Maidstone and Tunbridge Wells NHS
NHS Trust

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NHS Trust

Ref: FOI/CAD/ID 3244

Please reply to:
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Trust Management
Service Centre
Maidstone Hospital
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Maidstone
Kent
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18 April 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 internal and external patient transfer forms and procedures.

1. Does your hospital internally use 'ward-to-ward' and/or 'emergency / critical departments-to-ward' transfer ready-made forms? If so please send me a blank copy of the ready-made form or quote the data on the ready-made forms.

2. Does your hospital externally use 'ward/emergency / critical departments-to-other Trusts/nursing home/residential home' transfer ready-made forms? If so please send me a blank copy of the ready-made form or quote the data on the ready-made forms.

3. Please tell me who completes, authorises and signs the empty fields on the ready-made forms in questions 1. and 2. above?

4. If hospital consultant authorises but does not have to sign the ready-made forms in questions 1. and 2. above, where is their authorisation record kept?

5. What happens if there is no hospital consultant there in ward/departments to sign the ready-made forms in questions 1. and 2.
above?

6. What about 'ward/department-to-isolated room' in the ward/department transfers - is there a ready-made form form? If so please send me a blank copy of the ready-made form or quote the data on the ready-made forms. Please tell me who completes, authorises and signs the empty fields on this ready-made form? If hospital consultant authorises but does not have to sign the ready-made form, where is their authorisation record kept? What happens if there is no hospital consultant there to sign the ready-made form?

Please see the attached policies and admission and discharge sheet.

Maidstone and Tunbridge Wells NHS
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ADMISSION / DISCHARGE SHEET

PATIENT DETAILS	ADMISSION DETAILS
Hospital no:	Admission date: ..... / ..... / ..... Time: .....
NHS no:	Ward:
Title: Mr. Mrs. Miss. Ms. Other:	Consultant:
Last name:	Transferred from:
First name:	Transfer date: ..... / ..... / ..... Time: .....
Prefers to be called:	Medical diagnosis / reason for admission:
Date of birth: Age:	
Address:	Relevant medical history:
Home tel. no:	**Cardio-Pulmonary Resuscitation Status**
Religion:	For CPR: YES / NO Date: ..... / .... / .....
GP name:	For CPR: YES / NO Date: ..... / .... / .....
GP tel. no:	DNAR form completed: YES / NO Date: ..... / .... / .....
NEXT OF KIN DETAILS	Allergies:
1. Name:	Identification bracelet in-situ?: YES / NO
Relationship:	
Tel. no:	Previous MRSA history: YES / NO
2. Name:	MRSA screened on admission: YES / NO
Relationship:	Date: ..... / ..... / ..... Result: +ve / -ve
Tel. no:	Previous C. difficile infection: YES / NO
Next of kin informed / aware of admission: YES / NO	When: Month: ..... Year: .....

HOME CIRCUMSTANCES	
Patient lives: Alone: YES / NO	With partner: YES / NO (Partner fit / unfit)
With family: YES / NO	With dependants: YES / NO

TYPE OF ACCOMMODATION	COMMUNITY SERVICES PRIOR TO ADMISSION
House Bungalow	Care package details:
Flat Floor: Lift: YES / NO	
Warden controlled: YES / NO	District Nurse / Other (specify):
Nursing Home Residential Home	Home adaptation details (if applicable):

ADMITTING NURSE	
Name (print):	Signature: .....
Designation: ..... Date: ..... / ..... /	RN countersignature: .....

DISCHARGE PLANNING			
Referrals	**Date Referred**	**Signature of Referring Nurse**	Expected date of discharge: ..... / ..... / .....
Physiotherapy			Actual date of discharge: ..... / ..... / .....
Occupational Therapy			Discharge address (if different from home address):
Care Manager			
Speech and Language Therapy			
Dietician			
Other e.g. Specialist Nurse (specify below):			

Actions	**Yes**	**No**	**NA**	**Date**	**Initials**
Patient suitable for transfer to Discharge Lounge.					
Patient and carer(s) consulted regarding details of discharge and planned discharge date.					
EDN completed and sent to pharmacy.					
Copy of EDN sent to G.P. practice.					
Copy of EDN given to patient.					
District nurse contacted/message left.					
Transfer of care form completed.					
Hospital transport booked: Tier 1 Tier 2 Car Walking / Own wheelchair / Chair / Stretcher (*delete as appropriate*)					
Medications issued and explained to patient.					
3 working days of dressings supplied and explained to patient.					
Intravenous cannula removed.					
All of patient's property removed from bed space and given to patient / relative (*delete as appropriate*).					
Relative/carer given information to help aid patient's recovery.					
Trust discharge leaflet given to patient.					
Outpatient appointment given to patient/carer.					

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Patient Transfer Policy and Procedure

Requested/ Required by:	Quality and Safety Committee
Main author:	Directorate Site Matron
Other contributors:	Critical Care Outreach Sister Ward Manager Ward 21 TWH
Document lead:	Directorate Site Matron **Contact Details:** ext 33738
Division:	Corporate
Speciality:	Trust Management
Supersedes:	Patient Transfer Policy and Procedure (Version 2.2: July 2012) Treat and Transfer policy (Version 1.0: January 2012)
Approved by:	Standards Committee, 18th December 2012
Ratified by:	Quality and Safety Committee, 13th March 2013
Review date:	March 2015

Document history

Requirement for document:	• To ensure a comprehensive document that covers all transfers both internally and externally to the organisation, and prevents confusion arising from separate Transfer and Treat and Transfer Policies and documentation. • Patient transfers have increased since the development of MAUs and CDUs to ensure that patients are allocated and transferred safely to the correct ward by specialty. • Increasing numbers of transfers will occur as patients are sent to other wards or placements for rehabilitation. • Patients to be treated and transferred across site have increased with the escalation beds for the Trust being on the Maidstone Site since the opening of the Tunbridge Wells Hospital • Patients for planned transfer across site have increased due to service reconfiguration. • To reduce the risk of incidents associated with unsafe transfer of patients. • To ensure all parties involved in the transfer process are aware of their roles and responsibilities. • To reduce the incidents associated with unsafe transfer of patients, reduce risk of infection and loss of patient property. • NHSLA Risk Management Standard 4.9. "Clinical Handover of Care"
Cross references:	• Association of Anaesthetists of Great Britain and Ireland. (2009) *Safety Guideline. Interhospital Transfer*. Available at: www.aagbi.org • NICE guidelines on the acutely unwell 2007 • Department of Health Change Agent Team. (2003). *Medical Stability and 'Safe to Transfer'.* London: Department of Health. Available at: www.dh.gov.uk • Department of Health. (2007) *Procedure for the transfer of prisoners to and from hospital under section 47 and 48 of the mental health Act (1983)*. London: Department of Health. Available at: www.dh.gov.uk • Department of Health. (1998). HSC 1998/048. *The transfer of frail older NHS patients to other long stay settings.* London: Department of Health. Available at: www.dh.gov.uk • Department of Health. (2003). *Discharge from Hospital: Pathway Process and Practice.* London: Department of Health. Available at: www.dh.gov.uk • Department of Health. (2010). *Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care*. London: Department of Health. Available at: www.dh.gov.uk • Department of Health. *'Emergency Care Checklists'*. DH website page. London: Department of Health. Available at: www.dh.gov.uk • National Audit Office. (2003). *Ensuring the Effective Discharge of Older Patients from NHS Acute Hospitals*. London: The Stationery Office. Available at: www.nao.org.uk • 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. Available at: www.rpsgb.org.uk • Manual Handling Operations Regulations 1992 • Royal College of Nursing, (2008). *Improving the Safe Transfer of Care. A quality Improvement Initiative. Final Report*. Available at: www.rcn.org.uk • Kent and Medway Critical Care Transfer Policy (2006) adapted from Intensive Care Standard and Guidelines for the transport of Critically Ill Adults: *Intensive Care Society (2002)* *www.ics.ac.uk*

Associated documents:	**MTW Associated Documents** 1. Maidstone and Tunbridge Wells NHS Trust. *Patient at Risk (PAR) Score Algorithm.* [RWF-OWP-APP8] 2. Maidstone and Tunbridge Wells NHS Trust. *Patient Property Policy & Procedure.* [RWF-OPPPCS-NC-NUR1] 3. Maidstone and Tunbridge Wells NHS Trust. *Patient Handling Assessment Form.* [RWF-OWP-APP507] 4. Maidstone and Tunbridge Wells NHS Trust. *Health records Policy and Procedure.* [RWF-OPPCS-NC-TM31] 5. Maidstone and Tunbridge Wells NHS Trust. *Medical Devices Decontamination Policy and Procedure.* [RWF-OPPPCSS-C-PATH19] 6. Maidstone and Tunbridge Wells NHS Trust. *Infection Control Policy and Procedure.* [RWF-OPPPCSS-C-PATH15] 7. Maidstone and Tunbridge Wells NHS Trust. *Medicines Policy and Procedure.* [RWF-OPPPCSS-C-PHAR1] 8. Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Children Policy and Procedure.* [RWF-OPPPCS-C-NUR6] 9. Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure.* [RWF-OPPPCS-C-NUR5] 10. Maidstone and Tunbridge Wells NHS Trust. *Escalation Policy and Procedure for Emergency Admissions.* [RWF-OPPPES-C-AEM8] 11. Maidstone and Tunbridge Wells NHS Trust. *Diarrhoea, Policy and Procedure for the Assessment of Patients Presenting with.* [RWF-OPPPCSS-C-PATH10] 12. Maidstone and Tunbridge Wells NHS Trust. *Norovirus, Care and Management of Patients with* [RWF-OPPPCSS-C-PATH24] 13. Maidstone and Tunbridge Wells NHS Trust. *Clostridium difficile, Control and Management of* [RWF-OPPPCSS-C-PATH8] 14. Maidstone and Tunbridge Wells NHS Trust. *Risk Assessment Policy and Procedure.* [RWF-OPPPCS-NC-CG6] 15. Maidstone and Tunbridge Wells NHS Trust. *Discharge Policy and Procedure.* [RWF-OPPPES-C-AEM6] 16. Maidstone and Tunbridge Wells NHS Trust. *Paediatric Transfer Policy* [RWF-OPPWC-C-PD6] 17. Maidstone and Tunbridge Wells NHS Trust. *Maternal Transfer Policy* [RWF-OPPWC-C-OG36]

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	New policy and procedure documents	November 2007
2.0	Reviewed and reformatted	November 2009
2.1	Reviewed and reformatted with new documents	July 2011
2.2	Added section 7.4.18 (Tonbridge Cottage Hospital)	September 2011
3.0	Reviewed	March 2013

Policy Statement for

Patient Transfer Policy

The definition of 'transfer of patients' includes the movement of patients from one clinical area to another either as a result of changing clinical priorities or for investigations or treatment or due to the site being in escalation and requiring assistance from the other site. It includes, but is not exclusive to, the following types of transfer:-

- Internally ward to ward or ward to department.
- Internally department to ward e.g. from A&E/ MAU/ CDU/ OPD
- Internally ward to critical care areas e.g. HDU.
- Transfer of patients across site (excluding Women's and Children – see policy on Trust Intranet) for further treatment or due to escalation.
- Externally to Community Hospital; Stroke Rehabilitation Unit.
- Externally to Other Hospital Trusts for further treatment.

It does not include patients who are being discharged home or to a nursing or residential home; these patients should follow the Discharge Policy and Procedure[15].

All patients who are transferred will have had their treatment commenced on one of the Trust Sites and will be transferred to the appropriate physicians internally and externally for the continuation of the management of their care.

All transfers of patients must be clinically assessed and socially assessed; this will be undertaken using patient transfer forms and criteria assessment documentation. This documentation aims to ensure accurate assessment of patients prior to transfer and to enable accurate information is passed between staff to maximise the safe transfer of patients.

Patients who are due to be discharged home or to another place of care e.g. nursing / residential home / community hospital within the next 24 – 48 hours should not be transferred across site.

The clinical assessment will:-

- Minimise risk by assessment.
- Ensure appropriate personnel and equipment are involved in the transfer with regards dispatch and receipt.
- Enable complete and accurate communication between the transferring clinical area and the receiving clinical area or department or unit, in relation to nurses, physicians and relatives / carers.
- Enable complete and accurate communication between the sending physician and receiving physician where appropriate.
- Internal / External Transfer forms must be completed for all transfers.
- The policy is to facilitate effective and safe clinical transfers of patients between wards and departments and hospital sites both internally and externally and between nursing and medical staff.

Transfer forms must be completed for all transfers with the following exceptions:-

- **LOW RISK** patients attending a department for simple investigations e.g. X-ray, however the nurse is required to document assessment result (e.g. low risk).
- For patients going for investigations where the nurse will remain through out the procedure, the transfer form does not need to be completed. However, as a minimum, the same level of monitoring thought appropriate on the ward must continue.

HIGH risk patients who are critically ill and who have a PAR score of 3 in one area or a total score of more than 5 (Reference [1]) must have documented approval from the medical team before transfer takes place.

Transfer of ventilated patients or patients requiring ICU/HDU care must follow the Critical Care Network Transfer Policy (Kent and Medway Critical Care Transfer Policy 2006).

Particular care and consideration must be given to vulnerable adults and in particular patients with learning disabilities who require transfer. These patients, even if identified at low clinical risk, will require a nurse escort to remain with the patient during investigations or treatment. In the context of transfer between locations particular consideration must be given to preparing the patient for transfer.

Patient Transfer Procedure

Contents **Page**

1.0 Introduction and scope

The guidelines and procedures outlined within this document are intended to provide a policy for ensuring the safe transfer of adult inpatients between treatment areas at Maidstone and Tunbridge Wells NHS Trust both in and out of hours and out of the Trust to continuing care facilities.

Patients who may require transfer within the Trust include:

- Transfers to departments
- Transfers from A&E
- Transfers between wards
- Transfers between sites.
- Transfers to Stroke Rehabilitation Unit (Tonbridge Cottage Hospital)

Patients who may require transfer outside the Trust include:

- Transfers to Community Hospitals
- Transfers to other Acute Hospitals.

The principle responsibility of all staff is to maintain patient wellbeing, provide optimal care during the period away from the ward, report and document outcomes and actions taken.

Transfer will take place when a patient's needs would be better met in an alternative area, this may be due to a clinical or rehabilitative need. Transfers between sites will also occur when the site is in escalation.

It is the duty of the person managing a shift or other department in conjunction with the clinicians to take the responsibility of ensuring that patients are assessed prior to transfer and that the Internal / External Patient Transfer Form (**Appendix 4**) is completed and a risk assessment has been undertaken (**Appendix 5**) and documented on the Transfer Form. The Internal / External Patient Transfer Form records patient details, risk assessment result, clinical status, infection control status, patient property, observations, handover details etc. and should be attached to the front of the patients' notes so that it is easily accessible for the receiving ward.

The receiving member of nursing staff and clinician have the responsibility to check the patient's condition and to ensure that all appropriate documentation has been transferred with the patient and a clinical assessment takes place within ½ hour of the arrival of the patient.

The requirement to transfer patients across site due to escalation should be identified as early as possible to ensure the process is followed and patients are identified in a timely fashion and fully assessed prior to transfer. Initially patients in A&E will be identified, however if there are no suitable patients then patients from MAU or speciality wards will be identified. Patients due for discharge within 24 – 48 hours should ideally not be transferred unless this will benefit their care.

The Clinical Site Managers on both sites must be aware of all patients who are being transferred and ensure that these are reported on the site report and the AD / manager on Call must be aware if this process is being followed. Out of hours the Clinical Site Managers must review all patients prior to transfer.

Liaison must take place between the NIC of the area from where the transfer will take place to the NIC of the receiving area, whether internal or external transfer. The Registrar that is currently looking after the patient and the Registrar who will be taking over their care must also liaise with regards to the patient and their plan of care. The Clinical Site Manager from the sending site and the Clinical Site Manager at the receiving site must also liaise with regards transfers within the Trust.

The process and reasons for transfer must be explained to all patients and also their relatives / carers prior to the transfer taking place.

A care management plan must be documented in the notes by the clinician transferring care prior to the transfer process.

A full risk assessment (**Appendix 5)** must be undertaken and documented on all patients prior to transfer to ensure any risks associated with transfer are identified, any equipment requirements are identified and the best means of transport is identified prior to transfer.

1.1 Purpose

The purpose of the policy is to provide direction, guidance and the underlying principles for staff to support safe and appropriate transfer of patients.

The key to safety is through thorough risk assessment and communication. All patients undergoing transfer must be risk assessed for clinical need during transfer by a registered nurse / midwife who must take responsibility for providing the verbal handover of the patient to the receiving area.

2.0 Definitions

- A&E: Accident and Emergency Department
- AD: Associate Director
- MAU: Medical Assessment Unit
- NIC: Nurse in Charge
- Internal Transfer – Transfer within the hospital to a ward or department.
- Other site – Transfer between sites (Maidstone Hospital, Tunbridge Wells Hospital, Stroke Rehabilitation at Tonbridge Cottage Hospital) within Maidstone and Tunbridge Wells NHS Trust.
- External Transfer – Transfer to another Acute Hospital or Community Hospital.
- Out of Hours - 22:00 – 07:00. Transfers should be undertaken only when absolutely necessary following a similar rationale to NICE guidelines on the acutely unwell (2007).

3.0 Duties

3.1 Chief Executive

The Chief Executive has overall accountability for ensuring that the Trust meets its statutory and non-statutory obligations in respect of maintaining appropriate standard of patient transfer. The Chief Executive devolves responsibility for monitoring and compliance to the Medical Director and Chief Nurse.

3.2 Medical Director / Director of Nursing

Both are responsible for ensuring that Trust staff uphold the principles of correct patient transfer and that appropriate policies and procedures are developed, maintained and communicated throughout the organisation.

3.3 Clinical Directors / General Managers / Matrons

The Directorates have a responsibility to ensure that all staff adhere to Trust policy in relation to patient transfers to ensure safe practice. Any incident arising from the transfer of a patient should be investigated at a local level and actions taken to prevent a reoccurrence and minimise risk. Incidents should be reported via Datix e-reporting and should follow the process set out in the Trust Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22].

3.4 Ward / Department Manager

It is the responsibility of the ward/department manager to ensure that all of their staff are made aware of the Trust's policy for the safe transfer of patients to include risk assessing patients' escort requirements. These procedures should be included in the induction of all their staff as part of their orientation at ward / departmental level. Any incidents arising from patient transfer should be investigated and reported to the Matron or out of hours Clinical Site Manager in accordance with Trust policy.

3.5 Clinical Site Manager

It is the responsibility of the Clinical Site Managers out of hours to provide guidance and support to staff and where appropriate facilitate patients' safe transfers. They must ensure that staff know to contact them if concerns arise to include staffing difficulties to ensure patient care is not affected. Clinical Site Managers must be aware of all patients who are being transferred for admission between sites and review these patients prior to transfer and on arrival following a transfer and ensure these are reported on the site report. They must also ensure that the audit forms for transfer of patients across site are completed for all transfers.

3.6 Medical Staff

All medical staff should ensure they are familiar with the Trust's policy for the transfer of patients including the risk assessment of patients prior to transfer. They are responsible for assessing patients prior to transfer and within ½ hour of arrival following transfer to ensure the patient is safe and stable to transfer and safe and stable on arrival. Senior medical staff responsible for the

supervision and training of doctors should ensure that junior medical staff are aware of their role and are competent to undertake escort duties as and when required. All medical staff also need to ensure they communicate the need for transfer to patients and their relatives with regards investigations, further treatment etc and also ensure that this is clearly documented. Any incidents arising from patient transfer should be reported by all medical staff in accordance with Trust policy.

3.7 All Staff

It is the responsibility of every registered nurse / practitioner, support worker, clinician or other member of staff to ensure that the transfer policy is adhered to when transferring a patient. All registered nurses / practitioners involved in the patients care should ensure a full risk assessment is undertaken prior to transfer and documented on the internal / external patient transfer form, as well as ensuring that the appropriate escort accompanies the patient dependent on the risk assessment and patients condition. The patient should be assessed following transfer by a registered nurse / practitioner on arrival at their destination to ensure that their condition remains stable. All staff should report any patient incidents arising from transfers in accordance with Trust policy. Incidents involving any injury to patients being transferred by Trust patient Transport services or the Trust operated Tier 1 service must be notified to the on call transport manager at the earliest opportunity. If there are concerns raised whether to transfer a patient these should be raised with the nurse in charge of the ward / department and clinician responsible for the patients care before the transfer happens. It should also be raised to the Clinical Site Managers (out of hours).

3.8 Therapy / Dietician Staff

The designated therapist or dietician will ensure that all information required to take over responsibility with regard to their particular area of expertise is documented clearly and transferred with the patient.

3.9 Infection Control

Prior to transfer suspected or confirmed infectious patient's information / needs will be shared with the ward or facility. Advice and guidance will be offered to community and private healthcare settings.

3.9.1 Transfer to external healthcare facilities:

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.

- For ambulance transportation, clinical staff must notify the Ambulance Service in advance.
- 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[13], Norovirus[14] and Clostridium Difficile[15] policies for further guidance.

- Advice regarding patients with infection control issues should be sought from the infection control team as necessary.

3.10 Risk Management

All incidents will be recorded on the Trust database, as described in the Trust Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22]. Any unresolved risk identified from incidents will be recorded and managed through the local risk register.

3.11 Escorts

Assessment to determine the level of escort required should be undertaken using the Patient Transfer Risk Assessment Tool (**Appendix 5**). The designated escort if appropriate should remain with the patient at all times, ensuring that the patient is safe and that all care needs are delivered. The escort nurse must ensure that the receiving member of staff is provided with a full handover. If an escort is not required then the Nurse in Charge of the department / ward that is sending the patient should ensure a full handover is given to the receiving area by telephone prior to transfer.

A Registered Nurse should accompany all medium and high risk patients as outlined within the Patient Transfer Risk Assessment Tool. All low risk patients, as outlined within the Patient Transfer Risk Assessment Tool, may be transferred without an escort by PTS or SECamb. High risk patients, as outlined within the Patient Transfer Risk Assessment Tool, should only be transferred following consultation with the Critical Care Team and Medical Team for escort provision.

In the event that the receiving department has available and appropriate staff to care for the patient, the escort may return to their ward / department.

In the event that the time period away from the ward / department is longer than 30 minutes the escort should inform the Matron / Clinical Site Manager to enable them to assess the needs of the ward / department.

3.12 Transport

The transport department will co ordinate transport for all patients who require transfer between sites and to community hospitals and other acute trusts. The transport department have a responsibility to ensure that transfers are safe and appropriate in conjunction with the clinical staff who have requested the transfer.

The patient transfer service require one working days notice to provide timely appropriate transport, however transfers can be booked on the day using the correct booking system.

Out of hours the transport for any transfers will be coordinated by the Clinical Site Managers in conjunction with the on-call transport manager as required.

4.0 Training / competency requirements

Special training in patient transfer is not required as Registered Nurses and Physicians have the relevant competencies when accompanied by the guidance within this procedure. The procedure is available to all Nurses through the Trust intranet and awareness is shared during local induction training.

5.0 Out of hours transfer process

Transfer out of hours will not be taken after 22:00 with the exception of emergencies. The responsibility for this decision will be taken by the Clinician and Clinical Site Manager in conjunction with the Manager on Call and Executive on Call as required due to site escalation and should only happen when absolutely necessary. The principles and responsibilities for transfer remain the same.

Due to reconfiguration of services transfers between sites of Surgery, Orthopaedic and ENT patients may occur from A&E for further treatment and specialist opinion out of hours but all patients require a full risk assessment (**Appendix 5**) and transfer documentation (**Appendix 6**) completed prior to transfer.

Out of Hours (22:00 – 07:00) Transfers should be undertaken only when absolutely necessary following a similar rationale to NICE guidelines on the acutely unwell (2007).

6.0 Communication and documentation

6.1 Communication between staff, including documentation (how handover is recorded)

The Clinical Site Manger must ensure that the audit forms for transfer of patients across site are completed for all transfers that are admitted.

It is essential that a thorough handover is provided to the receiving area / hospital:

- by the nursing staff attending the patient to the staff receiving the patient
- by the registrar attending the patient to the registrar receiving the patient
- by the Clinical Site Managers from the site sending the patient to the Clinical Site Managers at the site receiving the patient (if out of hours)

For the purposes of transfers to departments for investigations, handover will be from the escorting nurse. In the event that the patient does not require a nurse escort the nurse in charge must ensure that any necessary information is given to the receiving department and appropriate checklists completed to accompany patient.

Relevant notes, both medical and nursing, should accompany the patient and an Internal / External Patient Transfer Form (**Appendix 4**) should be completed for all patients.

The registrar involved in the transfer should ensure that their Consultant is aware of the transfer as should the receiving registrar. A care management plan must be documented in all patients' notes by the attending physician and this should be handed over to the receiving physician verbally.

6.2 Communication with the patient / relatives / carers

Communication with the patient explaining the reasons for transfer must be given by the attending clinician and nurse in charge of the patient prior to transfer and this should be documented in the clinical records.

Communication with the relatives or carers must also take place prior to the patients transfer ensuring the reasons for transfer are explained as well as where the patient will be transferred to and ideally a contact number should be provided to them. This should be documented in the clinical records.

On arrival following transfer the relatives / carers should be contacted by the receiving ward to confirm the transfer of the patient and which ward they are on and contact number. This should be documented in the clinical records.

7.0 Handover requirements between all care settings

During a transfer patients should be treated and cared for in such a way as to maintain:

- Patient safety
- Necessary treatment and care
- Contact with appropriate staff
- Dignity
- Respect for the individual needs
- Communication with relatives / carers
- Confidentiality of patient information
- Infection control

The designated nurse will categorise the risk involved in relation to the transfer of care for individual patients in accordance with the Trust Risk Assessment Policy and Procedure[14]:

- Low risk
- Medium risk
- High risk
- Critically ill

The decision to transfer a patient to another ward / unit / department or external site must consider the potential risk and benefits to the patient and a clinical and social assessment should be undertaken within 1 hour or less of predicted transfer time and documented in the patient's notes. The registered nurse responsible for the patient should assess to determine that there has been no significant change in the patients risk category immediately prior to transfer and document this in the patient's notes. If a significant change to the risk category has occurred then the patient must be seen and assessed by the Registrar to ensure transfer is still appropriate, this should be documented within the clinical records.

A patient transfer form (**Appendix 4**) should be fully completed and attached to the front of the patients' notes so that it is easily accessible for the receiving ward. In the case of a patient attending a department the patient transfer form should be completed if the patient is assessed as **MEDIUM OR HIGH RISK** and attached to the front of the notes.

Transfer forms do not need to be completed for **LOW RISK** patients attending a department for simple investigations. However, the nurse is required to document assessment result (e.g. low risk) within the clinical records.

HIGH RISK patients who are critically ill and who have a PAR[1] score of 3 in one area or a total score of more than 5 must have documented approval from the medical team immediately before transfer takes place.

A **Care Management Plan** must be documented in all patients' notes by the attending physician and this should also have been handed over to the receiving team verbally.

7.1 Transfer to departments for investigation / treatment

7.1.1 The qualified nurse or physician attending the patient should inform the patient of the reason for investigation / treatments (include / inform relatives where appropriate) and ensure consent has been obtained for this.

7.1.2 The qualified nurse attending the patient should assess the need for an escort using the Risk Assessment Tool.

7.1.3 If an escort is required and the ward are unable to supply one, contact Matron or Clinical Site Manager for support to ensure patient's care is not compromised.

7.1.4 The qualified nurse attending the patient should ensure all necessary equipment required for transfer is present and in full working order.

7.1.5 The qualified nurse attending the patient should ensure the patient has an identification name band present.

7.1.6 Special attention must be paid to patient dignity. All staff at all times should ensure the patient is fully covered and appropriately clothed.

7.1.7 If a patient requires medication whilst away from the ward, the qualified nurse attending the patient should ensure that the receiving department is fully aware and that medication is available.

7.1.8 The qualified nurse attending the patient and attending physician should ensure all appropriate documentation needed to support the investigation is sent with the patient.

7.1.9 Changes in the patient's condition must be reported to the ward via the nurse escort (where present) or the receiving department and recorded in the clinical records[4].

7.2 Transfer between wards and Trust sites

7.2.1 The qualified nurse or physician attending the patient should ensure that patient, relatives and carers are fully aware of reason for transfer prior to the transfer taking place.

7.2.2 The qualified nurse attending the patient should assess the patient's care and escort needs using the Risk Assessment Tool.

7.2.3 Ensure receiving ward is prepared for patient transfer. In the event that a nurse escort is not required the nurse in charge must ensure that a comprehensive handover is given to the receiving area over the telephone.

7.2.4 The qualified nurse and physician attending the patient should ensure the receiving ward, Clinical Site Managers (where cross site transfer) and receiving physicians are all aware of patient transfer and have accepted patient prior to transfer.

7.2.5 The qualified nurse attending the patient should ensure the patient has an identification name band present.

7.2.6 The qualified nurse attending the patient should complete the Transfer Form.

7.2.7 The qualified nurse attending the patient should ensure that prior to transfer the receiving area, porters and transport are aware of any potential infection issues.

7.2.8 The qualified nurse attending the patient should ensure all equipment necessary for tranfer is fully charged, available and in full working order.

7.2.9 The qualified nurse attending the patient in conjunction with the Clinical Site Managers (out of hours) should ensure appropriate transport is booked for the patient journey. The qualified nurse attending the patient should provide a detailed and patient focused handover to the transporting ambulance crew prior to the patient leaving the ward / department.

7.2.10 The qualified nurse attending the patient should ensure porters are available for the transfer.

7.2.11 The qualified nurse attending the patient should ensure all documentation and transfer checklists are transferred with the patient.

7.2.12 The qualified nurse attending the patient should ensure required medication is available and sent with the patient where appropriate.

7.2.13 The qualified nurse attending the patient should manage patient property in line with Trust policy[2].

7.2.14 Special attention must be paid to patient dignity. All staff at all times should ensure patient is fully covered and that footwear is available for transfers between sites. Patients for cross site transfer must be afforded the appropriate coverings during the winter months and inclement weather conditions before they leave the ward / department.

7.2.15 The qualified nurse attending the patient should inform Matron / Clinical Site Manager of transfer if difficult to comply with transfer principles.

7.2.16 The qualified nurse or physician accompanying the patient should ensure care and treatment undertaken during transfer is documented including observations taken.

7.2.17 On arrival at the destination the escort must ensure that the patient is formally handed over to receiving staff. They should assist in settling the patient and ensure all equipment is transferred and the correct flow rates of infusions / oxygen flow rates are checked.

7.2.18 The qualified nurse or physician accompanying the patient should ensure the Nurse accepting the patient signs the patient transfer form, and the form is placed in the patient's notes.

7.2.19 The Nurse accepting the patient should ensure that the receiving physician signs the patient transfer form when they review the patient within ½ hour of arrival and that this is placed in the patient's notes.

7.2.20 Any patient requiring transfer to the Stroke rehabilitation Unit at Tonbridge Cottage Hospital will require an escort. The nurse arranging the transfer should refer to the risk assessment flow chart in **Appendix 5** to determine the level of escort required.

7.3 Mode of transport for internal transfer, e.g. bed / chair, must form part of the decision making.

7.3.1 The qualified nurse attending the patient should ensure a patient handling assessment[3] is undertaken for all patients on admission and continually reviewed in accordance with the Trust Manual Handling Policy and Manual Handling Risk Assessment Procedure.

7.3.2 The qualified nurse attending the patient should ensure the patient is assessed for the most appropriate mode of transportation using the moving and handling assessment flow chart (**Appendix 6).**

7.3.3 Permanent transfer of unstable dependent patients and patients who are being nursed on a specialist bed frame or mattress will occur on the bed and mattress and these will remain with the patient on the receiving ward.

7.3.4 Stable dependent patients may be transferred on a trolley but only where this will not create a significant risk to pressure area integrity. The patient handling assessment tool should give advice for the most suitable method of transfer.

7.3.5 Independent patients who may be able to walk independently should be transferred to the receiving ward in a wheelchair to reduce the risk of falls due to the distances between some wards and the possible moving between floors. The patient should be allocated an appropriate bed on the receiving ward.

8.0 Transport

Patients who need to be transferred between sites should have the appropriate method of transport booked prior to transfer to ensure they are conveyed safely to the most appropriate healthcare facility. See (**Appendix 7**) for specifics on patient transport services.

Patient Transport Services should be used in-hours where appropriate, and out of hours transport should be booked through the Clinical Site Manager.

Types of transport include:

- Seated or Stretcher Ambulances
- Tier 1 Ambulances

The overall aim is to reduce clinical risk and increase patient safety, this will be done through staff awareness of risks associated with conveying patients, and appropriate measures to minimise these risks, by ensuring the patient transfer form is completed, risk factors have been identified and moving and handling assessment has been undertaken.

Any special needs that the patients require must be identified with the transport office and made at the time of booking e.g. specialist mattresses or if the patient is considered to be Bariatric.

8.1 Patients transferring in own transport

For those patients who need to transfer between sites for a continuation of their treatment from areas such as A&E or Maternity and wish to do so in their own transport or with a friend / relative a full assessment must be undertaken by the Clinician responsible for the patient with regards their suitability to transfer by this method and the suitability of the transport being used. The Transfer of Patients in Own Transport Form (**Appendix 8**) as well as the patient transfer form and risk factor assessment must also have been completed prior to transfer.

If patients are transferred to another site by the patient transport service it is not the responsibility of PTS or the Trust to provide transport on discharge unless this is deemed clinically appropriate.

9.0 Monitoring and audit

The Clinical Site Management Team will take responsibility for monitoring the compliance and effectiveness of this policy and procedure on behalf of the Trust.

This includes the monitoring of:

- Handover requirements between all care settings to include both giving and receiving of information
- How handover is recorded
- Out of hours handover process

Details of the monitoring are provided in the table provided on the next page.

A representative of the Clinical Site Management Team will make six 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 Standard 4.9.

What needs Monitoring	Who will lead on this aspect of the monitoring – name the lead	Tool used to monitor /check that everything is working according to 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
Handover requirements and recording handover between all care settings to include both giving and receiving of information	Site Practitioner Team Leader	Audit of compliance with use of Patient Transfer Form and Patient Risk Assessment.	Daily documentation on audit form and collated every 2 months.	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
Out of hours handover process	Site Practitioner Team Leader	Through Site Report and collated monthly	Daily documentation on site report and collated 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
Review adverse incidents relating to transfer	Ward Managers / Matrons	Review themes and trends	6 monthly – April/ September.	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
Review Treat and Transfer Process and audits at Directorate Governance meetings	Directorate Matrons, GM's and CD's.	Directorate Governance Agenda item, and recorded in minutes.	Monthly	Quality and Safety Committee	Divisional Operations committee or Nursing and Midwifery group.	Actions will be identified from directorate governance meetings, and shared with other directorates.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- 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.
- 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.
- Introduction via ward sisters meeting to be managed by Directorate Matrons.
- Circulation to all consultants via Clinical Directors.

2.0 Review

This policy and procedure will be reviewed at the review date (2 years) or following any significant changes.

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 Transfer Policy and Procedure

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

Please return comments to: Directorate Matron Emergency Services

By date:

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 Operating Officer	26.10.12	1.11.12	Y	Y
Chief Nurse	26.10.12			
Medical Director	26.10.12			
Head of Governance	19.9.12	1.11.12	Y	Y
Members of Quality and Safety Committee	19.9.12			
Clinical Directors	26.10.12			
ADNS's	26.10.12	29.10.12	N	N
ADO's	26.10.12			
DIPC	26.10.12	1.11.12	Y	Y
Matrons	26.10.12			
Ward Managers	26.10.12			
Critical Care Outreach Team	26.10.12	5.11.12	N	N
Transport Manager	26.10.12	1.11.12	Y	Y
Risk Manager	20.9.12	1.11.12	Y	Y
Clinical Governance Assistant	24.9.12	27.9.12	Y	Y
Clinical Site Managers	19.9.12	27.9.12	Y	Y
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 Transfer Policy and Procedure
What are the aims of the policy or practice?	Safe transfer of Patients
Identify the data and research used to assist the analysis and assessment	Associated documents and references.
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	Translation of policy can be available if required.
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)	
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?	YES
When will you monitor and review your EqIA?	At the same time that the policy/procedure is reviewed
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three of this policy/procedure on the Trust Intranet (Policies and Guidelines)

No.	Title	Unique ID
4	Internal & external patient transfer form	RWF-OWP-APP79
5	Risk assessment flowchart	RWF-OWP-APP81
6	Patient transfer moving & handling assessment	RWF-OWP-APP82
7	Patient transport services: patient requires external transfer to another site	RWF-OWP-APP84
8	Transfer of patients in own transport	RWF-OWP-APP80

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**

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