Trust Procedure

Plymouth Hospitals NHS Trust

Simple Discharge Standard Operating Procedure

Date	Version
July 2012	**1**

Purpose

This procedural document sets out the Trust's approach to managing the discharge for a person who is deemed to be a Simple Discharge. A Simple Discharge is one that;

- Involves minimal disturbance to the patient's activities of daily living.
- Includes return to the patient's usual place of residence.
- Does not require a significant change in support offered to the patient or their carer in the community.

This procedural document outlines the roles and responsibilities of staff when discharging a person to the following destinations:

- Home with no support.
- Home with District Nurse Support.
- Home from Day Case Unit.

Who should read this document?

- Trust Directors, because they need to understand how the Trust manages simple discharge.
- Senior clinicians, because they are involved in the assessment of the needs of the person on discharge.
- All clinical and support staff who are involved in the discharge of a person from Hospital.

Key messages

- All persons should receive an Estimated Date of Discharge (EDD) within 24hrs of admission to a Specialist Ward.
- Discharge is a process and not an event.

Accountabilities

Production	Senior Operations Manager
Review and approval	Safe Care Group
Ratification	Chief Operating Officer
Dissemination	Senior Operations Manager
Compliance	Senior Operations Manager

Links to other policies and procedures

Complex Discharge SOP
Discharge Policy Children and Young People
Discharge Guidelines NICU

Version History

V1	July 2012	Operational Policy for the Discharge and Transfer of Patients from Hospital split into separate SOPs

Last Approval	Due for Review
July 2012	Extended to Sept 2016

Trust Commitment to Valuing People

PHNT is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff.

We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder:

<u>G:\TrustDocuments</u>

Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

Standard Operating Procedure (SOP)

Simple Discharge

1 Purpose and Scope

Discharge from hospital is a patient centred process that requires the collective contributions of various agencies and professional disciplines. It should be a planned, coordinated and systematic process with effective communication throughout. Individuals concerned and their carer(s) should be involved at all stages, and regular reviews and updates should take place to keep them fully informed.

This procedural document sets out the Trust's approach to managing the discharge for a person who is deemed to be a Simple Discharge. A Simple Discharge is one that;

- Involves minimal disturbance to the patient's activities of daily living.
- Includes return to the patient's usual place of residence.
- Does not require a significant change in support offered to the patient or their carer in the community.

Duties

The Director of Operations is the Executive lead for this SOP.

The Document Author is responsible for the development, implementation and review of the procedure, ensuring that it complies with local and national guidelines.

Managers and Matrons will ensure that all clinical and non-clinical staff understands their roles, duties and responsibilities with respect to patient discharge and patient flow throughout the organisation. This includes assessment of patient need, negotiation of appropriate onward care services, communication with the patient and with onward care services and provision of appropriate services, equipment and supplies for discharge and transfer from hospital.

Clinicians will work collaboratively to ensure appropriate, timely and safe discharge and transfer from hospital of patients; maintain their knowledge and skills in assessment of patients and planning of onward care needs and share information regarding those needs on a need to know basis through accurate records and written communication.

2 Monitoring and Assurance

Monitoring will be undertaken six monthly by the Discharge Case Management Team.

Patient notes, including the discharge checklist, for a sample of patients will be audited to review compliance with the processes described in this SOP. This will include an assessment of compliance with:-

1. discharge requirements for all patients

2. information to be given to the receiving healthcare professional and where this is recorded

3. information to be given to the patient when they are discharged and where this is recorded

The results of the monitoring will be reported to Safe Care Group together with recommendations and actions were appropriate to address any issues arising. The ongoing review and implementation of recommendations and actions will be overseen by Safe Care Group and will be managed in accordance with the severity and priority of the issue arising.

Management of medicines on discharge will be monitored by Pharmacy in line with the Medicines Management Policy.

3 Procedure to Follow - Points for a Simple Discharge

Points for a simple discharge

Simple Discharges will be co-ordinated and managed by hospital ward staff. A summary of the process is detailed in the flowchart at Appendix 1.

All patients will be allocated an estimated date of discharge (EDD). Elective inpatients and Daycase patients will receive their EDD at Pre-Admission whilst Emergency inpatients will receive their EDD within 24 hours of admission.

Patients and their relatives should be informed that the EDD is provisional, but that the clinical team will be working towards discharge from hospital on the EDD. Patients and Relatives need to also be planning discharge arrangements for their return from hospital on the EDD.

If the patient was in receipt of a care package prior to admission, the registered nurse/discharge case manager must inform any established care services of the patients' admission and their EDD within 24 hours, or as soon as possible on the next working day. Referrals to community staff District Nurses should be made through Devon Doctors.

4 Out of Hours Discharge

- The Senior Nurse is responsible for ensuring that Elective and Emergency Admissions are placed properly.

- Hospital @ Night provide out of hours clinical site advice management.

- Discharge out of hours is appropriate if deemed safe by the discharging Nurse and/or Doctor.

- The Inpatient Discharge Summary must be completed as normal for discharges out of hours and a copy given to the patient and another sent to the GP.

- Where urgent Social input may be required, the Emergency Social Worker should be contacted. This can be done via Switchboard.

- Community Nurse Referrals should be faxed via Devon Doc's.

- If no medications have been dispensed the Doctor and/or Nurse can dispense from the ward in pre prepared packs supplied by the Pharmacy.

- For Medications that are not available in a pre-packed form, the Senior Nurse/Hospital @ Night can call the On Call Pharmacist for assistance.

5 Discharge Against Medical Advice (Self Discharge)

- If a patient who has mental capacity wishes to leave hospital, despite explanation and encouragement from the clinical team, family, carers etc. then they should be allowed to leave although such a discharge still should be made as safe as possible.

- Having discussed the medical advice against discharge, if the patient still insists on leaving, he/she should be asked to sign a 'Discharge Against Medical Advice' form. In addition, the health care professional present should also document the patient's decision and action in the clinical record.

- The patient should be advised of information regarding ongoing care and advised to contact their G.P. practice as they may need services or treatment in the community. If social services are involved in the patient's care they must also be informed.

- The registered nurse on the ward should contact health and social care services within the community where a patient taking self-discharge has identified continuing needs. This should be through the onward care teams or Devon Doctors-on-call.

- The doctor will, as with regular discharges, send a discharge letter to the G.P. and should contact the G.P. by phone if they have any immediate concerns.

- Where TTA's have been dispensed, it is the responsibility of the discharging health professional to ensure that appropriate information is given to the patient regarding the prescribed medication.

- The registered nurse should contact the patient's family or next-of-kin to advise that the patient is taking self-discharge and that this is against medical advice. No details of the patient's clinical condition should be disclosed merely notification that they are no longer in hospital. A record of this communication should be made in the clinical record.

- For a patient who is deemed to lack mental capacity, due care and attention should be given to ensure that the person is not deprived of their liberty. Whilst it may be in the best interest of the patient to restrict their liberty for periods or even restrain the person in order to administer care or treatment, this must always be reasonable and proportionate. The patient's family or an IMCA should be involved in any decisions to restrict a person's liberty and to ensure that there is no deprivation of liberty without authorisation.

6 Discharge from Day Case Units

Patients who are admitted for day case procedures follow the perioperative pathway. This contains a hospital discharge checklist which needs to be completed by the nursing staff prior to discharge. Appendix 4

7 Key Duties and Documentation

Pharmacy
Ward pharmacists will assess patients' medicine needs during their inpatient stay. Prior to discharge from hospital, where appropriate, they will provide the following:

- Specific counselling for Amiodarone, Warfarin, inhaler technique and smoking cessation.

- Anticoagulant record books; steroid and lithium information cards.

- Assessment of likely medication compliance after discharge and transfer from hospital. Medication reminder sheets and compliance aids will be supplied to patients if assessed as necessary.

- If the patient was in receipt of a medical homecare package prior to admission e.g. medicines delivery and/or administration or home oxygen therapy, the pharmacist should liaise with the community pharmacist and/or GP about re-establishing the homecare service.

Further detail on the management of medicines on discharge can be found in the Medicines Management Policy.

Medical Staff
The medical team must ensure that discharge medicines (TTAs) are prescribed prior to 4pm the day prior to discharge. All medicines that a patient will be taking post– discharge must be listed in the TTA (whether supply is needed or not). All TTA prescriptions must be authorised by a pharmacist.

Medical Staff will be responsible for completing a Home Oxygen Order Form (HOOF) to request home oxygen.

If the patient is employed they may require a statement of fitness for work. The form MED3 must be completed by a member of the medical/surgical team.

Medical staff are responsible for generating the e-Discharge Summary to ensure clinical handover to the primary care clinician.

Nursing Staff
When the discharge medications are given to the patient, relative or carer these should be discussed in detail by a member of the ward's nursing staff. It is essential that adequate time is taken to ensure that the patient and carer understand how and when to take the medication. It may be appropriate to ensure that patients demonstrate how they will administer their medications with the nurse present.

Patients requiring administration of medicines by community health staff should have this medication prescribed on a Blue Community Prescription Card, which should be sent home with the patient's medication. Details of drugs to be administered by community nurses must be recorded on the day of discharge checklist (Appendix 2).

The registered nurse on the ward should complete the Day of Discharge Check list (Appendix 2) and ensure that the patient has all of the right equipment, medication, dressing supplies, property, valuables, advice and information and details of follow-up appointments prior to leaving the ward. A week's supply of dressings and supplies should be given. A record of any information supplied, should be made in the patient's notes.

If the patient needs to attend an outpatient or other hospital clinic it is important to ascertain whether they are eligible for hospital transport. This should be identified when the date of discharge and transfer from hospital is confirmed.

The registered nurse on the ward should ascertain how the patient will gain access to their property and ensure that any keys are sent with the patient and that family/carers/next of kin are aware of the planned discharge.

For the patient, relative and carer even the most simple discharge can be concerning. They may require additional information and advice about potential lifestyle changes following their discharge from hospital. Providing advice sheets or booklets are useful for the patient to take home. Always ensure that the patient and if appropriate, carer, is given the opportunity to ask questions prior to leaving the ward. A record of any information supplied should be made in the patient's notes.

Medical Documentation
General Practitioners (GPs) must receive a copy of the patients' Electronic Discharge Summary within 48 hours of Discharge.

The E-Discharge system produces 5 clearly labelled copies of the discharge summary for distribution as follows:

- One copy will be placed in an envelope and given to the patient to keep.
- One copy will be filed in the patients notes.

- One copy will be placed in an envelope and posted to the GP (this will be transferred electronically in the near future).
- One copy will be kept with pharmacy.
- A further copy will be given to the patient to be passed onto their community pharmacist.

For further information please refer to the Administrative Procedure Note for preparing paper discharge and edischarge summaries for doctors. Preparing Paper Discharge and eDischarge Summaries for Doctors

Ensure that, if required, the community prescription chart is completed to allow the district nurse to administer medications prescribed by us in the community.

Nursing Documentation
The staff nurse discharging the patient is responsible for providing the patient with any relevant information about the procedure or aftercare. The Day of Discharge Checklist must be completed Appendix 2. A record of any information supplied should be made in the patient's notes.

If a district nurse's input is required on discharge, the nurse will provide written documentation around wound care via the Devon Doctors service.

If we require the district nurse to administer medications, it is the nurse's responsibility to ensure that a community prescription chart is completed by medical staff and sent with the patient.

Discharge from Endoscopy will be managed through use of the checklist at Appendix 3. The completed checklist will then be filed, in the patient's notes

8 Document ratification process

The design and process of review and revision of this procedural document will comply with the Trust's formal policy on policy and procedural documents.

The review period for this policy document is set as three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Safe Care Group and ratified by the Chief Operating Officer.

Non-significant amendments to this policy document may be made, under delegated authority from the Chief Operating Officer, by the nominated author. These must be ratified by the Chief Operating Officer and should be reported, retrospectively, to the Safe Care Group.

Significant reviews and revisions to this document will include a consultation with consultants and matrons across the Trust. For non-significant amendments, informal consultation will be restricted to consultants and matrons who are directly affected by the proposed changes

Dissemination and implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

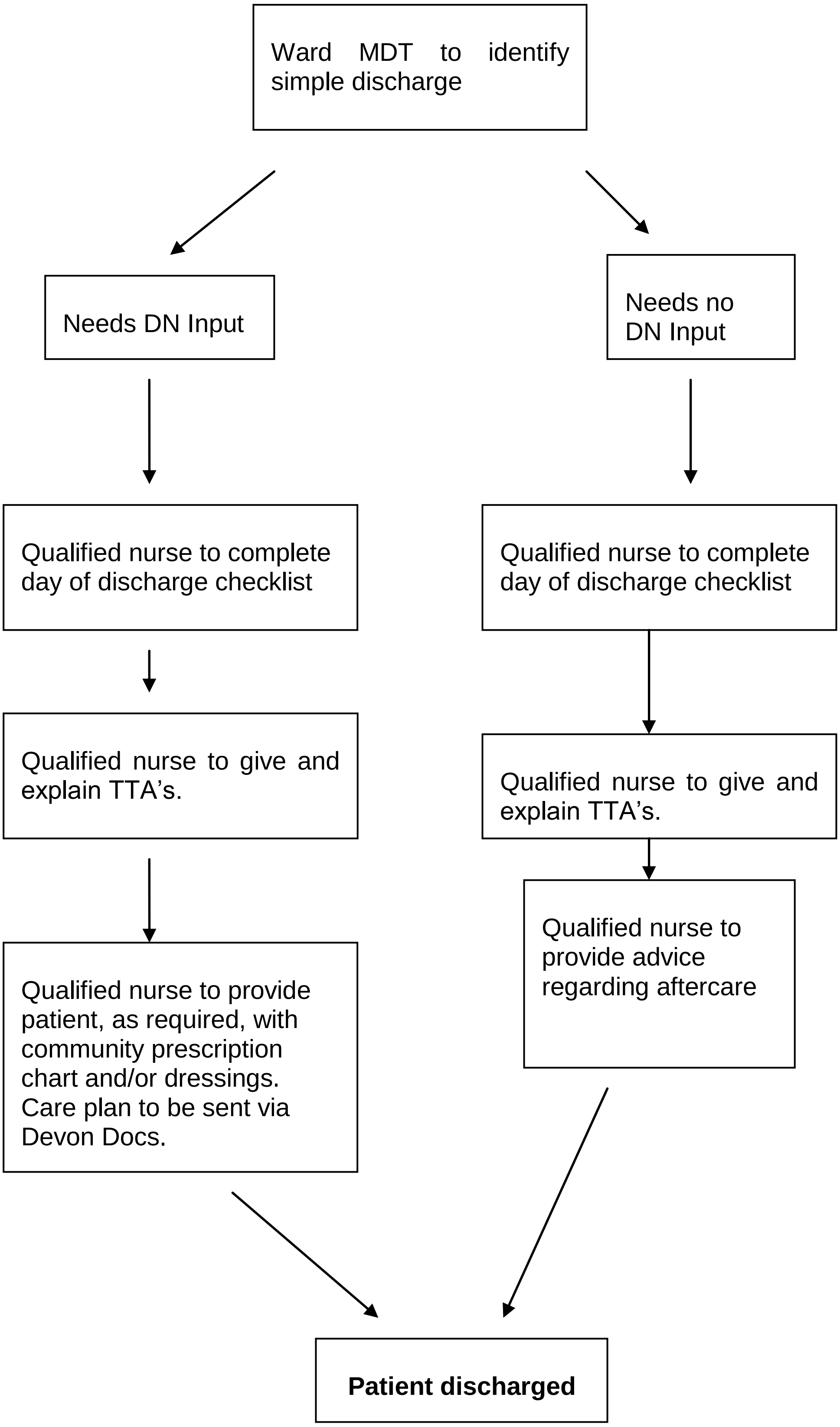
Document control arrangements will be in accordance with the Trust's formal policy on policy and procedural documents

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Chief Operating Officer and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Reference material

- Department of Health (2003) Community Care (delayed discharges etc) Act.
- Department of Health (2003) Discharge from hospital, Pathway, Process and Practice
- Department of Health (2005) Mental Capacity Act
- Department of Health (2007) Continuing Health Care
- Department of Health, Deprivation of Liberty
- Department of Health, Vulnerable Adults
- Department of Health (2002) Discharge Toolkit
- Department of Health (2001) Valuing People

Simple Discharge Flowchart | Appendix 1


Ward MDT to identify simple discharge
Needs DN Input
Needs no DN Input
Qualified nurse to complete day of discharge checklist
Qualified nurse to complete day of discharge checklist
Qualified nurse to give and explain TTA's.
Qualified nurse to give and explain TTA's.
Qualified nurse to provide advice regarding aftercare
Qualified nurse to provide patient, as required, with community prescription chart and/or dressings. Care plan to be sent via Devon Docs.
Patient discharged

DAY OF DISCHARGE CHECKLIST (Simple Discharge)

Planned Discharge Date ……………………….

Ward ……………………………………………………

Discharge via Discharge Lounge? Yes ☐ No ☐

Clinical components of discharge TTAs:

- Currently in hospital pharmacy ☐
- Given to patient ☐ In patient's property ☐
- TTA's explained to patient ☐
- Relevant patient information given e.g. Clexane, warfarin ☐

Wounds: Not applicable ☐

- Redressed before discharge ☐
- Wound drain site checked ☐
- Venflon/central lines removed ☐ needed for ongoing treatment ☐
- Urinary catheter bag emptied ☐ N/A ☐
- Patient identification band removed ☐ - to be removed in Discharge lounge ☐
- Notes/x-rays with patient if transfer to other hospital ☐

Discharge Details

Address (if not home):

Transport arrangements:

- Patient has made own arrangements for transport ☐
- Transport booked ☐ Estimated time …………….

  Booking code …………………………………………

Home arrangements:

- Patient has made own arrangements for discharge ☐

  Patient lives alone ☐ going home to empty house ☐

  House key is with patient ☐ with relative/neighbour ☐

  Key safe ☐ Other……………………………………..

- Arrangements have been made for the availability of:

  Food ☐ Heating ☐ Other home supplies ☐

Patient Property

- Patient packed all own property ☐
- Patient clothing/personal belongings packed ☐
- Personal items packed:
- Glasses ☐ Dentures ☐ Hearing aid ☐ Walking aids ☐
- Soiled clothing in separate, marked bag ☐
- Valuables and money returned to patient ☐
- Property listed (if going to other care setting) ☐
- Patient has walking aid to go with them ☐

Care on day of discharge

- Patient independent and self-caring ☐
- Personal hygiene needs met ☐ Patient dressed ☐
- Patient has eaten breakfast ☐ lunch ☐ supper ☐
- Pressure areas in tact ☐

  Pressure damage recorded ☐

  Pressure area care given ☐ N/A ☐
- Pain control given ☐ (time) N/A ☐
- Patient needs help with mobility ☐

  At risk of falls ☐
- Other care given (state)
- Do Not Attempt Resuscitation form signed & copied for transfer ☐

Follow-up care organised

GP Care:

- Discharge letter with patient ☐
- No follow-up care from GP ☐
- GP Blood tests arranged e.g. INR ☐
- Patient on Home oxygen ☐
- Other treatment arranged with GP ☐ (state)

Community Nursing: N/A ☐

- Referral via Onward Care team ☐ Devon Docs ☐
- Date of 1st visit needed ……………………………
- Transfer letter with patient ☐
- Community prescription complete (Blue Card) ☐
- Blood test/card given to patient ☐
- Supplies given/with patient:

  Dressings ☐ Urinary catheter ☐ Continence ☐

  Enteral feeding equipment ☐

  Other supplies ☐ (state)

Community therapists: N/A ☐

- Referral made ☐
- Transfer letter with patient ☐

Social Services commissioned care: N/A ☐

- Referral made ☐
- Patient aware of details of care package ☐
- Patient transferring to Care Home ☐
- Vulnerable Adult Risk Management plan in place ☐

Checklist completed by (signature of Registered nurse on ward)……………………………………………..

Discharge Lounge staff …………………………………….. Date of actual Discharge ………………………

DISCHARGE ASSESSMENT CRITERIA	Yes	No	Nurses Initials	DISCHARGE ARRANGEMENTS	Yes	No	Nurses
Alert and orientated				Written and oral instructions and relevant contact telephone numbers given			
Observations within patient's normal limits, record any details overleaf.				Venflon removed			
Any pain? If YES - please record actions taken overleaf.				Report explained & copies given by……………………			
Absence of bleeding				TTA's or Rx given explained Record details overleaf.			
Was patient satisfied -/c levels of sedation. If No was Endoscopist informed? Record overleaf.				Dressings given if necessary (P.E.G. patients). Record advice overleaf.			
Flatus				Escort available and understands role			
Do you feel that your privacy was maintained during your stay?				Suitable transport available			
Advice given by Endoscopist, if yes please record overleaf.				Patient discharged at ……………………….hrs. Discharged by ……………			

Day Case (Perioperative Pathway) Discharge Checklist

Appendix 4

Hospital Discharge checklist					
CRITERIA	**Yes**	**No**	**N/A**	**Nurse initials**	**DETAILS**
Observations within patient normal range					
Orientated to time and place					
Passed urine (if applicable)					
Able to mobilise / dress safely Competent on crutches (if required)					
Oral fluids tolerated					
Minimal pain					
Minimal nausea / vomiting / dizziness					
ECG electrodes removed					
Cannula removed					
Wound checked					
Dressing to be removed at home or in a					

GP surgery in ……………………days					
Dressing supplied					
TTA's supplied and explained					Next dose:
Information leaflet for tablets					
Patient copy of GP letter					
Fit certificate					
Outpatient appointment given / posted					
Has carer for 24-hour post op					
Responsible Adult / Escort present Available to transport patient home					
Carer knows who to contact in an emergency					
Post operative instructions given, Explained and understood by Relative/Friend/Carer (Responsible adult)					Relative / Friend / Carer (responsible adult) Signature………………………. Print Name …………………….
Discharged by: ……………………… …………………… Nurses Signature					

……………………………………………………………………..

Date: ………………………………………………………… Print Name: ……………………………………………………….................................

Patient's name: ……………………………………………………………………………………….…Hosp No ……………………..………………..

NHS No …………………………………....