Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 43/12

Title:	**Discharge and Transfer of Care Policy for General Acute Hospital Sites and Intermediate Care Settings - incorporates Adults Discharge Escalation Guidance**				
Author(s)	Angela Costello, Site Discharge Co-Ordinator Tel: 028 906 38915 Angela.Costello@belfasttrust.hscni.net Catherine Collins, Service Manager Intermediate Care & Reablement Services Tel: 028 950 44393 Catherine.Collins@belfasttrust.hscni.net Karen Devenney, Central Nursing Tel: 028 950 49907 Karen.Devenney@belfasttrust.hscni.net				
Ownership:	Brian Armstrong, Unscheduled and Acute Care Director Brenda Creaney, Nursing and User Experience Director Gillian Traub, Adult Social and Primary Care Director				
Approval by:	Standards and Guidelines Committee Executive Team Meeting			**Approval date:**	04/08/2020 09/09/2020
Operational Date:	September 2020			**Next Review:**	September 2025
Version No.	2.1	**Supercedes**	V2 – September 2020 – September 2025		
Key words:	Discharge, transfer, escalation				
Links to other policies	BHSCT Nurse Faciliated Discharge (2009) SG 08/08 BHSCT Hospital Transfer of Patients and their Records (2017) SG 24/09 BHSCT Community Medicines Code policy (2020) SG 06/13				

AWAITING INTERNAL REVIEW

No	Title	Page No
1.0	**INTRODUCTION / PURPOSE OF POLICY** 1.1 Background 1.2 Purpose 1.3 Objectives	4
2.0	**SCOPE OF THE POLICY**	7
3.0	**ROLES/RESPONSIBILITIES** 3.1 Trust Board 3.2 BHSCT Directors & Co – Directors 3.3 Service Managers/ Assistant Services Manager 3.4 All Clinical Staff 3.5 Medical Staff 3.6 Nursing Staff 3.7 Community Nurse Inreach Team (CNIR) 3.8 Hospital Social Work Staff 3.9 AHP Staff 3.10 Administration Staff	7
4.0	**KEY POLICY CONSIDERATIONS** 4.1 Policy Principles 4.2 Choice of Interim Care 4.3 Intermediate Care Services 4.4 Carers 4.5 Discharge of patients from the Emergency Department 4.6 Vulnerable Adults 4.7 Patients with General Palliative Care Needs 4.8 Discharge to Community Nursing in BHSCT 4.9 Discharge to Northern Ireland Prison Care 4.10 Patients with Mental Ill Health/Learning Disability	10
5.0	**DISCHARGE ESCALATION FROM ACUTE HOSPITALS & INTERMEDIATE CARE** 5.1 If the care home of Choice is not immediately available 5.2 Where family members have not identified a care home 5.3 Transer to interim care home placementwhilst awaiting care Package 5.4. Transfer to interim placement until home is ready 5.5 When agreement cannot be reached	16

AWAITING INTERNAL REVIEW

No	Title	Page No
6.0	IMPLEMENTATION OF POLICY 6.1 Dissemination 6.2 Resources 6.3 Exceptions	18
7.0	MONITORING	18
8.0	EVIDENCE BASE / REFERENCES	18
9.0	CONSULTATION PROCESS	19
10.0	APPENDICES / ATTACHMENTS	19
11.0	EQUALITY STATEMENT	19
12.0	DATA PROTECTION IMPACT ASSESSMENT	20
13.0	RURAL IMPACT ASSESSMENTS	20
14.0	REASONABLE ADJUSTMENTS ASSESSMENT	21

AWAITING INTERNAL REVIEW

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

This policy supports people's timely, effective discharge or a transfer of care from acute hospital beds, to a setting, which meets their needs. It applies to all Belfast Trust adult in patients in acute hospitals and Intermediate Care community funded beds, and should be applied before and during admission to ensure that those who are assessed as ready for discharge home or who are suitable for transfer to an alternative setting can leave in a safe and timely way.

The majority of acute hospital discharges should be 'simple and timely'; People should leave hospital with support from their family and friends, and/or follow up from their GP if necessary.

To enable a safe and effective discharge people should be supported to return home as a first option.

People may require further support and /or follow up care provided outside of the acute hospital setting. This may include: Outpatient appointments, community nursing assessment/care and/ or community AHP services.

There are other people who need rehabilitation and support and they should be enabled to return to their home wherever possible supported by Intermediate Care Services (1) and, if necessary, assessment of any ongoing needs should take place within their own home. This 'discharge to assess' model is crucial to allowing timely discharge from acute hospitals. If home is not an option for discharge, people should be transferred to an Intermediate Care community funded bed.

The consequences of a person who is ready for discharge remaining in acute hospital include:

- Exposure to an unnecessary risk of hospital acquired infection;
- Physical decline and loss of mobility / muscle use; (*Prof Brian Dolan, Last 1000 days: Valuing patients' time)*
- Increased dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge and ready to transfer to another environments;
- Severely ill people being unable to access services due to beds being occupied by patients who are ready to transfer
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;

AWAITING INTERNAL REVIEW

***(1) Intermediate care** is a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at home or in a bed based community bed wo are at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in*

a timely way and to prevent unnecessary admissions to hospitals and residential care. (Intermediate Care including Reablement NICE guidelines 2017)

People 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 their options and how services and systems work;
- Worry about expectations of what family and carers can and will do to support them;
- Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge;
- Concerns about moving to interim accommodation and moving again at a later stage;
- Concerns about either the quality or the cost of care;
- The choices available do not meet their preferences;

1.2 Purpose

The purpose of this Policy is to ensure there is a consistent approach to all aspects of the discharge process when the patient is declared medically fit. That risks associated with discharge are recognised and minimised through effective planning, early and consistent communication with the patient and their carer at the centre, and through collaboration with the multidisciplinary team within the Trust and with partner agencies outside the Trust.

This policy should be read in conjunction with the following BHSCT policies and national guidelines:

- BHSCT Community Medicines Code policy (2020) SG 06/13
- BHSCT Policy for the supply of discharge medications from wards when pharmacy is closed (2019) SG 55/11
- BHSCT Adult Safeguarding policy and procedure (2020) SG 20/19
- Mental Capacity Act Guidance (2019)
- BHSCT Nurse Faciliated Discharge (2009) SG 08/08
- BHSCT Hospital Transfer of Patients and their Records (2017) SG 24/09
- BHSCT Regioinal Core Child Protection Policy and Procedures (2017) SG 38/17
- BHSCT Self Discharge Contrary to Medical Advice (2014) SG 01/09
- HSCB Getting Patients on the Right Road for Discharge - Guiding Principles (January 2018)
- NICE Guidance ‘Transition between inpatient hospital settings and community or care home settings for adults with social care needs’ (2015)
- NHS Improvement SAFER Patient Flow Bundle (September 2017)

This Policy sets out a framework for staff, patients, families/carers to establish that a consistent approach is taken ensuring the effective, safe and timely discharge or transfer of patients. This includes making appropriate alternative arrangements should the patient be unable to return home.

AWAITING INTERNAL REVIEW

If the patient requires additional support at home or end of life care, staff should refer to the BHSCT Standard for nursing discharge of patients who are palliative or end of life or requires additional support at home or end of life care needs irrespective of diagnosis. (Appendix 1)

The policy seeks to ensure that there is a clear process in place when people remain in acute beds longer than is clinically required. Where people lack capacity to make decisions about discharge, then the application of the Policy should be in the context of the Mental Capacity Act (NI) 2016, The Mental Capacity Act (NI) 2016 Code of Practice and the BHSCT Mental Capacity Act Guidance.

If circumstances necessitate the use of a Deprivation of Liberty Safeguard (DoLS) as part of the discharge process, then no part of the use of or application for such a Safeguard should cause delay to a person leaving an acute hospital bed when their care, treatment and social care needs can be met in a more suitable and appropriate care environment.

When the discharge of a person who lacks capacity is to a setting that amounts to a deprivation of their liberty, an appropriate DoLS is required to make that move lawful and protect staff from liability. A Trust Panel Application or use of Emergency Provisions are the two mechanisms within the Mental Capacity Act that should be used.

When implemented consistently, this Policy should reduce the number of delayed transfers of care and increase the number of people successfully discharged home or transferred from an acute bed to services where their health and social care needs can be met.

1.3 Objectives

- To ensure patients who have been assessed as medically fit and are ready to leave hospital are discharged or transferred in a safe and timely manner to an environment which can safely and appropriately meet the patients' needs;
- To enhance patients', families and / or carers experience;
- To ensure that patients, families and/or carers are effectively communicated with and adequately prepared for discharge;
- To reduce the number of hospital bed days lost due to discharge delays;
- To facilitate emergency and elective admissions and avoid cancellation of elective activity;
- To reduce delays in discharge from Intermediate Care settings;

The practice of all staff engaged in discharge planning should be underpinned by the regionally agreed values:

- Working Together
- Excellence
- Openness & Honesty
- Compassion

AWAITING INTERNAL REVIEW

2.0 SCOPE OF THE POLICY

The scope of this policy includes all discharges:

- From acute hospital in patient settings
- From Intermediate Care community funded beds

The policy is to be applied by all Trust hospital and Intermediate Care staff, including locum and agency staff who are involved in any aspect of discharge planning for adults in all areas of the Trust.

The following areas are excluded from the scope of the policy:

- Learning Disability Inpatient environments
- Psychiatric care
- In patient maternity services

3.0 ROLES/RESPONSIBILITIES

It is the responsibility of all health and social care professionals involved in discharge and transfer of care planning, both in acute and Intermediate Care to follow the guidance and pathway set out in this document.

3.1 Trust Board

To ensure that appropriate resources are in place to facilitate the timely and safe discharge or transfer of care for patients from hospital

3.2 BHSCT Directors & Co – Directors

- To ensure that all staff are familiar with the policy and their individual responsibilities within the policy;
- To ensure dissemination of the policy to staff within their directorate.

3.3 Service Managers/Assistant Services Manager

- To ensure that discharge or transfer of care planning practice is in accordance with the Policy.
- To facilitate and encourage proactive multi-disciplinary care planning on a continuous basis.
- To advise on policy and procedure development in relation to discharge planning in the light of audit and research into best practice.
- To ensure the principles of **SAFER patient flow bundle** is embedded as best practise across all in patient wards practical tool to reduce delays for patients in adult inpatient wards (NHS Improvement 2017)

AWAITING INTERNAL REVIEW

3.4 All Clinical Staff

The multi- disciplinary team works collaboratively with the patient and their carers to plan care and agree who is responsible for specific actions and makes decisions on the process and timing of discharge or transfer of care.

Each discipline contributing to the discharge process must put in place a set of service standards which stipulates their role, set standard time frames for responsiveness of their service and support team working.

3.5 Medical Staff

- The Consultant or his/her nominated deputy is responsible for:
- Documenting an expected date of discharge (EDD) on admission or where for clinical reasons this is not possible, within 24 hours of admission and ensuring that this is communicated to the patients and or carers;
- Documenting and implementing an outcome focused management plan for each patient;
- Deciding when a patient is medically fit for discharge (no longer needs acute care) and for setting and documenting criteria that allows the patient to be discharged and to avoid unnecessary delay;
- Twice daily senior review that facilitates decision making that progresses the patient's journey. To support discharge processes continuing over weekends, on Thursdays & Fridays medical teams should identify those patients who are likely to be ready for discharge over the course of the weekend. If a patient requires a medical review prior to discharge this should be handed over to the weekend on call team;
- Completing transitional medical documentation to facilitate discharge as request by Community Discharge & Social Work Hub
- Completing discharge summary and prescription, which will accompany the patient on discharge. GAIN (2011) **Guidelines on Regional Immediate Discharge Documentation for Patients being discharged from Secondary into Primary care** should be taken in to account when completing discharge summaries;
- Where possible the discharge prescription should be completed the day before discharge, in accordance with the Trust Medicines code, so that medication to take home is available on the ward prior to discharge and, for discharges planned for over the weekend, during pharmacy opening hours;
- Alerting nursing staff to any required follow up appointments or tests post discharge, as appropriate;
- Ensuring that any results of diagnostic tests that arrive after a patient's discharge that require specific or immediate action are communicated to the GP by telephone and/or letter as soon as possible;
- Ensuring onward communication with the General Practitioner;

AWAITING INTERNAL REVIEW

3.6 Nursing Staff:

The Ward Sister/Charge Nurse/Nurse in Charge is responsible for the overall co-ordination of effective discharge planning for patients in their ward. Ensuring that each registered nurse on a shift is aware of their responsibilities for co-ordinating the discharge plan for each patient they are responsible for during their shift. For each registered nurse, this includes:

- Assessing the patient's health and social care needs at pre-admission clinic, on admission or within 24 hours of admission
- Completing the admission assessment document identifying potential discharge needs for their patients and identify potential issues as early as possible;
- Provide the Ward Discharge Information Leaflet on admission to help inform the patient and their family and initiate discussions about discharge arrangements;
- Completing transitional nursing documentation to facilitate discharge as request by Community Discharge & Social Work Hub;
- Ensuring equipment requests for patients are initiated with relevant professionals as soon as the need is identified, in preparation for discharge;
- Initiating referrals to relevant Allied Health Care Professionals and to Community Discharge & Social Work Hub;
- Ensuring that the discharge medications are provided in accordance with the BHSCT Community Medicines Code policy (2020) SG 06/13 and that medication are explained to the patient and where appropriate to the patient's carer/next of kin, with the patients consent;
- Ensure appropriate documentation is completed if the District Nurse is required to administer medication;
- Informing administration staff on the day a patient is declared medically fit, including the correct discharge code for recording on Patient Journey System or Patient Administration System (PAS);

Nurse-Facilitated Discharge (NFD) should be considered and undertaken where appropriate in line with the BHSCT Nurse Faciliated Discharge (2009) SG 08/08 This should include considering NFD to expedite discharges planned to take place over the course of weekends;

Transport - The nurse will ensure the patient is aware of their responsibility for arranging transport home. In the event that the patient and/or family cannot provide appropriate transport, the nurse will arrange this. If hospital transport is needed, where possible the booking must be made 24 hours prior to discharge and the appropriate mode of transport identified;

AWAITING INTERNAL REVIEW

3.7 Community Nurse Inreach Team (CNIR)

CNIR Support clinical colleagues to consider, where appropriate, alternatives to admission which are safe, effective and fit for purpose:

- Facilitate, guide and support all staff to take ownership of and maintain focus on their contribution to effective discharge planning;
- Any complex and/or IV antibiotic/ drug administration discharges must be in conjunction with CNIR;
- Collaborate with all members of the multi-disciplinary team to ensure patients are discharged from hospital promptly and smoothly;

3.8 Hospital Social Work staff are responsible for:

- Completion of social work assessment and development of a management plan to assist with discharge planning and ensuring onward community referrals to meet patients' needs;
- Support and educate patients/carers to prepare them for discharge and facilitate the offer of a Carer's Assessment to a next of kin or carer;
- Work closely with the Community Discharge & Social Work Hub to identify appropriate and timely discharge pathways;
- Provide contact names and numbers for patient/carers to use in case of difficulties;

3.9 AHP Staff are responsible for:

- Completion of the appropriate records including Transitional forms/ reports that will identify the needs of each patient who require rehabilitation and/or support to facilitate their discharge from an acute hospital setting or intermediate care facility.
- Inputting onto the Patient Journey System (PJs) information that will inform other members of the acute hospital team.
- Ensuring that the patient was been provided with equipment deemed essential for discharge

3.10 Administration Staff are responsible for:

Input onto Patient Journey System (PJs) or Patient Administration System (PAS) the date Patient is declared medically fit, applying the appropriate discharge code as communicated by nurse in charge.

4.0 KEY POLICY CONSIDERATIONS

Ensuring the patient and, where applicable, the carer is central to the discharge process.

Effective communication and consultation with the patient, their family and carers is of prime importance, ensuring that the patient experiences care within a clear and co-ordinated pathway.

Discharge Planning is a multi-agency, multi professional activity in which all disciplines including community staff have a contribution to make.

AWAITING INTERNAL REVIEW

4.1 Policy Principles

4.1.1 Ensuring the patient and, where applicable their carer, is central to the discharge process.

Communication and consultation with the patient, their family and carers are of prime importance in ensuring the patient experiences care as a coherent and coordinated pathway.

The process of assessment and decision-making should be compassionate, patient-centred, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process. All patients will be assessed for discharge, in terms of health, functional and social care needs, at or before admission, and these needs will be regularly reviewed during the patient's stay in hospital. The assessment should include an assessment of the patient's mental capacity to make decisions about their personal welfare, which includes decisions relating to discharge planning, their ability to be involved in the process and what may be needed to support them to be fully involved in the process.

4.1.2 Supporting people to make decisions

In hospital people should be involved in all decisions about their care and should be provided with high quality information, advice and support in a form that is accessible to them, as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge planning process and in making an informed choice.
No long term decisions regarding care needs should be made in hospital and 'discharge to assess' principles should be embedded across the hospital system.

4.1.3 Discharge planning is a multi-agency, multi-professional activity in which all professions including Community Staff have a contribution to make.

Planning for discharge, in collaboration with the person and/or their representatives and all Multi-Disciplinary Team (MDT) members, should commence at or before admission, or as soon as practically possible to support safe, timely discharge or transfer of care. The SAFER patient flow bundle should be applied to support patient discharge. (Appendix 2). Each individual should be told of his or her Expected Date of Discharge (EDD)

Where appropriate, people will be discharged home or if required transferred to Intermediate Care bed based facility for a period of rehabilitation, assessment or care planning to determine long term needs.

4.1.4 Home First – promoting independence and discharge to assess.

All possible efforts should be made to support people to return to their own homes using 'Home First' ethos. A range of services including community nursing and or intermediate care/rehabilitation may support these people. They may require the provision of aids and equipment at home to support their care and or independence.

AWAITING INTERNAL REVIEW

People should not normally be expected to make decisions about their long-term care while in an acute hospital setting. Over prescribing care has the potential to limit the independence and harm the individual involved, as well as reducing the available service capacity and compromising the discharge of individuals with more complex needs.

For those people who cannot go straight home, they should be transferred to an Intermediate Care community funded bed for rehabilitation and/or assessment and care planning.

4.2 Choice of interim care

If a person is ready for discharge or transfer, it is not appropriate that they remain in hospital due to the negative impact this can have on their health outcomes.

People do not have the right to remain in hospital longer than required.
From hospital, people will be offered the most suitable interim care, either at home or in an Intermediate Care community funded bed. If no capacity is available, they will be offered a suitable alternative that will meet their needs.

If a person is not willing to accept a reasonable offer of care to support discharge from the acute hospital, then it may be necessary to discharge them without care. This option would only be pursued following the offer and rejection of available, appropriate options of care that meet patient needs and with appropriate safeguards and risk assessments in place.
Where a patient lacks capacity, the decision to discharge must be made in line with the Trust's Mental Capacity Guidance, meeting their best interests.

People should be informed of their right to complain and provided with details on how to do so. In order to minimise the need for patients to have recourse to formal complaints procedures, the multi-disciplinary team should make every effort to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained.

4.3 Intermediate Care Services

The aim of Intermediate Care is to ensure that, with a period of rehabilitation and support; people can recover their independence and be discharged to their own home or to a community-funded bed.

For people discharged or transferred to an Intermediate Care setting:

- An assessment of need should be completed as soon as possible
- All efforts should be made to ensure that people's stay in interim care arrangements does not become unduly prolonged
- For people who require an assessment and who have substantial difficulty in engaging in the assessment and care planning process, the social worker must consider whether there is anyone appropriate who can support the individual to be fully involved such as a family member/carer. If there is no one available, the social worker must arrange for an independent care advocate to participate in the process.

AWAITING INTERNAL REVIEW

- Where the person has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act (NI 2016).

4.4 Carers

Where someone is considering providing care post discharge, they must be informed and included in the assessment process and informed of their rights and sources of support. People must be informed about their choices when establishing whether they are willing and able to provide care. Carers must be offered the information, training and support they need to provide care following discharge or transfer, including a carer's assessment. (DHSSP 2010 Carers and Discharge 2010).

4.5 Discharge of Patients from the Emergency Department

If the patient is discharged from the Emergency Department the following must be arranged:

- The discharge letter will be produced from Symphony (ED IT system) and will include the diagnosis, tests, results, admission ward if relevant and follow-up arrangements if required. The discharge letter will be sent to the relevant GP practice
- If the patient is discharged from the Short Stay Emergency Unit (SSEU), or any of the acute admissions wards across the three acute sites, the medical staff must complete a discharge summary and prescription form if required. The nurse must ensure a copy is sent to the GP and that any medication or dressings required are supplied.
- If a referral to the District Nurse is required appropriate discharge documentation/ dressings and/or medication must be supplied. (See appendix)

4.5.1 Specific Patient Groups

Children

The child and their family should be kept informed of all discharge arrangements. If the family is required to carry out care following discharge, arrangements should be made for any necessary teaching to be carried out prior to discharge. Other on-going health needs will be met by the relevant community paediatric nursing team. Referrals to other members of the multi-disciplinary team should be made as appropriate.

For children with complex needs, a family meeting should be held prior to discharge to include acute, community, social services and education as required. For children with long term conditions, information and advice should be given verbally and in writing with full details of support available post discharge, and arrangements for open access if further problems develop.

If there are any safeguarding issues the BHSCT Adult Safeguarding policy and procedure (2020) SG 20/19 must be followed.

Children (including neonates) and young people at risk of harm:

If a child or young person who is to be discharged has been or may be at risk of harm a multi-agency discharge planning meeting must be arranged by the consultant paediatrician or the designated paediatric lead for discharge, and an action plan agreed and documented before the child leaves hospital in accordance with trust policy.

AWAITING INTERNAL REVIEW

4.6 Vulnerable Adults

If an adult is at risk of harm, or may have suffered harm the nurse must refer the patient to Social Services in accordance with the BHSCT Adult Safeguarding policy and procedure (2020) SG 20/19

4.7 Patients with General Palliative Care Needs

All patients who have palliative or end of life care needs should be given the opportunity to have a palliative assessment at home, regardless of their perceived need in hospital and irrespective of diagnosis or care setting. Identification of patients who may be approaching the end of life; and awareness and understanding of the End of Life Operational System should be standard in all areas. Any patient identified as potentially nearing the end of their life and with possible palliative care needs should be referred to district nursing for assessment of their individual needs as per the *Standard for nursing discharge of patients who have palliative or end of life care needs.* Both the appropriate call management and manual discharge forms should be used.

4.7.1 Patients with Specialist Palliative Care Needs

Where patients have specialist palliative care needs, appropriate liaison with, or referral to the District Nursing and Specialist Palliative Care Team should be made. The referral would be to help support the patient prior to discharge OR to help ensure the appropriate follow-up after discharge.

If the patient is to be discharged to a hospice, a letter detailing the patient's care requirements and needs should accompany the patient.
Hospice referrals must go through the Specialist Palliative Care Team and can be to access the following hospice services:

- Community Specialist Palliative Care Teams
- In-patient care for specific symptom control and terminal care
- Day Hospice
- Hospice at Home

If the patient is known to hospice services, staff should liaise with the appropriate Community Specialist Palliative Care Team prior to discharge in order to access services.

4.8 Discharge to Community Nursing in BHSCT

Patients who have identified nursing needs, for example, nursing equipment required on discharge (See appendix 7) wound care, catheter care, sub cut medication/fluids, palliative care, enteral feeding, iv drugs and on-going long term condition management,(list is not exclusive) will require a referral to Community Nursing.

The discharging ward staff should liaise with the appropriate community nursing team to plan transfer to the patients' home environment as soon as discharge is planned. Whether this is home, nursing home, residential unit or hostel, ensuring the patient's healthcare needs can be met.

AWAITING INTERNAL REVIEW

All appropriate documentation including BHSCT discharge summary, if appropriate- 'Patients Specific' Direction to Administer' documentation' (see appendix 6) Medication and dressings where appropriate must accompany the patient.

Any complex and/or IV antibiotic/ drug administration discharges must be in conjunction with community nurse in reach CNIR.

4.9 Discharge to Northern Ireland Prison Care

Prisons are located on Maghaberry, Magilligan and Hydebank Wood. Prison healthcare provide a service at each of the three main sites. It is in essence a Primary Care Service with access to a small number of non acute inpatient beds.

Nursing services are currently provided onsite on a 24hour basis at each location. Relevant medical services are provided on a daily basis with out of hours covered by local General Practitioners (GPs).

Essentially patients who are prisoners should be discharged to prison healthcare only when they would be deemed well/fit enough for home discharge in normal circumstances.

The discharging hospital should liaise with the appropriate prison healthcare department to plan transfer to the prison ensuring the patient's healthcare needs can be met.

All appropriate documentation including BHSCT discharge summary and their belongings/medication where appropriate must accompany the patient back to the prison. While in custody on transfer in prison transport the prison officer has responsibility for the patient. If transfer back to prison is by ambulance the healthcare responsibility remains with ambulance staff or medical escort from hospital until recommitted to prison.

Discharge medication for a minimum of three days should be returned with the patient. The prison officer will deliver the medication to the prison healthcare staff.

If a patient already known to prison healthcare is transferred between wards or to another hospital, prison healthcare staff should be informed as soon as possible by the nurse in charge or medical officer using the direct line number provided. To enable regular contact between wards and prison healthcare direct telephone numbers will be exchanged on admission of a patient. Prison healthcare staff will maintain daily contact with the hospital for update on patient progress.

If there are specific discharge arrangements for a patient following a period of inpatient care who is being discharged to a prison, liaise with the Resident General Practitioner or Senior Nurse on Duty for the following prisons

Hydebank Wood – 028 90 494785
HMP Maghaberry – 028 92 614963
HMP Magilligan – 028 77 723474

AWAITING INTERNAL REVIEW

A patient discharge letter must be completed and provided for Prison Nursing Staff prior to discharge.

The Consultant responsible for the patient must discuss any post discharge requirements with the Prison Medical Staff/Resident General

Practitioner or Senior Nurse on Duty in the relevant prison, who will decide the appropriate prison care setting for the patient.

4.10 Patients with Mental ill Health/Learning Disability

If a patient is admitted to an acute inpatient bed and they have a mental health problem or learning disability that is affecting their medical episode, staff should follow appropriate DHSSPS guidance. The patient can be referred to the Mental Health Liaison Nurse or Hospital Social Worker for review and advice.

5.0 DISCHARGE ESCALATION PROCESS FROM ACUTE HOSPITALS & INTERMEDIATE CARE

Once declared medically fit it has been determined regionally, that all complex discharges should occur within 48 hours.

Consistent, timely and appropriate communication by all professionals involved with the service user and their family will help address many of the difficulties and misunderstandings that can occur.

On those exceptional occasions when a difference of opinion arises regarding the next step in care it is imperative that the best interests of the patient are uppermost in reaching a resolved position.

Families, carers and professionals must work collaboratively with the patient, to achieve a timely, safe and appropriate transfer of care or discharge from hospital beds.

While all patients and their families require individual person centred plans, to support patients, families and staff the following guidance should be considered.

5.1 If the care home of choice is not immediately available

People will be offered a suitable alternative interim care home placement. Staff will ensure that the placement does not cause significant disruption to those who wish to support and visit their loved ones. Whilst every effort will be made to ensure interim placements are as close to family and friends it is acknowledged that this is not always possible.

Regular effective communication with the patient and family should be established. They should be reassured that they will be supported to find a home of their choice, but that an interim arrangement has been put in place to allow the discharge from hospital.

AWAITING INTERNAL REVIEW

This arrangement will allow the patient to continue to recover in a more homely and appropriate environment.

5.2 Where family members have not identified a care home

Where families have found it difficult to identify a care home, which results in a patients discharge or transfer of care being delayed, it is vital that the risks associated with prolonged hospital stays are explained to the family. The urgent need for an interim placement should be explained and confirmed, if necessary, in writing. At the same time, staff should work flexibly to arrange visits for family members to homes to highlighting availability and providing every assistance and support to assist their decision-making.

5.3 Transfer to interim care home placement whilst awaiting care package

This situation can occur when a patient and their family have indicated a preference to go directly home and receive support in the home through a care package, but a suitable care package cannot be found. It is important in the circumstances that the risks and safety concerns are made clear to the patient and family. While the goal of transferring the patient to his or her own home remains, an interim care home placement will need to be secured. This will provide a more homely, quiet environment where access to a single room is more likely and care will continue. The patient and family should be reassured that the Trust would continue to pursue the care package so the patient can return home as quickly as possible.

5.4 Transfer to interim placement until home is ready

There will be a small number of occasions when the Trust will have to consider transferring a patient to an interim placement while the patient's own home is being made ready to receive the patient safely. This may be due to the need to clean or adapt the home due to changing circumstances.

It is important that the patient and family understand the risk associated with prolonged hospital stays. It should be carefully explained ~~at~~ that an interim placement has been found and the date of when the transfer will take place.

5.5 When agreement cannot be reached

In very rare and exceptional circumstances, there will be occasions where the patient, family and Trust cannot reach agreement on the next stage of care.

It is important that a meeting is convened within 3 days by an identified member of the multi-disciplinary team to review the care plan, share issues and concerns particularly those of the patient and family members and work to find solutions.

At the same time, the Trust will ensure that the family have access to support, though, for example, the Patient Client Council or an advocate if they wish.

If, every other option has been exhausted without reaching an agreed outcome, a meeting of the Multidisciplinary team should be convened within 5 days chaired by either the Site Discharge Co Ordinator/Senior Trust Manager/ or Director.

AWAITING INTERNAL REVIEW

At this stage, the Trust may need the support of their legal representatives to advise them.

It is anticipated that with good communication and effective involvement and engagement of patients/and or family members the escalation protocol should only be used in very exceptional circumstance.

6.0 IMPLEMENTATION OF POLICY

6.1 Dissemination

This policy will be posted on the BHSCT Hub and also communicated to all staff working within the Belfast Trust

6.2 Resources

This should include training, awareness raising, testing of new documentation associated with the policy etc and who is responsible for this.

6.3 Exceptions

The scope should detail all areas where the policy is to apply - this is to note any area that has been noted as exempt because it is currently unable to comply with or implement the policy.

7.0 MONITORING

Current Performance Standards

Discharge performance standards are set and monitored by HSCB:

Ensure that 90% of all Complex Discharges from an acute hospital setting take place within 48hours of a patient being declared medically fit for discharge

No Complex Discharge from an acute hospital setting takes longer than 7 days from when a patient is declared medically fit for discharge

All Non-Complex Discharges from an acute hospital setting take place within 6 hours of a patient being declared medically fit for discharge

8.0 EVIDENCE BASE / REFERENCES

Summary of the evidence base and references used including relevant external guidelines.

- DHSSPS **"Carers and Discharge – A Carers Guide to hospital discharge"** www.dhsspsni.gov.uk
- *DHSSPS 'Consent – what you have a right to expect: A guide for relatives and carers* (DHSSPS 2003) which can be accessed at:

AWAITING INTERNAL REVIEW

- http://www.dhsspsni.gov.uk/consent_relatives.pdf
- HSCB Draft Delayed transfers of Care from General Acute Sites (October 2019)
- HSCB Getting Patients on the Right Road for Discharge - Guiding Principles (January 2018)
- GAIN Guidelines on Regional Immediate Discharge Documentation for Patients being Discharged from Secondary into Primary care (2011)
- Northern Ireland Mental Capacity Act (2017) https://www.health-ni.gov.uk/mca
- NICE Guidelines – Intermediate Care and Reablement (2017)
- NICE Guidance 2015 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'
- Staffordshire and Stoke – on – Trent, Choice Policy and Procedure to avoid long hospital stays (November 2018)
- NHS Improvement SAFER Patient Flow Bundle (September 2017)

9.0 CONSULTATION PROCESS

- Disseminated via IMPACT DISCHARGE GROUP to Divisional Chairs, Divisional Nurses and Divisional Social Work in August 2019
- Meeting with HARG and G6 Carers Groups on September 2019 & December 2019.
- Meeting with Central Nursing January 2020
- Disseminated via IMPACT DISCHARGE GROUP to Divisional Chairs, Divisional Nurses and Divisional Social Work in March 2020

10.0 APPENDICES / ATTACHMENTS

Appendix 1: Discharge Checklist to be completed prior to the patients Discharge
Appendix 2: Discharge form for patients with palliative care needs
Appendix 3: Standard for nursing discharge of patients who have palliative or end of life care needs irrespective of diagnosis
Appendix 4: Patient Specific Direction to Administer Drugs prescribed by Hospital Consultant for administration by Community Nurses

11.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it should be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.

AWAITING INTERNAL REVIEW

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☒

No impact ☐

12.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

13.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

AWAITING INTERNAL REVIEW

14.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

_________________________ **Date:** 04/08/2020
Authors

_________________________ **Date:** 09/09/2020
Director

AWAITING INTERNAL REVIEW

Belfast Health and Social Care Trust

Appendix 1

NURSING ASSESSMENT AND PLAN OF CARE

Discharge Checklist

Discharge Destination:
Own Home ☐ Relatives/Carer's Home* ☐ Private Nursing Home* ☐ Respite Nursing Home* ☐ Other Hospital* ☐ Hospice*
(complete palliative discharge if required) ☐

*Record Destination Name: ______________________

Death: Date: ____________ Time: __________ GP Informed: ☐

Notification of Discharge:
Patient Informed: ☐
Relative/Main Carer Informed: ☐ Relationship: ______________
Relative/Main Carer aware of care requirements: ☐
Private Nursing Home Informed: ☐
Other Hospital Informed: ☐
Hospice Informed: ☐

Signature:	Date:	Time:

Community Services Notified:
District/Treatment Room Nurses/24Hr Nursing Team: Date: ________ Time: ______ Initials: ______
Social Services (e.g. Home Care Worker): Date: ________ Time: ______ Initials: ______
Care Manager (Care Package): Date: ________ Time: ______ Initials: ______
Other (specify): ______________ Date: ________ Time: ______ Initials: ______

Note any special discharge arrangements here: (e.g. date of first visit):	Equipment Required	Date Ordered	Date Delivered	Patient Informed *(form given to contact Halo Appendix7.)* date..........	Instruction Given	Initials

Discharge Medications:
Not Required ☐ Script at Pharmacy – Time: ________ Initials: Checked and given to patient (including CDs and Fridge Drugs) ☐ Initials: _____
Medications explained to patient and/or main carer ☐ Initials: ____ Own medications returned (if appropriate) ☐ Initials: _____

'Authorisation to Administer' Form: Yes ☐ No ☐ N/A ☐ Warfarin/anticoagulant prescription: Yes ☐ No ☐ N/A ☐

Transport Arranged:
Relative/Main Carer ☐ Who: ______________ Taxi ☐ Initials: ______
Ambulance: Time Ordered: _____ Booking No: ______________ Type: Chair ☐ Rear Lift ☐ Stretcher ☐ Special (e.g. oxygen, escort etc) ☐
Informed re DNAR: Yes ☐ No ☐ N/A ☐ Informed re Infection Status: Yes ☐ No ☐ N/A ☐ Signed: ______________

Discharge Checklist

Post-Operative Patients:
Wound: Treatment Room Nurse letter given ☐ Wound Care advice given ☐ 3-Day Dressing supply ☐
For Complex Wounds – photocopy and send Wound Assessment Chart ☐
Stoma/Urostomy/ Catheter: Appliance details completed and given ☐ **Pain:** Note Patient's VAS on discharge /10

Special Instructions: (e.g. Enteral Feed, PEG, Catheter on discharge, palliative prognosis

Refer to District Nurse: Date:____________________Time:________Initials: _______
Education and Information given to Patient/Relative/Main Carer: ☐ Initials: _______

Other advice/instructions given e.g. head injury – specify:

Initials: _____

Infection Prevention and Control Status:
Remaining MRSA decolonisation treatment given to patient ☐ Patient/Relative given appropriate information ☐
Care Pathway completed? ☐ GP/District Nurse informed of status/treatment ☐
Initials: ________

IV Cannula Removed:
Yes ☐ ☐ Initials: __________

Follow Up Arrangements:
Review:__________Weeks At:_________________ Appointment given: ☐ Initials:_______ Patient/Relative/Main Carer informed: ☐
Re-Admission arrangements: Yes ☐ No ☐ N/A ☐

Discharge Letters:

GP:	Completed ☐	Given to Patient ☐	Initials:_____	District Nurse:	Completed ☐	Given to Patient ☐	Initials: _____
PNH/Respite:	Completed ☐	Given to Patient ☐	Initials:_____	Hospital:	Completed ☐	Given to Patient ☐	Initials: _____
Other:	______________				Completed ☐	Given to Patient ☐	Initials: _____

Hospital Certificate Required: Yes ☐ No ☐ **Issued:** Yes ☐ No ☐
Initials: _______

Property Handed In and Returned: Yes ☐ No ☐ N/A ☐
Initials: _______

Aids and Appliances Returned: Yes ☐ No ☐ N/A ☐ Initials: _______

Discharged By:	**Date/Time:**	**Nurse Facilitated Discharge:** Yes ☐ No ☐ N/A ☐	**PAS Updated:** Yes ☐ No ☐

Enc: 1. *Standard for nursing discharge of patients who have palliative or end of life care needs*
2. *Discharge for patients with palliat8ive care needs form v3*

APPENDIX 2

Belfast Health and Social Care Trust

Priority of referral to DN: (please tick):
Urgent ☐
Routine ☐

DISCHARGE FORM FOR PATIENTS WITH PALLIATIVE CARE NEEDS

AWAITING INTERNAL REVIEW

Copy for : Notes ☐ DN☐ GP☐ NH☐	Other ☐
Patient's Name: Hosp Number: Address: D.O.B: Tel. No.	Date of discharge: Hospital Consultant:
Address discharged to if different from above:	Tel: No:
Next of Kin or carer: Relationship to patient:	Tel. No:
GP: Dr .... Address:	Tel. No:
Diagnosis: (If cancer diagnosis please list primary site and site of any metastases)	Date of diagnosis
Treatment (Including dates):	
Significant medical history:	

Current Problems: (continue overleaf if required)

Patient understanding of disease/prognosis Family understanding of disease /prognosis
Follow-up/treatment plan:

Patient known to Hospital Supportive and Specialist Palliative Care Team : Patient referred to Hospice Nurse Specialist or Macmillan Nurse (community): Patient referred to Palliative Medicine Consultant Out-patient clinic:		Yes □ No □ Yes□ No □ Yes □ No□
Community services referred to: DN □ OT □ Physio □ SW □ Dietitian □ SLT □ Other □		**Name of District Nurse spoken to prior to discharge**:
Date : **Number:** **Signature**:	**Contact** **Profession:**	**Ward:** **Hospital:**

FURTHER COMMENTS:

AWAITING INTERNAL REVIEW

Standards and Guidelines Committee_ Discharge from Acute Inpatient Settings Policy_V1.2_2015 Page

APPENDIX 3

Standard for nursing discharge of patients who have palliative or end of life care needs irrespective of diagnosis

All patients who have palliative or end of life care needs should be given the opportunity to have a palliative assessment at home, regardless of their perceived need in hospital

Following discussion with the patient, the ward nurse should gain verbal consent to make an onward referral to the district nursing service.

Discharge should be planned in advance in consultation with the patient, their family, carers and the multidisciplinary team. District nursing should be invited to a discharge planning meeting when necessary.

Prior to discharge, the ward nurse should make a referral for a district nurse palliative care assessment via the appropriate call management centre (see directory for all Trust/area all management centres) and complete the palliative care discharge form.
NB: *district nursing referral should not be requested via the GP*.

The ward nurse must request a home visit either on the day of discharge or the next day if urgent, or within three working days if non urgent, depending on clinical need.

Where a patient has complex needs, the ward nurse should engage in direct nurse to nurse communication

Copies of the discharge form should be forwarded to the GP, district nurse and relevant community specialist palliative care nursing service if involved

Ward nurses should report challenges hindering discharge through the normal channels.

Please ensure that the patient's carer(s) have been made aware of their entitlement to a carer's assessment, independent of the patient's needs or wishes. Please inform the district nurse if you are aware if this has been completed.

Nursing discharge of patients who have palliative or end of life care needs irrespective of diagnosis

From a governance perspective we, as health and social care professionals, have a duty of care to ensure that all patients who have palliative or end of life

AWAITING INTERNAL REVIEW

care needs irrespective of diagnosis are provided with the opportunity to be cared for/supported to die at home or as close to home as possible, where that is their wish.

To enable this to happen we must ensure that, with the patients' consent, we make them known to community services as early as possible. This ensures that good nurse/patient relationships are developed and, in partnership with the patient and family/carers, that all appropriate plans and services are in place including out of hours.

It is anticipated that the timely referral to district nursing services will result in:
The patient being identified and registered on a district nursing case load
The patient having the opportunity to access services only available via district nursing
A named key worker, who in partnership with the patient, will help to co- ordinate his/her care
Individualised holistic assessment of the patient's/carer's needs and the opportunity to engage in proactive planning
The patient/family/carer being given information on who to contact if needed both in and out of hours
The increased opportunity for GPs to provide all relevant information to out of hours services
The patient being placed on the resident Trust palliative and end of life care co ordination system

Palliative care can improve the lives of people living with a range of conditions including multiple sclerosis, motor neuron disease, dementia, COPD, cancer and heart failure, for example.

If you would like more information regarding the BHSCT Palliative and End of Life Care Service Improvement Programme, the Service Improvement Team would be very keen to hear any thoughts and comments and would be very keen to engage with local champions with regards to delivering this programme.
Contact Louise Hagan, Palliative and End of Life Care Service Improvement Lead Louise.Hagan@belfasttrust.hscni.net

AWAITING INTERNAL REVIEW

Belfast Health and Social Care Trust

caring supporting improving together

Patient Specific Drugs prescribed by Hospital Consultant for administration by Community Nurses

APPENDIX 4

Date: ____/____/____ Hospital Consultant: __________

Hospital No: __________________ H&C No: ____________________

Patients Name: _______________ G.P. Name: __________________

Address: ____________________ G.P. Address:_________________

Post Code: __________________ G.P. Tel No: _________________

D.O.B: ____/____/____ Patient's Allergy Status _________

Patient's Height: ____________ Patient's Weight ______________
(see medicines code) Date: ____/____/____

Please Administer:

Name of Drug: __________________ (each drug requires a separate sheet)

Dosage (Units): _________________

Frequency / Preferred Time: _____________________

Route: ________________________

Commencement Date: ____/____/____

Review / Completion Date (delete as appropriate): ____/____/____

Hospital: _______________________ Dept / Ward: _____________________

Presciber Name: ________________ Designation: _____________________

Prescirber Signature: ____________ Bleep / Tel No: ___________________

Additional Information (including monitoring arrangements

Please give to patient for attention of Community Nurse

AWAITING FINAL REVIEW