Blackpool Teaching Hospitals NHS
NHS Foundation Trust

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Title: **The Discharge of Adult Patients**	**Version Number:** 8
	Status: Ratified
Scope: Trust Wide	**Classification:** Organisational
Author/Originator and Title: Christine McCulloch, Discharge Co-ordinator Barbara Becker, Assurance and Compliance Manager	**Responsibility:** Clinical Support Division

Replaces: Version 7 Discharge Adults CORP/PROC/074	**Description of amendments:** NHSLA Minor Amendments to Appendix 2 Addition of Discharge Checklists for Cardiac Patients (Appendix 3 and 4)	
Name of: Divisional/Directorate/Working Group:	**Date of Meeting:**	**Risk Assessment:** Not Applicable
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Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Initial Assessment

1. PURPOSE

To ensure a safe and timely discharge of adults from hospital to the primary care setting. To ensure that the patient and/or carers are central to planning of discharge, that necessary information and education is available to the patient and/or carer, and that they are informed of likely outcomes (regarding discharge or transfer of care) at an early and appropriate stage.
To ensure that effective medicines management ensures the safe provision of discharge medication, information and support for patients and nursing staff at point of discharge.

2. SCOPE

The procedure will be used by any member of staff working within Blackpool Teaching Hospitals NHS Foundation Trust involved in the discharge of adult patients from secondary to primary care. Exclusions include Midwifery and Nurse Led Therapy Unit.

3. PROCEDURE

3.1 Duties

It is the duty of all staff involved in the discharge of an adult that they must adhere to this procedure.

Nursing responsibility for planning a safe discharge.

- Ensure a written discharge plan is commenced on admission.
- Ensure the patient/carer is central to the discharge process discussions.
- Document the anticipated date of discharge/transfer of care clearly in the case notes and ensure it is incorporated in the plan of care at an early and appropriate time. This will be revised/amended on a regular basis and when circumstances change during the hospital stay
- When the patient is medically fit for discharge, the doctor will review the date for discharge and record the agreed date in the patient's case notes.
- Ensure the clinical management plan is clearly documented and reviewed appropriately.
- Provide all relevant written and verbal information to the patient/carer, ensuring that this information is understood.
- Ensure that required medication at point of discharge is considered prior to discharge date.
- Ensure that a prescription for discharge medication is forwarded to Pharmacy as soon as feasible to prevent delayed discharge.

- A supply of prescribed medication is provided for patient discharge. Pharmacy policy is to supply full packs when applicable. In the event of antibiotics etc, the course duration will be supplied.

A qualified Nurse Will Be Allocated To Each Patient On Admission.
They must:

- Consider and document discharge needs in case notes/on discharge plan upon admission if possible.

- Explain the use of step down facilities that may be used during their hospital stay.

- Refer to the multi-disciplinary team appropriately and in a timely manner.

- Offer access to the Integrated Discharge Team to all that require/request their involvement, in accordance with the team's referral criteria.

- Facilitate the provision of any equipment that is required for discharge without delay, taking into account any training that may be required.

- Ensure adequate period of notice is given for any District Nursing services that are required.

Ward Nursing Staff must:

- Inform patient/family/carers of an estimated date of discharge.

- Ensure any required equipment is freely available, in good working order with a maintenance plan identified. Ensure adequate training and written instructions are available, including a back up plan in line with the procedure Patients Discharged from Hospital with a Loaned Medical Device (CORP/PROC/430).

- Aim to discharge as early in the day as possible.

- Ensure completion of the electronic discharge summary (appendix 1) along with the discharge plan checklist (appendix 2) together with the relevant specific discharge plan checklist for Elective Cardiology patients (appendix 3 and 4) prior to discharge. These should be completed for all discharges. Other approved discharge documents may be used where appropriate e.g. A&E.

- Ensure that an appropriate medical officer has documented in the case notes that the patient is medically fit for discharge. The discharge summary is to be completed as soon as possible before discharge and must be sent to pharmacy to allow discharge medicines to be prepared in advance of discharge.

- Ensure suitable and appropriate transport arrangements have been discussed, arranged and documented.

- Ensure discharge summary has been fully completed and sent electronically to the district nurse.

- Ensure relatives have been asked to provide suitable outdoor clothing.

- Ensure all property and valuables are returned according to the Trust Procedure Patients Property (Corp/Proc/106), being aware of accounts/general office hours of opening.

- Ensure that any outpatient arrangements are made and given to the patient prior to discharge, or that the patient is made aware that they will receive the appointment via the post.

- Record the discharge on the Trusts admission, discharge and transfer (ADT) system.

- Inform the Bed Manager at the earliest opportunity of the proposed discharge, and then of actual discharge.

3.2 Definition Of All Patient Groups

The definition of the patient group to be discharged in line with this procedure will be adults of 18 years or over.

3.3 Use Of The Electronic Discharge System

In order for accurate and timely discharge information to reach the patient's GP the Trust has adopted an electronic discharge system. As soon as the discharge is marked as complete the patient's GP practice will receive an electronic copy of the form via secure email.

- Once the decision has been made to discharge the patient a new e-discharge is completed by the doctor and any medications prescribed in the medication section of the e-discharge form. The eDischarge form and further guidance can be accessed via the intranet (Appendix 1)

- Prior to discharge the in-patient prescription chart is sent to Pharmacy by the ward clerk and the e-discharge is forwarded to Pharmacy by the doctor. Pharmacy check the medications section of the e-discharge against the in-patient chart. Medication is dispensed by Pharmacy and the in-patient prescription chart returned to the ward to be filed in the patient notes.

- Discharge is then completed by a member of staff on the ward.

- At the point of discharge the discharge plan is printed and filed in the patient's notes, a copy is given to the patient and a copy is transmitted to the GP via secure email. In the event of the GP not having the facility to receive the eDischarge a paper copy is sent via post.

3.4 Referral To District Nursing Services

If the patient requires referral to the District Nursing Services the discharge nurse will complete a District Nurse Referral Form (Appendix 5). This will be found on the Trust Intranet http://bfwnet/departments/discharge_team/ together with instructions for forwarding the completed document. Once the District Nurse Referral Form has been completed the document will be forwarded to the district nursing services by the discharge nurse as follows:

- For those patients within the Blackpool PCT area the District Nurse Referral Form will be sent via e-mail by the discharge nurse

- For those patients within the North Lancashire PCT area the District Nurse Referral Form will be printed and sent via fax by the discharge nurse

3.4.1 Referral to District Nursing Services for the Administration of Medication

The discharging nurse will:

- Ensure that the discharge letter /discharge prescription has been completed fully and signed by the Doctor/ prescriber and includes all medication prescribed for the patient, 'highlighting any changes e.g. drugs stopped or started during admission, dose changes etc'.

- Check that the prescription has been clinically checked in Pharmacy and is initialled by the Pharmacist.

- Document clearly on the District Nurse Referral Form that District Nurse input is required to administer the medication as prescribed on the discharge summary / prescription.

- Ensure that all the information and equipment required to safely administer the prescribed medication is provided for use by the District Nurse.

- Check the medication supplied by Pharmacy corresponds with the discharge summary/prescription, including patient name, dose, route and frequency of administration. Upon dispensing the medication the discharge nurse will record in the case notes that the medication dispensed is correct.

- Ensure that the patient or their carer is given information regarding their medication prior to discharge re dose / any monitoring needed / side effects and record this information on the discharge plan.

- Ensure that the patient or their carer is aware that the District Nurse will attend to administer medications as required and record this information on the discharge plan.

- Print two copies of the discharge summary and provide one copy for the patient and place one copy in the patient's case notes.

3.4.2 Discharge prescriptions for Peripheral / Community Hospitals

- Once the decision has been made to discharge the patient a new e-discharge is completed by the doctor and any medications prescribed in the medication section of the e-discharge form. The e-discharge form and further guidance can be accessed via the intranet Appendix 1).

- Prior to discharge the in-patient prescription chart is sent to Pharmacy by the ward clerk and the e-discharge is forwarded to Pharmacy by the doctor. Pharmacy checks the medications section of the e-discharge against the in- patient chart. Medication is dispensed by Pharmacy and returned to the ward by the portering service together with the in-patient prescription chart. The in-patient prescription chart is filed in the patient's case notes.

- On receipt of the discharge medications the discharging nurse will check the medication against the copy of the clinically checked discharge summary / prescription and upon dispensing the medication the discharge nurse will record in the case notes that the medication dispensed is correct.

3.4.3 Referral to District Nurse

- If referral for District Nursing Services is required, the directions or request e.g. for the administration of a medication are to be added to the District Nurse Referral Form.

- The completed documentation is to be sent to the District Nursing Service as per section 3.3.

3.5 Discharge Requirements Which Are Specific To Adults Including the Recording of Information Relevant to the Discharge of Adult Patients

- A qualified nurse / healthcare professional will ensure a written discharge plan is commenced on admission (Appendix 2).

- A healthcare professional will document the anticipated date of discharge/transfer of care clearly in the case notes.

- When the patient is medically fit for discharge, the doctor will review the date for discharge and record the agreed date in the patient's case notes.

- Once the decision has been made to discharge the patient an e-discharge is completed by the doctor. This will include, in the e-discharge medication section, any medications prescribed.

- The discharging nurse will complete the relevant discharge plan and checklists (Appendix 2, 3 and 4).

- The discharging nurse will make the patient/patient's relatives/friend/carer aware of the patient's discharge plan and document on the discharge plan.

- The discharging nurse will ensure suitable and appropriate transport arrangements have been discussed with the patient and transport arrangements made and documented on the discharge plan.

- The discharge nurse will return the patient's valuables to the patient prior to discharge and record the checking and return of the valuables on the discharge plan.

3.5.1 Management of Patient's Medicines on Discharge

- The in-patient prescription chart is sent to Pharmacy and the e-discharge is forwarded to Pharmacy by a member of the ward team. Pharmacy will check the e-discharge medication section against the in-patient prescription chart.

- Medication is dispensed by Pharmacy and returned to the ward by the portering service together with the in-patient prescription chart which is initialled by the pharmacist following dispensing of the medication. The in-patient prescription chart is filed in the patient case notes in Section 3 by the ward clerk upon discharge of the patient.

- The discharge nurse will check and dispense the medication supplied by Pharmacy to the patient and will explain the medication prescribed and record this on the discharge plan. Where necessary written instructions regarding medication will be written for the District Nurse on the District Nurse Referral form

- Upon discharge the discharge nurse will return the patient's own medications to the patient and record this on the discharge plan.

3.5.2 Information given to the Receiving Healthcare Professional

- Where District Nurse input is required for follow up the discharge nurse must complete an electronic District Nurse Referral Form (Appendix 5) which will be sent electronically to the District Nurse.

- Where the patient requires dressings or equipment for ongoing care at home by the District Nurse, the dressings or equipment will be provided by the discharge nurse and noted on the discharge plan.

- The discharge nurse will record on the discharge plan if an intravenous cannula is to remain in situ following discharge and ensure that any intravenous cannula not required following discharge is removed and noted on the discharge plan.

- The discharge nurse will record any information relating to catheter insertion on the discharge plan ensuring that where a patient is discharged with a catheter in situ that the date of insertion and the date for change are recorded on the discharge plan.

- The discharge nurse will record on the discharge plan the date of issuing a medical certificate to a patient prior to discharge.

- At the point of discharge the e-discharge form is printed and filed in the patient's notes. A copy is given to the patient and a copy is transmitted to the GP and District Nurse via secure e-mail. In the event of the GP not having the facility to receive the e-discharge form a paper copy will be forwarded via fax.

3.5.3 Information given to the Patient when they are Discharged

- Outpatient arrangements will be made and written information given to the patient by the discharge nurse prior to discharge and noted on the discharge plan.

- The discharge nurse will provide verbal and written discharge advice to the patient and record this on the discharge plan.

- The discharge nurse will sign the discharge plan prior to the patient's discharge.

- The doctor will sign the discharge plan prior to the patient's discharge.

- Upon discharge the patient will be provided with a copy of the discharge plan. This will include where, necessary arrangements for follow up by the District Nurse. A copy of the discharge plan is filed in the patient's case notes.

- At the point of discharge the e-discharge form is printed and filed in the patient's notes. A copy is given to the patient and a copy is transmitted to the GP and District Nurse via secure e-mail. In the event of the GP not having the facility to receive the e-discharge form a paper copy will be forwarded via fax.

3.6 Documentation To Accompany The Patient Upon Discharge

- Upon discharge the patient will be provided with a copy of the discharge plan by the discharge nurse. This will include, where necessary, arrangements for follow up by the District Nurse. A copy of the discharge plan is filed in the patient's case notes.

- The patient, upon discharge, will be given their prescribed discharge medication and the discharge nurse will ensure that the patient understands how to take this. The discharge nurse will confirm that the patient has received his discharge medication and understands how to take this by signing the discharge plan.

- Where necessary, the discharge nurse will provide written instructions for the district nurse regarding medication on the district nurse referral form.

- The patient, upon discharge will be given written details of any outpatient arrangements made by the discharge nurse and this will be recorded by the discharge nurse on the discharge plan.

3.7 Information To Be Given To The Patient

- Consider and document discharge needs in case notes/on discharge plan upon admission and ensure and/or family/carers are informed.

- Give an explanation, including written where appropriate, to the patient and his family/carer on how acute beds are used, including basic information about the discharge process and patients not being permitted to remain in an acute bed once the acute episode of care is complete.

- Explain the use of step down facilities that may be used during their hospital stay.

3.8 Process For Discharge Out Of Hours

- Aim to discharge as early in the day as possible, however if a discharge is planned for a time out of normal working hours then the same procedure applies.

3.9 The Hospital Integrated Discharge Team Must:

- Identify patient's needs early in the discharge process to enable a timely and safe discharge.

- All referrals to the Hospital Discharge Team are to be sent through the E referral link on the home page of the intranet. A quick reference to the E-referral process is listed below:

    - Click on the e-referral link within the "Divisions and Departments" purple area on the main Intranet page

    - Select Hospital Discharge Team from the blue list in the centre of the screen

    - If using a generic log in computer – such as the computers on wheels – select the "auto user" address in the top right corner

    - Select "Log in as different user" from the drop down menu

    - Input your windows user name (e.g. Grayc1) and password

    - Select "click here to make a referral"

    - Enter patient hospital number

    - Complete the rest of the form – all fields are mandatory

Staff must:

- Ensure multi-disciplinary team referrals are appropriate and co-ordinated.

- Make effective use of intermediate care services, social services, and primary care services (statutory and voluntary).

- Identify complex discharge needs at an early stage, and ensure necessary assessments and interventions occur by relevant individuals or agencies without delay.

- In collaboration with the multi-disciplinary team, assess and document patient needs with regards social care support, and commission essential services prior to discharge.

- Ensure adequate consideration is given to statutory requirements within Local Health Authority's Continuing Care Criteria.

- Ensure those patients (whom after multi-disciplinary team assessment or by patient/relative request), requiring consideration for NHS Continuing Care funding have all necessary and relevant assessments completed, and that they are presented to the appropriate local authority panel without delay.

- Liaise with Social Services with regards to delayed transfers of care, and appropriate 'notifications' are served to social services within the 'reimbursement' guidelines, in conjunction with The Community Care (Delayed Discharges etc) Act 2003.

3.10 Discharge Against Medical Advice

In the event of a self-discharge against medical advice, where appropriate and practical, the necessary arrangements for aftercare will be made and documented in the medical notes and the medical staff will inform the GP and other relevant services in the normal way. Staff must record in the notes action taken. The "discharge against advice" form should be signed if the patient is agreeable, otherwise this must be documented in the notes and signed by the Doctor and the Nurse.

3.12 Process For Monitoring Compliance

The process for monitoring compliance with this procedure is outlined in Appendix 7.

4. ATTACHMENTS	
Appendix Number	**Title**
Appendix 1	Electronic Discharge Summary
Appendix 2	Discharge Plan
Appendix 3	Ward 38 Discharge Checklist
Appendix 4	Cardiac Discharge Checklist
Appendix 5	District Nurse Referral Form
Appendix 6	Letters
Appendix 7	Process for Monitoring Compliance
Appendix 8	Equality Impact Assessment Form

5. ELECTRONIC AND MANUAL RECORDING OF INFORMATION
Electronic Database for Procedural Documents
Held by Policy Co-ordinators/Archive Office

6. LOCATIONS THIS DOCUMENT ISSUED TO		
Copy No	**Location**	**Date Issued**
1	Intranet	03/04/2012
2	Wards and Departments	03/04/2012

7. OTHER RELEVANT/ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/055	Ward 8 – Isolation Ward Operational Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-055.doc
Corp/Pol/107	Confidentiality Code of Conduct http://fcsharepoint/trustdocuments/Documents/CORP-POL-107.doc
Corp/Proc/102	Consent to Treatment Procedure http://fcsharepoint/trustdocuments/Documents/CORP-PROC-102.docx
Paed/Proc/005	Discharge of a Child Procedure http://fcsharepoint/trustdocuments/Documents/PAED-PROC-005.doc
Corp/Pol/054	Health and Corporate Records Management. http://fcsharepoint/trustdocuments/Documents/CORP-POL-054.doc
Corp/Pol/065	Information Governance http://fcsharepoint/trustdocuments/Documents/CORP-POL-065.doc
Corp/Proc/430	Patients Discharged from Hospital with a Loaned Medical Device http://fcsharepoint/trustdocuments/Documents/CORP-PROC-430.doc
Corp/Proc/106	Patients Property. http://fcsharepoint/trustdocuments/Documents/CORP-PROC-106.docx
VS719	Discharge Plan http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/13-0784%20BFWH%20VS719%20Discharge%20Plan.pdf

8. SUPPORTING REFERENCES/EVIDENCE BASED DOCUMENTS
References In Full
The Community Care (Delayed Discharges etc) Act 2003 (HSC 2003/09) Department of Health 2003
The Continuing Care (National Health Service Responsibilities) directions 2003, Department of Health 2003
HC (89) 5 Discharges of Patients from Hospital
Discharge from Hospital: pathway, process and practice. Department of Health. January 2003
National Service Framework for Mental Health: Modern Standards and Service Models. Department of Health 1999
National Service Framework for Older People. Department of Health 2001
Achieving Timely Simple Discharge from Hospital. Department of Health 2004
Making a Difference to Practice: Clinical Benchmarking Part 1. Ellis J. Nursing Standard 14.32 p33-37 2000.

Hospital Discharges Workbook. A Manual of Discharge Practices. NHSE 1994
NHS & Community Care Act 1990
NHS Funded Continuing Care Criteria (Version 12). Cumbria & Lancashire Strategic Health Authority
Nursing and Midwifery Council (2008) Standards for Medicines Management. NMC, London
Reference Guide to Consent for Examination or Treatment. Department of Health 2001

9. CONSULTATION WITH STAFF AND PATIENTS	
Name	**Designation**
Mary Aubrey	Deputy Director of Corporate Affairs and Governance
Gillian Thomas	Matron, Cardiac
Joanne Halliwell	Quality Manager, Scheduled Care
Stephanie Betts	Quality Manager, Unscheduled Care

10. DEFINITIONS/GLOSSARY OF TERMS	

11. AUTHOR/DIVISIONAL/DIRECTORATE MANAGER APPROVAL			
Issued By	C McCulloch	**Checked By**	M Aubrey
Job Title	Discharge Co-ordinator	**Job Title**	Deputy Director of Corporate Affairs and Governance
Date	April 2012	**Date**	April 2012

Appendix 1: Electronic Discharge Summary

Please Note: This form is only available on the electronic system.

Appendix 2

FILE IN SECTION 4

Discharge Plan

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Telephone:

Next of Kin/Main Carer:
Relationship:
Address:

Telephone:

Discharge Address: (if different)

Telephone:

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

Discharge Checklist	Date	Initials	Ward: / Named Consultant: / Named Nurse:	Admission Date:
Relatives Aware: Name:				
Transport: Own / Hospital - booked				
Medication: Requested / Checked / Given and explained to patient/relative / Own meds returned			Patient referral: Discharge team ☐ Physiotherapy ☐ SALT Specialist ☐ Specialist Nurse ☐ Occupational Therapy ☐ Community Social Worker ☐ District Nurse ☐ Other ☐	
Letters: General Practitioner / District Nurse (DN) • Faxed • DN Reply / Health Visitor / Nursing Home / Other.....			Person to contact if concerns on discharge	
Dressings: Not required/supplied			Please record discharge advice below	
Pressure Ulcer Present Y/N if yes complete detailed DN referral and inform TVA Date completed:				
Intravenous Cannula in situ: no/yes If yes, reason: Date of insertion: Date for change:				
End of life requirements				
Catheter in situ: no/yes Date of insertion: Date for change: Catheter pack provided: no/yes				
Equipment: Ordered / Arrived / Training given (when/by whom?)				
Valuables: Requested / Checked / Returned to patient				
Medical certificate: Not required/given Date:				
Is patient falls risk Y/N If yes complete referral to community services if required Date Completed:				
Infection Risk				
Critical Medicine identified (Please see Administration of Medicines Procedure, Appendix 4 (Corp/Proc/307) for list of critical medicines.				
Essential equipment provided for Medication				
Low molecular weight heparins: Dose: Weight (recent and accurate):			Creatinine clearance (latest & date): Indication and duration of treatment:	
DNAR: In place: N/Y Date of review:..... (NB. If yes, must remain active within 24hr of dx)				
Dysphagia ☐ Diet and Fluid modification/advice/equipment given ☐				
Appointments arranged: Name and dates:			Anticoagulant clinic ☐ Day hospital ☐ Other ☐	
Please document the discussion and information leaflet provided to the patient				
Discharging Nurse (Print Name)			Discharging Nurse Signature	
Date and Time of Discharge				

Patient: Top (White) Copy GP: Middle (Pink) Copy Notes: Bottom (Yellow) Copy

VS719 (R6) Approved by the Health Records Committee 25/11/2013 Document Library ID: Corp/Proc/074

Appendix 3

FILE IN SECTION 3

Ward 38 Discharge Checklist

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Abbreviations used in this document to be listed here with the full description:

N/A

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

No.	Discharge Checklist	Date	Signature
1	All wounds been reviewed and pacing wires removed		
2	Is a District nurse required?		
3	District Nurse form forwarded to the Practice and dressings supplied		
4	Is any medication required? If yes has it been given to the Patient?		
5	Has Venflon been removed?		
6	Has written and verbal discharge advice been given?		
7	Anticoagulant appointment made and referral sent		
8	Transport arranged if needed		
9	Please document the discussion and information leaflets provided to the patient		

Patient discharged home at……..Date…….

Signature of Nurse ……..Print Name……..

Signature of the nurse in charge ……

Appendix 4

FILE IN SECTION 3

Elective Cardiology Discharge Checklist

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Abbreviations used in this document to be listed here with the full description:

ECG – Electrocardiograph
FBC – Full Blood Count
PPM – Pacemaker
CXR – Chest X-Ray
PCI – Angioplasty
AICD – Defibrillator Pacemaker

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

Please tick for a positive response

No.	Discharge Checklist	PPM/ AICD Box change	Angio	PCI	Other
1	Wound shows no leakage/ haematoma				
2	CXR performed and reviewed by a Doctor (only if leads replaced)				
3	ECG performed and reviewed by a Doctor				
4	PPM checks performed and satisfactory				
5	If Reopro used : FBC taken and platelets within normal range ie > 150				
6	Does the Patient take Metformin? If yes has advice been given on when to restart as per Directorates Metformin policy?				
7	Does the Patient take Warfarin? If yes do they know when to restart it?				
8	Has anticoagulant referral been completed and sent?				
9	If PCI failed increased dose of Aspirin and Clopidogrel should not be given				
10	If Reopro used – give FBC form for the following day				
11	Is new medication required? If yes has it been given to the Patient?				
12	Has the PPM device ID card been given to the Patient?				
13	Has Venflon been removed?				
14	Has written and verbal discharge advice been given?				
15	Have they been referred to cardiac rehabilitation				
16	Please document the discussion and information leaflets provided to the patient				

Patient discharged home at……Date……..

Signature of Nurse ……..Print Name. . . . . ..

Signature of the nurse in charge . . . . . .

Appendix 5: District Nurse Referral Form

http://bfwnet/departments/discharge_team/

Please note: this form is only available on the electronic system

Appendix 6: Letters:

Appendix 6a

Dear […]

When your medical treatment comes to an end

As you are currently staying on a ward at Blackpool Victoria Hospital, I thought you might find it helpful if I were to explain what will happen when your medical treatment comes to an end.

You may rest assured that we will help to plan your discharge, so that when the time comes, you can be confident about leaving hospital.

As I am sure you will understand, patients cannot remain in hospital once they are fit for discharge or transfer, as this might deny valuable resources to others that still need them.

Most patients return home when they are discharged from hospital, but some patients need continuing support. This might be:

- Accommodation in a residential home or nursing home (whether in the short- or the long-term);
- Day-care facilities or carer support at home;
- Transfer to a community hospital, until resources become available or for intermediate care or rehabilitation.

If you need to be transferred to a community hospital, it is possible that it won't be the one nearest to your home. I understand that this might make it difficult for your friends and family to visit you, and would assure you that we will do what we can to move you closer to home as soon as possible. However, and as I'm sure you will understand, this depends on a suitable place being available for you.

If you need care in a residential home or a nursing home, we will support you when you come to make your choice. If you have not been able to do so within 10 days of becoming fit for discharge (or transfer), or if the place you have chosen currently has no vacancies, we will give you a list of homes that *do* have vacancies and that might be able to offer you a place for the time being.

I hope you will co-operate with us in ensuring that your discharge happens when planned, even if this might mean that you take up a temporary placement until somewhere more permanent becomes available.

If you have any questions about what will happen when your medical treatment has come to an end, please don't hesitate to speak to […]

Yours sincerely
Chief Executive

Dear […]

When medical treatment comes to an end

As your friend/relative is currently staying on a ward at Blackpool Victoria Hospital, I thought you might find it helpful if I were to explain what will happen when their medical treatment comes to an end.

You may rest assured that we will help to plan for discharge, so that when the time comes, you and your friend/relative can be confident about their leaving hospital.

As I am sure you will understand, patients cannot remain in hospital once they are fit for discharge or transfer, as this might deny valuable resources to others that still need them.

Most patients return home when they are discharged from hospital, but some patients need continuing support. This might be:

- Accommodation in a residential home or nursing home (whether in the short- or the long-term);
- Day-care facilities or carer support at home;
- Transfer to a community hospital, until resources become available or for intermediate care or rehabilitation.

If your friend/relative needs to be transferred to a community hospital, it is possible that it won't be the one nearest to their home. I understand that this might make it difficult for other friends and relatives to visit, and would assure you that we will do what we can to move your friend/relative closer to their home as soon as possible. However, and as I'm sure you will understand, this depends on a suitable place being available.

If your friend/relative needs care in a residential home or a nursing home, we will offer support in choosing a place. If no choice has been made within 10 days of your friend's/relative's becoming fit for discharge (or transfer), or if the place chosen currently has no vacancies, we will provide a list of homes that *do* have vacancies and that might be able to offer a place for the time being.

I hope you will co-operate with us in ensuring that your friend's/relative's discharge happens when planned, even if this might mean that they take up a temporary placement until somewhere more permanent becomes available.

If you have any questions about what will happen when your friend's/relative's medical treatment has come to an end, please don't hesitate to speak to […]

Yours sincerely

Chief Executive

Appendix 6c

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Dear […]

When the care we provide comes to an end

As you are currently staying on a ward at one of our community hospitals, I thought you might find it helpful if I were to explain what will happen when you no longer have any need for the care we provide.

As you will know, we began planning for your discharge when you were first admitted to hospital. You may rest assured that we will continue to do so, so that, when the time comes, you can be confident about leaving hospital.

As I am sure you will understand, patients cannot remain in a community hospital once they are fit for discharge or transfer, as this might deny valuable resources to others that still need them.

Most patients return home when they are discharged from one of our community hospitals, but some patients need continuing support. This might be:

- Accommodation in a residential home or nursing home (whether in the short- or the long-term);
- Day-care facilities or carer support at home;
- An interim care placement.

If you need care in a residential home or a nursing home, we will support you when you come to make your choice. If you have not been able to do so within 10 days of becoming fit for discharge (or transfer), or if the place you have chosen currently has no vacancies, we will give you a list of homes that *do* have vacancies and that might be able to offer you a place for the time being.

I hope you will co-operate with us in ensuring that your discharge happens when planned, even if this might mean that you take up a temporary placement until somewhere more permanent becomes available. In that way, we can ensure that our community hospital beds continue to be available for those that need them most.

If you have any questions about what will happen when your medical treatment has come to an end, please don't hesitate to speak to […]

Yours sincerely

Chief Executive

Appendix 6d

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Dear […]

When the care we provide comes to an end

As your relative/friend is currently staying on a ward at one of our community hospitals, I thought you might find it helpful if I were to explain what will happen when they no longer have any need for the care we provide.

As you may know, we began planning for discharge when your relative/friend was first admitted to hospital. You may rest assured that we will continue to do so, so that, when the time comes, you and your friend/relative can be confident about their leaving hospital.

As I am sure you will understand, patients cannot remain in a community hospital once they are fit for discharge or transfer, as this might deny valuable resources to others that still need them.

Most patients return home when they are discharged from one of our community hospitals, but some patients need continuing support. This might be:

- Accommodation in a residential home or nursing home (whether in the short- or the long-term);
- Day-care facilities or carer support at home;
- An interim care placement.

If your relative/friend needs care in a residential home or a nursing home, we will offer support in choosing a place. If no choice has been made within 10 days of your friend's/relative's becoming fit for discharge (or transfer), or if the place chosen currently has no vacancies, we will provide a list of homes that *do* have vacancies and that might be able to offer a place for the time being.

I hope you will co-operate with us in ensuring that discharge happens when planned, even if this might mean that your relative/friend takes up a temporary placement until somewhere more permanent becomes available. In that way, we can ensure that our community hospital beds continue to be available for those that need them most.

If you have any questions about what will happen when your medical treatment has come to an end, please don't hesitate to speak to […]

Yours sincerely

Chief Executive

Appendix 7: Process for Monitoring Compliance

Minimum requirement to be monitored		Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan and Implementation
a)	Discharge requirements for all patients	Audit	Discharge Team	Annual	Discharge Team	Discharge Team	Discharge Team /Clinical Improvement Committee
b)	Information to be given to the receiving healthcare professional	Audit	Discharge Team	Annual	Discharge Team	Discharge Team	Discharge Team /Clinical Improvement Committee
c)	Information to be given to the Patient when they are discharged	Audit	Discharge Team	Annual	Discharge Team	Discharge Team	Discharge Team /Clinical Improvement Committee
d)	How a patient's medicines are managed on discharge	Audit	Discharge Team	Annual	Discharge Team	Discharge Team	Discharge Team /Clinical Improvement Committee
e)	How the organisation records the information given in b) and c) above	Audit	Discharge Team	Annual	Discharge Team	Discharge Team	Discharge Team /Clinical Improvement Committee
f)	Process for discharge out of hours	Audit	Discharge Team	Annual	Discharge Team	Discharge Team	Discharge Team /Clinical Improvement Committee

Appendix 8: Equality Impact Assessment Tool

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Would the relevant Equality groups be affected by the document? (If Yes please explain why you believe this to be discriminatory in Comment box)

Title & Identification Number of the Document: The Discharge of Adult Patients Corp/Proc/074

	Questionnaire	Yes/No Double click and select answer	Comments
1	Grounds of race, ethnicity, colour, nationality or national origins e.g. people of different ethnic backgrounds including minorities: gypsy travellers and refugees / asylum seekers.	No	
2	Grounds of Gender including Transsexual, Transgender people	No	
3	Grounds of Religion or belief e.g. religious /faith or other groups with recognised belief systems	No	
4	Grounds of Sexual orientation including lesbian, gay and bisexual people	No	
5	Grounds of Age older people, children and young people	No	
6	Grounds of Disability: Disabled people, groups of physical or sensory impairment or mental disability	No	
7	Is there any evidence that some groups are affected differently?	No	
8	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
9	Is the impact of the document/guidance likely to be having an adverse/negative affect on the person (s)?	No	
10	If so can the negative impact be avoided?	N/A	
11	What alternatives are there to avoid the adverse/negative impact?	**Please Comment**	

12	Can we reduce the adverse/negative impact by taking different action?	N/A	**Please Identify How**

13 Q1 (a) **Is the document** **directly discriminatory?** No **(under any discrimination legislation)** • Racial Discrimination • Age Discrimination • Disability Discrimination • Gender Equality • Sexual Discrimination	**Q2 (b) (i)** Is the document indirectly discriminatory? No **b (ii)** If you said yes , is this justifiable in meeting a legitimate aim N/A	**Q3 (c)** Is the document intended to increase equality of opportunity by positive action or action to redress disadvantage N/A Please give details To safeguard vulnerable adults

14 If you have answered **no** to all the above questions **1-13** and the document does not discriminate any Equality Groups please go to **section 15**

If you answered **yes** to Q1 (a) and **no** to Q3 (b) this is unlawful discrimination.

If you answered **yes** to Q2 (b) (i) **no** to Q2 (b) (ii) and **no** to Q3 (c), this is unlawful discrimination

If the content of the document is not directly or indirectly discriminatory, does it still have an adverse impact?

No

Please give details

If the content document is unlawfully discriminatory, you must decide how to ensure the organisation acts lawfully and amend the document accordingly to avoid or reduce this impact

15 Name of the Author completing the Equality Impact Assessment Tool.

Name Christine McCulloch

Signature

Designation Discharge Co-ordinator

Date March 2012