The Royal Wolverhampton NHS Trust

CP04
Discharge Policy

Contents

Appendices

1.0 Policy Statement (Purpose / Objectives of the policy)

The Royal Wolverhampton NHS Trust's Discharge policy identifies the Trust's expectation that we ensure everything possible is done to enable all patients to be discharged in a co-ordinated, efficient and compassionate manner to a safe and secure environment.

The purpose of this Policy is:

- To highlight the importance of discharge planning from the time of admission (or before)
- To facilitate a safe and timely patient discharge
- To improve the patient's continuity of care and transition back to the community or care home setting
- To reduce the potential risks associated with patient discharge
- To standardise and manage the discharge process for in-patients at the acute hospital
- To ensure all staff understand their roles and responsibilities
- To inform all staff of current local practices pertaining to the discharge process
- To inform staff of specific patient groups discharge requirements

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Admission – Commencement of a hospital spell as a result of an elective/emergency/maternity decision by a clinician.

Attendance- Confirmed and recorded arrival of a patient to enable the receipt of a consultation, health advice, surgical procedure of intervention by a designated healthcare professional.

Carers – A person, who may be a paid carer or a relative or a friend who provides care on a voluntary basis.

Complex Discharge SBARD Letter – A letter that is completed if triggered on the Discharge Checklist (Appendix 2a). The letter ensures that more detail is provided in regard to the ongoing care a patient needs on discharge from hospital.

Criteria to Reside: A clinical criteria which details the reasons patient remain in hospital who are NOT fit for discharge.

Day Case – Patient's admission is 23 hours or less.

Delayed Discharge: Occurs when a patient has been declared medically fit for discharge, a multi-disciplinary decision has been made that they are safe and ready

for discharge but are still occupying a hospital bed.

Discharge: Conclusion of a patient care spell.

Discharge Lounge: a specified area within the Trust to facilitate a timely discharge from the wards. If a patient has been medically or professionally led discharged, they will transfer to the lounge whilst awaiting final arrangements to be made.

Discharge Notification Process Letter:(usually an electronic discharge or equivalent notification process) A summary of care received by the patient upon discharge detailing diagnosis, treatment given during the admission/attendance, medications upon discharge (or, for short admissions, any changes to the medication taken at the time of admission) and aftercare arrangements.

Discharge to Assess(D2A): The process to support and fund patients to leave hospital when declared medically fit for discharge, to continue their care and assessment out of the acute Trust.

E-Discharge: Discharge summary which will be forwarded to the GP/GDP via E-mail within stated time period (24hrs) and a copy of which is given to the patient at discharge.

EDD: Expected date of discharge

Fast Track: Referral made by medical staff to enable prompt social input to allow a patient to go to their preferred place of death.

GDP: General Dental Practitioners.

Huddle Tool: The Trusts electronic data system in which the patients' reason to reside and medically for discharge data is captured.

Independent Mental Capacity Advocate (IMCA): supports a person who lacks capacity ensuring that their views are heard and rights upheld.

Integrated Care Board (ICB): an NHS organisation responsible for meeting the health needs of the population.

Integrated Care System (ICS): Partnerships of organisations that come together to deliver joined up health and social care systems.

Local Authority: Organisation responsible for meeting the social needs of its population.

Medically Fit for Discharge: A patient has been declared medically fit for discharge, a multi-disciplinary decision has been made that they are safe and ready for discharge.

Multidisciplinary: When professionals from different disciplines, such as medical staff, social workers, nursing and therapy staff work together.

Out of Hours Discharge: Discharge of an inpatient after 2000 hours.

Rapid Home to Die Bundle: Pathway to discharge patients who are deemed to be in the final days of life.

Trust: The Royal Wolverhampton NHS Trust.

TTOs: Medications for patients to take with them upon discharge.

Ward Huddle: A short stand-up meeting with representation from medical staff nursing, therapy and patient flow team.

3.0 Accountabilities

3.1 Chief Executive

The Chief Executive has overall responsibility for the implementation, monitoring and renewal of this policy. This responsibility is delegated to the Chief Nurse.

3.2 Medical Director

It is the responsibility of the Medical Directors to oversee the monitoring and application of this policy, and to report as necessary to Trust Board, via Trust Management Team Meeting.

3.3 Clinical Directors

Clinical Directors are responsible for ensuring that Consultants within their directorates comply with this policy.

3.4 Consultant Medical Staff

Consultant Medical staff are responsible for:

- To lead a daily ward huddle ensuring that clear management plans are in place for all in patients in their care. In addition, they are responsible for ensuring that the expected date of discharge is communicated to their teams and discussed with patients.
- To inform Criteria Led Discharge
- To liaise with the Multi-Disciplinary Team (MDT) on a regular basis to enable co-ordination of the EDD.

3.5 Medical Staff

Medical staff are responsible for completion of E discharge and prescribing of any TTO medications (to take home) within 24 hours of the anticipated discharge date. Medical staff also have a responsibility to contribute to any discussions and engagement required with the patient or family prior to discharge. They are also responsible for providing information for the Fast track Discharge.

3.6 Directorate Management Teams

The Directorate Management Teams are responsible for implementing and communicating the Discharge Policy to all staff under their supervision.

3.7 Matrons

Matrons are responsible for ensuring that all nursing staff within their remit comply with the Discharge policy. They are also responsible for ensuring that nursing staff are competent to undertake discharge and complete the discharge checklist appropriate to their roles and responsibilities. Matrons may delegate day to day responsibility of competency assessment to the individual healthcare workers line manager.

3.8 Senior Sister / Charge Nurse

The senior sister/charge nurse is responsible for:

- Ensuring that the policy is understood and implemented.
- Ensuring that appropriate processes are in place to ensure the safe and timely discharge of patients from the ward ensuring there is full communication with the patient, the patients carer/relative, relevant agencies and services.
- Identify and escalate any delays in a patients discharge once identified as medically fit.
- Ensuring members of staff conducting discharge from health care settings have had appropriate training, this includes fast track training.
- Attend the ward huddle or ensure the nurse in charge of the ward is in attendance.
- Identifying appropriate training opportunities for staff to support the development of competence in relation to the discharge process.
- Ensuring that any temporary nursing staff, including bank staff, are competent to undertake and respond appropriately during the discharge from hospital process.
- Auditing practice and policy compliance within their own clinical area using the discharge checklist (in accordance with the admitted patient discharge process).
- Ensure correct discharge address is verified and handed over to all relevant agencies/departments (this may differ from permanent address if being discharged to a temporary placement) and ensure PAS is updated and patient labels updated. Refer to flow chart Appendix 14.

3.9 Nursing Staff

Nursing staff on the ward are responsible for:

- To provide patient information leaflet upon admission: Welcome Booklet-Planning your Discharge from Hospital (Appendix 7)
- To gather, record and communicate all relevant information using the nursing process or checklist.
- To identify simple and complex patient discharge.

- To promptly and appropriately refer patients requiring MDT assessment or other services through the appropriate referral methods.
- To attend the MDT meetings as appropriate.
- To ensure the patient/ carer is fully involved at all stages of discharge planning and aware of the potential date for discharge.
- To assess patients who have on-going health and social care needs that requires detailed planning and delivery.
- For staff to communicate appropriate patient information to Residential or Nursing Care homes, or to informal/ formal carers.
- To ensure that the patient/ carer have the appropriate medication, equipment, support/ services and relevant information deemed necessary for a safe discharge.
- To encourage patients/ carers to arrange personal transport unless the criteria for the ambulance service is met.
- To commence the discharge checklist as soon as appropriate from the point of admission.
- To commence discharge planning at the time of admission, or when most appropriate.
- Ensure correct discharge address is verified and handed over to all relevant agencies/departments (this may differ from permanent address if being discharged to a temporary placement) Refer to flow chart Appendix 14.

3.10 Therapy Staff

Therapy Staff are responsible for:

- Assessing a patient if a functional deficit is identified. Referrals will be prioritised according to clinical urgency and assessed within an appropriate timescale as determined by the therapist.
- To work with a home first mind set.
- To participate in the daily ward huddle and as part of a multidisciplinary approach inform the patents discharge pathway.
- To provide home equipment essential for safety with education to patient/carer and ensure nursing staff are aware of if equipment should be taken home on discharge.
- To ensure continuity of rehabilitation is met through regular communication with the MDT during in-patient stay.
- To take part in MDT meetings and participate in case conferences as appropriate.
- To refer patients requiring on-going therapy services on discharge to services such as the Community Intermediate Care Team (CICT).

3.11 Patient Flow Assistants /Co-ordinators

Patient Flow Assistants/Co-ordinators are responsible for:

- To co-ordinate and facilitate a patient discharge.
- From the point of admission start to collate the patient's current social history to try and identify early issues which may prevent discharge once the patients is deemed medically fit.
- To actively participate in the ward huddle and escalate any issues identified which will delay the patients discharge to the MDT.
- To co-ordinate the completion and submission of the required referral paperwork in relation to discharge with input from the professional members of the MDT
- To liaise with internal and external agencies with regards to the patients identified discharge pathway.
- To communicate regularly with patients/family/carers in relation to discharge planning.
- To update the Huddle Tool daily with each patients' criteria to reside and identify patients who are medically fit for discharge.
- Document discharge address in patients notes (this may differ from permanent address if being discharged to a temporary placement) and ensure that this information is handed over to the nurse in charge of the ward and the ward receptionist.

4.0 Policy Detail

The operational procedure for decision making and discharge of patients is set out in Appendix 1: Discharge Process and Procedure.

4.1 Self Discharge

Where patients are deemed to have unofficially discharged themselves against medical advice, or choose to leave hospital, the decision as to whether to regard the patient as self discharged must be taken by the Senior Nurse in conjunction with the Consultant or his deputy (Security Policy OP26 4.6.2).

Consideration should be made as to whether the patient has the mental capacity to make this decision or whether this is a mental health or safeguarding issue and refer to the appropriate policy.

If patients discharge themselves against medical advice they must be requested to sign a refusal to accept medical advice notification witnessed by a clinician or Senior Nurse; if they refuse to do so, that must and documented in the patient's case notes (Appendix 13).

If patients discharge themselves before any community services deemed necessary can commence, the nurse responsible for the patient's care must inform the General Practitioner. In addition, Social Workers and others involved in the patients care where appropriate and practicable must be informed as soon as possible, to ensure that any arrangements for aftercare are made.

4.2 Discharge Out of Hours

The discharge of patients after 20:00 hrs must not be routine except for specific services within the Trust where discharge out of hours is normal practice (e.g. day case areas etc). Where there is a plan to discharge patients after 20:00 hrs, particularly the elderly, this must only occur if it is clinically appropriate, safe and convenient for them, their families and, or/ carers or their Residential or Nursing home (if applicable). The rationale for the out of hours discharge must be documented in the patient case notes. Any inappropriate discharges occurring out of hours must be incident reported via Datix and investigated by the directorate management team and lessons learned shared across the Trust.

4.3 Delayed Discharges

A medically fit for discharge (MFFD) list will be generated from the Huddle Tool which details all of the patients identified as fit to leave the hospital and will provide the detail as to the patients discharge plan and the reasons and outstanding actions required to discharge the patient.

Where there is a delayed transfer of care between the acute Trust and the Local Authority or ICB responsible for the discharge pathway the Capacity Team will work collaboratively with these organisations to expedite the patients discharge.

Delayed transfer of care data will be submitted to the ICS daily Monday- Friday.
A MFFD meeting is held daily Monday – Friday to action plan against both the internal and external delays prohibiting the patients discharge.

In the event that a patient's delayed discharge is due to refusal of advised care the Senior Sister /Charge Nurse along with a member of the Capacity Team (if appropriate) will make every effort to explain the reasons behind the planned care option. In the event that the patient refuses to accept the planned discharge the Senior Sister/Charge Nurse will talk to the patient alongside a member of the directorate management team and issue letter 1 and proceed to letter 2 a week later if there is no resolution. (Appendix 3-4)

Where it is identified that a patient's condition has been adversely affected by a delay in discharge an incident must be raised via the Trust Datix System and forwarded to the relevant agency to investigate.

4.4 Discharge Planning for Patients who Lack Capacity

Patients who do not have capacity to make decisions are given rights under the Mental Capacity Act (2005) refer to the Trust's Mental Capacity Act (2005) Policy and Guidelines are available through on the Trust's Intranet.

4.5 Patients requiring an Independent Mental Capacity Advocate (IMCA)

When a patient lacks capacity as defined under the Mental Capacity Act (2005) and has no family or registered Health and Welfare Lasting Power of Attorney (POA) to support the patient with decisions about daily routine, discharge plan or moving into a care home an IMCA must be requested to act on the patient's behalf and assist in the decision-making process, particularly those associated to:

- Long term care move into, or between, care settings (including hospital)

An IMCA does not need to be instructed if:

- The patient who now lacks capacity has nominated someone to be consulted specifically on the same issue.
- The patient has a personal welfare attorney who is authorised specifically to make decisions on these matters.
- A personal welfare Deputy has been appointed by the Court with powers to make decisions on these issues.

Where a person has no family or friends to represent them but does have an Attorney or Deputy who has been appointed solely to deal with property and affairs, then an IMCA must be instructed.

Decision-makers in the NHS and LA's need to determine if there are family or friends who are willing and able to be consulted about the proposed decision. If it is not possible, practical and appropriate to consult anyone, an IMCA must be instructed. The person who lacks capacity may have friends or family but there may be reasons why the decision-maker feels it is not practical or appropriate to consult with them.

The IMCA's role is to give an independent report on the person's current or past wishes, culture, beliefs and known needs to help the professionals making the decision to ensure that they are working in the person's best interests.

4.6 Patients Who are Homeless or Living in Temporary Accommodation

Identifying a person's housing status on admission is essential for successful discharge to take place. People who are homeless or living in temporary or insecure accommodation must be referred to the relevant homeless or housing service promptly. The Capacity Team will provide details of the relevant service.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
X	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

This policy will be the responsibility of the Matron for Capacity and Patient Flow It will be reviewed in line with Trust Policy OP01 every 3 years or following any significant changes to the way patients are discharged from hospital.

8.0 Communication and Training

- An electronic copy of this policy will be available on the Trust intranet.
- All staff will be notified of a new or renewed policy.
- Staff will receive training on discharge as part of the Trust local induction program.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
a) information to be given to the receiving healthcare professional	Matrons	Audit of checklist/patient case notes	Annual	Quality and safety committee
b) information to be given to the patient when they are discharged	Matrons	Audit of checklist/patient case notes	Annual	Quality and safety committee
c) The discharge checklist is completed for all patients upon discharge	Matrons	Audit of checklist/patient case notes	Annual	Quality and safety committee
d) Out of hours discharge process	Matrons	Audit of checklist/patient case notes	Annual	Quality and safety committee
Adverse events due to delayed discharge	Directorate Management Teams	Datix	Monthly	Governance

10.0 References - Legal, professional, or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

- Wolverhampton Discharge from Hospital and Transfer of Care Strategy (2010)
- Care Act 2014. London: HMSO
- The Mental Capacity Act DH (2005)
- Discharge Planning – Emergency and acute medical care in over 16's: service delivery and organisation, NICE (2017) [https://www.nice.org.uk/guidance/ng94/documents/draft-guideline-35]
- The Hospital Discharge Service Policy and Operating Model: HM Government 2021
- Government Legislation (2006), Safeguarding Vulnerable Groups Act,
- Department of Health (2018), National framework for NHS continuing Healthcare and NHS-funded nursing care [https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care]

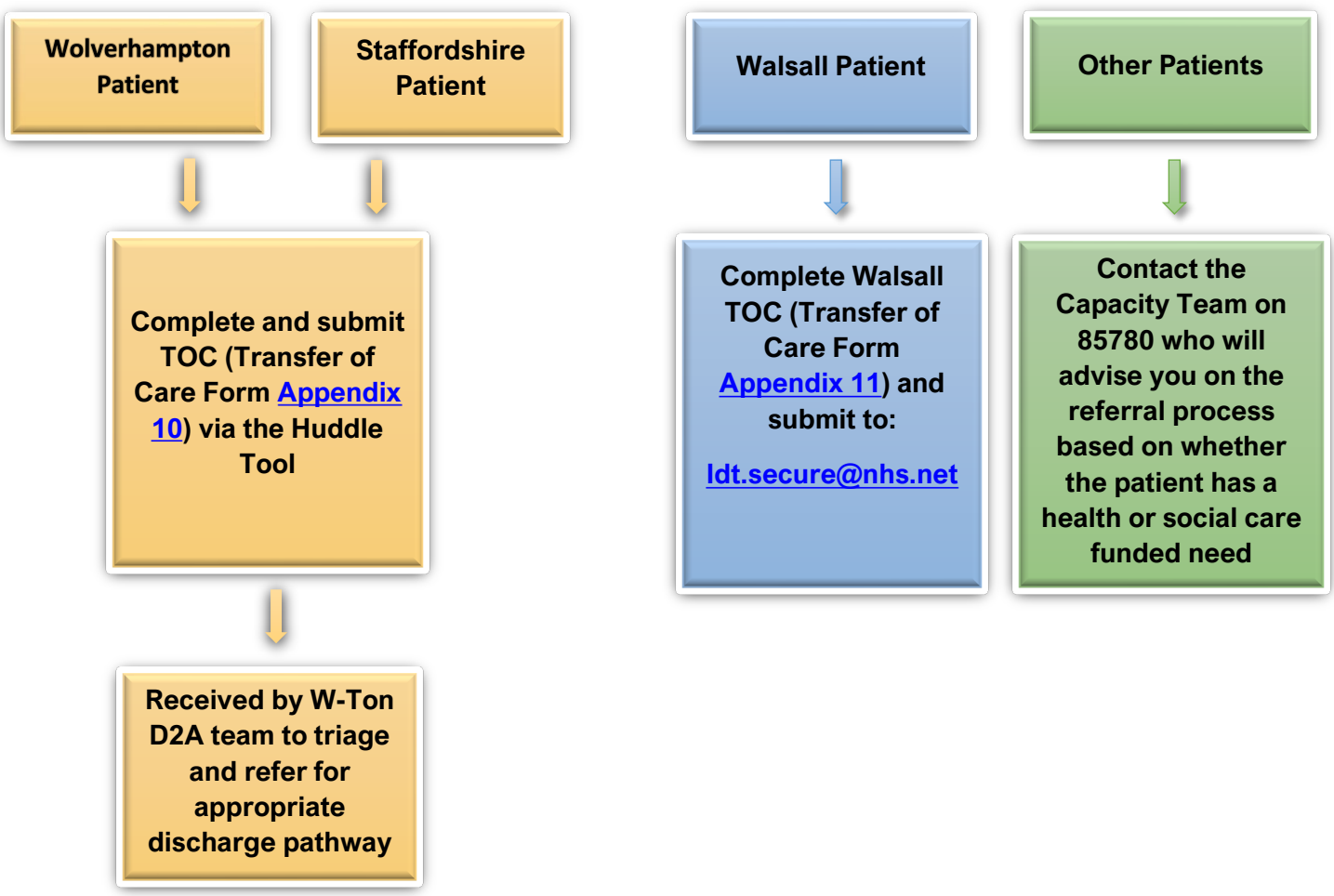
Part A - Document Control

Policy number and Policy version: **CP04 – V7.1**	**Policy Title** **Discharge Policy**	**Status:** Final		**Author: Matron Capacity & Patient Flow** **Chief Officer Sponsor: Chief Nursing Officer**
Version / Amendment History	Version	Date	Author	Reason
	7.1	August 2023	Matron for Capacity and Patient Flow	Inclusion of sections 4.1 – 4.6
	7	January 2023	Matron for Capacity and Patient Flow	Full review of policy
	6.3	May 2022	Matron for Capacity and Patient Flow	Inclusion of Appendix 13 – Refusal to Accept Medical Advice Disclaimer
	6.2	February 2022	Matron Lead for CBP	Updates to Appendix 2 and Appendix 2a
	6.1	January 2021	Matron Lead for CBP	Update to Appendix 2 and inclusion of new appendices 2a
	6.0	Oct 2019	Capacity Manager	Review
	5.0	June 2015	Matron Group	Review
	4.1	April - Sept 13 2013	Capacity Manager	Review
	4	July 2012	Capacity Manager	Review
	3	October 2011	Capacity Manager	Review
	2	Sept 2010	Capacity Manager	Review
	1	Sept 2009	Capacity Manager	Development
Intended Recipients: All healthcare professionals involved in the discharge of patients following an episode of care				
Consultation Group / Role Titles and Date: Matrons MFFD Group				

Name and date of Trust level group where reviewed	GNCP Ratification Committee Trust Policy Group March 2023 Virtual Approval – Trust Policy Group – Version 7.1 – August 2023
Name and date of final approval committee	Policy Group and the Trust Management Committee
Date of Policy issue	August 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	March 2026 (3 yearly or as required)
Training and Dissemination: As and when required by staff involved in Discharge of patients. This will be disseminated via Heads of Nursing, Matrons, community staff and All Users Bulletin	
To be read in conjunction with: • Wolverhampton Safeguarding Adults Policy & Procedures 2010 • Safeguarding Vulnerable Adults Policy CP53 • Policy for the prevention and management of pressure ulcers OP96 • Policy for simple discharge of patients by suitably trained professionally qualified staff CP39 • Booking non urgent patient transfers OP29 • Patient property OP18 • Medicines Policies • Medical Devices HS11 • Infection Prevention and Control Section • Health Records Policy – OP07	
Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	Monitoring: MFFD data Quality and Safety Committee
Document summary/key issues covered. Planning safe, timely and effective discharge from hospital	
Key words for intranet searching purposes	CP04 Discharge Policy

Discharge Process and Procedure

- Following admission discharge planning will commence therefore discuss discharge with patient and issue patient with Discharge Leaflet 'Planning your discharge from hospital' Mi074614. Discuss with patient/family/carer any issues which need to be addressed to ensure a safe and effective discharge from hospital
- Ensure EDD is entered correctly on Teletracking and supply patient /family/carer with EDD (Expected Date of Discharge)
- If the MDT have assessed that the patient will require additional support at home or a period of assessment within another care setting, follow the flow chart below



- The Huddle Tool is to be updated daily to indicate when a patient is medically fit for discharge and provide detail /progress on the patients discharge pathway.

- If there is an anticipated delay in discharge once the patient has been declared medically fit for discharge this is to be escalated to the Directorate Management Team. Patient Flow Assistants and/or Coordinators for the ward are to escalate as a delay to the Capacity Team for onward escalation as required.

- If the patient is medically ready to leave the hospital and no longer needs the level of care provided within an acute hospital setting and the patient and/or family are delaying the discharge the Senior Sister in charge of the ward will issue Letter 1 adjusted to reflect the reason for the delay (appendix 3-4). This action must be documented in the medical case notes. When issuing Letter 1 a meeting should be held between the Senior Sister in charge of the ward and the patient/carer/family to discuss the delay and the risks associated with delaying discharge and a time scale agreed for patient to be discharged.

- If there is no identified date of discharge following 1 week of issuing Letter 1 a further meeting should be held between the Senior Sister in charge of the ward and the patient/carer/family to discuss progress in the discharge. If no progress has been made at the meeting the Senior Sister in charge of the ward will issue Letter 2 to the patient/carer/family present at the meeting (appendix 3-4). This action must be documented in the medical notes.

- Discharge medications (TTOs) are to be prescribed and ordered 24 hours before the patients discharge date. Pharmacy is to be informed at the earliest opportunity if the patient will require a Dossett box.

- Organise transport if required – The Royal Wolverhampton NHS Trust will only provide transport if there is a clinical need. Transport is to be booked via the non-urgent transport booking office; they are to be informed of any specialist requirements e.g., require bariatric equipment or if the patient has any known infections. If the patient has a Do Not Resuscitate (DNR) order in place a letter is to be provided to the ambulance staff upon collection of the patient informing them of this. Ensure the correct discharge address is given to the transport booking office. It is important to notify the transport booking office of the need for transport so that ambulances can be arranged in a timely manner and prevent delays.

- Arrange necessary referrals and outpatient appointments not already covered with earlier discharge planning and ensure the patient/carer/family is aware of the arrangements. If not able to organise prior to discharge the appointments are to be forwarded to the patients discharge address.

- All Pending/Confirmed discharges must be updated on Teletracking to ensure a live bed state at all times.

- All adult patients are expected to be transferred to the Discharge Lounge with the exception of patient with challenging behaviour, very complex needs or end of life, as early as possible on the day of discharge. Patients are to be transferred with their medical notes. Ensure that pharmacy and transport are informed of the patients move to the Discharge Lounge.

- Discharge medications are to be checked against the discharge prescription and EPMA or treatment sheet. The discharge Nurse will inform the patient/carer/family of the medication regime and any possible side effects and specialist instructions.

- The E-Discharge notification is to be forwarded to the GP/GDP. Copies should be printed off to give to the patient, residential/nursing home and a copy is to be filed in the patient's medical notes. If E-Discharge is not available a manual copy of the discharge notification is to be completed and copies given to the patient, residential/nursing home, one to be posted to the GP/GDP and a copy to be filed in the patient's medical notes.

- The Discharge Checklist must be completed and filed in the patient's medical notes.

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NHS Trust

Discharge Checklist

Questions answered 'yes' with a * ensure the Complex Discharge form is also completed.

State discharge address and telephone number:

.....

.....

.....

Surname	NHS No
Forename	Unit No
Address	DOB
Postcode	(or affix patient label)

Prior to discharge	Yes	No	N/A	Date	Comments	Signature / Name / Designation / Stamp
Communication						
Medically fit for discharge documented in the medical notes?						
Electronic systems reflect any change of discharge destination?						
Local authority confirmed safe to discharge if safeguarding raised (SA1)?						
Form 10 completed if DOLS in place following discharge?						
Patient / advocate / relative / parent / care home aware of discharge (Please circle as applicable)						
Verbal or written information given (e.g., medical condition, driving)?						
Appropriate individuals have been informed of **ReSPECT** status **(includes ambulance crew, original given to the patient, copy placed in medical notes)**?						
E-discharge summary completed?						
How does the patient communicate?.....						
Infection Prevention						
Infection risk/s? (Please circle as appropriate) C diff / MRSA / CPE If other please specify..... Date of result: ____/_____/_____						
COVID-19 positive during this admission to hospital? Yes / No Date of Test:..... Routine 48 hour COVID-19 testing completed prior to discharge for patients going to ongoing care facilities e.g. care home? Yes / No / N/A (if N/A enter reason why in comments section e.g positive test in last 90 days). Patient being discharged to a care home or another Trust? Yes / No: COVID contact? Date that isolation finishes:						
Appointments post discharge						
Follow up appointments required? If 'Yes' specify:						
Advised patient to contact consultant if follow up appointment not received? (If no follow up required, enter N/A)						
Clothing and Accommodation						
The patient has suitable clothes & footwear for discharge?						
Does the patient have access to the property i.e. keys or key safe and code?						
Patient has access to food / heating if house is empty?						
Medication						
TTO's are checked any discrepancies have been escalated?						
Does the patient require oxygen at home? If Yes is this booked?.....						
Does the patient require a dosette box on discharge? If 'Yes' please allow extra time when planning discharge.						
Transport						
Mode of transport to discharge destination?						
Patient requires hospital transport has it been booked? Date & time booked:.....						
***Ongoing Care Needs – Complex Discharge Form must also be completed if answering 'yes' to following questions**						
* If the patient has a wound, PU, catheter or a device that requires on-going nursing care, falls clinic / community falls service has it been arranged? **(Please circle as applicable and specify in comments box)**						
* Funding confirmed if discharging to residential / nursing home?						
***Equipment – Complex Discharge Form must also be completed if answering 'yes' to following questions**						
*Mobility aids are with the patient for discharge?						
*Equipment has been delivered to discharge destination?						

At the point of discharge

14 days of giving sets, syringes and enteral feeding pump or 7 days of oral supplements supplied:			Yes / No / NA
7 days of Dressing supplied:	Yes / No / NA	Cannula removed:	Yes / No / NA
Safe hands badge has been removed:	Yes / No / NA	Drains removed:	Yes / No / NA
Medication supplied to patient and locker items emptied:	Yes / No / NA	Urinary Catheter Passport completed?	Yes / No / NA
If medications in locker are no longer prescribed, discuss with patient or carer if OK to return them to pharmacy:			Yes / No / NA
Confirmed discharge destination with transport crew and documentation correct? Yes / No / NA			
ReSPECT form in place (Please tick): ☐ Yes ☐ No – If 'yes' original form included and a scanned copy placed in medical notes.			
ReSPECT form given to ambulance team?	Yes / No / NA		
Property returned:	Yes / No / NA		
7 days of continence equipment supplied	Yes / No / NA		
Outpatient appointment requested	Yes / No / NA	If Yes when for (days / weeks)	
Outpatient appointment booked	Yes / No / NA	Date / Time:.....	
Been discharged off computer system PAS	Yes / No / NA		

Signature: ..... Designation: .....

Date:..... Time: ..... Stamp:

ADULT Complex Discharge

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☐ Please tick to confirm that you have discussed the patient / legal representative / NOK who and why this information will be shared e.g. residential care

A copy of this letter is be sent in conjunction / with the e-Discharge.

A Discharge Checklist is also still required to be completed.

Please remember residential, nursing homes and community care providers do not keep a stock of dressings, feeds, catheters or oxygen.

Past Medical History refer to e-discharge

Discharge date: ..... Time: .....

Discharging Ward: ..... Ward contact number: .....

Care home details, name and contact details: .....

.....

CHC Eligible: ☐ Yes ☐ No

If 'yes' commissioning CCG and named contact:.....

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Communication:

Verbal handover given to:.....

Other Referrals made to: ☐ BULLEN ☐ Community nursing team ☐ Compton Hospice ☐ District Nurses ☐ Falls ☐ HOOF ☐ OPAT ☐ Pain clinic ☐ Social worker ☐ Tissue Viability

Reason for referral specify details: .....

Care home patients - is the red bag with the patient? ☐ Yes ☐ No ☐ N/A

Outpatient's appointment? ☐ Yes ☐ No If yes, state date and time planned:.....

Safeguarding:

Safeguarding concerns ☐ Yes ☐ No

If 'yes' discussed with the discharge health care provider

Date:..... **Time:**.....

Does the patient require a DoLS to be put back into place?

☐ Yes ☐ No ☐ N/A

Infection Prevention status:

Please refer to discharge checklist

Patient Handling and Moving / Mobility

Any patient handling needs? ☐ Yes ☐ No

Specify:.....

Type of mobility aids in use: .....

.....

Mobility aids with the patient ☐ Yes ☐ No ☐ N/A

Continence

Continence care required? ☐ Yes ☐ No If 'Yes', please specify:

.....

If urinary sheath used, 7 issued? ☐ Yes

Delivery of equipment planned? ☐ Yes Date of delivery:.....

Continence pads required? ☐ Yes ☐ No

If yes, 1 pack of pads issued? ☐ Yes

Continence assessment sent to activate order? ☐ Yes

Urinary Catheter:

Urinary catheter in situ ☐ Yes ☐ No

Date of insertion: ..... Date urinary catheter due to be changed:.....

Self-Intermittent Catheter 7 days' supply sent with the patient?

☐ Yes ☐ N/A

☐ Short term ☐ long term urinary catheter

1 catheter, 1 anaesthetic gel, 7 night bags and 1 leg bags with patient?

☐ Yes ☐ N/A

TWOC planned ☐ Yes ☐ No Date TWOC planned for:.....

Nutrition and Hydration State if any allergies:

Swallowing Risk: ☐ Yes ☐ No

Modified level of diet or fluids: ☐ Yes ☐ No

Level of diet:..... Level of Fluids:.....

Assistance required with eating and drinking? ☐ Yes ☐ No

Community SALT team referral: ☐ Yes ☐ No

Date referred if applicable: .....

Current MUST Score:.....

Enteral feeding tube in place Yes [] (document care plan overleaf)

☐ Yes ☐ No

Enteral feeds - competency to administer demonstrated ☐ Yes ☐ No ☐ N/A

Enteral feeds - 14 days supply of NG feeds been sent with the patient?

☐ Yes ☐ N/A

Oral nutritional supplements - 7 days supply been sent with the patient?

☐ Yes ☐ N/A

Fluid target:.....

ReSPECT status:

Please refer to discharge checklist

Falls:

At risk of falls? ☐ Yes ☐ No

Fallen during this admission? ☐ Yes ☐ No

Strategies in place to manage the risk e.g. tagging / slipper socks: .....

.....

.....

.....

Tissue Viability:

Risk of pressure ulcers ☐ Yes ☐ No

Patient has a pressure ulcer ☐ Yes ☐ No

Patient has moisture associated skin damage: ☐ Yes ☐ No

Site of pressure ulcer: .....

Category of pressure ulcer: .....

Site of Moisture Associated Skin Damage:.....

DATIX ref: .....

Does the patient require any (circle) mattress / cushion / hospital bed / social equipment / specialist equipment

Date equipment ordered:..... Delivery date of equipment:.....

(Please document list overleaf)?

Wounds

Wound circle: ☐ None ☐ Yes if 'yes' site: .....

Wound type: .....

Photograph taken: ☐ Yes ☐ No Date: .....

For Negative Pressure Wound Therapy (NPWT) (e.g. VAC) only - have TVN informed of discharge ☐ Yes ☐ N/A

Are staples / sutures due to be removed? ☐ Yes ☐ N/A

(Removal device issued) ☐ Yes

Type of wound dressing:.....

Wound dressing last changed: ..... Frequency: .....

Wounds - sent 7 days of dressings with the patient? ☐ Yes

(Please document list overleaf)

Medication

Anticipatory medications required ☐ Yes ☐ No

If yes supplied ☐ Yes ☐ No

Does the patient require oxygen? ☐ Yes ☐ No

If yes, has a HOOF form been completed by the medical staff? ☐ Yes ☐ No

If yes, date of delivery of oxygen:.....

Are community specialist nurses required to administer any medications?

☐ Yes ☐ No

If yes, has referral to Community Team been made? ☐ Yes ☐ No

Date & Time:.....

Patient Specific Direction signed & sent to community nursing service

☐ Yes ☐ N/A

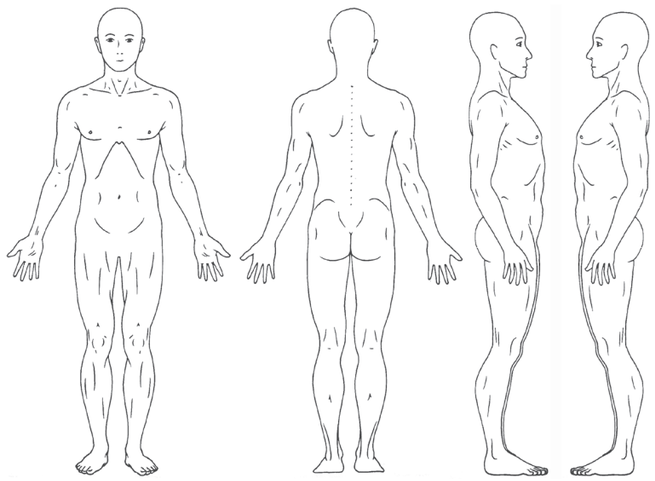
(Please document any further information overleaf)

Signature: ..... Designation:.....

Date:.....Time: .....Stamp:

Please use the back of this letter to add any additional information that you feel is relevant to the patients discharge.

Type of protection / prevention e.g. Primary / secondary / skin protection	Generic product	Tick as applicable	Wound / site
Primary (next to wound bed)	Non-adherent		
Primary (next to wound bed)	Foam		
Primary (next to wound bed)	Hydrocolloid		
Primary (next to wound bed)	Hydrogel		
Primary (next to wound bed)	Other – please state:		
Skin protection- periwound or protection from other moisture	Skin protectant		
Secondary dressing to absorb or secure	Absorbent pad		
Secondary dressing to absorb or secure	Bandages / hosiery – state what:		



Body Map

Please enter any:

- Wounds
- Bruises (include any bruising from prophylactic VTE treatment)
- Pressure ulcer (including blanching skin, category 1-4, deep tissue injury, unstageable or moisture associated skin damage)
- Any visible injection / venepuncture sites.

Signature: ..... Designation:.....

Date:.....Time: .....Stamp

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The Royal Wolverhampton
NHS Trust

New Cross Hospital
Wolverhampton Road
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Our ref: Patient Letter 1

Date:

INSERT PATIENT DETAILS

Dear

Re: Your Discharge from Hospital

We are pleased that you are now medically ready to leave hospital. Your discharge assessment has been completed and the key Nurses, Doctors, Therapists and Social Worker should have discussed with you what your needs will be when you are discharged.

You have been advised you no longer require acute hospital care and your future health needs with be met in another environment. It is not possible for you to remain in hospital and we will make every effort to assist you in finding a discharge plan/destination of your choice that meets your needs. However, if you are unable to identify a suitable destination within the next 7 days or placement you prefer has no vacancies within this timescale we shall assist you by identifying an alternative temporary placement.

Please be aware that it is important that you accept the placement as you will be unable to remain in hospital once you are ready for discharge and a suitable place has been offered. Please be assured that wherever this is the case the placement offered to you will fully meet your needs.

We recognise that this letter may cause some anxieties and if you would like to talk to a member of the Discharge Team, Social Worker, Nurse or your Consultant who can support you in your decision, please let a member of staff looking after you know.

Yours sincerely

NHS
The Royal Wolverhampton
NHS Trust

New Cross Hospital
Wolverhampton Road
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Our ref: Carer Letter 1

Date:

INSERT PATIENT DETAILS

Dear

Re: Your …… Discharge from Hospital

We are pleased that …… is now medically ready to leave hospital.
Their discharge assessment has been completed and the key Nurses, Doctors, Therapists and Social Worker should have discussed with them/you what their care needs will be when discharged.

You have been advised …… no longer require acute hospital care and their future health needs with be met in another environment. It is not possible for …… to remain in hospital and we will make every effort to assist in finding a discharge plan/destination of choice that meets their needs. However, if you are unable to identify a suitable destination within the next 7 days or preferred placement has no vacancies within this timescale we shall assist by identifying an alternative temporary placement.

Please be aware that it is important this placement is accepted as they will be unable to remain in hospital once ready for discharge and a suitable place has been offered. Please be assured that wherever this is the case the placement offered and will fully meet their needs.

We recognise that this letter may cause some anxieties and if you would like to talk to a member of the Discharge Team, Social Worker, Nurse or your Consultant who can support you in your decision, please let a member of staff looking after you know.

Yours sincerely

The Royal Wolverhampton
NHS Trust

New Cross Hospital
Wolverhampton Road
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Our ref: Patient Letter 2

Date:

INSERT PATIENT DETAILS

Dear

Re: Your Discharge from Hospital

We are pleased that you are now ready to leave hospital. You will have already received our initial letter indicating the need to arrange a suitable discharge destination. We understand that up until now, you have been unable to secure a discharge destination of your choice.

Whilst we understand that this may cause anxiety, you will be aware that there is an increased demand on hospital services and we need to be able to provide treatment to everyone as soon as possible.

In order to discharge you from hospital as smoothly as possible the Trust will formally discharge you to the alternative temporary placement in the next few days, and you may stay there until there is a place in your preferred choice of destination.

Any questions regarding your discharge can be answered by the staff caring for you. If you would like to discuss the decision to move with a Senior Manager, please speak to the Senior Ward Sister.

If you remain dissatisfied, we can investigate your complaint under the NHS complaints procedure. Please contact your Senior Ward Sister who will provide guidance on how to make your complaint.

I would like to offer you my best wishes for your ongoing care/rehabilitation.

Yours sincerely

The Royal Wolverhampton
NHS Trust

New Cross Hospital
Wolverhampton Road
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Our ref: Carer Letter 2

Date:

INSERT PATIENT DETAILS

Dear

Re: Your …… Discharge from Hospital

We are pleased that ……is ready to leave hospital and you/they will have already received our initial letter indicating the need to arrange a suitable discharge destination. We understand that up until now a discharge destination has been unable to be secured.

Whilst we understand that this may cause anxiety you will be aware that there is an increased demand on hospital services and we need to be able to provide treatment to everyone as soon as possible.

In order to discharge ……. from hospital as smoothly as possible the Trust will formally discharge them to the alternative temporary placement in the next few days and may stay there until there is a place in the preferred choice of destination.

Any questions regarding the discharge can be answered by the staff caring for …….
If you would like to discuss the decision to move with a Senior Manager, please speak to the Senior Ward Sister.

If you remain dissatisfied, we can investigate your complaint under the NHS complaints procedure. Please contact the Senior Ward Sister who will provide guidance on how to make your complaint.

I would like to offer you my best wishes and thank you for your co-operation.

Yours sincerely

Name ……. Unit No…….

Date…….

Criteria for Discharge

To be completed by Named Nurse

Patient returned to ward at ……

Prior to discharge, I confirm that the patient:

	Yes	No	Comments
1. Is fully conscious and orientated	☐	☐	……
2. Has a stable pulse and blood pressure	☐	☐	……
3. Has passed urine (where relevant)	☐	☐	……
4. Has had a drink and been offered food	☐	☐	……
5. Has had the wound site checked (if appropriate)	☐	☐	……
6. Venflon removed	☐	☐	……
7. Can walk with minimal assistant	☐	☐	……
8. Has had post operative instructions verbal and written	☐	☐	……
Fact Sheet ☐ Shield/Pad/Other ☐			
9. Has analgesia/medication as appropriate	☐	☐	……
10. Is aware of outpatient follow up (where relevant)	☐	☐	……
11. MED 3 given (if appropriate)	☐	☐	……
12. Has a responsible adult to escort them home	☐	☐	……
13. Has a responsible adult to stay with them overnight	☐	☐	……
14. Has reasonable access to a telephone	☐	☐	……
15. Change of dressing / wound care advice	☐	☐	……
16. Has removal of sutures instructions	☐	☐	……
17. Has District Nurse booked or advised to attend practice nurse	☐	☐	……
18. Discharge notification	☐	☐	……
19. Has contact telephone number	☐	☐	……

I confirm that these criteria have been met:

Named Nurse …… Signature …….

Discharging Nurse …… Signature …….

Time of discharge …… Date …….

Name ……. Unit No…….

Date…….

Criteria for Discharge (For Day Case Only)

To be completed by Named Nurse

Patient returned to ward at ……

Prior to discharge, I confirm that the patient:

	Yes	No	Comments
1. Is fully conscious and orientated	☐	☐	……
2. Has a stable pulse and blood pressure	☐	☐	……
3. Has passed urine (where relevant)	☐	☐	……
4. Has had a drink and been offered food	☐	☐	……
5. Has had the wound site checked (if appropriate)	☐	☐	……
6. Venflon removed	☐	☐	……
7. Can walk with minimal assistant	☐	☐	……
8. Has had post operative instructions verbal and written	☐	☐	……
DVT Leaflet ☐ Physiotherapy ☐			
9. Has analgesia/medication as appropriate	☐	☐	……
10. Is aware of outpatient follow up (where relevant)	☐	☐	……
11. MED 3 given (if appropriate)	☐	☐	……
12. Has a responsible adult to escort them home	☐	☐	……
13. Has a responsible adult to stay with them overnight	☐	☐	……
14. Has reasonable access to a telephone	☐	☐	……
15. Change of dressing / wound care advice	☐	☐	……
16. Has removal of sutures instructions	☐	☐	……
17. Has District Nurse booked or advised to attend practice nurse	☐	☐	……
18. Discharge notification	☐	☐	……
19. Has contact telephone number	☐	☐	……

I confirm that these criteria have been met:

Named Nurse …… Signature ……

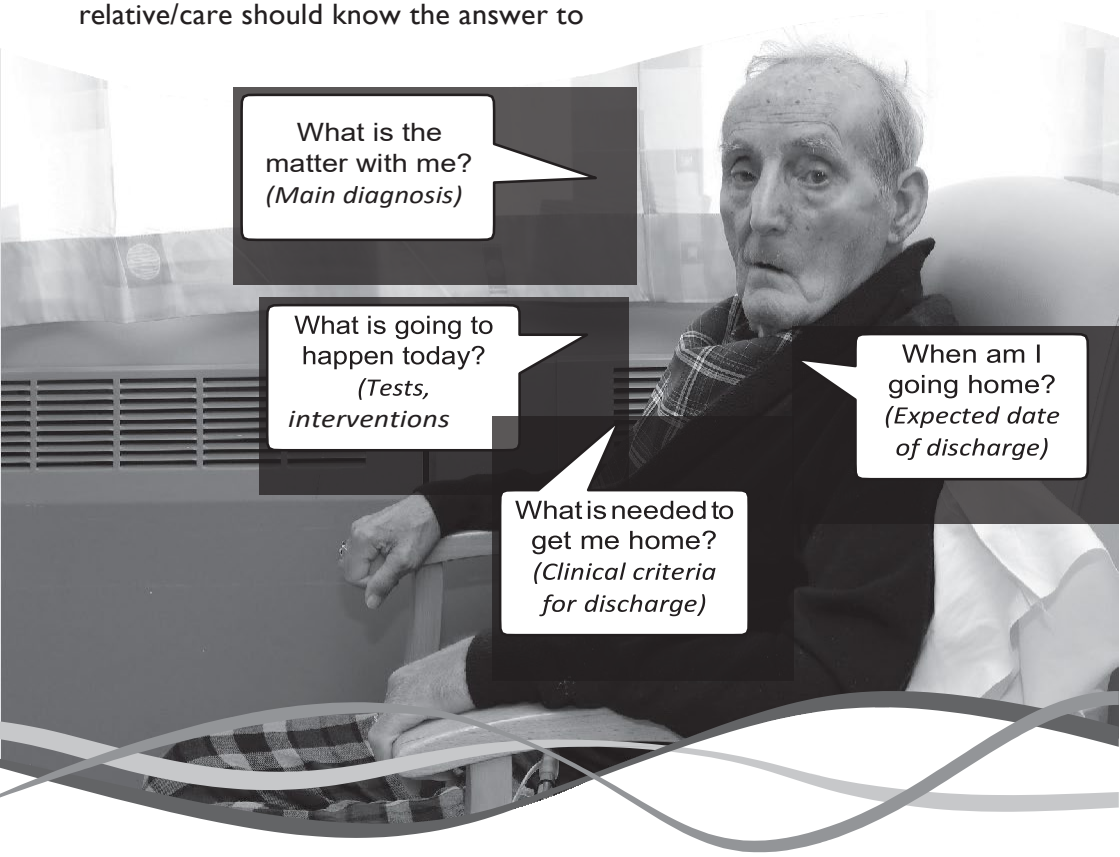
Discharging Nurse …… Signature ……

Time of discharge …… Date …….

The Royal Wolverhampton
NHS Trust

Planning your discharge from hospital

Four key questions every patient, relative/care should know the answer to



Safe & Effective | Kind & Caring | Exceeding Expectation

Your discharge from hospital

We will involve you in planning your discharge from an early stage. Preparation for discharge usually commences from the point you are admitted, with staff assessing your health and social care needs in preparation for your discharge from hospital.

You will be given an estimated date of discharge to help you and your relatives plan when you will return home. Your estimated date of discharge may change depending how quickly you are recovering. You will be informed if this date changes.

Beds at this hospital are classed as 'ACUTE' which means that we need to be able to admit patients in emergencies and have the ability to discharge patients as soon as we consider them safe to leave with care plans that may continue in the community either at home or in another care setting.

Why might I be moved to another ward?

We aim to care for all patients in the most appropriate wards. You are currently in an acute bed designed to deliver care in the first stages of your illness. As your condition improves your nursing, medical and therapy team may make the decision to move you to another ward based on treatment or rehabilitation needs.

What will happen when I move?

The Nurse in charge of your care will discuss with you the plan to move you to your new ward. The ward will inform your next of kin when you are transferred to your new ward. The medical team for that area will take over your care. If you have further questions please ask to speak to the Matron for your area.

What will happen when you are ready for discharge from hospital?

When you no longer require an acute hospital bed to receive your care you will be discharged back to your usual place of residence to continue your recovery.

If you receive care from social services or other agencies we will help to re-instate that care.

If it is felt that you need additional support on discharge this will be arranged to support you - this may include returning home with temporary support and may include further assessment at your usual place of residence or being stepped down on a short term basis to a bed outside of the acute hospital setting. If additional support is not essential for your discharge you will go straight home and any further social service or other support considered to be non-urgent should be arranged by yourself after discharge.

Wolverhampton Information Network (WIN) is a free online resource to help you find local health, care and community services. To view services go to: http://win.wolverhampton.gov.uk/kb5/Wolverhampton/directory/home.page

Prior to your discharge from hospital, please ask a relative or carer to bring in a full set of outdoor clothes for you. On the morning of your discharge you will be transferred to the Discharge Lounge while you wait for your medications to take home to be prepared and your transport home. Wherever possible please arrange for someone to come and pick you up upon discharge.

We aim to ensure that your discharge/transfer from hospital is smooth and as comfortable as possible.

If you have any questions please speak to the Nurse in charge of your care.

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

Designed & Produced by the Department of Clinical Illustration,
New Cross Hospital, Wolverhampton, WV10 0QP Tel: 01902 695377.

Review Date 03/21 Date Produced 2014 MI_074614_01.11.18_V_5

HM Government

NHS

You are leaving hospital: returning home

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to return home to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is at home where you can continue to recover in a familiar environment.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact:

Administration Team
Capacity Team
01902 695780

HM Government

NHS

You are leaving hospital: moving or returning to another place of care

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to move to another place of care to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is a bed in the community which can best meet your needs at this time. If you are a care home resident this will most likely be your care home.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact:

Administration Team
Capacity Team
01902 695780

TRANSFER OF CARE FORM WOLVERHAMPTON:

Name:		**DOB:**		**NHS:**	
		Allergies:			
Address & Postcode:		**End of Life Care (EOLC) Consider whether the rapid home to die pathway is appropriate**	**Gold standard framework status:**		
			ReSPECT document:		
		DNACPR in place?	Yes: ☐ No: ☐	**Date:**	
Tel No:		**Next of Kin Details:**			
		Address & Contact Number:			
Hospital:	The Royal Wolverhampton NHS Trust				
Ward (including ward tel no):		**Date & results of any Covid-19 test:**			
GP:		**Date of onset of Covid-19 symptoms:**			
GP Address in Full:		**Details about isolation period MUST be included in discharge documentation** (tick to confirm):	☐		
		Infection Alert e.g. MRSA, C.Diff	Yes: ☐ No: ☐		
GP TEL:		**Infection details:**			
Past Medical History **(no abbreviations)**		**Admission date:**		**Discharge date:**	
		Date & time referral received:			

Past Medical History **(no abbreviations)**	
Reason for admission (incl. date and cause for attending hospital)	
Pen Picture / patient overview include significant new diagnoses, co-morbidities where possible categorised (e.g. stage 3 CKD; include if patient is wearing/using brace) **Pre-admission details, care, mobility, support**	
Rehabilitation /Reablement Goals - pathway 1 or 2 (to be provided by ward in the first instance) *Please indicate here if specialist equipment is required?*	

CICT Therapy required: ☐

Medication e.g. blister pack, timed meds; anticipatory meds, do carers need to admin meds Does patient need prompting with medications?	
Mobility and Transfers e.g. manual handling, equipment, transfers, and mobility, how many carers required	

Continence e.g. pads, catheter, stomas, requires assistance of carers	
Nutrition e.g. peg, pureed, assistance, loss of weight?	
Breathing (e.g. oxygen reqs, inhalers, nebs, does breathlessness affect ADLs).	
Skin and hygiene (including pressure care/ equipment/ back dressings)	
Communication Needs (incl. spoken language, hard of hearing, requires interpreter?)	
Psychological & emotional needs (incl. mood, anxiety, causes, medications, interventions)	
Cognition and Behaviour (must include mental capacity status. Consider 6-CIT, MoCA (Montreal Cognitive Assessment), does patient have insight into needs)	
Behaviour (incl. details about challenging, poses risk self or others, causes, how managed? Does patient have Mental Health needs?)	
Altered state of consciousness (eg. Does patient suffer seizures, loss of consciousness)	
Pain and symptom management (incl. diagnosis specific information, causes)	

Consent to share information

The person fully understands the information given and is able to consent to the sharing of information

Yes Complete section A

No - lacks capacity Complete section B

Section A

I have received information about Discharge to Assess and I would like to access Home First. I understand this involves review and sharing of my health and social care records with relevant professionals who need access in order to provide care and management. I understand that the record will remain confidential at all times.

Patient Has Consented ☐

Section B

In cases where the patient is believed to lack capacity a separate MCA assessment must be carried out and is filed in the persons medical records.

If the person lacks capacity or is too ill to consent to the assessment process I believe it is in their best interest for the assessment process to commence and their health and social care records be reviewed and shared as specified in Section A

☐

MCA Complete and in persons medical records

Does the patient have a Lasting Power of Attorney? (please highlight)	Yes: ☐	No: ☐			
If Yes which type (please highlight	**Personal welfare** ☐	**Property and Financial Affairs** ☐	**Power of Attorney for health and welfare** ☐		
I confirm that I have had this conversation with the patient regarding their consent to share their information.	Yes: ☐	No: ☐			

Name and designation of referring clinician:	
Bleep Number:	
Date:	

SECTION 2: TRIAGE CHECKLIST tick list below must be completed

Principles

- *'Why not home, why not today' drives all decisions*
- *Care for discharge based on what is only absolutely necessary, 'just sufficient', not 'convenience' or 'just in case'*
- *Patients with no capacity for functional improvement, not to go round and round D2A, ongoing care package or placement sourced directly from acute as per Covid-19 discharge guidance*

CHECKLIST (to be completed by ward and T&T)	**Tick**		**CONSIDERATIONS**
	Y	**N**	
Is there a difference between the patient's pre-morbid functional state and current functional state? (i.e. previous and current Barthel)	☐	☐	
Delirium excluded?	☐	☐	
Delirium can be managed at home?	☐	☐	
3x 6 week periods of D2A continuously in the last 12 months without going home/permanent placement and/ or < 6 weeks from last D2A episode?	☐	☐	
NEW development of the following (new development of, really important, not relevant if not a new development) • Hoist with 2 and/or or 2 x hourly continence needs Or Barthel < 5	☐	☐	

Triage staff member name and signature:	

SECTION 3: TRIAGE DECISION *(tick to indicate discharge pathway)*

Pathway 1 **HOME FIRST** *(95% of D2A pts)* Go to Sec 4	☐	**Pathway 2** **REHAB BED** *(4% of D2A pts)* Make referral	☐	**Pathway 3** **24 HR CARE** *(1% D2A pts)* Go to Sec 4	☐	Residential: Nursing:	☐ ☐

SECTION 4: PATHWAY 1; HOME FIRST.

Lives alone Y/N/Carer	
Property details (Is home safe to return to? Have Wolverhampton Homes been informed?)	
Health & safety (e.g. access to property/ pets/ risks/male carer)	
Key Safe Y/N:	

Contact details of person who has keysafe number:	
Is Telecare required?	
Support Plan (including any specific clinical, medication, or care needs inc. informal carer support)	
Reablement/Care Calls Required:	
Number of carers, calls and time slot required: (AM/PM/Late)	
Frequency of calls (please specify)	**Everyday** ☐ **Weekday only** ☐ **Other:**
Overnight requirements? (please specify needs, any risks and frequency)	
Reason for visits please highlight:	**Washing, dressing and hygiene needs** ☐ **Pressure area care** ☐ **Toileting** ☐ **Prepare and feed meals** ☐ **Transfer bed/chair/ bed** ☐ **Administer medication** ☐ **Other reasons** ☐

PATHWAY 3: CARE HOME WITH NURSING REQUIREMENTS

Care Home with Nursing care required:	
Record any special requirements (including mental health needs for example S117):	
Identify any health-related tasks i.e. PEG feeds, suction, tracheostomy, catheter care, medicines, dressings etc.	
Additional relevant information e.g. postcode different from the address above as used for searching a home, rationale for night-time needs, behaviour charts where possible	

DISCHARGE CHECKLIST

IS ALL EQUIPMENT IN SITU?	
CAN TTO'S BE ARRANGED FOR SAME DAY DISCHARGE?	
CAN TRANSPORT BE ARRANGED FOR SAME DAY?	
IS THERE ANY REASON THIS PATIENT CANNOT BE DISCHARGED SAME DAY?	
HAS THE "PAYING FOR CARE" LEAFLET BEING PROVIDED WHERE APPLICABLE?	
IF "NO" FOR ANY OF THE ABOVE PLEASE SUPPLY ADDITIONAL INFORMATION:	

Walsall Healthcare NHS
NHS Trust

Walsall Council

Profile

Name:		**DOB:**		
		NHS No:		
Address: **Post Code:**		**Mosaic No:** **Key-safe Location: in situ** **Key-safe Number:** **Telecare: none** **Detail:**		
Tel No:		**Spoken Language: English** **Religion:**		
Email address:				
Sensory/communication difficulties:		**Household information/Lives alone**		
Doctor's (GP) details: **Telephone No:**		**Property type/details:**		
Next of Kin Details:			**Key Holder Details:**	
Emergency Contact Details:			**Health and Safety information:** **(Pets/risks/smoker etc.)**	
PMH and Current medical issues		**Allergies:**		
End of Life Care (EOLC) Consider whether the rapid home to die pathway is appropriate	**Gold standard framework status:**	**R/A/G**		

Respect document	Yes No
Admission Date	
Reason for admission	
COVID 19 Information	Date of test: Results of the test: Date of symptoms starting: End date of isolation period: **Has the patient been in contact with COVID-19 during admission:**
Pen Picture: **Preadmission details, care, mobility, family support.**	

Support required with personal care	
Skin Care/Monitoring	
Pressure care equipment in situ – EG hospital bed/mattress	
Is support required with medication? **Medication Information:** **(Blister pack, needs support, needs timed meds etc.)**	
Manual Handling: **(Equipment in place, transfers, and mobility)**	
Continence Information: **(pads, stoma, catheter – needs assistance etc.)**	
Nutritional Information: **(Peg, pureed, gluten free, needs assistance feeding, finger food etc.)**	
Cognition/memory /psychological and emotional well-being support	
Altered state of consciousness	
Pain management/symptom control	
Does the individual have reablement potential? What are the goals	
Support Plan: **Care calls required and number of staff** **Tasks to be completed** **Family/other support networks involved**	
Completed by: **Designation:** **Date:**	
Ward:	
Estimated discharge date	

Consent to share information
The person fully understands the information given and is able to consent to the sharing of information **Yes Complete section A** **No - lacks capacity Complete section B**
Section A **I have received information about Discharge to Assess and I would like to access Home First. I understand this involves review and sharing of my health and social care records with relevant professionals who need access in order to provide care and management. I understand that the record will remain confidential at all times.** **Patient Has Consented ☐** **OR:** **I wish to nominate …… ……..to act on my behalf and participate in the assessment process**
Section B **In cases where the patient is believed to lack capacity a separate MCA assessment must be carried out and is filed in the persons medical records.** **If the person lacks capacity or is too ill to consent to the assessment process I believe it is in their best interest for the assessment process to commence and their health and social care records be reviewed and shared as specified in Section A** **MCA Complete and in persons medical records ☐**

Does the patient have a Lasting Power of Attorney? (please highlight)	Yes	No

If Yes which type (please highlight	Personal welfare	Property and Financial Affairs	Power of Attorney for health and welfare

I confirm that I have had this conversation with the patient regarding their consent to share their information. Yes ☐ No ☐
Date referral received:

Further information required if referring for discharge to assess bed required

Why can the individual not return home	
Any presenting Cognitive/behavioural issues. If Yes, please attach behavioural chart completed to date.	
What are the presenting night time needs?	
Mental Capacity assessment regarding discharge destination, please attach MCA if the individual lacks capacity	
Individuals/next of kin view about the placement	
Professionals consulted/involved for discharge planning	
Will a checklist be required upon discharge?	
Recommendation of the type of placement	

If Rehab bed required ICT paperwork to be completed by ward please

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Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Rapid Home to Die Care Bundle
- From hospital to home -

To be used by health care professionals for patients in the last hours or days of life.

The aim of this care bundle is to facilitate a safe, timely and well coordinated discharge home for patients that are imminently dying and are expressing a wish to die at home. As with all care bundles the rapid home to die care bundle aims to support, not replace clinical judgement.

Consultant:.....

Patients Discharge Address (if different from above):

.....

.....

G.P. .....

Surgery: .....

Surgery Number:.....

Patients NOK / main contact for discharge planning

Name: .....

Relationship: .....

Telephone Number:.....

For further support and guidance please refer to palliative care intranet site or contact 01902 695212 ext. 5212

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When and how to use.

Why commence the care bundle?

Most people would prefer to receive their end-of-life care at home and would not wish to die in an acute hospital. Despite this a lack of communication with the patient, their carers and between health and social care professionals often results in patients dying in an acute hospital setting with no clinical need for them to be there.

The Rapid home to die care bundle can be used to support those patients and their families who wish to return home for their end of life care (including residential and nursing care) and are thought to be in the last few days of life.

When to use this care bundle

- The patient is thought to be in the last days of life.
- All 5 initial assessments criteria have been achieved (see initial assessment section page 3).
- There has been an open and honest conversation with the patient and their family / carers / care establishment, and they recognise that the patient is thought to be in the last days of life. A summary of the discussion should be clearly documented in the care records.
- The patient has the capacity to make a decision to return home to die.
- Or the decision has been made in accordance with a 'best interests' decision.
- Or in response to information contained within an 'advance statement of wishes' document.

When the care bundle should not be used

- A decision has been made to continue active treatment i.e. IV antibiotics/ IV fluids.
- The prognosis is likely to be greater than a few days.
- The patient and / or their family / carer have poor insight in relation to the patient's impending death, or it has not been discussed.
- Not all 5 initial assessment criteria have been met (see initial assessment section page 3).
- There is inadequate family support available from the family / carers / care establishment or from essential community services to safely support the patient to die at home.
- The patient is assessed as lacking capacity to make the decision to return home to die and they do not have an advance statement of wishes containing information to suggest that this was their expressed wish, or the MDT do not consider the discharge to be in the best interest of the patient.

Initial assessment

All 5 criteria detailed below **must** be achieved in order for the patient to be commenced on the rapid home to die care bundle. (Please tick)

1. ☐ The multidisciplinary team have agreed that the patient is in the last days of life.
2. ☐ The patient chooses to die at home or a care facility (or carer if patient does not have capacity).
3. ☐ The family / carer / care facility support the patient's decision.
4. ☐ The medical team have completed a DNACPR form.
5. ☐ The patient has the relevant CHC fast track document completed in full and faxed to the appropriate area.

Once commenced this care bundle offers general guidance. Please refer to the Palliative and End-of-life Care Department intranet site for guidance for discharging to specific areas. The area details to follow are dependent on the patients GP address e.g. Wolverhampton, Wyre Forrest, Dudley, Sandwell, Walsall, Staffordshire and Cannock.

In order to complete the rapid home to die care bundle successfully outcomes 1-4 are to be completed in full.

Initiating staff (one doctor, one trained nurse)	Doctor's Name: .....Signature / Stamp Contact number: .....
	Nurse's Name: ..... Signature / Stamp Role: .....

Date of commencement: ..... Time: .....
Palliative Care Team informed of commencement: ☐
Actual date / time of discharge: ..... / .....
Date & time of discontinuation if appropriate: ..... /.....
Reason for discontinuation: .....

For audit purpose inform the palliative care team on ext. 5212 when commencing rapid home to die care bundle. Please state patients name, unit number and ward if leaving message.

Outcome 1

Community teams are aware of the impending discharge and are able to support the patient to die at home.

Please refer to palliative and End of Life Care intranet page

1. GP aware of impending discharge. ☐	Signature / Stamp: Date:..... Time: .....
2. District nurses aware of impending discharge. ☐ Or Patient is being discharged to a nursing home. ☐	Signature / Stamp: Date:..... Time: ..... District Nursing Team:..... District Nurse telephone:..... Referral date:.....
3. Appropriate District Nurse authorisation form completed **in full.** ☐	Signature / Stamp: Date:..... Time: .....
4. Appropriate care provision organised. ☐ Not applicable ☐	Signature / Stamp: Date:..... Time: ..... Agency providing care:..... .....
5. Other appropriate services have been informed of impending discharge. ☐ Please consider - Community palliative care service Night sitters service	Signature / Stamp: Date:..... Time: ..... Please state which services have been referred to:..... ....
6. Are there any information needs for the family / carer to consider? e.g. catheter care, oral care, medication, leaflets. Yes ☐ No ☐	Relative / carer information needs identified: ..... Date:..... Signature / Stamp: .....
7. Going home in the last days of life information leaflet handed to family or carers Yes ☐ No ☐	Date:..... Signature / Stamp: .....

Outcome 2

Consideration has been given to the environment to which the patient will be discharged.

Please refer to palliative and End of Life Care intranet page

Complete with family / carer or community health care professional.

1. Details of patients discharge address are discussed with patient / relatives / carers or care establishment. Consider the following:

Is the patient entirely bed bound?

Yes ☐ ➡ ward to facilitate equipment order.

No ☐ ➡ refer to OT ☐

Date referred: .....Signature / Stamp:.....

2. Is equipment required? (e.g. hospital bed, bed rails, bumpers, bedside tables, commode). Yes ☐ No ☐ See area specific intranet page for ordering details.	Equipment ordered .... Date:..... Signature / Stamp: ..... Equipment Delivered ☐
3. Has access to property been considered? ☐	Who will provide access to property? .....

4. Where will the equipment will be situated.

.....

There are sufficient electrical points. ☐

5. Are there any environmental risks? i.e. dogs, high risk relatives. (Inform District nurse) Yes ☐ No ☐ Identified risks .....

6. Does the patient require home oxygen? Yes ☐ No ☐	Home oxygen ordered: ..... Date:..... Signature / Stamp: .....
7. Necessary and appropriate supplies been given to the patient / carers. i.e. continence products, dressings, stoma bags, catheter bag. ☐ Not applicable ☐	Signature / Stamp: Date:..... Time: ..... Please state which supplies have been sent with patient carers: ....

Outcome 3

Medications have been reviewed, prescribed and dispensed ready for discharge.

Please refer to palliative and End of Life Care intranet page for prescribing information and District Nurse Authorisation Forms.

All medications have been reviewed and unnecessary medications have been discontinued. ☐	Action achieved Signature / Stamp: Date:..... Time: ..... (To be completed by prescriber)
• Ensure that TTO's are completed early in the process. Patients should not to be discharged without TTO's. • Anticipatory medications should be prescribed for all patients, even if they are currently symptom free.	
1. Ensure all anticipatory medication and syringe driver medications are prescribed on e-discharge. ☐	Signature / Stamp: Date:..... Time: .....
2. Ensure ward Pharmacist / Technician has been informed that TTO's have been completed, and that patient is on rapid home to die care bundle. ☐ If prescribed correctly TTO's will be fast tracked in 2 hours.	Signature / Stamp: Date:..... Time: .....
3. Complete District Nurse Authorisation appropriate for patient discharge address (see area specific intranet page). Ensure that drugs are prescribed correctly, the form is signed and allergy box is completed. ☐	Signature / Stamp: Date:..... Time: .....
Additional information	

Outcome 4

Transport arrangements have been made to support a safe and efficient transfer home.

Book transport as soon as possible **Consider the points below.**	Time booked:..... Name:..... Date booked:.....

1. Transport have been informed that this is the patients 'final Journey'? ☐

2. The crew are aware of any hazards within the patient's home? ☐ And where the patient will be nursed? i.e. upstairs transfer. ☐ And whether there are stairs / steps leading to the property? ☐	See outcome 2 for further information

3. Transport are aware that a DNACPR in place. ☐

Form to be shown to ambulance crew on arrival.

4. Transport are aware of any O_2 needs? Yes ☐ NA ☐

5. Transport are aware of any infection control concerns i.e. MRSA / CDIFF positive. Yes ☐ NA ☐

6. Relatives / carers are aware that they are able to escort the patient home? Inform ambulance team if they wish to do so.	Are relatives / carers travelling in the ambulance? Yes ☐ No ☐ Relative / carers name: .....

7. Is there is a risk of the patient dying in the ambulance? Yes ☐ No ☐

Has this been communicated with the patients family? Yes ☐ No ☐

Additional information

Signature / Stamp:

Print .....

Date: ..... Time:.....

Patient Name: ..... NHS No: ..... Unit Number: .....

Pre-discharge Checklist

This checklist is to be completed at the point of discharge by the discharging nurse. All areas should be considered and ticked / signed appropriately.

	Yes	No	N/A	Signature / Stamp / Date
Has rapid home to die care bundle been completed in full?				
Is the patient sufficiently stable to transfer?				
Does the patient require administration of anticipatory medication to enable comfortable transfer?				
Is the relative / carer available to ensure access to discharging property?				
Is the patient as appropriately dressed as possible to maintain comfort and dignity?				
Have TTO's & District Nurse Authorisation been handed to family / ambulance team?				
Has appropriate equipment been handed to family / ambulance team - e.g. catheter bags, dressings, continence products?				
Has property been packed securely and any valuables returned?				
Have patient wristband and SafeHands badge been removed?				
Has discharge letter been completed (copy given to patient / posted to GP / e-discharge / copy filed in patients notes)?				
Has cannula been removed?				
Has DNACPR been handed to family / ambulance crew?				
Has community feed back form been sent for the attention of district nurses?				
Has Care in the last days of life individual plan of care been discharge with patient?				

I confirm the above information. Date..... Nurse Signature .....

MRSA Status Positive ☐ Negative ☐

CDI status Positive ☐ Negative ☐

If positive inform ambulance crew ☐ WUCTAS ☐ GP ☐

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Date / Time	Additional Information	Signature / Stamp

Patient Name: .....NHS No: ..... Unit Number: .....

Date / Time	Additional Information	Signature / Stamp

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Community Services feed back

The information provided within this form will be used to audit the effectiveness and appropriateness of the 'rapid home to die' care bundle.

No confidential patient information should be included within this form.

Please complete the form, detach and forward to:

Palliative Care Team office
Deanesly Centre
New Cross Hospital
Wolverhampton
WV10 0QP
or
Fax (01902) 695787

Community Nurse details

Name:.....

Designation: .....

Base (full address): .....

.....

.....

.....

.....

Contact number: .....

Date of death: .....

Discharge date:.....

Discharging ward: .....

Date of first community services visit following discharge: .....

Were there any problems encountered during the rapid discharge process?

Yes ☐ No ☐

If yes please indicate what you think may have caused these problems? (Please tick as many as appropriate)

☐ Poor communication
☐ Symptom management issues
☐ Carer issues
☐ Medication / PSD issues
☐ Availability of community services
☐ Transport
☐ Equipment issues
☐ Other

Please provide further details:

.....

.....

.....

.....

For further information on completing this form please contact palliative care team on (01902) 695212

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Refusal to Accept Medical Advice

..... Hospital

I ..... of .....

.....

wish to take my discharge. I appreciate that this is against the advice and wishes of the consultant in charge or their deputy. I acknowledge that I have been informed of the danger of doing so and I accept full responsibility for my action and any consequences arising therefrom.

Date ..... (Signed) .....

I confirm that I have explained to the patient the dangers that might arise out of their decision to take their own discharge.

Date ..... (Signed) .....
(Medical Practitioner)

Verification of Patients Discharge Address