Standard Operating Procedure for the Acute and Community Hospital Discharge

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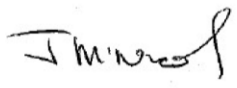
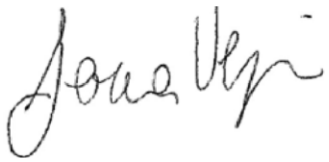
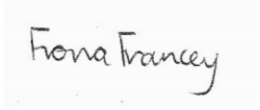
Signature: 	Signature: 	Signature: 
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Contents

Standard Operating Procedure for Acute and Community Hospital Discharge

1.0 Scope

This SOP refers to all patients within Acute and Community Hospitals being discharged from hospital to home or another residence, including a care home or nursing home, and being transferred to a Community Hospital.

2.0 Introduction

Home First challenges healthcare professionals in hospital to undergo a cultural shift and recognise that home is the best place for people to recover and rehabilitate. This approach requires hospitals to work with community partners to proactively plan a patient's discharge and jointly agree a planned date of discharge in every case as soon as possible.

When discharge of patients from hospital does not happen in a timely manner it has a negative impact on patient experience and delivery of services for that patient and families, and other patients waiting for treatments and access to hospital beds. Effective discharge will improve bed

Term	Definition

Care Management	Input from social work to enhance coordination of care providers to improve patient care and reduce the need for medical services by, eliminate duplication, and helping patients and caregivers more effectively manage health conditions.
Clinically Fit for Discharge	Point at which all members of the Multi-Disciplinary Team consider a patient to be ready for discharge.

NHS Grampian Discharge SOP availability and thereby maximise accessibility to acute services. Timely discharge requires a whole system approach working in the best interest of the individual patient and family. Working towards a Planned Discharge Date will facilitate good communication and ensure patient well-being, considering things like time of day of discharge are considered, is maintained as a focus.

People should be supported to return home where an assessment, if required, can then take place among familiar surroundings. Where the patient is clinically stable, no longer requires acute medical input, but require a period of intermediate care or rehabilitation in a step-down facility this should be arranged. The Traffic Lights Discharge Process should be utilised to support early identification of actions required to facilitate discharge.

3.0 Purpose of Document

The purpose of the SOP is to provide a clear and concise procedure for the timely discharge of patients, when they are clinically fit for discharge, out of ARI, DGH and community hospitals. The SOP will define:

- Terminology
- Principles
- Roles and responsibilities
- Process to achieve prompt discharge of patients once clinically fit including escalation
- Monitoring and review
- More information

4.0 Terminology and Definitions

Criteria Led Discharge	Criteria-led discharge is a generic term that relates to the use of discharge criteria to assist clinical decisions within agreed clinical parameters to support patient discharge from hospital. The criteria can be used in conjunction with existing care pathways to speed up the patient's discharge, as appropriate.
Discharge	When a patient no longer requires to stay in a hospital and can go home. NB. This does not refer to movement from the Emergency Department to an inpatient ward or from Critical Care to an inpatient ward.
Discharge Hub	Central point for referrals for social work input to assess patients.
Discharge Lounge	Where available, discharge lounges are used to transfer patients from wards on day of discharge whilst they await transport, medication, or completion of final paperwork.
Discharge to Assess	People are supported to return home where an assessment of care needs can take place amongst familiar surroundings.
Hospital at Home	One of a range of Intermediate Care Services, including rapid response admission avoidance, step-up / down beds, virtual wards and Enhanced Care at Home, that can provide alternatives to an acute admission, and support timely discharge home.
Intermediate Care Services	Intermediate care is provision of enhanced care services for patients who no longer require to stay in an acute hospital bed, however are not ready for discharge to their community setting.
Multidisciplinary Team (MDT)	The range of health professionals, from one or more organisations, working together to deliver comprehensive patient care.
Planned Discharge Date (PDD)	Date set within 24 hours of admission, which is reviewed throughout patients' inpatient admission, to predict when they will be discharged. This is an agreed date and plan for discharge that the multi-disciplinary team, as well as the patient, family and carers, are involved in.
Step Down	Movement from Critical Care to ward level care or to more generic, non-speciality or general, ward level care.
Step Up / Down Care	Short stay beds where rehabilitation is provided.
Transfer of Care	When care is passed from one team to another either within ARI, community hospitals, or community teams. The original paper notes should move with the patient until they are discharges at which point they should be returned to their base.

Virtual Wards	An enhanced package of healthcare, provided within a patient's own home. Whilst on the virtual ward, a patient's medical requirement can be overseen by a consultant physician, with the medical responsibility being with their own registered GP.

5.0 Key Principles of Discharge/Transfer of Care

Health and Social Care are working together, through the Home First approach, which is a simple ethos that a person's own bed is the best bed and that people will recover from illness better and faster at home.

- Patients are discharged home or transferred to a community hospital as soon as they are clinically fit for discharge home and it is safe to do so. This should include communication with all care providers where appropriate.

- A Discharge Lounge should be used, where clinically appropriate and available, to facilitate smooth discharge.

- A whole system approach is required where information is shared appropriately and at the earliest opportunity through primary care, acute services, and community hospital.

- Planning for discharge or transfer should start as early as possible by the MDT and is an integral part of the clinical pathway. At the point of admission all patients should have the initial sections of the discharge document completed using the traffic light system. Patients will be classified as: uncomplicated discharge (green); consider MDT discussion (amber) or complex discharge (red). All red pathway discharges require completion of a complex discharge document. (Annex A)

- Discharge or transfer must occur in a timely manner to ensure the best use of bed capacity across the whole system and allow patients to be supported to return home as soon as this is clinically safe.

- MDT discussion takes place to ensure that patients are cared for in the most appropriate clinical setting or discharged.

- Nurse/AHP criteria led discharge is implemented in all areas. We have to make sure we include all members of the team.

- Care Management is vital early in the patient journey where it is identified complex discharge planning is required.

- Once the patient is clinically fit and safe for discharge from hospital the patient will be discharged within four hours. This highlights the importance of completing the Core Discharge Document at the earliest opportunity to enable the pharmacy dispensary to

prepare any required take home medication packs, and hence achieve the four hour timeframe.

- Time required for the following discharge scenarios indicate the very latest time periods the activity needs to occur in relation to the Planned Discharge Date:

    - Self-caring and utilising own transport within 4 hours
    - Self-caring and utilising hospital arranged transport within 24 hours ○ Discharge to Assess (inpatients less than 7 days) or transfer Community Hospital within 24 hours
    - Discharge with restart of care at home package within 3 days ○ Discharge with new care package within 5 days ○ Discharge to supported care facility within 7 days

- Daily 09:30 System Wide Huddle to discuss whole system discharge and transfer to ensure safe optimal flow through the whole system.

- Delays should be escalated, as per escalation flow chart in Annex A, as soon as identified to aid early resolution.

- Patients and/or relatives will be involved in discharge or transfer arrangements throughout the process.

- The Scottish Ambulance Service will transfer patients from ARI to community hospitals and support discharges, where criteria for provision of SAS transport is met, using the scheduled care service. Vehicles can accommodate patients on stretchers, seated patients and patients in wheelchairs. This may be enhanced by external transport contracts both for ARI and for other sites.

6.0 Discharge Documentation

The core principle of the process is to facilitate the flow of patients throughout ARI and to support the efficient and effective discharge or transfer of care of patients who are identified as being ready to leave the acute hospital setting. This will reduce length of stay and minimise variation in practice.

This process is supported by the use of a traffic light system. This process categorises patients on admission to facilitate early identification of where additional activity, resources and multidisciplinary input are required to support discharge.

- Green – Uncomplicated discharge
- Amber – Some consideration required may need MDT input Red – Complex discharges where MDT input will be required.

7.0 Roles and Responsibilities

To achieve and maintain a strong relationship, each party should clearly understand the principles of the Operation Home 1st approach as well as the key role that they play during its implementation.

Operation Home 1st has been developed to build on what has been learnt across the health and care system in Grampian to ensure that there is a robust plan in place to deal with any future surge or demand on services, better outcomes for patients and the needs of our vulnerable populations are met.

Operation Home 1st is overseen by a steering group made up of the Chief Officers of all three HSCPs, the Chief Executives of all three Grampian Local Authorities and the Chief Executive of NHS Grampian. Together they have developed, in consultation with the Chairs and Vice Chairs of the three Integration Joint Boards, a set of principles which are:
We will adopt a principle of 'home first' for all care

- We will have a greater focus on better, evidence based, outcomes for our patients.
- We will remain flexible and agile so that should there be a surge in demand we are ready to respond.
- We will maximise digital solutions wherever we can.
- We will look at the whole person, their circumstances and supports when deciding on whether admission to hospital is required.
- We will deliver on the strategic aims of the three Integration Joint Boards (IJBs) and the NHS Grampian Board.
- We will work within the constraints of physical distancing and the needs of our 'shielded' population.
- We will work as a whole system.

As with any collaborative working, everyone needs to know their own roles and responsibilities, while respecting those of others in the team. While everyone will have distinct roles and responsibilities, it is important to work as “one team” and to work together towards agreed, shared goals with a common sense of purpose. To ensure good communication all multidisciplinary team members should be working towards using one shared record.

Home should always be the default position for people. All staff, at all points in the patient’s journey, should ask “why not home, why not today?” with the aim of returning people home without any needless delay. Staff focus on “why not home, why not tomorrow?” enables the forward planning for smooth and timeous discharge.

Patient, family and carers

- Should be fully engaged in the discharge process
- Treated as equal partners in decision making
- Should be given information, advice and support about the discharge process, including access to independent advocacy services
- Support the need for timely discharge and avoid unnecessary barriers and delays

All staff

- ☐ Initiate use of discharge documentation at point of admission (Annex A)
- ☐ Assess when someone is clinically ready for discharge (as part of MDT process)
- ☐ Support sensitive discussions around choice
- ☐ Take a positive attitude to risk
- ☐ Should be consistent in the messaging that the patient should go home and that remaining in hospital is not an option
- ☐ Ensure the involvement of family and carers in discussions about care needs at earliest opportunity so the Discharge plan begins then
- ☐ Agree a Planned Date of Discharge
- ☐ Work on discharge arrangements **towards** the discharge date and not **from** it

The Acute Medical Staff

- ☐ Assess when someone is clinically ready for discharge (as part of MDT process)
- ☐ Support sensitive discussions around choice
- ☐ Take a positive attitude to risk
- ☐ Ensure timely and accurate production of informative Core Discharge Documents
- ☐ Ensure prompt arrangements of any discharge medicines

The Primary Care Multidisciplinary Team

- ☐ Support sensitive discussions around choice
- ☐ Take a positive attitude to risk
- ☐ Ensure timely and accurate production of informative Core Discharge Documents
- ☐ Ensure prompt arrangements of any discharge medicines

Nursing staff

- Initiate use of discharge documentation at point of admission (Annex A)
- Assess when someone is clinically ready for discharge (as part of MDT process)
- Support sensitive discussions around choice
- Take a positive attitude to risk
- Ensure effective and inclusive engagement with the patient, family and carers throughout the discharge process
- Liaise with care team in primary care, as appropriate, for additional information that will support effective and safe discharge
- Senior Charge Nurse will develop expertise in discharge planning within the whole nursing team
- Ensure discharge planning starts from admission to provide high quality referrals for further assessment
- Liaise with Community Care Teams including nursing and GP as soon as possible when nursing needs are identified, particularly in the case of end-of-life care or complex care packages
- Always ensure 7 days' supply of dressings/catheter stock etc are sent with the patient

- Liaise with social care staff to ensure early notification of people who might need on-going support
- Provide information and advice to ensure people have realistic expectations of care
- Keep patients as active and stimulated as possible to avoid deconditioning through full implementation of “End PJ Paralysis” and “Fit to Sit”.
- Ensure prompt arrangements of any discharge medicines
- Ensure patients leave the hospital with any newly dispensed medicines and any medicines of their own medicines which they brought in to hospital following checking this against the CDD

Allied Health Professionals

- Initiate use of discharge documentation at point of admission (Annex A)
- Assess when someone is clinically ready for discharge (as part of MDT process)
- Support sensitive discussions around choice
- Take a positive attitude to risk
- Identify equipment needs and facilitate process to secure this
- Liaise with community teams to ensure early notification of people who might need on-going support
- Provide information and advice to ensure people have realistic expectations of care
- Keep patients as active and stimulated as possible to avoid deconditioning

Acute Hospital Pharmacy

- Initiate use of discharge documentation at point of admission (Annex A)
- Assess when someone is clinically ready for discharge (as part of MDT process)
- Support sensitive discussions around choice
- Take a positive attitude to risk
- Review Prescribing information within Core Discharge Documents including medicine reconciliation.
- Ensure take home medications are dispensed and supplied where required
- Ensure that the patient's nominated community pharmacy is informed of the patient's discharge and changes to medicines, particularly important for complex medicines and compliance aids. Note the patient must be consented for this information to be transferred.

Social care staff

- Participate in the MDT process from admission to support everything to be in place for discharge when clinically fit.
- Support sensitive discussions around choice
- Take a positive attitude to risk
- Lead responsibility for assessment and facilitating provision of on-going community support
- Ensure discharge planning starts as early in the process as possible
- Help family and carers through the process
- Ensure a reablement approach is taken and avoid unnecessary delivery of care

Transport

- Assess when someone is clinically ready for discharge (as part of MDT process)
- Support sensitive discussions around choice
- Take a positive attitude to risk
- Ensure process is in place for booking transport
- Ensure appropriate transport is available when patients are ready for discharge

8.0 Process

Hospitals and community partners' work together to proactively plan a patient's discharge and jointly agree a planned date of discharge in every case as soon as possible including use of discharge documentation. The Home First approach is linked to the "Discharge to Assess" approach. People should be supported back home where an assessment of needs can take place amongst familiar surroundings.

Some patients will move between community hospitals and Acute Hospitals. Whilst there is a move towards electronic patient records in recognition that not all records are yet electronic it is vital that

their paper records follow them to ensure continuity of care across their whole pathway. These moves should be considered transfers of care, not new admissions. It should not require an additional medical assessment therefore transfer out of hours should be facilitated.

Generic high level pathways are shown in Annex B for elective and emergency admissions.

9.0 Timeframe

9.1 Receiving hospitals/local areas must be notified as early as possible of potential to step down a patient or a patient requiring further care.

9.2 The default aim is to discharge patients home. If step down care is required the treatment reason for transfer must be identified along with the anticipated benefit of step down. Discharge to home should be the default.

9.3 As soon as it is known that a patient will be clinically fit for transfer, a request for transfer must be made to the receiving hospital/local area.

9.4 A bed will be allocated to step down patients by the receiving hospital/local area as early as possible. The transfer must take place within 48 hours of the formal request to the receiving hospital.

9.5 Transport will be requested by the ARI as soon as a bed has been allocated by the receiving hospital/local area.

9.6 All requests for Scottish Ambulance Transport must be made by 12 noon the day prior to transfer. The Scottish Ambulance Service cannot guarantee same day transport for short notice requests.

10.0 Delays to Discharge and Escalation

To deliver a Home First ethos a whole system approach is required underpinned by processes that support communication to enable prompt action and prevent delays. Communication should be through daily system wide meetings coordinating delays and through Chief Officers as the highest escalation point. Each area has processes in place to support this.

11.0 Monitoring and Review

11.1 The System Wide daily meeting will provide a report to the relevant clinical governance committees at the end of each month with details of all delayed discharges and the reason for delay. The discharge hub should have an awareness of upcoming complex cases and record of all patients who are clinically fit for discharge but delayed. This can be communicated through the use of the discharge documentation traffic light system.

11.2 Discharge Leads are asked to put in place a system for monitoring daily the number of clinically fit for discharge patients that are waiting for a bed in their community

hospital or a step down care provider. This should be made available to the relevant Discharge Lead.

11.3 All delayed discharge DATIX forms will be reviewed by the relevant Discharge Governance Lead and reported to the Clinical Governance meeting.

11.4 This SOP will be reviewed in six months.

12.0 Glossary

ARI Aberdeen Royal Infirmary
CDD Core Discharge Document
DGH Dr Gray's Hospital
IJB Integrated Joint Board
MDT Multi-Disciplinary Team
SAS Scottish Ambulance Service
SOP Standard Operating Procedure

13.0 Group Membership

This SOP was developed with whole system MDT input. Membership is as detailed below:

Name	Role	Representing
Ms Jenny McNicol (Chair of Group)	Associate Director of Nursing and Midwifery for Acute	Acute
Mrs Fiona Abbott	Service Manager, Discharge Hub and Site and Capacity	Acute
Dr Elspeth Aspinall	GP	Aberdeen City IJB
Mrs Catherine Bonnar	Senior Charge Nurse	Acute
Mrs Maya Cross	Senior Charge Nurse	Aberdeenshire IJB
Mrs Kim Cruttenden	Principle Pharmacist	Acute
Ms Joanne Duncan	Quality Improvement & Performance Manager	Dr Gray's
Mrs Jill Ferbrache	Excellence in Care Lead	Corporate
Mrs Frances Ferguson	Clinical Pharmacist	Acute
Mrs Wendy Greenstreet	Lead AHP Acute, Head of Occupational Therapy	Acute
Dr Caroline Howarth	GP	Aberdeen City
Mrs Denise Johnson	Team Leader, Acute Care at Home	Aberdeen City IJB
Mrs Ruth Jones	Nurse Manager	Acute
Mr Kapil Kumar	Consultant Surgeon, Unit Clinical Director	Acute

Dr Robert Laing	Consultant Physician, Unit Clinical Director	Acute
Mrs Anna Mark	Service Manager - Out Of Hours - Nursing	Aberdeen City IJB
Mrs Jill Matthew	Location Inverurie	Aberdeenshire IJB
Dr Denise McFarlane	GP, Director of Primary Care for COVID-19	Corporate
Mrs Linda Oldroyd	Chief Nurse	Acute
Mrs Alison Pirie	Nurse Manager	Acute
Ms Dorothy Ross-Archer	Service Improvement Manager	Dr Gray's
Mrs Lisa Scott	Senior Charge Nurse	Acute
Mrs Lorna Stephen	Senior Charge Nurse	Acute
Mrs Jacqueline Sutherland	Flow Co-ordinator	Acute
Mr Sandy Thomson	Lead Pharmacist	Acute
Dr Ivan Tonna	Consultant Physician, Unit Clinical Director	Acute
Mrs Sandra Whyte	Senior Charge Nurse	Acute
Mr Bruce Wilkie	Principle Pharmacist Supply	Acute
Mrs Cathy Young	Head of Transformation for Acute	Acute

Replaces: First Version

Lead Author/Co-ordinator:

Responsibilities of the Lead Author/Co-ordinator

- Ensuring registration of this document on Document and Information Silo
- Disseminating document as per distribution list
- Retaining the master copy of this document
- Reviewing document in advance of review date

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Document application: NHS Grampian

Purpose/description: SOP for Acute and Community Hospital Discharge

Policy statement:
It is the responsibility of all staff to ensure that they are working to the most up to date and relevant clinical process documents.

Responsibilities for implementation:

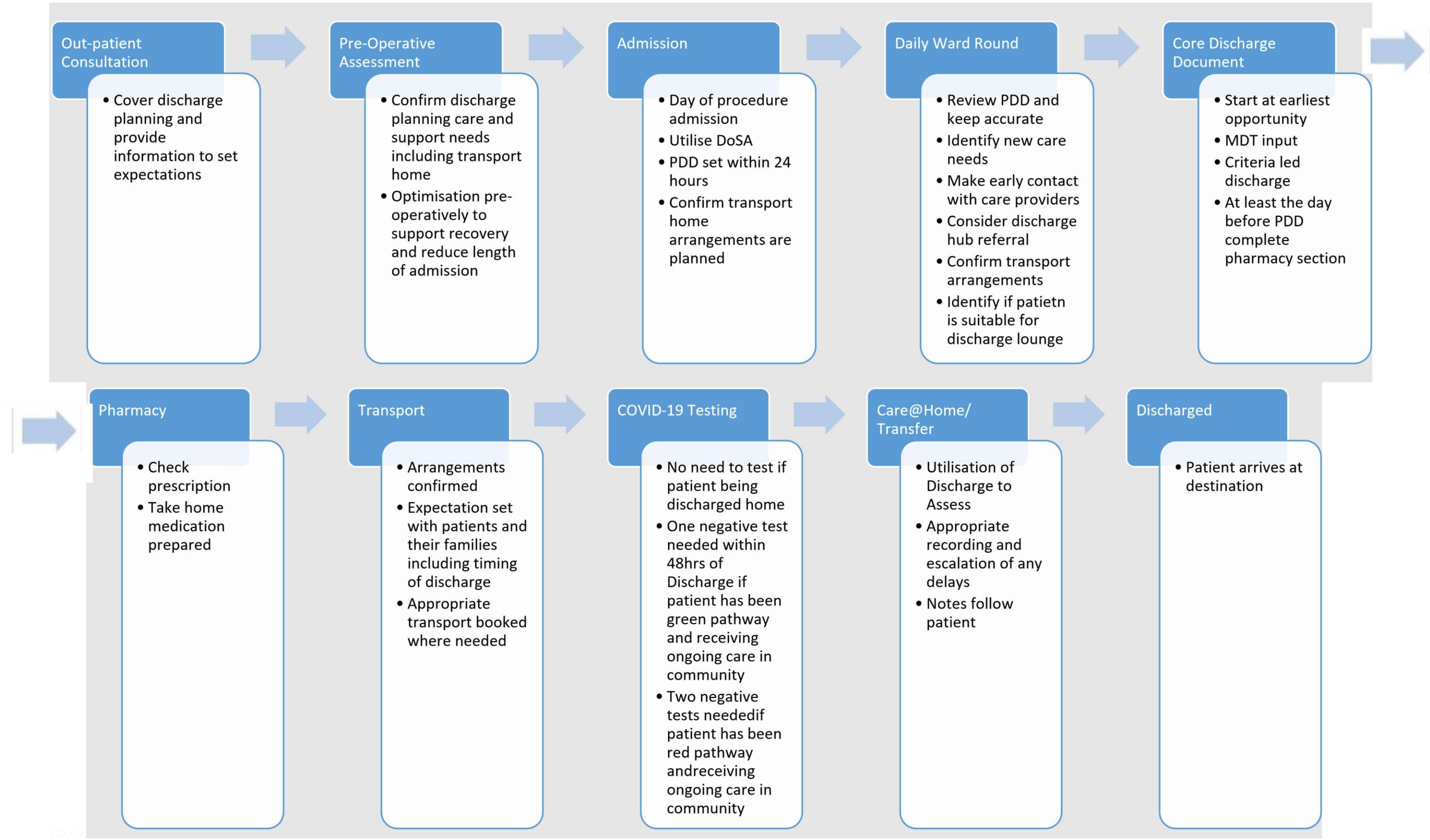
Organisational:	Operational Management Team and Chief Executive
Sector	Chief Officer , Medical Leads and Nursing Leads
Departmental:	Nurse Managers, UOMs, Area Managers
Area:	Senior Charge Nurses

Review frequency and date of next review:	6 monthly

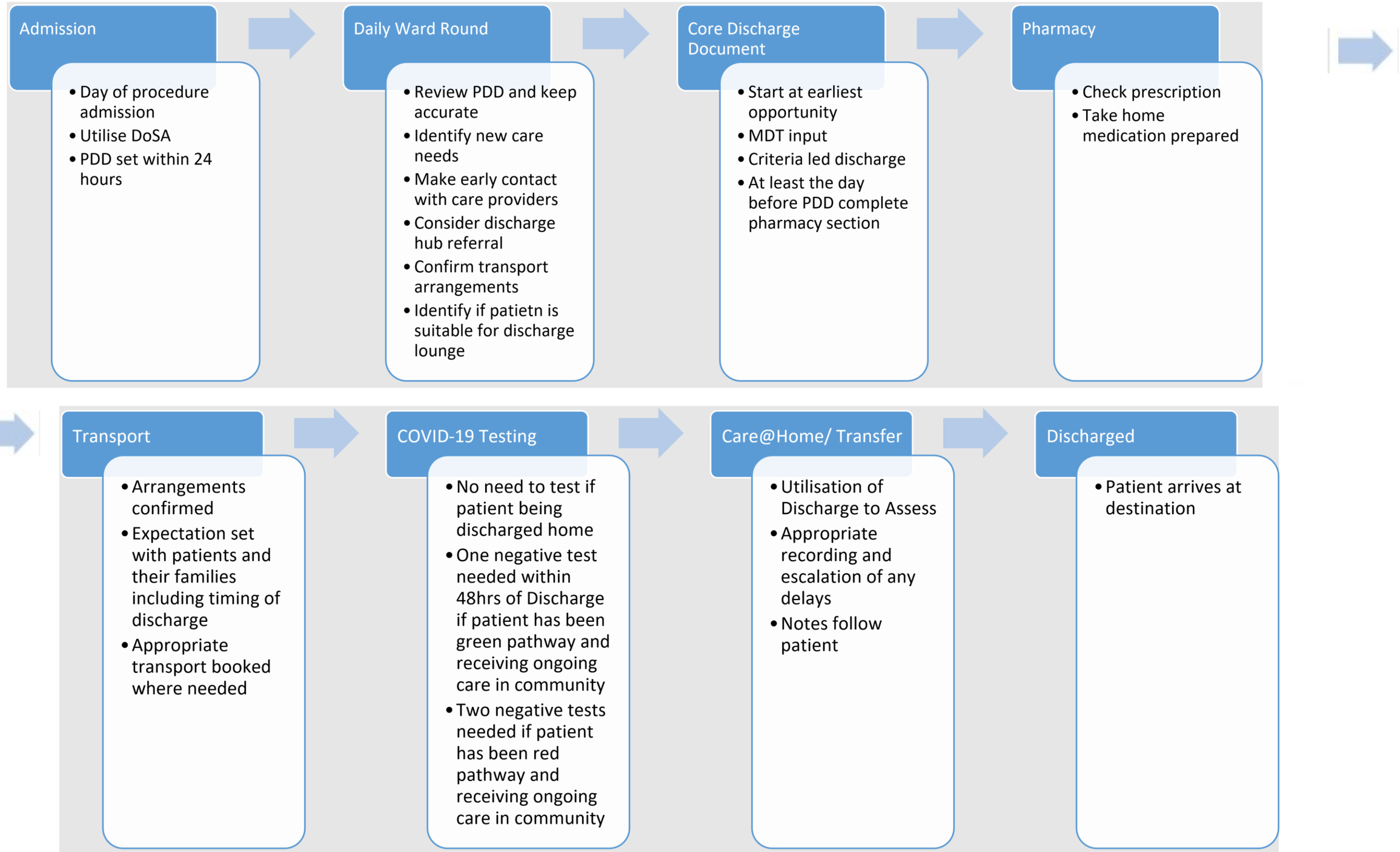
Revision History:

Revision Date	**Previous Revision Date**	**Summary of Changes (Descriptive summary of the changes made)**	**Changes Marked (Identify page numbers and section heading)**

Annex A - Elective Admission



Annex B - Emergency Admission



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