NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and adult social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- Transfer from the ward to a designated discharge area should happen promptly; for persons on pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways. Discharge from the discharge area should happen as soon as possible and appropriate, preferably before 5pm.
- Due to COVID-19, everyone being discharged to a care home must be tested for Coronavirus and, irrespective of test result, will need to be isolated in that setting.

MEDICAL STAFF (DOCTORS)

What will I be able to stop doing?

- Detailed functional inpatient assessments prior to discharge (describe need not provision)
- Making decisions about the care people will need after discharge

All people who no longer meet the criteria to reside for inpatient care in acute hospitals should be discharged home or to a non-acute setting.

Reviews and discharge co-ordination

- At least twice daily multi-disciplinary review (consultant review at least daily) of all people in acute beds to agree who no longer meets the clinical criteria to require inpatient care and will therefore be discharged.
- Ensure clear clinical plans in medical notes to enable criteria-led discharge.
- Request immediate arrangements for discharge with a plan for virtual follow up where needed.
- Limited functional assessments should take place in an acute setting once people no longer have a medical need for inpatient care. People requiring on-going support will be discharged to assess.
- The multi-disciplinary team need to clearly describe the support people will require when they are discharged or transferred.
- Ensure that the discharge summary includes the date that COVID-19 testing was conducted and the results, if known.

Safety netting

- Patient initiated follow up. Give people the direct number of the ward they are discharged from to call back for advice. Do not suggest going back to their GP or going to the emergency department.
- If required, telephone people the following day after discharge to check on them for reassurance.
- If required, call people after discharge with the results of investigations and their management plan.
- Manage people virtually in outpatient clinics care under the same team/ speciality.
- Request community nursing follow up where appropriate.
- Request GPs to follow up in some selected cases.

Criteria led discharge

- Document clear clinical criteria for discharge that can be enacted by the appropriate junior doctor, qualified nurse or allied health professional without further consultant review.
- Ensure arrangements are in place to contact the consultant directly for clarification about small variances from the documented clinical criteria.

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- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.
- Due to COVID-19, everyone being discharged to a care home must be tested for Coronavirus and, irrespective of test result, will need to be isolated in that setting.

MATRON, WARD MANAGER (NURSE IN CHARGE)

What will I be able to stop doing?

- Detailed functional inpatient assessments prior to discharge (describe need not provision)

All people who no longer meet the criteria to reside for inpatient care in acute hospitals should be discharged home or to a non- acute setting.

What do I need to do?

- Ensure at least twice daily multi-disciplinary review (consultant review at least daily) of all people in acute beds to agree who no longer meets the clinical criteria to require inpatient care in an acute hospital and will therefore be discharged.
- Ensure every person has a clearly written plan which includes clinical and functional criteria for discharge. Make sure the plan is communicated to all multi-disciplinary team members, the person and their loved ones.
- Limited functional assessments should take place in an acute setting once people no longer meet the criteria to reside in an acute hospital. People requiring on-going support will be discharged to assess. The multi-disciplinary team need to clearly describe the support, i.e. the discharge to assess pathway, people will require when they are discharged or transferred.
- Liaise with managers of the discharge team for pathway 0 (where the person is discharged home without any support needs/requirements).
- Ensure that testing follows the latest national infection control and testing guidance and is planned in advance so that, where possible, results are available before discharge.
- Follow the system to share testing results with individuals and receiving care homes where applicable.
- During every ward round, board round or case discussion ensure the following questions are asked:
  - Does the person require the level of care that they are receiving, or can it be provided in another setting?
  - What value are we adding for the person staying in an acute hospital balanced against the risks of them being discharged home or to a non-acute setting?
  - What do they need next and what action is required?
  - 'Why not home, why not today?' for those who have not reached a point where long-term 24-hour care is required.
  - If not for discharge today, then when? Ensure there is an expected date of discharge.
  - Can a nurse or allied healthcare professional discharge the person without a further review if documented clinical criteria are met?

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MANAGERS OF THE DISCHARGE TEAM

What will I be able to stop doing?

- The guidance reduces current requirements to collect and report various forms of activity

A significant part of your work will now be co-ordinating care input and oversight in non-acute settings (mainly in people's homes).

How will I need to work differently with colleagues?

- Effective liaison with wards for pathway 0 (where the person is discharged home without any support needs/requirements).
- Close collaboration with the role of single co-ordinator for pathways 1, 2 and 3.

What will I do differently?

- Ensuring that people are assessed for short term care needs as they arrive home.
- Ensuring assessment and tracking capacity for pathways 1, 2 and 3 to ensure people are tracked and followed up to assess for long term needs at the end of the period of recovery.
- Arranging dedicated staff to support and manage people on pathway 0.

When and where will I do my work?

- You will work much more fluidly between community settings, and within the acute trust, depending on the capacity demands and learning from during the COVID-19 emergency period.
- Cover will continue to be required over 7 days, so you may find your hours of work are adjusted.

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ACUTE THERAPY TEAMS

What will I be able to stop doing?

- Detailed functional assessments for discharge
- Equipment ordering for anyone requiring ongoing input

A significant part of your work will now be in non-acute settings (mainly in people's homes).

What will I do differently?

- Limited assessments for discharge will be undertaken within award or other hospital environments/designated therapy assessment areas.

Roles could include (this is not an exhaustive list and will depend on individual skillsets):

- A single coordinator role will direct (for each person) who will take on the case management role and undertake the first assessment at home.
- Acute therapists will assess people in their own home/usual place of residence at the request of the single coordinator and agree a recovery and support plan with the person including reablement support and/or equipment.
- This will be a trusted assessment which will be accepted by the receiving care provider (agreement as to universal document to be used across acute and community services).

When and where will I do my work?

- You will work much more fluidly between community settings, people's homes and within the acute trust, depending on the capacity demands and learning from the COVID-19 Level 4 emergency.
- Cover will continue to be required over 7 days so you may find your hours of work are adjusted.

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty. If they cannot resolve your concern, please contact our Patient Experience Team on **01932 723553** or email **asp-tr.patient.advice@nhs.net**. If you remain concerned, the team can also advise upon how to make a formal complaint.

We can provide interpreters for a variety of languages, information in larger print or other formats (e.g. audio) – please call us on **01932 723553**.