the Bristol stool chart to indicate the frequency and type of stools over the past week.

  a. Indicate if the diarrhoea is due to a confirmed underlying non infectious disease.
  b. Indicate if the diarrhoea is known or suspected to be infectious.
- Patient with 'no known risks' do not meet either of the above criteria

3.7 Discharge Liaison Team Responsibilities

3.7.1 Facilitate staff training on the Discharge planning process and policy. This is a central resource for the Trust providing information on services which support and enable safe patients' discharge.

3.7.2 The Discharge Liaison Team will:

- Provide advice and support to relatives
- Coordinate, support and advise the Multi Disciplinary Team
- Negotiate timely and appropriate decisions
- Liaise with local authorities, community services and carers

3.7.3 Assist in organising the safe transfer of patients from hospital to the community.

3.7.4 Attend and represent the Trust at discharge related meetings.

3.7.5 Audit and monitor discharge delays.

3.7.6 The designated nurse will refer all homeless or potentially homeless patients to the Discharge Liaison Team via switchboard.

3.8 Hospital based Case Managers (Social Services) Responsibilities

3.8.1 There are currently two Social Services Teams based within the Maidstone and Tunbridge Wells NHS Trust, one in Farm Cottage at Maidstone and the other in Tunbridge Wells Hospital.

3.8.2 Social Services Case Managers provide an assessment and purchasing service for older people and for disabled adults within the provision of the National Health Service and Community Care Act (1990) and other relevant Acts of Parliament.

3.8.3 Case Managers carry out a holistic assessment in conjunction with the patient, their carers and any other relevant agency and members of the multi-disciplinary team. They also arrange the provision of appropriate services to safely support the patient post-discharge.

3.8.4 The hospital based Case Managers work across most specialties for adults, 18 years and over, excluding those patients who are known to Mental Health Community Services.

Case Management Team Referrals

3.8.5 All vulnerable adults must be offered a referral to the Case Management Team; this will include patients over 65, those living alone, patients with a new disability or chronic disease. The outcome of the patient's decision must be documented in their medical/nursing notes.

3.8.6 A patient's permission must be sought before a referral can be made unless the patient lacks capacity in which case the Mental Capacity Act 2005 Code of Practice must be followed. Capacity to make a particular decision at a particular time must be assessed appropriately and documented. The decision maker must consult with the patient's representative to determine the most appropriate course of action in the patient's best interests (reference Trust MCA Policy and Procedure).

3.8.7 All patients referred to the Case Management Teams will be seen by a hospital based Case Manager, even if the patient has a community based Care Manager.

3.8.8 For patients who are not residents of Kent, referral is via the PAS system, to the Hospital Social Services Team. These referrals are forwarded by the hospital team, to the appropriate Social Services. All out of area Social Services also require notification of hospital admission via Fax 1 and notification of discharge date by Fax 2 (Reimbursement, Protocols for Delayed Transfer of Care [RWF-OPPCS-NC-TM20]).

(Please see **Appendix 6** of this policy: Flow chart for referral to East Sussex Social Services).

3.8.9 The hospital based Case Managers are responsible for transferring the care of their patients to the community based Case Managers on the patients discharge. Information regarding selecting a Care Home and local vacancies will be given to self-funding patients and their families. The Discharge Liaison Team will assist self funding families to gain access to Case Manager information systems. This will enable choice relating to gaining an appropriate care provider. The PCT Continuing Health Care are responsible for transferring patients once they have been accepted for Continuing Health Care funding.

3.8.10 The hospital Case Manager will respond to a referral from a ward within two working days.

3.8.11 The assessment will be of the patient's social and/or housing needs. Where there are complex needs or a residential/nursing home placement is being considered the MDT process using the Individual Needs Portrayal (INP) assessment will be used.

3.8.12 The outcome of the assessment will inform the care plan for any agreed services to be provided in the community.

3.8.13 When eligibility and funding has been confirmed as Social Services responsibility the Case Manager on discussion with the patient, family, or carer, will arrange placement/organise a home care package.

When eligibility and funding has been confirmed as NHS Continuing responsibility the Continuing Care Liaison nurse on discussion with the patient, family, or carer, will arrange for the appropriate placement/organise a home care package.

Self funding clients who do not meet the NHS Continuing Care Criteria will be offered support by the Acute Trust and Social services to identify a suitable placement or care package to meet their ongoing needs upon discharge.

3.9 Kent Community NHS Trust Liaison Team

3.9.1 To facilitate discharge from an acute hospital to a more appropriate setting following an acute medical episode for e.g. rehabilitation, IV antibiotics at home. Also to act as an information and support resource for the community services.

3.9.2 Referral to team by Health professional, information will be gathered to ascertain where the patient's health needs can be met e.g. Community Hospital, community rehabilitation, home with Rapid Response support. With the patient's consent discharge will be facilitated.

4.0 Training / competency requirements

The Discharge Liaison Team will facilitate staff training on the Discharge planning process and policy. This is a central resource for the Trust providing information on services which support and enable patients' discharge.

5.0 Discharge procedure

5.1 Discharge for Specific Patients Groups

All patients should receive the highest quality of care on transfer although it is recognised that there are defined groups of patients for whom special consideration should be given.

Patients with complex ongoing Health and Social Care needs relates to patients who:

- Will be discharged to their own home or to a carer's home, intermediate care or to a care home.
- Who have complex, ongoing health and social care needs which require detailed assessment, planning and delivery by the multi disciplinary team and multi-agency working.
- Patients wishing to go home at risk.
- Patients whose length of stay in hospital is more difficult to predict.

- Patients whose needs have changed as a result of their admission to hospital resulting in an inability to manage at home or whose needs cannot be met by present long term care arrangements.
- Patients who are at the end of life. Rapid discharge pathway for patients going home for end of life care (**Appendix 7**).
- Patients who have Dementia.

Discharge for specific patient groups	Social Services Referral	District Nurse Referral	Discharge Liaison involvement	Continuing Care input	Specialist nurse referral	Therapies input	Transport To take patient home	Pharmacy
1. Vulnerable Adults	√	√	√	As required	As required	As required	As required	√
2.Learning Disabilities	√	As required	√	As required	Community team for L/D	Occupational therapy	As required	√
3.Patients with complex social needs including Prison inmates	√	As required	√	As required	As required	As required	As required	√
4.Terminally ill patients. End of Life patients	√	√	√	√	As required	As required	Book 24 hours prior to discharge	
5.Continuing or newly acquired disability	√	As required	√	As required	As required	Occupational therapy and Physiotherapy √	Book 24 Hours prior to discharge	√
6.Patients from Care Homes	√	As required	√	As required		As required	Book 24 hours prior to discharge	√
7.Patients with mental health problems	√	As required	√	As required	Mental Health team /CPN	As required	Book 24 hours prior to discharge / transfer	√
8.Homeless	√	As required	√			As required		√
9.Patients with Dementia	√	√	For complex cases	As required	As required	As required	As required	√
Babies and children at Risk	Refer to paediatric policy							

5.2 Arranging Medications

5.2.1 Details of medication to be taken on arrival at home will be explained to the patient or main contact. When appropriate, practice in the self-administration of medication etc, will have taken place with the patient.

5.2.2 Electronic Discharge Notification. To Take Out medicines (TTO's) must be ordered as soon as possible (preferably a minimum of 24 hours notice should be given to Pharmacy prior to discharge) to ensure they are returned to the ward in time for the patient's discharge.

5.2.3 Arrangements for drug administration, in conjunction with carers and the District Nurse, must be made for those unable to self-administer treatment/medications. The assistance of the Ward Pharmacist/Specialist Nurse may be sought to facilitate this.

5.2.4 Sufficient notice must be given of patients requiring specialist medication, e.g., enteral feeds, to ensure an adequate supply is available on discharge. Enteral feeding prescriptions and related equipment for patients being discharged are organised by the Dietician. 48 hours notice must be given to allow the Dietician to liaise with the company representatives.

5.3 Social Care Arrangements

5.3.1 It is essential that notice of the estimated date of discharge and progress on agreed discharge plan plus any relevant written information is given to the relevant Community, Social and Healthcare services as soon as possible.

5.3.2 The designated nurse must ensure that in cases where the patient is returning to an empty house, relatives/carers/named contact are aware of the discharge date in advance and that keys and clothes are available. A member of the patient discharge team should be informed immediately if any difficulties are anticipated.

5.3.3 In cases where disagreement arises with regards to a planned discharge process legal advice can be sought via the Legal services manager, Quality and Patient Safety Manager or Head of Quality and Governance during core hours. Out of hours via the Executive on call.

5.3.4 If a Lasting Power Attorney exists for property and affairs or personal welfare the attorney/s become the decision makers with regard to the best interests of the patient.

5.4 Self Discharge

5.4.1 When patients discharge themselves against medical advice, the GP/Community Nursing Service and/or the hospital based Case Manager will be notified. The self-discharge form must be completed at this time. No aspect of this Discharge Policy affects the patients' right to discharge themselves at any time.

Unless it is assessed and documented that a patient lacks the mental capacity to make this decision at this particular time for themselves. If this is the case a 'best interest decision' will need to be made with regards to what is the least restrictive intervention. The patients' safety must be maintained (Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure [RWF-OPPPCS-C-NUR1]).

Patients who discharge themselves against Medical advice from the Accident and Emergency Department will be assessed for referral to the Primary Care Trust Community Liaison Team.

5.4.2 It must be ensured that the patient has all of his/her belongings, relevant documents, medications and dressings prior to their discharge plus information leaflets.

5.5 Information to Accompany the Patient

5.5.1 The designated nurse is to ensure that the appropriate information is given to patients; this will include but not be exclusive to the following information:-

Electronic Discharge Notification Forms
Final copy given to patient, copy filed in patient's notes and an electronic copy sent to patient's GP.

Transfer of Care Summary
Must be completed by nursing staff for all patients who are being discharged to a care home. Transfer of care summary (**Appendix 8**) must include a body map (**Appendix 9**) for patients who have any pressure damage, wounds or leg ulcers etc. This should be faxed to the home as appropriate or given to the patient.

5.5.2 **Patient information given to patients on discharge**
Appropriate information should be given to all patients leaving hospital to support them, identifying complications early or enhance compliance with discharge advice. All information must be given in a format which is comprehensible to the patient and carer.

This should include but not be exclusive to the following:

- Trust's leaflets 'Going home after surgery' and 'Going Home from Hospital'
- Condition Specific information advice
- Contact details for local support groups
- Patient Information Leaflets (PIL) with all medication
- A copy of the discharge summary should be issued to every patient on discharge.
- It is particularly important that all patients being discharged to Intermediate Care, Residential or Nursing Care must have a copy of their Electronic Discharge summary. The discharge summary may be given to the patient, their carer or ambulance personnel with instructions to give the copy to the care home manager.
- Clinic appointment if required
- Other relevant information sheets e.g. post operative advice sheets
- Hospital Sick Certification (if relevant)

5.6 Transport Arrangements

5.6.1 Where patients are unable to make their own transport arrangements, after all options have been explored i.e. Family, neighbour or taxi. (The right to patient transport is not extended to patients who self discharge). If hospital transport is appropriate in respect of defined medical/agreed specific needs. The ward staff should note the following:

- The correct information when requesting transport is vital for timely discharges.
- The Patient Transport Office normally requires one working day's notice to provide timely appropriate transport. Discharges over long distances require discussion with Patient Transport Service.
- Patient Transport Service should be informed prior to the date of discharge of any expected discharge where a Patient is travelling to a home address with an identified requirement to travel by stretcher. This is in order for Patient Transport Service to facilitate a risk assessment of the property prior to discharge, to establish access and egress.

5.6.2 Patient Transport Crew are instructed to carry out individual dynamic risk assessments for each and every patient they transport. The outcome of this assessment may affect the patient's discharge.

5.6.3 Ensure that the Administration Department is given one working day's minimum notice wherever possible in order to return valuables that are in safekeeping. Monies up to the amount of £100 may be returned in cash; the remainder is payable by cheque.

5.6.4 If transport to the Outpatient Department/Day Hospital etc. is required, arrangements will be made with the appropriate services and the patient informed.

5.6.5 If discharge plans are altered the designated nurse will ensure that those affected, are informed and any changes necessary are made to the arrangements for care (if appropriate) in the community. The cancellation or amendment of any journey must be notified to Patient Transport Service at the earliest opportunity.

5.6.6 Full documentation of the patient's discharge will be included in the patient's medical record and nursing discharge planner.

5.6.7 Patient Transport Crews are not permitted to operate hoists. Patients requiring the use of a hoist to transfer must have a trained hoist operator at the patient's address waiting to receive the patient, the designated nurses will confirm this with the collecting crew. Risk assessments performed by the Occupational Therapy Team must be forwarded to the Patient Transport Crew prior to any patient being discharged.

5.6.8 Essential information required by the Patient Transport Service when collecting a patient are:

- A handover of the patient must be given to the Patient Transport Service crew by the designated nurse. This will include any special needs that may have to be catered for during the discharge.
- An accurate indication of the patient's mobility.
- Patient's current infection control status must be identified by the designated nurse.
- When any Packages of Care will start.
- Arrangements for the Patient Transport Crew to gain access to the patient's property confirmed.

- Transfer of care letters and Doctor's letter, and any other confidential information must be in a sealed envelope.
- Patient's personal effects e.g. jewellery must be placed in a sealed envelope.
- Do Not Resuscitate Forms must be completed by the patient's consultant, signed and in date, and a copy to be identified and handed to the crew separately from all other notes.

5.6.9 Patients are only permitted to travel with one bag of personal effects.

5.7 Use of Discharge Lounge

Planned Admission patients are sent 'Coming into Hospital' leaflets explaining the use of Discharge Lounge. All patients within the protocol limits will be notified by ward staff when discussing discharge plans that they will be moved to the Discharge Lounge on their day of discharge. They will be collected from the ward by Discharge Lounge staff and transferred to the Discharge Lounge to await completion of their discharge plan.

Discharge Lounge staff will routinely visit all the wards between 8am – 9am to identify patients suitable for the discharge lounge that day and what they still require prior to transfer.

Patients transferred to the lounge must meet the following criteria:

- Be medically fit for discharge
- Be over the age of 16
- Be medically fit to wait in the lounge when transferring to another site
- Patients awaiting transfer to residential or nursing homes.
- MRSA patients can be transferred to the lounge, if they have an open wound this will need to be appropriately covered and dressed prior to transfer to the lounge.
- The lounge will accept patients being discharged on Oxygen at home
- Patients must be adequately dressed prior to transfer to the lounge due to its position at the front of the hospital, to ensure privacy and dignity.
- Patients with active diarrhoea need to be discussed with Infection Control and be cleared by them prior to transfer to the lounge.

The following patients will <u>not be accepted</u> for transfer to the lounge:

- Bed bound patients – due to no capacity for beds, although those with limited mobility will be accepted as recliner chairs available.
- Any patients with active diarrhoea not cleared by infection control.

The discharge lounge is available for all patients awaiting transport home following discharge from the ward; however these patients must be adequately dressed and not bed bound. It will also accommodate patients awaiting transfer to other sites, those awaiting discharge medication to be dispensed prior to discharge, those awaiting collection by relatives, and those who are awaiting final input from services that will not stop discharge (i.e. dietician review / advice).

Ideally referrals to the discharge lounge should be made the day before discharge in order to aid prioritisation of collection; however, referrals can be made on the day of discharge.

The Consultant team will retain medical responsibility until the patient leaves the discharge lounge.

In the event of anticipating a delay in discharge beyond the hours of opening, arrangements will be made to readmit the patient or relocate if appropriate, this should occur as early as possible once the delay has been identified but no later than 6pm.

5.8 Discharge out of hours

5.8.1 Most discharges will take place between the hours of 8.00 am and 5.00 pm, in order to promote patient safety. Discharging patients outside of these hours will only be simple discharges and with the discharge plan completed.

Risks must be carefully assessed by Site Manager and patient's doctor when discharging at weekends or before Bank Holidays. Communication with Social Services and Health Care Services in the community will be considered as vital in these circumstances.

5.8.2 It should not be assumed that if a patient lives in a Care Home setting that it is automatically safe or appropriate to discharge the patient back to their original placement. The risk assessment must consider changes in medication, staffing levels out of hours to safely receive the patient back in their care provision. (This list is not exhaustive).

5.8.3 If Transport is a consideration, the On Call Transport Manager can be contacted for advice via the Site Practitioners.

5.9 Purpose of the Multi-disciplinary Team Meetings

- To enable communication between members of the Multi-Disciplinary Team in the appropriate planning of a patient's transfer of care.
- To include the views of the patient/carer/family.
- To agree an action plan in the achievement of shared goals.
- To review the estimated date of discharge (EDD) and agree the action plan required to achieve this.

5.10 Discharge Planning Pathway

DISCHARGE PROCESS

BEFORE ADMISSION OR WHEN PATIENT IS ADMITTED

Nursing assessment within 24 hours
Nursing care plan within 24 hours
All referrals made
Expected Date Discharge set and discussed with the patient and MDT
Discharge Planner commenced

↓

24 HOURS PRIOR TO DISCHARGE

Electronic Discharge Notification written by medical team
Case Management informed of discharge date
e.g. To reinstate a Package of care
Transport arranged if required, 48 hours notice needed for patients travelling long distances and Patient Transport to be informed of any cancellations amendments immediately
Discharge Plan updated
Family and/ or 'main contact' informed of discharge
Medication explained by Pharmacy

↓

DAY OF DISCHARGE

Doctor review (if not nurse led)
Information to patient and carers regarding any aftercare required
District Nurse contacted if input required
Patient to Discharge Lounge if appropriate – inform transport of change of pick up address if patient was booked to travel from ward originally
Copy of Electronic Discharge Notification given to patient
Discharge Plan Completed

6.0 Monitoring and audit

The Discharge Liaison Team will take responsibility for monitoring the compliance and effectiveness of this Policy and Procedure on behalf of the Trust. Undertaking monthly audits of the admission/discharge form of all inpatients at time of the audit.

1. This includes the monitoring of:
   a. Discharge requirements for all patients
   b. Information to be given to the receiving healthcare professional
   c. Information given to the patient when they are discharged
   d. How a patient's medicines are managed on discharge
   e. How the organisation records the information given in minimum requirements b. and c.
   f. Out of hours discharge process
   g. Timescales of assessment and referrals
   h. Completion of patients' Discharge plans
   i. Estimated Dates of Discharge documented and reviewed

Details of this monitoring can be found in the monitoring table on the following page.

A representative of the Discharge Liaison Team will make monthly reports on the results of this monitoring to the Quality and Safety Committee and the minutes of these meetings will constitute the evidence for the NHSLA Risk Management Standards: Standard 4.10.

2. Ward Managers will undertake bi-annually Nursing Documentation section three questions 18-22 of the Quality Assurance Framework Audit. Results reported and reviewed at:

   - Key Performance Indicator meetings.

What needs monitoring	Who will lead on this aspect of the monitoring – name the lead	What tool will I use to monitor /check that everything is working according to this element of the policy	How often will we need to monitor/ frequency	Who or what committee will I report the results to for information and action	Who will undertake the action planning for deficiencies and recommendations	How will changes be implemented and lessons shared
Discharge requirements for all patients	Discharge Liaison Team	Audit Tool	monthly	Quality and Safety Committee	Divisional Operations committee or Nursing and Midwifery group.	Action plan monitored through Divisional operations committee and the Quality and safety committee.
Information to be given to the receiving healthcare professional Information given to the patient when they are discharged How a patient's medicines are managed on discharge How the organisation records the information given in minimum requirements	Ward Managers, Qualified Staff, Pharmacist	Copy of EDN in Notes. Discharge Planner audit	monthly	Quality and Safety committee	Divisional Operations committee or Nursing and Midwifery group.	Actions shared at Directorate Governance meetings via matrons.
Out of hours discharge process	Site Managers	Recorded daily on Hospital Site reports	Collated monthly	Quality and Safety Committee	Divisional Operations Committee or Nursing and Midwifery Group	Actions shared at Directorate Governance meetings via the Matrons.

APPENDIX ONE

Process Requirements for the Discharge Policy and Procedure

1.0 Implementation and Audit Plan

- Once approved the lead or author will send this policy/procedural document to the Clinical Governance Assistant who will publish it on the Trust intranet.
- A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under “Trust Publications”, and a notification email circulated Trust wide by the COMMS team.
- On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.
- All staff shall be made aware of the revised Policy by means of Team Communication.

2.0 Review

This policy and procedure will be reviewed 3 years or earlier if standards or national recommendations for good practice require.

3.0 Archiving

The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Discharge Policy and Procedure
In response to NHSLA recommendations, policy added to July 2011, changes agreed by the members of Quality and Safety committee.

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Discharge Liaison Nurse (JH)

By date: 31/03/2012

Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Head of Nursing / Deputy Head of Nursing	19.3.12	20.3.12	Y	Y
Risk Manager	19.3.12			
Discharge Liaison Team	19.3.12	31/03/2012	Y	Y
Chief Operating Officer / Deputy Chief operating officer	19.3.12			
Medical Director	19.3.12			
ADNS's	19.3.12	28.3.12	Y	Y
ADO's	19.3.12			
Matrons	19.3.12	22.3.12	Y	Y
Transport Manager	19.3.12			
Clinical Directors	19.3.12			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Discharge Policy and Procedure
What are the aims of the policy or practice?	To ensure safe timely and efficient discharge service to all Maidstone and Tunbridge Wells NHS Trust patients
Identify the data and research used to assist the analysis and assessment	Quality Assurance Framework Quarterly reports By Discharge Liaison
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details**.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	Not applicable
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	Not applicable
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Every three years on review of the Discharge Policy and Procedure
Where do you plan to publish the results of your Equality Impact Assessment?	On the Trust Intranet (Policies and Guidelines) as Appendix 3 of this Policy and Procedure

FURTHER APPENDICES

The following appendices are published as links beneath the main policy /procedure on the Trust Intranet (Policies and Guidelines), under:

Appendix	Title	Unique ID
4	Medical Admission Proforma	RWF-OPF-ES-C-AEMM1
5	Admission and discharge sheet	RWF-OWP-APP47
6	Flow chart for referral to East Sussex Social Services	RWF-OPPM-ES1
7	Rapid discharge pathway for a patient going home for end of life care	RWF-OWP-APP121
8	Transfer of care summary	RWF-OPF-ES-C-AEMM2
9	Body map	RWF-OWP-APP668

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Venous Thromboembolism Prevention Policy and Procedure

Requested/ Required by:	Thrombosis Committee to comply with NICE Clinical Guidance 92
Original author:	Anticoagulation Nurse Specialist (CG) Contact Details: ext 24485
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Document lead:	VTE Nurse Facilitator (JB)
Directorate:	Specialty Medicine
Specialty:	Venous Thromboembolism (VTE)
Supersedes:	Venous Thromboembolism Prevention Policy and Procedure, Version 2.0 (October 2011)
Approved by:	Thrombosis Committee (June 2013)
Ratified by:	Standards Committee (June 2013)
Review date:	June 2015

Document history

Requirement for document:	• To comply with national guidance on the prevention of venous thromboembolism in hospitalised patients.

Cross references:	• NICE. (2010). *Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital.* NICE Clinical Guidance 92 (2010) • NICE. (2012). *Venous thromboembolic diseases: the management of venous thromboembolic diseases and the role of thrombophilia testing.* NICE Clinical Guidance 144 (2012) • Department of Health. (2007). *Report of the independent expert working group on the prevention of venous thromboembolism in hospitalised patients.* London: Department of Health • Department of Health. (2008). *Risk Assessment for Venous Thromboembolism.* London: Department of Health • National Patient Safety Agency. (2009). *Patient Safety Alert. WHO Surgical Safety Checklist.* • The NHS Confederation (2009). *Briefing paper: Reducing Deaths from Blood Clots in Hospitals.* • NHSLA Risk Management Standard 5.9.
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Venous Thromboembolism (VTE) in Pregnancy and Puerperium: prophylaxis, diagnosis and management* [RWF-OPPPW&C-C-O&G2] • Maidstone and Tunbridge Wells NHS Trust. *Policy and Procedure for the Safe Management of Anticoagulant Therapy* [RWF-OPPPCSS-C-CAN3] • Maidstone and Tunbridge Wells NHS Trust. *Venous Thromboembolism: Diagnosis and Management* [RWF-OPPPES-C-SM15] • Maidstone and Tunbridge Wells NHS Trust. *Pharmacy anti-coagulation guidance* [available on the pharmacy pages of the staff intranet] • Maidstone and Tunbridge Wells NHS Trust. *Anti-embolism stockings (AES), Policy and Procedure for the use of* [RWF-OPPPES-C-SM13] • Maidstone and Tunbridge Wells NHS Trust. *Intermittent Pneumatic Compression Devices (IPCD), Policy and Procedure for the use of* [RWF-OPPPES-C-SM14] • Maidstone and Tunbridge Wells NHS Trust. *Medical Devices Policy and Procedure* [RWF-OPPPCS-NC-EST2] • Maidstone and Tunbridge Wells NHS Trust. *Blood clots (thrombosis), Preventing hospital acquired* [STANDARD PRINT LEAFLET] [RWF-OPLF-PES89] • Maidstone and Tunbridge Wells NHS Trust. *Blood clots (thrombosis), Preventing hospital acquired* [LARGE PRINT LEAFLET] [RWF-OPLF-PES92]

	• Maidstone and Tunbridge Wells NHS Trust. Blood clots (thrombosis), Preventing hospital acquired; information for maternity patients [STANDARD PRINT LEAFLET] [RWF-OPLF-PES90] • Maidstone and Tunbridge Wells NHS Trust. Blood clots (thrombosis), Preventing hospital acquired; information for maternity patients [LARGE PRINT LEAFLET] [RWF-OPLF-PES94]

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of the policy/procedure	July 2010
1.1	Amendment to Appendix 4 Risk Assessment	July 2010
1.2	Amendment to Appendix 4 Risk Assessment	January 2011
2.0	Revision of the policy/procedure	October 2011
3.0	Revision of the policy/procedure	June 2013
3.1	Added section 7.9 and appendix 11 to policy/procedure; removed references to NHSLA standards, which have ceased to exist	April 2014

Policy statement for

Venous Thromboembolism Prevention Policy

The purpose of this policy is to ensure that all adult in-patients are appropriately and regularly assessed for risk of venous thromboembolism (VTE) and if appropriate receive VTE prophylaxis according to that risk throughout their stay at Maidstone and Tunbridge Wells NHS Trust (MTW).

Patients admitted to the Trust should have the opportunity to make informed decisions about their care and treatment, in partnership with their health care professionals and the Trust will offer best practice advice on reducing the risk of VTE in patients admitted to hospital.

Venous Thromboembolism Prevention Procedure

Contents

Page

Appendices

1.0 Introduction

The House of Commons Health Committee reported in 2005 that an estimated 25,000 people a year in the UK die from preventable hospital-acquired venous thromboembolism (VTE). This includes patients admitted to hospital for medical care and surgery. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. A UK survey suggested that 71% of patients assessed to be at medium or high risk of developing deep vein thrombosis (DVT) did not receive any form of mechanical or pharmacological VTE prophylaxis.

Deep vein thrombosis (DVT) is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism. Pulmonary embolism (PE) is when the thrombus is carried to and lodges in the lungs.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. The patient typically suffers chest pain, breathlessness and collapse. Deep vein thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes). Pulmonary embolism can leave a legacy of pulmonary hypertension.

VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service.

The purpose of this policy is to enable healthcare practitioners at MTW to identify patients at risk of developing VTE and select the appropriate therapy to reduce the associated mortality and morbidity risks associated with this disease.

The diagnosis and treatment of VTE (DVT and PE) is covered in the *MTW Policy for the Diagnosis and Management of VTE* and the *MTW Policy and Procedure for the Safe Management of Anticoagulation Therapy*. However should a DVT or PE be suspected or confirmed the following appendices describe the appropriate pathways that should be followed (see **Appendices 5 - 8**).

1.1 Scope

The policy applies to:

All those 18 years and older admitted to hospital as inpatients or formally admitted to a hospital for day-case procedures, including:

surgical and medical inpatients

orthopaedic and trauma inpatients

patients admitted to intensive care units

cancer inpatients

people undergoing long-term rehabilitation in hospital

patients admitted to a hospital bed for day-case medical or surgical procedures.

Within this population, pregnant women admitted to hospital have been identified as a group requiring special consideration.

The policy does not apply to:

- People younger than 18 years (but please use clinical judgement for teenage inpatients).
- People attending hospital as outpatients.
- People presenting to emergency departments without admission.
- Elderly or immobile people cared for at home, or in external residential accommodation, unless admitted to hospital.
- Women in pregnancy; a separate policy exists relating to women in pregnancy *(Venous Thromboembolism (VTE) in Pregnancy and Puerperium)*

Patients admitted to hospital with a diagnosis of, or suspected diagnosis of, deep vein thrombosis or pulmonary embolism should follow a treatment plan and not the prophylactic plan. Please refer to the Trust Policy and Procedure for the Diagnosis and Management of VTE and the Trust Policy and Procedure for the Safe Management of Anticoagulation Therapy and this policy: **Appendices 5 – 8**.

2.0 Definitions

Venous Thromboembolism (VTE)	Venous thrombosis is a condition in which a blood clot (thrombosis) forms in a deep vein. Blood flow along the affected vein can be limited by the clot, causing swelling and pain. Venous thrombosis most commonly occurs in the 'deep veins' in the leg or pelvis. This is known as a deep vein thrombosis (DVT). An embolism is created if a part or all of the thrombosis in the deep vein breaks off from the site where it is created and travels along the venous system. A leg DVT can travel to the lungs, known as pulmonary embolism (PE). DVT and PE are the most common manifestations of venous thrombosis. DVT and PE are known collectively as venous thromboembolism (VTE).
Deep Vein Thrombosis (DVT)	A thrombosis occurring in a deep vein, most commonly a deep vein of the leg or pelvis but can affect any deep vein.
Pulmonary Embolism (PE)	If the clot lodges in the lung a very serious condition, pulmonary embolism (PE) arises.
Thromboprophylaxis	Thromboprophylaxis is the treatment to prevent blood clots forming in veins – this may be chemical or mechanical.

Chemical Thromboprophylaxis	Pharmaceutical agents (oral or parenteral) used to decrease the clotting ability of the blood.
Mechanical Thromboprophylaxis	Devices including anti-embolism stockings (AES) and intermittent pneumatic compression devices (IPCD) can be used to increase venous blood flow and reduce stasis within the leg veins.
Significantly reduced mobility	Used to denote patients who are bedbound, unable to walk unaided or likely to spend a substantial proportion of the day in bed or in a chair.
Major bleeding	Refers to bleeding events that result in one or more of the following: • Death • a decrease in haemoglobin concentration of 2g/dl or more • transfusion of 2 or more units of blood • bleeding into a retroperitoneal, intracranial or intraocular site • a serious or life-threatening clinical event • a surgical or medical intervention.
Thrombosis Committee	The Thrombosis Committee was established under the auspices of the Medical Director to lead on the prevention, reduction and treatment of VTE. It ensures best practice for the prevention and management of VTE, based on national guidance and other examples of best practice.

3.0 Duties (roles and responsibilities)

- **Chief Executive** has overall responsibility and accountability for the implementation of this policy.
- **Medical Director** has delegated responsibility for the implementation of this policy.
- **Clinical Directors** will be responsible for ensuring that the clinical staff within their area follow this policy. They will also review any undertaken audits to ensure highlighted actions are completed and implemented in a timely manner.
- **Clinical staff** (Medical/Nursing/Midwifery) will be responsible for undertaking appropriate and timely risk assessments on patients (as detailed in this policy) and entering these onto patient centre, as well as ensuring that necessary prophylactic treatment is prescribed as necessary. This applies to all patients admitted whether emergency or planned.

- **Theatre staff** should ensure that the MTW checklist is performed ensuring that appropriate VTE risk assessments have been undertaken as necessary. If no appropriate risk assessment has been undertaken this should be a 'hard stop' to the commencement of the procedure.

  Pharmacists: The Pharmacists are responsible for checking chemical prophylaxis is appropriately prescribed and administered. Any discrepancies should be recorded in the patient's notes and discussed with the prescriber and / or the patient's medical team.

4.0 Training / competency requirements

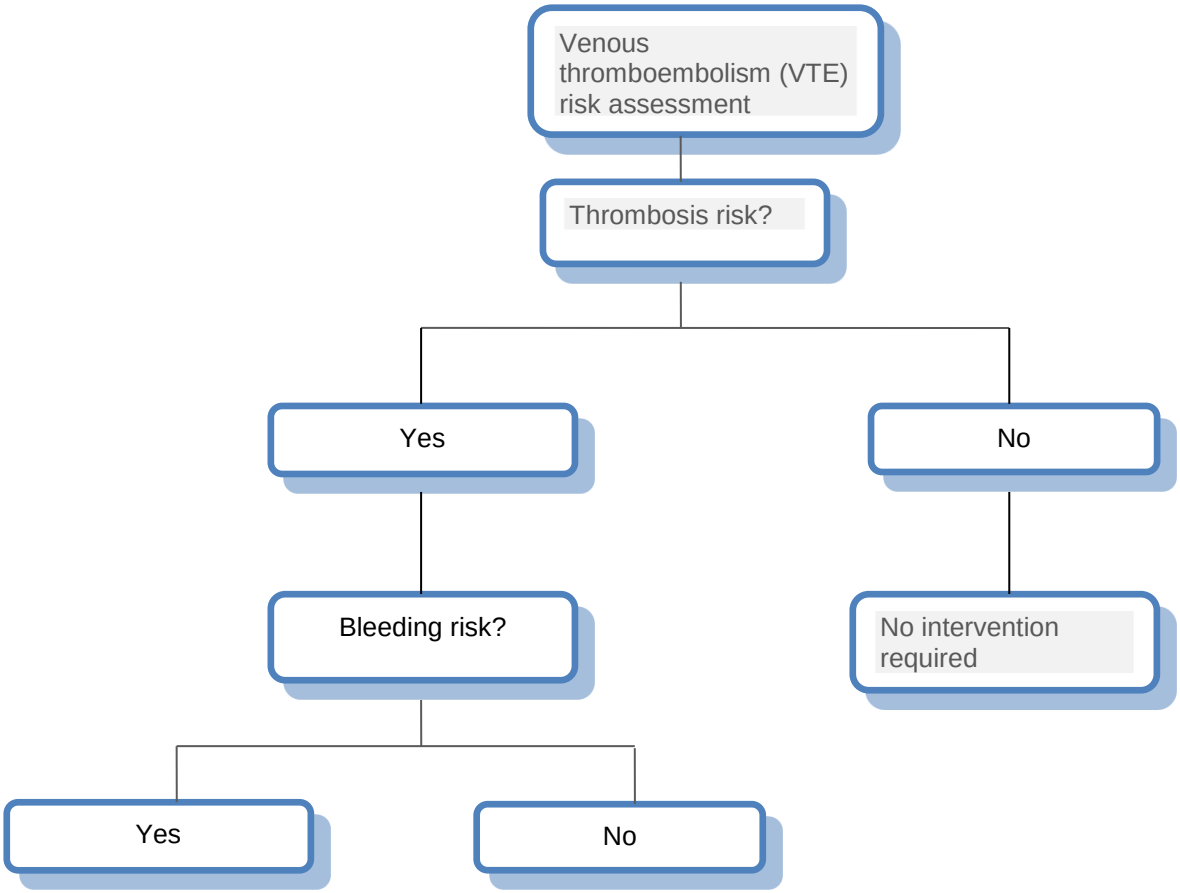
All medical, nursing and midwifery staff are made aware of the VTE risk assessment tool, thromboprophylaxis and patient information documents in conjunction with this policy at local induction.

Doctors, nurses and midwives will undertake VTE training either through e-learning or the mandatory update study day VTE session and this will be monitored as part of their annual appraisal.

Pharmacists will undertake VTE training either through e-learning or the mandatory update study day VTE session and this will be monitored as part of their annual appraisal.

The above training will be monitored via the TS4 training database. The training should take place every 2 years. (**See Appendix 9**).

5.0 Care pathway



6.0 Patient risk assessment

- All patients admitted to Maidstone and Tunbridge Wells Trust will be screened within 2 hours of admission for risk of VTE and considered for thromboprophylaxis using the screening tool. Please refer to the VTE Risk Assessment form: **Appendix 4**.
- All patients will be assessed for risk of bleeding before being offered chemical VTE prophylaxis. Patients with any of the risk factors for bleeding will not be offered chemical prophylaxis unless the risk of VTE outweighs the risk of bleeding. See **Appendices 4 and 10**.
- The patient's VTE risk will be recorded on the risk assessment form and if appropriate, thromboprophylaxis (chemical, mechanical or a combination of both) will be commenced.
- The risk of VTE and bleeding must be reassessed within 24 hours of admission and whenever the clinical situation changes and treatment adjusted accordingly, taking into account the need for extended thromboprophylaxis in certain cases.
- Treatment must take into account any contraindications to chemical or mechanical therapies. Contraindications must be recorded in the patient's healthcare record.

7.0 Thromboprophylaxis

- Treatment should continue until the patient is fully mobile. Extended thromboprophylaxis should be considered in high risk patients (please refer to extended thromboprophylaxis guidelines within VTE risk assessment: see **Appendix 4**).
- All patients who have risk factors for VTE will be prescribed low molecular weight Heparin (LMWH) from admission at 22.00 hours unless this is contraindicated.
- Patients who are at risk of VTE but who have an absolute contraindication to LMWH must be prescribed anti-embolism stockings unless contraindicated.
- Pre-operative LMWH should not be given to elective surgical patients unless this has been specifically requested and prescribed by the admitting consultant.
- Trauma list and non-elective surgical patients should where possible be delayed until at least 12 hours after the last dose of LMWH has been administered.
- All patients should be adequately hydrated.

- Patients should be mobilised as early as possible. Patients should be shown how to exercise their legs if they are on bed rest.
- Consider offering temporary inferior vena cava filters to patients who are at very high risk of VTE (such as patients with a previous VTE event or an active malignancy) and for whom mechanical and pharmacological VTE prophylaxis are contraindicated.
- Invasive procedures with a risk of bleeding (e.g. liver biopsy, endoscopy with biopsy) should where possible be delayed until at least 12 hours after the last dose of LMWH has been administered.

7.1 VTE prophylaxis in surgical patients

Surgical patients are at high risk if their combined surgical and anaesthetic time is 60 minutes or longer **or** they have any additional risk factor as identified on the MTW VTE risk assessment form. High risk surgical patients should be prescribed LMWH daily as per actions on MTW VTE risk assessment form plus AES (unless contraindicated) and/or intermittent pneumatic compression device.

Patients undergoing major cancer surgery in the abdomen or pelvis should continue chemical and mechanical thromboprophylaxis for 28 days post-surgery. Surgical patients with a body mass index of 30 or greater should have extended chemical and mechanical thromboprophylaxis for 7 days post-surgery. Other high risk surgical patients (including day surgery patients) should continue thromboprophylaxis until their mobility is no longer significantly reduced, including after discharge if necessary.

Surgical patients are at low risk if their combined surgical and anaesthetic time is less than 60 minutes **and** they have no additional risk factor. Low risk surgical patients should mobilise early and AES should be considered (unless contraindicated).

If a spinal or epidural is used, additional care must be exercised when planning or removing the catheters. Placement should be delayed until at least 12 hours after the last LMWH dose to avoid bleeding complications at the catheter site. Presence of a spinal or epidural catheter is not a contraindication to LMWH use. At the discretion of the anaesthetist, LMWH may be started immediately after the catheter is removed, or immediately after a regional block.

For patients booked on the emergency theatre list, there needs to be a 12 hour gap between chemical thromboprophylaxis and spinal anaesthetic. Therefore consideration must be given to the timing of the pre-operative dose, i.e. this should be prescribed at 20.00 hours on the evening pre surgery as a stat dose with the 22.00 dose cancelled. Thromboprophylaxis must not simply be omitted.

7.2 Thromboprophylaxis for orthopaedic patients

Unless contraindicated, patients admitted for elective hip or knee replacement should have mechanical VTE prophylaxis which should continue until the patient's mobility is no longer significantly reduced. The patient should be commenced on chemical thromboprophylaxis 6-10 hours post operatively. This should continue for 35 days for hip replacements and 14 days for knee

replacements. Each patient should be reviewed on a case by case basis. Hip fracture patients should be prescribed LMWH daily as per actions on MTW VTE risk assessment form plus AES (unless contraindicated) and/or intermittent pneumatic compression device. LMWH should be continued for 28 days.

It is acceptable to reduce thromboprophylaxis to 2,500 units s/c daily for trauma patients over 80 with a BMI 18 or less.

For patients booked on the orthopaedic trauma list, there needs to be a 12 hour gap between chemical thromboprophylaxis and spinal anaesthetic. Therefore consideration must be given to the timing of the pre-operative dose, i.e. this should be prescribed at 20.00 hours on the evening pre surgery as a stat dose with the 22.00 dose cancelled. Thromboprophylaxis must not simply be omitted.

7.3 VTE prophylaxis in medical patients

Patients expected to have ongoing reduced mobility plus one or more risk factors and no contraindications identified should be prescribed LMWH daily as per actions on MTW VTE risk assessment form. Patients who have a bleeding risk or an absolute contraindication to LMWH must be prescribed AES instead unless contraindicated. If AES also contraindicated (e.g. acute stroke patients) then an intermittent compression device should be considered.

7.4 VTE prophylaxis in acute stroke patients

Patients admitted with an acute stroke should have a VTE risk assessment on admission but LMWH should be withheld until CT imaging has excluded a haemorrhage. Once haemorrhage has been excluded and the patient has been reviewed by the stroke/medical consultant, VTE risk assessment should be repeated within 24 hours. Unless contraindicated, prophylactic LMWH should be prescribed within the first 72 hours of admission. Care should be taken if there are large territorial infarcts, if there is a risk of haemorrhagic transformation or there is a high risk of intra or extra cranial haemorrhage. Thrombolysis patients should not receive LMWH until they have undergone follow up CT brain imaging. If there is no haemorrhage then the above guidelines apply.

Anti-embolism stockings should not be offered to acute stroke patients. Intermittent pneumatic compression devices may be considered in some cases but this is at the stroke consultant's discretion.

7.5 VTE prophylaxis in cancer patients

If the patient is undergoing oncology treatment and is ambulant, then pharmacological or mechanical VTE prophylaxis should not routinely be offered with the exception of patients receiving Thalidomide or Lenalidomide. However, if the patient has reduced mobility and the risk of VTE is increased then they should be offered LMWH, which should be continued until there is no longer an increased risk of VTE.

7.6 VTE prophylaxis in end of life patients

Patients in palliative care, who have potentially acute reversible pathology, should be considered for LMWH. However, if the patient is in terminal care or on an end-of-life care pathway, pharmacological or mechanical VTE prophylaxis should not routinely be offered. In both cases, decisions about VTE prophylaxis should be reviewed daily, taking into account potential risks and benefits and views of the patient, family and/or carers and multidisciplinary team.

7.7 Patients already on anti-platelet or anticoagulant therapy

Consider offering additional mechanical or pharmacological VTE prophylaxis if the patient is at risk of VTE. Take into account the risk of bleeding and of co-morbidities such as arterial thrombosis.

If the risk of VTE outweighs the risk of bleeding, consider offering pharmacological VTE prophylaxis according to the reason for admission.
If the risk of bleeding outweighs the risk of VTE, offer mechanical VTE prophylaxis.

Do not offer additional pharmacological or mechanical VTE prophylaxis to patients who are taking vitamin K antagonists and who are within their therapeutic range, or novel anticoagulants, providing anticoagulant therapy is continued.

Do not offer additional pharmacological or mechanical VTE prophylaxis to patients who are having full anticoagulant therapy (for example, Fondaparinux sodium, LMWH or UFH).

7.8 VTE Prophylaxis in pregnancy and up to 6 weeks post partum

Please refer to separate policy for Obstetrics: Maidstone and Tunbridge Wells NHS Trust. *Venous Thromboembolism (VTE) in Pregnancy and Puerperium*

7.9 Lower limb immobilisation and LMWH

Immobilisation is defined as rigid immobilisation in plaster or fibre-glass. This specifically excludes removable devices such as walking boots or cricket-pad splints as there is no evidence for VTE prophylaxis in these patients. There is no evidence for VTE prophylaxis in upper limb injuries.

The use of prophylactic LMWH is effective at reducing incidence of VTE in ambulatory patients with lower limb immobilisations. If commenced, prophylactic LMWH should be given for the duration of immobilisation. The use of LMWH is associated with low rates of heparin induced thrombocytopenia (HIT) and major bleeding when used for thromboprophylaxis in ambulatory patients with cast immobilisation.

See **Appendix 11** for the *Lower limb immobilisation and LMWH pathway.*

8.0 Patient information and consent

Treatment and care should take into account patients' needs and preferences. People admitted to hospital should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare

professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Trust's Consent Policy written with regard to the Department of Health's advice on consent and the Mental Capacity Act.

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

All patients admitted to hospital will receive a patient information document, produced by the Trust, relating to the prevention of thromboembolism, i.e. one of the following:

- *Blood clots (thrombosis), Preventing hospital acquired* [STANDARD PRINT LEAFLET] [RWF-OPLF-PES89]
- *Blood clots (thrombosis), Preventing hospital acquired* [LARGE PRINT LEAFLET] [RWF-OPLF-PES92]
- *Blood clots (thrombosis), Preventing hospital acquired; information for maternity patients* [STANDARD PRINT LEAFLET] [RWF-OPLF-PES90]
- *Blood clots (thrombosis), Preventing hospital acquired; information for maternity patients [LARGE PRINT LEAFLET]* [RWF-OPLF-PES94]

This information will be used to obtain verbal consent from the patient allowing healthcare staff to assess and where necessary provide prophylactic treatment to the patient to reduce the risk of VTE.

Ward medical and nursing staff will be completely familiar with the patient information provided, enabling them to answer general questions that may arise while obtaining verbal consent.

9.0 Discharge

On discharge, all patients and/or their families will be informed of the signs and symptoms of DVT and PE and the importance of seeking medical help if this is suspected.

If discharged with VTE prophylaxis (pharmacological and/or mechanical), patients and/or their families or carers will be given verbal and written information on the correct use and duration of VTE prophylaxis at home and who to contact if problems occur.

If VTE prophylaxis is either pharmacological or mechanical, the patient and/or their family should be shown how to use it. The patient's GP should be notified that the patient is being discharged with VTE prophylaxis.

Patients should be advised to wear their anti-embolism stockings until they regain their usual mobility or longer if advised. When patients are discharged with anti-embolism stockings, it should be ensured that they are able to remove and replace the stockings for daily hygiene needs or that they have someone who can do this for them. Patients should also be informed to check for skin marking, blistering or discolouration, particularly over heels and bony prominences.

10.0 Monitoring and audit

- VTE risk assessments will be logged onto the patient administration system and data is extracted and available daily. Retrospective periods can also be viewed. Data is submitted monthly via Unify for the VTE CQUIN requirement.
- Audits of VTE risk assessment and thromboprophylaxis will be undertaken and data submitted to local commissioners if requested.
- Other formal audits of VTE risk assessment and thrombo-prophylaxis may be undertaken with support from the audit department.
- Random spot check audits will be carried out ad hoc to ensure that VTE risk assessment, prescription of chemical thrombo-prophylaxis and data capture processes are being followed. The results of which will be shared appropriately.
- Information from audits and the data capture will be reported at ward level and to the directorates, standards committee and trust executives.
- The VTE policy and procedure document will be reviewed annually.
- Minutes from the Thrombosis Committee and Standards Committee, along with any supporting documentation and reports, will be used as evidence of "monitoring" for the NHSLA Risk Management Standard.
- All hospital acquired VTE incidents should be reported either verbally to the VTE Nurse Facilitators or by using the e-reporting system.
- Investigation and Root Cause Analysis will be undertaken on all hospital acquired VTE incidents and lessons learned will be forwarded. Actions will be added to the VTE trust wide action plan.

10.1 Monitoring of minimum requirements

a. how patients are assessed for their risk of developing venous thromboembolism (VTE), including timescales (See section 6.0)

Risk assessments will be logged onto the Patient Administration System and data extracted on a monthly basis and reviewed as part of the CQUINS requirements. This will also be reported to the VTE Committee monthly.

Information from the audits and the monthly dashboards will be included in regular reports to the Standards Committee from the Thrombosis Committee.

Audits of VTE risk assessment and thromboprophylaxis will be undertaken.

b. prophylactic treatment regime for high risk patients

Audits of VTE risk assessment and thrombo-prophylaxis will be undertaken.

c. procedure to be followed if venous thromboembolism is suspected

Review of the diagnosis and management of all hospital acquired VTE will be undertaken. Ad hoc audits may be undertaken with support from the audit department.

d. management of the patient once a positive diagnosis has been made

Review of the diagnosis and management of all hospital acquired VTE will be undertaken. Ad hoc audits may be undertaken with support from the audit department.

The above data will be reported to the Thrombosis Committee.

e. how the organisation trains staff in line with the training needs analysis – see Appendix 10.

Training will be monitored via the education and training department by reviewing training numbers and reporting to the directorates for action if necessary.

The Thrombosis Committee will monitor the VTE prevention policy and the document will be reviewed every 2 years.

APPENDIX ONE

Process requirements

3.0 Implementation and awareness

- Once approved the document lead/author will submit this policy/procedure to the Clinical Governance Assistant who will activate it on the Trust approved management database on the intranet.
- A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust Intranet) under 'Trust Publications', and a notification e-mail circulated Trust wide by the COMMS team.
- On receipt of the Trust wide Bulletin Board notification, all managers should ensure that their staff members are aware of the new publications.
- The policy will be disseminated to all clinical staff and ward areas.
- The policy/procedure will be launched via cascade through directorate nurse managers.

4.0 Review

This policy/procedure will be reviewed once every two years, as a minimum; however, if changes in legislation or Trust practice require, amendments will be made following Trust consultation and approval procedures.

5.0 Archiving

The Trust approved document management database on the intranet retains all superseded files in an archive directory (obsolete register) in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Venous Thromboembolism Prevention Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: VTE Nurse Facilitator

By date: 6th June 2013

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Director of Nursing	24.5.13			
Deputy Director of Nursing	24.5.13	24.5.13	N	N
ADNS	24.5.13			
Matrons	24.5.13			
Ward / Theatre Managers	24.5.13			
Head of Quality and Governance	24.5.13			
Senior Nurses Practice Development	24.5.13			
Thrombosis Committee	24.5.13	25.5.13	Y	Y
Medical Devices Trainer	24.5.13			
Medical Director	24.5.13			
Standards Committee	24.5.13			
Patient Safety and Risk Manager	24.5.13			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Venous Thromboembolism Prevention Policy and Procedure
What are the aims of the policy or practice?	The purpose of this policy is to ensure that all in-patients are appropriately and regularly assessed for risk of venous thromboembolism (VTE) and treated according to that risk throughout their stay at Maidstone and Tunbridge Wells NHS Trust (MTW). Patients admitted to the Trust should have the opportunity to make informed decisions about their care and treatment, in partnership with their health care professionals and the Trust will offer best practice advice on reducing the risk of VTE in patients admitted to hospital.
Identify the data and research used to assist the analysis and assessment	NICE Guidance, VTE Exemplar Centres
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	N
People of different ages	Policy does not apply to those under the age of 18 - based on NICE guidance
People of different ethnic groups	N
People of different religious beliefs	N
People who do not speak English as a first language	N interpreting services available. Leaflets to be made available in different languages
People who have a physical disability	N
People who have a mental disability	N
Women who are pregnant or on maternity leave	N
Single parent families	N
People with different sexual orientations	N
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	N
People in deprived areas and people from different socio-economic groups	N
Asylum seekers and refugees	N

Prisoners and people confined to closed institutions, community offenders	N
Carers	N
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N
When will you monitor and review your EIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	VTE risk assessment form	RWF-OWP-APP220
5	Suspected DVT pathway (Two Level Wells score for DVT / DVT diagnostic pathway)	RWF-OWP-APP221
6	Confirmed DVT pathway	RWF-OWP-APP222
7	Suspected PE pathway (Two Level Wells score for PE / Diagnosis of PE)	RWF-OWP-APP203
8	Confirmed PE pathway	RWF-OWP-APP204
9	Training matrix	RWF-OWP-APP226
10	Guideline for thromboprophylaxis and patients with a bleed or suspected bleed	RWF-OPG-ES7
11	Lower limb immobilisation and LMWH pathway	RWF-OPPM-ES8