* Please note: Throughout this policy there is reference to the Cumbria Wide Discharge and Transfer Policy which is currently being updated. This supplement policy reflects the process for Discharge and Transfer within North Cumbria University Hospitals NHS Trust.
North Cumbria University Hospitals NHS Trust
North Cumbria University Hospitals NHS Trust Supplement to the Cumbria Discharge & Transfer Policy
Publication Date: 26/01/2012

DOCUMENT CONTROL

<table>
<thead>
<tr>
<th>Author/Contact</th>
<th>Business Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:Chris.walbank@ncuh.nhs.uk">Chris.walbank@ncuh.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td>Tel No: 01228 814734</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Version</th>
<th>3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Approved</td>
</tr>
<tr>
<td>Publication Date</td>
<td>26/01/2012</td>
</tr>
<tr>
<td>Review Date</td>
<td>31/01/2015</td>
</tr>
</tbody>
</table>

Approved by: -
Trust Policy Group Date: 23/01/2012
Governance & Quality Committee Date: 25/01/2012

Please note that the Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as “uncontrolled” and as such, may not necessarily contain the latest updates and amendments.

Approved policies related to this policy

<table>
<thead>
<tr>
<th>Name Policy</th>
<th>Document Reference / Hyperlink</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumbria Wide Discharge Policy</td>
<td></td>
</tr>
</tbody>
</table>

Statement of changes made

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Changes / comments received from</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>22/02/2010</td>
<td>Approved at Governance Committee</td>
</tr>
<tr>
<td>1.1</td>
<td>30/06/2010</td>
<td>Amendment to section 6.2 no discharge facilities at WCH</td>
</tr>
<tr>
<td>1.2</td>
<td>12/11/2010</td>
<td>Section 6.2 removed as there are no discharge facilities at CIC</td>
</tr>
<tr>
<td>2.1</td>
<td>01/12/2011</td>
<td>This update is a Draft publication pending a system wide review of DTOC across the whole North Cumbria health economy.</td>
</tr>
<tr>
<td>2.2</td>
<td>12/1/2012</td>
<td>Reformatting, corrections to proof</td>
</tr>
<tr>
<td>2.3</td>
<td>16/01/2012</td>
<td>Updated front sheet regarding information on Cumbria Wide Discharge Policy on title sheet.</td>
</tr>
<tr>
<td>2.4</td>
<td>23/01/2012</td>
<td>Amended following TPG comments</td>
</tr>
<tr>
<td>3.0</td>
<td>25/01/2012</td>
<td>Approved at Governance &amp; Quality Committee</td>
</tr>
<tr>
<td></td>
<td>25/01/2012</td>
<td>Entered onto the Trust Intranet site</td>
</tr>
</tbody>
</table>
SUMMARY

The Trust is committed to the safe and prompt discharge of patients from acute care. It recognises that appropriate, timely discharge planning is fundamental to the provision of effective health care, and to the wellbeing of the patient.

This document is for use as a local supplement to the Cumbria Discharge and Transfer Policy, (November 2009) and sets out specific local arrangements that are not detailed in the above policy for discharge from North Cumbria University Hospitals NHS Trust (NCUHT). The specific local arrangements are:-

- Discharge Risk assessment tool, appendix 1
- Out of hours discharge process arrangements (section 6.1)
## TABLE OF CONTENTS

**SUMMARY** ................................................................................................................................. 3  
1. **INTRODUCTION** ...................................................................................................................... 5  
2. **PURPOSE OF THE DOCUMENT** ............................................................................................ 5  
3. **SCOPE** ...................................................................................................................................... 5  
4. **DUTIES (ROLES & RESPONSIBILITIES)** .................................................................................. 5  
4.1 **CEO / Board Responsibilities** .................................................................................................. 5  
4.2 **Director of Nursing Responsibilities** ....................................................................................... 5  
4.3 **Clinical Director & Divisional Responsibilities** ......................................................................... 5  
4.4 **Ward sisters / Charge Nurses** .................................................................................................. 5  
4.5 **Nursing / Midwives Responsibility** .......................................................................................... 6  
4.6 **Consultant Medical Team** ......................................................................................................... 6  
4.7 **Allied Health Professionals (AHP’s)** ......................................................................................... 7  
4.8 **Roles of other Multi-disciplinary Team Members** .............................................................. 8  
5. **PROCEDURES FOR SAFE AND EFFECTIVE DISCHARGE** ...................................................... 8  
5.1 **Simple and Complex Discharge Planning** ................................................................................. 10  
5.1.1 **Simple Discharge Planning – Definition** ........................................................................ 10  
5.1.2 **Complex Discharge Planning – Definition** ...................................................................... 10  
5.2 **Information Given To Patients** ................................................................................................ 13  
6. **HOSPITAL REFERRALS TO SOCIAL SERVICES** ................................................................... 13  
7. **RESPONSIBILITIES RELATING TO ISSUE AND PRESCRIBING OF MEDICINES** [DRESSINGS AND APPLIANCES] ...................................................................................................................... 13  
7.1 **Discharge Letter** .................................................................................................................... 14  
7.2 **Medicines Reconciliation** ........................................................................................................ 14  
7.3 **Medicines Adherence** ............................................................................................................. 15  
7.4 **Process – ordering Take Home Medications** ......................................................................... 15  
7.4.1 **One-stop dispensing** ............................................................................................................ 16  
7.4.2 **Patients’ Own Drugs** ......................................................................................................... 16  
7.4.3 **Monitored Dose Medication / “Blister” Packs** ................................................................... 16  
7.4.4 **Discharge – less than 72 hours / out of hours** ................................................................... 17  
7.4.5 **Ordering Take Home Dressings and Appliances** ........................................................... 17  
8. **RESPONSIBILITIES RELATING TO THE SUPPLY OF INTERMITTENT HOME OXYGEN** ................................................................................................................................. 17  
9. **RESPONSIBILITIES RELATING TO INFECTION CONTROL** .................................................... 18  
10. **REFUSAL OF TREATMENT / SELF-DISCHARGE** .................................................................. 18  
10.1 **Additional responsibilities where patients self discharge** ........................................... 18  
11. **DISCHARGE PROCESS OUT OF HOURS** ........................................................................... 19  
11.1 **Weekend discharges** .......................................................................................................... 19  
11.2 **Evening discharges** ............................................................................................................. 19  
11.3 **Emergency Services Available Out-of-Hours** ............................................................. 19  
12. **IMPLEMENTATION** .................................................................................................................. 20  
13. **PROCESS FOR MONITORING COMPLIANCE WITH POLICY / PROCEDURE** ............... 20  
14. **ASSOCIATED DOCUMENTATION** .......................................................................................... 21  
15. **REFERENCES** ...................................................................................................................... 21  
**APPENDIX 1 - DISCHARGE PLANNING RISK ASSESSMENT TOOL** ........................................... 22  
**APPENDIX 2 - REFUSAL OF TREATMENT FORM** .................................................................... 23  
**APPENDIX 3 - GLOSSARY OF TERMS** ....................................................................................... 24
1. INTRODUCTION

This document is for use as a local supplement to the Cumbria Discharge and Transfer Policy, (November 2009) and sets out specific local arrangements for discharge from North Cumbria University Hospitals NHS Trust (NCUHT).

2. PURPOSE OF THE DOCUMENT

The purpose of this document is to provide staff with additional detailed information of local arrangements for discharge of patients from the Trust. This is NOT a stand alone document but a supplement to the Cumbria Wide Discharge and Transfer Policy. Nursing staff will take responsibility and act with the best interest of the patient in their care, to facilitate safe and effective discharge from the acute hospital setting.

3. SCOPE

This supplement and the main Discharge and Transfer policy apply to the discharging of in patients from all parts of the Trust and must be followed by any staff involved in that process.

4. DUTIES (ROLES & RESPONSIBILITIES)

4.1 CEO / Board Responsibilities

The CEO has over all responsibility for the safety of patients. In relation to discharge the CEO has delegated the overseeing of the discharge process to the Director of Nursing and Quality.

4.2 Director of Nursing & Quality Responsibilities

The Director of Nursing & Quality has overall responsibility for this policy. On a day to day basis the discharge planning and coordination will be the responsibility of the following staff involved in the discharge process. Duties and responsibilities for each staff group are detailed below.

4.3 Clinical Director & Divisional Responsibilities

Clinical Directors are responsible for the effective delivery of clinical care within their divisions. They must ensure that all relevant staff are familiar with and adhere to the process for discharge of patients and access expert help and advice in all occasions when discharge may be delayed or a problem for specific reasons.

4.4 Ward sisters / Charge Nurses

Ward Sisters / Charge Nurses are responsible for ensuring that discharge planning is started when appropriate within 24 hours of admission to the acute hospital or as early as possible in a patient’s stay and that staff are familiar with and follow the detailed processes set out in the main policy. They will escalate risks arising from delayed discharge to relevant senior staff and access expert advice if any risk is identified. Furthermore the Sister/Charge Nurse will escalate any delays in discharge to the identified discharge lead within the relevant hospital.
4.5 Nurses / Midwives Responsibility

To be familiar with and follow processes for effective discharge as set out in the main policy along with ensuring that;

- any discharge planning will be undertaken in a safe and timely manner.
- discharge planning will not start at the end of a patient’s treatment, but much sooner in their inpatient stay.
- take responsibility for the overall coordination of the discharge plan for patients in their care, and should prevent/delay discharge if, in the opinion of the nurse or midwife, the patient is not fit for discharge. In these circumstances the nurse or midwife must ensure that concerns are raised with the multidisciplinary team.
- ensure that initial discharge planning at the point of assessment of the patient takes place and identifying potential problems as early as possible and involving relatives/carers and initiating referrals to relevant disciplinary team members.
- ensuring that an anticipated (predicted) discharge date is set within 24 -48 hours of admission.
- contacting the patient’s current community support team when relevant to inform them of the admission.
- completing a Section 2 Notification (refer to section 6 of this Policy), if adult care services will be required on discharge and sending this notification to the correct authority, ensuring it includes details of the expected discharge date (Cumbria Wide Discharge Policy section 2).
- completing a Section 5 Notification (refer to section 6 of this Policy) following multi-disciplinary agreement that the patient has had all relevant assessments, and is safe and medically fit for discharge or transfer. This notification is jointly owned and signed by Health and Social Care partners.
- if the discharge date is cancelled, the nurse or midwife caring for the patient on that shift must ensure that the patient, relatives, carers and appropriate services are informed as soon as possible.
- ensuring that allied health professional intervention is complete prior to discharge.
- educating and providing information to patients and/or their carer(s) relevant to specific needs upon discharge, including medication (Cumbria Wide Discharge Policy section 5) and section 1.11 of the Medicines Management Policy.
- providing the patient with details of contact names and numbers in case of difficulties.
- making records relating to discharge planning and decisions in the patients file.

4.6 Consultant Medical Team

The Consultant and medical team are responsible for:
• having in place an Estimated Discharge Date (EDD) and fully communicate this to the wider nursing and MDT team, this is in order to allow ward staff to better plan for patients discharge from the acute hospital.
• prescribing patient’s take out medication (TTO’s) prior to discharge.
• completing a discharge summary for the patient’s GP, usually on day of discharge.
• alerting nursing staff to any required follow up appointments or tests post discharge, as appropriate.
• ensuring that any results of diagnostic tests that arrive after a patient’s discharge that require specific or immediate action are communicated to the GP by telephone and/or letter as soon as possible.
• making records relating to discharge planning and decisions in the patients file.
• determining when the patient is medically **fit for discharge** as per below.

**How is medically fit and clinical stability defined?**

The terms clinical stability and medical stability/fit broadly are understood to mean the same thing. The patient can be defined as clinically or medically stable/fit when clinical tests such as bloods and investigations are considered to be within the normal range for the patient. It is normal practice that it is the consultant who declares a patient as medically fit. ‘Fit for discharge' however has a different meaning.

**Is the patient ‘fit for discharge’?**

The patient is ‘fit for discharge’ when physiological, social, functional, and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate. It is safe for the patient to be discharged or safe to transfer from hospital to home or another setting. The patient who is ‘fit for discharge’ no longer requires the services of acute or specialist staff within a secondary care setting, and where:

- review of the patient’s condition can be shared with the GP including adjustments to medication
- ongoing general, nursing, and rehabilitation needs can be met in another setting at home or through primary/community/intermediate/social care services.
- additional tests and interventions can be carried out in an outpatient or ambulatory care setting.

_Achieving timely ‘simple’ discharge from hospital DOH 2004_

**4.7 Allied Health Professionals (AHP’s)**

Allied Health Professionals include, but are not limited to, Social Workers, Physiotherapists, Pharmacists and Occupational Therapists. Their duties include:

- Making assessments, management plans and referrals appropriate to the patient’s needs that these are undertaken in a timely manner and are accurate and clear.
• Supporting and educating patients /carers to prepare them for discharge
• Providing contact names and numbers must be provided in case of difficulties.
• Making records relating to discharge planning and decisions in the patient’s file.
• Where necessary liaising with community-based counterparts

4.8 Roles of other Multi-disciplinary Team Members

• Any member of the multi-disciplinary team who has been trained to undertake discharge responsibilities can be the responsible person for co-ordinating the transfer/discharge of the patient. This will be determined by the needs of the patient and the skills of the relevant professional. At present it is usually the Named Nurse who undertakes the role.

• The nominated professional will ensure that all processes, investigations and interventions have been undertaken and completed prior to discharge or transfer. This will also include ensuring any identified carer is willing and able to continue in the caring role. Individual carers should be offered an individual carers assessment as required.

• The nominated professional will ensure that arrangements for discharge or transfer are in place 24 hours prior to the agreed discharge/transfer date.

• The nominated professional will aim to ensure that all requirements to facilitate a safe discharge are in place. This may include dressings, medication and equipment.

• Where patients and/or carers require education or training in the use of medicines, dressings or equipment this must be carried out prior to discharge and the patient and/or carer must be given all relevant information in written form. This training will be carried out by the relevant health professional involved.

• Follow up appointments and referrals to other professionals or agencies will be discussed with the patients and/or carers. Arrangements for these will be made prior to discharge or transfer.

5. PROCEDURES FOR SAFE AND EFFECTIVE DISCHARGE

Effective discharge will be achieved as a result of timely assessment of discharge needs and effective arrangements to achieve these needs. For the successful discharge/transfer of patient to take place it is essential that there is good communication in an appropriate language/format between all parties involved.

The Start of the Discharge Process for Emergency and Elective admissions is charted in Figure 1:
Fig 1 Emergency and Elective Admissions

Emergency

Triage

Initial Assessment, Intervention, Treatment

Decision to Admit, discuss with patient and carer

Yes
Patient agrees

Follow up required YES

Take-home dressings, medications, prescriptions

Contact GP and/or DN or Community Hub or Out of Hours to arrange a follow up

No
Patient disagrees

Follow up Required NO

Complete Refusal of Treatment Form

Further assessment and diagnosis
- Clinical
- Social
- Functional

Pre admission assessment
- Clinical
- Social
- Functional

Anticipated LOS / ESS discussed with patient carer

Referral to MDT professional for assessment of ‘Complex Need’ if appropriate.

Initial Clinical Management Plan

Patient admitted for elective episode

Estimated Date of Discharge is based on anticipated LOS - determined by pre-admission or within 24hrs of admission. Reviewed daily – becomes Expected Date of Discharge – and finally Proposed or Agreed Date of Discharge based on criteria. Patient no longer requires acute care & is safe to discharge.
5.1 Simple and Complex Discharge Planning

To accompany the discharge process for simple / complex discharges, and to assist nurses to determine whether a patient requires planning via the simple or complex discharge flow chart (Figure 2 below), NCUHT is introducing a discharge risk assessment tool. (Appendix 1). The tool provides a scoring system according to how straightforward/complex a patient’s needs will be at discharge. If a patient has a discharge risk of 10 or less then the simple discharge plan is to be followed. If a patient has a discharge risk of 11+ then the complex plan should be followed. (Simple and Complex Discharge flowchart above). The use of the tool is optional, however it is recommended that is used unless the patient’s discharge plan is very straightforward.

5.1.1 Simple Discharge Planning – Definition

The action needed in the discharge planning for these cases does not usually require the involvement of a full multi-disciplinary team or require the involvement of another agency.

Patients with simple discharge needs are defined as those:

- being discharged to their own home or usual place of residency
- having simple ongoing care needs that do not require complex planning or delivery
- In addition they:
  - are identified on assessment as having a predicted length of stay
  - no longer require acute care
  - can be discharged from Accident & Emergency, Primary Care Assessment Service, Step-up/Step-down Units, In-Patient wards or other assessment units.

5.1.2 Complex Discharge Planning – Definition

Patients who are in hospital with complex needs will require referral for assessment by a range of members of the multi-disciplinary team, or the involvement of another agency or care provider.

Patients who have complex discharge needs are defined as:

- patients would be discharged home or to a carers home or to intermediate care or to a residential or nursing care home.
  - And
  - 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.
  - And
  - whose length of stay is more difficult to predict (Source DOH).
Following admission of a person to an acute or community hospital ward or step-up/step down unit, multi-disciplinary assessment and discharge planning will commence.

Where a patient has a known community matron/care manager/care co-ordinator, district nurse or social worker, they should be contacted as soon as possible to ensure that they are fully involved with, and where appropriate co-ordinate, the discharge planning process. This information may be available in some areas by contacting the Community Hub.
**Figure 2  Discharge process for simple / complex discharges**

**Complex Discharge**
- Make appropriate referrals to AHP’s, social services, STINT & community services
- Requires multidisciplinary input
- MDT to confirm discharge date & transfer destination in consultation with patient/carers
- Continuing assessment/ongoing arrangements for transfer/discharge
- Mentally and physically independent or care arrangements fulfil care needs.

**Initial Assessment by professional, involving patient/carers**
- Identify need for multidisciplinary input to facilitate discharge/transfer of care (refers to input other than existing care package
- Not mentally & physically independent, and/or carers unable to fulfil care needs
- Finalise discharge arrangements. Document in patient record

**DECISION TO ADMIT**
- Simple Discharge
  - No predicted requirement for multidisciplinary input to facilitate discharge
  - Inform patient/carers of anticipated discharge date
  - Continuation assessment/review pre-discharge
  - Mentally and physically independent or care arrangements fulfil care needs

- Complex Discharge
  - MDT to confirm discharge date & transfer destination in consultation with patient/carers
  - Continuing assessment/ongoing arrangements for transfer/discharge
  - Mentally and physically independent or care arrangements fulfil care needs.

**Discharge/Transfer**
5.2  Information Given To Patients

The separate specialities should offer diagnosis/speciality specific information leaflets up to and on discharge from hospital i.e. ‘Driving after a Stroke’. It is the individual ward staff who should provide such information before and at the point of discharge, based upon their knowledge of the patient during their inpatient stay. In addition information on medicines should be given to patients as outlined in section 7.3 Medicines Adherence.

6.  HOSPITAL REFERRALS TO SOCIAL SERVICES

In order to comply with the Community Care (Delayed Discharges) Act (2003) it is important that referrals to, and communications with, social workers are documented and the agreed procedure is followed. The good practice of identifying potential social care needs as early as possible after admission is assumed to continue. Patients will be screened to determine whether they meet NHS continuing care criteria. If they do not meet NHS Continuing Care criteria, Adult Social Care will be informed and will carry out an assessment. A copy of the screening assessment will be sent to the Team Manager in Adult Social Care. When predicting future care needs, consideration should be given to the potential for further rehabilitation or the impact of any treatments that may affect the outcome for the patient. Referrals to social workers will only be made with the consent of the patient. The referral will be submitted on a Single Assessment contact one referral form. Upon receipt of the contact one referral the Adult Social Care and Cultural Services Directorate will undertake the necessary assessment and arrange for a social care package to support the safe discharge from hospital. This constitutes a Section 2 Notification

The discharge date will be agreed by the clinician and the multi-disciplinary team when care in an acute setting is no longer required and the patient is safe for discharge. Patients may be fit for discharge who are not clinically stable, but who can be managed safely at home or in the community with input from services for example: Short-Term Interventions [STINT]. This constitutes a Section 5 Notification

Note  Section 2 and Section 5 Notifications can be given at the time that the initial referral is made provided that the discharge date is known and it is made clear that it is the proposed / agreed discharge date.

7.  RESPONSIBILITIES RELATING TO ISSUE AND PRESCRIBING OF MEDICINES [DRESSINGS AND APPLIANCES]

Medication errors are one of the leading causes of injury to hospital patients. Therefore, every time a transfer of care takes place it is essential that accurate and reliable information about the patient’s medication is transferred at the same time. The discharge summary should include accurate and concise information such as name, address and DOB of the patient, it should also be specific on admission details (dates) including diagnosis and outcome of investigations, should these be known.
7.1 Discharge Letter

It is imperative that the discharge letter contain a full and comprehensive list of all medications that a patient is currently taking – including the name, dosage, frequency and route. This information should be clear, unambiguous and legible and available to the GP [or other Primary Care Prescriber] within 24 hours of the patient’s discharge. It should also be included in the District Nurse letter, especially in cases where the District Nurse is likely to visit before the GP letter arrives, within the first 24 hours of discharge.

Information relating to medicine which should be included in the discharge letter:

- A list of all medicines prescribed for the patient on discharge [and not just those dispensed at the time of discharge]
- Dose, frequency, formulation and route of all the medicines listed
- Medicines stopped and started, with reasons
- Length of courses where appropriate [e.g. antibiotics]
- Details of variable dosage regimes [e.g. oral corticosteroids, warfarin etc.]
- Known allergies, hypersensitivities and previous drug interactions
- Any additional patient information provided such as corticosteroid record cards, anticoagulant books, etc.

7.2 Medicines Reconciliation

The process for medicines reconciliation is described in detail in the Medicines Reconciliation for Adults Policy. Briefly, medicines reconciliation is defined as the process of obtaining up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes, deletions or additions, resulting in a complete list of medications accurately communicated.

The person in-charge of coordinating the discharge is also responsible for ensuring the list of medication on the discharge letter is legible, accurate and complete. This can be done more easily and effectively if medicines reconciliation has been carried out, soon after admission by a pharmacist, doctor, experienced pharmacy technician or suitably trained nurse. A full medicines reconciliation will document and explain:

- When a medicine has been stopped, and for what reason [including topical preparations]
- When a medicine has been started and for what reason
- The intended duration of a treatment [e.g. antibiotics or hypnotics]
- When a dose has been changed, and for what reason
- When the route of the medicine has been changed, and for what reason [this is particularly important, when the route or administration has changed from parenteral, often intravenous, to oral].
7.3 Medicines Adherence

It is the responsibility of the person coordinating the discharge to make certain that the patient [or their carer, where appropriate] will be able to use their medicines as prescribed either by assessing them themselves or checking that an assessment has been carried out and documented up to 72 hours prior to discharge.

This will include but should not be limited to:

- What the medicine is, how to use it and likely benefits
- Likely adverse effects and what to do if they think they are experiencing them
- What to do if they miss a dose
- Whether another prescription is needed and how to get further supplies

It is the responsibility of the person coordinating the discharge to ensure that:

- the patient has all relevant information in the format and content that meets their individual needs.
- And any individual issues or concerns have been addressed by the most appropriate person, before the patient is discharged.
- Link with services to check where relevant, that Domiciliary Care Workers can manage the patient’s medicines

NICE has published guidelines on interventions to increase adherence. These include:

- Finding out if non-adherence is because of beliefs and concerns [intentional non-adherence] or practical problems [unintentional non-adherence]
- Identifying solutions to practical problems
  - Suggesting patients record their medicine-taking
  - Encouraging patients to monitor their condition
  - Simplifying the dosing regimen
  - Using alternative packaging
  - Using a multi-compartment medicines system
- Determining if side effects are a problem
  - Discuss benefits, side effects and long-term effects and how the patient would like to deal with side effects
  - Consider adjusting the dosage, switching to another medicine, and other strategies such as changing the timing of medicines
- Asking if prescription costs are a problem and consider options for reducing costs.

Further detailed guidance can be found in the [Self-medication Policy](#), together with risk assessment guidance.

7.4 Process – ordering Take Home Medications

Medications should be re-ordered / restocked 72 hours before planned discharges.
7.4.1 **One-stop dispensing** – medication will already be labelled for discharge, as it has been provided as a patient pack and kept in a locked cabinet by the patient's bedside. The supply will be regularly topped up by the Pharmacy Technician. Checks on discharge include:
- Supplies – the patient should have at least 14 days supply to go home with
- Whether the patient is “self-medicating” and checking adherence with medicines, as described above

7.4.2 **Patients’ Own Drugs** - where patients’ own drugs [PODs] have been brought in and been assessed on admission, usually by pharmacy staff, and found to be of satisfactory quality, they may be used during the inpatient stay and on discharge. Checks on discharge include:
- Obtaining permission from the patient to destroy any medicines no longer in use
- Supplies – the patient should have at least 14 days supply to go home with
- Whether the patient is “self-medicating” and checking adherence with medicines, as described above

Further detailed guidance is available in the [Patient’s Own Drugs Policy](#).

7.4.3 **Monitored Dose Medication / “Blister” Packs**

Monitored dose systems will only be filled by the pharmacy department if they are in a sealed system. Dosette boxes and other similar devices will not be filled under any circumstances.

Patients are only entitled to free MDS packs if they meet certain criteria under the Disability Discrimination Act, details of which can be found in the [Self Medication Policy](#).

The Pharmacy department will only dispense medication in a blister pack if the following procedures are adhered to:

**A minimum of 24 hours notice** is required

For NEW compliance aids, a DDA assessment MUST be completed by an appropriately trained individual. The form can be obtained from the Pharmacy department. The patient must identify which community pharmacy they would prefer to obtain their medicines from and contact MUST be made with this community pharmacy to ensure they are willing to take on an additional patient BEFORE any request for a compliance aid for discharge is made to the pharmacy department. The pharmacy department will not dispense medication in a compliance aid unless it is clear which community pharmacy has agreed to take the patient.

A list of medications must be faxed to the Patient’s GP and the community pharmacist accepting the patient.
For patients whose medication was already packed in a compliance aid on admission:

- If the medication on admission is EXACTLY the same as the medication on discharge, then existing blister packs can be reissued.
- If there are any changes to medication then new blister packs will need to be issued, bearing in mind that the pharmacy department requires 24 hours notice.
- Any changes to medication must be communicated to the community pharmacist as soon as possible after the decision has been made to discharge the patient.

Blister packs will not be dispensed for patients whose discharge destination is a nursing or residential home where the patient is not looking after their own medicines.

7.4.4 Discharge – less than 72 hours / out of hours

Discharge prescriptions ordered from the Pharmacy, Monday – Friday, 8.30 – 3 pm will take a minimum of 4 hours before they are ready to collect. A minimum of 24 hours notice is required for See policy for obtaining medications from pharmacy out of hours. Patients should have a minimum of 14 days supply of medication on discharge. Adherence with medication must always be checked before discharge.

7.4.5 Ordering Take Home Dressings and Appliances

Dressings and appliances should be ordered 72 hours before planned discharge. A minimum of 7 days supply of dressings and appliances should be sent with the patient on discharge / transfer. A 7-day supply of dressings means sufficient dressings to last for one week. For patients whose dressings are designed to last up to a week, the dressing may be changed on the day of discharge and no dressings are required to be sent with the patient. Do not send 7 dressings if the dressings are designed to stay in situ for longer than 24 hours.

8. RESPONSIBILITIES RELATING TO THE SUPPLY OF INTERMITTENT HOME OXYGEN

- Home oxygen is supplied in compliance with national guidelines.[Clinical Component for the Home Oxygen Service in England and Wales, British Thoracic Society, January 2006]
- In most circumstances involvement with a Respiratory Nurse Specialist [RNS] prior to discharge is advisable to ensure guidelines are followed and appropriate follow up arranged.
- The clinical team, with help from the RNS if appropriate, are responsible for the completion of the Home Oxygen Order Form [HOOF], the Home Oxygen Consent Form [HOCF] and the Home Oxygen Record Form [HORF].
• The HOOF form is faxed to the home oxygen supplier [Air Products] at the latest by 5 pm the day before discharge is planned. Copies of the HOOF form are sent to the patients GP, PCT and RNS. In exceptional circumstances home oxygen can be requested in an emergency. In this situation four hours notice is required.

• A member of the clinical team discharging the patient must confirm that the home oxygen is in place before the patient is discharged.

9. RESPONSIBILITIES RELATING TO INFECTION CONTROL

Infection Control risks must be identified with any patient discharge and plans instigated to deal with these in compliance with the Infection Control Policy, Healthcare Act and Hygiene Code. There will be liaison with the Infection Control Nurse on identification of risk. Any infection control risks must be shared with those delivering care following discharge.

10. REFUSAL OF TREATMENT / SELF-DISCHARGE

10.1 Additional responsibilities where patients self dischage

There are occasions when patients will be determined to leave hospital against medical advice

10.1.1 Every effort must be made by members of the multi-disciplinary team to persuade the patient to continue with their treatment. A senior practitioner will have discussed and explained all the risks of premature discharge to the patient. When this fails, certain action MUST be taken protect the patient as much as possible. The patient should be asked to sign the Refusal of Medical Intervention form [see Appendix 2]. Should the patient refuse to sign the form, this must be documented in the nursing records and counter-signed by another member of staff.

10.1.2 It is the responsibility of the Medical Staff to document all information in the patient’s medical record.

10.1.3 The following action must be taken by the ward team in all instances where patients are discharging themselves:

• Inform the patient’s GP and/or other primary health care professional as required, as a matter of urgency.

• Where appropriate contact the patient’s Next of Kin

• Where appropriate for patient and/or public safety inform the police.

• Where a patient is known to Adult Social Care the social worker should be informed.

• Inform the relevant Senior Nurse in the Directorate

• Inform the Discharge Liaison / Coordinator if relevant.

• Arrange appropriate transport if necessary

• An entry must be made in the patient record and a copy or the refusal of medical intervention form be filed in the patient record.
10.2 Patients who refuse to return to hospital following a home assessment, period of leave, or those who leave the ward and fail to return, will be considered as taking their own discharge.

10.3 Staff escorting patients for home assessments should carry a refusal to medical intervention form with them.

11. DISCHARGE PROCESS OUT OF HOURS

11.1 Weekend discharges

To ensure a flow of patients through the hospital is possible, the discharge process needs to occur over seven days. On Thursday and Friday all medical teams when reviewing their patients should identify those who are likely to be ready for discharge over the weekend. Arrangements for Nurse Led Discharge must be used where appropriate. If a patient requires a medical review prior to discharge the nursing team on that ward will pass this information over to the identified weekend on-call and nursing team. A list of probable discharges will be provided by the senior nursing sister on duty to the Bed Manger by 3 pm on Friday. The discharging clinician must ensure completion of any discharge summaries and medication (TTO’s) should be written up before the end of duty.

Some admissions over the weekend will involve simple discharge processes that can occur at any time. The full discharge checklist should be completed by the senior nurse on the ward to ensure such discharges are safe and effective.

11.2 Evening discharges

Simple discharges can continue to take place into the evening. Decisions about the appropriateness of late discharge should consider the age of the patient, home circumstances, support required post discharge. All documentation and medication should be completed before a patient is discharged, by the senior nursing sister on the ward.

11.3 Emergency Services Available Out-of-Hours

If patients attend out-of-hours who do not require admission to hospital but require other support, there are a number of services who operate during these hours:

- Intermediate Care Team or Early Intervention Team (08:00 to 22.30 x 7 days)
- District Nursing Service (08:00 to 22:00 x 7 days)
- Out of Hours Nursing Service
- Emergency Duty Social Work Team
- On-call Psychiatric Team and Emergency Mental Health Team

Alternatives to admission should be considered, it is not the acute hospital trust responsibility to admit for social care or lack of community services. Patients with a learning disability should be fully involved in the discharge planning process.
12. IMPLEMENTATION

This policy and the main Cumbria Discharge policy will be made available to staff via the intranet. Ward managers and senior clinical staff will be expected to ensure that their teams are familiar with the content of the policy and follow it in practice.

In addition the discharge coordinators will support effective discharge through being available for advice and support

13. PROCESS FOR MONITORING COMPLIANCE WITH POLICY / PROCEDURE

The effectiveness of this policy will be monitored in a number of ways that are summarised in the table below:

<table>
<thead>
<tr>
<th>Assessment of Effectiveness of Policy</th>
<th>Monitoring method and reporting line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency readmissions within 28 days</td>
<td>Trust KPIs – reviewed and responded to by Business Managers and reported via Divisional scorecard to the Director of Operations.</td>
</tr>
<tr>
<td>The number, type and severity of discharge-related patient safety incidents in different divisions of the Trust.</td>
<td>Data from the Trust’s incident reporting system will be reviewed and acted upon by the Business Managers, concerns will be reported up to the Director of Operations.</td>
</tr>
<tr>
<td>Patient feedback from the NHS Surveys, PALS, Complaints on their experiences of discharge, for example, were they given relevant written discharge information and was there good communication between staff at patients at the point of discharge.</td>
<td>Will be reviewed via the Discharge Lead and reported to the Director of Nursing.</td>
</tr>
<tr>
<td>Review of discharge documentation for a random sample of patients to ensure that it is completed as per the requirements of this policy.</td>
<td>Records Standards Audit reported to the Director of Nursing.</td>
</tr>
<tr>
<td>A review of out of hour’s discharges will be carried out to ensure that staff are complying with the processes described in this policy.</td>
<td>This will be initiated by the Director of Nursing who will assign a lead and reporting line.</td>
</tr>
<tr>
<td>Evidence that GPs are communicated to within 24 hours of patient discharge.</td>
<td>Divisions to undertake ad hoc audits if evidence of late communication is raised by GP, audit or other means. The results of these audits will be considered by the Discharge Lead and reported to the Director of Nursing.</td>
</tr>
<tr>
<td>Weekly monitoring of delayed discharges, which are confirmed using DOH SITREP definitions</td>
<td>Numbers, attributable codes agreed at a weekly meeting between acute hospital staff, Local Authority staff and Partnership Trust staff.</td>
</tr>
</tbody>
</table>
14. ASSOCIATED DOCUMENTATION

- Transfer Policy
- Cumbria Discharge and Transfer Policy
- Incident Reporting Policy
- Medicines Management Policy
- DETOC collection and monitoring, guidance for staff.

15. REFERENCES


www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4077239

Joyce, Theresa, (2007) Guidance on Determining the Best Interests of Adults who lack the Capacity to make a Decision (or Decisions) for themselves (England and Wales), British Psychological Society


NHS Cumbria “Control of Infection Manual which constitutes the policies and procedures for infection control throughout the Trust”

NHS Cumbria “Transfer of Patients Policy” CPCT/001/002


www.rpsgb.org.uk/pdfs/safsechandmeds.pdf

APPENDIX 1 - DISCHARGE PLANNING RISK ASSESSMENT TOOL

DISCHARGE PLANNING RISK ASSESSMENT TOOL (*mark all that apply and calculate total score*)

To be completed for ALL adult patients within 24 hours of admission

<table>
<thead>
<tr>
<th>Age</th>
<th>Score</th>
<th>Social support</th>
<th>Score</th>
<th>Home circumstances</th>
<th>Score</th>
<th>Medical condition</th>
<th>Score</th>
<th>Previous admissions in past 3 months</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - 55 yrs</td>
<td>1</td>
<td>No care package required</td>
<td>0</td>
<td>Lives only with spouse/partner</td>
<td>0</td>
<td>Pre existing confusion</td>
<td>3</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>56 - 64 yrs</td>
<td>2</td>
<td>Existing care package</td>
<td>5</td>
<td>Lives with family</td>
<td>1</td>
<td>Insulin dependent diabetic</td>
<td>3</td>
<td>One</td>
<td>1</td>
</tr>
<tr>
<td>65 - 79 yrs</td>
<td>3</td>
<td>Patient is a carer</td>
<td>10</td>
<td>Lives alone but has support from carers</td>
<td>2</td>
<td>Catheter in situ</td>
<td>3</td>
<td>Two</td>
<td>2</td>
</tr>
<tr>
<td>80+ years</td>
<td>4</td>
<td>Existing care package inadequate</td>
<td>10</td>
<td>Lives alone - no support</td>
<td>4</td>
<td>Leg ulcer/pressure ulcer</td>
<td>3</td>
<td>More than 2</td>
<td>2</td>
</tr>
<tr>
<td>Type of admission</td>
<td>Score</td>
<td>Will need care package on discharge</td>
<td>10</td>
<td>Warden controlled housing</td>
<td>5</td>
<td>None</td>
<td>0</td>
<td>Other</td>
<td>Score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Admission</th>
<th>Score</th>
<th>Care home/nursing home</th>
<th>Score</th>
<th>Stairs at home</th>
<th>Score</th>
<th>Toilet not same level as bedroom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Emergency</td>
<td>4</td>
<td>Possible major change in function</td>
<td>10</td>
<td>Homeless</td>
<td>10</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Total score Column 1 | Total score column 2 | Total Score column 3 | Total Score column 4 | Total Score column 5

Total Discharge Risk Score = \( (add \text{ score columns } 1+2+3+4+5) \)

Date: Signed: Print name:

A score of 10 or less = SIMPLE discharge. A score of > 10 = COMPLEX discharge.

Please refer to the discharge policy for simple and complex pathways both in and out of hours
APPENDIX 2 - REFUSAL OF TREATMENT FORM

REFUSAL OF TREATMENT

Patient Details:

______________________________________________________________
of __________________________________________________________

hereby declare that I am leaving the hospital by my own choice and contrary to medical advice.

I have had the risks of doing so explained to me and I accept the full responsibility for my action.

Date  ________________________________
Signature  ________________________________

In the presence of:

Signature  ________________________________
Name of Witness _____________________________________________(please print)
Address ______________________________________________
________________________________________________
________________________________________________

Signature  ________________________________
Name of Witness _____________________________________________(please print)
Address ______________________________________________
______________________________________________
_____________________________________________

Comments:
**APPENDIX 3 - GLOSSARY OF TERMS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated.</td>
</tr>
<tr>
<td>Care Management</td>
<td>A process whereby an individual's needs are assessed and evaluated, eligibility for services is determined, care plans devised and implemented, and needs are monitored and re-assessed.</td>
</tr>
<tr>
<td>Care Manager</td>
<td>A practitioner who, as part of their role, undertakes care/case management.</td>
</tr>
<tr>
<td>Care Package</td>
<td>A combination of services designed to meet a person's assessed needs.</td>
</tr>
<tr>
<td>Care Pathway</td>
<td>An agreed and explicit route an individual takes through health and social care services.</td>
</tr>
<tr>
<td>Carer</td>
<td>A person usually relative or friend who provides care on a voluntary basis.</td>
</tr>
<tr>
<td>Case Co-ordinator</td>
<td>A professional who co-ordinates the care plan, monitors provision and facilitates communication between agencies. Maintains contact with the patient and ensures reviews are undertaken.</td>
</tr>
<tr>
<td>Closer to Home</td>
<td>A policy to develop services to support patients receiving appropriate care closer to their homes.</td>
</tr>
<tr>
<td>Community Hub</td>
<td>To act as the central point of referral for community services within a locality for service users who require rapid access to care, reassessment of care needs following a new episode of illness or breakdown of social care, have complex and multiple needs, require an episode of rehabilitation including short term intervention or longer term rehabilitation or access to a community bed.</td>
</tr>
<tr>
<td>Community Matron</td>
<td>A case co-ordinator who actively manages and joins up care by offering, amongst others, continuity of care, coordination and a personalised care plan for vulnerable people most at risk.</td>
</tr>
<tr>
<td>Fit for Discharge</td>
<td>When physiological, social, functional and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate, and it is safe for the patient to be discharged or safe to</td>
</tr>
</tbody>
</table>
transfer from hospital to home or another setting. Patients do not have to be clinically stable to be discharged where they can be managed safely at home / community through input from services such as Short-Term Interventions.

Individualised Budgets

The value of the sum determined by a local authority to support a person following an assessment of their needs for social care support.

Medicines Reconciliation

Defined as the process of obtaining up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes, deletions or additions, resulting in a complete list of medications accurately communicated.

Multi-agency

Services or activities which involve staff drawn from a range of organisations, such as statutory agencies (health, social services, education etc) and voluntary groups.

Multi-disciplinary

When professionals from different disciplines work together.

Multi-disciplinary assessment

An assessment of an individuals needs that has actively involved professionals from different disciplines in collecting and evaluating this information.

NHS Funded Continuing Healthcare -

Continuing Care - care provided over an extended period of time to a person aged 18 or over. This care may be delivered by a combination of health and social care services to meet the physical or mental health needs of someone as a result of disability, accident or illness.

NHS Continuing Healthcare - a package of Continuing care arranged and funded solely by the NHS.

Joint Package of Continuing Care - arranged where a person does not qualify for NHS Continuing Healthcare, but the NHS and Local Authority both have responsibility to contribute to that person’s care.

NHS Funded Nursing Care - funding provided by the NHS to care homes providing nursing. This supports the provision of nursing care by a registered nurse for those assessed as eligible.
Primary Care Assessment Service  A unit staffed by Primary Care which undertakes assessment and treatment of minor illnesses and injuries; care that was previously managed by GP Out of Hours, Minor Injury Units and A&E for less serious attendees.

Rehabilitation  A programme of therapy and re-enablement designed to restore independence and reduce disability.

Self-directed Support  The County Council recognises that, apart from a very few individuals, people make decisions affecting their lives on a daily basis. It is important that those individuals who are able to do so, are supported in making their own decisions and deciding for themselves how support should be organised to meet their needs. This is equally true if they require support and meet the criteria for services determined by the County Council.

Single Assessment Process  A process that places the individual at the heart of assessment, with care plans that ensure people receive effective and timely responses to their health and social care needs with care that is co-ordinated to prevent duplication by professionals.

Timely Discharge  Timely discharge is when the patient is discharged home or transferred to an appropriate level of care as soon as they are safe for discharge/transfer.