

East Kent Hospitals University  
 NHS Foundation Trust

## POLICY DOCUMENT

### Hospital Discharge and Criteria to Reside Policy

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<b>Applies to (include subsidiary companies):</b>	All Staff Trust-wide involved in the discharge planning process



## Version Control Schedule

Version	Date	Author	Status	Comment
1.0	26/2/21	Senior Improvement Practitioner, Improvement and Transformation Team	Superseded	New policy
1.1	9/01/23	Director of Nursing William Harvey Hospital	Final	Amendment to policy approved by Emergency Care Delivery Group (see below)

## Policy Reviewers

Name and Title of Individual	Date Consulted
Chief Nurse and Director of Patient Experience and Quality	May 2019
Chief Operating Officer	May 2019
Interim Chief Operating Officer	November 20
Board Advisor for Emergency Flow and Hospital Director, QEQMH	January 2021
Interim Chief Nurse and Director of Patient Experience and Quality	February 2021
Senior Nursing Team	February 2021

Name of Committee	Date Reviewed
Clinical Executive Management Group	14 April 2021
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Emergency Care Delivery Group	11 January 2023

## Summary of Key Changes from Last Approved Version

- Add patient choice process; (section 12.7)
- Add Discharge planning - patient choice letter; Appendix 1

## Associated Documentation

People at Risk Policy (Safeguarding Vulnerable Adults)

Safe Discharge of Children and Young People from Hospital Settings

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## **1. Policy Description**

- 1.1. This policy provides direction and guidance, sets expectations and describes underlying principles to support staff in the safe discharge of patients or transfer of care from the acute setting to another care setting, based on the assessment of on-going patient needs.
- 1.2. It applies to all clinical and operational staff involved in the care and discharge of inpatients, over the age of 18 years.
- 1.3. This policy replaces version 0.5 of the Integrated Discharge policy.

## **2. Introduction**

- 2.1. This policy adheres to the national 'Hospital Discharge Service: Policy and Operating Model' issued in August 2020, which was authored in partnership with the Academy of Royal Colleges. It reflects the intention that Discharge to Assess principles will be fully implemented throughout England and clinical Criteria to Reside assessments should be undertaken daily, to optimise acute bed utilisation following the Covid-19 world-wide pandemic.

## **3. Background**

- 3.1. East Kent Hospitals University NHS Foundation Trust (EKHUFT) is committed to enhancing the patient experience and reducing any potential risk of harm, associated with patient flow and the discharge planning process.
- 3.2. The national guidelines are clear that the point of discharge is when the patients no longer meets the 'Criteria to Reside'. Patients that are 'medically optimised' but require ongoing health and/or social care input, should be transferred to a non-acute setting.
- 3.3. The NHS Constitution states that Trusts have a responsibility to ensure care delivery, which includes discharge planning, is co-ordinated around the needs of the patient, resulting in a smooth transition between care settings. Therefore, communication and engagement with patients and their families is a key aspect of patient care. Lack of information sharing at the point of discharge is a contributory factor to reduced patient experience and has a direct impact on avoidable readmissions.
- 3.4. Hospital-related functional decline and the subsequent harm that can occur, is something that every member of staff should aim to reduce or avoid. The Guide to Reducing Long Hospital Stays (NHSI, 2018) states that:
  - 3.4.1. A stay in hospital over 10 days leads to 10 years of muscle ageing for some people who are most at risk (frail, elderly etc.)

- 3.4.2. 35% of 70 year old patients experience functional decline during hospital admission in comparison with their pre-illness baseline. For people over 90 years of age, this increases to 65%
  - 3.4.3. Extensive research has shown that 20 – 25% of admissions and 50% of acute bed days do not require an ‘acute’ hospital, as these patient needs can be safely managed in a more appropriate environment or lower level of care, including the patient’s own home.
  - 3.4.4. 39% of people delayed in hospital could have been discharged using different, lower dependency pathways and services, more suited to their assessed care needs.
  - 3.4.5. Typically, up to 50% of the reasons patients are not discharged earlier are within the remit of the acute hospital itself and often relate to ineffective internal assessment processes, lack of decision-making and poor organisation of care management.
  - 3.4.6. Congested hospitals struggle to deliver best care and are too full to treat 95% of Emergency department patients within the four-hour patient safety and quality standard.
- 3.5. Admission and Discharge processes are closely linked and form an essential aspect of patient experience, yet these are areas where staff often underestimate their importance. Giving clear and concise information regarding when a patient is likely to go home, is a major aspect of their care and is referenced in a high number of complaints received by the Trust.

## 4. Definitions

- 4.1. **Discharge:** The term discharge in the context of this policy, applies to all adult inpatients discharged or transferred from the provision of acute care within EKHUFT, irrespective of complexity of need. A patient death is also recorded on Allscripts as a discharge.
- 4.1.1. **Simple Discharge:** A simple discharge is where the patient can return home to their usual place of residence. It incorporates Discharge to Assess Pathways 0 and 1. 95% of all discharges will fall within this category. In most cases there are few or no changes to the patients’ care needs on discharge. Patients requiring a Care Package restart, Hospital at Home, privately funded respite or family arranged placement, end of life care or transfers to a hospice facilitated by the Acute Oncology Team or End of Life Facilitators / Palliative Care team are all classified as Simple Discharges. However, Pathway 1 means that patients require a short-term care package, or temporary increase in an existing care package, to enable them to safely return home. This will require the input of the Rapid Transfer Service (RTS).

- 4.1.2. **Complex Discharge:** A complex discharge usually requires the use of external capacity such as community beds (community hospitals and assessment beds) and care homes (spot purchase, continuing healthcare, Fast Track etc.) or processes such as safeguarding, homelessness or multi-agency working. The RTS is responsible for supporting any patients who require new or additional support on discharge due to a change in care needs. Therefore, whilst Complex Discharges predominantly fall within Discharge to Assess pathways 2 and 3, the RTS will also provide support for patient being discharged via Pathway 1.
- 4.2. **Hot Floor Discharge Team:** The aim of the Hot Floor Discharge Team (HFDT) is to rapidly assess patients within the emergency floor and facilitate admission avoidance or short stay (<72 hours). The team supports patients within emergency departments, the observation wards and the Acute Medical Units (assessment and bedded areas).
- 4.3. **Expected Date of Discharge (EDD):** In most instances a patient's EDD is predictable, based on their acute clinical needs. The EDD must be Consultant led and can only be changed for clinical purposes authorised by a Consultant. Where a patient is experiencing a delay in discharge or transfer but they remain medically ready for discharge, the EDD will not be changed.
- 4.4. **Rapid Transfer Service (RTS):** The aim of the Rapid Transfer Service is to bring together agencies in the delivery of a robust and facilitated discharge model seven days a week 8am – 5pm (including bank holidays). The ultimate aim is to discharge patients back to their own home unless there is a specific reason this cannot happen, for example carer breakdown or for a short period of rehabilitation or assessment. The RTS will provide a critical role in ensuring that patients are transferred to the most appropriate pathway, to meet their needs in a timely way.
- 4.5. **Golden Patients:** Golden patients are those patients where all necessary arrangements are in place to enable the patients to be discharged or transferred to the Discharge Lounge before 10am. Safe emergency patient flow can be maintained by generating a minimum of ten discharges by 10am, which is effectively one patient per ward.
- 4.6. **Same Day Emergency Care (SDEC):** Up to 40% of patients attending hospital via the Emergency Department, should be treated and discharged on the same (ambulatory care) or have a maximum of 48 hours length of stay, ideally within an assessment area (or Emergency Care Village).

## **5. Purpose and Scope**

- 5.1. This Policy is required to ensure timely and appropriate discharge planning is undertaken, in line with the national Hospital Discharge Policy and Operating Model (2020)
- 5.2. The aims of this Policy are to ensure compliance against the Criteria to Reside process and correct utilisation of Discharge to Assess pathways, relevant to individual patient needs.
- 5.3. The Policy applies to all clinical and operational staff involved in the care and discharge of inpatients, over the age of 18 years.

## **6. Duties**

### **6.1. Executive Leads**

- 6.1.1. The Chief Executive has overall responsibility for ensuring that this policy is fully implemented within the Trust. This will be delegated to the Chief Operating Officer, Chief Nurse and Director of Patient Experience and Quality, and the Chief Medical Officer who have shared responsibility to ensure that Trust staff adhere to the principles of this policy.

### **6.2. Clinical Consultants**

- 6.2.1. Consultants will be expected to adhere to the to the Safer Flow Bundle (see section 10) and the Criteria to Reside requirements (section 7). Wherever possible, the provision of clearly documented Clinical Criteria for Discharge (CCD) will enable the multi-disciplinary team to ensure patients are sufficiently prepared for discharge and minimal delays are incurred.
- 6.2.2. Undertake daily board and/or ward rounds, ideally in the in the morning, which will be considered to be complete once the 'actions' identified have been done.
- 6.2.3. Consultants also have a duty to ensure the junior members of their team are adhering to the principles of safe and timely discharge; in particular the completion of the patient's Electronic Discharge Notification (EDN). This is effectively the 'patients discharge passport' and they cannot go home without it.
- 6.2.4. Once the Consultant has deemed that a patient no longer meets the Criteria to Reside, the ward team will be responsible for discharging patients who do not require RTS involvement.

### **6.3. Rapid Transfer Service (RTS)**

- 6.3.1. Adhere to the principles of Discharge to Assess and proactively support timely transfers to community resources as per individual assessed needs.
- 6.3.2. Monitor the RTS Patient Tracker List (PTL), generated from the inpatient PTL, to identify patients flagged as potentially having complex needs on discharge (referral process).
- 6.3.3. Ensure the RTS PTL is updated as a live record to ensure the multi-disciplinary teams are aware of plans and can support as relevant.
- 6.3.4. Ensure patients are assessed and referred to relevant community services at the earliest possible opportunity; assessment and planning should not be delayed until the patient is 'medically fit for discharge'.
- 6.3.5. Escalate any issues or potential areas of delay to the relevant ward manager and ultimately the Head of Clinical Operations, via the site-based access meetings (10am and 3pm daily).

### **6.4. Matrons and Ward Managers**

- 6.4.1. Provide senior clinical support and advice to ward teams in proactive discharge planning.
- 6.4.2. Provide support and senior leadership for investigation of safeguarding concerns.
- 6.4.3. Undertake a formal weekly review of all patients with a length of stay greater than seven days and escalate delays to the relevant professionals / departments. This supports the daily review as part of the Board Round process
- 6.4.4. Ensure delays are pursued at ward level, and subsequently escalated through the relevant Care Group or professional discipline if local resolution is not achievable.
- 6.4.5. Ensure ward staff are updating Allscripts regularly to provide a 'live' reflection of EDD's, and the Inpatient PTL to reflect a live bed state and patients' progress.
- 6.4.6. Actively promote a 'pull' culture within wards to ensure inpatients are transferred within 30 minutes of a vacant bed being allocated and resolve associated delays.
- 6.4.7. Actively promote the use of the Discharge Lounge (QEQM and WHH).
- 6.4.8. Escalate any unresolved issues to specialist areas for resolution and brief the Care Group Head of Nursing / Operations Director if any concerns have arisen.

### **6.5. Clinical Support Services**

- 6.5.1. Ensure that all Radiology and Pathology referrals are responded to within internally agreed timescales.
- 6.5.2. Where possible, respond to clinical urgency / discharge dependant requests within a reduced timeframe (patient names should be shared at the site-based access meetings).



## 6.6. **Therapy Staff**

- 6.6.1. Collaborate with the MDT to achieve the agreed EDD ensuring that there are no unnecessary delays built into the patient's discharge pathway.
- 6.6.2. As far as possible, support the patients in being discharged to their own environments in order to maximise independence and engender a self-care philosophy.
- 6.6.3. Clearly document status of therapy input, in line with the criteria to reside categories.
- 6.6.4. Work in collaboration with RTS where appropriate, to discuss resources to support discharge of patients from the acute hospital setting for any ongoing rehabilitation needs.
- 6.6.5. Utilise a solution-focused approach to discharge planning.

## 6.7. **Pharmacy Staff**

### 6.7.1. **The clinical pharmacy team**

- 6.7.1.1. Liaise with the MDT caring for the patient and supporting effective planning for discharge
- 6.7.1.2. Ensure that MDT are aware of the medicine needs for each individual patient as part of discharge planning.
- 6.7.1.3. Ensure any medicine related barriers to discharge are highlighted to the MDT and resolved before discharge.
- 6.7.1.4. Ensure that discharge prescriptions are safe and appropriate for dispensing & transfer by screening and liaising with prescriber if needed.
- 6.7.1.5. Ensure that the patient has the medicines they need for discharge
- 6.7.1.6. Ensure that the patient can manage their medicines at home
- 6.7.1.7. Provide a patient help line for medicines supplied at discharge

### 6.7.2. **The operational pharmacy team**

- 6.7.2.1. Safe, accurate and timely dispensing of medicines required for discharge

## 6.8. **Discharge Lounge Staff**

- 6.8.1. Discharge Lounge staff have a responsibility to ensure patients are proactively "pulled" from ward areas and transferred to the discharge lounge at the earliest opportunity.
- 6.8.2. Discharge Lounge staff should aim to have accepted and taken up to ten patients before 10am every day.

- 6.8.3. Ensure patients ongoing care needs are met.
- 6.8.4. Proactively liaise with pharmacy services and transport providers to minimise patients' waiting times in the discharge lounge.
- 6.8.5. Escalate any issues which cannot be resolved with the relevant ward or department, to the Head of Clinical Operations
- 6.9. **2gether Support Solutions**
- 6.9.1. All patient moves should be completed within 30 minutes of the request
- 6.9.2. Any issues which may affect achievement of this should be escalated both to the Portering Supervisor and the Operational Control Centre.
- 6.9.3. All bed 'vacation cleans' should be completed within 30 minutes (this will be co-ordinated via the Operational Control Centres on each site).
- 6.9.4. Any issues which may affect achievement of this should be escalated both to the Domestic Supervisor and the Operational Control Centre.

## 7. Discharge to Assess

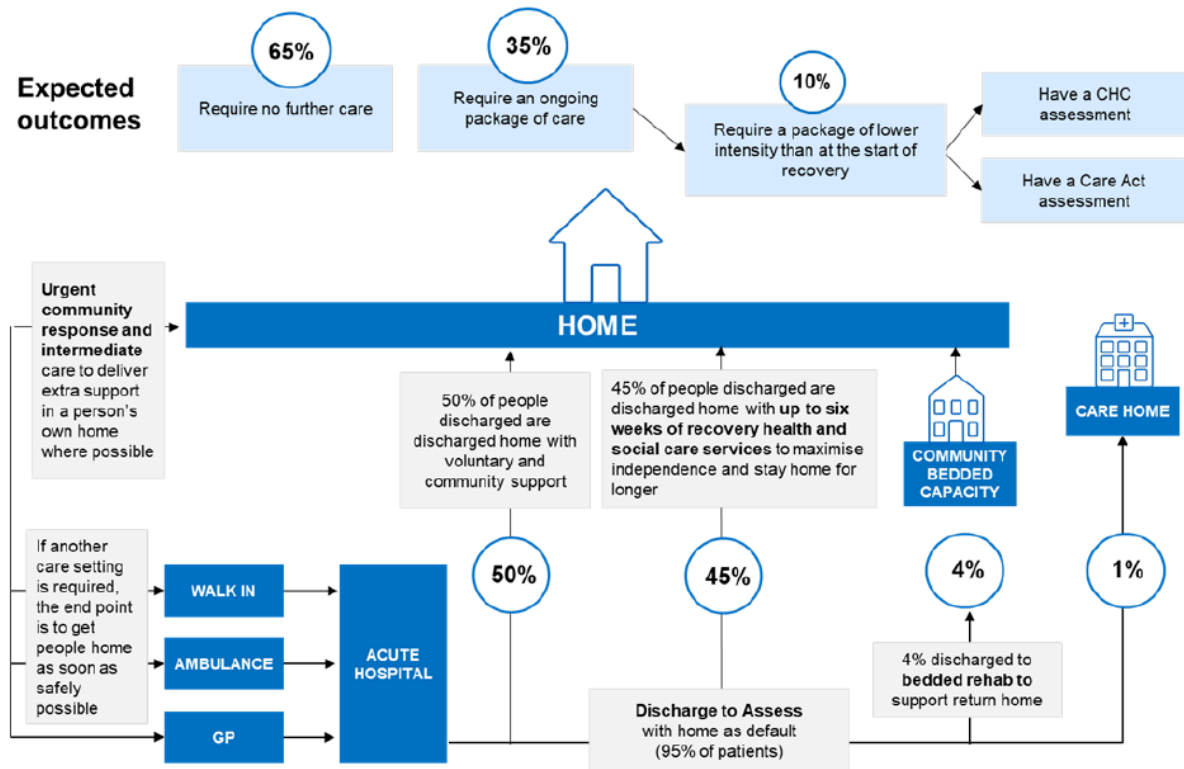
- 7.1. Consultant driven EDD's are essential for safe and proactive management of patient care and patient flow. Without this clarification, a co-ordinated and timely approach to discharge planning will be unachievable. The EDD should be set on admission and reviewed on transfer to inpatient wards. EDD's should be included in each ward and board round.
- 7.2. The discharge to assess model, is based on four clear pathways for discharging people, as shown below and in Picture 1:

<b>PATHWAY</b>	<b>IMPACT</b>	<b>DESCRIPTION</b>
Pathway 0	50% of people	Simple Discharge. No formal input from health or social care is needed once home.
Pathway 1	45% of people	Simple Discharge. Support to recover at home; able to return home with support from health and/or social care.
Pathway 2	4% of people	Complex Discharge. Rehabilitation or short-term care in a 24hr bed-based setting
Pathway 3	1% of people	Complex Discharge. Require ongoing 24hr nursing care, often in a bedded environment. Long term care is likely to be required for these individuals

- 7.3. Acute hospitals will continue to be the responsible organisation for discharge of all people on pathway 0, ensuring that the 50% of people who can leave the hospital and only need voluntary or community support, do so on time and safely.
- 7.4. The National Discharge Guidance states that Care Package restarts are classified as Pathway 1.

Picture 2:

**Aim:** to support people to maximise their independence and remain in their own home



- 7.5. There are three stages to the Discharge to Assess model:

STAGE	PRINCIPLE	INTERVENTIONS / CONSIDERATIONS
Stage One	Review each patient daily and identify people for discharge that day	<ul style="list-style-type: none"> <li>Begin discharge planning from the point of hospital admission, including the identification of immediate needs of the individual at home following discharge.</li> <li>Undertake daily clinically-led reviews of all people at a morning ward round; utilising SHOP (Sick, Home, Other Patients) approach.</li> <li>Any person not meeting the <b>clinical criteria to reside</b> (see Section 7) will be deemed suitable for discharge.</li> <li>Information about the home circumstances for people should have been collected at the point of admission.</li> </ul>

		<p>If further home assessment is required this should be undertaken in good time, coordinated between health and social care and should include equipment and reablement support. Trusted assessment arrangements should be used.</p> <ul style="list-style-type: none"> <li>• All people who are suitable for discharge will be added to the daily discharge list.</li> <li>• Discharge home should be the default pathway.</li> <li>• Undertake twice daily review of all people in acute beds to agree who no longer needs to be in hospital and can be discharged.</li> <li>• For people being discharged into a care home, supported housing or other temporary accommodation, a COVID-19 test should be carried out prior to leaving the acute hospital.</li> <li>• Senior clinical staff should be available to support staff with appropriate risk-management and clinical advice</li> </ul>
<p>Stage Two</p>	<p>Details of how to discharge people</p>	<ul style="list-style-type: none"> <li>• On discharge, the patient and their family should be informed.</li> <li>• Community health, social care and acute staff need to work in full synchronisation (include housing professionals where necessary) to ensure people are discharged in a safe and timely manner.</li> <li>• For people who are going straight home with no support (pathway 0) the ward staff should arrange discharge.</li> <li>• For those who will require reablement, rehabilitation and/or some care followed by further assessment after recovery (pathways 1 and 2, for up to six weeks), details of their immediate needs will be given to the RTS and a decision made about which pathway will be used.</li> <li>• All people must be transferred to an allocated discharge area or lounge from their ward, as soon as possible, to leave hospital the same day.</li> <li>• Ward staff will be responsible for ensuring (for all those leaving hospital on pathways 1-3): <ul style="list-style-type: none"> <li>○ Patients and families are fully informed of the next steps</li> <li>○ Transport arrangements are confirmed</li> <li>○ Covid status information is documented in any accompanying information</li> </ul> </li> </ul>

<p>Stage Three</p>	<p>Assessment and care planning at home  (OUTSIDE of an Acute Hospital bed)</p>	<ul style="list-style-type: none"> <li>• Post discharge, community teams will work with relevant partners to ensure the staff and infrastructure are available to meet immediate care needs.</li> <li>• The use of personal budgets should be discussed with the individual and their family as an option, if longer term support is needed.</li> <li>• For all those discharged on pathways 1-3, services providing additional care to that in place pre-admission will be at no cost to the individual for a period not exceeding six weeks.</li> <li>• It is the community team's responsibility to ensure that there is frequent review of the support package and adjustments are made when appropriate.</li> <li>• Care Home Managers (temporary placements) will liaise with the appropriate professionals to ensure timely assessments for any longer-term care provision and/or associated financial assessments (as required).</li> </ul>
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**7.6. Important considerations for all pathways:**

- 7.6.1. For people where new mental health concerns are considered in light of discharge, psychiatric liaison teams should be contacted by community teams in the first instance to review and assess as appropriate.
- 7.6.2. For people with a pre-existing mental health concern who are known to mental health services, their care coordinator or relevant mental health clinician should be involved in their discharge planning to ensure their mental health needs are considered as part of this.
- 7.6.3. Duties under the Mental Capacity Act 2005 still apply during this period. The Department of Health and Social Care (DHSC) has published emergency guidance for health and social care staff in England and Wales who are caring for or treating a person who lacks the relevant mental capacity during the COVID-19 pandemic.
- 7.6.4. If there is a reason to believe a person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made, then there should be a best interest decision made for their ongoing care in line with the Trust's People at Risk policy. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes and orders from the Court of Protection for community arrangements still apply.

7.6.5. Information essential to the continued delivery of care and support must be communicated and transferred to the relevant health and care partners on discharge. This must include, where relevant, the outcome of the last COVID-19 test.

## **8. Criteria to Reside - Maintaining Good Decision Making in Acute Settings**

8.1. In line with Stage One of the Discharge to Assess process (section 6), every person on every general ward should be reviewed on a twice daily multidisciplinary ward round to determine the rationale for their continued acute hospitalisation.

8.2. If the answer to each of the questions below is 'no', active consideration for discharge to a less acute setting must be made.

- ✓ **Requiring ITU or HDU care?**
- ✓ **Requiring oxygen therapy/NIV?**
- ✓ **Requiring intravenous fluids?**
- ✓ **NEWS2 > 3? (Clinical judgement required in persons with Atrial Flutter and/or chronic respiratory disease)**
- ✓ **Diminished level of consciousness where recovery is realistic?**
- ✓ **Acute functional impairment in excess of home/community care provision?**
- ✓ **Last hours of life?**
- ✓ **Requiring intravenous medication more than twice daily. (including analgesia)?**
- ✓ **Undergone lower limb surgery within 48hrs?**
- ✓ **Undergone thorax-abdominal/pelvic surgery within 72 hrs?**
- ✓ **Within 24 hours of an invasive procedure? (With attendant risk of acute life-threatening deterioration)**

8.3. Every patient's daily Criteria to Reside outcome must be recorded onto the inpatient PTL, by the ward staff.

8.4. It is accepted that clinical exceptions will occur, but they should be warranted and justified within the patient's medical records. Recording the rationale will enable meaningful and time efficient review.

- 8.5. **Review questions for the clinical team** should include:
- 8.5.1. Is the patient medically optimised?
  - 8.5.2. What management can be continued as Ambulatory Care (e.g. Heart failure treatment)?
  - 8.5.3. What management can be continued outside the hospital (e.g. intravenous antibiotics)?
  - 8.5.4. People with a low NEWS score (0-4) - Can they be discharged with a suitable follow-up? For example:
    - If not scoring 3 on any one parameter
    - If their oxygen needs can be met at home
    - Stable and not needing frequent observations (i.e. less than four hourly)
    - Not needing any nursing or medical input after 8pm
      - People waiting for results
        - Can they come back?
        - Can they be phoned through?
      - Repeat bloods
        - Can they be done after discharge in an alternate setting?
      - People waiting for investigations
        - Can they go home and come back as outpatients, but with the same prioritisation as inpatients?

## 9. **Specific Information Regarding Discharge**

- 9.1. In order to improve patient experience and flow throughout the Trust, this policy requires the following take place:
- 9.1.1. Discharge processes within the acute Trust and community work effectively and consistently, to allow discharge from hospital to take place seven days a week.
  - 9.1.2. Optimisation of self-care and independence for patients in their own environment is actively promoted, wherever possible. This should be supported by a more focussed approach within the acute Trust to maintain patient independence with activities of daily living and mobility as able.
  - 9.1.3. Discharges are arranged for earlier in the day, ensuring that a minimum of ten patients are discharged home by 10am daily and 50% of all discharges are completed by 3pm daily. This effectively means one Golden Patient per ward.

- 9.1.4. All discharged patients will be transferred to the discharge lounge (QEQM and WHH) to await family or Patient Transport Services. Exceptions to this rule must be approved by Matrons.
- 9.1.5. A multidisciplinary, multi-agency approach to discharge planning which will result in patients being safely discharged either to their own homes or to the right place with the right care.
- 9.1.6. There are processes in place to systematically review the patient experience regarding discharge and evaluate “lessons learned” from discharging patients, to ensure continuous patient safety and quality improvements are made.
- 9.2. Wherever safe and possible, unnecessary acute admission will be avoided via the use of the Hot Floor Discharge Team, Acute Frailty Units or Specialist Assessment Units, and in liaison with Local Care Hubs (Primary Care) and Community Care resources.
- 9.3. Continuity of care is maintained for any patient who require transfer to another health or social care setting, as part of their on-going care needs, or for patients being discharged home with support services.
- 9.4. Effective, timely and appropriate communication will be maintained throughout the discharge planning process between all relevant staff, patients, relatives/carers and service providers to ensure that potential issues or concerns are raised in a timely manner and resolved accordingly.
- 9.5. Patients, carers and relatives will be supported to have realistic expectations of hospital stays and that they are psychologically prepared for transfer to their onward destination following completion of the acute episode of care.
- 9.6. Every patient will have a clearly documented discharge plan tailored to their individual care needs, irrespective of whether the discharge is considered to be simple or complex.

## **10. SAFER Patient Flow Bundle**

- 10.1. The SAFER patient flow bundle is established on most inpatient wards and aims to reduce delays for patients on adult acute wards (excluding maternity, paediatrics and intensive care), by combining five elements of best practice. It is important to ensure that all elements are implemented together to achieve the cumulative effect. When SAFER is followed correctly, length of stay reduces, patient experience and satisfaction increase and patient flow and safety improve.



10.2. The five elements of SAFER are:

S	Senior Review	All patients will have a senior review before midday to make management and discharge decisions.
A	All Patients	Must have both an EDD and a CCD (Clinical Criteria for Discharge) set, assuming the ideal recovery and there are no associated delays.
F	Flow	Flow of patients from assessment units to inpatient wards must start as soon as possible (ideally before 10am). A 'pull' culture from assessment units by specialty wards should enable this.
E	Early discharge	The Golden Patient principle enables 10 patients to be discharged by 10am, thereby promoting flow, as highlighted above. Routine use of the Discharge Lounge is a key aspect of achieving this.
R	Review	All patients that have been in hospital for seven days or more (stranded patients) should be reviewed weekly as part of routine business.

10.3. The benefits associated with the SAFER Flow Bundle are that:

10.3.1. Patients benefit from improved care co-ordination ensuring they receive their care in a timely manner.

10.3.2. Patients benefit from planned and timely discharge.

10.3.3. Staff benefit from being able to provide patients with the specialist care they need.

10.3.4. Staff will have access to all the information they need to provide patient care.

10.3.5. Staff can provide accurate, real time information to the Site Management and Patient Flow team.

10.3.6. The Trust benefits from improved patient flow throughout the organisation.

10.4. To underpin the principles and elements of the SAFER Flow bundle, the Trust has clinically and operationally implemented the use of the Inpatient PTL.

## **11. Simple or Complex Discharge**

- 11.1. On or shortly after admission, the initial assessment should assist the nurse in deciding whether the patient's needs are likely to result in a simple or complex discharge.
- 11.2. Irrespective of the type of discharge, it is the ward staff's responsibility to ensure patients and relatives / carers are aware of the expected length of inpatient stay and discharge arrangements. Patients should be informed when they are likely to be going home and, wherever possible, the patients and their family should organise for clothes to be brought in and transport home.
- 11.3. **Simple Discharge: Pathways 0 and 1 (as listed below)**
  - 11.3.1. Most patients will have simple discharge pathways, irrespective of their reason for admission or the potential complexity of their care needs.
  - 11.3.2. This includes:
    - 11.3.2.1. home without support (P0)
    - 11.3.2.2. home with Hospital at Home (P0)
    - 11.3.2.3. home with support (P1)
    - 11.3.2.4. home with Care Navigator support (i.e. key safe) (P1)
    - 11.3.2.5. home with Community nursing or specialist nurse (P0)
    - 11.3.2.6. home with existing care package (P1)
    - 11.3.2.7. home to previous care home (residential or nursing) (P0)
    - 11.3.2.8. private respite care (P0)
    - 11.3.2.9. self-discharge against medical advice (P0)
    - 11.3.2.10. home with support from British Red Cross (P0)
    - 11.3.2.11. palliative care input arranged by Acute Oncology Nurses / MacMillan team (P0)
- 11.4. **Complex Discharge: Pathways 2 and 3**
  - 11.4.1. A complex discharge is any discharge where a patient's pre-existing discharge arrangements may not be safe or appropriate due to a change in care needs or behaviour.
  - 11.4.2. Complex patients include:
    - 11.4.2.1. Any patient who may be eligible for Continuing Health Care
    - 11.4.2.2. Home First Bed in a community hospital or dedicated short term facility
    - 11.4.2.3. Short term Spot Purchase bed for a period of assessment
    - 11.4.2.4. Any patient who requires a placement for Fast Track

- 11.5. The Rapid Transfer Service (RTS) are required to support Discharge to Assess Pathways 1, 2 and 3.

## **12. Specific Instructions Regarding Discharge**

### **12.1. Discharge to Care Homes**

- 12.1.1. All patients must be tested for Covid-19 prior to discharge/transfer to a care home. The date of the last test should be clearly communicated to the receiving care home.
- 12.1.2. Where test results are awaited, the care home will isolate the patient as per national guidance (as with Covid-19 positive patients), until known otherwise.
- 12.1.3. Asymptomatic patients who have tested positive, must still be isolated for fourteen days on arrival to the care home.
- 12.1.4. If care homes cannot accommodate Covid-19 positive patients, the Local Authority (Kent County Council) should be asked to find a suitable alternative placement for a period of fourteen days, until the patient can return to their own care home.
- 12.1.5. All patients being discharged/transferred to a care home should have a clearly documented Treatment Escalation Plan (TEP) or Advanced Care Plan (ACP) prior to discharge. This document should reflect the patient's wishes with regards future treatment plans and subsequent admissions to hospital, irrespective of clinical presentation.

### **12.2. Weekend Discharges / Out of Hours**

- 12.2.1. To ensure that patient flow throughout the hospital is maintained, it is expected that discharges will occur seven days a week, in the same way that patients are admitted seven days a week. Every Friday, all medical and surgical teams, when reviewing their patients, must complete and clearly document a weekend plan for all patients ensuring that EDNs are completed if there is potential for discharge.
- 12.2.2. The Trust is currently piloting having additional Consultants working during weekends, to focus on admission avoidance and discharges. Care Groups must ensure they have sufficient resources on duty to allow for seven-day discharging (weekends should achieve around 80% of normal week day discharges).
- 12.2.3. A list of all probable and planned discharges should be provided to the Operational Control Centre, via the relevant Matrons. It is the responsibility of the discharging team to ensure that the patient's EDN is completed prior to doctors leaving on the Friday.
- 12.2.4. Any outstanding investigation results or interventions (such as bloods) which need to be checked prior to discharge, should be documented as part of the weekend handover and a copy forwarded to the Operational Control Centre and

Medical ward-based team who will assume responsibility for checking the results, on-going interventions and discharging the patient.

- 12.2.5. Some admissions over the weekend will involve simple discharge processes that can occur any time. However, all discharge principles remain the same across seven days and the Discharge Checklist should be completed to maintain patient safety and ensure sufficient communication. Escalation of problems and support is provided by the Clinical Site Manager.

### 12.3. **Self-Discharge**

- 12.3.1. All staff should remember that patients do have a right to self-discharge (assuming they have capacity to do so). In these situations, staff must consider the following in order to facilitate self-discharge to achieve the best outcome possible.
  - 12.3.1.1. Does patient have capacity? Has this been evidenced by completion of an assessment under the Mental Capacity Act as appropriate?
  - 12.3.1.2. Has a Deprivation of Liberty checklist been completed?
  - 12.3.1.3. Inform and discuss with medical staff, matron, or care manager as required.
  - 12.3.1.4. If out of hours, liaise with Operational Site Manager.
  - 12.3.1.5. Inform and discuss with GP and any other relevant agency.
  - 12.3.1.6. Ensure patient has prescribed medications to take away.
  - 12.3.1.7. Inform next of kin, if known and appropriate.
  - 12.3.1.8. Self-discharge form should be completed.
  - 12.3.1.9. Document clearly within medical and nursing notes all actions taken.
- 12.3.2. The Nurse in Charge will ensure that the patient has the required medications and dressings and that referrals are made to the appropriate agencies to undertake assessments and treatments that the patient may need in order to ensure that the discharge remains as safe as possible.
- 12.3.3. The patient should be asked to sign the Self Discharge Form which must be filed within the patient's case notes.
- 12.3.4. If the patient is unable to arrange suitable transport, the ward should arrange transport as required.
- 12.3.5. If the patient has capacity they can self-discharge if homeless, but communication with external agencies are key.
- 12.3.6. Following discharge, the ward should make a welfare check telephone call, to ensure the patient has arrived home safely

#### 12.4. **Palliative Care or Discharge Home to Die**

- 12.4.1. The Palliative Care team or End of Life Nurses within the Trust will provide advice, support and guidance on discharge. Specialist Palliative Care referrals can be completed by nursing and medical staff and faxed directly to the Hospice Team in the event that the Hospice at Home Rapid response Team are required to support patients going home to die.
- 12.4.2. NHS-funded Continuing Healthcare Fast Track provision can be made for patients who meet the criteria (rapid state of decline). The referral should be completed by the ward nursing team, supported by the MDT, at the earliest possibility when prognosis is identified and appropriate clinical discussions with the patient and their family have taken place.

#### 12.5. **Paediatric Discharges**

- 12.5.1. In most cases, the discharge of a child will occur without the need for additional support services. Refer to the Safe Discharge of Children and Young People from Hospital Settings.

#### 12.6. **Homelessness / Housing Issues: Discharge and 'Duty to Refer'**

- 12.6.1. There may be situations where a patient is homeless and refuses to be discharged to the relevant homeless persons unit/shelter. Where this is the case, the following process **must** be followed:
  - 12.6.1.1. Notify patient and support agencies of discharge as early as possible and involve the patient in planning.
  - 12.6.1.2. Complete Duty to Refer form as early as possible and send this to local authority making sure we receive an electronic acknowledgement (see adult safeguarding page on Staff Zone).
  - 12.6.1.3. Refer to Porchlight 'Kent Connect' if the person will have enhanced need on discharge such as addiction, physical or mental health need.
  - 12.6.1.4. In deciding on 'fit for discharge', clinicians should take in to account whether the patient has somewhere suitable to go to convalesce or are they returning to the harsh environment of the street. This should be taken into account when considering discharge date/district nurse referral/GP follow up and outpatient care.
  - 12.6.1.5. Although we cannot always delay discharge for a homeless person, do not discharge on to street unless every other option has been tried or if the patient desires this, following a capacity assessment under the Mental Capacity Act (2005)

- 12.6.1.6. Keeping the person informed about discharge and giving reassurance of support, will help them to feel cared for and reduce fear, which in turn will benefit their physical recovery.
- 12.6.1.7. There is a clothing store within our hospitals which can provide clothes if needed.
- 12.6.1.8. Ask if we can contact people for the homeless person on discharge.
- 12.6.1.9. Discuss whether the patient has a useable GP registration and, if needed, provide letter of ID with NHS number and address on discharge to register with local GP, stating that if GP surgery refuse they are to contact the safeguarding team to explain the refusal. A template letter is available on the homeless patients page on the adult safeguarding intranet page.
- 12.6.1.10. Book transport on discharge to location of patient choice within Kent.
- 12.6.1.11. If discharging a person to the street, the following checklist should be completed:

- Contact EKHUFT homelessness lead to establish that everything has been tried to find an alternative.
- Housing referral must be completed under the duty to refer.
- Discharge as early in day as possible giving time for attending housing appointments or daycentres.
- Give information on services local to the discharge destination from staff homeless resource on Adult Safeguarding intranet page.

12.6.2. Failure to adhere to the above checklist constitutes a serious breach of this policy. The Safeguarding team will monitor this

12.6.3. Record discharge of person to the streets on Datix incident reporting system.

## **12.7. Patients Refusing to be Discharged / Patient Choice**

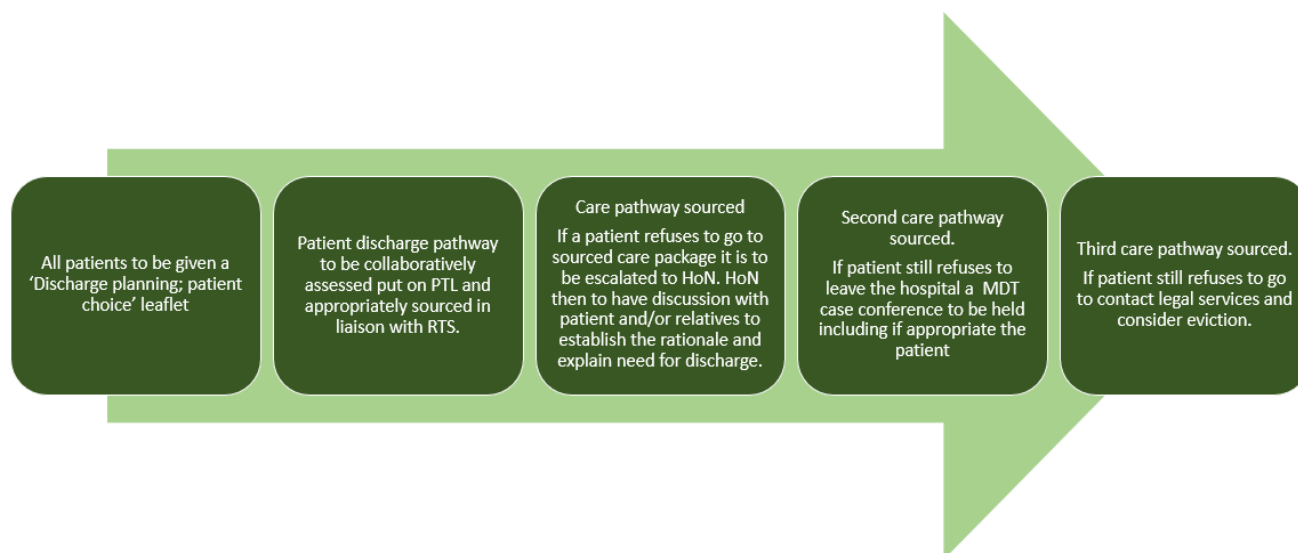
12.7.1. If a patient's Lead Consultant decides that the patient's medical condition cannot be further improved by acute care, the patient and relatives need to be involved and/or informed of this decision.

12.7.2. Patients do not have a legal right to continue to occupy an acute hospital bed. Once their acute episode of illness has been treated and/or stabilised, and any ongoing care needs can be safely provided in a community environment (ideally the patient's own home) the patient will be discharged in line with the Hospital Discharge Policy

- 12.7.3. All patients admitted to the Trust should be issued with a 'Discharge Planning-Patient choice' letter (appendix 1)
- 12.7.4. If patients continue to refuse to leave the Hospital once they no longer meet the criteria to reside, then the following should be followed;
- 12.7.5. If a patient refuses to go to sourced care package it is to be escalated to Head of Nursing, they then have a discussion with patient and/or relatives to establish the rationale and explain need for discharge.
- 12.7.6. Second care pathway sourced; If the patient still refuses to leave the hospital an MDT case conference to be held, if appropriate involving the patient and/or relatives.
- 12.7.7. Third care pathway sourced; If patient still refuses to go please contact legal services and consider eviction

**Picture 3:**

## Discharge planning, patient choice.



### **13. Information to be Given to the Receiving Healthcare Professional Regarding a Patient's Transfer of Care**

- 13.1. The following documentation should accompany the patient on discharge, for attention of the receiving Healthcare professional:

- 13.1.1. Copy of the patient's Electronic Discharge Notification Summary and DNAR (Do Not Attempt Resuscitation), as appropriate.
- 13.1.2. Copy of the Discharge Checklist and/or Handover Document (including Rehabilitation Prescription), for patients being transferred to a non-acute community bed or residential care setting.
- 13.1.3. Any appointments for follow-up management.
- 13.1.4. Instructions regarding administration of patient's medication, as appropriate.

## **14. Patient Involvement**

- 14.1. It is essential that the patient and, with their permission, their carer or family are included in on-going assessment and care planning, and that this provides information in a way that helps them to make decisions about their treatment and care. Patients may be selective in whom they wish to give information; this must be recorded and respected.
- 14.2. During their stay in hospital a patient and, if appropriate, their carer or family should be provided with verbal/written information which will include:
  - 14.2.1. Treatment plan and expected date of discharge:
  - 14.2.2. Reason for admission admitted and what the diagnosis was.
  - 14.2.3. Investigations carried out, what were their results and what does that mean.
  - 14.2.4. Treatment received and relevant information re: continue taking that treatment and for how long.
  - 14.2.5. What side effects the patient might expect and what they should do if they experience them.
  - 14.2.6. What the follow up arrangements are, including the need to have any further investigation.
  - 14.2.7. What is likely to happen in the future and does the patient have to change anything.
  - 14.2.8. Arrangements, contact details and any relevant information regarding the patients' future treatment and care.
  - 14.2.9. Full information of the assessment of their health and social needs.
  - 14.2.10. Information regarding their medication.
  - 14.2.11. Discharge arrangements and expectations.



- 14.2.12. Where patients have undergone a surgical procedure, they will be given written/verbal information which must include post-discharge advice.
- 14.3. The following documentation should be given to the patient on discharge:
  - 14.3.1. Copy of the Electronic Discharge Notification Summary and DNAR where appropriate
  - 14.3.2. Any appointments for follow-up management.
  - 14.3.3. Instructions regarding administration of their medication.
  - 14.3.4. Additional Information regarding Support Services on Discharge, i.e. Hospital at Home, Community Nursing letter
  - 14.3.5. Relevant leaflets about condition where appropriate
  - 14.3.6. Medical Certificate, if required.

## **15. Policy Development, Approval and Ratification**

- 15.1. This Policy has been developed in association with representatives from clinical and operational staff. External input to relevant sections has also been sought, from Health and Social care community service providers.
- 15.2. This policy will be approved by the Clinical Executive Management Group
- 15.3. This policy will be ratified by the Policy Authorisation Group.

## **16. Review and Revision Arrangements**

- 16.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.
- 16.2. Legislative changes will be implemented on an ad hoc basis as directed by the Department of Health and Social Care. Responsibility for on-going review and revision of this policy will be determined by the Chief Operating Officer, the Chief Nurse and Director of Patient Experience and Quality and the Chief Medical Officer, in association with the Care Groups.
- 16.3. It will be ratified by the Policy Authorisation Group every three years, or when there are significant changes and/or changes to underpinning legislation in accordance with the policy for the Development and Management of Trust Policies (and other Procedural Documents).

## **17. Policy Implementation**

- 17.1. Policies are uploaded to the Trust's Policy management system and available to all staff via the Policy Centre.

## **18. Document Control including Archiving Arrangements**

- 18.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.
- 18.2. This policy will be uploaded to the Trust's policy management system.

## **19. Monitoring Compliance**

- 19.1. Performance against this Policy will be monitored via the Emergency Recovery Plan (ERP) daily report, the daily Simple and Complex discharges (185 target), Operational Control Centre (OCC) Dashboard, the Inpatient PTL, Readmission rates, patient complaints and compliments and through compulsory submissions to National databases such as the Discharge PTL (super-stranded patients) and Reportable Delayed Transfers of Care.
- 19.2. In addition, a number of Key Performance Indicators have been identified to monitor safe, efficient and effective patient flow. These include:
  - 19.2.1. Achievement of the 4-hour A&E Access Standard (Emergency Department);
  - 19.2.2. Achievement of the 60 minute 'golden hour' within the Emergency Department;
  - 19.2.3. A minimum of 10 discharges by 10am per day, per site
  - 19.2.4. A minimum of 50% discharges from inpatient wards by 3pm, per day, per site and 100% by 8pm.
  - 19.2.5. Achievement of 185 discharges across the trust per day from the General and Acute bed base
  - 19.2.6. The RTS will achieve a minimum of 6 discharges per day per site, with an expectation that up to 37 complex discharges Trust-wide will be achieved daily (7 days a week).
  - 19.2.7. Support the reduction of number of Reportable Delays within the acute Trust.
  - 19.2.8. Number of avoidable Readmissions within 7 days and 30 days.
- 19.3. Monitoring of incidents, complaints and claims reported on Datix that relate to the discharge of patients, and those reported through the Transfer of Care process, should also be reviewed quarterly within each Care Group Governance Team.
- 19.4. In addition to the monitoring arrangements described above the Trust or clinical Care Groups may undertake additional monitoring of this policy as a response to

the identification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice.

## **20. References**

HM Government (August 2020) Hospital Discharge Service: Policy and Operating Model.

Department of Health and Social Care (April 2020) Covid-19: Our Action plan for Adult Social Care

## **21. Appendices**

**Appendix A- Discharge Planning patient choice letter**

## Discharge planning; patient choice

Our aim is to get you home as soon as you are well enough as we know that patients recover better in familiar surroundings with their personal effects around them. Staying in hospital for longer than necessary may reduce your independence, affect your muscle strength and your ability to return to activities that you have previously enjoyed or expose you to infection. When you are admitted to hospital we will plan and discuss discharge arrangements with you.

Leaving hospital when you are ready is not only best for you but helps us to provide a bed for other seriously ill patients who require our care.

Once the team caring for you have agreed that you no longer require hospital care you will be discharged to the right place that will meet your needs. Most people will return to their own home, sometimes with some practical support such as shopping and personal care. Some people will have ongoing care needs which can best be met in a community hospital or a care home.

Community hospitals often act as a bridge between hospital and home, particularly for people who may need rehabilitation to help them regain their independence as they recover from an illness. The number of inpatient beds each community hospital provides varies, as does the range of services they offer. Similarly, it may be identified that a care home is best to meet your needs to provide either the short term or long-term care.

There are a number of community hospitals and care homes in Kent, and the first available appropriate bed for you may not be the one closest to where you live. As hospital beds need to be available for patients who require emergency and acute care, we may have to transfer you to a community hospital bed or care home when you are fit to leave the hospital that is not the closest to your home.

You will not be able to remain in hospital if you choose not to accept the care that is being offered.

It may also be that while you wait for the appropriate care home bed to become available we ask you move to Kent and Canterbury hospital. Kent and Canterbury Hospital will have everything that you will need to continue to meet your health care requirements.

Your health care team are here to support you and answer any questions you and your family may have. Each ward has access to a Discharge Coordinator who is able to meet with you and your family if you would like more advice or information.

The ward nursing team, led by the Ward Manger or Matron are also available to speak with you.

## Appendix B – Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	Sarah Maycock	
Job title	Senior Improvement Practitioner, Improvement and Transformation Team	
Care Group/Department	Corporate	
Date completed	19/02/21	
Who will be impacted by this policy	<input checked="" type="checkbox"/> Staff (EKHUFT) <input checked="" type="checkbox"/> Staff (Other) <input checked="" type="checkbox"/> Service Users	<input type="checkbox"/> Carers <input checked="" type="checkbox"/> Patients <input checked="" type="checkbox"/> Relatives

### Assess the impact of the policy on people with different protected characteristics.

When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.

Protected characteristic	Characteristic Group	Impact of decision Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	Adults over 18 years	Positive Neutral
Disability	All	Positive Neutral
Gender reassignment	All	Positive Neutral
Marriage and civil partnership	All	Positive Neutral
Pregnancy and maternity	All	Positive Neutral
Race	All	Positive Neutral
Religion or belief	All	Positive Neutral

Sex	All	Positive Neutral
Sexual orientation	All	Positive Neutral

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.

Has there been specific consultation on this policy?	N/A. Follows national Policy	
Did the consultation analysis reveal any difference in views across the protected characteristics?	As Above	

<b>Mitigating negative impact:</b> Where any negative impact has been identified, outline the measures taken to mitigate against it.	N/A	
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<b>Conclusion:</b> Advise on the overall equality implications that should be taken into account by the policy approving committee.	Adherence to national Policy	
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## Appendix C – Policy Implementation Plan

To be completed for each version of policy submitted for approval.

<b>Policy Title:</b>	Hospital Discharge Policy and Criteria to Reside
<b>Version Number:</b>	1.0
<b>Director Responsible for Implementation:</b>	Chief Operating Officer, Chief Nurse, Medical Director
<b>Implementation Lead:</b>	Jon Scott

<b>Staff Groups affected by policy:</b>	All Clinical staff groups
<b>Subsidiary Companies affected by policy:</b>	
<b>Detail changes to current processes or practice:</b>	Adherence to new Hospital Discharge Policy national guidance, 2020.
<b>Specify any training requirements:</b>	
<b>How will policy changes be communicated to staff groups/ subsidiary companies?</b>	Via Trust News, Trust Net and email