**Learning Disability Assessment & Treatment (Inpatient)**

**Discharge Checklist**

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| **Date & time of Discharge:** |  |
| **Location of Discharge:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Completed** | **Comments / Actions** | **Date Completed** |
| **1.** | **Legal**  | Yes / No |  |  |
| 1.1 | Patient been assessed to have capacity for formal discharge? |  |  |  |
| 1.2 | If no, has formal discharge been agreed & recorded as MCA / Best Interest Decision meeting. |  |  |  |
| 1.3 | Funding requirements for accommodation / ongoing care agreed. |  |  |  |
| 1.4 | Application to Court of Protection. |  | If applicable |  |
| 1.5 | Section 117 aftercare arrangements. |  | If applicable |  |
| 1.6 | Carers Assessment offered |  | Date of referral to Local Authority |  |
| 1.7 | Discharge from Section paperwork completed. |  | Date MH Leg informed of Section discharge. |  |
| 1.8 | Application for DoLs completed by receiving organisation / social worker. |  |  |  |
| 1.9 | Discharge date agreed. |  |  |  |
| **2.** | **Provider**  | Yes / No / N/A |  |  |
| 2.1 | Housing/accommodation confirmed. |  |  |  |
| 2.2 | Transition Plan agreed. |  |  |  |
| 2.3 | Adaptations completed as necessary. |  |  |  |
| 2.4 | Specialist equipment in place. |  |  |  |
| 2.5 | Staffing team confirmed. |  | ICB / LA confirmation  |  |
| 2.6 | Staff training from ATU, patient & family / carers completed. |  |  |  |
| **3.** | **Shared information between statutory / local services and discharge team** | Yes / No / N/A |  |  |
| 3.1 | Social Worker identified. |  | Name & Locality  |  |
| 3.2 | Identified Community Team* Intensive Support
* Community LD Team
 |  | Named team |  |
| 3.3 | Community Learning Disability Keyworker Identified  |  |  |  |
| 3.4 | Have the below been shared by / to relevant professionals. |  | Date completed / reviewed |  |
|  | Health Action Plan. |  |  |  |
|  | Hospital Passport. |  |  |  |
|  | Communication Passport. |  |  |  |
|  | Sensory Profile. |  |  |  |
|  | Positive Behaviour Support Plan. |  |  |  |
|  | Epilepsy Management Plan(s). |  |  |  |
|  | Environmental assessment. |  |  |  |
|  | Autism Assessment. |  |  |  |
|  | MPAS ID |  |  |  |
|  | HoNOS (LD)  |  |  |  |
|  | Health Screening |  |  |  |
|  | RESPECT plan |  |  |  |
|  | Health Care Plan Interventions. |  |  |  |
|  | FACE Risk Assessment. |  |  |  |
|  | Safety Plan |  |  |  |
|  | Referral to Humberside Fire Brigade |  |  |  |
| 3.5 | Discharge MDT Report completedIncluding:NursingPsychologySpeech & Language TherapyOccupational TherapyPhysiotherapy Other as required |  | Date completed / reviewed |  |
| 3.6 | Lorenzo Alert reviewed / updated |  |  |  |
| 3.7 | GP Confirmed  |  | Initiated within 48 hrs of admission  |  |
| **4.** | **Medication** | Yes / No / N/A |  |  |
| 4.1 | Leave/ discharge medications arranged? |  |  |  |
| 4.2 | Medication Administration Chart provided. |  |  |  |
| 4.3 | Information provided to Patient / Family members or Carers regarding discharge medications. |  |  |  |
| 4.4 | Medication Protocols completed & shared. |  |  |  |
| 4.5 | Patient named medications on unit disposed of. |  |  |  |
| 4.6 | Patient own medications returned  |  |  |  |
| **5.** | **Patient / Carer Information**  | Yes / No / N/A |  |  |
| 5.1 | Patient Monies handed over and recorded on discharge |  |  |  |
| 5.2 | Patient property fully handed over. |  |  |  |
| 5.3 | Contact details of professionals involved shared. |  |  |  |
| 5.4 | Details of crisis support / safety plan shared. |  |  |  |
| **6.** | **Follow up arrangements**  | Yes / No / N/A |  |  |
| 6.1 | Inpatient unit daily telephone contact agreed for 7 days upon discharge. |  |  |  |
| 6.2 | IST Nurse support arranged? |  |  |  |
| 6.3 | First visit within 48 hrs |  |  |  |
| 6.4 | Community LD Nurse support arranged? |  |  |  |
| 6.5 | First visit within 48 hrs |  |  |  |
| 6.6 | Planned Health appointments, tests, treatments shared. |  |  |  |
| 6.7 | Psychiatry Outpatient appointment within 6 weeks of discharge arranged. |  |  |  |
| 6.8 | Discharge summary shared with GP. |  |  |  |
| **7.** | **Other**  | Yes / No |  |  |
| 7.1 | Transport / Travel arrangement agreed. |  |  |  |
| 7.2 | Friends & Family Test offered. |  |  |  |