Health and Social Care Moray

Hospital Discharge

POLICY

Overall responsibility for the policy:
Moray Health and Social Care Practice Governance Board

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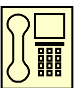
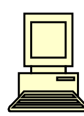
 01343 563321  equalopportunities@moray.gov.uk

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1.0 Introduction

1.1 The planning of Discharge Care is endorsed by the Government, and outlined in a series of publications http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets/Delayed-Discharge. Prompt and efficient discharge of patients from acute hospital beds to the next level of care plays a vital part in ensuring capacity is available for patients needing to access acute care beds.

1.2 The purpose of planning is to ensure that patients are discharged in a timely fashion, to clinically appropriate and agreed environments. For most patients multi-disciplinary assessment of individual patient needs is the key factor in planning and co-ordinating discharge care.

1.3 This document defines the aims of co-ordinated, safe and timely discharge, the rationale for achieving this, the scope of the policy, the responsibilities of individuals and teams, and the operational procedures, systems and documentation involved.

2.0 Aims of the Policy

2.1 To ensure that patients are discharged safely to an appropriate destination that meets the needs of the patient. Paying particular attention to patients deemed vulnerable who may be less able than others to voice their wishes and any concerns. These groups include people with learning disabilities, mental health problems or dementia, victims of neglect or of sexual or domestic violence, and those people who are particularly frail or nearing the end of their life.

2.2 To achieve effective discharge through good communication between professionals, whether verbal or written.

2.3 To ensure that multidisciplinary discussions are timely and robust.

2.4 To ensure that all perceived risks relating to the discharge of a patient are identified and discussed so that appropriate management plans can be put into place.

2.5 To ensure that all appropriate patients, before leaving hospital, have their eligibility for Hospital-based Complex Clinical Care considered. All relevant assessments to be completed and outcomes documented in the patient's notes.

2.6 To ensure that appropriate documentation is completed throughout the discharge process

3.0 Rationale

3.1 Written information will be provided to patients/carers by those agencies responsible for providing the support service. For proposed domiciliary/residential care packages any financial implications will be made clear to the patient prior to discharge.

3.2 Adequate supply of medication and sufficient dressings and disposables for a minimum of 7 days (preferably 14 days), unless on a short treatment course, will be given as appropriate. The discharging nurse should ensure that the patient/carer are advised appropriately regarding their medication. The patient will be made aware of the support in place and how to contact the providers as well as any equipment to be provided.

3.3 Discharge will only occur when professionals, service providers and agencies have confirmed appropriate care is available.

N.B. The discharge Process out of hours is the same as in hours. We have agreed within the patient transfer group that all discharges to a community hospital will be completed by 8pm, and only under exceptional circumstances will such a discharge occur any later than that time.

4.0 Scope of the Policy

4.1 This policy applies to all staff involved in any way with the discharge of patients, including the health and social care team, any required statutory services (i.e. TMC Housing Service) and voluntary agencies based within Moray. The discharges covered by this policy are those from any ward or department within Moray.

4.2 The policy aims to ensure that all necessary arrangements are made for discharge.

4.3 Medically fit for discharge refers to patients no longer requiring an acute hospital bed. For those patients being discharged to a community hospital, home, to their usual place of residence, temporary accommodation or are homeless/potentially homeless this policy applies.

4.4 For Patients who are deemed medically fit but require a period of further rehabilitation in another healthcare setting please refer to Procedure. It would be the same procedure as any other patient with the added responsibility of onward referral to appropriate services

4.5 The policy will apply without exception to patients in all specialities within Moray.

5.0 Definitions

5.1 Simple discharge refers to patients who will usually be discharged directly from Emergency Department, wards areas and assessment areas to their own home or usual place of residence (but could also involve temporary accommodation or homelessness).

5.2 Complex discharges relate to patients who have, for example, complex ongoing health and social care needs, capacity issues impacting on the ability to make welfare decisions, housing/homelessness/domestic violence issues etc. which require detailed assessment, planning, and delivery by the multi-agency team

5.3 Expected Date of Discharge is the date the patient would be expected to be ready for discharge, or is medically fit to be discharged. Documentation to accompany the patient on discharge is included in the Electronic Discharge Summary.

The Multi-disciplinary team consists of medical and nursing staff, therapists, pharmacists, social workers, carer development officers, discharge liaison nurses, housing liaison officers, mental health liaison nurses and community workers where appropriate.

6.0 Responsibility and Duties

6.1 Multi-Disciplinary Team (MDT)

Responsible for:

- Multi-disciplinary Team to agree and manage a discharge plan for the patient.
- Prescribing 'Discharge Medication,' at least 24 hours prior to the anticipated discharge date
- Documenting expected discharge date on the electronic record
- Documenting that the patient is 'Medically fit for discharge' on the electronic record
- Ensuring that the Electronic Discharge Summary is completed prior to discharge and electronic record is updated. This should be initiated on admission.

6.2 Senior Charge Nurse(SCN)/Ward/Departmental Manager

Have responsibility for ensuring that this policy is publicised within their area of control and that all staff are aware of their responsibilities with regards to the safe discharge of patients, particularly where homelessness is an issue.

6.3 Registered Nurses

It is the responsibility of the Registered Nurse to undertake the actions outlined in Patient Discharge Process for both simple and complex discharges **sections 7.1 and 7.2** (see also Appendices 13 and 14) of this policy. The discharging nurse must ensure that patients are aware of all arrangements for their ongoing management and review and that they receive any relevant information leaflets including Electronic Discharge Summary.

6.4 Allied Health Professional (AHP) Therapy Services

A pro-active discharge and intervention service is provided by Therapists, as part of the Multi-disciplinary Team (MDT). Professionals include Occupational Therapy, Physiotherapy, Nutrition & Dietetics, Speech and Language Therapy and Podiatry.

Onward referral at the earliest opportunity will enable the appropriate assessments and interventions to be carried out post discharge. Referrals should be made at an appropriate time during admission in relation to the local referral criteria. Record on the electronic record.

6.5 Pharmacists/Pharmacy Technicians

Where ward-based pharmacy teams are in operation on the ward, pharmacists are responsible for pro-actively planning for discharge from the point of admission. This should include confirming the medicines reconciliation, documenting any pharmaceutical care issues on the prescription and administration record (PAR), documenting any ongoing pharmaceutical care issues at the point of discharge on the electronic immediate discharge letter (eIDL) and working with the MDT to ensure that discharge medication is available as far ahead of the expected date and time of discharge as is clinically appropriate. Under exceptional circumstances pharmacists may transcribe/prescribe discharge prescriptions to facilitate safe and timely discharge.

6.6 Medical Director/Hospital Manager/Superintendent

The Medical Director/Hospital Manager/Superintendent ensures compliance with this policy, and ensures that a robust process is in place for reporting, investigating and responding to all problematic discharges or transfers, and, in the process, identifying and addressing any trends

7.0 Discharge Planning

Discharge Planning commences at the pre-admission stage for elective cases. Individual needs should be identified. Admission documentation will help identify if a patient has housing/tenancy/support needs. The anticipated length of stay/discharge date is discussed and agreed with patient and carer.

For emergency admissions discharge planning will be initiated within 24 hours of admission. If a patient's actual discharge is identified as likely to be complex, a referral should be forwarded to the MDT. An expected discharge date will be agreed and communicated to the patient and their family/carer within 24hours of admission.

For more information about discharge planning for patients who have **social housing, housing needs or who are potentially homeless,** the provision of information, potential referrals for housing support and the **statutory duties** that The Moray Council has under Housing Legislation for such patients **please see section 8.3 (also see Appendix 8)**.

In order to identify whether a patient's discharge from hospital will be simple or complex please refer to **Appendix 5.**

Ward staff must clarify with Care Homes the latest time they will accept admissions.

Discharges/transfers of care to Community Hospitals should take place as early in the day as possible. Later discharges after 8pm need to be discussed and agreed with the receiving ward.

NHS staff must liaise with The Moray Council Housing Service if there is a housing/homeless issue and need to be fully aware of the Out of Hours (OOH) process and contact details if discharging between 5pm and 8-45am.

N.B In times of heightened escalation and extreme bed pressures later discharges may be necessary and should be discussed and agreed with patients, carers, families and receiving care facility.

7.1 Simple or Complex Discharge

For the majority of hospital admissions there will be a planned or a simple discharge. The length of stay and the discharge plan will have been agreed prior to the admission or as soon after admission as possible. The discharge plan could include, for example, care provision by relatives, or restart of the care package or return to the usual care home

7.1.1 Patient Discharge Process

Patient discharge process for simple discharges - see the chart for simple discharges (**Appendix 13)**.

7.2 Complex discharges

Once a patient has been identified as having complex needs, they should be referred, as soon after admission as possible, to the MDT. The majority of the referrals to the team will be elderly with complex needs, physical, social and mental health/capacity. There may also be issues around housing, homelessness and finance.

Complex discharges may also include patients deemed vulnerable who may be less able than others to voice their wishes and any concerns. These groups include people with learning disabilities, mental health problems or dementia, victims of neglect or of sexual or domestic violence, people who are homeless (with or without support needs) and those people who are particularly frail or nearing the end of their life.

With regard to neglect/abuse please refer to the **Grampian Interagency Policy and Procedure for the Support and Protection of Adults at Risk of Harm** http://www.moray.gov.uk/moray_standard/page_95357.html **(**this link also includes the Adult Support & Protection Reporting Form and the Medical Examination Protocol). Please also see the **Datix** link for NHS staff here http://www.datix.co.uk/

All discharges should be planned to take place before midday. If there are delays in patients being collected, they should wait in the dayroom if available.

Patients should not be discharged from inpatient ward areas after 9pm (this does not include Emergency Department (ED), Clinical Decision Unit (CDU), Acute Medical Admission Unit (AMAU) or Surgical Admission unit (SAU)) unless a late discharge has been discussed and agreed with the patient, family or carers where appropriate, the OOH Team and/or The Moray Council Housing Service (including the emergency, weekend or OOH contact - http://www.moray.gov.uk/moray_standard/page_70843.html) if appropriate.

N.B In times of heightened escalation and extreme bed pressures later discharges may be necessary and will be discussed then confirmed and agreed with patients, carers, families and receiving care facility.

7.2.1 Patient Discharge Process for Complex Discharges (see chart for complex discharges)

Please see **Appendix 14.**

7.3 Choosing a Care Home on Discharge

Grampian Integrated Approach has an established procedure for the timely management of those patients who for one reason or another either refuse to leave a hospital acute bed or assume that they are entitled to stay in a hospital bed until suitable arrangements are made for them to be discharged.

A series of letters have been developed (see **Appendices 1 and 2** for examples), which should be used, in appropriate circumstances **(see 16.0)**.

Action Required	Rationale	By Whom
Moving On Policy		
Flowcharts		

Related statutory guidance

Statutory **Guidance on Choosing a Care Home on Discharge from Hospital** can be accessed here http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf.

One of the guiding principles is;

"The potential for recovery, rehabilitation and reablement will be fully considered before any decisions are made on long term care plans. The aim should always be to return home if possible and appropriate. Wherever possible, decisions about long term care should not be made in an acute hospital setting. Ideally, the patient should be discharged to a more appropriate non-acute setting such as a community hospital, or intermediate care facility for further rehabilitation and assessment".

8.0 Specialist Patient Groups

8.1 Patient taking own discharge

- It must be established whether the patient has capacity. If there is any doubt about the capacity of the patient, an assessment must be carried out by relevant professional.
- The relevant doctor should be contacted to explain to the patient the importance of staying in hospital and the possible risks of a self-discharge. Medication that can be safely prescribed should be and follow up arrangements should be made unless the patient does not want this.

- Ward staff should ensure, where possible, that a self-discharge form is completed and filed in patient's medical notes. These forms are held on wards.
- If a full and accurate documentation of events and conversations with the patient should be documented in the medical file by the ward nurse.
- The GP and other relevant services should be informed.
- If a social care need is identified then the Access Team should be informed 01343 563999.

8.2 Patients receiving opiate substitution therapy (for example methadone or suboxone)

A member of the MDT should contact both the Moray Drug and Alcohol Service and the patient's community pharmacy to clearly communicate doses of therapy given to the patient during their inpatient stay and whether any doses have been supplied on discharge. Generally only one dose is supplied on discharge, and only when dose not given before discharge (or a weekend/PH).

8.3 Patients started on oral anticoagulant therapy during their admission

Patients should be provided with a printed information booklet and alert card on their new therapy. The doctor or pharmacist should counsel the patient using this booklet and provide opportunity for the patient to ask questions. This should be carried out prior to discharge.

8.4 Patients discharged on Warfarin

A copy of the inpatient anticoagulant prescription should be faxed to the patient's GP surgery on discharge. The patient should be given written information on their Warfarin dosing covering the entire period between discharge and GP review. A follow up appointment for INR check must be booked before the patient is discharged.

8.5 Discharge of patients requiring palliative care

Palliative care is the active total care of patients whose disease is not responsive to curative treatment and encompasses both the patient and their family/carer. Palliative Care should be an integral part of clinical practice available to all patients with a life threatening illness.

The discharge summary will include:

- Key facts about the diagnosis
- Results of key investigations
- Clinical information including different interventions tried for symptom control and social, emotional and spiritual needs
- Patient and family understanding of the illness and prognosis
- Suitability of housing if returning home or housing issues
- Plans for follow-up
- Other professionals/agencies involved in ongoing care
- Anticipatory Care Plan (ACP) created or updated in liaison with the District Nursing Team

- DNACPR form if applicable

8.6 Discharge of patients who have social housing, housing needs or who are potentially homeless

Housing is a key part of a safe, effective and planned discharge from hospital. If a patient is admitted to hospital it is fundamental to identify **at the point of admission** if there are any potential housing issues that may need effective intervention to ensure a smooth discharge. This can range from identifying that the patient has a social housing tenancy and if any action is required so they do not risk losing their home during their stay in hospital, to identifying if the patient is homeless and has insecure or no accommodation to return to upon discharge.

Homeless is defined in Section 24 of the Housing (Scotland) Act 1987 (as amended), as a person who has no accommodation in the United Kingdom or elsewhere which they are entitled, or permitted to occupy, in one of the following ways:

- They have a legal interest in the property - as an owner or tenant; or
- They have a right or permission to occupy the property - as a lodger or as a member of an existing household; or
- They have a court order that they can stay in the house.

A person is also homeless if they have accommodation but:

- Cannot get access to the property or
- Where occupation of the property will lead to violence or threats of violence from another resident within the property that is likely to carry out such threats.

The Moray Council has a **statutory duty** to ensure that any patient with potential homelessness issues receives advice and assistance in line with this legislation and as set out in The **Moray Council's Homelessness Policy** (http://www.moray.gov.uk/moray_standard/page_43625.html). This can only be done effectively by working in partnership with NHS Grampian staff through the admissions and discharge processes.

If applicable, a pre-planned, co-ordinated approach with The Moray Council's Housing Service or relevant housing provider should take place as part of discharge planning. **Please see Appendix 8 for contacts**.

8.7 Discharge of patients with Dementia or learning disabilities

Where applicable in individual cases refer as early as possible to the relevant professionals, including wider community professional involvement.

8.8 Discharge of patients from Emergency Departments

- A letter with full clinical details will be sent to the patient's GP (General Practitioner) within 1 (one) working day electronically.
- All patients should be given a verbal / written explanation of the circumstances of their condition before discharge from the A&E Department/Minor Injury.
- Vulnerable patients (including patients with capacity issues) being discharged from the A&E Department/Minor Injury should be assessed to ensure they are returning to a safe environment and should not be discharged whenever possible after 10pm. Where Adult Support & Protection issues are identified, such patients should be referred to Health and Social Care Moray Access team at Accesscareteam@moray.gov.uk and Adult Support & Protection Policy/Procedure followed http://www.moray.gov.uk/downloads/file47828.pdf .
- Those with a housing issue or potentially homeless people being discharged from A&E should be signposted to The Moray Council Housing Service. The A&E Department should provide them with up-to-date information as contained within **Appendix 8** regarding homelessness. Referrals to other relevant Community Organisations who can provide the required help and support should also be made at this stage.
- All patients will be given clear instructions on follow up appointments, where required.
- All patients will be given explicit instructions regarding where to seek further medical advice if their condition does not resolve.

Also see **Appendix 7 - Algorithm for the transfer of patients from ED Out of Hours/ Weekends/ Public Holidays**

8.9 Patients/carers refusing discharge (with capacity)/Unsafe to discharge home

8.9.1 Patients/carers refusing discharge (with capacity)

- Setting an estimated discharge date (EDD) with the family early in the patient pathway may reduce the likelihood of refusal to leave hospital and reduce anxieties. Every effort should be made to ensure the patient and/or carer as appropriate is in agreement with the discharge planning and is clear about what is expected of them.
- If the patient is refusing to be discharged back to their home address despite being medically ready for transfer and safe for discharge, every effort should be made to ascertain the reasons for refusal and advice on solutions provided. The discharge coordinator can be contacted to offer advice and support to ward staff in counselling the patient and family, but are not available to act as the evictor.
- A meeting between families and the relevant agencies involved in care planning may be required and a resolution sought. A carer has the right to choose not to provide unpaid/informal care but does not have the right to stop a patient with capacity and who wants to return home from hospital

from doing so. Legal support may be sought by the teams to achieve discharge in these circumstances. See also **sections 7.2 and 7.3**.

- Where the carer withdraws from their caring role, the MDT should consider an alternative discharge plan that might include respite care. If considered safe the patient should return home with alternative care provision.

8.9.2 In the event that discharge home is no longer safe

- In the event that discharge home cannot be achieved because it is no longer safe, a patient who has capacity to make relevant decisions will be fully involved in their discharge plan.
- If a patient lacks capacity to make decisions about their discharge plan then a proxy with legal authority to make decisions on their behalf (Welfare Attorney or Welfare Guardian) must be involved fully in the decisions about discharge.
- If a patient lacks capacity and there is nobody with legal authority to make those decisions then it may not be possible to discharge the person to an appropriate care facility until legal powers are in place. A referral to social work will be required and a multi-agency Adults with Incapacity meeting will be held to decide what legislation is required in the circumstances to facilitate discharge to an appropriate placement. In these circumstances discharge from an acute setting to a community hospital while the legal process (e.g. Guardianship application) is taking place should be considered.

8.10 Discharge of patients with an Infection

8.10.1 Introduction

The Infection Control Nurses are available to visit patients or their relatives on the ward to explain the reasoning behind any Infection Control measures that are being taken and precautions needed on discharge.

The ward nurse should contact Infection Control when they feel additional advice/input is required for the patient/relatives or community staff.

8.10.2 Discharge to a Care home

Before discharge the ward staff should inform the care home about the nature of the patient's infection so that the necessary infection control precautions can be put into place.

8.10.3 Discharge to Own Home with District Nurse Input

The ward staff should inform the District Nurse about the patient's infection.

8.10.4 Discharge to Own Home With Non-Nursing Support Services

The ward nurse will supply information in a suitable format, pertinent to the infection in relation to:

Infection Control precautions in place

- Treatment (i.e. – Antibiotic Therapy) – dressing regime, etc.

8.10.5 Information on Specific Infections

Clostridium Difficile

Unless specific arrangements for isolation have been made, patients with Clostridium difficile diarrhoea should not be discharged to Care Homes/Other Hospitals/Intermediate Care until they are symptom free for 48 hours. A negative stool specimen is not required for any transfer as carriers are not a risk for cross-infection unless diarrhoea is present. Details of any current treatment must be communicated. Asymptomatic patients who have been in contact with symptomatic patients must remain isolated for 48hrs as per NHSG Policy and should not be transferred / discharged to another hospital / nursing home until they are 48hrs symptom free. They can however be discharged home with advice given to patients/families with details given of any current ongoing treatment.

Norovirus

Unless specific arrangements for isolation have been made patients must not be discharged to Care Homes/Other Hospitals/Intermediate Care/Community Hospitals/Home until they are symptom free for 48 hours. Asymptomatic patients who have been in contact with symptomatic patients must remain isolated for 48hrs as per NHSG Policy and should not be transferred / discharged to another hospital / nursing home until they are 48hrs symptom free. They can however be discharged home with advice given to patients/families with details given of any current ongoing treatment.

MRSA - (Methicillin Resistant Staphylococcus Aureus)

Where applicable, before discharge, patients (or their relatives) should be notified about how to access information about MRSA. The GP or other health care agencies involved in the patient's care should be informed that the patient has MRSA. The GP and District Nurse should be sent a copy of treatment protocol if this is to be continued after discharge (this is unnecessary in most cases).

Repeat screening swabs are not required unless requested by Infection Control.

The patient will need to be advised that there is no risk to healthy relatives or others outside the hospital. Continued carriage of MRSA is not a contra-indication for the transfer of the patient to a Care home, although patients should not be sharing a room with anyone who has open wounds.

8.10.6 Transport by Ambulance

If the patient has to be transported by ambulance and the patient has skin lesions, these should be covered with an occlusive dressings. Patients may be transported with other patients, but not patients

going to or from high-risk areas of the hospital. Gloves and plastic aprons should be worn by staff moving the patient.

Ambulance service must be notified if any patient to be discharged and transported by ambulance has any infectious diseases i.e. MRSA, C Diff etc.

8.11 Discharge into custodial care

8.11.1 Police Custody

When discussing discharge of the patient under Police custody, give as much notice as possible and discuss the impending discharge with the Police officers present. They will then advise of where the patient is being discharged to and will arrange transport for that area.

8.11.2 Prison Custody

Refer to NHS Bed Watch Policy.

9.0 Adult Support and Protection

9.1 Adults at Risk

The guidelines for the Protection of Adults has been agreed by Police Scotland, NHS Grampian, Health and Social Care Moray. An ASP concern form should be completed and sent directly to the access.careteam@moray.gov.uk . The ASP concern form can be found on the Datix system for NHS staff. There should be no discharge of individual until the concern has been screened. This may lead to a case conference which will include a risk plan. Link to the Grampian Interagency Policy is; http://www.moray.gov.uk/moray_standard/page_95357.html - this includes the ASP reporting form and Medical Examination Protocol.

10.0 Delayed Discharges

10.1 Monitoring delayed discharges

NHS Grampian and The Moray Councils Adult Social Care Services have a joint responsibility for managing delayed discharges and transfers of care. These must be recorded on Edison as appropriate.

10.2 Situation Reporting

A snapshot of delayed transfers of care (informed by the situation report) will be taken on the 29th of each month. This report must include all patients who no longer need acute hospital care or are ready to be discharged from rehabilitation wards.

A weekly Resource Allocation Meeting (RAM) meeting and weekly meetings with Social Work confirm responsibility for individual delayed transfers of care and discharge plans are discussed and agreed for each individual patient.

The outcome of this meeting will be reported to Health & Social Care Moray performance management and the Department of Health through the weekly situation report.

11.0 Related Policies/Procedures/Legislation

- Data Protection Act 1998;
- Freedom of Information (Scotland) Act 2002;
- The Human Rights Act 1998
- The Equality Act 2010
- GIRFEC
- Adult Support and Protection (Scotland) Act 2007
- Grampian Adult Support & Protection Policy
  http://www.moray.gov.uk/moray_standard/page_95357.html
- Housing (Scotland) Act 1987 as amended by the Housing (Scotland) Act 2001 and the Homelessness etc. (Scotland) Act 2003
- Code of Guidance on Homelessness 2005
- Homelessness Policy 2013
- Eligibility Criteria Policy
- Moray (Partners in Care) Three Tier Policy
- Reablement Policy
- SDS Policy, SDS Procedure & SDS Short Stay/Respite Procedure – 2016 updates
- National Health & Wellbeing Outcomes (for the integration of health and social care)
- Adults with Incapacity (Scotland) Act 2000
  Codes of Practice - http://www.gov.scot/Topics/Justice/law/awi/010408awiwebpubs/cop
- Adults with Incapacity (AWI) Policy and AWI Procedure – 2016 updates
- Ordinary Residence Policy

12.0 Equalities Statement

Health & Social Care Moray will not and does not discriminate on any grounds. Health & Social Care Moray advocates and is committed to equalities and recognises its responsibilities in this connection. We will ensure the fair treatment of all individuals and where any individual feels that they have been unfairly discriminated relating to, that individual shall have recourse against Health & Social Care Moray in line with the grievance and harassment procedures.

In relation to equality of information provision, Health & Social Care Moray will ensure that all communications with individuals are in plain English, and shall publish all information and documentation in a variety of formats and languages. Where required, Health & Social Care Moray will use the services of its translation team to enable effective communication between us and the individual. Where an individual has sight, hearing or other difficulties, we will arrange for information to be provided in the most appropriate format to meet that individual's needs. Health & Social Care Moray will also ensure that there are no physical barriers that could prohibit face to face communications.

If there is a complaint against discrimination, click on the link below for reporting form and procedure: http://www.moray.gov.uk/downloads/file62366.pdf.

Equality and Human Rights Commission Scotland

https://www.equalityhumanrights.com/en/commission-scotland

Advice and Guidance section - https://www.equalityhumanrights.com/en/advice-and-guidance.

13.0 Data Protection

The Data Protection Act 1998 http://www.legislation.gov.uk/ukpga/1998/29/contents governs the way information is obtained, recorded, stored, used and destroyed. Health & Social Care Moray complies with all the requirements of the Act and ensures that personal data is processed fairly and lawfully, that it is used for the purpose it was intended and that only relevant information is used. Health & Social Care Moray will ensure that information held is accurate, and where necessary kept up to date and that appropriate measures are taken that would prevent the unauthorised or unlawful use of any "personal information".

Please see the following link for more information https://ico.org.uk/for-organisations/guide-to-data-protection/

14.0 Freedom of Information

The purpose of the Freedom of Information (Scotland) Act 2002 http://www.legislation.gov.uk/asp/2002/13/contents is to "provide a right of access by the public to information held by public authorities". In terms of section 1 of the Act, the general

entitlement is that a "person who requests information from a Scottish public authority which holds it is entitled to be given it by the authority". Information which a person is entitled to is the information held by the public authority at the time that the request is made. This is a complex area of the law that can overlap with the Data Protection Act and other legislation.

Please see the following link for guidance to the law in Scotland; http://www.itspublicknowledge.info/Law/FOISA-EIRsGuidance/Briefings.aspx

All Freedom of Information requests to Health & Social Care Moray should be directed to **The FOI/DPA team** via info@moray.gov.uk.

15.0 Human Rights Act

In October 2007 the three equalities commissions: Racial Equality, Disability Rights and Equal Opportunities were merged to form one Commission: **The Equality & Human Rights Commission** https://www.equalityhumanrights.com/en/commission-scotland/human-rights-scotland.

The main aspects covered in the **Human Rights Act 1998** are:

Right to life; protection from torture; protection from slavery and forced labour; right to liberty and security; right to a fair trial; no punishment without law; right to respect for private and family life; freedom of thought, belief and religion; freedom of expression; freedom of assembly and association; right to marry; protection from discrimination; protection of property; right to education and right to free elections.

The Human Rights Act can overlap with many areas of Health & Social Care Moray's policies, any doubts or queries regarding its effect or implications must be referred to the Legal Services Manager (Litigation and Licensing).

16.0 Use of Appendices 1 and 2

Appendix 1 & 2 applies when the person has been assessed as lacking capacity to make decisions about their discharge plan *and* has been assessed as requiring 24 hour care *and* has a proxy with appropriate powers (Welfare Attorney or Welfare Guardian). The letter must be sent/given to their proxy.

N.B. relatives without the necessary legal powers cannot lawfully place the patient in a care home without that person's consent *or,* if the patient is incapable of consenting, without due process of law.

17.0 Monitoring and compliance

As a minimum this will be carried out through; the Delayed Discharge Group, monitoring of Complaints and the Patient Transfer Group.

18.0 Policy Review

The Policy will be reviewed every 12 months by Health & Social Care Moray.

Appendix 1 – Discharge from Hospital Letter 1 (Moving on Policy) legal proxy

Health & Social Care Moray Headed Paper

Our Ref:- MR/SNB

Dear

Discharge from hospital – (Name of Patient)

We are writing to you because (name of patient) has been assessed as having lost capacity to make decisions about or arrange their own discharge. This letter is based on the understanding that you have the necessary legal powers to make the relevant decisions on their behalf.

We are pleased that your (name of patient) consultant has confirmed that he/she is now ready to leave hospital. The person who will be co-coordinating (name of patient) discharge will be ……………… (Tel No. ……..). The health and social care assessment (with input from the Multi-Disciplinary Team including a clinical decision on Hospital-based Complex Clinical Care eligibility) has been completed and the assessment concluded that his/her support needs would best be met in a Care Home. This decision has been agreed by the management team (having considered his/her support needs) at the weekly Resource Allocation Meeting (RAM). We will do everything possible to help you to transfer (name of patient) to a care home which will meet his/her support needs.

When a patient no longer needs to be in hospital, it is in their best interest to move as soon as possible to a more appropriate place. Also, as you will understand, hospital beds are in great demand and we need to ensure that they are available for patients who are acutely ill and need them for urgent care. The risks associated with remaining in hospital (including risk of infections and risk to the patient's capacity for independence/independent living) once someone is fit to be discharged have been recognised for some time. Hospital is not the appropriate environment for someone who is fit and safe to be discharged.

To enable beds to be available to patients that require them we need to ensure that when a Consultant has decided that a patient no longer needs to be in hospital, they transfer to an appropriate place as soon as possible.

If you select a home that does not have a current vacancy, it is our expectation that you will select a second home which does until the home of your choice becomes available. Please discuss this with your Social Worker.

Thank you for your help in this matter.

Yours sincerely

Patient's Notes

Appendix 2 – Discharge from Hospital Letter 2 (Moving on Policy)

Health & Social Care Moray Headed Paper

Our Ref: - MR/SNB

Dear

DISCHARGE FROM HOSPITAL – (Name of Patient)

I understand that we have been unable to discharge (name of patient) from hospital because you have not identified a suitable home with a vacancy. We need to ensure that (name of patient) is discharged without further delay to an appropriate place, where his/her needs can be met.

I am pleased to be able to confirm that the following (Care Homes) currently have vacancies and will be happy to come in and assess (name of patient). An interim placement will then be arranged until you have selected the home of your choice and they have a vacancy.

(List the names, telephone numbers of three homes)

When people are clinically assessed as fit to leave the Hospital it is in their best interest to do so as quickly as possible due to the recognised risks of loss of independence and risk of hospital acquired infections if they remain in hospital. Also, hospital beds are in great demand and we need to ensure that they are available for patients who are acutely ill.

Please will you contact (Name and telephone number of Social Worker) as soon as possible and advise them which homes you would prefer for an interim placement until the first choice vacancy becomes available.

Yours sincerely

cc Patient and/or Patient's relative/carer

Multi-Disciplinary Team

Patient's notes

Appendix 3 – Patient Satisfaction Survey (Example)

Please answer the following questions by putting a tick in the box that applies.

Please tick a box to show where you live					
Forres area	Elgin area	Lossiemouth area	Speyside area		
Who is the person filling in this form?					
Myself	A friend, carer or relative	Social Care Representative	Somebody else		
Please indicate the age band that you are in					
16-29	30-49	50-64	65 –79	80-89	90+

Please answer the following questions by putting a tick in the box that applies.				
	FULLY AGREE	**PARTLY AGREE**	**DISAGREE**	**DOES NOT APPLY**
1. Did you receive relevant information about how your assessment would happen?				
2. Did the Social Worker inform you that there may be a financial assessment and that you may be required to pay for the cost of services provided?				
3. Was the information you received provided so that you could easily understand it?				
4. Was the information (verbal or written) that you received from the discharge liaison nurse and your Social Worker helpful?				
5. Your views should be taken to be the most important part of the assessment. Was this the case?				
6. Do you feel that you have been treated with dignity and respect?				
7. Was your assessment completed promptly?				
8. Did your Social Worker help you to get the services you were assessed as needing?				
9. Did you feel that you were involved in choosing the type of services to support you?				
10. Were your planned services delivered promptly?				

	FULLY AGREE	PARTLY AGREE	DISAGREE	DOES NOT APPLY
11. Were matters about your, lifestyle taken into account? (If no, give details in comment box).				
12. Did your Social Worker and hospital staff respect your views about your situation?				
13. Do you feel that you can contact the Social Work Service easily if you need to?				
14. Do you know how to make a complaint or compliment about Social Care Services if you wanted to?				
15. Has Social Care Services involvement helped to improve your quality of life?				
16. Were you made aware whether you were eligible for continuing Healthcare Funding?				
17. Please make additional comments about your experience of the discharge Service, particularly for any question to which you ticked the ‘Disagree’ box.				
Additional Comments:				

Thank you for taking the time to fill in this questionnaire.

Please return to:

Public Involvement Officer

Telephone: 01343 567187

Email: involvement@moray.gov.uk

Appendix 4 - Booking PTS Transport

24 Hours' Notice (Minimum) in normal operating conditions for booking of PTS Non Urgent Discharge Transport is required

Please book transport before 1500 Hrs for the following working day discharge to enable an efficient planning process.

Bookings taken after 15.00hrs may delay the discharge process.

As soon as an expected day of discharge is determined a provisional discharge booking should be made with Transport Booking Office on 0300 123 1236. This booking can then be planned and altered according to the patient's needs/situation.

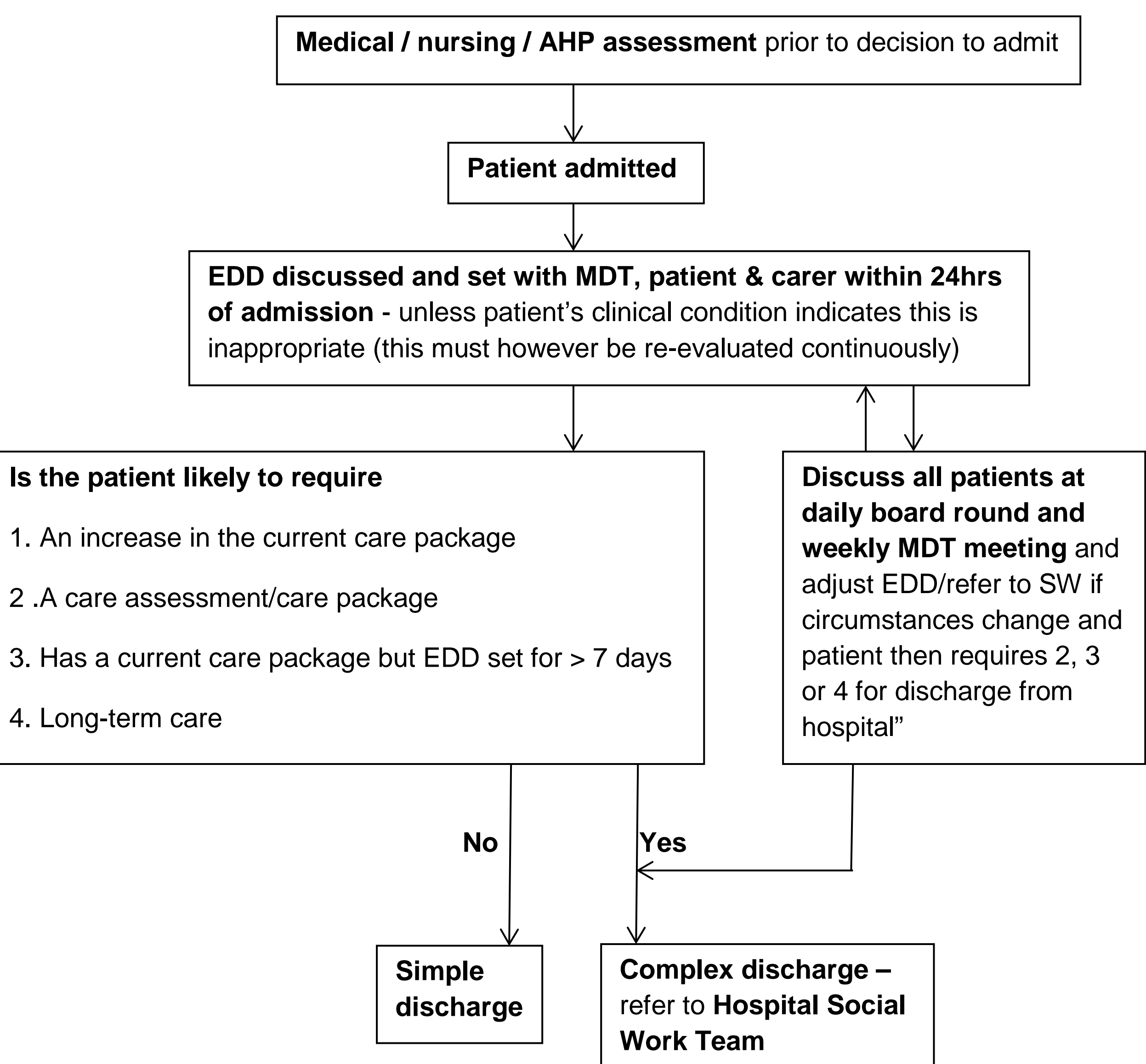
For mobile (walking, car) patients, relatives should be asked where possible to collect their relative from hospital on the agreed day of discharge.

Please inform staff in the Transport Booking Office of any infectious diseases (CDIF+, MRSA etc.) the patient may have, so that this may be noted on their booking.

Please follow the DGH Transport guidelines available for transport options (**see the transport flowchart in the Appendices**)

Appendix 5 – Flowchart to identify whether a patient's discharge from hospital will be simple or complex

Flowchart to identify whether a patient's discharge from hospital will be simple or complex – December 2016



SIMPLE DISCHARGE

- Often only a single disciplinary assessment is required
- Support of relatives can be assumed (always ask if they choose to do so)
- Existing care package may already be in place and needs are unchanged (ask SW)

Or

- May have other needs
- May already have Housing support in place, need to make contact with the Housing Support Worker, TMC, see **Appendix 8**
- No ongoing care needs are identified
- Discharge planning needs are typically met by simple actions
    - Tablets to take out
    - Transport (remember criteria)
    - Arranging appointments
    - Engaging district nursing service
- Estimated day of discharge may be relatively easy to predict with few variables to manage

COMPLEX DISCHARGE

- Multidisciplinary assessments required
- Financial assessments required
- May not have family support networks
- Support was not required previously
- Housing/homelessness issue has been identified and referral required to TMC

Or

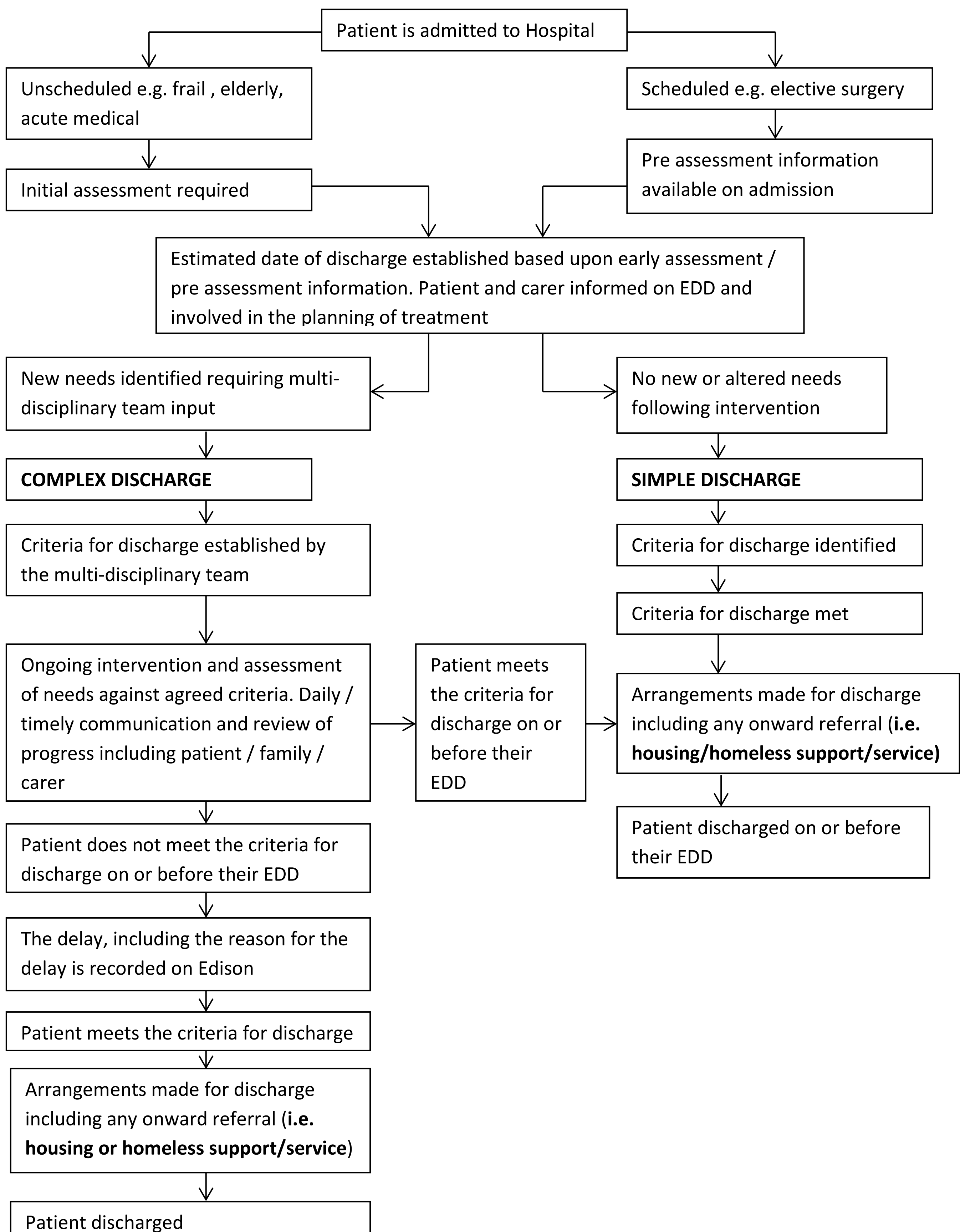
- Increased level of support now required

And

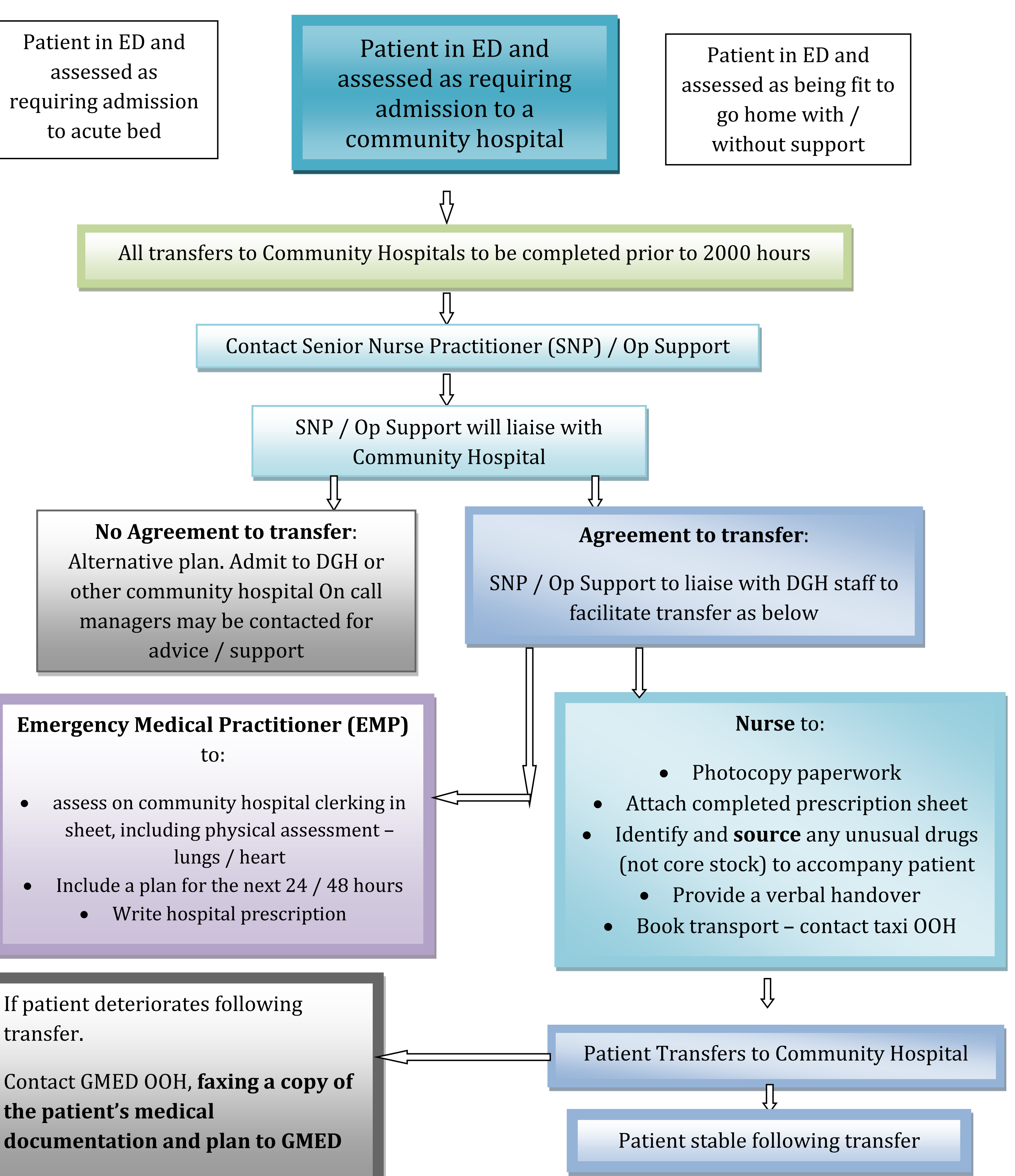
- Ongoing health care needs have been identified
- Discharge coordinator support is needed as pivotal to the discharge panning
- Multidisciplinary team meetings are central to the planning

Source: *Nurse facilitated hospital discharge.* Lees, L. (2006)

Appendix 6 – Patient Flow Admission to Discharge



Appendix 7 - Algorithm for the transfer of patients from ED: Out of Hours/Weekends/Public Holidays



Appendix 8 – Housing and Environmental Issues

Upon Admission to Hospital

Any discharge process for people with any housing need must start on admission to hospital. Early identification is vital to ensure that the housing service, along with appropriate agencies, can ensure that the housing/support needs of the patient are met and addressed properly during and after their stay in hospital. Arrangements for assessing the suitability of their current accommodation, including the need for adaptations or the provision of alternative accommodation upon their discharge, needs to be identified at the earliest stage possible.

Some cases are not always distinguishable from the outset. For example, a patient may give a friend or relative's address or last known address but are no longer living there and then admit when they are about to leave that they have nowhere to go. Targeted questions by NHS staff upon admission are the only way to find out the accurate housing situation of a patient.

NHS staff must contact the relevant section of The Moray Council Housing Service (**see the table below**) to discuss the most appropriate action relevant to the person's circumstances. Please refer to the table below to see which team to contact in different situations.

The Moray Council may ask for medical information or a copy of the Support Plan, Occupational Therapy or Physiotherapy reports.

The relevant person (**see the table below for contacts**) from TMC Housing Service should be asked to attend the relevant case conference as part of the preparation for discharge.

How to identify if someone is homeless?

Homelessness means not having a home. Being roofless is not the only type of homelessness. Someone can have a roof over their head and still be homeless. This may be because they don't have any rights to stay where they are living or their home is unsuitable for them.

A patient may be homeless if they:

- are sleeping on the streets;
- are staying with friends or family and have no settled, permanent accommodation;
- are staying in temporary or emergency accommodation such as bed and breakfast, hotel, hostel B&B or supported accommodation;
- have a right to stay in their home, but it would put them at risk of violence;

ON ADMISSION OF A PATIENT (where there is no family/friend to assist with the process)		
Q. - WHAT TYPE OF ACCOMMODATION WAS THE PATIENT ADMITTED FROM?		
Accommodation type	**Action**	**Contact Details**
TMC Tenancy	It is vital that NHS staff inform the housing service of the tenant's admission to ensure they do not lose their property as it may be perceived to have been abandoned. The property may also need drained down if the hospital stay is long during the winter months to avoid frozen pipes.	The relevant Moray Area Housing Team Tel: 0300 123 4566 E-mail Housing@moray.gov.uk to inform relevant housing officer
Housing Association Tenancy	Contact the relevant housing association to inform them so property is not classed as abandoned.	Various
Staying in temporary OR emergency homeless accommodation (this can include a hostel, unit, B&B, hotel, supported accommodation)	It is vital that the NHS staff inform the Supported Accommodation Team immediately to ensure the patient is able to access the appropriate support in order to sustain their interim accommodation for the duration of their stay and for when they leave hospital. Where possible their accommodation will be retained for them to return to upon their discharge if it is still suitable. **Failure to do so may result in the loss of their temporary accommodation as it may be perceived to be abandoned.**	The Moray Council Temporary Accommodation Team Tel: 0300 123 4566 E-mail Housing@moray.gov.uk
Insecure Accommodation: for example staying with family/friends for interim period or is renting a property but has been served notice to leave.	It is important to inform the Housing Service of anyone who may not have secure accommodation upon discharge at the earliest indication to allow liaison with agencies such as CAB to assist with independent housing advice as well as assessment and forward planning of their housing options.	**Between 8.45 am and 5pm:** The Moray Council's Housing Options Team Tel: 0300 123 4566 ask to speak to our Housing Options Duty Advisor. E-mail Housing.Options@moray.gov.uk
Has no secure accommodation and/or nowhere to go upon discharge – potentially homeless	It is important to inform the housing service of anyone who may be homeless or potentially homeless upon discharge at the earliest indication to allow assessment and forward planning of their housing options.	**Between 8.45 am and 5pm:** The Moray Council's Housing Options Team Tel: 0300 123 4566 ask to speak to our Housing Options Duty Advisor. E-mail Housing.Options@moray.gov.uk
Q. - IS THE PATIENT CURRENTLY RECEIVING HOUSING SUPPORT FROM THE MORAY COUNCIL HOUSING SUPPORT TEAM?		
YES ➡	If the patient is receiving housing support it is very important that the housing support worker is made aware of the patient's current situation. They can	The Housing Support Duty Officer on Tel: 0300 123 4566 or

	continue providing support while the patient is in hospital as well as assisting in facilitating the home from hospital process.	Email: HousingSupportTeam@moray.gov.uk
Q. - IS THE PATIENT IN RECEIPT OF ANY HOUSING BENEFITS/UNIVERSAL CREDIT FOR PAYING THEIR HOUSING COSTS?		
YES ➡	If the patient relies on benefits/Universal Credit and is in hospital for any prolonged period of time it is vital that the DWP (Department for Works and Pensions) are contacted. The no payment of the benefits to the housing provider/landlord can result in the patient losing their accommodation. This needs to be reported as early as possible	**DWP contact number** depends on what other benefits (if any) someone receives **(Pension Credit, Universal Credit, IS/JA/ESA) -** https://www.gov.uk/housing-benefit/how-to-claim
Q. – ARE THERE ANY ENVIRONMENTAL ISSUES WITHIN THE PATIENT'S HOME THAT IS HAVING AN IMPACT ON THEIR PHYSICAL HEALTH AND RESULTING IN REPEAT ADMISSIONS? This could include the fabric of the property not meeting a basic standard, landlord not auctioning essential repairs, no heating etc.		
YES ➡	All landlords whether social or private have basic minimum standards that their properties must meet for renting to a member of the public. If there is an issue with the property that the patient is experiencing recurring health problems this should be reported to the landlord. The Moray Council's Environmental Services department can carry out specific functions relating to the fitness of a property. They may be able to offer advice and assistance on a range of interventions that could facilitate discharge back to the property.	**If Private Owned Property:** Contact The Moray Council Environmental Health service on Tel: 01343 563345 E-mail: public.health@moray.gov.uk **If Private Rented Property:** Contact the Private Rented Sector Home Improvement Team at Tel: 0300 123 4566 or E:mail homeimprovementteam@moray.gov.uk **If Moray Council Property:** The relevant Moray Area Housing Team Tel: 0300 123 4566 E-mail Housing@moray.gov.uk to inform relevant housing officer
PRIOR TO DISCHARGE		
Q - IS THE PROPERTY THEY ARE RETURNING TO SUITABLE CONSIDERING THE NATURE OF THEIR STAY IN HOSPITAL, CONDITION		

OF PROPERTY, MOBILITY AND FUNCTIONALITY?		
YES	No action required from a housing perspective.	
NO ➡	Review if it is appropriate to discharge the patient. Assess what action should be taken to make the property suitable (e.g. aids and adaptations, care package etc).	
Yes BUT will need more suitable accommodation in the longer term - Adaptations or Home Improvements to current property. **OR**	Patient may be discharged home with equipment, pending further assessment and consideration by both NHS staff and Housing Service regarding the possibility of adaptations/improvements to their current accommodation. **Key actions include:** ➢ The hospital occupational therapist identifying what the potential issues are with the accommodation whilst the person is in the acute setting. ➢ The hospital occupational therapist referring to the community occupational therapist at the earliest stage. ➢ Assessment and recommendations for works under the Scheme of Assistance Grant are the statutory responsibility of social services occupational therapist. The administration of the Scheme of Assistance Grants remains the responsibility of the local housing authority. Handyperson Service is available in Moray and offers assistance to accessibility problems that may delay discharge e.g. grab rails, ramps, handrails, relocating bedroom furniture, wireless door chimes and door entry systems.	**Contact details MDT?** The Moray Council Home Improvement Team at Tel: 0300 123 4566 or E:mail homeimprovementteam@moray.gov.uk Moray Handy Persons Service Tel: 01343 559739 E-mail admin@MorayHPS.org.uk

Yes BUT will need more suitable accommodation in the longer term - rehoused from ordinary housing to more suitable, adapted or sheltered housing.	The patient would need to complete a Moray Council Housing Application and Medical Assessment Form to be considered for a specially adapted property that meets their specific requirements. NHS staff should contact The Moray Council Housing Service.	The Moray Council Housing Service Tel: 0300 123 4566 E-mail Housing@moray.gov.uk.
Q. - IS THE PATIENT HOMELESS OR POTENTIALLY HOMELESS AND IT IS AFTER 5PM ON A WEEKDAY OR THE WEEKEND AND THEY HAVE NO ACCOMMODATION TO BE DISCHARGED TO?		
YES	**It is vital that NHS staff contact The Moray Council Out Of Hours Homeless Service**	**OUT OF HOURS - 5pm and 8.45am weekdays and at weekends:** Contact our Out Of Hours Duty Officer on 03457 565656.

Appendix 9 – Multi-disciplinary meeting Guidelines

GENERAL PRINCIPLES

- Should be Multi-disciplinary
- Each member should feel that their opinion is of equal value to that of the rest of the team.
- All disciplines involved in the care of an individual patient should attend each meeting. When this is not possible or appropriate they are responsible for ensuring that an up to date progress report is available for the rest of the team. Each individual is responsible for ensuring that they obtain a report from any meeting that they are unable to attend.

ATTENDEES

- The relevant Medical Team
  - The doctor must be familiar with the individual patients under discussion.
- A member of the ward nursing team
- The Occupational Therapist
- The Physiotherapist
- The relevant Social Worker
- Discharge Co-ordinator
- Other disciplines as appropriate to individual patients. The onus should be on each professional to attend the meetings of patients with whom they have involvement.

GENERAL GUIDELINES FOR ATTENDEES

- Interruptions should be avoided
- All attendees should be punctual
- Discussion should be restricted to the specific patient being considered
- All relevant notes (medical, nursing, etc) should be available and should form focus for discussion

FORMAT FOR MEETING

1. A medical / social summary should be presented by an appropriate member of the team at the first meeting at which an individual patient is discussed. This should include:

- Name

- Age

- Address

- Type of accommodation, and information regarding others living there

- Known support already available.

- Medical Diagnosis

- Main problems / potential problems

At all subsequent conferences a BRIEF summary of the above information should be given as a starting point for the discussion.

2. Each member should provide additional information if appropriate, including feedback from actions agreed at previous meetings.

3. General discussion, resulting in the formation of a plan of action.

4. A plan of action, that all those present agree should be discussed with the patient and their family and documented in the patients record.

5. Outcomes should include clear actions, agreed by all, with identified personnel taking responsibility for specific actions within an agreed timescale. These actions will be logged in the medical & nursing notes.

Appendix 10 – Timescales (Measureable Outcomes)

Social Work referral:

Adult Social Services will be involved in setting an estimated discharge date, and respond within a minimum of 2 working days from a Section 2 (notification from health that the patient is ready for assessment). They will aim to provide a service/facilitate access to support to facilitate earliest discharge by the confirmed discharge date and Section 5 (notification that the estimated discharge date is confirmed).

Occupational therapy referral:

The Occupational Therapist will commence assessment within 2 days of receipt of the referral. A home visit if deemed essential will be arranged within 5 working days and equipment assessed to meet patient need, may take up to 5 days.

Physiotherapy referral:

The physiotherapist accepts referrals as documented in their diary on each ward. They aim to respond the same day if the patient is assessed as fit for assessment to facilitate safe transfer of care

Hospital-based Complex Clinical Care

The Consultant (or MDT member with sufficient experience) will make a clinical decision on eligibility for Hospital-based Complex-Clinical Care at the earliest opportunity to facilitate coordination of timely discharge for those who are not eligible – **patients who are eligible will stay in hospital**.

Appendix 11 – Transport Guidelines

- The Trust expects patients to make their own way to and from hospital unless there is a clearly defined clinical /medical need for transport to be provided.
- Each patient should be able to get to and from the hospital in a reasonable time and in reasonable comfort without detriment to his or her clinical condition. Non-emergency Patient Transport should only be arranged where it is judged that the patient's health would suffer through the use of public or private transport.
- Patients granted hospital transport may only have an escort travelling with them if there is a clear clinical need for attention **on the journey**. Relatives are asked to meet the patient at the hospital.
- Patients may travel in their specially adapted wheelchair if they fit the eligibility criteria Patients who are able to transfer from a wheelchair to a seat, will, for their own comfort and safety, not be able to bring their own wheelchair. Arrangements will be made to transport patients with specialist equipment.
- The Emergency Ambulance Service deals with patients requiring urgent transport (e.g. urgent inter hospital transfer)
- The use of private transport to move patients either in to or out from the Trust should be kept to a minimum and correct procedure must be followed by contacting the Transport coordinator in hours and Senior Charge Nurse out of hours

Eligibility for ambulance transport

- Ambulance transport is not an automatic right for patients attending the hospital. It is the patients' responsibility to make their way to and from hospital. Transport will be provided only if there is a clear clinical need.
- Cost to the patient, of getting to the hospital, is not a reason for granting transport
- Patients in receipt of mobility allowances are not eligible for transport unless there are very special circumstances, to be discussed on an individual basis.
- Patients may find that independent travel is more convenient with less risk of missing an appointment time.
- Patients choosing to be discharged home or to a private rest/nursing home outside of the local area are responsible for arranging their own transport where applicable.

See also – **Patient Requires Transport** (Appendix on page 44)

Appendix 12 – Drugs and treatment for discharge

- The prescriber should prepare the eIDL as soon as the patient's drug regime is stable, at least 24 hours before the anticipated discharge date.

- Consideration should be given to compliance issues and any predicted problems discussed with the ward pharmacist prior to dispensing. Compliance aids, medication cards, plain bottle tops etc. should be considered.

- Under exceptional circumstances a patient may need to be assessed for a compliance aid as an inpatient and should be discussed with the pharmacist as near to admission as possible. It is recommended that this assessment take place when the patient is at their normal state of functioning and is in their own home.

- If an injectable medicine is to be given by the DN services, an authorisation form must be completed by the Doctor and accompany the patient home. If at all practicable patients should be taught to self-inject prior to discharge, but a DN referral will still be necessary.

- At least 14 days' supply of any new medication in the nearest original pack will be dispensed, except where a shorter course is indicated clinically.

- All patients' own medications should be returned to them or permission sought for their destruction by the pharmacy department. If a patient is confused, experiences problems with drug compliance or has a complex regime that has been subject to change, destruction by pharmacy may be the preferable option.

- Patients and carers should be advised to obtain further supplies of medication from their GP.

Appendix 13 – Patient Discharge Process

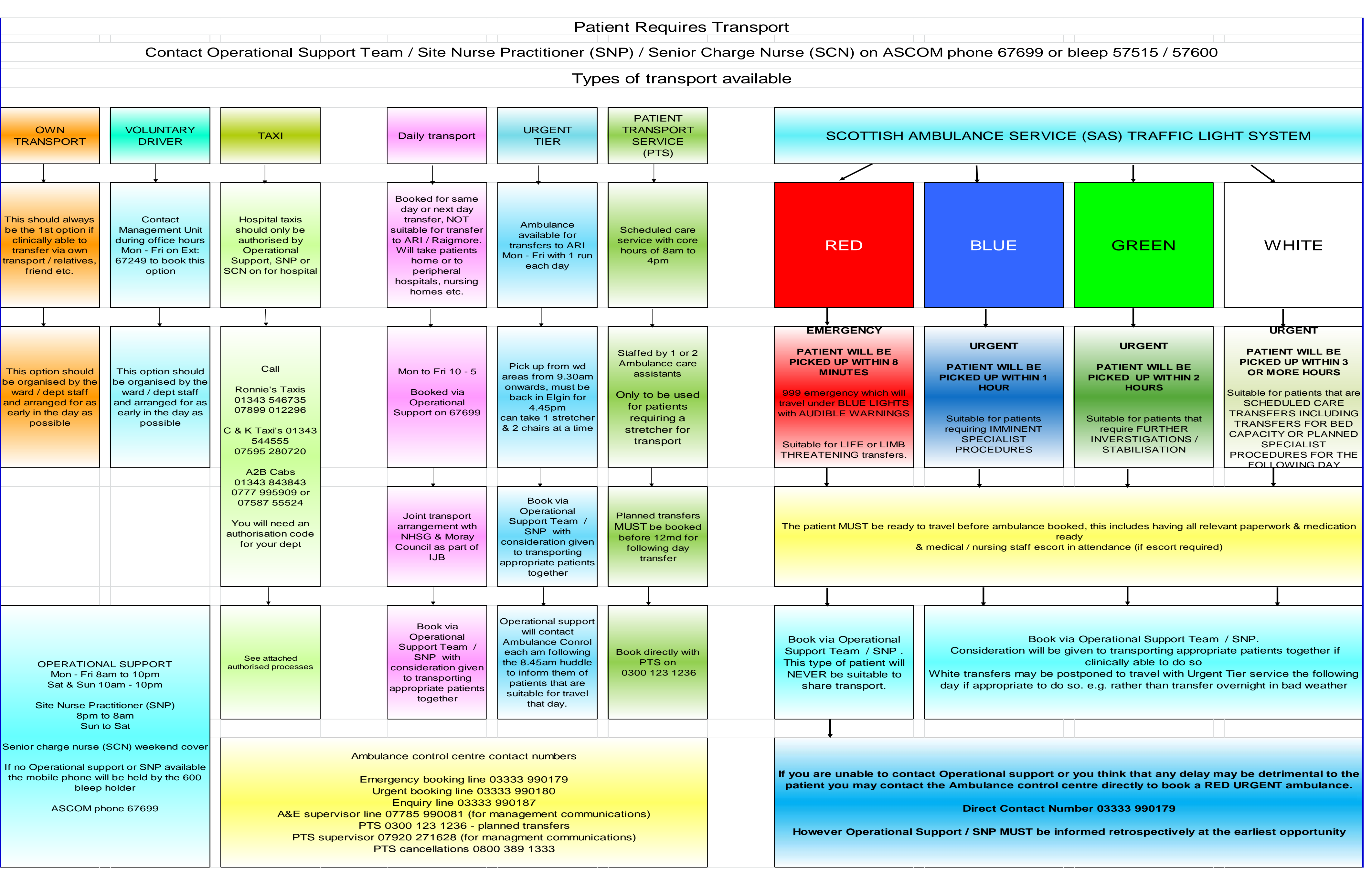
Action Required	Rationale	By Whom
Commence discharge plan with expected discharge date	To ensure plan in place and to identify any potential issues requiring referral to other services	Multi-disciplinary team overseen by Senior Charge Nurse
Facilitate ongoing involvement of patient/carer/relatives in the discharge planning process	To ensure effective and timely communication with patient/family/carers regarding all aspects of discharge including estimated discharge date.	Multi-disciplinary team
Assess patients for safe discharge and advise MDT of potential risks around management of the discharge	Effective communication within MDT and ensure safe discharge	Occupational Therapist Physiotherapist And other relevant professional
All arrangements in relation to discharge planning should be clearly documented, signed and dated within the Clinical Record	To maintain accurate documentation and ensure effective communication	Medical team/Registered Nurse/Therapy Staff, Housing Service and other Health Professions where appropriate
To work together with partner agencies to ensure all pre-existing services are in place prior to discharge	To ensure safe discharge to home or usual place of residence	Registered Nurse
Assessment of medication needs made and discharge prescription completed	To ensure patients medication needs are met in full and all medicines required are provided in a safe, accurate and timely fashion. This should include a review of their own medicine brought into hospital and those they may have at home	Prescriber +/or pharmacist
Electronic Discharge Summary is to be completed prior to discharge	To ensure accurate data recorded and sent to G.P	Medical team/Registered Nurse/Pharmacist
Ensure relevant information related to specific speciality/discharge is given to patient and discussed with patient/carers/relatives as required	To ensure patients understanding of any follow up arrangements	Registered Nurse
If a care home is usual place of residence, prior to discharge contact the nurse/manager to provide a handover of the patient, including the infection status and document in clinical records	Effective communication to ensure continuity of care on discharge Ensure provision is adequate in the care home to support discharge back.	Registered Nurse

Action Required	Rationale	By Whom
Ensure Patients medication to take home is correct as prescribed, discussed with patient/carer/ relatives and is given to patient prior to discharge	To ensure patients/carer/relatives understanding of medication doses and treatment	Registered Nurse
Ensure all patients, relatives and carers are fully informed and advised of danger signals to look out for any signs of deterioration	To ensure patients/carers/relatives are aware of diagnosis/ prognosis	MDT
Any incident during a hospital stay must be communicated to professional colleagues.	Effective communication to ensure continuity of care on discharge	MDT or other relevant professional
Ensure carers/relatives/care home are asked to provide patients own clothing/outdoor wear/foot wear prior to discharge	Maintain dignity and ensure patients are appropriately dressed for discharge from hospital	Registered Nurse/Healthcare Assistant
Pack or assist the patient to pack all belongings and ensure patient property form is completed	To prevent loss of patient property	Healthcare Assistant/Registered Nurse
Inform patient/carers/relatives and partner agencies of time of discharge	To provide communication regarding patients expected time of arrival.	Registered Nurse/Healthcare assistant/ward clerk
Communicate with the Operational Support Team to arrange transport where appropriate **(see Transport Appendix)**	To ensure arrangements complete	Registered Nurse/Operational Support Team
Transfer patient to day room if available to await transport/collection by relatives/carers where appropriate	To allow bed space to be prepared for next admission	Registered Nurse/Healthcare Assistant

Appendix 14 - Patient Discharge Process for Complex Discharges see chart for complex discharges

Action Required	Rationale	By Whom
Commence discharge planning at pre admission clinic, for planned admissions or as soon after admission as possible for non-elective admissions.	To identify any potential issues requiring referral to other services	Registered Nurse
Refer to appropriate discipline for prompt assessment of patients needs by member of Multi-disciplinary team (MDT)	Prompt Intervention by Therapy Staff/Specialist Nurse	Registered Nurse
Assess patient's needs and respond appropriately carrying out interventions as required. Document in clinical records.	Effective communication within MDT and ensure safe discharge following interventions/treatments	Occupational Therapist Physiotherapist
Clinical decision on eligibility for Hospital-based Complex Clinical Care	Required for any patient receiving services after discharge – the eligibility question is; **"Can this individual's care needs be properly met in any setting other than a hospital?"**	Consultant in Charge of patient care or GP
Assessment by Social Worker	Need identified for support for patient/carers/family either in own home or change of circumstance requiring placement	Social Worker
Carers Assessment	Need identified for support for family/ carers	Social Worker/ Quarriers?
Confirm arrangements following any decision that a patient is eligible for Hospital-based Complex Clinical Care with consent and agreement of patient/carers/relatives, involving other members of MDT.	Only required for any patient where **'No'** is the clinical decision/response resulting from the question **"Can this individual's care needs be properly met in any setting other than a hospital?" (These patients will remain in hospital)**	The responsible consultant or equivalent specialist informed by the Multi-Disciplinary Team
Arrange follow up services, including the loan of essential equipment and domiciliary treatment.	To help patients and their families/carers to facilitate a safe discharge from hospital	Occupational Therapist Physiotherapist
Assessment of medication needs made and discharge prescription completed	To ensure patients medication needs are met in full and all medicines required are provided in a safe, accurate and timely fashion. This should include a review of their own medicine brought into hospital and those they may have at home.	Prescriber +/or pharmacist
Electronic Discharge Summary is to be completed prior to discharge	To ensure accurate data recorded and sent to G.P	Medical team/Registered Nurse/Pharmacist

Action Required	Rationale	By Whom
If discharge to placement has been arranged, prior to discharge contact the nurse/manager to provide a verbal handover of the patient, including the infection status and document in clinical records	Effective communication to ensure continuity of care on discharge	Registered Nurse/Social Worker
Ensure carers/relatives are asked to provide patients own clothing/outdoor wear prior to discharge	Maintain dignity and ensure patients are appropriately dressed for discharge from hospital	Registered Nurse/Healthcare Assistant
Ensure all relevant patient information if required for specific speciality or discharge is discussed with patient/carer/relatives and is given to patient prior to discharge	To ensure patients/carer/relatives understanding of any follow up arrangements.	Registered Nurse
Ensure Patients medication to take home is correct as prescribed, discussed with patient/carer/ relatives and is given to patient prior to discharge	To ensure patients/carer/relatives understanding of medication doses	Registered Nurse
Ensure all patients, relatives and carers are fully informed and advised of danger signals to look out for any signs of deterioration	To ensure patients/carers/relatives are aware of diagnosis/ prognosis	MDT
Pack or assist the patient to pack all belongings and ensure patient property form is completed	To prevent loss of patient property	Healthcare Assistant/Registered Nurse
Inform patient/carers/relatives and partner agencies of estimated time of discharge at least 24hs-48hrs prior to discharge	To provide communication regarding patients expected time of arrival.	Registered Nurse/Healthcare assistant/ward clerk
Communicate by telephone with the ambulance service to arrange transport where appropriate	To ensure arrangements complete	Ward clerk/Registered Nurse/Healthcare assistant
Transfer patient to day room if available to await transport/collection by relatives/carers where appropriate	To allow bed space to be prepared for next admission	Ward clerk/Registered Nurse/Healthcare Assistant


Patient Requires Transport
Contact Operational Support Team / Site Nurse Practitioner (SNP) / Senior Charge Nurse (SCN) on ASCOM phone 67699 or bleep 57515 / 57600
Types of transport available
OWN TRANSPORT
VOLUNTARY DRIVER
TAXI
Daily transport
URGENT TIER
PATIENT TRANSPORT SERVICE (PTS)
SCOTTISH AMBULANCE SERVICE (SAS) TRAFFIC LIGHT SYSTEM
This should always be the 1st option if clinically able to transfer via own transport / relatives, friend etc.
Contact Management Unit during office hours Mon - Fri on Ext: 67249 to book this option
Hospital taxis should only be authorised by Operational Support, SNP or SCN on for hospital
Booked for same day or next day transfer, NOT suitable for transfer to ARI / Raigmore. Will take patients home or to peripheral hospitals, nursing homes etc.
Ambulance available for transfers to ARI Mon - Fri with 1 run each day
Scheduled care service with core hours of 8am to 4pm
RED
BLUE
GREEN
WHITE
This option should be organised by the ward / dept staff and arranged for as early in the day as possible
This option should be organised by the ward / dept staff and arranged for as early in the day as possible
Call
Ronnie's Taxis 01343 546735 07899 012296
C & K Taxi's 01343 544555 07595 280720
A2B Cabs 01343 843843 0777 995909 or 07587 55524
You will need an authorisation code for your dept
Mon to Fri 10 - 5
Booked via Operational Support on 67699
Pick up from wd areas from 9.30am onwards, must be back in Elgin for 4.45pm can take 1 stretcher & 2 chairs at a time
Staffed by 1 or 2 Ambulance care assistants
Only to be used for patients requiring a stretcher for transport
EMERGENCY
PATIENT WILL BE PICKED UP WITHIN 8 MINUTES
999 emergency which will travel under BLUE LIGHTS with AUDIBLE WARNINGS
Suitable for LIFE or LIMB THREATENING transfers.
URGENT
PATIENT WILL BE PICKED UP WITHIN 1 HOUR
Suitable for patients requiring IMMINENT SPECIALIST PROCEDURES
URGENT
PATIENT WILL BE PICKED UP WITHIN 2 HOURS
Suitable for patients that require FURTHER INVERSTIGATIONS / STABILISATION
URGENT
PATIENT WILL BE PICKED UP WITHIN 3 OR MORE HOURS
Suitable for patients that are SCHEDULED CARE TRANSFERS INCLUDING TRANSFERS FOR BED CAPACITY OR PLANNED SPECIALIST PROCEDURES FOR THE FOLLOWING DAY
Joint transport arrangement with NHSG & Moray Council as part of IJB
Book via Operational Support Team / SNP with consideration given to transporting appropriate patients together
Planned transfers MUST be booked before 12md for following day transfer
The patient MUST be ready to travel before ambulance booked, this includes having all relevant paperwork & medication ready
& medical / nursing staff escort in attendance (if escort required)
OPERATIONAL SUPPORT
Mon - Fri 8am to 10pm
Sat & Sun 10am - 10pm
Site Nurse Practitioner (SNP)
8pm to 8am
Sun to Sat
Senior charge nurse (SCN) weekend cover
If no Operational support or SNP available the mobile phone will be held by the 600 bleep holder
ASCOM phone 67699
See attached authorised processes
Book via Operational Support Team / SNP with consideration given to transporting appropriate patients together
Operational support will contact Ambulance Conrol each am following the 8.45am huddle to inform them of patients that are suitable for travel that day.
Book directly with PTS on 0300 123 1236
Book via Operational Support Team / SNP . This type of patient will NEVER be suitable to share transport.
Book via Operational Support Team / SNP.
Consideration will be given to transporting appropriate patients together if clinically able to do so
White transfers may be postponed to travel with Urgent Tier service the following day if appropriate to do so. e.g. rather than transfer overnight in bad weather
Ambulance control centre contact numbers
Emergency booking line 03333 990179
Urgent booking line 03333 990180
Enquiry line 03333 990187
A&E supervisor line 07785 990081 (for management communications)
PTS 0300 123 1236 - planned transfers
PTS supervisor 07920 271628 (for managment communications)
PTS cancellations 0800 389 1333
If you are unable to contact Operational support or you think that any delay may be detrimental to the patient you may contact the Ambulance control centre directly to book a RED URGENT ambulance.
Direct Contact Number 03333 990179
However Operational Support / SNP MUST be informed retrospectively at the earliest opportunity