

DISCHARGE TOOLKIT

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Discharge Toolkit

The discharge toolkit is designed to support the discharge procedure and the discharge policy. There is a lot of information within this toolkit and staff do not need to be familiar with it all. However if they have any questions regarding discharge this is a good place to find some answers. If you think that something is missing from the toolkit or needs amending please get in touch with [Policy Adviser](#).

Glossary of terms

Simple Discharge: Patients are discharged to their own home and have simple ongoing health care needs which can be met without complex planning. (DOH, 2004)

Complex Discharge: Patients who will be discharged from hospital and have complex ongoing health and / or social care needs. The discharge will require detailed assessment, and planning by both the multi-disciplinary team and multi-agency teams. (DOH, 2004)

Unpaid Carer: Individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system e.g. carers allowance. (Scottish Government, 2006)

Carer: Someone who provides substantial amounts of care on a regular basis for either an adult or a child, where that adult or child receives, or is eligible to receive, support services under the Social Work (Scotland) Act 1968 or the Children (Scotland) Act 1995. A carer is generally defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live independently without the carer's help due to frailty, illness, disability or addiction. (Scottish Government, 2007)

Young Carer: Young carers are considered to be different from adult carers and have specific support needs. Young carers are children and young persons under 18 who provide, or intend to provide, care, assistance or support to another family member. They carry out on a regular basis, significant or substantial caring tasks and assume a level

of responsibility which would usually be associated with an adult. (Blackwell's Encyclopaedia of Social Work).

Roles and Responsibilities

Multidisciplinary Team

Membership of a multidisciplinary team (MDT) will vary depending upon the patient and the reason for their attendance at an NHS Lothian facility. Members may include medical, nursing, AHP and/or social services staff.

The named member of the MDT is responsible for the discharge process, which will be carried out by members of the MDT. The MDT will support effective communication and co-ordination throughout the process. Wherever possible the patient and, where appropriate, their relatives and/or carer(s) will be involved and any decisions should be discussed at a multidisciplinary level. The MDT lead is responsible for identifying the need for a case conference and/or discharge-planning meeting for complex discharges, especially where the health/social care needs have changed significantly. The appropriate lead from the MDT will chair the conference and will liaise with the relevant health and care professionals as necessary to arrange these, and agree appropriate people to attend. The format of the meeting should be patient focused and needs led. A fully completed outcome report must be compiled and shared with all attending the case conference within five working days. The Consultant in discussion with the MDT, and where appropriate, relatives and/or carer(s) must ensure that the patient has capacity to understand the decisions that are being made and the information he/she is being given. If this is in doubt, the principles of the Adults with Incapacity (Scotland) Act 2000 should be followed with advice from a Mental Health Officer. The medical team is responsible for ensuring that:

- Discharge documentation is completed, in a timely manner, to allow for prompt ordering of medication;
- An appropriate discharge summary/letter (or electronic equivalent) is sent to the patient's GP clearly indicating any actions required of the GP, either by email or post; and
- A medical decision is made as to whether or not ambulance transport is required.

The MDT lead is responsible for timely and appropriate referrals to other professionals, taking into account the expected date of discharge, and recognising relevant legislation. The MDT will:

- Plan and instigate diagnostic tests and other interventions to avoid delays in treatment; and
- Ensure regular review of their patient's response to treatment and their condition, which must be recorded.

Named or Lead Consultant

The patient must be assessed as clinically ready for discharge by their Named or Lead Consultant who is responsible for that patient's discharge, in partnership with members of the MDT for the patient's discharge planning. The MDT will ensure effective communication and coordination throughout the process. The Consultant will inform the MDT of the expected date of discharge prior to or as soon as possible after admission to facilitate timely discharge planning. The patient, and where appropriate, their relatives and/or carer will be involved in the care and discharge planning process and any decisions should be discussed at a multidisciplinary level. The Lead Consultant in discussion with the MDT, and where appropriate, relatives and carer will provide information and the opportunity to question or discuss those decisions. The Consultant is responsible for ensuring that:

- Discharge documentation is completed, in a timely manner, to allow for prompt ordering of medication; and
- An appropriate discharge summary/letter (or electronic equivalent) is sent on the day of discharge, or as soon as reasonably practicable, to the patient's General Practitioner (GP) clearly indicating any important information about the person's case and actions required of the GP.

Named Nurse, Lead Nurse or Nurse-in-charge

Many of the tasks on discharge planning will be undertaken by nursing staff in the hospital environment and the patient's named nurse should be closely involved with the patient's discharge planning. As part of the discharge process, the named nurse (if possible the nurse responsible for the patient's discharge care) will ensure that the patient receives their medication, follow-up instructions, discusses the discharge with their patient, relatives and/or carer(s) and reports any concerns to the Named or Lead Consultant and MDT prior to discharge.

Core Responsibilities (All nursing staff regardless of grade)

- He/she is responsible for the nursing assessment of a patient's care needs for discharge and can initiate MDT assessments to determine necessary arrangements;
- He/she will ensure that a holistic plan is understood and agreed by the patient, and where appropriate relatives and carers;
- In order to meet recent guidelines for nutrition and the NHS Lothian Nutrition Strategy, it is necessary that all patients are screened for malnutrition on admission to hospital. The outcome of this screening, and where appropriate, a recommendation for action by the primary care team and/or other carers on discharge, will be included in discharge documents for every patient;
- Co-ordinate the discharge arrangements for a patient in their care. Discuss potential care needs and solutions with their patient, where appropriate their relatives and/or carer;

- Update the Patient Journey Form at each stage of the planning process. Advise the Multi Disciplinary Team (MDT) and/or carers of changes in the patient's condition which may affect discharge;
- Ensure that the patient can gain access to their home on discharge and is dressed in clothing that will respect patient dignity;
- Arrange appropriate patient transport, appointments and supplies when necessary and advise the patient, where appropriate their relatives and/or carer;
- Complete the Patient Journey Form on the day of discharge;
- Refer patients to the Discharge Lounge before 11:00 am on the day of discharge, if appropriate and applicable;
- Inform the Capacity & Site Management Team of the vacant bed in a timely manner; and
- Discharge the patient on the Trak system in a timely manner.

Specific Role Responsibilities (i.e. Ward Manager/Sisters/Designated Deputy)

- He/she has responsibility for ensuring that good practice and an effective discharge planning process operates within the ward;
- This responsibility will be discharged through named nurses leading and managing an individual patient's care;
- He/she will ensure that each patient has a discharge plan in which arrangements for care on discharge will be documented. This will be monitored and evaluated from admission to implementation of discharge process; and
- He/she will participate in MDT planning meetings as required.

Discharge Liaison Nurse, Community Children's Team Royal Hospital for Sick Children, Edinburgh

The purpose of the Discharge Liaison Nurse is to oversee and facilitate the discharge of children with particular complex health needs and their families from RHSC to home.

The role involves working very closely with families and all members of the multi-disciplinary team within the hospital and in the community. Often these families have or will need multi-agency support for the rest of their life, including bespoke "packages of care" to promote family life and ensure safety at home. Setting these up requires careful planning through multi-disciplinary team meetings, including Social Work and Education professionals. These meetings result in action plans with identified timescales to be met by the relevant professional in order to ensure timely and safe discharge. As part of this integrated working, this role is further being developed using GIRFEC as a standard of practice in communicating with the Named Person & Lead Professional.

Further detail can be found in the [Children's Services Discharge Procedure & Toolkit](#) on the NHS Lothian Intranet.

Allied Health Professionals

Allied Health Professions (AHP) may be required to carry out assessment intervention as part of the MDT. Advice and information will be given to the patient and where appropriate their relatives and/or carers. Any requirement for ongoing physiotherapy will be communicated to the Community Physiotherapist. Requests for aids and adaptations should be made as early in the process as possible to streamline the discharge process. The Occupational Therapist will arrange visits to the person's home, as appropriate, to assess the environment and advise/arrange any equipment appliances or adaptations that may be necessary for appropriate safe activities of daily life or manual handling requirements. Compliance aids for medication will only be supplied after 'appropriateness' is assessed by a pharmacist.

Physiotherapists

Patients who have mobility problems should be referred to the Physiotherapy Department by completing and signing the referral form (or electronic equivalent). In-patients will receive an assessment within 24 hours of referral (depending on available staff resources), Monday to Friday. Following assessment, the patient will, if appropriate, receive a course of physiotherapy treatment. When the patient has reached their maximum physical potential, and in discussion with the MDT, the patient will be discharged from further physiotherapy. When a patient is discharged from a ward, any requirement for ongoing physiotherapy will be arranged by the ward physiotherapist.

Podiatrists

Inpatients are referred by completion of the inpatient referral form (paper or electronic equivalent) stating the need and indicating priority. Depending on the information contained within the referral, Urgent patients are seen within 72 hours of the referral being received. Patients who as a result of their admission to hospital have missed a home visit will be seen, if at all possible, whilst in hospital. Inpatients who are able to come to clinics can be accommodated and slotted into short notice cancellations. Follow up in the Community is arranged at the patient's nearest local clinic and an assessment carried out within agreed timescales.

The Podiatry service also runs a self-referral scheme.

Occupational Therapists

Occupational Therapy (OT) enables people to achieve health, well-being and life satisfaction through participation in occupation. The OT Service provides Occupational Therapy throughout NHS Lothian. It is an integrated service - in that both health and local authority obligations are delivered by the same service. The OT Service works with different client groups of all ages and assesses/provides intervention with regard to activities of daily living, productivity, and leisure. To enable effective discharge planning, referral to

OT should be made as soon as possible after admission either at the patient's own request or when it becomes evident that the patient has need of OT services (some areas have blanket referral to OT services). However, referral to the OT Service must be made with patient's consent. OT endeavours to assess patients as quickly as possible (within specified departmental standards for example 'patient to be screened/assessed within 2 working days of admission') but this process may take time and is dependent on patient need, which may be simple or complex. Occupational Therapists, as part of their assessment, may arrange visits to the person's home as appropriate to assess functional abilities, aids and adaptations. Early referral will minimize any delay in discharge due to equipment and adaptations being required. Equipment and adaptations are recommended based on an assessment of need by the OT.

Dieticians

Dieticians provide a service to all wards/specialties and nursing, medical and AHP staff can refer to the department using the referral documentation (paper or electronic version). In line with the QIS Food, Fluid and Nutritional Care in Hospital Standards a discharge plan should be developed with the patient and, where appropriate, carer. This should provide information about:

- The patient's nutritional status;
- Special dietary requirements; and
- The arrangements for follow up required on nutritional status.

All patients should be screened for risk of under-nutrition¹ using the Malnutrition Universal Screening Tool (MUST) within one day of admission, although another appropriate method which achieves the same aim may be used (e.g. Renal Services). The results of the screening should be recorded in the medical notes and the screening should be repeated regularly (weekly for acute, monthly for continuing care). Management guidelines should be followed based on the outcome of screening. The department provides a seamless service by providing follow-up in outpatient or community clinics/home. In relation to patients who require an enteral feed, either via a PEG or an NG tube the following the following process would be followed:

- Ensure patient is tolerating feeding regime;
- Provide training on use of pump for carers (approx one hour per carer);
- The administrative tasks associated with sending a patient home on a feed would take approx two hours this would include setting up the Hospital to Home service which means the patient is supplied with a supply of feed and equipment on a monthly basis, delivered directly to their homes;
- The department requires as much notice as possible that a patient is being discharged from hospital to ensure everything is set up in advance, however patients will require a pump, supply of feed and equipment on discharge until they receive their first delivery from the Hospital to Home Service; and

¹ Clinical Standards for Food, Fluid and Nutritional Care in Hospitals

- Patients requiring nutritional supplements have their information documented in the supplement chart and follow up outpatient/home visit appointments are confirmed.

Speech and Language Therapists

Speech and Language Therapists/Assistants (SLT/SLTA) provide a service covering swallowing and communication to all wards within the hospital and community setting. Nursing, medical and other AHP staff can refer.

Swallowing

Ideally a swallow screen is carried out prior to referral to determine whether there is a swallowing problem and also whether the person is fit for assessment. The response time from receipt of referral is one working day, which is dependent on staffing levels. The persons swallowing function is assessed and continually monitored during their stay in hospital and recommendations regarding diet texture, consistency of fluids and safe swallowing techniques provided. If the swallowing function has not recovered to its pre-admission level by discharge, the person is followed up in the community. Advice regarding diet textures and safe swallowing techniques are given to the person, family and/or carers as appropriate. If the person is still being fed via a PEG at discharge their swallowing function is reviewed in the community. Specialised swallowing assessments such as videofluoroscopy can be offered. The person continues to be reviewed until their full potential for recovery has been reached.

Communication

The level of service provision for communication is currently determined by staffing levels and could change in the future. Informal assessment is carried out during the stay in hospital, preferably within two working days of receipt of referral, to determine the severity and type of communication difficulty. Speech and language therapists will also prioritise and will attempt to see patients who are scheduled for early discharge to ensure assessment of speech and language need and appropriate onward referral if necessary. General advice is then offered to other professionals, carers and family regarding facilitating communication. The amount of rehabilitation in hospital is, of course, dependent on staffing levels; patients are prioritized according to clinical need.

These assessments are very detailed as this is required to contribute to differential diagnosis and the overall MDT assessment of clinical risk and need for intervention. The advice given is based on a detailed assessment and is person-specific rather than general. Speech and language therapists will then refer on to our community colleagues for follow-up and again there is certain prioritization according to clinical need

The therapists will then follow up patients as out-patients from some sites to provide continuity of care and where the patient is better managed within the hospital MDT e.g. requiring instrumental assessments of swallowing.

Capacity and Site Management

The Capacity & Site Management Team are responsible for bed capacity and site coordination issues across the various NHS Lothian sites, ensuring patients are managed in line with the principles detailed in the Capacity and Patient Flow Policy.

The role of the Capacity & Site Team is to ensure:

- Timely and safe patient flow, with regards given to national emergency and elective access targets;
- Equitable access for all patients; and
- Ensure patients are admitted into appropriately resourced clinical environments.

Discharge Lounge Service

The primary function of the discharge lounge is to aid the timely flow of beds within the LUHD Hospitals. This is achieved by transferring medically stable patients from the ward to the discharge lounge. This allows for the freeing of beds, ideally earlier in the day, for other patients who may otherwise have been delayed either as an emergency or elective admission.

This also aids in the facilitation of the 4-hour waiting time targets and reductions in length of stay (LOS). Another function is to provide a central point of contact for wards, family, friends and transport providers for the transfer and collection of patients.

There are currently three discharge lounge areas located at the Royal Infirmary of Edinburgh (RIE), the Western General Hospital (WGH) and St John's Hospital (STJ) in Livingston.

Further details can be found in the Discharge Lounge Standard Operating Procedure.

Delayed Discharge Team

The key principles for the delayed discharge team are to:

- Ensure the Delayed Discharge Manager communicates and liaises with patients, relatives and the MDT involved in discharge planning;
- Ensure the smooth running of the service to meet the needs of patient centred care;
- Communicate with the site coordinator and patient flow managers, informing of transfers and discharges;
- Ensure that health and social care colleagues are updated on all aspects of delayed transfers of care;

- Communicate with distressed/anxious/worried patients and relatives frequently;
- Communicate complex issues with the MDT;
- Achieve challenging local and national targets, sustaining good working relationships and practice between health and social care partners; and
- Liaise with the Scottish Ambulance Service, Community Health Care Partnership regarding patient discharge, other hospitals and local authority care facilities outwith NHS Lothian and health and social care departments across Lothian.

Discharge Facilitator

The key principles for the discharge facilitator are to:

- Promote good practice within discharge planning process to improve patient pathway;
- Work in partnership with all agencies to provide a patient/carer centred approach throughout the admission and discharge pathway;
- Promote and facilitate improved communication, joint working and discharge planning between primary and secondary care;
- Support the development of joint assessment and care management with all care agencies, thus maximising the opportunity for holistic care provision;
- Act as a resource to staff throughout primary and secondary care; and
- Explore discharge issues identified by staff throughout primary and secondary care.

Pharmacy

Medicines management plays an important role in preparing patients and their carers for transfer or discharge which has a subsequent impact on recovery and/or maintenance of their conditions following discharge.

The Pharmacy Department provides discharge medications and advice, where applicable, for patients. Where appropriate, advice should also be given to the carer or representative. The pharmacy should receive discharge prescriptions or electronic notification of discharge at least 4 hours in advance of discharge from acute wards and 24 hours before discharge from long stay settings. Wards/departments/clinical areas that have one stop dispensing and/or operate To Take Out (TTO) medicines should follow the appropriate procedures². Piece on one stop dispensing and alternatives for supply.

Liaison with Social Services is useful where there are specific requirements for administration arrangements at home, e.g. as part of a care at home package. Requests for patient counselling, medication compliance aids or existing arrangements in the community should be discussed with the ward pharmacist during the discharge planning process.

Please check that the prescription is signed and all details completed before sending it to Pharmacy, unsigned prescriptions will be returned to the ward

² One Stop Dispensing Policy (NHS Lothian, 2004)

and this leads to unnecessary delays in the patient's discharge. Patients and their relatives and/or carer(s) are **not** allowed to collect discharge prescriptions. Discharge medications are delivered to the ward by Pharmacy staff in a sealed green bag, if used, or delivered to the discharge lounge if the site has one.

Nursing staff should allow time to counsel the patient on the medication and complete the discharge process. In times of Pharmacy staff shortages, wards/departments will be contacted to let them know any revised process for discharge prescriptions.

Discharge Prescriptions

Timely submission of discharge prescriptions is an important element in avoiding unnecessary delays in the patient's discharge. This is imperative for medication compliance aids due to the added work involved in dispensing and checking these items before release.

In-patient Discharge Prescriptions

In-patient discharge prescriptions must be reviewed by a pharmacist before dispensing takes place and this will normally be undertaken at ward level by the clinical pharmacist. Once the prescription has been written, contact the pharmacist assigned to the ward.

Electronic Discharge Prescriptions (Incremental Discharge Letter)

Once generated, must be approved by the prescribing doctor and pharmacist before being sent to Pharmacy, or on the ward where one-stop dispensing is employed.

Patients' Own Drugs

On admission to hospital, patients are asked to bring along any medicines they may be taking. These are handed to the nurse on admission and stored on the ward until the ward pharmacy technician assesses them or nursing staff using the checklist in the Medicines Management Policy. The pharmacy technician will mark on the front of the patient drug administration chart if any of the patient's own medicines are being used while the patient is in hospital.

On discharge, any of the patient's medicines that are suitable for re-use will be dispensed according to the discharge prescription. These **must** be returned to the patient as they form part of their medication regime and is their personal property. This **only** includes medication with directions on the label, **not** medication dispensed by pharmacy with only the patients' name on it.

Out of Hours Discharges

What is the procedure for this?

The key principles for pharmacy³ are:

³ NHS Lothian Pharmacy Procedure

- Organisation and planning of patients discharge medicines should begin as soon as the patient is admitted to hospital;
- Please refer to the NHS Lothian Safe Use of Medicines Policy for specific detail on the procedure for the discharge of patients with medicines;
- Discharge prescriptions must be written legibly, unambiguously and must comply with the legal requirements for the prescribing of controlled drugs (ref British National Formulary, Guidance on prescribing);
- Junior doctors should be encouraged to write discharge prescriptions at least 24 hours in advance of the patients estimated discharge time;
- Discharge prescriptions should be checked by a clinical pharmacist in line with NHS Lothian Safe Use of Medicines Policy. This ensures the accuracy of the prescription and can make the process more efficient;
- Arrangements must be in place to ensure that medicines which are required and not already available on the ward for discharge are obtained from the dispensary well in advance of the discharge time;
- In areas where the 'one stop dispensing system' has been implemented, ensure all medicines are available and correctly labelled, either the patients own medicines or a pre-labelled pack from ward stock. Where a medicine is not available on the ward as a pre-labelled pack an order should be sent to dispensary. Do not issue unlabelled packs from ward stock;
- On occasions where presentation of a discharge prescription or order to the dispensary 24 hours in advance of discharge is not possible, dispensary staff will prioritise prescriptions according to need and complete these as soon as possible. As a minimum, prescriptions or orders must be delivered to the pharmacy within 4 working hours before the patient is discharged to allow adequate time for dispensing and return;
- Note that additional time is needed to dispense prescriptions requiring controlled drugs or compliance aids e.g. dosette boxes, and advance planning is essential;
- If a patient is transferred to the discharge lounge while an order for discharge medicines is in the pharmacy, the pharmacy dispensary must be notified to ensure correct delivery. Refer to the Discharge Lounge Standard Operating Procedure for further details; and
- At least 7 days supply of medicines will be provided unless otherwise specified.

Research demonstrates that the NHS may be at risk of failing to prevent harm to patients from medicines unless it improves sharing of vital information when people move between services⁴. During visits by the Care Quality Commission (CQC) they found that there are generally good systems in place to ensure that repeat prescribing is safe, and that people don't carry on taking a medicine for longer than they should. However they did have some concerns and these included:

- GPs and hospitals do not always exchange enough information about medicines, and don't share it on time;

⁴ Managing Patients' Medicines after Discharge from Hospital (Care Quality Commission, 2009)

- In a minority of GP practices (17%), administrative staff rather than clinical staff update records, and they don't have the clinical skills to check whether medications are right;
- There's not enough being done to talk to patients themselves about their medications, either when they are discharged from hospital or in the longer term; and
- Monitoring and learning from serious incidents is patchy.

Further details can be found in the NHS Lothian Medicines Management Policy and Safe Use of Medicines Policy.

GP Surgeries and Practice Nurses

Discharge planning should start before the admission of the patient, where reasonably practicable, and prior to the referral if an elective procedure; particularly for patients with complex needs.

With our philosophy of holistic healthcare, increased liaison between hospital staff and GP surgery staff will promote an ethos of effective discharge planning and aid early identification of any issues that may affect the continuum of care for patients.

In planning for a patient's discharge, it is important that the best and most timely arrangements are made, communicated and agreed. Medical and nursing staff should establish and maintain regular contact with a patient's General Practitioner (GP) and other members of the Primary Care Team, as appropriate.

Patients who are discharged from hospital should return to the care of a GP who will be responsible for communicating within the Primary Care Team. Where appropriate, for those patients not registered with a GP, advice and support should be provided on registering with a GP, as part of NHS Lothian's philosophy of holistic healthcare.

On referral, pending admission to hospital, the Primary Care Team and/or GP should be contacted for information regarding any circumstances, which may impact on the patient's hospital care and discharge plan including important details concerning carers. For elective patients this would normally be in the pre-admission setting and for emergency admissions this will be dependent on individual circumstances and needs. Communication particularly regarding patients who will return to be supported within their own homes is essential. In some circumstances good practice would include the advance discussion of discharge plans between all professional agencies.

Good discharge practice includes:

- Ensuring the patient is discharged with relevant information regarding their hospital admission and any ongoing healthcare needs and treatment;
- Ensuring, wherever possible, any equipment essential to support discharge of the patient is available on the day of discharge at the latest; and

- Advising the patient, if applicable, to visit their GP and/or Primary Care Team following discharge, with special instructions indicated on the discharge letter.

General Practice Nurses work in practices from 8.30am to 6:00pm, Monday – Friday. They have diverse skills and manage patient’s physical and psychological conditions, ranging from sexual health to Long Term Conditions and many also see unscheduled emergency presentation of a variety of illness and injury. All practice nurse’s work by appointment and there are currently 294 nurses in the 126 practices in Lothian. It is appropriate for many patients on discharge from hospital to be referred to the Practice Nurse, either by asking the patient to make an appointment, or by telephoning the practice to make the appointment for the patient before discharge so that they have clear instruction and information.

Community Health Partnerships

Part of NHS Lothian, Community Health Partnerships (CHPs) provide a focus for the integration between primary care, specialist services, social care and ensure that local population health improvement is placed at the heart of service planning and delivery. To achieve this, CHPs:

- Link clinical and care teams;
- Work in partnership with local authorities, voluntary sector and other stakeholders;
- Actively involve the public, patients and carers.

The CHPs provide services including Health Visiting, District Nursing, Mental Health, Physiotherapy, Occupational Therapy, Podiatry, Dietetics and Speech and Language.

District and/or Community Nurses

District and Community Nursing Staff are experienced healthcare professionals who provide nursing care, treatment, interventions and support for patients in the community, including their carers and families. They also play a key role in supporting the holistic care of patients in the community, ensuring they are supported towards independence and self-care. They provide palliative and terminal care ensuring patients remain in their own homes for as long as possible. Community Nurses on discharge carry out Single Shared Assessments for patients on their caseload with complex needs or those referred to them for nursing need who they identify on assessment as having a high level of need and support from other agencies and/or disciplines and who they have accepted onto their caseload. Community nursing staff are not authorised to fill medication compliance aids such as dosette boxes, but can support patients to manage their medication regimes.

The Community Nursing Team may have information about a patient’s home circumstances which could aid our philosophy of effective hospital discharge planning. For those patients whose Community Nurse is either involved in, or

aware of, a planned admission to hospital should communication with the Secondary Care Team providing appropriate and relevant information.

The Community Nursing Team should be involved in all discharge planning of patients with complex needs and communication should be, where reasonably practicable, at least 24 hours in advance of the discharge.

District nurses provide holistic assessment and treatment dealing with complex patients who are housebound and require ongoing community based care and support to ensure a seamless service and a successful outcome. District nurses should be involved in the discharge planning process at an early stage to ensure that appropriate support equipment and services are in place to reduce the chance of readmission. It is essential that high quality, relevant, discharge information is provided to the District Nurses well in advance of discharge, wherever possible.

The service operates over a 24 hour period throughout Lothian, 365 days per year.

- Referrals to the service come from many different sources: e.g. professionals, GPs, hospital, carer or self referral but patients must be assessed as requiring nursing intervention within their home
- Mon-Fri 8:00am to 4:30pm contact District Nurse aligned to a cluster of GP surgeries (separate phone number listed on contact list distributed throughout hospital)
- Evening/night, week-ends and public holidays contact out of hours HUB on 0131 5372713 (note; for City Edinburgh only) East/Midlothian out of hours contact NHS 24 on 08454 242424. West Lothian out of hours contact St John's switchboard 01506 523000

The service deals with a wide variety of activity including:

- Patients with multiple pathology and complex needs e.g. ventilation/tracheostomy care, PEG/NG feeding, complex urological care, bowel management, end of life care with sub-cut infusion and/or syringe drivers, wound management, diabetic management and assessment for provision of specialist equipment
- Teaching and supporting patient and carer towards self management of condition
- Carers needs are assessed and identified
- Out of hours community staff link closely with NHS 24, LUCS and the HUB
- District nurses are registered nurse prescribers
- Edinburgh IMPACT team consists of case managers providing anticipatory care, advanced nursing support and treatment for patients with complex long term conditions and their carers
- District nurses work as part of a multidisciplinary community team including GPs, respiratory physiotherapy services mental health teams
- Mobile patients should be referred to the practice nurse
- Discharge facilitator who has a district nurse background will link in with district nurses and provide specialist advice and support to patients and staff

Health Visitors

The Health Visiting/Public Health nursing service operates Monday to Friday, generally 9:00am to 5:00pm. It is a universal service for all children and their parents/carers, 5 years and under. In aspects of discharge planning, the health visiting service aim is to smooth transition irrelevant of geographical areas and education establishment.

- In aspects of child protection all procedures are followed as per NHS Lothian policy. Appropriate documentation and verbal communication is utilised from one professional Health Visitor to another irrelevant of NHS area. This is recorded and supported by Child Protection Advisors and CP Team
- Discharging to education and school nurse teams. The teams set up annual meetings to ensure transition and communication for all children's notes when age 4-5 years and school identified irrelevant if local authority or private education
- Specific needs of children being discharged from hospital are communicated to health visitors through GP/Children's Community Nursing Service/RHSC as part of discharge planning service.
- Children discharged from GP Practices to another are notified through Child Health Surveillance Unit and appropriate paperwork and notes sent through CHSU.
- All discharge paperwork has universal utilisation of CHI
- All children have had an assessment using Lothian Child Concern Model and have an identified Health Plan Indicator (HPI). The HPI is also recorded and held at Child Health Surveillance
- If children are discharged from GP Practice out with GP practice boundaries, e.g. to another area of the (City of Edinburgh) there are Health Visitors on a rota to pick up non-GP registered children. West Lothian and East/Mid Lothian have a system also.

Community Mental Health Teams

Community Mental Health Teams will support and treat people with a wide range of mental health problems with the aim of enabling people to live well. They will commonly be delivered by Multidisciplinary teams with Psychiatry, Mental Health Nursing, Psychology OT and Social Work (in some teams). The teams provide expert assessment, treatment plan and regular review for people of all ages. Psychological therapies can be delivered by trained staff. Community Mental Health Teams will also offer advice and support to carers.

For more information please go to:

<http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/PIREAS/Patient%20and%20carer%20information/Community%20Mental%20Health%20Services%20Booklet.pdf>.

(This booklet contains information for Edinburgh only)

In addition there has been considerable work done across mental health settings on the patient pathway. For more information please go to:

<http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/MentalHealthandWellbeing/ICPSinMentalHealth/Pages/ICPSinMentalHealth.aspx>.

Social Services

Where either the patient's circumstances indicate that care services will be needed on discharge or where the patient is currently receiving services, Social Services should be notified by hospital staff of the patient's admission to hospital. This is so that the patient's social worker can be informed or if this is a new case, a lead assessor allocated. Where an assessment or re-assessment of needs is required, this will be done using the Single Shared Assessment process (either Carenap or eAssess). Targets for completion of assessments are indicated in the Single Shared Assessment documentation, which is available separately. The Lead Assessor will liaise with the MDT and agree on the need and timing for a case conference, agree on contact with relatives and familiarise all concerned with the current demands and pressures on the service, however the needs-led focus on assessment and care planning will always be uppermost. Unmet need will be documented, with appropriate interim measures discussed at the case conference. The Lead Assessor should be identified or confirmed at the case conference, and the care plan agreed. It is then the Lead Assessor's responsibility to request, monitor and review provision of the agreed services.

Discharge to a Care Setting

Where the patient is returning to residential care, staff at the care home will ensure that this is achieved in the shortest possible timescale. If the outcome of the Single Shared Assessment identifies a care setting, or if it is apparent early in the assessment process that a care setting may be the preferred option to meet ongoing needs, then information on this process and the available choices should be given to the patient or where appropriate, the patient's relatives, representative or carer at the earliest practicable stage in the process. Premature discussion of long-term care can cause considerable distress and should be avoided. The process for admission to residential care is documented separately. The responsibility for the allocation of residential care home places rests with Social Services.

The NHS and Community Care Act⁵ places a duty on Social Services to assess all people who require community care support. Referrals should be made to Social Services, always with the patient's informed consent, when it is clear that 'social care' will be required in order for the patient to be discharged safely.

Following assessment, support or services may be provided which would enable the patient to return home to living as independently as possible or in arranging residential or nursing home care, if this is more appropriate. The outcome will depend on assessed needs of the patient. Older people who are faced with having to make life changing decisions should not expect to be assessed on an acute ward and should be transferred to a more appropriate setting with access to the appropriate specialist care⁶.

⁵ The Community Care and Health (Scotland) Act 2002

⁶ Older People in Acute Care: National Overview – February 2004 (NHS QIS, 2004)

Scottish Ambulance Service

The Scottish Ambulance Service (SAS) provides services to NHS Lothian and patients through their A&E Ambulance Service and the Patient Transport Service (PTS). The A&E Service and PTS are core functions that take patients:

- To and from their pre-arranged hospital appointments;
- For their admission to hospital;
- Being discharged from hospital; and
- Requiring an inter-hospital transfer.

Psychology Services

Upon receipt of a referral the psychologist will assess the patient's cognitive, functional and psychological status. The psychologist may use specialist assessments, e.g. risk dependant upon identified need. The psychologist will contribute to the care plan through individual sessional input or in an advisory capacity in terms of management. The psychologist will liaise closely with the care coordinator and named nurse verbally and record all activity within our patient's care plan.

Infection Control and Healthcare Associated Infections (HAI)

The discharge of any patient with known or suspected communicable diseases will be co-ordinated with the Infection Control Teams guidance and advice⁷. Specific information on discharge or transfer is available and can be gained from the Infection Control Team along with guidance on precautions, management and care for a variety of infections. It is essential that this information is considered both when transferring a service user with a known infection to other health care settings such as hospitals/wards, nursing/residential homes and also when a service user is going home and receiving either district or community nursing input or non-nursing support services to ensure that appropriate precautions and care can be put into place.

Further information may be obtained from the appropriate hospital Infection Control Team member, up to date contact details are available on the intranet. Staff requiring Infection Control Advice outside of normal working hours including the weekends should contact the Duty Microbiologist through the hospital switchboard.

Spiritual and Pastoral Care

⁷ NHS Lothian Infection Control Manual

NHS Lothian recognises that the healthcare challenges faced by the people it cares for may raise their need for spiritual or religious care, and is committed to addressing these needs. Spiritual care is usually given in a one to one relationship, is completely person centred and makes no assumptions about person conviction or life orientation. Spiritual care is not necessarily religious, religious care should always be spiritual. Spiritual care services provided by the NHS are impartial and accessible to persons of all faith communities and none, and facilitate spiritual and religious care of all kinds.

Spiritual Care should function on the basis of respect for the wide range of beliefs, lifestyles and backgrounds found throughout Scotland and the NHS today particularly in relation to age, gender, ethnicity, sexual orientation, disability and religious/belief. It should be characterised by openness, sensitivity, integrity and compassion, in the effort to achieve attentive, supportive and caring relationships. When admitted to hospital a member of staff will ask the patient if they would like to be given the opportunity for spiritual care and the appropriate form will be sent to the Hospital Chaplaincy Service.

This spiritual care support may be given by their own Faith Leader or the Hospital Chaplaincy Service and will be offered throughout their stay within the healthcare facility. Upon discharge, the continuing of spiritual care will be offered to the patient via the availability of services in GP practices and partnership working of local faith/belief communities, alongside community chaplains and those based in hospital units. It is intended that the care be as seamless as possible.

Palliative Care

What is palliative care?

Palliative care aims to improve the quality of life of patients and their families facing the problems associated with any life-threatening illness, through the prevention and relief of suffering by means of early identification and careful assessment and treatment of pain and other problems, physical, psychosocial or spiritual.

Palliative care:

- provides relief from pain and other distressing symptoms
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- is relevant all through the course of an illness, in combination with many other treatments that are intended to prolong life, such as chemotherapy, radiotherapy, surgery, medication or renal replacement therapy.

Who provides palliative care?

Palliative care is part of the care delivered by a wide range of health and social care professionals working in the community, in care homes and in hospitals. Some patients with more complex problems need advice or care from a palliative care specialist.

Discharge of palliative patients from hospital requires careful planning as often these patients have complex needs.

See flow chart.

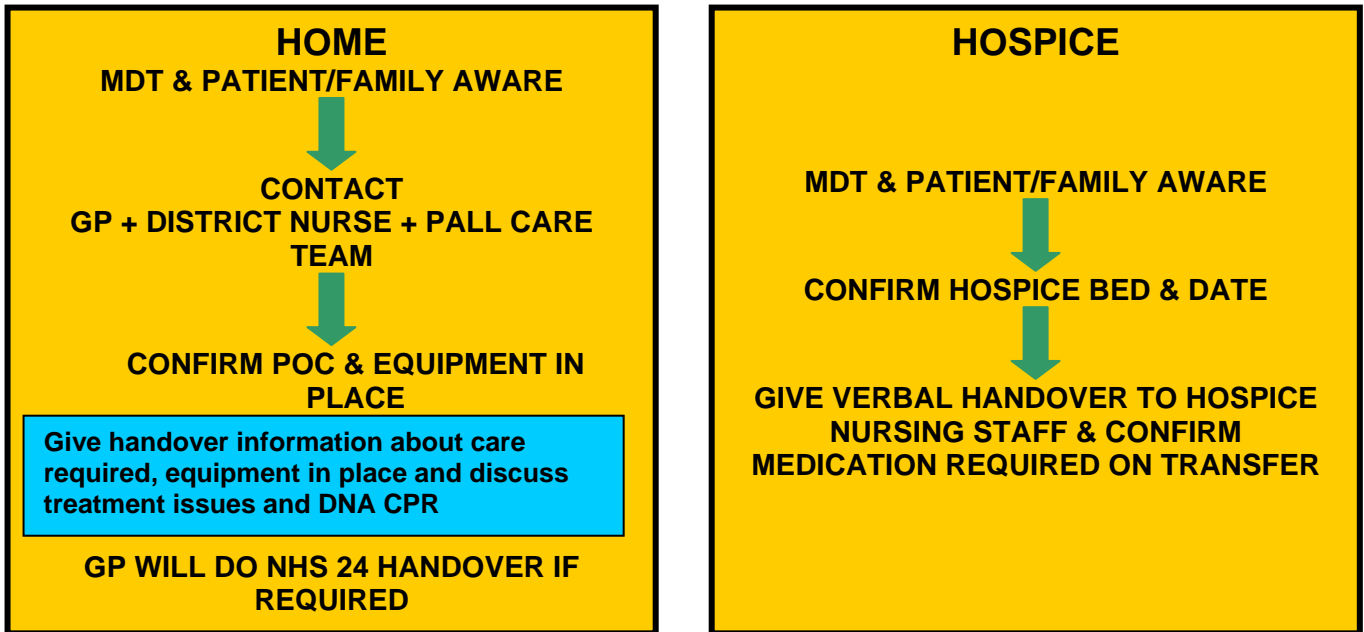
What is the LCP?

The LCP is an integrated, multi-professional pathway that supports clinical teams to care for the dying in the last days and hours of life. It replaces all other documentation during this period of care.

The pathway provides a series of goals and prompts to ensure all aspects of care are assessed and delivered. Most patients who are commenced on an LCP will die in hospital however occasionally a patient may be transferred to a hospice or home to die.

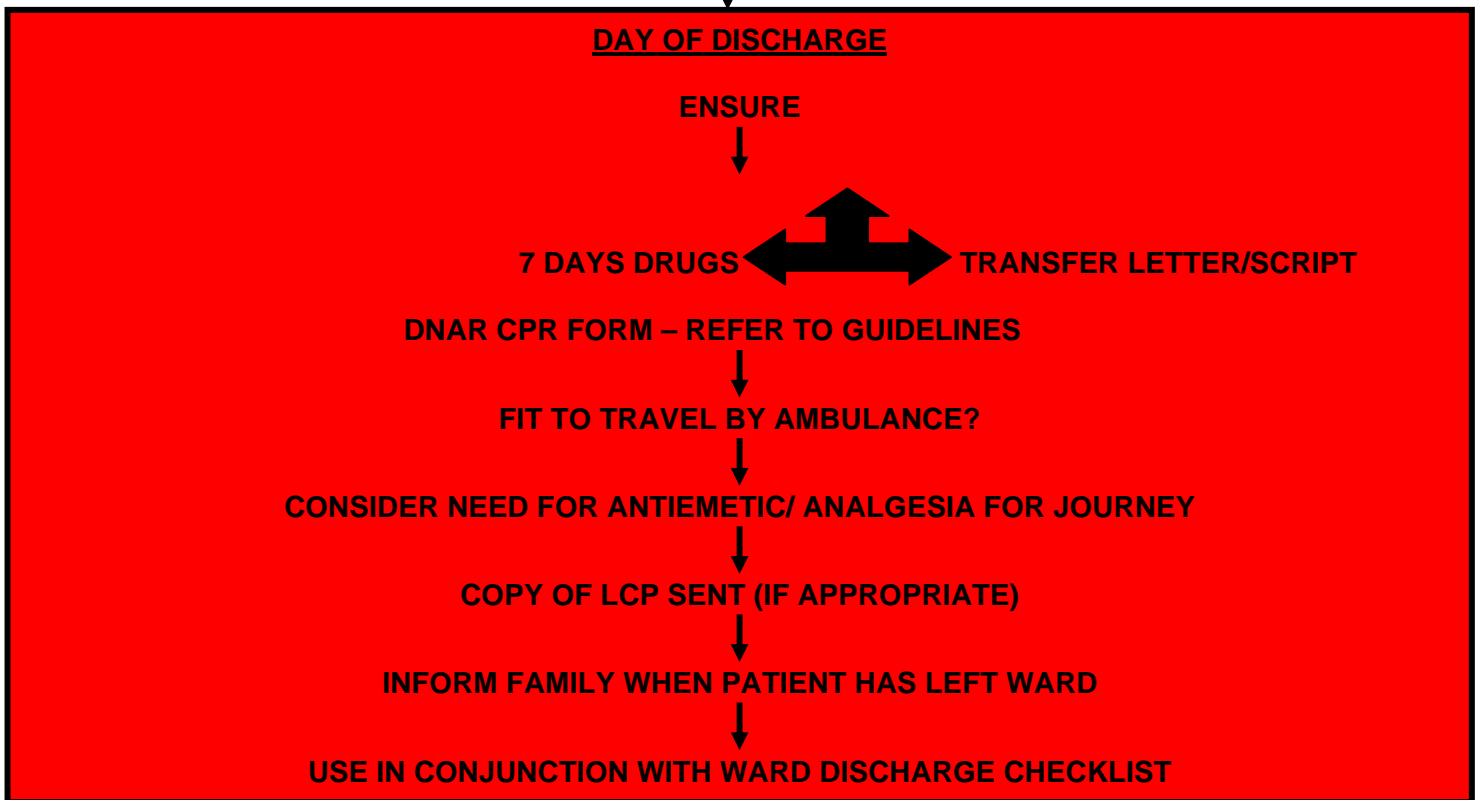
Royal Infirmary of Edinburgh Palliative Care Service
Final Discharge to Home/Hospice Checklist

DISCHARGE PLANNING FOR PALLIATIVE CARE PATIENT



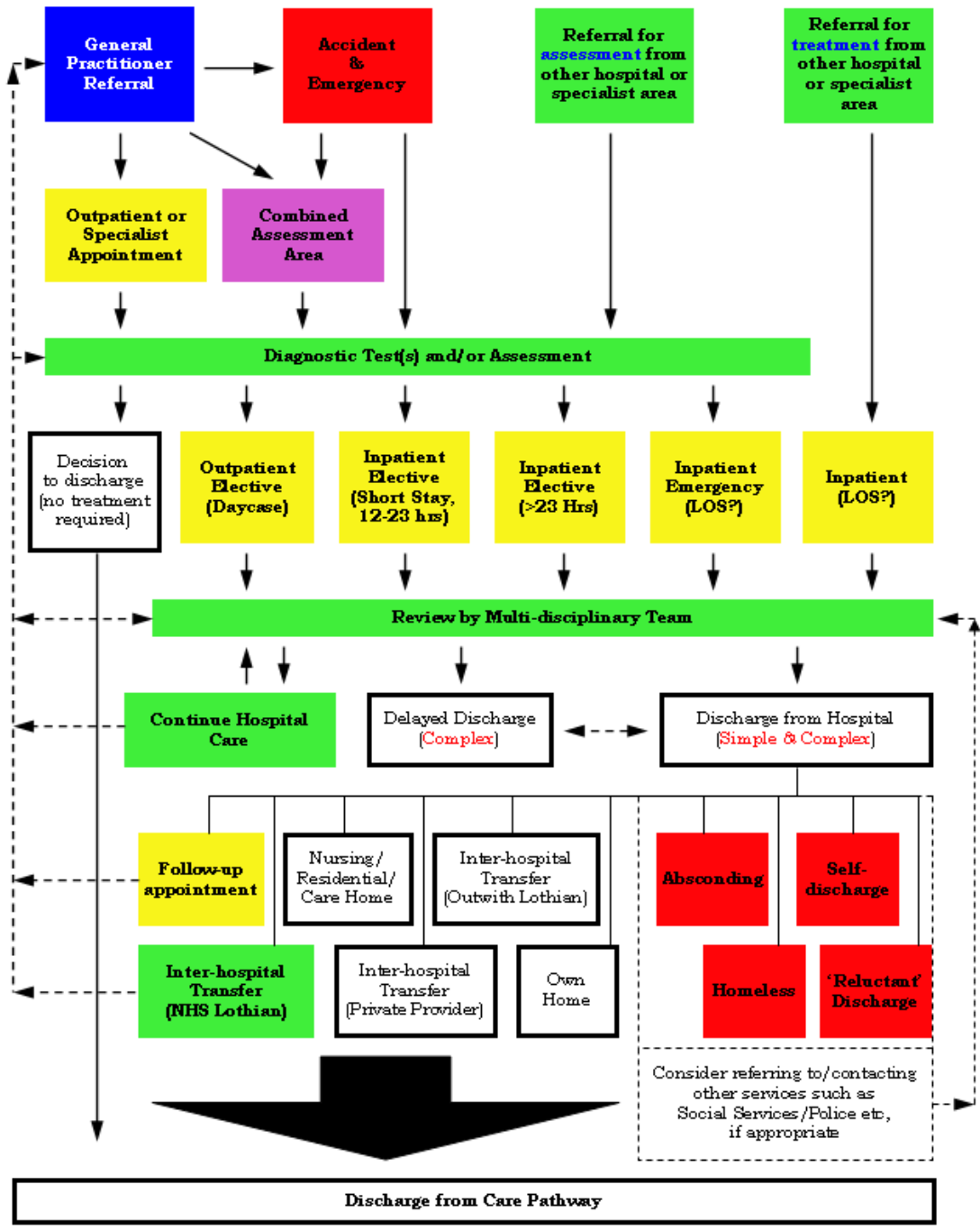
- ASSESS TRANSPORT REQUIREMENTS**
- oxygen, syringe pump (must travel with patient)
 - must book morning ambulance or Type I SAS on day of discharge
 - refer to SAS algorithm - palliative care

BOOK AMBULANCE



MOST PALLIATIVE CARE PATIENTS WILL NOT MEET CRITERIA FOR DISCHARGE LOUNGE OR BOARDING

Whole Journey Pathway



Discharge Lounge S.B.A.R.

Discharge Lounge S.B.A.R.

S

SITUATION

Nurse _____ Ward _____
Accepted By _____
Time _____ Date _____
Patient Name _____
Onward _____

Address _____

Patient Ready _____

B

BACKGROUND

Patient Condition _____
Mobility _____
MRSA/Infection Status _____
Medication Required _____
Key/Access Requirements _____
DNR (completed for SAS) YES/NO
P.O.C. YES/NO
Are the Family aware of Discharge/Transfer YES/NO

A

ASSESSMENT

Do you require the patient to be assessed by staff/crew prior to discharge?
YES/NO

Do you require an escort for this patient? YES/NO

R

RECOMMENDATION

CREW 1 2 3 PRIVATE CAR OWN TAXI
CAR/ESCORT

Transport Required _____ 1m/c 2m/c 2m/s scoop chair 2/4

Approx Time for Transport _____

Staff to collect patient YES/NO

Staff informed transfer cost attached to the ward YES/NO

Additional Information:- (on admission to D/L)

Additional Clinical Information

SIGNED:

DESIGNATION:

DATE:

Discharge Lounge Form

**PLEASE NOTE: INFORMATION MUST BE CLEARLY PRINTED
FIELDS MARKED WITH AN * ARE MANDATORY
CIRCLE WHERE REQUIRED**



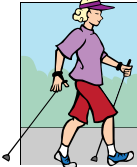



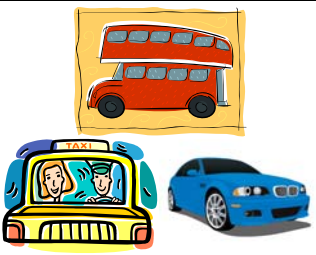

WARD		Ward Contact No.	
DATE		Time of Discharge	
*NAME			
ADDRESS			
*DIAGNOSIS	Clinical condition:		
*INFECTION	MRSA Yes / No	C.DIFF Yes / No	
ALLERGIES	Yes / No Please detail:		
*RESUS STATUS	Yes / No	*NO = (DNR form Requires Completion)	
DISCHARGE ARRANGEMENTS			
CARE PACKAGE	Yes / No	Time care package starts	
DESTINATION		Destination Tel No.	
*NEXT OF KIN NUMBER		HOUSE KEYS	
MODE OF TRANSPORT		NUMBER OF STAIRS	* Yes / No
FALLS RISK ASSESSMENT	Yes / No	WHEELCHAIR Leg extension	Yes / No Yes / No
		ZIMMER	Yes / No
PACKED LUNCH	Yes / No	VALUABLES	Yes / No (description req'd)
DISCHARGE DRUGS	Yes / No	*Venflon Checked:	Yes / No
MEDICINES REQUIRED 12 NOON	Yes / No	Insulin req'd	Yes / No

PLEASE PRINT

***Name & Designation:** _____

***Date:** _____






Patient Pictorial Pathway for Discharge

	Before or On Admission	During Your Stay	Discharge from Hospital
Diet	Please inform the nursing team if you have any special dietary requirements	 <p>You will be encouraged to eat a healthy diet within any dietary restrictions</p>	
Activity	On arrival to the ward, you will be introduced to the staff and ward routine	You will be actively encouraged to be independent within your capabilities. You will be encouraged to perform light physiotherapy exercises whilst in bed. You may be required to wear compression stockings. Please let us know before the day of discharge if you require a Medical (Sick) Certificate	
Tests	<p>You will have tests</p>  <p>X-Ray</p> 	You may require further tests. Your team will explain the reason for these tests and their results to you	We will discuss with you if you require further tests after discharge
Medication	If you take regular medication, please discuss with the nursing team before taking them	 <p>Any new medication will be discussed with you</p>	A supply of medication may be given to you to take home, and this will be discussed with you
Education	If you have any concerns, questions or queries then please ask the medical and nursing team	We will discuss your diagnosis with you and explain the best way for you to look after yourself at home. You will be given contact numbers to use if symptoms return	On the day of discharge we will aim to discharge you before 11:00am. You may discharge direct from the ward or from the discharge lounge
Travelling to & from Hospital	You are expected to arrange your own transport to and from hospital. Hospital transport is for people with medical need only. If you are unsure if you have a medical need then speak to your nursing team	 <p>Please consider how you are going to get home and return to any follow-up appointments. Make sure you start sending any belongings home with relatives/carers so you have the minimum amount of luggage on the day you go home</p>	Please discuss collection arrangements with your relatives/carers. Arrange with the nursing team for discharge from the ward or discharge lounge
Discharge Planning	So you can start making plans for home, your team will discuss your anticipated length of stay with you before or on admission. On admission, your estimated date of discharge will be discussed with you. We expect you to be fully involved in planning your own discharge	If you require help at home, you will be seen by the health and social care professionals who will assess your needs and arrange support services on discharge	 <p>HOME</p>

Variations may occur based on your individual situation

Patient Poster

Before you go home, have you thought about how we can help you?

What we will do	What we expect from you	Medication	Day of discharge and follow-up	Help at home and equipment
				
<p>We will discuss your diagnosis with you and explain the best way to look after yourself</p>	<p>We expect you to be fully involved in planning your own discharge, together with your relative(s) or carer(s), as appropriate</p>	<p>If applicable, the medication that you brought into hospital will be returned to you</p>	<p>On the day of discharge, we aim to discharge you before 11:00am. You may be discharged from the ward or the discharge lounge, and staff will be present to attend your needs</p>	<p>If you and your team have agreed you require help at home, you will be given a clear, legible discharge letter detailing the support services that will visit you. The support services will have been arranged prior to your discharge</p>
<p>Your discharge plan will start on or before admission, where possible. We will discuss your estimated date of discharge with you so you can start making plans</p>	<p>You will need to arrange transport home. Hospital transport is for those with medical needs only</p>	<p>If you have started new medication, you will be given a supply to take home with you. Your GP will then prescribe more as required</p>	<p>You will be given a letter to give to your GP on the way home or it will be sent by the hospital. This details the reason for your hospital care and your medication</p>	<p>If you require equipment at home, arrangements will be agreed with you. Training in the use of the equipment will be completed before you leave hospital. If appropriate, your carer will also be trained on how to use the equipment</p>
<p>Working with you, we will assess your needs, agree together the help you need at home and plan your discharge from hospital</p>	<p>You need to arrange outdoor clothes, your house keys, whether you have the heating on and any food at home. Please speak to your nurse if you have any problems</p>	<p>Your medication will be explained to you. There are also written instructions on the packaging and an information sheet will be provided</p>	<p>We will discuss with you if you require further follow-up, e.g. an out-patient appointment or other further investigations</p>	
<p>With your agreement, we will involve your relatives/carers in your discharge plan</p>	<p>Please let us know if you will require a medical (sick) certificate</p>			

Core principles for admission of patient with a Learning Disability

