Summary
This policy has been developed to reflect the standards required in relation to the admission, discharge and transfer of patients for all inpatient services. Due to the diversity of in-patient services this is the overarching policy across all of Southern Health NHS Foundation Trust services.

Keywords
Admission, Discharge, Transfer, Patients, In-patients Choice, Complex discharge, capacity, Delayed Transfers of Care, DToC

Target audience
All clinical and ward administration staff.

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December 2019

Approved & Ratified by
Patient Safety Group
Date of meeting:
24 October 2019

Next review date
December 2020 or if national policy requires update

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Equality Impact Assessment (for policies only)
The Equality Impact Assessment has been completed. The assessment document is held centrally and is available by contacting policies@southernhealth.nhs.uk
## Version Control

### Change Record

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<td>20/01/17</td>
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<td>Sarah Olley</td>
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<td>Reviewed whole document and updated as per National Best Practice Guidance</td>
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<td>Sam Chapman</td>
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<td>Updated with information relating to the sending of Electronic Discharge Summaries within 24 hours of Discharge. Sections 4.3, 12.1, 13, renumbered from 14, 19.1, App 2&amp;3. Updated cover page</td>
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<td>10/09/18</td>
<td>Sarah Olley</td>
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<td>Update with Why not home? Why not today 4 questions approach to planning discharge. Policy review –review date reset Feb 2020</td>
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<td>Updated Appendix 5 to reflect changes in DToC reporting Removed Appendix 6 as Tableau has replaced the need for Excel recording of DToC</td>
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### Reviewers/contributors

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Admission, Discharge & Transfer of Patients
(In-Patient settings)

1 Introduction

1.1 This policy document provides overarching quality principles for the Admission, Transfer and Discharge (ADT) of patients to Southern Health NHS Foundation Trust’s (SHFT) in-patient services within all services.

1.2 The admission to an in-patient unit takes place when the patient is severely unwell and at their most vulnerable. It is important that the process for admission, transfer and discharge safeguards and promotes patient safety, is person-centred and ensures that communication between patients and their families is effective and timely. All services should put the patient at the centre of plans involving relevant care and provide information in a format the person can access and understand involving family and carers as appropriate. Permission to share and mental capacity must be referred to in all cases.

1.3 An admission should be planned. Even in urgent situations a degree of planning will occur, however quickly the admission takes place. The assessment prior to admission should be based on clinical practice decisions utilising all appropriate information and include information from the patient whenever possible.

1.4 Admissions to adult mental health wards will always be gate-kept by the Acute Mental Health Team (AMHT) to whom patients should be referred (i.e. they should not be referred ‘for admission’) and alternatives to hospitalisation should be fully considered. Where assessments under the Mental Health Act are made, there is a legal obligation to consider such alternatives and the AMHT should be involved in the process.

1.5 It is recognised that every patient will be admitted when there is a clearly identified need for admission in order to receive clinical in-patient assessment and treatment and SMART treatment objectives set with predicted date of discharge (PDD). Every admission will be lawful in relation to the patient’s needs, wants and wishes and that the admission process takes account of all appropriate legislation e.g. Disability Discrimination Act; Mental Capacity Act; Mental Health Act.

1.6 Transfer of care can occur within the same unit/hospital or within the Division and across Divisions. It is also the process of moving patients to their post-inpatient destinations which covers a multitude of Health and Social Care Locations.

1.7 Timely, safe and appropriate discharge is the result of good care planning from the decision to admit to providing post discharge support. Consideration should be given to alternatives to inpatient admission whenever possible e.g. Hospital at Home services which will help to reduce unnecessary and inappropriate admission; promote early discharge and support recovery.

1.8 The principle concern of SHFT must be to maintain patient wellbeing via the use of a robust and effective discharge planning process commenced at, prior to or near the point of patient admission. All discharge plans will have involved as necessary, detailed assessment from inpatient and community services, Adult Social Services and the voluntary care sector. Patient’s views should be taken into account as far as is reasonably possible whereas the patient’s best interest should always be upheld. The view of carers, relatives, advocates and significant others should also be taken into account whenever appropriate and possible.
1.9 For patients being discharged from mental health inpatient services, there are specific follow up requirements to consider and book prior to the patient being discharged. See Appendix

1.10 This document is written for all SHFT services to enable admission, transfer and discharge standards to be consistently applied.

1.11 The policy is based upon national good practice principles, guidance and CQC standards.

1.12 The terms ‘patient’ and ‘service user’ are used interchangeably to relate to anyone accessing physical and/or mental health services or learning disability in-patient settings. Whilst this policy outlines the role that Trust clinical staff have in supporting the admission, discharge and transfer of service users, it also recognises that this is often provided in partnership with primary care, social care and third sector services. The overarching principles will apply to all services; the implementation of this policy will be in close cooperation with primary care, secondary care, Ambulance service, the Police and all SHFT services in line with established practice as per the procedures defined within this policy.

2 Scope

2.1 This policy is inclusive of all in-patient services within SHFT’s Adult Mental Health, Older Peoples Mental Health, Learning Disability, Specialised Mental Health Services and Community Hospitals within SHFT.

2.2 It is expected that all relevant staff involved in the admission, transfer and discharge of patients within each service will be affected by, and will need to comply with this policy.

2.3 SHFT will expect other services that utilise and support in-patient settings, to apply the principles of this policy as a minimum standard within their services, thus ensuring the provisions of a robust patient admission, discharge and transfer process.

2.4 Patient records may include OpenRiO, SW Electronic Records (CAMIS) and/or paper records.

3 Definitions

3.1 Pre-Admission: Is the assessment process used to identify the need for admission to an in-patient setting.

3.2 Admission: Admission is the act of transferring care from community or another environment to a Trust in-patient service.

Planned:

i. Where the admission has been negotiated with the community team, general practitioner or carer but the process started the day or days previous to the admission.

ii. When the admission is part of a CPA or MySafety&Crisis Plan.

iii. Where the patient had been receiving Home Treatment or Intensive Home Support immediately prior to requiring admission.

3.3 Emergency: Where the admission process was initiated and carried through on the same day from any service (except same day referrals from other inpatient units/hospitals).

3.4 Transfer: Transfer is defined as the movement of a patient and their care and treatment needs from one in-patient unit to another (of any in-patient care setting), or a community based service for continuation of care. This may be because the needs of the patient are best met at another in-patient or care setting.
3.5 Discharge: Discharge is the act of concluding an episode of care within an in-patient setting. This may include handing over responsibility of the care to another service or care provider or discharge to a person’s place of choice: These include:

- Community team;
- Acute Mental Health Team
- Hospital at Home;
- Primary care;
- Nursing Home;
- Care Provider;
- Another hospital service e.g. acute hospital care.
- Patients own home

3.6 Follow Up: This may be for the patient to arrange to see their own GP, attend a clinic or in the case of patients discharged from mental health and learning disability care settings, an appointment will be made to be seen within a maximum of 48 hours following discharge. See Appendix 3 for full guidance.

3.7 Delayed Transfer of Care: The national definition states that delayed transfer of care occurs when a patient is ready to depart and is delayed. A patient is ready for transfer/discharge when:

a) A clinical decision has been made that the patient is ready for transfer/discharge
AND
b) A multi-disciplinary team decision has been made that patient is ready for transfer/discharge
AND
c) The patient is safe to discharge/transfer.

Please refer to the Delayed Transfers of Care Policy for further guidance on process, definitions and measuring guidelines.

4 Duties/Responsibilities

4.1 The Chief Executive has ultimate responsibility for ensuring that safe and effective patient discharges occur from SHFT in-patient facilities.

4.2 Senior nursing and managerial staff must ensure that all staff involved in the admission, discharge and transferring of patients are aware and adhere to this policy. They are responsible for ensuring that any deviation or errors arising are reported, dealt with in a correct manner and that risks are identified and acted upon.

4.3 All Trust clinical and non-clinical staff involved in a patient admission, discharge and transfer process, are responsible for applying the principles contained in this policy. The role of all clinicians/team members will be clearly defined within the admission, discharge and/or transfer process DOH (2002) and the 2015/16 NHS Standard Contract Service Condition 11.6.

4.4 All localities and services are expected to produce an integrated care pathway for admission through to discharge pertinent to their area. Each service is expected to utilise procedures and other tools to help support the implementation of the policy and ensure that patients and carers are able to understand and engage in the pathway.

4.5 All members of the multi-disciplinary team should be aware of individual patients’ needs related to admission, discharge and transfer and undertaking their responsibilities to ensure
safe admission, discharge and transfer in a timely and appropriate manner according to patient need.

4.6 The multi-disciplinary team should ensure that all care and planned support is scheduled and confirmed to commence with specified dates and times. This is to promote seamless care including transfer, discharge and follow up of the patient (DH 2010).

4.7 In a situation when a patient refuses discharge from an inpatient setting either on or prior to the confirmed day of discharge, the Modern Matron/Area Matron or Area Manager has the responsibility to follow their local choice policy which should be read in conjunction with this policy to ensure discharge occurs. This could involve implementation of a discharge plan including section 117 arrangements (MHA 1983). In any event the clinical team should seek appropriate advice from senior managers including Divisional Directors who will be able to access other support including legal advice if appropriate.

4.8 Clinical leads/Managers/Supervisors will:

- Ensure that sufficient priority is given to the successful implementation of the policy in in-patient wards.
- Ensure that all staff attend appropriate training;
- Monitor compliance with current standards by all clinical staff;
- Ensure the availability, functioning and maintenance of all appropriate materials plus equipment utilised in the assessment, discharge and transfer of patients also ensuring that staff have appropriate training to use them;
- Ensure clinical documentation and records used are in line with Trust policy including where this interfaces with other services e.g. Commissioners, Ministry of Justice;
- Ensure that any change in practice recommendations are notified to all clinical staff;
- Ensure all staff participate in audit processes to help identify good practice and identify deficits in order to support improvement and learning.
- Ensure that processes for daily assessment of risk and need for continuing admission, identification of delayed transfer of care (DTOC) and provision are in functioning effectively.
- Ensure that social care leads are notified as soon as social care needs are identified and that DTOCs are agreed.

4.9 Clinicians Staff responsibilities:

- Registered staff will be accountable as per their Professional Body;
- Maintain clinical competency as per competency framework (SHFT 2011);
- Attend relevant training provided by SHFT and put it into practice;
- Bring to the attention of appropriate senior staff any deficiencies in knowledge, ability or resources that may mediate against safe admission, discharge and transfer of patients;
- Participate in audit programmes related to measuring the quality and safety of admission, discharge and transfer of patients. This would include addressing any improvements required and celebration of good practice;
- Ensuring they are familiar with relevant policies and procedures in their area of practice. Specific attention should be given to ensuring staff competence in the care and discharge planning for patients with co-morbidity and that risk assessment processes are consistently applied and recorded across the care pathway.

5 Minimum requirements for all clinical staff

5.1 All patients must have an appropriate holistic assessment of their physical and mental health needs. This assessment must be appropriately documented as per Trust record keeping guidance. Additional content and the procedure for this will vary depending on the person’s mental or physical illness, medication, age, initial findings and the involvement of
primary care. Issues of sensitivity, gender, ethnicity and preference should also be considered. Clinical staff must follow the Physical Assessment & Monitoring Policy.

5.2 Relevant patient documentation will be obtained from the referring service (for example GP, Acute or Community Team, Consultant or Hospital Clinician, Ambulance Crew) including current problems and risks, past medical history and medication history.

5.3 Clinical staff should engage the services and skills of associated staff relative to admission, discharge and transfer of patients e.g. Pathway Coordinators, Transfer Facilitator, Care Navigators, MHA Administrators, and Acute Care Support Team/Bed Managers.

6 Main policy content

6.1 Pre-Admission: Prior to admission the following best practice principles will be adhered to:

6.2 The decision for admission will be based upon a comprehensive assessment of risks and needs.

6.3 The referring clinician/team member (for example GP, Consultant or Hospital Clinician, Ambulance Crew) will have completed a comprehensive assessment of needs and risks. This assessment will be appropriate and specific to the needs of the patient.

6.4 The decision to admit will be made when all other options for assessment and treatment have been considered and deemed inappropriate.

6.5 In the case of patients admission for step down or rehab Physical health services referrals will be gate-kept by the Single Point of Referral (SPoR) where referrals are triaged for admission based on rehab goals.

6.6 In the case of patients accessing mental health and learning disability services, referrals will be gate-kept by the Acute Mental Health Team (AMHT) and alternatives to hospitalisation should be fully considered. Where assessments under the Mental Health Act are made, there is a legal obligation to consider such alternatives and the AMHT should be involved in the process. Admission will be considered when lesser restrictive options are deemed inappropriate due to risk e.g. Hospital at Home.

6.7 In order for the patient to maintain contact with his/her friends and family as well as the local community and to ensure effective working relationships with community agencies; the admission should be arranged to the unit designated to provide for the area or, if there is no such designation, to the nearest clinically appropriate in-patient unit. In the event of this not being possible an explanation must be given to the patient and relatives as to why this could not be facilitated. Clinical need and bed availability will be an important factor.

6.8 All consideration should be given to the need to repatriate patients who have not been able to be admitted to their nearest hospital. Repatriation to the nearest appropriate in-patient unit should be arranged as soon as is possible as long as this is in the best interests of the patient. The decision about repatriation is a key issue which should be informed by what is important for the patient and is clinically appropriate. When it is the best interest of the patient and clinically appropriate, repatriation should occur as soon as possible.

6.9 If the service user is admitted under a section of the Mental Health Act all the legal requirements of detaining a person under the Act will have been met so that the detention is lawful. The Trust has set itself a standard of completing the process of identifying an inpatient bed within one hour in these circumstances. If this is not possible, a bed will be sought elsewhere to ensure that delays involving risks to self and others are avoided as far as is possible. Where an informal admission is required, a similar standard has been set of six hours.
6.10 The admission is person centred and the decision includes consultation with carers/relatives as appropriate.

6.11 The decision to admit to an in-patient unit will form part of an individualised care plan which will include the objectives and likely care outcomes of the admission and the pathway out of hospital/in-patient care. This will be shared with the carer and nearest relative, where appropriate, prior to admission.

6.12 The reason for admission, expected outcomes and likely length of stay will be discussed with the patient and carer.

6.13 The rationale for the admission will be made clear to the patient and their carer. An explanation of the proposed care pathway will be communicated to the patient and carer including the likely length of stay, prior to admission.

6.14 The reason for admission, expected outcomes and likely length of stay (proposed discharge date) will be discussed with the in-patient unit.

6.15 The information to be communicated should be delivered in a clear and concise manner wherever possible using a recognised and agreed communication tool such as “Situations”, “Background”, “Assessment”, “Recommendation” and “Decision” (SBARD). The SBARD tool is a structured method for communicating important information that requires prompt attention and action. Its purpose is to improve the effectiveness of verbal communication at important events such as at patient admission. It encourages prior preparation for communication and should help to reduce the likelihood of misleading or missed communication.

6.16 A full record of the assessment will be provided on electronic and/or paper records in accordance with Trust record keeping policies. This will include RiO and any secondary records, which will be made available to the admitting in-patient unit prior to the admission.

6.17 Admission information should include all relevant clinical information pertinent to the needs of the patient e.g. Personal History, Past History, Mental capacity, Capacity assessment if required, Risks, Diagnosis, Infection Risks, Physical health Needs, Mobility and Sensory Impairments, Safeguarding Concerns, Cultural and Religious needs.

6.18 The referring clinician/team member, care navigator or Acute Care Support Team coordinating the admission will contact the ward as soon as admission is identified and ensure that there is an appropriate bed available for the patient. They will communicate to the patient which in-patient unit they are to be admitted to and the expected time of their arrival for admission.

6.19 The bed will be needs-based and gender appropriate for the service user as per the equality and diversity policy.

6.20 The referring clinician/team member/care navigator/ACST will ensure that in relation to the risks, resources at the patient’s disposal, and needs of the service user/carer, appropriate transport arrangements are made with the patient for them to arrive at the in-patient unit in a safe and timely manner.

6.21 This will be arranged as soon as possible after confirming the need for admission and availability of a suitable bed. Other relevant care agencies will be informed of the admission.

6.22 The referring clinician/team member will ensure that the GP and other care services provided for the patient are made aware of the admission and likely length of stay. This could be deferred to the ward staff where they may be best placed to do so, however the
responsibility for doing this needs to be clearly communicated by the referring clinician/team member.

6.23 The referring clinician/team member will request that the service user brings all medicines currently prescribed into hospital with them.

6.24 Infection, Prevention & Control measures: Patients with an infection can expect relevant information about it to be shared between providers when they are admitted, transferred to, or discharged from a hospital to ensure seamless care. The risk assessment undertaken on admission will include risks associated with health care acquired infections where appropriate.

6.25 The IP&C procedure for documenting and sharing information about infections and their treatment will be followed. This includes evidence of information sharing to manage and support patients with an infection on an ongoing basis (including transfer and isolation arrangements for them) during admission, transfer and discharge.

7 Admission, including Emergency Admission: Within 2 hours of admission the following good practice should be adhered to.

7.1 It is the admitting nurse’s responsibility to ensure that the patient is met and greeted and orientated appropriately to the ward on arrival. The time and date of arrival will be recorded in the patient care record.

7.2 An initial risk assessment/mental capacity, risk management plan and care plan will be undertaken immediately on arrival appropriate to the patient needs by a registered nurse. This will take into account the immediate and potential risks relating to the safety of that patient within the clinical setting e.g. pain management, risk of self-harm, falling, patient going missing from the ward etc. in order to establish appropriate intervention and level of observation. Medication brought into hospital including any drugs purchased over the counter will be recorded (quantitatively); retained by the staff and kept securely in the ward for appropriate use in accordance with the Patient's Own Drugs (PODs) procedures. Permission will be obtained from the patient/relative/carer to record details of medicines brought in. Any controlled drugs MUST be entered in the register in line with Medicines Control Administration Prescribing Policy (MCAPP).

7.3 Medicines Reconciliation: Patients should have their medicines reconciled within 24 hours of admission. A minimum of two sources of information should be used to obtain a list of the medicines being taken by the patient prior to admission (single sources are rarely complete and accurate). The sources of information used should be recorded in the medicines reconciliation form (See Medicines Reconciliation Policy) and within the case notes/electronic record. The admitting nurse which may be the Named Nurse/Key worker will ensure that medicines reconciliation occurs in line with trust policies.

7.4 Hospital policy is to have smoke-free wards. The ward staff will assist patients to access smoking cessation services and information whilst an in-patient.

7.5 The patient will be provided with a ward information leaflet and a Welcome Pack and their personal information/contact details checked and accurately recorded.

7.6 Alerts including drugs, allergies, foodstuff sensitivities and reactions will be recorded in line with Trust Policy on record keeping, if not previously noted. This information will also be recorded on the prescription chart and on the electronic record. The person entering this information will sign the front of the prescription chart. Important allergies and the expected response(s) e.g. anaphylaxis will also be recorded on the prescription chart.
7.7 Resuscitation status will be confirmed on the inpatient admissions record as will any advance directive or lasting power of attorney. Any subsequent change to any of these must be recorded in the patient’s care records.

7.8 The patient will be asked to sign an information sharing consent pro forma and will be provided with an appropriate information sharing leaflet. If the service user declines to grant consent, the reasons will be recorded in records and on the pro forma.

7.9 Information in line with the local choice policy should be completed and given to the patient or - if they have limited or no capacity - their principle carer or supporting family member within 24 hours of admission.

7.10 With the patient’s agreement, the ward will contact the next of kin to advise them of the admission if they are not already aware. Emergency contact information will be confirmed and recorded in the appropriate healthcare records.

7.11 The patient’s GP will be informed of the admission and request from the GP details of the current prescription and relevant medical history. This information should be faxed back to the admitting in-patient unit.

7.12 The following will be clearly recorded on the patient record:

- The reasons for the admission;
- The patient’s understanding of the reasons for admission;
- The goals/objectives for admission from both the professional and service user perspective
- Predicted Date of Discharge (PDD)
- Information about the admission will be recorded in the admission book/electronic patient administration system and the patient’s notes.

7.13 If the service user is detained under the Mental Health Act, the relevant paperwork will be completed and the Mental Health Act Administrator will be informed and the appropriate information given to the patient and the admitting nurse will undertake receipt and scrutiny procedures.

7.14 For people detained on a section of the Mental Health Act (1983), the policies relating to rights, information and Independent Mental Health Advocacy (IMHA) provision in accordance with additional policy and protocols related to admitting any patient subject to conditions of the Mental Health Act (1983).

7.15 The patient must be informed about their care and the treatment they will receive. This should be documented within records and include an assessment of their capacity to consent to treatment, outcomes relating to their consent should be fully documented.

8 Admission, including Emergency Admission: Within 6 hours of admission the following will be undertaken.

8.1 Generally a physical examination is expected soon after the admission. However there may be exceptions e.g. admission occurs at the weekend to meet patient/carer need when there is no medical cover on the ward. In this case the physical examination will be undertaken prior to the admission. All physical examinations occurring outside of the expected timescale will be clearly documented and in any event the Physical Assessment & Monitoring policy should be implemented.

8.2 Patients’ property will be checked and recorded on arrival using the ward property form; valuables should also be recorded and, with the patient’s agreement, taken into
safekeeping. If patients refuse safe keeping of valuables this should be recorded in the health care records and the patient’s signature obtained if possible.

8.3 An initial care plan will be recorded which details the next steps of care including any immediate assessment or tests to be undertaken as part of the admission. The initial care plan should include orientation to the clinical environment; meeting immediate care needs e.g. ‘observation care plan’ detailing observation level, rationale for observation level and process for review; immediate risk management.

8.4 A Named Nurse/Key Worker will be allocated to the patient. It is the Named Nurse/Key Worker responsibility to complete the initial assessment which should include:

8.5 Appropriate support will be provided to carers if required, e.g. help with arranging transport to get home, explanation of patient’s needs and visiting times.

8.6 This plan should include any further assessment or investigations, plans for therapy and treatment. Ultimately this plan should be recorded as a multidisciplinary plan and in the case of Mental Health & Learning Disability Patients, recorded using the Care Programme Approach (CPA).

8.7 All previous historical clinical records of the patient will be requested and obtained from the Clinical/Medical Records Department.

9 Admission, including Emergency Admission: Within 24 to 48 hours of admission the following processes will be undertaken.

9.1 If not already agreed, Predicted Date of Discharge (PDD) will be set by the admitting/Named Nurse/Key Worker, in collaboration with the admitting practitioner/MDT and communicated to patient and carer. An estimated date of discharge is based on the expected time required for investigations, assessments and interventions to be completed, the care pathway and the time taken for the patient to be clinically stable and fit for discharge.

9.2 A clinical Management plan must be developed for every patient within 24 hours of admission. This should set out the goals for the patient and include:

- Identification of the problem(s);
- Goals for treatment activities to achieve outcomes;
- Methods for achieving these goals;
- Estimated time to meet the goals/EDD/PDD.

9.3 As part of the above clinical management plan (9.2), the Named Nurse will discuss with the patient the Why not Home? Why not today? approach to planning their discharge and confirm to the patient the following within now and daily during their stay.

- Why am I here?
- What is going to happen today?
- What needs to happen for me to get home?
- When is this going to happen?

9.4 Within 24 hours the Named Nurse should document whether the patient has simple or complex discharge and transfer planning needs, involving the patient and their Carers’ in this decision (as appropriate). Complex discharge will likely involves support from other health and social care services and ward staff should refer to their local choice policy.

9.5 The decision regarding discharge should involve the patient, relatives and carers (as appropriate) and should be made following an assessment at pre-admission or on
admission. It should also take account multiple pathology/multiple needs. All those involved in the patient’s care should be aware of the estimated date of discharge. Records should state clearly who has authority to change the estimated predicted date of discharge after consultation with the senior doctor.

9.6 In the case of mental health and learning disability patients, the date for the initial Care Programming Approach (CPA) review will be established (which may involve face-to-face or teleconference contact). Where the patient already has an identified Care Co-ordinator in the community, communication will be maintained between the Care Co-ordinator and the Named Nurse/Key Worker regarding progress and steps towards discharge, including attendance at relevant formulation or review meetings as per the CPA Policy.

9.7 The initial care plan, drawn up within the first 6 hours, will be reviewed to ensure it meets the patient's needs and is in accordance with the patient's condition pathway (e.g. organic or psychosis). It will be reviewed again after 72 hours. If the patient is detained under the Mental Health Act, they must be informed about their care and the treatment they will receive. This should be documented within the care record and include an assessment of their capacity to consent to treatment, and outcomes relating to their consent should also be fully documented.

10 Transfer

10.1 Transfer of care can occur within the same unit/hospital or within the Division and across Divisions. It is important to consider the patient journey in full and only discharge a patient from the care of the Trust. If the patient is moving between units/wards the correct process to follow is Patient Transfer NOT discharge.

10.2 Prior and during the process of transfer of care, the following best practice principles will be adhered to. This includes transfer between wards within the same unit e.g. Intensive care ward to Acute ward or transfer between wards and hospital sites. The following ‘Transfer Principles’ will be applied:

10.3 A decision to transfer a patient to another ward or community service will be based on assessment of risk and needs. It will be in the best interest of the safety and clinical management of the patient. It may also be to re-patriate a patient to a more suitable ward or location.

10.4 The ward multidisciplinary team will have conducted a full and thorough assessment of risk and health which will be specific to the needs of the patient and will have identified that their clinical care needs a best meet in a different inpatient setting.

10.5 Where acuity and risk has increased in a patient on a mental health ward (or prior to admission), a Psychiatric Intensive Care Unit (PICU) screen may need to be performed and can be requested from either of the Trust PICUs.

10.6 A formal transfer request will be made to the receiving in-patient unit.

10.7 The reason for the transfer, expected outcomes, likely length of stay and discharge plans will be fully discussed with the patient and their carer and recorded in the patient record.

10.8 Rationale and an explanation of the care pathway through to discharge will be made clear with the patient and if possible, an opportunity to view the environment and meet the staff will be arranged.

10.9 Transfer of care to another ward or community service will be agreed and confirmed as appropriate by the Responsible Clinicians of both the current and receiving ward.
10.10 There will be full clinical discussion within the multidisciplinary teams and between both inpatient consultants or appropriate clinicians regarding the reason for transfer, the current treatment and clinical management, all significant risks, how these risks will be managed within the transfer process and most appropriate timing of the transfer of care to take place.

10.11 Coordination of the transfer of care process will be delivered through effective leadership and handover responsibilities at ward level and no transfer will take place until all transfer arrangements are fully agreed by both the discharging ward and the receiving wards or community service.

10.12 The ward staff are responsible and accountable for communicating all necessary information to the receiving transfer ward and ensuring that the care transfer process is safe, effective, timely and maintains continuity of care for the patient.

10.13 All clinical information will be fully handed over to the receiving ward and is accessible on RiO, prior to the transfer; this will include all care records, comprehensive assessment, risk history and assessment, clinical management plan, current care plan and current prescribing plan. The name and position of the receiving nurse/clinician must be clearly documented in the patient's electronic/paper record and on the discharge checklist. The patient record should state clearly the information which has been given to receiving clinicians/carers. Any communication should be described and noted in the patient record including where a specific communication aid such as SBARD, has been used.

10.14 If RiO is not used then the information will be written and sent to the receiving unit using agreed transfer documentation. In addition the receiving ward must be informed prior to the transfer of:

- Any known infection risks such as Clostridium Difficile, MRSA;
- Unexplained diarrhoea;
- Significant physical health concerns;
- Significant mental health concerns;
- Any significant mobility and sensory impairment needs;
- Any significant safeguarding concerns;
- Risk assessment and management plans including safety & crisis plans.

This will enable the receiving ward or community service to fully plan, meet and accommodate these needs safely. Infection Prevention and Control risks should be ascertained prior to or on admission utilising a risk assessment within patient admission documentation e.g. Physical health assessment within RiO; Admissions checklist. Any risk of infection/known infection should be clearly recorded in records (electronic and paper) and appropriate notice using stickers and alerts. Risk assessment and management plans including safety & crisis plans will be within the risk summary section of RiO and should have been recently updated.

10.15 The nurse in charge of the ward at the agreed date and time of the transfer is responsible for leading the transfer process. They will ensure that the receiving ward or community service has all necessary medicines and medical equipment that may be required to meet specific care plan needs to ensure continuity of care and safety through the transfer process. Should the patient’s prescribed medication not be available immediately at the receiving ward it will be sent with the patient and their escort.

10.16 The procedure within the Medication Control and Prescribing Policy (MCAPP) section 2.4 for supporting patients with medicines on transfer should be followed. Section 14 within this policy related to medicines will be undertaken.
10.17 Prior to transfer to another ward or community service a detailed risk assessment will be carried out by a designated nurse to determine the mode of transport and level of escort required (including chaperone arrangements if required).

10.18 A comprehensive transfer summary will be sent with the patient and escorting nurse to the receiving ward and hospital. Each service will utilise a transfer form as part of their own SOP, guidelines or procedure.

10.19 Transfer of a patient detained under the Mental Health Act will follow the procedures related to the transfer and admission of a patient subject to the MHA.

10.20 Patients will be admitted to a ward in their local area and if not, repatriation to their local area ward should be arranged as soon as possible. All transfer decisions are made with the patient’s best interest and continuity of care is paramount.

10.21 If a patient has been admitted to a ward outside of their local area due to unavailability of a local bed, the aim will be to transfer the patient to their local area within 7 days from admission where possible and appropriate to clinical need and speciality of clinical service required.

10.22 The patient and their carer will be kept fully informed as to when they will be able to be transferred to their area ward.

10.23 The Named Nurse/Key Worker will liaise daily with the area ward to review bed availability for transfer back and inform the patient and carer with daily updates.

10.24 The area community team who are responsible for the patient will work collaboratively with the outlying inpatient team to maintain clinical coordination of the patient’s care and ensure continuity of care on transfer back to them.

10.25 The Care Coordinator from the local area community team will contact the out of area ward at the earliest opportunity to discuss the clinical management plan of patient placed out of area and will liaise with the in-patient consultant, multidisciplinary team and patient regularly.

10.26 Transfer back to the patient’s area ward will be led by the outlying ward who will make arrangements for the transport based on the risk assessment. (Authorisation for payment for transport costs will be requested of the home area ward).

11 During an inpatient stay

11.1 During the inpatient stay SHFT will do everything possible to assist in the patient recovery and reablement ensuring that the patient recovers as quickly as possible.

11.2 Patients will be reviewed at least once a week by way of a full ward round.

11.3 Patients will also receive a review daily as part of the daily ward processes, e.g. Patient Status at a Glance (PSAG) board rounds and Bed Flow meetings to ensure that the next stage of their pathway has been organised and is progressing. This will include updating the Patient Status at a Glance (PSAG) boards/Bed management spreadsheets and updating the Predicted Date of Discharge (PDD) as appropriate.

11.4 All patients will receive a Predicted date of discharge (PDD) which will be communicated to them daily along with the following to ensure that they are aware of the progress that they are making and are supported in planning their discharge during their admission.

- Why am I here?
What is going to happen today?
What needs to happen for me to get home?
When is this going to happen?

11.5 A plan for their end discharge destination will be made as soon as possible if not on admission.

11.6 Patients experiencing delays of 7 or more days will be reviewed once a week at a Stranded Patient Review to ensure that the patient has a plan and to help escalate any issues both internal and external to SHFT.

11.7 Patients that have been an inpatient for longer than 21 days will be referred to a Hard to Place Patients panel which will meet with local health and social care organisations to help expedite discharge.

12 Discharge

12.1 The Department of Health (DoH) Document “Discharge from Hospital: Pathway Process & Practice” (2003) confirmed that discharge is a process and not an isolated event that happens at the end of a patient’s stay.

The NHS Standard Contract 2016/17 mandates the use of AoMRC (Association of Medical Royal Colleges) headings for sending eDischarge summaries from 1st December 2016.

The following section details the underpinning principles and organisational standards that apply to clinical services to ensure that this DoH expectation is achieved. Discharge from Hospital should be a managed process with a designated person in the role of discharge coordinator (DOH 2002; DH 2010). There are 10 key steps outlined by the document (DH 2010):

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in the decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Discuss with the patient or carer an expected likely length of admission or date of discharge or transfer within 24–48 hours of admission.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence. This includes seeking permission from the patient or their family to assess needs for discharge. Please refer to local choice policy procedures.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer. The discharge checklist will be contained within the local procedure or SOP.
10. Make decisions to discharge and transfer patients each day.

12.2 Planning for discharge will commence at the point of admission (or earlier where admissions are planned) (DOH 2002; DOH 2003; DH 2010).

12.3 On admission the Named Nurse/Key Worker will discuss the reasons and the goals for the admission with the patient and where appropriate with their carers’. As part of this process the Named Nurse/Key Worker will outline to the patient the anticipated length of stay.
12.4 Planning for discharge will be detailed in a discharge care plan which will be agreed with the patient and reviewed and updated on a regular basis and at a minimum at each multi-professional ward meeting including CPA within Mental Health and Learning Disability settings.

12.5 Comprehensive, ongoing assessment and review will inform the discharge process and discharge destination.

12.6 During multi-disciplinary meetings which could include PSAG ward rounds progress against the goals for admission will be reviewed and revised as appropriate in agreement with the patient. If not identified earlier the estimated discharge date will be agreed with the patient and clearly recorded in the patient care record.

12.7 It is essential that social care needs are identified as early in the admission as possible or preferably prior to admission occurring, and a request for assessment made to the social care lead, e.g. by issuing an Assessment Notice which can also alert management, family and community agencies and clearly define the timing and reasons for the request.

12.8 The relevant Division discharge planning guidance should be used to ensure that all relevant issues are considered at the initial and subsequent multidisciplinary case review meetings e.g. is a continuing health care assessment indicated? SMART (Specific, Measureable, Agreed, Realistic & Timed) targets for discharge planning should be set and updated daily or at least 3 times weekly.

12.9 Ongoing review of the discharge care plans will take place weekly as a minimum. The estimated discharge date and expected destination will be reviewed and amended as required by the team together with the patient. Care plans will be signed by and copied to the patient/carer as he/she wishes.

12.10 All options for discharge will be discussed with the patient and/or their representative(s) as early in the admission process as possible and daily as part of the Why not home?, Why not today? conversation.

12.11 Referrals to Adult Services if a financial assessment is required will take place in a timely manner as soon as the need is indicated. This will be recorded in the care plan.

12.12 Where it is expected that a move to a care home or an individualised care package will be required, and the discharge cannot be arranged until the funding source has been identified and agreed, the process to do this will begin as soon as the need is indicated. This can be prior to the discharge meeting. The service will liaise as required with Adult/Social Services and the relevant Primary Care Service and Commissioner.

12.13 Ward Managers or other Senior Nurses will monitor the time it takes for clinical staff to complete assessments and ensure this function receives prompt attention.

12.14 A discharge multidisciplinary case review meeting will be arranged at a time as close as possible to the point of the patient being expected to be ready to leave hospital but should not delay discharge. The date of this discharge CPA/multi-disciplinary case meeting will be recorded on the patient care record.

12.15 The Named Nurse/Key Worker will ensure outcomes are communicated to the team and the patient to ensure timely follow-up. In some instances, the initial meeting will fulfil this function e.g. short admission and the patient will be deemed to be ready for discharge at a ward round.

12.16 The patient will be identified as ready for discharge when:
1. The patient is deemed medically fit and ready for discharge by the multi-disciplinary team, and
2. Management of their psychiatric condition and risks to self or others can occur in the community, and
3. Support and resources are identified and available within an alternative setting to meet their care needs effectively.
4. A discharge checklist will be completed for every patient who is discharged in any circumstances. The discharge checklist will be included within each service guideline, protocol, SOP or procedure.

12.17 The outcomes of this discharge/multidisciplinary case review meeting will be discussed and agreed with the patient and where appropriate their carer/representative and clearly recorded in the discharge care plan of the patient care record. Correspondence should be issued to the patient detailing what is being proposed as part of transfer of care arrangements as per local choice policies.

12.18 The expectation that discharge to a residential placement if required will take place within 5 days (previously 4 weeks) of the ready-for-discharge date will be made clear at the discharge multidisciplinary case review meeting.

12.19 Wherever possible, the aim will be for the patient will be home first, to be enabled to return to their own home or usual care setting.

12.20 Patients and/or their relative/carer/other representative (who may be an Independent Mental Capacity Advocate) will be involved with and should if possible agree with the discharge destination and future intervention decision(s).

12.21 Where patients are unable to participate in the process, decisions will be made in the best interests of the individual, as defined within the Mental Capacity Act 2005. The opinion of representatives will be sought, ensuring, where possible, their interests and wishes do not conflict with those of the patient.

12.22 All discussions with the patient and/or their representative(s) will be recorded in the patient care record in line with record keeping policy.

12.23 As soon as a decision to discharge is agreed the multidisciplinary team will ensure that adequate preparation for discharge is made.

12.24 The care arrangements following discharge will be clearly identified and recorded on the discharge care plan to ensure that all patients leaving hospital will either return home with any necessary support in place or have other appropriate care arranged.

12.25 The multi-professional team will ensure that patient/carers/representatives receive appropriate advice and education relating to all aspects of their ongoing care needs, e.g. medication, compliance aids, moving and handling, correct use of equipment, physical health needs. Assessment of concordance with medication will take place, and will be recorded in their discharge plan.

12.26 The Named Nurse/Key Worker will liaise with other professionals involved to ensure the availability of and supervision arrangements for all necessary equipment, dietary supplements etc. where required.

12.27 The Named Nurse/Key Worker working closely with other professionals will advise community services colleagues in writing and verbally if necessary, of the discharge and follow up care required.
12.28 All patients will have appropriate arrangements for follow up after discharge. This may be for them to arrange to see their own GP, attend a clinic or in the case of patients discharged from mental health and learning disability care settings, an appointment will be made to be seen within 48 hours following discharge. If community services have been involved in the discharge planning they will be aware of the current risk and treatment plans and are therefore best placed to complete the follow up. If a Care Coordinator has not been allocated on discharge, the recommendation is that the inpatient team complete the follow up. Best practice recommends that the follow up appointment is booked with the patient prior to discharge.

12.29 Where discharge is delayed due to the service user being unwell, the identified professional will inform the patients’ relatives and any other relevant persons/agencies involved. The DTOC should be closed on Rio.

12.30 If a patient chooses to self-discharge ideally they will talk to the nurse in charge and medic responsible for their care. The medic in charge must be made aware and the incident recorded in records and via incident reporting. Immediate plans for medication and safe follow up must be made as soon as possible.

12.31 In the event that the patient/representative(s) decline to accept the care arrangements proposed, staff will ensure that the service user fully understands the implications of that decision and the acceptance of responsibility and is competent to do so. Staff will document the content of conversations fully within the patient care record.

12.32 All patients will receive information about risks of infection where relevant. This will be included within the discharge checklist. The clinician discharging the patient must be assured that the patient and carers (where appropriate) understand the care process associated with any infection, including the prevention of infection, risk factors, how to gain support and steps to take to prevent the risk of spread of infection. Advice should also include how to use medicines (e.g. anti-microbial medicines) associated with infection prevention and control and the safe use of any medical device.

12.33 All clinical information will be fully handed over to the receiving ward/clinician and is accessible on RIO, prior to the transfer; this will include all care records, comprehensive assessment, risk history and assessment, clinical management plan, current care plan and current prescribing plan. The name and position of the receiving nurse/clinician must be clearly documented in the patient’s electronic/paper record and on the discharge checklist. The patient record should state clearly the information which has been given to receiving clinicians/carers. Any communication should be described and noted in the patient record including where a specific communication aid such as SBARD, has been used.

12.34 Where either the patient or their families are either being challenging or not engaging fully in discussions around transfer of care planning staff should refer to the detail of their local choice. These policies discuss in detail the issue of patient choice and provides details of the escalation process which includes making senior operational staff aware of the situation as well as SHFT’s legal team.

12.35 If a patient is currently clinical stable and Medical Fit for Discharge (MFFD) and safe to transfer and there is a delay in their discharge, the patient should be identified recorded on local system as 'DTOC delayed' and the process for agreeing this with the relevant social care lead followed - see Error! Reference source not found.

13 Discharge Correspondence

13.1 All SHFT in patient units are required to send electronic discharge summaries to GP Practices within 24 hours of discharge
14 Medicines

14.1 Patients should have their medicines reviewed and reconciled prior to completing the immediate discharge prescription/letter. This includes any withheld during their stay.

14.2 The review and reconciliation should use the information recorded on the prescription chart and on the medicines reconciliation form completed on admission. Further information can be obtained from the case notes/electronic record. The doctor will write up the prescription for medication required on discharge on an approved Trust prescription and sign all relevant documentation.

14.3 Discharge medicines supporting treatment will be prescribed for 14 days. Short term treatment should be indicated by writing “X’ days only and then stop”. Patients for whom there is a risk of self-harm identified should be written up for whatever quantity of medicines is considered appropriate by the prescriber and stated “x days only”. Any risk should be assessed and written in the patient care record. The Medication Control and Prescribing policy (MCAPP) section 2.4 should be followed when making arrangements for patients to be discharged.

14.4 The discharge medicine pro forma will record all medicines being taken at the time of discharge with their dosage and frequency. Non-specific directions e.g. od (daily) or PRN must not be used. If patient’s have sufficient supply of their own medicines (a minimum of 14 days) the quantity should be endorsed by writing “POD” (patient’s own drugs). This is usually done by pharmacy staff e.g. medicines management technician. This pro forma is then the formal record of their medicines at discharge.

14.5 The discharge address will be confirmed and all professionals involved in ongoing care informed of the estimated discharge date.

14.6 Discharge medication (TTOs) will be ordered and checked. A copy of the medication summary will be faxed to the current GP. In the discharge of patients with Mental Health & Learning Disabilities, a risk assessment of suicide/self-harm in relation to PODs/TTOs will be undertaken and the outcome recorded in the healthcare record.

14.7 The following will be included into the discharge plan:

- Continuing NHS care criteria assessment;
- Provision of equipment, which has been identified and agreed by the Multi-Disciplinary Team;
- A minimum of 14 days’ supply of medicines;
- Transfer of care documentation as required related to medicines;
- An assessment for patients to self-medicate who will be responsible for managing their own medicines on discharge should be made with the patient where appropriate prior to discharge;
- An essential part of any discharge plan is ensuring that the registered nurse/clinician has adequate time to go through all the discharge medicines with the patient and/or carer and answer any questions which may arise. The patient and/or carer should know the purpose of the medicine, how to take it, and how long for. The registered nurse/clinician is also responsible for checking the discharge medicines are complete and up to date. Special care must be taken to ensure any medicines which are not supplied by pharmacy but are already on the ward labelled for leave or discharge, e.g. inhalers, PODs, are added to the bag of medicines.

14.8 Controlled Drugs as discharge medicines: Controlled drugs to take home must be stored in the ward/department in the Controlled Drug cupboard. These medicines should be segregated from the ward CD stock and clearly marked and remain in the bag. The Controlled Drug should be recorded in the POD section of the register or separate POD.
register and witnessed as outlined in 2.2.4. On discharge the Controlled Drug must then be booked out by the registered nurse and witness who both sign and date the register. The following must be checked:

- Patient Name;
- Date;
- Drug name + strength + form;
- Quantity;
- The patient/carer/driver should also sign the register for the receipt of the controlled drugs.

14.9 If a discharge has been delayed for any reason whilst waiting for care home placement, a medical assessment of the service user will be undertaken within the 24 hours prior to leaving the ward.

15 **Within 24 Hours before Discharge**

15.1 On the planned day of discharge the patient will be assessed by the Named Nurse/Key Worker to ensure that they remain fit for discharge and the nurse will confirm that all necessary support arrangements post discharge are in place; this will be confirmed and documented in the patient's care records.

15.2 The Named Nurse/Key Worker will ensure completion of the appropriate service discharge pathway. All necessary written information regarding discharge advice, details of telephone help lines and contact telephone numbers of services and other professionals involved in their care etc. will be given to the patient and recorded in the patient record. Subject to agreement, the nursing summary and person centred information will be sent to care homes upon placement. Information given to patients should include how to take/use any prescribed medicines and include over the counter remedies e.g. medicines the patient may purchase for pain relief.

15.3 Administrative staff will ensure prompt and timely completion of administrative/electronic records relating to patient discharge.

15.4 Effective discharge planning should ensure that the following is booked and ready for the patient before the day of discharge. This is to ensure that there is no delay in moving the patient on their day of discharge and to free up bed capacity for the current days admitted patients. Discharge should where possible happen before 11am (SAFER care bundle).

- Booked Patient Transport;
- Completed ‘To Take Home’ (TTO) Medications;
- Completed discharge summary.

16 **Out of Hours Discharge**

16.1 No discharge should be unplanned and should not be delayed inappropriately. Our policy is that there would not be an unplanned discharge with the exceptions of patients undertaking their own discharges (see section 12). For patients who require transfer to another clinical in-patient setting, this would follow the same process as a planned discharge or transfer of care.

16.2 It is not our policy to discharge patients from hospital out of hours unless this is patient and carer choice. Should this be the case, for example at a weekend the standard process for discharge should be adhered to out of hours according to the criteria set out in sections 12, 13 and 15.
16.3 A patient who has a planned discharge may arrange to leave the hospital out of hours e.g. during the evening when relatives have arranged to provide transport. This is not an out of hours discharge since the planning and arrangements will have been made in advance. This should be regarded as an unusual occurrence and avoided through negotiating with the patient, their carers or significant others.

17 Managing Complex Discharge

17.1 Complex discharge is a specialist area requiring core skills and competencies in planning and expediting complex discharge in order to support timely transfer of care. This will support effective patient flow through acute and community hospital beds. In support of this it is vital that secondary and community healthcare providers harmonise their approach in order to ensure there is no confusion or conflict around the implementation of patient choice by standardising the way this is managed across hospital systems.

17.2 Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

- A lack of knowledge about the options and how services and systems work;
- Concerns about either the quality or the cost of care;
- Feeling that they have insufficient information and support;
- There is uncertainty or conflict about who will cover costs of care;
- Concerns about moving into interim accommodation and then moving again at a later stage;
- The choices available do not meet the patient’s preferences;
- Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge;
- Worry about expectations of what family and carers can and will do to support them.

17.3 Across SHFT’s Local Delivery Systems we have system agreements for the implementation of Local Choice Policy’s. The purpose of these policies is to ensure that choice is managed sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support to make a choice. These are detailed below:

- Managing Complex Discharge (Mid and North Hampshire Choice Policy).
- Managing Complex Discharge: Supporting patients choices to avoid long hospital stays (Southampton Choice Policy).
- Managing Complex Discharge: Supporting patients choices to avoid long hospital stays (Portsmouth Choice Policy).

18 Training Requirements

18.1 All clinical staff involved in the admission, discharge and transfer of patients should receive training through their local induction processes on commencing work and should include the following

- Choice policy;
- DTOC policy;
- Accurate recording of DTOC to ensure Care Act 2016 compliance;

19 Monitoring Compliance

19.1 This policy will be reviewed through the clinical audit programme and regular monitoring by senior nurses/matrons e.g. regular monitoring of the discharge checklist, electronic discharge summaries and associated standards and time lines.
<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
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<th>Reporting arrangements</th>
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<td>Discharge Checklist</td>
<td>Monthly</td>
<td>Divisional Q&amp;S meetings</td>
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<tr>
<td>Information is given to receiving healthcare professionals in accordance with policy</td>
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<td>Discharge Checklist</td>
<td>Monthly</td>
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<tr>
<td>Information is given to patients when they are discharged in accordance with policy</td>
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<td>Matron Walk Round Tool</td>
<td>Monthly</td>
<td>Quality dashboard. Quality and Safety Committee.</td>
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<td>Discharge Checklist</td>
<td>Monthly</td>
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<td>Duties and responsibilities</td>
<td>Line Manager</td>
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<td>Six Monthly/Annually</td>
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<td>Monthly</td>
<td>Divisional Q&amp;S meetings</td>
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20 **Policy Review**

20.1 This policy will be reviewed in 1 year or sooner if national guidance or legislation require.

21 **Associated Documents**

- Choice policy;
- DTOC policy;
- Accurate recording of DTOC to ensure Care Act 2016 compliance SOP
- NICE Quality Standard (QS159): Transition between inpatient mental health settings and community or care home settings
- Ensuring the effective discharge of older patients from NHS acute hospitals. REPORT BY THE COMPTROLLER AND AUDITOR GENERAL HC 392 Session 2002-2003: 12 February 2003
- Royal Pharmaceutical Society: July 2011. Keeping patients safe when they transfer between care providers – getting the medicines right. A guide for all providers and commissioners of NHS services
- Standard Operating Procedures and Processes for each type of in-patient service.
- AMH bed management processes.
- Managing Complex Discharge (Mid and North Hampshire Choice Policy).
- Managing Complex Discharge: Supporting patients choices to avoid long hospital stays (Southampton Choice Policy).
- Managing Complex Discharge: Supporting patients choices to avoid long hospital stays (Portsmouth Choice Policy).
Supporting References

- CSIP/DH/NIMHE March (2007) Improving discharge from Inpatient mental health care – A good practice Toolkit
- Department of Health (2010) Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care
- Association of Medical Royal Colleges-Electronic Discharge Summaries
Appendix 1: Admission Flowchart

Within 2 Hours

- Meet and Greet Patient, Orientate them on the ward.
- Issue them with Welcome and Information Pack
- **Complete**: Risk Assessment, Initial Medication Review
- **Note**: any allegies, Resusitation Status, Reasons for admission, Patients understanding for admission.
- **Contact**: Next of Kin and GP informayion required
- **Decide**: Inital goals from admission and EDD.

Within 6 Hours

- Patient will have property checked in
- **Complete**: General physical exam, Initial Care Plan
- **Allocate**: Named Nurse/Key worker
- **Request**: Existing medical records will be requested

24-48 Hours

- **Complete**: Estimated Date of Discharge, Clinical Management Plan
- **Catagorise**: Nurse to catagorise simple or complex discharge
- **Review**: Initial Care plan
- **Arrange**: next stage of intervention or CPA
Appendix 2: Transfer Flowchart

Prior to Transfer:

• Assess risks and health needs to move the patient.
• Formal request to move patient issues to destination ward including: reason for the transfer; expected outcomes; likely length of stay and discharge plans.
• Clinical Agreement from senior clinical decision makers on impending transfer.

Information Handover:

• All patient information will be handed over in the electronic patient record and/or secondary notes. Please ensure the following is communicated: Any known infection risks such as Clostridium Difficile, MRSA; Unexplained diarrhoea; Significant physical health concerns; Significant mental health concerns; Any significant mobility and sensory impairment needs; Any significant safeguarding concerns; Risk assessment and management plans including safety & crisis plans.

Outliers:

• Where patients for capacity reasons have been moved out of area SHFT will look to re-patriate these patients within 7 days. Organisation of the transfer will be complete by the outlier ward.
• Authorisation for payment for transport costs will be requested of the home area ward.
Appendix 3: Discharge Flowchart

Discharge Best Practice:

- Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in the decision.
- Develop a clinical management plan for every patient within 24 hours of admission.
- Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
- Discuss with the patient or carer an expected likely length of admission or date of discharge or transfer within 24–48 hours of admission.
- Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
- Book the follow up appointments with the patient prior to discharge. If community services have been involved in the discharge planning they will be aware of the current risk and treatment plans and are therefore best placed to complete the follow up. If a Care Coordinator has not been allocated on discharge, the recommendation is that the inpatient team complete the follow up. Best practice recommends that the follow up appointment is booked with the patient prior to discharge.
- Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence. This includes seeking permission from the patient or their family to assess needs for discharge. Please refer to local choice policy procedures.
- Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
- Use a discharge checklist 24–48 hours prior to transfer. The discharge checklist will be contained within the local procedure or SOP.
- Make decisions to discharge and transfer patients each day.
- Send the electronic Discharge Summary to GP Practice within 24 hours of Discharge.
- Complete the Rio notes, selecting Discharge for patients having left the care of the Trust, and Transfer for patients leaving the ward/unit for another ward/unit within the Trust.

Discharge Checklist:

- Follow local discharge checklist to ensure that as a minimum these are ready before the day of discharge:
  - Patient Transport
  - To take home (TTO's) Medication
  - Follow up appointment is booked
  - Discharge Summary

Delays:

- Where a patient has all of the above but the requested onward discharge destination is unavailable please refer to the DTOC policy and also the Choice policy.
Appendix 4: Inpatient Flowchart

All Patients will have:

- A Plan for their discharge.
- An Estimated Date of Discharge (EDD/PDD)
- An Operational model for escalating any issues with their stay or discharge plan.
- The first factsheet from the local Complex Discharge Policy issued.

Daily:

- Daily Reviews via the Patient Status at a Glance (PSAG) Boards or Bed flow meetings
- Will be having their risks and treatment progressed.

Weekly:

- At least one full ward round.
- Review at a Stranded Patient Review if stay exceeds 7+ days.
- Review at a Hard to Place Patient Review if stay exceeds 21+ days (or specified time in AMH).
Appendix 5: Process for Reporting DTOC on RiO

How to Record a DTOC on Open-RIO

A ‘Delayed Transfer of Care’ is a hospital inpatient who has been judged clinically ready for discharge by the multi-disciplinary team and who continues to occupy a bed beyond the ready for discharge date. It is a requirement for the Trust to collect information on the number of bed days occupied by delayed transfer of care patients.

A patient is a ‘Delayed Transfer of Care’, once declared fit for discharge, but cannot leave whilst:

- Awaiting completing of assessment
- Awaiting public funding
- Awaiting further NHS Care (non-acute)
- Awaiting residential home placement
- Awaiting care package in own home
- Awaiting community equipment and adaptions
- Patient or family choice
- Disputes
- Housing (patients now covered by NHS Community Care Act)

How to Record on Open-Rio?

There are a number of ways to find the Delayed Discharge form on Open-RIO, a few are listed below:

**Patient Flow:**
- Click on the Patient Flow report
- Select the appropriate ward and click ok (opens in a secondary window)
- Click on the service users name and open the patient flow form
- Click on the link to the Delayed Discharge form

**Ward View**
- Go to the ward drop down and select the appropriate ward
- Find the service user in the bed view
- Click on the delayed discharge link under the bed number
- A new form will open automatically or if you are going back to update an existing record then click edit current

**Completing the form:**
- **Date / Time** = The date and time the entry was made
- **Inpatient Episode** = Select the correct admission
- **Delayed Start Date** = The date the service user is fit for discharge
- **Delayed End Date** = The date the service user has been discharged or a decision has been made they are no longer fit for discharge (this part of the form only needs completing once the end date is known)
- **Delay Responsibility** = Who is responsible for the delay
- **Number of Days** = If known then please enter, if not leave blank
- **Reason for the Delay** = What is the reason for the delay, select the appropriate reason
- **Click add** once complete
- **End Reason** – If the delay is being ended with a Delayed End Date, then a reason also needs to be entered (this part of the form only needs completing once the end date is known)
- **Click Save** once completed

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**Help Screen**

Every screen in OpenRIO has a Help Screen. Click the help icon on the appropriate screen for more details on this topic.

**Further Guidance**

eLearning and/or audio videos are available to explain this topic in more detail and demonstrate screenshots with guidance.

Click below to access the eLearning on the LEaD Training Database:

INSERT LINK TO eLearning.