POLICY FOR THE DISCHARGE OF ADULTS FROM BRIGHTON & SUSSEX UNIVERSITY HOSPITALS NHS TRUST

DRAFT
To Be Agreed by:
Brighton & Sussex University Hospitals NHS Trust
South Downs Health NHS Trust
Brighton & Hove City Council
East Sussex Social Services Department
Sussex Ambulance Service Trust
Surrey and Sussex Strategic Health Authority
Brighton & Hove City Primary Care Trust
Sussex Downs and Weald Primary Care Trust
Mid Sussex Primary Care Trust
Adur Arun and Worthing Primary Care Trust
West Sussex Social Services
SUMMARY OF DISCHARGE

Admission

Initial assessment within first 24 hours by admitting nurse. Compete detailed history of support involving appropriate professionals & family members and friends to gain a comprehensive picture of the patients home care arrangements and ability to cope preadmission

Inform PHCT if required and cancel services as necessary

Has patient got new or altered needs?

Yes

MDT assess patient within timescale

No

Keyworker prepares care plan

Is patient fit for discharge?

Yes

Care plan funded and implemented

Discharge / Transfer

Prior to

- Confirm arrangements with RH/NH
- Start / Restart social care
- Check patient has transport / arrange transport
- Obtain and explain TTO’s to patient
- Give GP letter to patient

- Return property
- Check access arrangements
- Give supply dressing / equipment
- Confirm FU arrangements
- Provide information to patient
- Ensure patient understands the arrangements

MDT - multidisciplinary team
PHCT - primary health care team
TTOs - to take out medication
LOS - length of stay
RH - rest home
FU - follow up
NH - nursing home
CC - continuing care
NOK - next of kin
DN - district nurse
# Table of Contents

1 Introduction .............................................................................................................................. 4  
1.1 Scope .................................................................................................................................. 4  
1.2 Content .............................................................................................................................. 4  
1.3 Management Arrangements ............................................................................................. 4  
1.4 Responsibilities of Staff Groups ..................................................................................... 4  
2 Principles of discharge planning ............................................................................................ 4  
3 The Discharge Process ............................................................................................................. 5  
3.1 Assessment ........................................................................................................................ 5  
3.2 Planning ............................................................................................................................. 5  
3.3 Provision of Service and Discharge/Transfer of care or discharge .................................. 6  
4 Performance Management and Clinical Governance ........................................................... 6  
5 Training and Education ........................................................................................................... 6  
6 Protection of vulnerable adults ............................................................................................... 6  
7 Arbitration ................................................................................................................................. 7  
8 Appendices ................................................................................................................................ 8  
9 Bibliography .............................................................................................................................. 8
1 Introduction

1.1 Scope
This policy applies to all members of the multidisciplinary team working in the partner organisations involved in planning the discharge of patients from Brighton and Sussex University Hospitals NHS Trust.

1.2 Content
The policy comprises the following components:

- **TOP LEVEL POLICY**
- **SITE SPECIFIC DISCHARGE PROCEDURES**
  - PRH
  - RSCH
  - BGH
  - RACH
- **WARD LEVEL RESOURCE FILES**

1.3 Management Arrangements
Overall management of the policy is the responsibility of the Whole Systems Focus on Discharge Steering Group. Responsibility for the development, implementation and audit of site-specific policies is the responsibility of local Admission and Discharge Groups.

1.4 Responsibilities of Staff Groups
There is a clear requirement that staff from all disciplines will adhere to the discharge planning process as prescribed in this policy. Roles and responsibilities of individual staff groups are set out in more detail in the ward resource packs however, as a minimum, members of the multi disciplinary team will:
- work collaboratively
- share skills and information
- ensure effective communication
- keep accurate and contemporaneous records
- work to jointly agreed levels of risk
- ensure that all assessment and service provision is based on need.

2 Principles of discharge planning
Discharge planning can be defined as “a systematic, multidisciplinary process by which the needs and resources of inpatients and their carers are assessed in order to enable comprehensive discharge preparation and the arrangement of appropriate community support and services on discharge from hospital”.

Effective discharge planning can be described as having the following features:
- it is a process in which individuals and their carers are engaged and actively participate
- it is an actively managed process which begins at the point of admission (if not before e.g. elective admissions with agreed pathways)
− it is managed by a named person responsible who is responsible for coordinating all stages of the ‘patient journey’
− it prepares the patient and their family or carers physically and psychologically for transfer from a hospital environment.
− it ensures patients are transferred from hospital to a safe and appropriate environment, prepared to receive them.
− it provides the patient with appropriate information and equipment to encourage and restore maximum independence and optimise health.
− it provides continuity of care through effective communication between professionals.
− it makes the best use of available resources so that existing acute hospital capacity is utilised appropriately

3 The Discharge Process
The discharge process comprises three key stages - assessment, planning and discharge or transfer to other services.

3.1 Assessment
On admission, an initial assessment will be undertaken by nursing and medical staff. The purpose of this is twofold:
− to determine whether the patient has new or altered needs and consequently is likely to need an actively managed transfer and ongoing health and social care services, and
− to determine the expected length of stay and predicted discharge date

Following this initial assessment other members of the multi disciplinary team will be involved as appropriate. Roles and responsibilities of the multi disciplinary team are specified in the site specific procedures.

Where a patient is identified as ‘likely to need community care services in order to be safely discharged’ staff will initiate reimbursement procedures as specified in the site-specific policies.

A named individual from the multi disciplinary team (the ‘keyworker’) will be identified to coordinate the assessment process and actively manage the rest of the patient journey in conjunction with the multi disciplinary team.

3.2 Planning
The keyworker will coordinate the planning stage and ensure that the patient and their family and carers are fully involved in this process.

The planning stage will comprise identification of:
− what services and equipment are required to meet the assessed need
− where or by whom the services will be provided
− how the services will be funded – consideration must be given to eligibility for free nursing care, continuing care or local authority funding
− when the services need to start
what practical arrangements are required to ensure effective discharge e.g. transport etc

The decision that the patient is medically fit for discharge will be made by the patient’s consultant or by someone to whom the consultant has delegated his or her authority. Patients who have both health and social care needs must only be discharged when they are clinically fit. This decision will be made by the multi disciplinary team.

3.3 Provision of Service and Discharge/Transfer of care or discharge

When a patient requests to be discharged against medical advice, every effort should be made to resolve this by following the guidelines laid down in the ward resource pack.

The keyworker is responsible for confirming the discharge destination is suitable, safe and accessible and all necessary arrangements have been made by other staff (e.g. social care and health, O.T. etc) prior to discharge.

Prior to discharge the keyworker will ensure the patient has received all relevant information about the treatment they have received and details of any follow up care.

4 Performance Management and Clinical Governance

This policy is subject to regular monitoring and audit by local Admission and Discharge Groups. Site specific procedures stipulate the frequency, scope and process for monitoring and audit, but as a minimum they will address:

- the audit of the discharge process in hospital and community settings.
- the monitoring of delayed transfer of care via SITREPs
- the monitoring and investigation of clinical incidents, which affect the discharge of patients.

5 Training and Education

It is the responsibility of all members of the multidisciplinary team involved in discharge planning to familiarise themselves with and adhere to the procedures contained within this policy. Line managers have an additional responsibility to ensure their staff familiarise themselves with and adhere to these procedures.

This will be supported by continuous training and education programmes developed and implemented by site specific Admission and Discharge Groups.

6 Protection of vulnerable adults

All staff must be aware of and work to the multi agency guidelines on the protection of vulnerable adults. Local Admission and Discharge Groups have a specific responsibility to ensure the staff receive the appropriate training and education.
7 **Arbitration**

In the event of a significant dispute between professionals from any agency or agencies involved in discharge planning, staff should endeavour to resolve the problem through existing line management structures. However, if the dispute cannot be resolved promptly via this mechanism, key senior professional staff from the relevant agencies will be alerted and meet within 48 hours of the request to resolve the dispute. Disputes relating specifically to reimbursement procedures will be escalated to the Strategic Health Authority Panel. Disputes as to the outcome of patients' assessments or as to how their assessed needs should be met will be dealt with according to the Choice Protocol.
8 Appendices

Site specific procedures for Brighton General Hospital
Site specific procedures for Royal Sussex County Hospital
Site specific procedures for Princess Royal Hospital
Site specific procedures for Royal Alexandra Children’s Hospital
Ward level resources files

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