Wirral Community NHS
NHS Trust

DISCHARGE POLICY
General Policy No: GP9

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Name of responsible committee/individual:	Quality and Governance Committee
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Target audience:	All employed staff within the organisation with responsibility for discharging patients

Discharge Policy

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Appendices

1. Introduction

The aim of this policy is to provide a standardised, co-ordinated approach to the discharge of patients from Wirral Community NHS Trust.

It is written in accordance with the following documents:

- Department of Health (DoH) Discharge from Hospital: Pathways, Process and Practice 2003,
- Community Care Act (Delayed Discharge) 2003
- National Framework for Continuing Healthcare and NHS Funded Nursing Care 2007, Achieving Simple Timely Discharge from Hospital 2004 and Ready to Go (DoH 12th March 2010).

Safe, efficient discharge requires input from an experienced practitioner who has an understanding of the discharge planning process, working closely with the multi professional team and other agencies.

2. Scope

This policy applies to all clinical staff who are involved in the discharge of patients from Wirral Community NHS Trust Services.

The policy does not cover transfer from one facility to another; the process for the transfer of patients is detailed in General Policy 38: Policy for the Clinical Handover of Care.

3. Duties/Responsibilities

3.1 The Chief Executive

The Chief Executive has overall responsibility for ensuring that Wirral Community NHS Trust is meeting its legal responsibilities that affect the safe discharge of patients from the Trust. This responsibility is delegated to the Quality and Governance Committee.

The Chief Executive is the lead for partnership working with secondary care providers to ensure smooth and safe discharge

3.2 The Head of Quality and Governance

The Head of Quality and Governance is responsible for ensuring Reporting monthly statistics by exception relating to discharge, co-ordinating the development of risk management practices in a non clinical and clinical setting.

Advising the organisation in relation to risk related reviews undertaken by the National Health Service Litigation Authority (NHSLA), Health and Safety Executive (HSE), Care Quality Commission (CQC) and Audit Commission, including any action plans and internal Risk Assessments regarding those that concern discharge

Supporting Wirral Community NHS Trust in relation to risk management issues which promote best discharge practice for the Trust.

3.3 Quality and Governance Committee

The primary function of the Quality and Governance Committee is to provide assurance to the Board of overall compliance with all statutory and regulatory obligations and to ensure the effective management of incidents, complaints, claims and subsequent dissemination of lessons learnt. This includes incidents, complaints, and claims which relate to the safety and quality of discharges. This group formally ratifies Trust general policies.

3.4 Quality, Patient Experience & Risk Group

This group will ensure the effective management of Wirral Community NHS Trust's risk and governance. In addition the group will provide information and assurance to the Quality and Governance Committee regarding how risks are being managed within the organisation.

3.5 Specific Duties for Staff

3.5.1Divisional Managers

- Have responsibility for identifying and managing any risks in relation to standards of discharge into Wirral Community NHS Trust.
- Have overall responsibility for monitoring and implementing action plans to improve quality of discharges as required.
- Have responsibility for highlighting any concerns in relation to discharge from Secondary care providers

3.5.2Service Leads/Team Leaders

The Service Leads/Team Leader is responsible for ensuring:

- Identifies and reports all incidents relating to discharge and ensures all relevant staff are compliant with this policy
- All relevant staff comply with Trust procedural documents and procedures that outline expected standards for managing the quality of discharges

Individual Employees are responsible for:

- Complying with this policy and Trust procedural documents that outline expected standards for discharge
- Reporting clinical incidents and near misses in relation to discharges
- Keeping up to date with relevant legislation relating to information governance and record keeping

4. Discharge Requirements for all patients

Discharge is when an episode of care has been completed. Discharge will occur in the following circumstances:

- Completion of episode of care
- Failure to engage with the treatment plan
- Self discharge
- On death

The Service specific systems and processes for recording that a patient has been discharged including any relevant information to self manage, are detailed in Appendix 1. Patients should also be offered a copy of their discharge letter.

All patients must be discharged from electronic or manual system and a summary of contact sent to their General Practitioner (GP), along with any self management plans and Service contact details.

Discharge requires effective communication between patient and clinician. It is important to communicate specific needs where appropriate to enhance the patient experience and reduce the risks of incidents, complaints or claims which may result from the sub-optimal discharge of patients.

All patients receiving care will be registered, permanently or temporarily with a Wirral GP. Therefore, the GP will always be the receiving Healthcare professional.

5. Information to be given to the receiving healthcare professional

When patients are discharged from Wirral Community NHS Trust Services, the receiving healthcare professional will always be the patient's GP.

On discharge from Wirral Community NHS Trust the following information must be given to the receiving healthcare professional:

- A discharge letter; an example of information recorded can be seen in Appendix 2.

- Any assessments or tests performed whilst a patient is in Primary Care Assessment Unit (PCAU) will be forwarded to the patient's GP

In circumstances where a patient is referred to another speciality, the appropriate referral information needs to be completed and documented in both the patient's case notes and clearly within the patient's discharge letter, when the patient is discharge by the discharging clinician.

6. Information to be given to the patient when they are discharged

The following information will be given to the patient when they are discharged:

- The Contact details of the discharging service
- Where relevant, self care plan will be explained to the patient/carer and this will be documented in the healthcare records.
- In PCAU a discharge plan is always documented and a full explanation of the discharge plan will be explained to the patient/carer. This plan will then be documented in the health records via the discharge letter by the GP or discharging nurse
- A copy of the discharge letter is offered to patient and provided on request.

7. How a patient's medications are managed on discharge

Patient's medication will be managed on discharge in the following way, if a medication is initiated, stopped or amended this will be communicated to GPs as per GP11 Safe Handling & Administration of Medicines Policy

All authorised prescribers (medical and non medical) from all services are required to ensure that details of medication prescribed are shared with the patients GP to reduce any potential risks of duplication and update the patient's health care record for safe continuity of care.

For staff working in PCAU there is a Standard Operating Procedure: For the Safe Prescribing, Administration and Self-Administration of Medicines within Primary Care Assessment Unit (PCAU),

- Patients will only will get a supply of medication, if there has been a change in medication or addition to therapy
- Prescriptions will be issued on FP10 to be dispensed in a community pharmacy
- When required, nursing staff can take the FP10 prescription to be dispensed at Lloyds pharmacy, Arrowe Park Site
- If nursing staff have collected the medication, or are working from a Patient Group Direction, they should go through the patient information leaflet with the patient, fully explaining the potential side of effects of the medication and possible signs and symptoms associated with reactions to the medication. Clear instruction regarding the frequency of administration should also be explained to the patient.

8. How the organisation records the information given to the receiving healthcare professional and patients

The following information is recorded in the healthcare records in a timely manner

- A Discharge letter. This is a document issued to the patient by the lead healthcare professional or care professional of the service responsible for the patient's care or treatment for the patient to use in the event of any query or concern immediately following discharge, containing information about the patient's treatment, (Appendix 2)

- A copy of the discharge letter must be placed within the patient's health records. Exception to this will be clinical services that use Adastra system whereby automated summaries are sent direct to GP by 01:00 hours, thereby enabling the GP to access the episode the next morning. If the patient is due to see their own G.P before the next day, a copy of the episode of care is given to the patient to take with them to the GP appointment.

- In areas where a Discharge Plan is completed, this must be clearly documented in healthcare records by the clinician completing the discharge plan

- The discharge plan must be documented in the discharge letter and the plan placed in the patient's healthcare records.

- If a patient declines any information offered on discharge, this must be clearly documented within the patient's electronic or paper health care records.

9. Discharges from Primary Care Assessment Unit

- A discharge Checklist will then be completed by a registered nurse in PCAU, and a copy will be placed in the patient's healthcare records by the discharging nurse (Appendix 3).

- Patient discharge needs to be recorded onto the computer system after the discharge letter has been written by the GP. The discharging nurse will then discharge the patient from the computer system.

- Case notes will then require to be booked back to medical records on the computer system by PCAU Receptionist.

- When the patient has left the unit the bed space and bed area will require cleaning as per Infection Control Policy ICP7 by the discharging nurse.

10. Out Of Hours Discharge Process

Out of Hours is the time period between 17:00 hours and 09:00 hours Monday to Friday and for the entire duration of Public holidays and weekends.

During the out of hours period, any patients discharged from Wirral Community NHS Trust Services, must ensure that the patients electronic or paper health care records are fully completed.

The information to be offered to the patient, and to be sent to the receiving Health Care Professional, will remain consistent with the in hours approach to patient discharge.

11. Failure to Attend (DNA)

Where patients fail to attend two consecutive appointments, without prior notification to the service, a letter will be sent to the patients G.P, referrer to review the clinical requirement for the service.

12. How the Organisation Monitors Compliance

Wirral Community NHS Trust monitors compliance using the processes outlined in Appendix 4.

13. Training Requirements

Staff involved in the discharge process will attend Essential Learning Training once every two years as per the Trust's Mandatory Training Matrix for staff which includes care planning, risk assessment, safeguarding and record keeping.

14. Equality Impact Assessment

In line with the Trust's Equality Scheme, each procedural document should be screened using the Policy Equality Impact Assessment Screening Tool by the manager responsible for its development, to consider whether there is an equality dimension or whether it is applicable to the Trust's duty to promote equality. The equality screening process and any wider impact assessment should be forwarded with the policy when approved to the Compliance Officer.

As part of its development, this policy and its impact on equality have been reviewed as described above. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

15. Incident Reporting

Staff need to complete a Trust Incident Form via DATIX, the web-based incident reporting system, if the standards for managing the quality of discharges in this policy are not upheld.

This is important if they identify any error or anomaly within a record they are handling e.g. an error in recording patient identification details or health care information inserted into the wrong health records.

The aim of reporting incidents is to make timely improvements to the discharge process by providing a record of issues that can be addressed. Continuous quality improvements demonstrate the importance staff place on the accuracy, safety and storage of patient information recorded in discharges.

16. References

DOH: (2010) Ready to Go? Planning the discharge and transfer of patients from hospital and intermediate care.

DOH: (2003) Discharge from hospital: pathway, process and practice: Health & Social Care Joint Unit & Change Agent Team

Appendix 1 Discharge Requirements for all Patients

Service	Arrangements
All Day Health Centre	All patients seen in a 24 hour period has an episode of the patient care sent electronically to the GP at 01.00 hours and therefore the GP can access the episode the next morning. If the patient is to be seen before the next day a copy of the episode of care is given to the patient to take with them to the GP
Atrial Fibrillation (AF)/Deep Vein Thrombosis (DVT) Service	Printed discharge letter sent to GP within 24 hours.
Community Nursing	No discharge letters issued to patient /GP. Contact details of team are left with the patient.
Community Therapy Services (CTS) – Physio	Service specific Standard template -CTS Target is within 48 hours
Community Therapy Services - Occupational Therapy	Rapid Access: standard discharge letter sent by admin staff. Hoylake Intermediate Care: letter written by GP Grove House –Standard letter
Continence Service	Dictated discharge letter sent to GP, & /or referrer (if different) within 24 hours. Copy of letter offered to patient on request
Dental Service	Discharge letter sent to General Dental Practice (GDP) or other referrer within 72 hours of completion of treatment. Copy of letter offered to patient
Dietetics	A discharge letter / report is sent to GP, referrer (if different) and other Health Care Professionals involved in care. Copy of all correspondence offered to patient on request. We aim to send all discharge letters / reports within 48hours.
Discharge Team	Wirral University Teaching Hospital populate discharge summary and send to GP Forms generated electronically from WUTH are faxed to (populated via Community Discharge Liaison Team (CDLT) Community Nursing Services by CDLT regarding patient need/level of Community Nursing intervention required and CDLT will also send any other relevant patient information that they have collated regarding condition/intervention required.
Falls Team	Typed discharge letter sent out to GP and referrer if different within 48 hours. Copy of letter sent to patient on request
GP Out of Hours	All patients seen in a 24 hour period have an episode of the patient care sent electronically to the GP at 01.00 hours and therefore the GP can access the episode the next morning. If the patient is to be seen before the next day a copy of the episode of care is given to the patient to take with them to the GP

Service	Arrangements
Heart Support Service	Letter is written to GP or referrer at both occasions and copy offered to cardiac rehabilitation patient. Intermediate clinic patients are discharged by clinician and letter dictated. Copy sent to GP or referrer and every patient also offered copies of all literature at first attendance.
Integrated Specialist Palliative Care Team (ISPCT)	A summary of assessment is faxed to all involved in patient care indicating patient discharged from palliative care team and under whom the patient's future care is to be delivered. Discharge discussed with patient/patient carer.
Lifestyle and Weight Management	Outcome letter sent to referring health professional at discharge.
Ophthalmology Service	Opticians A discharge summary template will be filled in by hand and a copy sent to GP same day. Consultant led clinic Patients will be seen by a clinician and then discharged. A GP letter will be dictated and then typed up and sent to GP within 2 working days
Parkinson's Disease Service	Dictated discharge letter sent to GP, referrer (if different) within 24 hours. Copy of letter offered to patient on request
Podiatry	Discharge letter as per contract. NB – the majority of routine patients are not formally discharged but just ring for their next follow up appointment when needed
Primary Care Assessment Unit	Discharge letters written on Patient Care Information System (PCIS) and sent via post to patients own GP. If urgent sent via Fax. Advice letter given to patient.
Safeguarding Team	Service specific Standard template – see CTS
Sexual Health Services	GP will be informed, unless patients opt out. **Contraception and Sexual Health (CaSH) service**- Mostly open access clinics- patients are not usually discharged as most need ongoing care/follow up. Where appropriate and with the patient's permission, the GP is advised of any treatment given by the service. **Specialist Contraceptive Service-** Where a referral has been received from a GP, a letter is sent back to the GP by the clinician and the patient has a choice of where to attend for follow up (CaSH or GP). **Psycho sexual** a letter is sent to the referrer after the clinic appointment at which they are discharged. A copy of this letter is sent to the GP if they are not the referrer provided the patient has consented to this information going to the GP.

Service	Arrangements
	In the case of patients who do not attend (DNA) then a standard letter goes to the referrer after the person has been advised that they will be discharged because of failure to attend an appointment. The new Adastra system should generate standard letters to go to patient and referrer in the case of failed appointments
Speech & Language	At point of discharge a discharge letter / report is sent to GP, referrer (if different) and other Health Care Professionals involved in care. Copy of all correspondence offered to patient on request. All discharge letters are sent to GP / Referrer within 48 hours.
Stop Smoking	Mostly self referral. Outcome letter sent to referring Health Professional.
Tissue Viability Service	Dictated discharge letter sent to GP, &/or referrer (if different) within 24 hours. Copy of letter offered to patient on request
Walk in Centres/Minor Injuries	All patients seen in a 24 hour period has an episode of the patient care sent electronically to the GP at 01.00 hours and therefore the GP can access the episode the next morning. If the patient is to be seen before the next day a copy of the episode of care is given to the patient to take with them to the GP
Wheelchair Service	Patients remain with the service as long as they have a wheelchair so are not discharged If discharged for any reason this is done directly to patient verbally All patients receive an initial appointment letter and once issued with a wheelchair they can self refer back into the service

Appendix 2

Discharge letter contains information about the patient's treatment, including without limitation:

1. The service user's demographics
2. The dates of the service user's referral or assessment
3. The date of the service user's discharge
4. Details of any care plan or treatment delivered
5. The name of the service user's responsible lead healthcare professional or care professional at the time of the service user's discharge
6. Details of any medication prescribed amended or stopped at the time of discharge
7. Any other relevant or necessary information or instructions
8. Contact details for the provider
9. Any immediate post-discharge requirement from the GP or referrer or other healthcare or social services provider
10. Any planned follow-up arrangements
11. Whether the Patient has any relevant infection
12. The name and position of the person to whom questions about the contents of the Discharge Letter are addressed, and complete and accurate contact details (including telephone number) for that person
13. And which shall, where required, be accompanied by a certification of sickness.

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APPENDIX 3

PRIMARY CARE ASSESSMENT UNIT
DISCHARGE CHECKLIST

Name: Unit Number: Date of birth:

FP10 Completed and photocopied.	YES / NO/NA
Life Style advice given and leaflets given.	YES / NO
Discharge letter completed	YES / NO
Discharge letter / advice letter given to Patient	YES / NO
Urgent Discharge letter and results faxed to GP.	YES / NO/NA
Venflon Removed and documented	YES / NO/NA
Own Medication given to Patient and side effects Explained	YES / NO
Fax referral completed to: District nurses, COPD Team, cardiology, other? (Circle appropriate)	YES / NO/NA
Rapid access referral completed to Therapies? Integrated Social Services Practitioner	YES / NO

Plan explained and documented by GP/Nurse to Patient Or carer and Life style advice given.	YES / NO

Signature: .....
(Print).....
Designation: .....
Date: ..... Time: .....

Appendix 4

Process for Monitoring Compliance with the Procedure for Discharge of Patients

Minimum requirement to be monitored	**Process for monitoring (e.g. audit)**	**Responsible individual / group/ committee**	**Frequency of monitoring**	**Evidence**	**Responsible individual for development of action plan**	**Responsible committee for monitoring of action plan and Implementation**
a. Discharge requirements for all patients	Trend analysis of related incidents reports and relevant action plans arising from the standards in the policy and the Discharge/ Compliance Audit	Policy Author Supported by Datix lead	Reports a minimum of twice a year Audit a minimum of once a year	Copy of reports	Divisional Manager	Quality, Patient Experience & Risk Group and by exception to the Quality and Governance Committee
b. Information to be given to the receiving healthcare professional	Discharge/ Compliance audit	Policy Author and nominated Service Lead	A minimum of once a year	Copy of audit report	Divisional Manager	Quality, Patient Experience & Risk Group

Minimum requirement to be monitored	Process for monitoring (e.g. audit)	Responsible individual / group/ committee	Frequency of monitoring	Evidence	Responsible individual for development of action plan	Responsible committee for monitoring of action plan and Implementation
c. Information to be given to the patient when they are discharged	Discharge/ Compliance audit	Policy Author and nominated service lead	A minimum of once a year	Copy of audit report	Divisional Manager	Quality, Patient Experience & Risk Group
d. How a patient's medicines are managed on discharge	Discharge/ Compliance Audit	Policy Author and nominated service lead	A minimum of once a year	Copy of audit report	Divisional Manager	Quality, Patient Experience & Risk Group
e. How we record the information given in b. and c.	Discharge/ Compliance audit	Policy Author and nominated service lead	A minimum of once a year	Copy of audit report	Divisional Manager	Quality, Patient Experience & Risk Group
f. Out of hours discharge process	Discharge Process Audit	Policy Author and nominated service lead	Annual	Copy of audit report	Divisional Manager	Quality, Patient Experience & Risk Group