Ref No: 32

DISCHARGE POLICY AND PROCEDURES

SECTION 1
PROCEDURAL INFORMATION

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1	October 2007	Claire Robinson	Ratified	
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4a	February 2012	Claire Newey	Draft	
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4d	February 2013	Claire Newey	Draft	Comments incorporated from consultation process.

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Section 2 Appendices

1. INTRODUCTION

The policy is designed to ensure that every patient discharged from the care of The Rotherham NHS Foundation Trust is discharged safely to the community with appropriate arrangements made for their continuing care, involving all the appropriate agencies at the correct stage.

2. PURPOSE & SCOPE

2.1 Purpose

The purpose of this policy is to ensure that the discharge process is patient focussed, and that relevant staff are aware of their responsibilities with regards to the discharge of patients.

2.2 Scope

The policy covers the discharge arrangements and documentation requirements for the following patient groups;

- Adults
- Children / Babies
- Another healthcare provider/community services
- Nursing/Residential homes
- With medicine/equipment
- Patients admitted for planned procedures and discharged on the same day.
- Patients admitted for investigation/treatment and discharged on the same day.

Special requirements for certain patient groups are contained within Appendix 1.

3. ROLES & RESPONSIBILITIES

Role	Responsibilities
Chief Executive	The Chief Executive is responsible for supporting this policy operationally and financially, in order to fulfil the purpose of this policy.
Chief Nurse	The Chief Nurse is responsible for ensuring that this policy is implemented into all parts of the Trust and for ensuring that the policy is reviewed and updated by the specified review dates.
Lead Nurse Care Management Team	Responsible to the Service Director. Responsible for the support of Matrons and Ward Managers in the Implementation, monitoring and auditing of the policy to ensure best practice.
Matrons/Lead Nurses	Matrons/Lead Nurses are responsible for

	ensuring that there are adequate resources, both staff and otherwise, to ensure this policy is adhered to, and for supporting their teams with the familiarisation of this policy and with any training that may be required.
Medical Staff	Responsible to the Chief Medical Officer, for ensuring compliance with this Policy, within their CSU/FU.
Nursing Staff	The named nurse or designated other (as recorded in the patients nursing notes) will act as the coordinator for all discharge arrangements.
Nursing staff on children's wards	The nurse will act as co-ordinator of all discharge arrangements, with responsibility for assessing, planning and liaising with patient, family, members of the MDT team and all other relevant agencies.
Moving and Handling Specialist	Where there are difficult or complex moving and handling issues the Moving and Handling team will support staff and offer advice regarding equipment and techniques. This will be in conjunction with the multi-disciplinary team. The Moving and Handling team can facilitate the communication with, and the sharing of relevant information with receiving health and social care providers on discharge.
Hospital Based Social Work Team	It is the responsibility of the Social Work Team Manager to ensure an assessment by the appropriate Social Worker/Social Services Officer is undertaken and completed in conjunction with the other members of the multi-disciplinary team and an appropriate discharge plan agreed, in accordance with the procedures and statutory time frame identified in the Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy
All Staff	Every employee of the Trust involved in the transfer of patients, are responsible for ensuring that they have read, understood and are working in accordance with this policy.
Patient Safety Committee	Are responsible for monitoring this policy and escalating issues as appropriate.

4. PROCEDURAL INFORMATION

4.1.1 Initial Activities

Inpatients

Within 24hours of admission the registered nurse will gather detailed information regarding the patient's social circumstances, activities of daily living, packages of care and Allied Professionals input. This is documented within the health records discharge page. This information is communicated to all members of the multi-disciplinary team as required.

Preparing for discharge begins on admission by the admitting registered nurse. As soon as possible following admission the consultant or their deputy should discuss with the patient and /or family/carer/advocate, the likely outcome and length of stay, including giving a predicted discharge date that the patient is likely to be ready for leaving hospital. For patients being admitted as part of a planned process, wherever possible discharge planning will commence as part of a pre-admissions process.

A copy of Leaving Hospital Information Booklet should be given to the patient upon admission or pre-admission and completed throughout the patients' journey.

Where appropriate, and as part of an MDT assessment process, refer the patient for specialist assessments and treatment by other members of the multi-disciplinary team.

In cases of patients with mental health needs or dementia, medical staff may need to refer to the Mental Health Team to be involved in the discharge process.

Where it is suspected or known that patient has an infection please refer to the Policy for the Admission, Transfer and Discharge of Infected Patients.

4.2 During Patients Stay

4.2.1 Preparing for Discharge

On admission the registered nurse must:

- Discuss all aspects of discharge with the patient, family, relatives or carers as appropriate and with relevant consent.
- Record all information of actions, referrals and discussions in the health records.
- Access the services of an interpreter if required.
- Give the patient a Leaving Hospital leaflet.
- Advise patients of their overall treatment plan, and a description of what the milestones and criteria for safe discharge will be.
- Ascertain whether transport is required and what transport most suits the patients' needs. This must done utilising the Transport Criteria Form. A transport form will be completed and sent to the Care Management Team to be booked. Please refer to section 4.5.

- Inform the patient and relatives, carers or Nursing/Residential/IMC home of the date of discharge.
- Complete and send an assessment notification (a Section 2) to Social Services, OT and Physiotherapy where applicable. Followed when appropriate with a section 5.
- Liaise with external agencies where applicable e.g. Community Rehabilitation Team, Community Matrons.
- Ensure that the patient has appropriate clothing and footwear for discharge and weather conditions, and have the means in which to access their discharge address.
- Arrange a case conference (for complex discharges) involving all appropriate members of the MDT including patients and families/ carers/ advocates and community staff. A time and date for the case conference should be arranged within 48 hours of recognition of a need for the same.
- For enquiries relating to mattresses and cushions please contact the Tissue Viability Service.
- Complete a pressure relieving equipment form (Appendix 8) and fax to Pressure Relieving Equipment Co-ordinator on 3225
- For equipment REWS require 7 working days' notice so early requests are required.
- Fast track patients requiring equipment MUST be identified /highlighted on the form that it is a request for equipment relating to a fast track.
- For information regarding when equipment will be delivered the wards need to contact Rotherham Equipment Wheelchair Service (REWS) (3250) for delivery dates.
- Ascertain whether a waste collection is required and if so confirm with the Borough Council or District Nurse the type of collection required, so that appropriate arrangements can be made. Community waste collections by the Borough Council will automatically default to an 'Offensive' waste stream i.e. that waste that is not known or believed to be infectious/hazardous.
- Follow the local policy if additional equipment for use at home is required e.g. bedpans, bottles, traction equipment.
- All patients who are admitted to the Rotherham NHS Foundation Trust should expect to have discharge planning commenced within 24 hours of being admitted.

<u>Medical staff</u> must:

- Identify a predicted date of discharge.
- Provide a comprehensive medical management plan and clearly document this in the patient's health records.

4.2.2 Management of medicines Pre discharge

Medicines for patients to take home must be prescribed as soon as possible prior to discharge, giving a minimum of 24 hours notice in advance of the proposed time and date of discharge. If a District Nurse is required to administer these medications a signed notification by the medical staff is required.

It is anticipated that the discharge process will plan so that all prescriptions can be dispensed within the normal pharmacy opening times.

- **Process for Multi Dose Systems (MDS) dispensing via LloydsPharmacy**

  - MDS items (and any other TTO items for the same patient) are to be prescribed on a LloydsPharmacy prescription pad. The pads will be provided to wards by TRFT pharmacy. More than one sheet can be used if required.
  - Please allow for a 24 hour turnaround on MDS as these items are time consuming to produce
  - Prescription passed by ward to TRFT pharmacy clinical team.
  - TRFT clinical team clinically check the prescription, check MDS criteria has been met, check date and time of discharge and whether home delivery will be needed.
  - TRFT clinical team pass the prescription and delivery instructions to Lloyds.
  - Lloyds dispense. If for home delivery, Lloyds deliver home as per delivery instructions. If not for home delivery, Lloyds inform TRFT wards that MDS is complete.
  - Lloyds staff send completed MDS to dispensary where they will be placed in relevant wards pigeon hole in TRFT dispensary.
  - Ward staff collect from pigeon hole.

4.3 Patient wishing to leave against medical advice

If a patient wishes to take his/her own discharge, medical staff must be informed by nursing staff caring for the patient and appropriate action taken by both the medical and nursing staff to ensure the patient has the relevant information to make an informed decision.

The nurse in charge of the ward or the member of medical staff who has seen the patient, must ask the patient to sign a self-discharge form and a copy retained in the patients' medical notes. Full details must be documented in the medical and nursing records, dated and signed. If the patient will not sign, this must be clearly documented in the patients' notes.

If appropriate the patient must be provided with medication, dressings and equipment that they require, by the ward nursing staff.

Complete a Datix of the incident.

Usual measures will be taken to inform community services and the patients GP by telephone or letter.

In the event that it is suspected a patient may lack capacity to make an informed decision, consideration must be given to the need for a capacity assessment to be undertaken. In the case of a patient who is showing clear evidence that they may lack capacity, and who is refusing to remain on the ward to wait for an assessment by the mental health team a decision will need to be made as to whether or not the patient meets the criteria for detention under a section 5/2 of the 1983 Mental Health Act.

In hours inform the relevant Matron covering that area.
Out of hours inform the 221 bleep holder of any concerns and any plan of action that has been instigated.

Complete a Datix of the incident.

In the event of the patient taking a self discharge whilst on a home visit, the Nurse caring for the patient must refer to: Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge.

4.4 Day of Discharge

4.4.1 Patients who are admitted and spend more than 24 hours within the Trust:

The Registered Nurse must:

- Inform the Patient Flow Support Worker of pending and actual discharges for the day.
- For patients being referred to District Nurse on discharge, referrals must be sent via the Strata referral pathway. At weekends and bank holidays referrals to District Nurses must be made via Yorkshire Ambulance Service, who will forward information to District Nurse team. NB. Community staff do not have access to health centres at weekends and Bank holidays. For patients who require first District Nurse visit from the evening or night service - referral Information must be faxed direct to 01709 336787.
- Ensure that transport is in place and arrangements for access visit is made if applicable.
- The nurse coordinating the patients discharge must liaise with the MDT regarding appliances and/or equipment that require transportation to the patient's discharge destination.

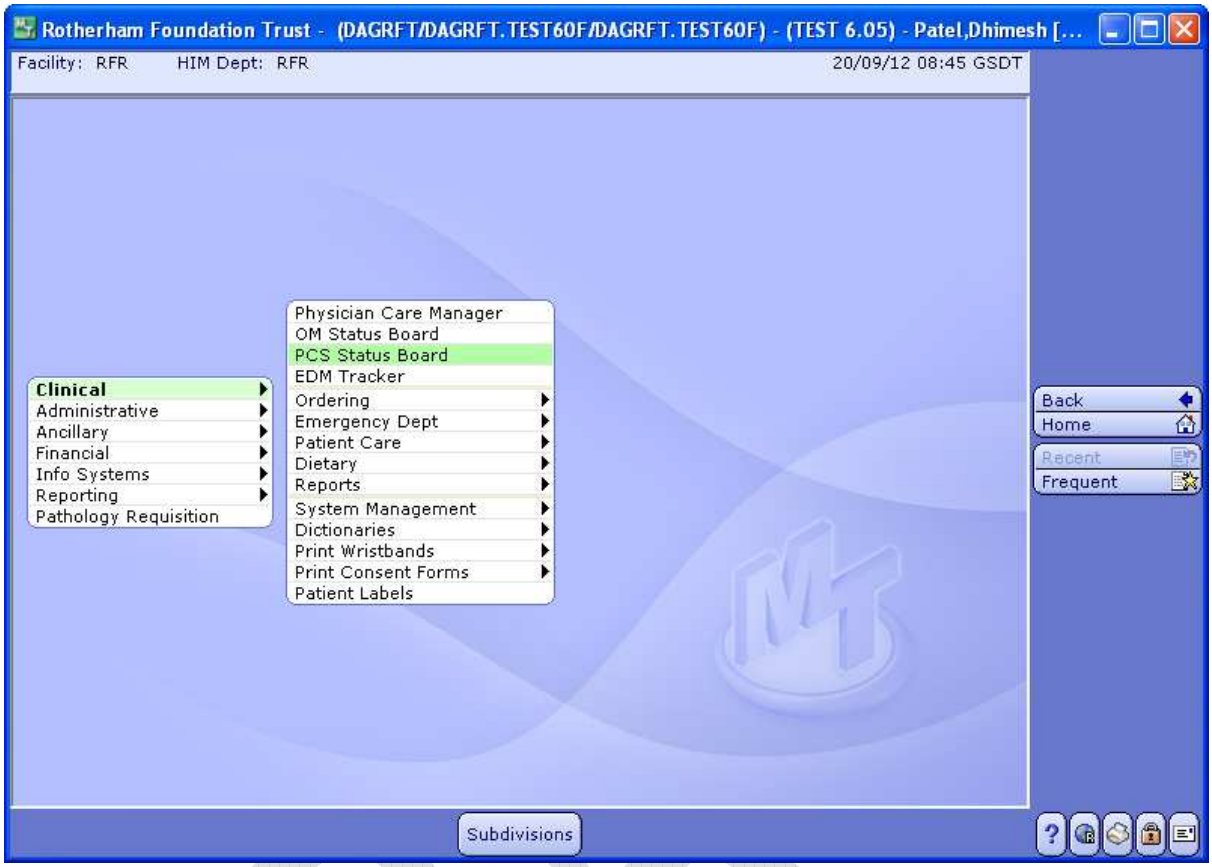
- Check that the discharge arrangements are complete and that the discharge care plan is complete on discharge.
- Confirm the discharge address and ensure basic provisions and amenities are available.
- Confirm with the patient and relatives, carers or Nursing/Residential/IMC home that the discharge is taking place.
- Provide the patient with the a computer generated discharge summary which includes reason for admission, treatment given, TTO's dispensed and any follow up appointments required.
- Give any condition specific information leaflets to the patient and carer/ family/ advocate and discuss these prior to the patients discharge.
- Document the discharge and discussions in the patient's health records.
- Provide education to the patient and relatives /carers regarding take home medications. Sufficient dressings are provided for a minimum of 48 hours and longer if discharge occurs at weekends and bank holidays.
- Ensure that continence products are supplied.
- Ensure that all elements of the discharge letter is completed prior to discharge.
- Ensure that the discharge summary is available and sent to the patient's general practitioner.
- Provide the patients sickness notification for up to 1 week if applicable. The type of sickness notification and the period of time given are to be recorded in the discharge summary letter at all times (if sickness notification is not given this should also be recorded).

Medical staff must:

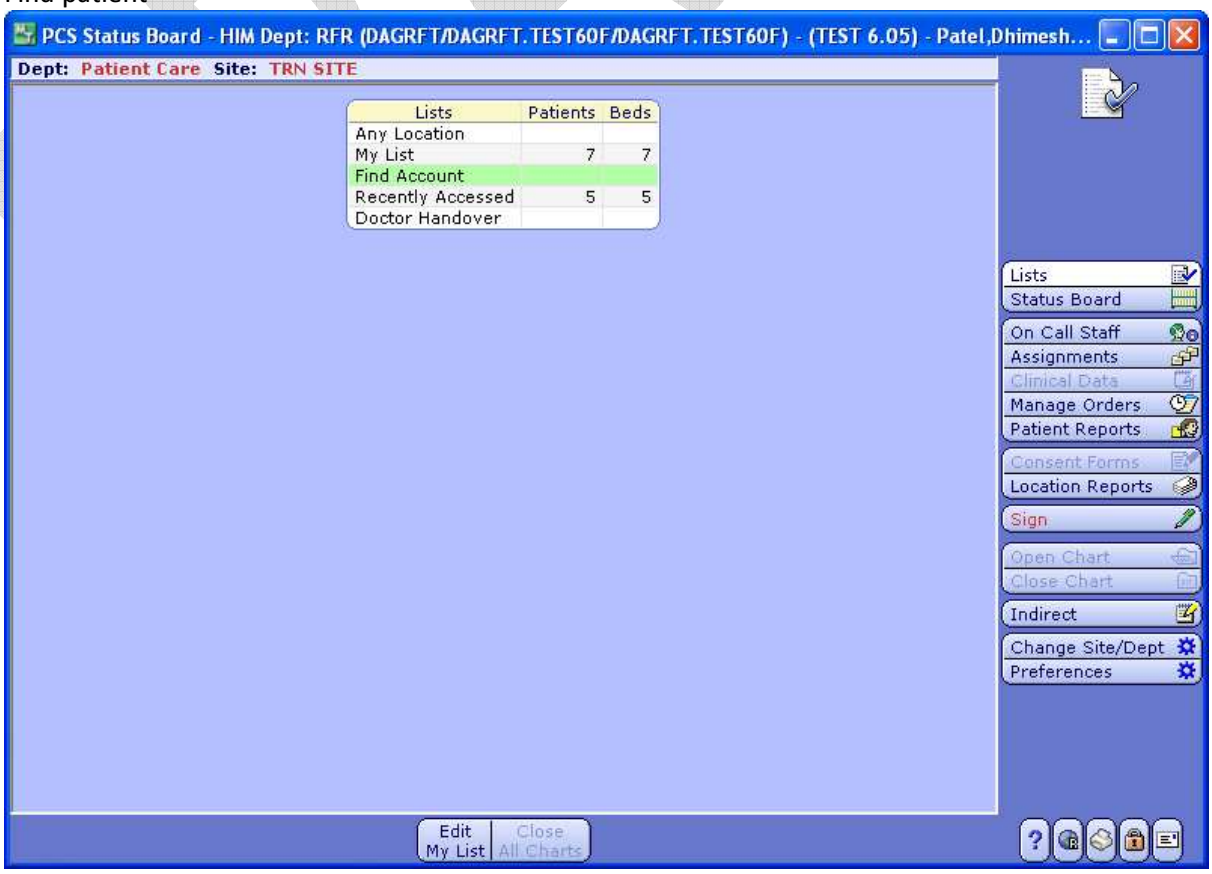
- Ensure the medical element of the discharge plan and discharge letter is completed in a timely manner.
- Forward a copy of the discharge letter to the relevant MDT members within two working days of discharge.
- Provide statement of fitness to work, if more than one week away from work is required.
- The ward must discharge the patient from the bed board as soon as the patient leaves the ward.

How to discharge patients from Meditech

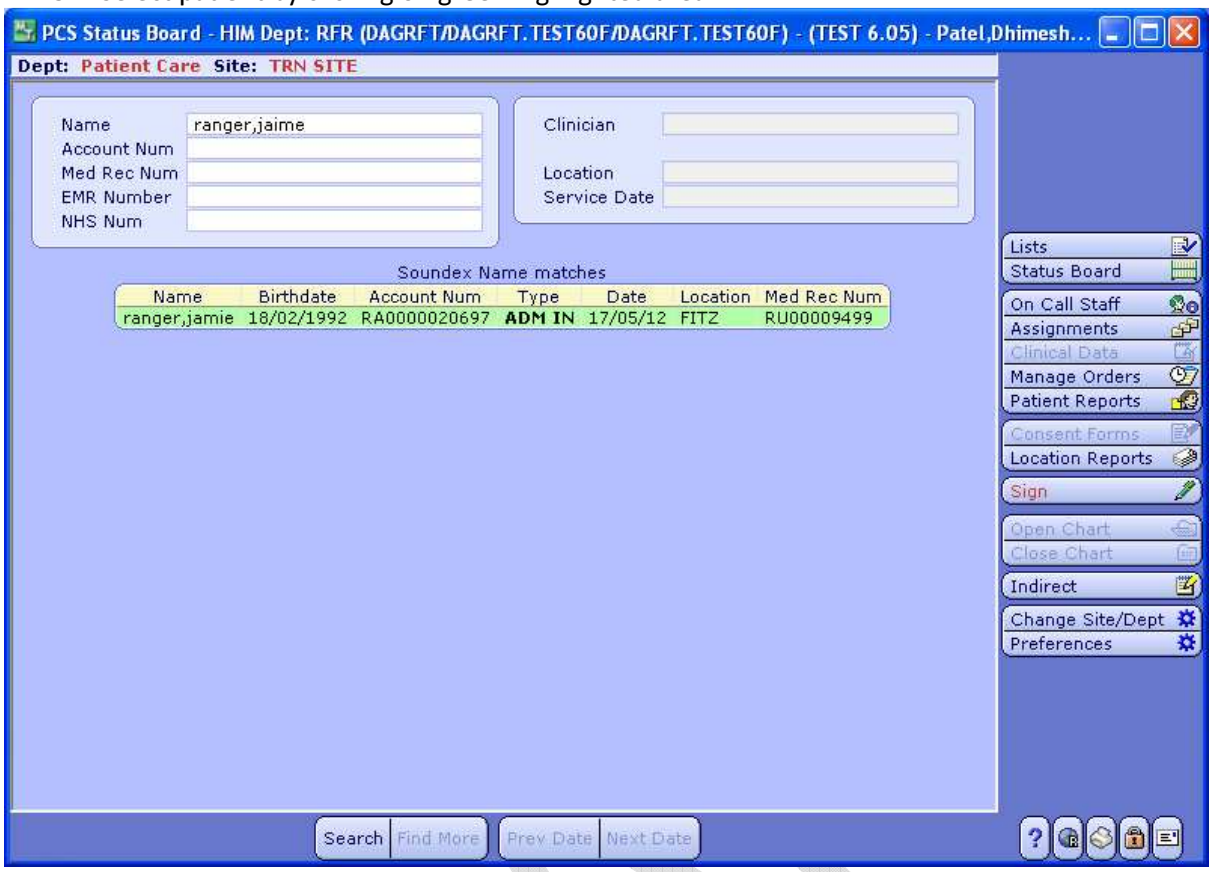
1. Clinical - PCS



2. Find patient

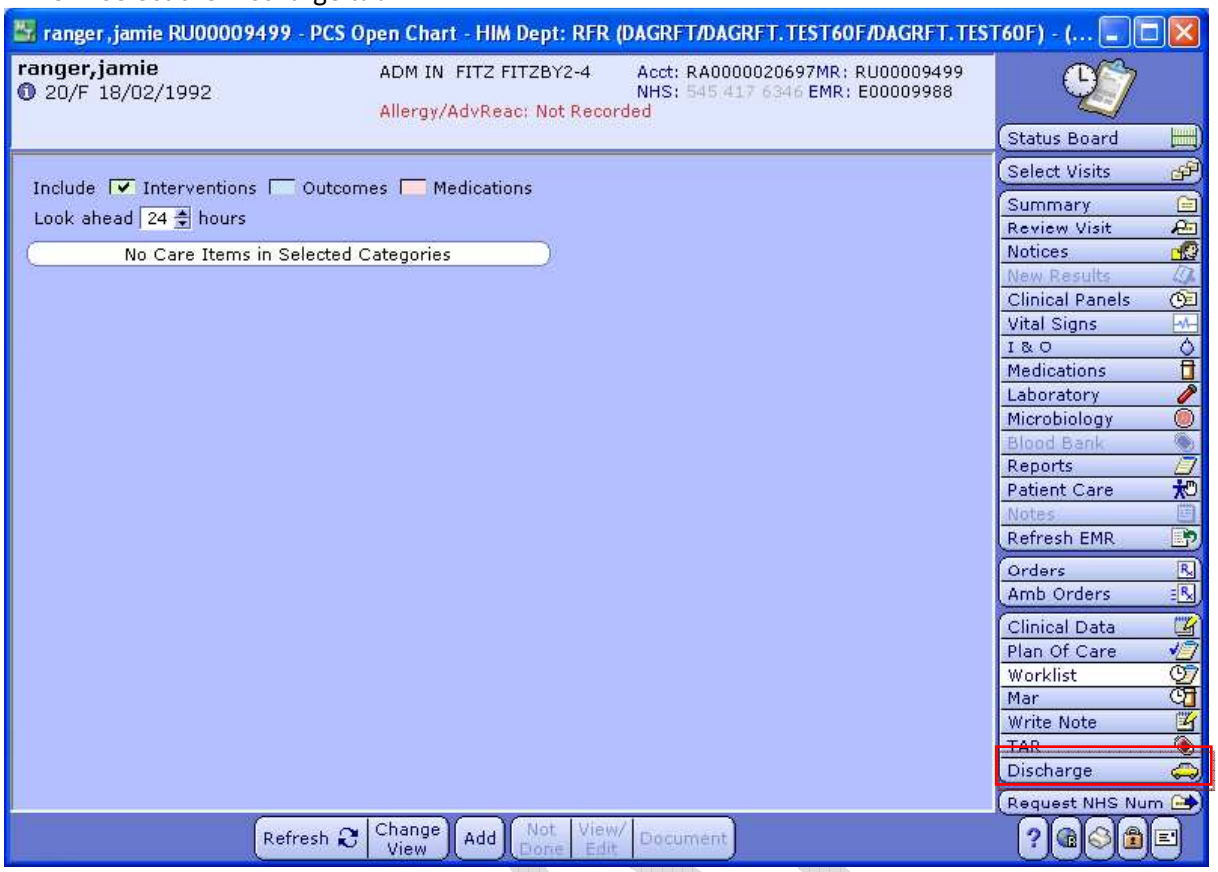


3. Select patient by clicking on green highlighted area

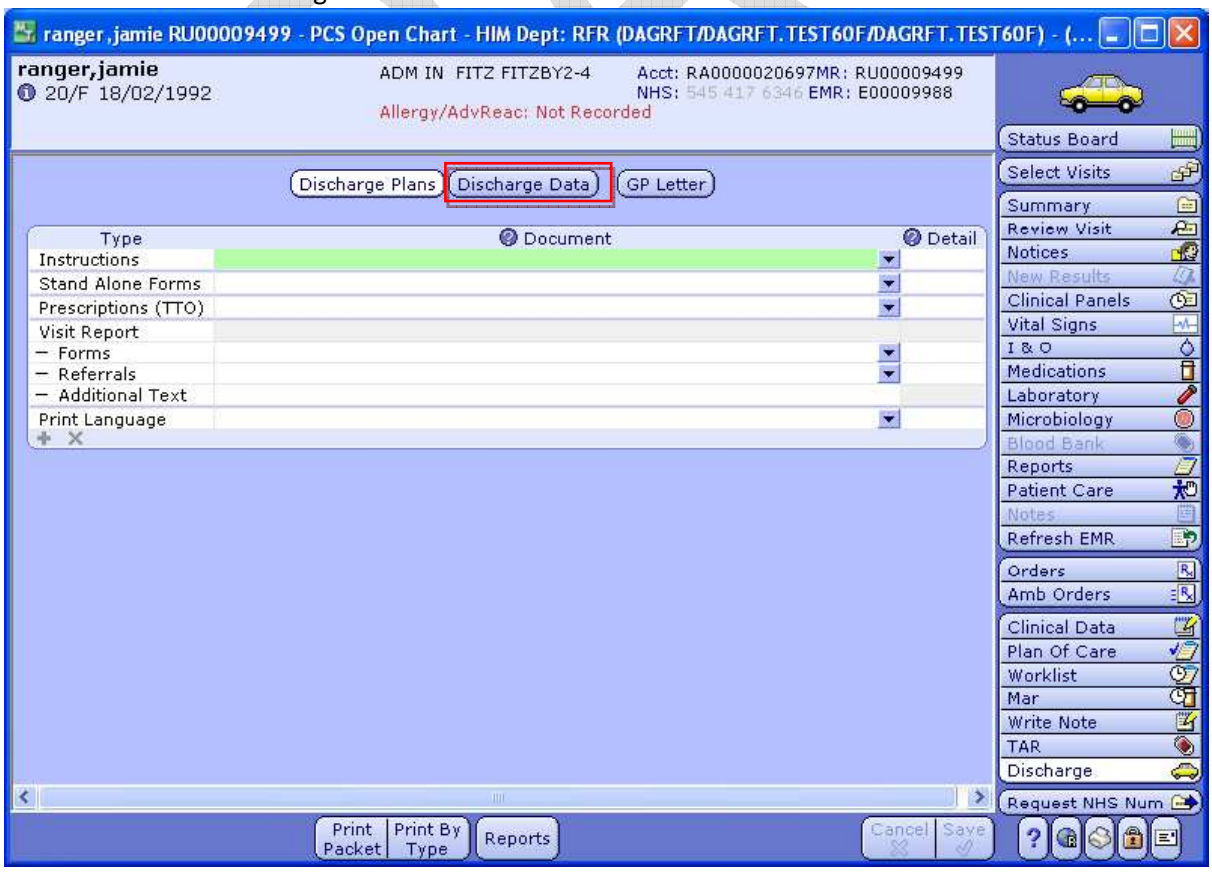


4. Open Chart (either by clicking left if name or Open Chart)

5. Select the Discharge tab

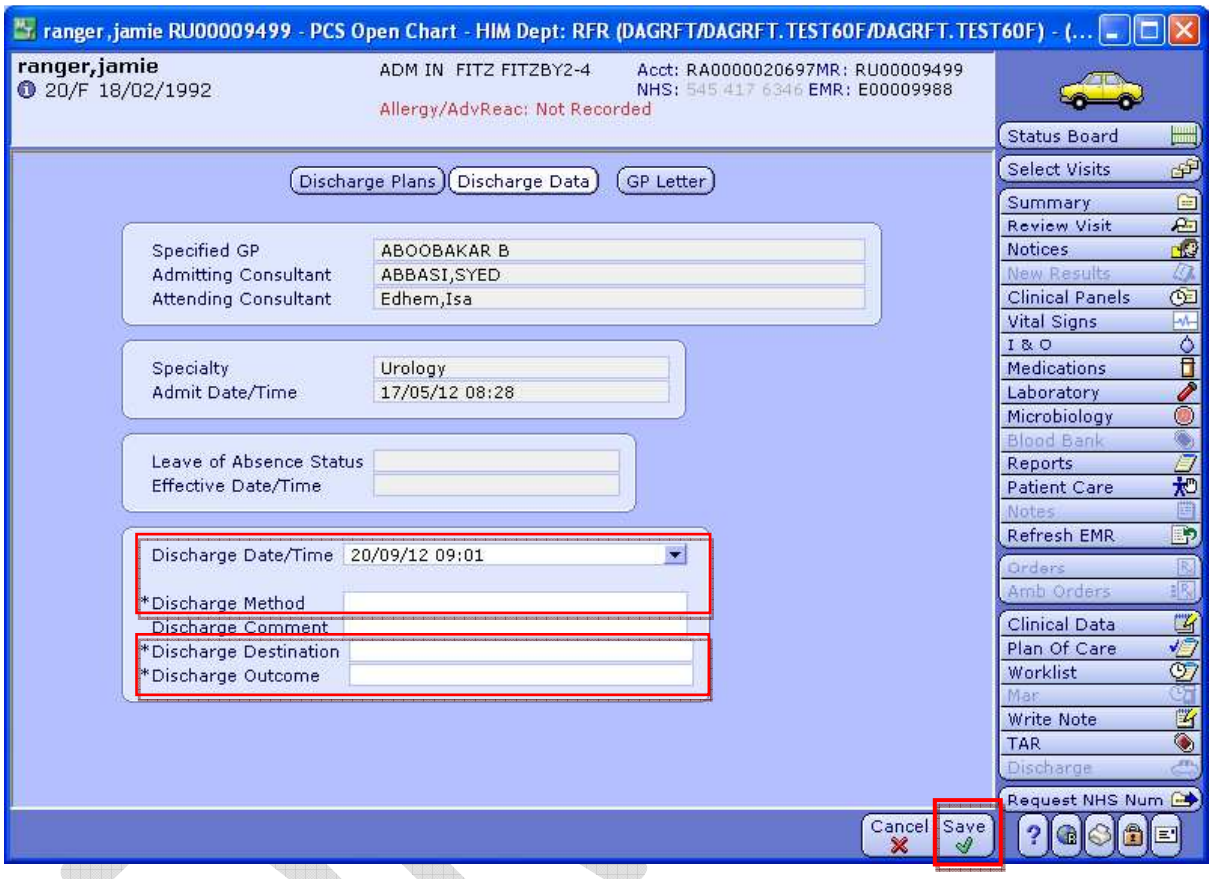


6. Select the Discharge Data tab



7. Enter data into the four fields
   NB. For *Discharge Outcome choose one of 3 options:
   - Exit – Diagnostic Admission
   - Exit – No Treatment Given
   - Exit – Treatment Admission

Then click Save



- The **ward must not** move the patient within the ward to the 'Sent on Leave' beds or chairs and discharge them from there once the discharge process has been complete

- **How to complete the discharge letter after the patient has been discharged-** access the correct patient's account (which will be in DIS IN status) and check that the TTO medications and IP Discharge Summary (Doctor) have been completed by the doctor first and is in signed status. **Only then** should the registered nurse open the IP Discharge GP letter **(retro)** which will pull in data from the doctor's letter.

- **For more training support please refer to the training packages found on the Intranet.**

4.4.2 Patients Admitted and Discharged within 24 hours

Patients are given a copy of their 24 hour discharge summary and any new medications required with instructions for use as per Trust policy. Outpatient's appointment cards will also be given on discharge if required. A copy of the discharge summary will be sent to the GP.

4.4.3 Medicine supplies on Discharge

Medicines will only be dispensed or issued for discharge against a valid prescription written by a prescriber employed by the Trust. Written information must be given indicating medication prescribed, dosage, route and timing. Medical staff must ensure the time of PRN or specifically timed drugs are indicated on the discharge summary.

MDS' (NOMAD's) will require 24 hours turnaround. (See 4.2.2)

A 28 day supply will normally be dispensed for long term medicines. Analgesics will be supplied as a single pack unless intended for long term use and drugs such as antibiotics or steroids will be provided for the length of any course intended.

Those wards undertaking medicines management services may have their inpatients provided with original packs of medicines labelled in a manner suitable for discharge. These medicines will be assessed by a member of the pharmacy staff for suitability and accuracy and be issued as part of the discharge process.

All medicines issued on discharge will be accurately and appropriately labelled with full instructions for patients/carers to use. Under no circumstances will medicines that are not labelled be given to patients.

The nurse designated to care for the patient must obtain medication, (including any food/fluid thickeners or dietary supplements) and dressings prior to discharge.

The Registered Nurse must ensure that all take home medications are discussed with the patient and/or carer including times, doses and side effects.

Good practice dictates that medications are given to the patient upon discharge. When this is not possible contact the Care Management Team to discuss the use of the discharge crew to deliver the medications and only in exceptional circumstances should a taxi be used.

For more information please refer to The Trust's Medicines Management Policy.

4.4.4 Out of Hours Discharge

Where discharge cannot be facilitated prior to 9pm, the 221 must be notified for authorisation for the discharge to occur.

Particular care must be taken when discharging patients in the evening, at weekends or bank holidays and inclement weather as services they require may be difficult to organise. Therefore pre-planning for weekend and bank holiday discharges is essential to ensure the safety of the patient.

Ensure that all the relevant information/appointments is given to the patient prior to discharge.

The Registered Nurse documents all interactions/outcomes in the patient's health records.

4.4.5 Day-Case patients

All patients scheduled via the elective surgical pathway will have a pre-operative assessment prior to their admission for surgery. Patients will be issued the 'You and Your Anaesthetic' booklet to advise them of the precautions to be taken before and after anaesthetic, and this must be documented in the patients notes.

- **For Surgical Day Cases:**
    - Patients who meet the day surgery guidelines will be discharged via the nurse led discharge protocol following the written/verbal instructions given by the surgeon/anaesthetist in the operation notes/ward round.
    - Any patient who does not meet the day surgery guidelines pre-operatively must be reviewed by a Surgeon or Anaesthetist prior to discharge with a written instruction given that they are fit for discharge.
    - Nurses will complete the discharge documentation within the DSC Care Plan and issue a discharge letter to the patient containing all pertinent discharge and follow up information as instructed by the Surgeon and any other Clinical Colleagues..
    - If patients do not meet the nurse led discharge criteria and is deemed fit for discharge this must be documented by the attending Doctor within the patient's notes.
    - If patients are not fit for same day discharge then a request is to be made to the Patient Flow Team for an inpatient bed. A transfer document accompanies the patient to the ward and a copy of this is retained by DSC. This can be initiated by the nurse or doctor.

- Patients transferred to an inpatient ward must be transferred with all discharge documentation, appointments, prescribed TTO's and any necessary dressings.
- A contact number for in and out of hours must be given to the patient, in case they have any concerns or queries after discharge by the nurse coordinating the patients' discharge.
- Discharge information should be given to the patient with an accompanying responsible adult, who has private transport to take the patient home.

A record of patients discharge letter is to be placed in the patient notes. A copy of the discharge letter is to be forwarded to the patients GP from DSc Reception

For Medical Day Cases:

- Nurses complete discharge documentation within the patients Nursing Records.
- Medical notes of discharged patients remain in the ward clerk office until a discharge letter is completed. The discharge letter is forwarded to the patients GP.

4.4.6 Patients refusing to leave a hospital bed

Patients do not have the right to occupy a hospital bed when they have been assessed as no longer requiring acute inpatient care, and appropriate discharge Package of Care/Equipment is either identified or is actually in place.

If a patient refuses to leave hospital on the planned date of discharge, then the nurse coordinating discharge must contact the Site 221 bleep holder out of hours and the Matron or Business and Service Manager in hours, who will take appropriate action.

4.5 Booking Transport for Patients

Eligibility is based upon clinical and not social care needs, the aim being to ensure non-urgent Patient Transport Services are patient focused by being more responsive to patient and service needs, whilst improving the efficiency and effecting cost improvements.

Where appropriate the named nurse or designated other will encourage patients to make their own arrangements. Advice on suitable forms of transport may be required.

Where patients or carers family/carers/Next of Kin request transport home, it is the responsibility of all Rotherham NHS Foundation Trust staff to advise the patient that an assessment will need to be made utlising specific criteria, to assess eligibility for transport, and clearly document this in the patient's

notes. A patient's eligibility/ requirements for transport must be assessed by a Health Care professional. Appendix 4 Ascertaining Eligibility for Patient Transport Services (PTS)

For patient's assessed as needing transport home whether from wards or Outpatient departments, the Named Nurse or designated other holds the responsibility for ensuring that the request is made.

From 08:00 – 21:00 hours Monday – Friday

Complete a patient transport request form (found on all wards or an electronic copy can be obtained from the Care Management Team 4373), taking the form to the Care Management Team Office A1/A2 to make a request.

For Outpatients contact 7323 with patient details and type of transport requested.

From 10:00 – 19:00 hours Saturday / Sunday and Bank Holidays

Complete a patient transport request form (found on all wards or an electronic copy can be obtained from the Care Management Team), taking the form to the Care Management Team Office A1/A2 to make a request.

Any patient that is on the Liverpool Care Pathway will be booked to travel alone unless an escort or family member is required. If so please make sure that this is communicated when booking transport to ensure that appropriate provisions are made.

Please note: Any patient that is to be discharged after 9pm needs to be in discussion with and authorisation for discharge obtained from the 221 bleep holder.

Patient's luggage will be taken i.e. 1 bag and 1 frame with the patient (frames need to be booked on the transport at time of request. Any excess luggage will need to be taken by other means, which must be arranged by the ward, and wherever possible with families/carers/advocates.

The named nurse or designated other must ensure that the patient is clothed appropriately for their journey and weather conditions.

Please refer to Appendix 6 – Inter Facility Transfer Algorithm and Guidance.

4.6 Delays in Discharge

When a patient is medically stable and deemed by the MDT as safe to transfer from acute care, but is unable to transfer due to waits for provision of services, equipment or suitable accommodation then this patient is determined as a delayed discharge.

A delay in discharge will be determined by the MDT and reported on the weekly Delayed Discharge sheets by qualified ward nursing staff. Discharge delays should be reported to the Lead Nurse Care Management Team or designated other.

Delays in discharge will also be documented in the patient's health records by the registered nurse and in the health records by the medical team.

The Care Management Team will collate and disseminate this information via the monthly SITREP.

If the Neighbourhood and Adult Services have been involved in discharge planning assessment notification 3 (if withdrawing request) or 5 will be sent, as appropriate in accordance with the Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

5. DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

Discharge

The process where the patient transfers from hospital care to the appropriate care setting. This may be associated with the end of treatment or may involve home care (either self care or provided by community staff.)

5.2 Abbreviations

A&E	Accident and Emergency
ADL	Activities of Daily Living
CHC	Continuing Health Care
CRT	Community Rehabilitation Team
CSU	Clinical Service Units
CTR	Central Treatment Room
DF	Discharge Facilitator
DIS	Discharge
DSN	Discharge Specialist Nurse
DST	Decision Support Tool
FU	Foundation Unit
GP	General Practitioner
HCP	Health Care Professional
IMC	Intermediate Care
IP	Inpatient
MDS	Multi-Dose Systems

MDT	Multi-Disciplinary Team
NAS	Neighbourhood and Adults Services (Social Services Care)
NHS	National Health Service
OPD	Outpatients Department
OT	Occupational Therapy
PEG	Percutaneous Endoscopic Gastrostomy
PRN	Pro Re Nata (when required)
REWS	Rotherham Equipment and Wheelchair Service
RN	Registered Nurse
SW	Social Worker
TRFT	The Rotherham NHS Foundation Trust
TTO	To Take Out
YAS	Yorkshire Ambulance Service

6. REFERENCES

- Discharge of patients from hospital HC(89)5 and LAC(89)7
- Achieving a timely simple discharge from Hospital (3573)
- Discharge from Hospital: pathway, process and practice (30473)
- Community Care Act, (Delayed Discharges) 2003
- National service Framework Continuing Health Care 2004
- NHS Responsibilities for Meeting Continuing Health Care Needs. HSG(95)8/LAC(95)5
- Independence, choice and risk: a guide to best practice in supported decision making. DOH. May 2007
- Mental Health Act (1983)

7. ASSOCIATED DOCUMENTATION

- The Rotherham NHS Foundation Trust Leaving Hospital Information booklet
- The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

- Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge
- The Rotherham NHS Foundation Trust Safeguarding Policy
- The Rotherham NHS Foundation Paediatric Bed Management Policy
- The Rotherham NHS Foundation Policy for the Admission, Transfer and Discharge of Infected Patients
- The Rotherham NHS Foundation Medicines Management Policy
- The Rotherham NHS Foundation Transport Criteria
- Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge.

APPENDIX 1

SPECIAL REQUIREMENTS

Occupational Therapists

Any patient experiencing difficulty with personal and/or domestic function needs to be referred to the Occupational Therapist.

A Referral must be made via STRATA by the nurse caring for the patient or designated other, to Therapy Services as soon as the need is identified.
In the interim, a verbal referral will be accepted and action taken if appropriate.

The Occupational Therapist (OT) will:

- Assess the patient in hours within 24 hours and initiate an appropriate treatment plan to ensure satisfactory and timely arrangements are made for the continuing care of the patient on discharge.
- Discuss and determine with the patient, if a home visit assessment is necessary as part of the discharge plan.
- Organise and coordinate the visit, after which a written report will be provided for in the patient's health records detailing action taken and any recommendations. The visit will normally include the patient and/or carer, two members of the Occupational Therapy staff and any appropriate hospital/community based member of the MDT.
- Issue a report and recommendations which must be discussed by the MDT and appropriate action agreed and implemented.
- Discuss with the patient and or carer any onward referral, which is deemed appropriate. This discussion must include details of the service referred to, how the patient will be contacted, likely timescales for treatment and how to contact the service if the patient has any concerns or feels that the timescale has been exceeded.
- Ensure that where patients are being referred to out of area services such as Intermediate Care; a comprehensive discharge summary accompanies the patient, including details of present functional status, rehabilitation to date and intended goals of further rehabilitation.
- Advise of equipment required/ordered and being used. If specific training is required for equipment e.g. PEG feeding this will be arranged prior to discharge by the named nurse or designated other. Any equipment/minor adaptations needed for discharge must be ordered as soon as the need is identified especially if the patient lives outside the Rotherham MBC boundary. The patient and/or their carer will be informed of this.
- Instruct the patient and/or carer in the safe use of equipment. Written instructions will be issued by the provider of the equipment. This includes details of reporting any defects and how to return the equipment when no longer needed.
- Discuss details of discharge arrangements with the patient and/or carer and other members of the MDT and record on the discharge care plan.

Physiotherapists

On admission the ward staff must identify if the patient has been experiencing problems with their cardio-respiratory status, mobility or function at home, which would necessitate referral to Physiotherapy

A Referral must be made via STRATA by the nurse caring for the patient or designated other, to Therapy Services as soon as the need is identified. In the interim, a verbal referral will be accepted and action taken if appropriate.

If the patient is identified as being medically stable the Physiotherapist should be consulted as regards their on-going rehabilitation needs.

The Physiotherapist will:

- Ensure that if the patient requires a period of further rehabilitation this is discussed with the MDT as to the most appropriate service provider.
- Organise the provision of equipment required for discharge e.g. mobility aids, compressors etc.
- Inform ward staff of equipment required for discharge in order that the appropriate transport arrangements can be made by the named nurse or designated other. This will also include educating the patient and/or carer on the appropriate use of the equipment, where to report problems and where to return the equipment when no longer required, and provide written information where appropriate.
- Discuss details of the discharge plan with the patient and the MDT and record on the discharge care plan. Details of the referrals made will be documented in the Physiotherapy notes or copies of the referrals attached to the Physiotherapy notes.
- Discuss with the patient and or carer any onward referral, which is deemed appropriate. This discussion must include details of the service referred to, how the patient will be contacted, likely timescales for treatment and how to contact the service if the patient has any concerns or feels that the timescale has been exceeded.
- Ensure that where a patient is being referred to out of area services such as intermediate care; a comprehensive discharge summary accompanies the patient, including details of present mobility status, rehabilitation to date and intended goals of further rehabilitation.

Social Worker

If it is likely that the patient will require community care services on discharge, once the patient has been identified as fit to commence discharge planning, a section 2 assessment notification of the social work team should be made by named nurse/designated other. Refer to TRFT discharge planning and reimbursement policy.

The Social Worker/Social Services Officer will:

- Liaise with other members of the Social Services Department already involved with the patient's case. On completion of the appropriate assessments and when agreed by the Consultant and the MDT that the patient is medically stable and safe to transfer in accordance with The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy, the patient

will be transferred from an acute bed into the appropriate environment with the relevant support services.

- Discuss the details of the discharge arrangements with the patient and/or carer and other members of the multi-disciplinary team and record this in the nursing record.

Patients discharged with a Subcutaneous Syringe

As soon as it is known that a patient is to be discharged with a hospital MS26(Green fronted) syringe driver
The registered nurse will ascertain the area to which the person is being discharged to

- Immediately prior to discharge from hospital ensure the syringe driver is running as per prescription instruction in other words on time not fast nor slow. Any problems replace the syringe driver with one from the library and return the other one to the equipment library to be serviced. A Datix will then be completed.
- Prior to leaving the hospital the lock box will be removed and the original plastic sleeve put in its place correctly, as community staff will not have keys to access the syringe
- Ensure contact is made with the district nursing service in order to alert them that this patient is going home with a syringe driver so that the local syringe driver can be commenced and the hospital one is returned to the equipment library
- Ask the medical team to contact the patients General Practitioner in order for a home prescription form to be completed in order for the District Nurse to transfer over to the syringe driver that is used for that area We would advise that a copy of the TTO form is faxed to the General Practitioner These forms are not kept in the hospital and a syringe driver chart is not recognised in the community
- The General Practitioner can also notify the Out of Hours Service regarding the patients condition treatment and the usage of the syringe driver should problems occur out of normal hours or the weekend
- As part of the discharge medication supplied to the patient to take home ensure that there is sufficient medication for the syringe driver and prn medication If the patient is on the end of life care pathway ensure there is sufficient injectable medication for the syringe driver and prn medication , this is to include opioid analgesia/ anti agitation /antiemetic/ antisecretory plus either water for injection or normal saline dependent on the dilutent used in the syringe driver. Ensure sufficient quantity of medication as some of these will not be readily stocked by the local pharmacist
- Advise the family that the District Nurse will be coming in to check on the syringe driver and change it on a daily basis. The District Nurse will leave their contact details once they have been. A copy of their number can be given to the families prior to discharge from the discharge liaison nurses covering that area
- Advise the family if there are any problems with the syringe driver or symptom control or medication they are to contact their General Practitioner or District Nurse

- Ensure the ambulance service are aware that the patient is going with a syringe driver and the medication being supplied with the patient as a paramedic ambulance crew may be required The ambulance team will also require the original DNARCPR form to go with the patient
- Ensure the patient is known to the hospital palliative care team ext 7180 in order to arrange community palliative care services
- If patient is going home on the Liverpool care pathway and with /or without a syringe driver ensure that the instructions on Page 22 Appendix 2 are followed

Patients who are being discharged from hospital who are receiving intravenous therapy

- Equipment required will vary depending upon the patient's needs and the type of vascular access device in use. The Vascular Access Team can help obtain the equipment from the list below if ward staff require assistance.
- The supply of equipment relates to the short to medium term treatments for patients whom remain under the care of a hospital consultant. This guidance does not include the supply of equipment for patients on long-term intravenous therapy for whom the day-to-day responsibility of their care remains with the GP.
- The equipment list below is for advice only. The exact equipment required will depend upon individual requirements.

Item	Notes
Yellow/Black heavy duty clinical waste bag	Usually one
Wound care pack	Number required will depend upon prescription
Alaris **solution** sets	For short term infusions
Alaris **pump** sets	For continuous infusions
Chloraprep 3ml	For weekly dressing change
Tegaderm 1650	Change weekly
Cavilon/Sorbaderm 3ml	Required at weekly dressing change
Biopatch	Required at weekly dressing change
Statlock (PICC's only)	Required at weekly dressing change
Standard needlefree	Weekly change required
Positive pressure needlefree (Midlines only)	Weekly change required
Sharps container 1L/5L	Usually one
10ml syringes	Number required will depend upon prescription
20ml syringes	Number required will depend upon prescription
23g blue needles	Number required will depend upon prescription
Clinell **green** swabs	Number required will depend upon prescription
10ml Prefilled saline flush	Number required will depend upon prescription
IV medication and appropriate diluent	As per prescription

- The number of items supplied will mirror the prescribed intervention e.g. if TDS drug administration is prescribed then three wound care packs per day will be supplied. The number of 'days' of equipment supplied will be either the number of days to the next outpatient appointment/vascular access team review or end of therapy (whichever is sooner).
- Once community Intravenous therapy has been agreed, the patient/family/carer should be offered relevant information both verbal and written regarding the care of their intravenous therapy. Peripheral cannula, midline and PICC patient information leaflets are available.
- Medical staff must ensure that the discharge letter indicates the type and length of Intravenous therapy treatment and follow-up arrangements to be sent to GP and community Fast Response Nursing Team.
- A 'new' drug kardex must be written for the community nursing team and the TTO's supplied.
- The nurse caring for the patient must contact Vascular Access Team telephone 7545 so that they may insert an appropriate vascular access device as soon as possible to prevent delay in discharge. The Vascular Access Team can also provide assistance with the discharge process and continuing support if required following the patient's discharge. If unavailable, the ward staff should liaise with the District Nursing Service and Fast Response Nursing Team as appropriate.
- If required the community nurse must obtain electronic infusion devices from the equipment library and a loan receipt completed. It is the community nurses responsibility to ensure they are trained to use the equipment and return the equipment, in a clean condition, to Biomedical Engineering, Level A, The Rotherham Hospital Foundation Trust.
- Outpatient follow up must be arranged prior to discharge by the team responsible for patient discharge. The Vascular Access Team are also available for advice if required.

Discharge from Special Care Baby Unit (SCBU)

- Babies should be fully examined at discharge and findings recorded in the patient's health records and the Red Book (Personal Child Health Record).
- If the discharge is planned for the weekend, examinations must be undertaken on Friday to reduce weekend workload.
- Discharge summaries are completed for all patients admitted to SCBU. These are normally done by the middle grade but the straightforward discharges may be delegated to the SHOs. Please take special care over drug dosages, formulations, inhaler devices, etc. (your letter may be used for repeat prescribing in primary care).
- The discharge letter must be completed on Badger. A hard copy is retained in the case notes and copies sent to GP, Health Visitor, Community Children's Nurse, Child health and Obstetrician
- One copy is given to parents at discharge. Nursing staff on SCBU must go through it with parents before they take their baby home.
- Parents of Babies below 32 weeks gestation should be asked to consent to the PANDA 2 year follow up prior to discharge.

- Wherever possible follow up appointments should be made prior to discharge as per the routine follow up schedule for neonates or in accordance with consultant instructions.
- Ensure that parents receive and understand all relevant condition specific and general baby care information prior to discharge.
- Ensure that the parents have been offered all relevant parent-craft information and practical demonstrations prior to discharge.
- If the baby has continuing care needs e.g. nasogastric feeds or long term oxygen therapy, ensure that all relevant equipment has been issued to parents and that parents are competent to provide ongoing care with the support of a community healthcare professional. Ensure that parents receive written information re replacement equipment and monitoring of the baby's condition post discharge.

Discharge to other Healthcare settings

- **Where a Patient was Resident in a Nursing and Residential Care Homes On Admission**

    - Discharges to Nursing and Residential Care Homes from In-patient beds, excluding the Emergency Admission Units, are generally planned 24 hours in advance of the discharge date, therefore medications to take home, and discharge summaries should be completed and prepared at least the day before the actual discharge.

    - Once discharge planning has commenced, the named nurse or designated other will invite the care home manager to reassess the patient's condition and needs prior to discharge, to establish if their condition or care needs have changed.

    - When the care home manager comes to assess the patient, if they believe they can no longer deliver care to meet the patients needs and refuses to accept the patient for transfer back to the home, the named nurse or designated other must instigate a re-assessment process, including a CHC checklist.

- **Discharging to Nursing/Residential Home**

    - The RN will ensure that appropriate transport has been requested.

    - The RN will inform the patient and relatives, and Nursing/Residential home of the date of discharge. If the patient is transferring to a Care Home or Intermediate Care bed, the nurse coordinating the discharge must call the home to confirm final arrangements.

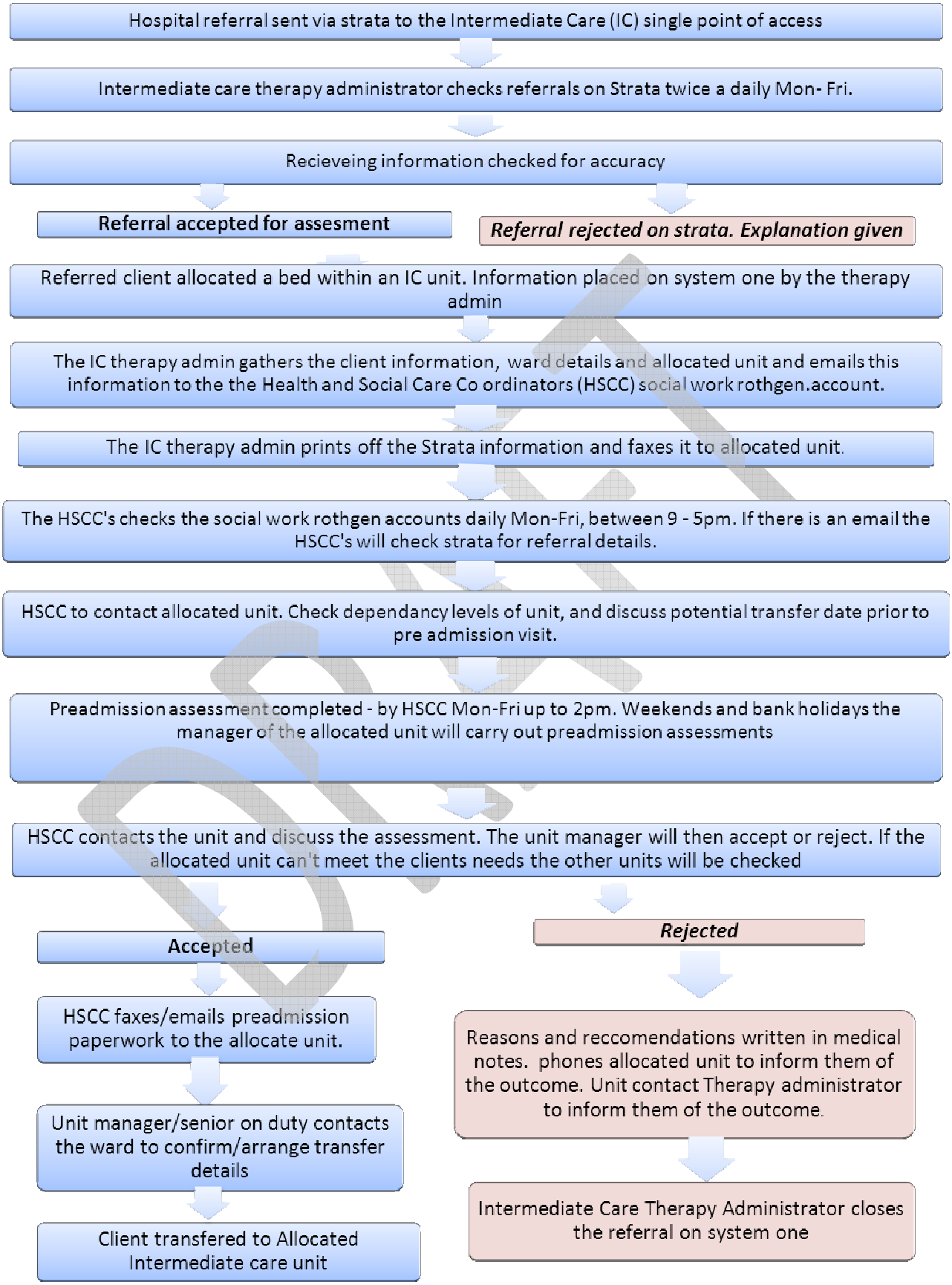
    - The RN will provide information to the patient, and Nursing /Residential home, regarding take home medications.

    - The RN will ensure the correct amount of take home medications are obtained before discharge.

- The RN will provide the patient with a discharge letter and any other relevant appointments or information.
- The RN will document the discharge and discussions in the nursing records.

- **Consideration of Intermediate Care Facilities as the discharge pathway**
  - Once discharge planning has commenced; the MDT will assess for and agree a need for on-going rehabilitation, i.e. have potential to regain or adapt function within a 6-week period, be medically stable and safe to transfer.
  - The MDT involved in caring for the patient, will identify the appropriate Intermediate Care pathway that is required for the patient to follow, i.e. Residential, Community or Day Services.
  - Once Intermediate Care is identified as the chosen discharge pathway; all members of the MDT will complete their relevant section on the Intermediate Care multi-disciplinary referral form (for Community Rehabilitation Team or Day Rehabilitation referrals) and STRATA for an Intermediate Care bed.
  - The last member of the MDT to complete the referral will ensure that the form is sent via STRATA as appropriate. Staff can communicate directly with the IMC team if it is felt necessary, via telephone: 01709 423970.
  - The MDT will identify which member of the team will be responsible for explaining IMC rehabilitation to the patient and carer/relative, and will document all conversations in the patients' health records.
  - Once the referral has been received for an Intermediate Care bed; the preadmission assessment will be carried out by a Health and Social Care Coordinator (HSCC) to look at the dependency levels of the patient referred and the availability of a bed to meet that need.
  - The HSCC will coordinate the discharge arrangements in conjunction with the ward and the allocated unit.
  - Whilst Intermediate Care will try to accommodate patient preferences as regards to which unit they would like to be discharged to, this may not always be possible.
  - Patients discharged to IMC must have 28 days medication and necessary dressings and/or equipment, with them on discharge.
  - For further information regarding an Intermediate Care bed referral please see the Intermediate Care Referral Process document.

○ Intermediate Care Referral Process for The Rotherham Hospital



- **Patients being discharged from ward and outpatients departments to Community Nursing Service**

  - On admission to hospital/hospice, if the patient is known to a District Nurse, a Strata referral must be completed and sent to the appropriate District Nurse, by the nurse coordinating the patient's discharge. This information may help discharge process.

  - At referral, clearly identified nursing needs are to be stated, using referral Criteria required by the Community Nursing Services. Patient's name, home address, address being discharged to, date of birth, home telephone number, general practitioner, next of kin contact, and NHS number. Details of diagnosis and treatment required must be completed on the referral form.

  - The named nurse on the ward or designated other must advise any other agencies involved. The RN/DSN/DF will liaise with external agencies where applicable e.g Community Rehabilitation Team, Community Matrons.

  - The named nurse on the ward or designated other must advise regarding equipment ordered and in use.

  - District Nurse referral paperwork for medication requiring administration by a District Nurse, the RN or designated other must enclose clearly written instructions signed by medical staff, as part of the

  - Nursing staff should ensure that dressings, catheter bags including leg bags, and any other equipment required by the District Nurse accompany the patient home. District Nurses (DN) do not carry spare equipment, dressings, tape etc.

  - The MDT must invite community nurses /community matrons to a home visit assessment if they are being asked to visit after discharge.

  - If a discharge is deemed to be complex, either because of patient's condition or equipment used as part of the patient's assessment for discharge, the community nurse /matron should be invited to the ward prior to the patient's discharge to familiarise themselves with patient's needs, by the named nurse or designated other.

  - The nurse coordinating the patient's discharge must give the patient their discharge letter and any other appropriate documentation or written instructions appropriate to patient's condition and treatment, explaining reason for District Nurse input.

  - The patient should be informed that they will be contacted by the District Nursing Service to arrange the date and time of their visit.

  - For discharge of patients requiring treatment/assessment by the district nursing team, the named nurse or designated other must refer as soon as the discharge date is known.

- For patients being referred to a District Nurse on discharge, referrals should be sent via the Strata referral pathway. At weekends and bank holidays referrals to a District Nurses should be made via YAS, who will forward information to District Nurse team. NB. Community staff do not have access to health centres at weekends and Bank holidays. For patients who require a first District Nurse visit from the evening or night service - referral Information must be faxed direct to 01709 336787.

- Referrals for community nursing services must be made 24 hours prior to discharge by the Named Nurse or designated other. The District Nurse should have a request for treatment made via the Strata pathway. For unexpected discharges (less than 24 hours notice) the DN can be contacted by Ambulance Control on 0845 1219993 to inform them of referral and request they bleep the relevant District Nurse.

- All relevant information regarding the patient's on-going care arrangements must be given to the patient in writing on the day of discharge by the nurse Named Nurse or designated other to the patient, relatives /carers/ advocates. The patient's and their relatives/carers/advocates must be advised to give this written information to the community nurse on their first visit to their home.

- It must be made clear to ambulant patient's not requiring a District Nurse visit to contact the Practice Nurse for follow up treatment if required. Only housebound patients will be visited by a District Nurse.

- **Community Rehab Team (CRT)**

  - CRT will be organised by Therapy staff prior to the day of discharge.

  - If involved the SW team will be informed of the provision of CRT by Nursing Staff and if appropriate a section 3 issued to SW.

  - The procedure for discharge will follow as per instructions for 'Day of Discharge'.

- **Patients Discharged back to Own Home**

  The RN must:

  - Inform the patient and relatives of the date of discharge

  - Where appropriate inform any existing home care providers at least 24 hours before the patients pending date of discharge. This is the responsibility of the nurse and not the patient/relative/carer even if they offer to do so.

  - Where appropriate ensure that basic provisions / amenities will be available on discharge.

  - Obtain the relevant amount of take home medication 24hrs prior to discharge.

- Ensure the discharge documentation is completed and given to the patient upon discharge.
- Ensure that the patient is properly clothed for discharge and weather appropriate.

CHCS Providers Contact Details

APPENDIX 2

Provider Name and Branch Office Address	Branch Manager(s)	Out of Hours Telephone Number	Contract Quality Assurance Officer	Area /Business Manager
360 Healthcare Suite 6 Dinnington Business Centre Outgang Lane Dinnington Rotherham S25 3QX Fax: 01709 263361	Mandy Walker mandy@360healthcare.co.uk Tel: 01709 263360	07714 771200	Maxine Dulcamara	David Johnson david@360healthcare.co.uk Mob: 07931 365 647
Ark Homecare Office 34-35 Bradmarsh Business Park Rotherham S60 1BY Fax: 0845 034 2281	Theresa Hooker theresahooker@arkhealth.co.uk Tel: 08450 342280 Claire Wright, Co-ordinator clairewright@arkhealth.co.uk Debra Berry, Field Care Supervisor debraberry@arkhealth.co.uk	08450 342280	Maxine Dulcamara	Leanne Watson Leanne.watson@Arkhealth.co.uk Mob: 079205448277
Care UK 29 President Buildings President Way Saville Street East Sheffield S4 7UQ	Amanda Howe amanda.howe@careuk.com Tel: 0114 2798228	Tel: 0114 2798228	John Lingard	Beverley Sims Manley Beverley.sims-manley@careuk.com Mobile: 07880853416
Carewatch 27 Moorgate Crofts Business Centre South Grove Rotherham S60 2EN	Angie Kay akay@carewatch.co.uk Tel: 01709 331134 Tel: 07881 845165	01709 331134	Maxine Dulcamara	Bev Peters bpeters@carewatch.co.uk Mob: 07889166748
Comfort Call Unit B7 Taylor's Court Taylor's Close Rawmarsh Rotherham S62 6NU	Debbie Fletcher debbiefletcher@comfortcall.co.uk rotherham@comfortcall.co.uk Tel: 01709 529661	07912 597829	Maxine Dulcamara	Jonathan Lees jonathanlees@comfortcall.co.uk Mob: 07702887255

Crossroads Care Rotherham (Carers Service) Unit H, The Point Bradmarsh Rotherham South Yorkshire S60 1BP Fax No: 01709 389518	Liz Bent liz@crossroadsrotherham.co.uk rotherhamxroads@btclick.com Tel: 01709 389516 Tel: 01709 360272 Helen Cryan helen@crossroadsrotherham.co.uk	07527 925067 07711 697387	John Lingard	Liz Bent liz@crossroadsrotherham.co.uk
Direct Health Unit C 14 Taylor's Court Taylor's Close Rawmarsh Rotherham S62 6NU	Emma Povey emma.povey@direct-health.co.uk Tel: 01709 710243	01709 710243 0114 2798228	Maxine Dulcamara	Judith Proctor Judith.proctor@direct-health.co.uk
Domus Healthcare Unit A07 Ground Floor Magna 34 Business Park Temple Road Rotherham S60 1FG Fax: 01904 720008	Keith Boland KeithB@domushealthcare.com Tel: 07595 567557 Tel: 01709 363797 tracyw@domushealthcare.com	07860 503359	John Lingard	Andrea Jetten AndreaJ@domushealthcare.com Mob: 07850 044424
Housing 21 Unit 19 President Park President Way Saville Street East Sheffield S4 7UQ	Gerri Kelly – Care Manager geraldine.kelly@housing21.co.uk Tel: 07799 715678 Tel: 03031 231291 Bianca Murtag – Registered Manager	07799 715678 03031 231291	Maxine Dulcamara	Gary Kent Gary.kent@HOUSING21.co.uk Tel: 03007901145
Mears Unit 1 Claire Court Rawmarsh Road Rotherham South Yorkshire S60 1RU	Bev Green bev.green@mearsgroup.co.uk Tel: 07771 645600 Tel: 01709 722420	07787 156989	John Lingard	Leigh Tudour Leigh.tudor@mearsgroup.co.uk Mob:

SAGA Suite 2, Floor 2, Building 1 Hawke Street Industrial Estate Hawke Street Sheffield S9 2SU	Julie Wales julie.wales@saga.co.uk Tel: 01142 613003 Deborah Scott – Co-ordinator deborah.scott@saga.co.uk	07909 894754	Maxine Dulcamara	Lisa Hillman Lisa.hillman@saga.co.uk
Sevacare A4 Taylor's Court Freshfield House Parkgate Rotherham S62 6NU Fax: 01709 710497	Janet Senior janet.senior@sevacare.org.uk Tel: 07891 335522 Tel: 01709 523635	01709 523635	John Lingard	Debbie Dennis debbie.dennis@sevacare.org.uk T: 01902 625088 M: 07807104665
TLC Homecare A3 Taylor's Court Freshfield House Parkgate Rotherham S62 6NU	Lynne Smallwood lynne.smallwood@tlc-homecare.co.uk Tel: 07889 002361 Tel: 01709 524364	07794 219485	John Lingard	Leanne Archbold Leanne.archbold@warrencare.co.uk Mob: 07530282422
Voyage Unit 18 Moorgate Croft Business Centre Alma Road Rotherham S60 2DH	Hayley Odemis Hayleyodemis@voyagecare.com Denise McClure Denisemcclure@voyagecare.com Tel ; 01709 331242	Hayley 07793 616697 Denise 07793 616633	John Lingard	Yetwo Li yetwoli@voyagecare.com

APPENDIX 3

Responsibility of all RFT staff to complete Continuing Health Care Assessments

- All Patients or their families/carers/advocates have the right to an assessment of their health care needs against Continuing Health Care criteria, and may request a Continuing Care Assessment (Rotherham Hospital Discharge Planning and Reimbursement Policy: A Partnership Agreement.)
- Therefore patients may refuse a discharge option until this process is completed in accordance with the criteria.
- The eligibility criteria for Continuing Health Care operates in conjunction with the assessment for the Registered Nursing Care Contribution (also known as NHS Funded or Free Nursing Care), and both will be complementary to the Fair Access to Care Services (FACS) eligibility criteria operating within the Local Authority.
- The decision for eligibility will be taken by the multi-disciplinary professionals involved in the individuals care and their identified needs will considered against Continuing Health Care checklist criteria.
- Following the request for a Continuing Health Care Assessment, the multi-disciplinary team will complete the Decision Support Tool and will liaise with the patient and family/carer/ advocate ensuring that necessary information is made available for a full and comprehensive assessment.
- A summary of the reviewed assessment made against the Continuing Health Care eligibility criteria will be completed and discussed with the patient/family/carer/ advocate who can apply in writing for a copy of this document.
- In the event that the MDT identifies that the patient may meet the criteria for Continuing Health Care eligibility or joint eligibility with Social Services, then the Decision Support Tool document must be completed with the MDT recommendation, and faxed to the Primary Care Trust Continuing Health Care Panel fax number 01709 308826 for review and confirmation of Continuing Health Care eligibility at the appropriate
- A CHC information leaflet will be given to the patient and family/carer/ advocate which explain the CHC process including that of formal disputes, reviews and eligibility criteria.
- If the CHC ratification is not in agreement with the MDT recommendation then the MDT should meet to discuss the additional evidence/information requested by CHC. If there is no further evidence available the MDT will evoke a formal dispute process and write to CHC stating areas of disagreement. If further evidence is available this will be included in the DST and sent for CHC consideration.
- If the patient or family/carer/ advocate consider their health needs have not been correctly assessed they should be advised to follow the CHC dispute process. This is described in the decision letter sent from CHC.

APPENDIX 4

Ascertaining Eligibility for Patient Transport Services (PTS)

Opening statement:
NHS transport is an expensive resource and it is important that all alternatives are explored to enable patients to travel to or from a healthcare location by their own means, rather than using PTS. It is only provided if the patient's medical condition prevents them safely using other travel options to get to or from their appointment. Previous use of PTS isn't a guarantee that the patient will be eligible in future.

Question 1
Is the patient travelling to or from an NHS healthcare provider for NHS care?

No → **The Patient is not eligible for NHS Transport For this Journey**

Yes

Question 2
Can the patient use their own transport to safely get to/from their appointment?

Yes → **The Patient is not eligible for NHS Transport For this Journey**

No

Question 3
Can the patient travel safely to/from their appointment with a friend or relative?

If the friend or relative is not available at the date & time of the appointment it may be possible to re-arrange it.

Yes → **The Patient is not eligible for NHS Transport For this Journey**

No

Question 4
Can the patient safely access and use other forms of transport - public transport, taxis – to get to/from their appointment, without detriment to their medical condition. Options may be available for wheelchairs.

Yes → **The Patient is not eligible for NHS Transport For this Journey**

But if cost is an issue, they may be eligible for help with travel costs through the Healthcare Travel Costs Scheme.

Alternatively they may be able to access other forms of community transport.

No

Question 5
Does the patient have a medical condition which affects their mobility and means they cannot use non-NHS transport or do they need the facilities available on a PTS ambulance and/or a the help of a PTS Crew in order to travel safely?

Yes → **The Patient is eligible for NHS Transport For this Journey**

Pleas

No

Pag

sion.

Guidance Information

Guideline Information

Question 1

A Healthcare provider could be community, secondary or tertiary care based.

Question 2

Consideration needs to be given to the following:-

- How the patient normally gets out & about.
- The effect of treatment or diagnostics which the patient may be subjected to at the Healthcare provider and which may affect their ability to transport themselves.
- The frequency of journeys the patient has to make in a short time period, for example, if more than 3 return journeys per week.

Question 3

Consideration needs to be given to the following:-

- The frequency of journeys the patient has to make in a short time period, for example, if more than 3 return journeys per week.

Question 4

Consideration needs to be given to the following:-

- Any effect of treatment or diagnostics which the patient may be subjected to at the Healthcare provider.
- The frequency of journeys the patient has to make in a short time period, for example, if more than 3 return journeys per week.
- The complexity of the journey, if for example the patient needs to make more than one change of vehicle.
- Access to and from transport.

Question 5

Examples will be:-

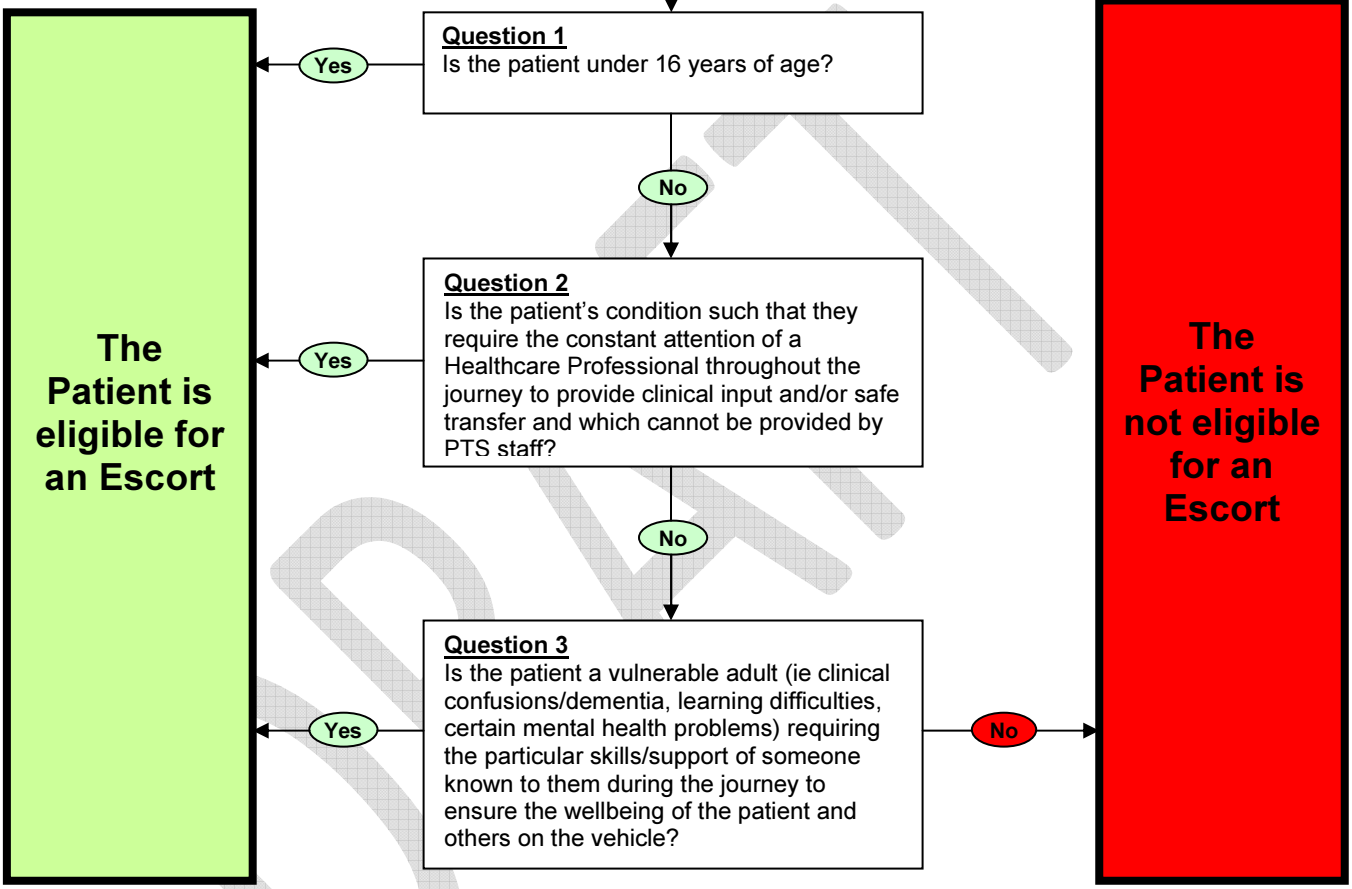
- The need to utilise on-board oxygen.
- The requirement for a stretcher, carry chair, ambulance service wheelchair or bariatric vehicle.

APPENDIX 5

Ascertaining Eligibility for an Escort

Opening statement:
Once a patient's eligibility has been established, it is equally important that any request for an Escort is properly assessed to avoid inappropriate use of PTS resources.

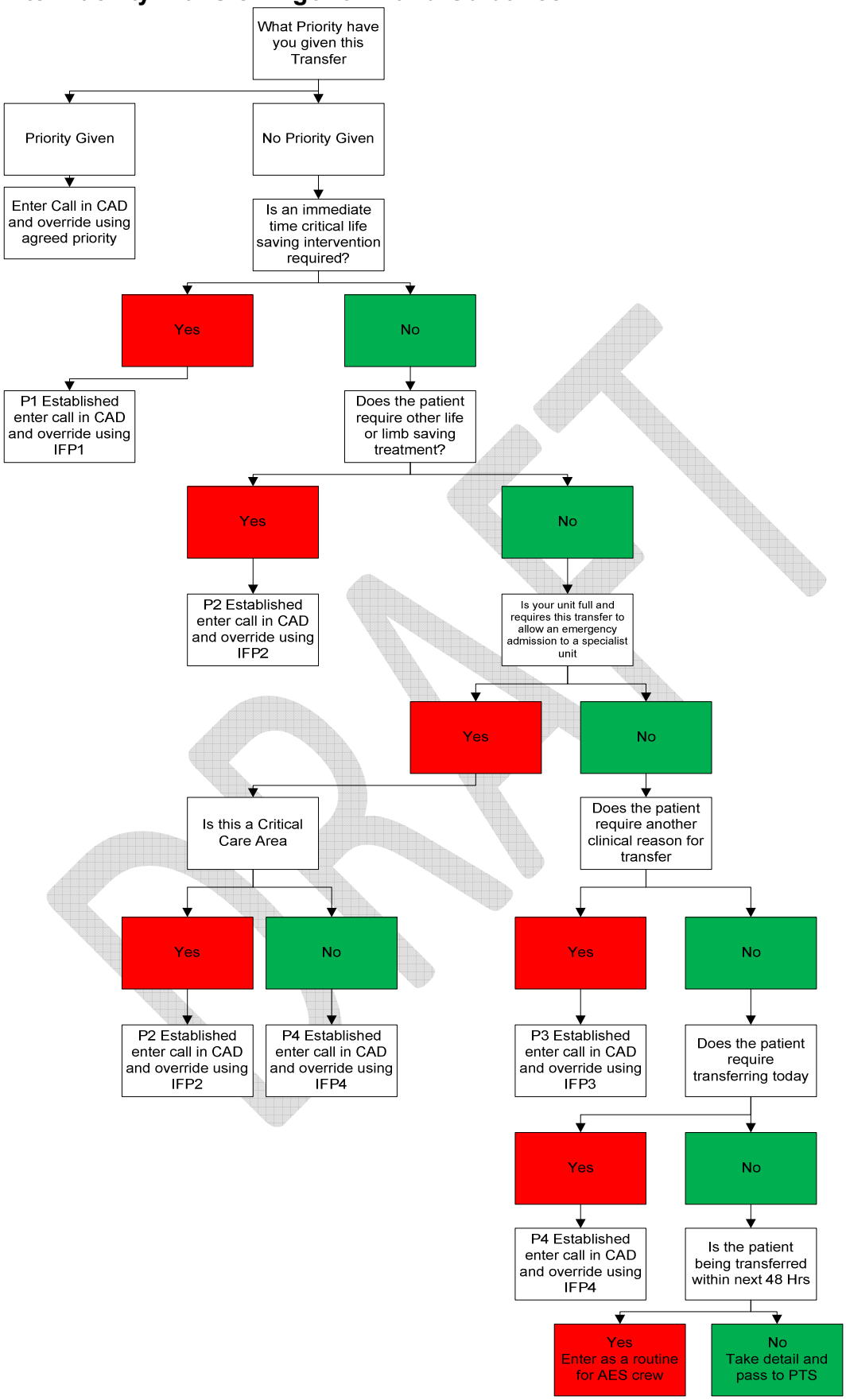
Previous approval for an Escort isn't a guarantee that a patient will be eligible in future. In the event that the patient is admitted, it is the responsibility of the escort to make their own way home.



Question 3 Guidance

There may be cases where an Escort is not specifically required during the actual journey, but is necessary whilst the patient is at the Healthcare location to provide support. In such cases the Escort should travel independently to the Healthcare location.

Sometimes Escorts are not able to travel on their own and such cases will be considered on an exception basis provided that it is in the best interest of the patient.


What Priority have you given this Transfer
Priority Given
No Priority Given
Enter Call in CAD and override using agreed priority
Is an immediate time critical life saving intervention required?
Yes
No
P1 Established enter call in CAD and override using IFP1
Does the patient require other life or limb saving treatment?
Yes
No
P2 Established enter call in CAD and override using IFP2
Is your unit full and requires this transfer to allow an emergency admission to a specialist unit
Yes
No
Is this a Critical Care Area
Does the patient require another clinical reason for transfer
Yes
No
Yes
No
P2 Established enter call in CAD and override using IFP2
P4 Established enter call in CAD and override using IFP4
P3 Established enter call in CAD and override using IFP3
Does the patient require transferring today
Yes
No
P4 Established enter call in CAD and override using IFP4
Is the patient being transferred within next 48 Hrs
Yes
Enter as a routine for AES crew
No
Take detail and pass to PTS

P1	R1 Call - 8 minute Response
P2	G4 Call - 1 Hour Response (Upgrade to G2 if response > 60 Minutes)
Retrieval	Treat as usual through Embrace or P1-P4
P3	Urgent Call - up to 4 hours Response (with 30 minute warning of arrival)
P4	Routine call - up to 8 hours Response (where contracted)
Routine	Suitable for AES crew

Inter-facility Transfer Questions

1. What Hospital ward or department are we collecting the patient from? – Ensure correct ward / department is entered from hospital table and refrain from using General as an option

2. Where are taking the patient to?

3. What is the condition/diagnosis of the patient?

4. What is the patients name and date of birth?

5. Is this a ***Critical Care Transfer***?

If Yes

   a. Tag on system as CRIT
   b. Advise doctor must accompany the patient
   c. Ask if the patient will be transferred on a Critical Care Trolley

6. Is the patient connected to specialist equipment which cannot be disconnected for the journey or is likely to require clinical intervention en-route?
   a. Yes **Advise that suitably qualified staff must accompany the patient**
   b. No

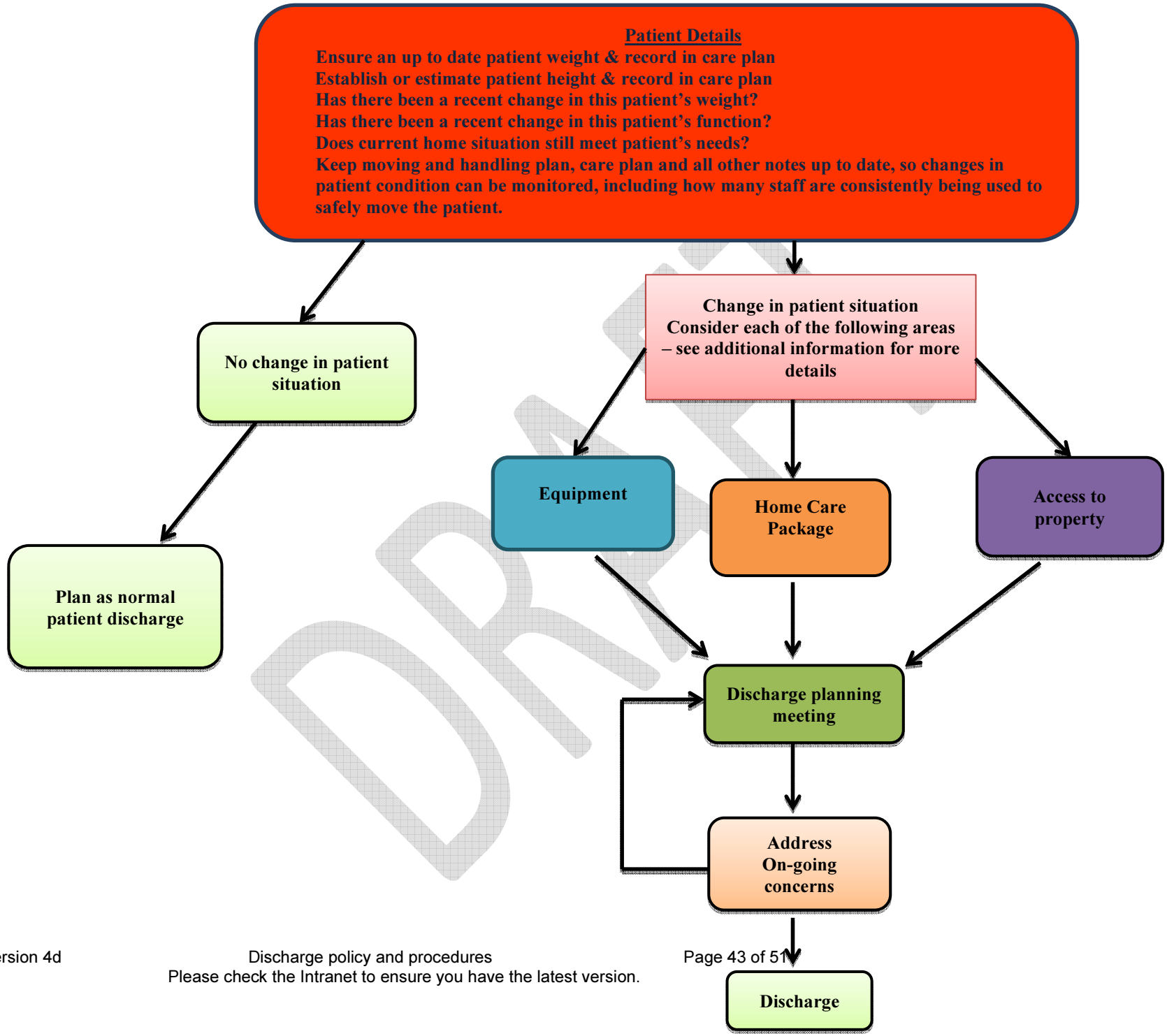
7. Does the patient have a current Do Not Attempt Resuscitation (DNAR) Order in place?

   a. Yes **Advise crew of DNAR**

   If DNAR in place can you make sure it is available for the crew to see.

   b. No

APPENDIX 7: BARIATRIC PATIENT



Equipment

Specialist assessments may be required prior to discharge of some bariatric patients by: - therapists, moving and handling, transport, tissue viability, district nurse teams.
Refer to OT who will ensure that the equipment being used at home is adequate or if further equipment needs to be ordered. An assessment will be made of the home environment to check space, lifting heights, flooring,

Bed

If a bariatric bed is needed on discharge home – contact Moving & Handling Team for availability of beds and the suitability of available beds for your patient. Beds generally are available in standard (approx. 3ft), 3ft 6 and 4ft widths.
Establish which type of bed is available for D/C. A trial of the bed maybe required – Speak with Therapists and Moving & Handling Team.
Can bed be delivered into property? Contact REWS to complete their own assessment

Mattress

Request a mattress assessment. Liaise with Tissue Viability and Moving & Handling Team to establish an appropriate mattress and that it is compatible with bed.

Bed Rails

Most bed rails on community beds are not designed to be pulled on by the patient. If patient requires bed rails for safety reasons ensure can be rolled without using rails to pull on. There is limited availability of pull handles for bariatric beds, but they cannot be used in conjunction with bed rails. Liaise with Therapists/ M & H/ REWS

Hoist & Slings

Usual checks and assessments are made. Extra consideration needs to be given to safe working loads of equipment, whether sling can be easily inserted or removed or if a specialist sling is required?

Other equipment

Liaise with Therapists regarding any additional equipment that may be required such as commodes, walking aids, etc. Therapists will

Home Care Package

Establish if new or existing care package is required.
Check how many staff are assisting to move and care for patient on the ward. Is this consistent?
If more than 2 carers are required – start DST **as soon as possible**
Once care provider is established ensure they are familiar with any special instructions/ equipment, and have been given all appropriate information.
If informal carers/family are helping with care ensure this is appropriate and they have had appropriate instruction – liaise with therapists and Moving & Handling Team.

Access to Property

Consider how patient will be taken home - Ambulance/relatives/own
Check whether the property has steps/stairs or difficult access?
Check if patient will be able to get into property, will they need help?
Check if OT needs to complete environmental assessment?
Is stair assessment required?
Ask if property suitable for wheelchair or stretcher access
Liaise with Patient Transport - They may need to risk assess property; give them min 72 hour's notice.
Once in property consider how patient will be transferred onto bed etc.

Discharge Planning Meeting

Arrange a MDT meeting in advance of discharge. Consider inviting: -
Nursing staff, OT, Physio, District Nurses, Discharge Nurses, Moving & Handling, Tissue Viability Nurses, Patient Transport, Home Care, Social Workers, Community OT, patient, patient's family, and any other relevant parties.

APPENDIX 8

The Rotherham NHS
NHS Foundation Trust

REQUEST FOR PRESSURE RELIEVING EQUIPMENT

Ward…….. **Tel Ex**…… **Planned discharge date**……..

Discharge destination……..…….. …….**Tel**….....

Next of kin/person dealing with discharge…….……**Tel**……

Name of Occupational Therapist……..……**Tel**……

Patient diagnosis…….

Weight…… **Waterlow**…. **Pressure ulcers -** Yes/No **Site and grade**……..……**Hours in bed** 19-24 □ 13-18 □ 6-12 □

Type of bed frame to be used at home: Single □ Double □ Double shared □ ¾ bed □ Hospital □ Delivery date for hospital bed……

Mattress currently in use: Foam □ Standard dynamic overlay □ Dynamic replacement □ Dynamic therapy □

Cushion currently in use: Propad □ Flo-tech Plus □ Flo-tech Solution □ Dynamic □ Other □

Continence: Catheterised □ Incontinent urine □ Incontinent faeces □ Stoma bag □ Continent □

Care package: Single handler □ Double handlers □ Night visits □ No. of visits …… daily District Nurse to visit: Yes/No Date arranged……..

Any other information……
……..

……
……

……
……

Equipment requested: Standard foam mattress □ Standard dynamic □ Dynamic replacement □ Dynamic therapy □ Cushion □

Referred by…… Designation…….……
Tel…… Date…….....

When this form is complete, fax to Tissue Viability Office NHS Rotherham on 3255

For advice on equipment delivery on discharge call the Equipment Coordinator on 3250

DISCHARGE POLICY AND PROCEDURES

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Management Team
Business and Service Managers
Clinical Directors
Matrons
Group Nurses
Quality Governance Team

9. APPROVAL OF THE DOCUMENT

This document will be/was approved by:

Patient Safety Committee

10. RATIFICATION OF THE DOCUMENT

This policy will be/has been ratified by Trust Document Ratification Group.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years unless such changes occur as to require an earlier review.

The Lead Nurse, Care Management Team is responsible for the review of this document.

13. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
Quality Governance Team via polices email	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform Quality Governance Team if a revision and which document it

				replaces and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.
Communication Team (documents ratified by the document ratification group)	Quality Governance Team	Email	Within 1 week of ratification	Communication team to inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals Staff with a role/responsibility within the document Heads of Departments /Matrons	Author	Meeting/ Email as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.
All staff within area of management	Heads of Departments /Matrons	Meeting / Email as appropriate	As soon as received from the author	Ensure evidence of dissemination to staff is maintained. Request removal of paper copies Instruct them to inform all staff of the policy including those without access to emails

14. IMPLEMENTATION AND TRAINING PLAN

What	How	Associated action	Lead	Timeframe
Completion of Continuing Healthcare	Workshops for authors Support via email and telephone	Upload blank document templates to the intranet	Quality Governance Team	Ongoing
Approval Process/form	Workshops/ meetings with	Upload blank approval form to		Within 3 months of publication of

	approving committees	the intranet		revised policy

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF, THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

Audit/Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Discharge Requirements for all patients	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee
Information to be given to the receiving healthcare professional and how this is recorded	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee
Information to be given to the patient when they are discharged and how this is recorded	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee
How a patient's	Audit	CSU's/Care	Twice yearly	Relevant	Patient

medicines are managed on discharge		Management Team in conjunction with the relevant Ward Managers and Matrons		CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Safety Committee
Process for discharge out of hours.	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee

A report will be prepared by the Lead Nurse Care Management Team or designated other for Business and Service Managers and Performance Managers regarding the number of **Delayed Discharges** areas and reasons for delay, so that trends can be monitored locally, and actions to resolve can be developed within CSU's/FU's.

15.2 Standards/Key Performance Indicators (KPIs)

- Reduction in delayed discharges
- Reduction in outlying patients
- Reduction in time of 'boarding out' for patient's in A&E

The Rotherham NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name: _____ Date/Period of Document: _____

Lead Officer: _____ Directorate: _____ Reviewing Officers: _____

❑ Function	❑ Policy	❑ Procedure	❑ Strategy	❑ Joint Document, with whom?
Describe the main aim, objectives and intended outcomes of the above:				

*You must assess **each** of the 9 areas separately and consider how your policy may affect people's human rights.*

1. Assessment of possible adverse impact against any minority group				
How could the policy have a **significant** negative impact on equality in relation to each area?		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	**Age**?			
2	**Sex** (Male and Female?			
3	**Disability** (Learning Difficulties/Physical or Sensory Disability)?			
4	**Race** or Ethnicity?			
5	**Religion and Belief**?			
6	**Sexual Orientation** (gay, lesbian or heterosexual)?			
7	**Pregnancy and Maternity**?			
8	**Gender Reassignment** (The process of transitioning from one gender to another)?			
9	**Marriage and Civil Partnership**?			

You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community of group? **Yes/No**
- Will any group be **excluded** because of the policy? **Yes/No**
- Will the policy have a negative impact on **community relations**? **Yes/No**

If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment

2. Positive impact:				
Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	Promote **equal opportunities**			
2	Get rid of **discrimination**			
3	Get rid of **harassment**			
4	Promote **good community relations**			
5	Promote **positive attitudes** towards disabled people			
6	Encourage **participation** by disabled people			
7	Consider **more favourable treatment** of disabled people			
8	Promote and protect **human rights**			

3. Summary On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?						
Positive	*Please rate, by circling, the level of impact*					**Negative**
HIGH	**MEDIUM**	**LOW**	**NIL**	**LOW**	**MEDIUM**	**HIGH**
Date assessment completed:	Is a full equality impact assessment required?		❑ Yes (documentation on the intranet)		❑ No	