STANDARD OPERATING PROCEDURE
DISCHARGE AND TRANSFER
FOR COMMUNITY INPATIENT UNITS

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
3.0	*28.05.2019*	*Changes to page 5 re ambulance* *Wound care products on discharge*
3.1	*9 May 2023*	*Reviewed with no content changes made. Will be reviewed again once new overarching policy from the ICB is received. Approved by Community Services Clinical Network Group - 09 May 2023.*

Contents

1. INTRODUCTION

Across all Neighbourhood Care Service teams all nursing staff is to comply with the following Standard Operating Procedure (SOP) to ensure safe and efficient way of admission and discharge of patients from community inpatient units. Humber Teaching NHS Foundation Trust is committed to ensuring safe and effective practice when admitting, transferring or discharging patients from its inpatient wards.

The Trust will ensure that all staff, including clinicians, senior managers, general practitioners and all other relevant agencies, e.g. acute trusts, are fully conversant with the admission and discharge criteria and any escalation plans in accordance with capacity planning, e.g. the Winter Plan Escalation Framework.

All patients will have a management/care plans in place within 24 hours of admission.

The Trust is committed to ensuring all staff are appropriately qualified and competent to deliver safe and effective clinical care over 24 hours, seven days a week for patients as agreed in the admission criteria categories.

The decision to accept an admission to a community hospital bed will be made by the senior nurse on duty.

2. SCOPE

This SOP will be used across all Neighbourhood Care Services teams within Humber NHS Foundation Trust. It includes both registered and unregistered community nursing staffs that are permanent, temporary, bank and agency staff excluding students, on commencement of working within the Neighbourhood Care Services.

The purpose of this SOP is to establish safe and consistent pathways of care for patients for admission through to discharge. This SOP helps define the purpose of In-patient care at our Community Hospitals and how to access these services.It also sets the clinical standards to improve the admission of appropriate patients.

The Trust will ensure that all staff, including clinicians, senior managers, general practitioners and all other relevant agencies, e.g. acute trusts, are fully conversant with the admission and transfer criteria and any escalation plans in accordance with capacity planning, e.g. the Winter Plan Escalation Framework.

3. DUTIES AND RESPONSIBILITIES

The Chief Executive retains overall responsibility for ensuring effective implementation of all policies and procedures.

The Trust Board – will ensure that this standard operating procedure is acted on through delegation of implementation to Assistant Directors or equivalent General Managers/Service Managers/Modern Matrons/Lead Professionals.

Service Managers, Modern Matrons and appropriate professional leads will ensure dissemination and implementation of the policy within the sphere of their responsibility. They should also ensure staff are supported in attending relevant training and that time is dedicated to the provision and uptake of training and sign off competencies.

Charge nurses/team leads will disseminate and implement the agreed SOP. They will maintain an overview of associated training needs for their respective teams. The Charge Nurse/Team Leader

will ensure mechanisms and systems are in place to facilitate staff to attend relevant training as part of their Performance and Development Review (PADR) process in order to undertake training and sign off competencies.

All clinical staff employed by the Trust will familiarise themselves and follow the agreed SOP and associated guidance and competency documents. They will use approved documentation and complete relevant paperwork as per policy and Standard Operating Procedures as relevant to each clinical activity. They will make their line managers aware of barriers to implementation and completion.

4. PROCEDURES

Principles

The following section details the principles of discharge from a community hospital bed

- The “Home First” principle has been considered by a multi-disciplinary team in order to avoid an admission to a community bed.
- Patient stay should not be expected to exceed three weeks (six weeks for complex rehabilitation) in total and incorporate an Estimated Date of Discharge (EDD) and a clear plan of treatment goals/ assessment to enable to patient to move forward along the patient pathway to their ultimate destination.
- Patients with dementia will be admitted if they have been assessed as having rehabilitation potential and the ability to follow an active programme or have a physical health need that is best served by being on the community ward as part of assessment.
- Patients will be repatriated to their local community hospital (subject to patient choice) as soon as possible, if their health needs/ assessment cannot be achieved in their own home

Discharge Process

Medical staff

- Ensuring timely prescribing of discharge medication
- Prescribe anticipatory medications for patients under End of Life (with an End of Life care plan)
- Provide authorisation letter to the district nurse confirming details of any medications prescribed by injection or infusion pump

Ward staff

- Ensuring all discharge medication is requested for delivery at least 24hrs before discharge.
- Ensure patients transferring under End of Life (with an End of Life care plan) have anticipatory medications prescribed and dispensed accordingly.
- Ensuring that when a patient is discharged with medication prescribed via injection or an infusion pump an authorisation letter is provided to the district nurse confirming details of the prescribed medication.

Senior Nurse /Nurse in Charge has overall responsibility for:

- Ensuring every patient has a copy of the Discharge Leaflet.
- Ensuring the Discharge Checklist is complete.
- Ensuring that all patients have an EDD recorded in their notes, detailed on the patients journey and that this date has been communicated to the patient, relatives/carer, as appropriate.
- All information relating to the discharge is recorded on SystmOne
- Ensuring that systems are in place so that patient discharge is co-ordinated and progresses according to plan.

- Jointly work with the MDT to ensure review of patients at daily Board Rounds and later in the day follow up of actions
- Ensuring that information required to plan and manage patient discharges is gathered, and recorded accurately, especially in respect of conversations with the patient, their family and/or carers: including the date and times of those conversations
- Continuously monitoring the discharge progress of all patients, ensure positive action is taken to expedite discharges for those who are fit to leave an acute bed and have exceeded their EDD.
- Ensuring assessment and discharge notifications are submitted.

Ward staff are responsible for:

- Key Professional/ named nurse caring for the patient has responsibility for coordinating discharge for patients and takes responsibility for completion of discharge leading up to discharge and on day of discharge
- Key profession/ named nurse to ensure patient and family members are involved in discharge planning and kept abreast of progression
- Discharge planning commences within 24 hours of admission and that progress is appropriate to achieve the EDD.
- Assessment fit and discharge notifications are submitted
- The patient and relatives / carers are fully involved in the discharge planning process, their needs and wishes are taken into account and they have at least 24 hours notices of the discharge date, whenever possible
- In the absence of the Senior Nurse /Nurse in Charge ensure review of patients at daily Board Rounds and later in the day follow up of actions
- All information relating to the patients discharge is recorded
- Consideration of the need for continuing health care assessment for all patients with ongoing care needs before referral to Social Services using the continuing care check list.
- Ensuring all discharge medication is requested for delivery at least 24hrs before discharge. Appropriate transport arrangements are made and that all pertinent information regarding the patient's condition is given to the ambulance service transporting patients, e.g. Do Not Resuscitate (DNAR) status, infections, issues regarding transferring and in respect to manual handling. When arranging transport for discharge it is vital that the discharge address including Post Code is confirmed and checked as correct, as it may differ to the patient's home address. It is equally important to check that the patient can access their destination address, e.g. do they have a key, can they manage any steps at the property.
- Transport for bariatric patients and for property that is difficult to access must be booked 24 to 48hrs prior to discharge.
- Transport should be made via the On-Line Transport system
- Transport should only be provided for discharge when there are no family or friends to transport or for patients whom it may be unsafe for the family/friends to transport or those who require ambulance staff to assist them into their home property.
- The receiving hospital if a transfer, care home or social care facility (or community nurse team, if the patient is returning home) is notified of any known infection and the current infection control practices in place, e.g. antibiotic therapy, dressing regime, barrier nursing.
- The patient has the necessary medication, dressings and relevant information about post discharge care, this needs to be seven days including dressings are sent home with the patient.
- If appropriate wound care passport / catheter care passport to encourage effective communication regarding the wound/ catheter
- All arrangements and referrals in relation to discharge planning are clearly documented, signed and dated within SystmOne
- All necessary information for discharge/transfer of care and management is gathered, recorded and communicated appropriately

Appendix 1: The 10 Steps

The 10 steps

1. Start planning for discharge or transfer before or on admission.

2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.

3. Develop a clinical management plan for every patient within 24 hours of admission.

4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.

5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.

6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.

7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.

8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.

9. Use a discharge checklist 24–48 hours prior to transfer.

10. Make decisions to discharge and transfer patients each day.