NHS
Sheffield Health and Social Care
NHS Foundation Trust

Policy:

OPS 016 - Inpatient Discharge Policy

Executive Director Lead	Director of Operations
Policy Owner	Nurse Consultant
Policy Author	Nurse Consultant

Document Type	Policy
Document Version Number	V5
Date of Ratification	27/07/2020
Ratified By	Quality Assurance Committee (QAC)
Date of Issue	05/08/2020
Date for Review	30/09/2023 extension from 31/07/2023

Summary of Policy
This policy covers the discharge of service users from Inpatient Wards within all SHSC mental health and learning disability services.

Target audience	Service Directors, Operational managers of clinical teams Clinical Leads and Clinical staff working in inpatient areas.

Keywords	Discharge, inpatient, patient, service user

Storage

Version 5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (v4 November 2016). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Contents

Section		Page
	Version Control and Amendment Log	
	Flow Chart *(not applicable)*	
1	Introduction	1
2	Scope	1
3	Purpose	1
4	Definitions	2
5	Details of the policy	2
6	Duties	2
7	Procedure	2
	7.1 Standards for Discharge	2
	7.2 Information/ documentation to be provided to the service user when being discharged	3
	7.3 Information/documentation to be provided to the receiving healthcare professional	4
	7.4 Unplanned discharge, and discharge outside normal hours	4
	7.5 Disputes	4
	7.6 Unplanned Discharge, and Discharge outside normal hours	5
	7.7 Out of Area Placements	6
8	Development, consultation and approval	6
9	Audit, monitoring and review	7
10	Implementation plan	8
11	Dissemination, storage and archiving (control)	8
12	Training and other resource implications	9
13	Links to other policies, standards, references, legislation and national guidance	9
14	References	9
15	Contact details	10
	APPENDICES	
	Appendix A - Equality Impact Assessment Process and Record for Written Policies	11
	Appendix B. Discharge Best Practice guidance	13

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
4 D0.1	Initial draft developed on new policy template.	Oct 2016	Full review undertaken.
4.0	Ratification / issue	Nov 2016	Ratification / finalisation / issue.
5.0	Review	July 2020	Full review undertaken

1 Introduction

Discharge planning is essential to ensure that patients leaving inpatient care have the best chance of recovery and appropriate services in place to meet their needs and continue their journey to recovery.

Poor discharge planning can result in:

- Adverse consequences for the service user or their carers or relatives;
- The failure of support arrangements;
- Untoward delays in being discharged and over-long inpatient stays.
- An early return to hospital;

Delays to discharge may have the following adverse affects:

- The service user loses contact with their social support and friends;
- Independent accommodation may become increasingly at risk and difficult to access;
- Loss of social function and independent living skills;
- Possible financial implications for the service user or their relatives through the reduction or loss of benefits or even loss of employment;
- Inpatient resources are not available to be used by the other service users who may need them.

2 Scope

This policy applies to all clinical staff working on inpatient wards.

This policy covers the discharge of service users from Inpatient Wards within all SHSC mental health and learning disability services. It is not intended to cover the arrangements for non-hospital accommodation provided or managed by Sheffield Health & Social Care Trust.

Adult Mental Health, Older Adults, Learning Disability Services and Substance Misuse Services will have specific care pathways setting standards for discharge planning and arrangements according to the specific needs of different service user. These must be referred to for detailed standards.

3 Purpose

To clarify the standards which clinical teams should work to, to ensure that discharge from inpatient care is:

- Collaborative
- Safe and effective;
- Timely and neither premature or unduly delayed;
- Properly planned.

4 Definitions

Discharge refers to the end of an inpatient episode of care within SHSC Trust. These include the service user' own home or to a carers home, to a Nursing or Residential home, supported living or another NHS hospital or Private sector hospital.

It does not cover transfer from one ward to another within a Care Network Within SHSC Trust, transfer to another ward in a different Care Network within SHSC Trust, or transfer to Inpatient care in another hospital or Trust.

5 Detail of The Policy

This policy covers the discharge of service users from Inpatient Wards within all SHSC mental health and learning disability services.

6 Duties

Consultant medical staff with responsibilities for in-patients hold ultimate responsibility for decisions on discharge from inpatient care, but must take account of the judgement and opinions of their colleagues in the multidisciplinary team, as well as the views of the service user and their carers or relatives.

The duties of different staff groups within clinical teams with respect to discharge should be identified by the service and team leadership, according to the needs of individual patients and the normal operational duties within the inpatient, and other relevant clinical teams.

7 Procedure

7.1 Standards for Discharge

The MDT meeting in collaboration with the patient is to identify what might be needed such as social work or care co-ordinator referral, housing repairs, support or any other issues alongside their mental health needs.

An estimated discharge date must be set at the first MDT and reviewed every week thereafter.

The purpose of admission is to be clarified by the Home Treatment Team (HTT) and/or Community Mental Health Team (CMHT), this should include any specific treatment and care plan recommendations as well as highlighting issues in the community (social/practical) or at the service user's place of residence that need addressing prior to discharge. This should be recorded on Insight.

All patients should have an agreed discharge plan which has been developed with the involvement of:

- The Multi Disciplinary Team
- The patient / service user;
- Carers or relatives as appropriate;
- Home treatment team as appropriate

- The relevant Community Mental Health Team including the Care Coordinator where the service user is allocated one;
- The housing provider or hospital team the service user is being discharged to
- GP / Primary Care Mental Health service
- Secondary care physical health care team.
- Other relevant agencies, e.g. Probation, Housing, charities or social enterprises

The discharge plan should:

- Be considered and commence development as soon as in-patient care episode begins utilising the collaborative care plan or service specific care planning.
- Be developed in collaboration with patients and their carers and family
- Be individual to the service user, reflecting their choices as far as possible
- Be made available in a format which is accessible for the service user and their carers/family, e.g. in an appropriate language. This may be a print-out from Insight system, an interpreted plan into patients own language or in pictorial form.
- Be consistent with and developed within the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working;
- Be developed with the involvement of advocacy services where service users / patients request their help or lack capacity to engage in the process or decision-making;
- Consider statutory requirements including Mental Health Act (1983) and Mental Capacity Act provisions, e.g. Section 117, CTO arrangements, capacity assessments and Best Interest meetings.
- Include leave plans in preparation for discharge that incorporates the service user maintaining or establishing links with the community
- Should have a clearly identified risk management plan for any identified risks of concern including suicide risk.
- Consider involvement of the Quit teams (Smoke free)
- Identify the roles and responsibilities of people involved for each part of the plan; and identify a named co-ordinator of these care arrangements.

Please refer to the discharge checklist in Appendix 1

7.2 Information/Documentation to be provided to the service user when being discharged

- A copy of the discharge plan will be given to the service user at the point of discharge. It will include: arrangements for the next appointment or contact with services, information about medication, information about strategies and tools that had supported recovery and information necessary to enable the service user or carers to attend future appointments or otherwise access the services;
- Information for the services user and their carers or relatives to access help and support in the event of crises;
- The discharge plan, together with confirmation who this has been communicated to and that a copy has been provided to the service user will be recorded on Insight.

7.3 Information/Documentation to be provided to the receiving healthcare professional

- An e-discharge summary which includes a summary of the patients progress and relevant mental and physical health care and treatment on the ward, risks and management plan and their medication will be completed and sent **with 24hours** of discharge to the service user's GP, and all others involved in the onward care of the service user, e.g. accommodation providers, community teams, primary care services, secondary physical health care services, probation, other support services or agencies as appropriate.
- For SHSC staff, the e-discharge summary can be accessed through Insight
- The e-discharge summary, together with confirmation that this has been communicated to and a copy provided to the receiving healthcare professional/other service/agency will be recorded on Insight.

7.4 Medication

- Discharge medications needs to be ordered with as much notice as possible to give pharmacy time to dispense the discharge medication in time for the discharge.
- Detail required on order – amount of medication, depot information, where and who is taking responsibility for prescribing, dispensing and administration as appropriate.
- Discharge medication is normally prescribed for 14 days, however each individual service user should have a supply amount clearly written as there maybe individual variations which should be documented on Insight and in the e-discharge summary, examples below;
  a) Service users with identified risk of self harm or suicide may have the amounts of medication ordered reduced. This will be according to the risk management plan or where there is an identified team or individual that will be taking responsibility for storing and administering the medication on discharge
  b) Clozapine – 31 days supply, the order needs to include where they are having bloods tests taken and how often.
- Where a need for a compliance aid has been identified this should be discussed with the ward pharmacist as early as possible. Determining if the prescribed medication can go in the requested aid and identifying a chemist that will dispense using the requested compliance aid. Where agreed pharmacy require 48hrs notice for the discharge order.

7.5 Early discharge and follow up following discharge

Home Treatment Team (HTT)

Follow up

- HTT provides 72 hour follow up for every service user discharged from the inpatient wards into the community.

Inpatient interface

- Mon – Fri 9-5pm the duty HTT interface nurse will visit the wards a few times a week to discuss all service users and review all the service users identified for early discharge with HTT.
- HTT referrals can also be made directly to the interface nurses outside of ward visits.
- After a decision is made for a service user to be discharged with HTT the interface

nurse will meet with the service user and also speak to relatives/carers regarding leave arrangements, discharge plans, the role of the HTT and contact on discharge
- As part of the interface, first contact on discharge will be planned and arranged.
- HTT can support step down placements to facilitate early discharges or minimise delays in discharge from inpatient wards.

- The Older adult HTT provide follow up within the 72 hour window following discharge where appropriate, and can be referred into using Trust referral process or via an identified interface nurse where assigned.
  Once a discharge referral to them has been made a representative will visit the ward and complete the OAHTT assessment of need to ascertain as to whether the referral is suitable for the service, or if referral onwards is needed. Following an accepted referral, the OAHTT commence liaison with the ward, relatives and carers regarding individual needs and care pathway on discharge.

Stepdown

Wainwright Crescent (WWC) is an 11 bed step down facility within SHSC for adults over the age of 18. It facilitates early discharge and or minimises delays in discharge from inpatient wards offering a transitional period before service users returning home or supports service users who are require rehousing or supported accommodation.

WWC gatekeeps its own beds. Referrals are to be completed by the inpatient ward staff, all service users referred are to undertake a site visit, have a referral meeting with WWC staff and agree to the service user contract.
WWC discharge facilitator can reach into inpatient wards to support the smooth discharge of service users.

Complex/Challenging/Delayed discharges
If a patient is identified as no longer requiring in patient care and treatment and there are anticipated delays in discharge alternative discharge plans are to be explored with:

- Case Complex Reviews
- Complex/ Challenging and Delayed Discharge Meeting
- Care Network Directors/Senior managers

7.6 Unplanned Discharge, and Discharge outside normal hours

There will be occasions where service users wish to discharge themselves from inpatient care which can be facilitated unless they are subject to or requiring detention under the Mental Health Act. There will also be situations where service users do not return from leave, also consider these points alongside the Missing Patient procedure if appropriate. Refer to Missing Persons Policy.

In both these circumstances, discharge plans may not have been fully completed.
In these situations, the following must be considered:
- Appropriate arrangements for medication see SHSC Pharmacy Out Of hours medication supply guidance about ordering discharge medication from Pharmacy at Northern General Hospital, Sheffield Teaching Hospitals.

- Arrangements for communicating as soon as possible with relatives or carers and community services or teams or outside agencies (e.g. Police Secondary care physical health teams, probation etc) who need to be aware;
- Multi-disciplinary review at the earliest opportunity to consider further plans;
- The consideration of 'leave' rather than discharge;
- The consideration of Home Treatment referral:
- The provision of written information for the client and their carers or relatives appropriate, regarding arrangements for follow-up.

7.7 Out of Area Placements

Short term acute placements – weekly review by Flow coordinator and Care – co-ordinator or relevant CMHT

Long term Rehab or Secure care placement – a review (visit /contact) every 6-8 weeks as per NHS England guidance by care co-ordinator or nominated individual at time of placement agreement. If any concerns safe and well checks to be completed regularly.

7.8 Disputes

Discharges should not occur until there are clearly agreed arrangements as above which address identified risk. Guidance on the resolution of clinical disputes should be consulted and used where there are clear professional disagreements about discharge arrangements.

Inpatient teams should raise any concerns or problems relating to the implementation of this policy either generally or in relation to specific patients with their Directors

Refer to Clinical dispute policy

8 Development, Consultation and Approval

- Consultation email sent to all key stakeholders 29/01/2020
- Draft sent for final comments 24/06/2020

9 Audit, Monitoring And Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Implementation	Review	Clinical Operations	Annual	Clinical Operations	Clinical Operations	Quality Assurance Committee
Discharge Collaborative Care plan	Audit	Ward manager	Bi-monthly	Senior Operational Managers	Clinical Operations-Network	Clinical Operations
72hr Follow up	Audit	Senior Operational Manager/Clinical Leads	Quarterly	Clinical Operations - Network	Clinical Operations	

This policy will be reviewed by July 2023

10 Implementation Plan

Local governance systems should be used to implement the inpatient discharge policy.

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust Website	Director of Corporate Governance	5 days	05/08/2020
Communication to be sent to all staff via Connect	Director of Corporate Governance	5 days	06/08/2020
Communication to be sent to Crisis and Emergency Network and Planned and Scheduled Network for dissemination	Director of Corporate Governance	5 days	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	5 days	

11 Dissemination, Storage And Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
V4 D0.1	Oct 2016	Oct 2016		
4.0	Nov 2016	Nov 2016		
5.0	05/08/2020	05/08/2020	06/08/2020	-

12 Training and Other Resource Implications

To be included in local induction

13 Links To Other Policies, Standards

MD 013 Medicines Optimisation Policy - Risks and Processes (Formerly Medicines Management Policy Risks and Processes)
Missing Absent Without Leave and Missing Patients
Records Management Policy

14 References

Care Services Improvement Partnership: National Institute for Mental Health in England (2006) 10 High Impact Changes for Mental Health Services
www.nimhe.csip.org.uk/10highimpactchanges

Care Services Improvement Partnership: National Institute for Mental Health in England (2007) A Positive Outlook – a good practice discharge toolkit to improve discharge from inpatient mental health care

Department of Health (2004)
Achieving timely 'simple' discharge from hospital: A toolkit for the multidisciplinary team
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088366

Department of Health (2003)
Discharge from hospital, pathways, process and practice

Department of Health (2006)
Dual diagnosis in mental health inpatient and day hospital settings

Department of Health (2005)
Everybody's Business: A service development guide for older people with mental health needs

Department of Health (2005)
Independence, Well being and Choice

Department of Health (2006)
Our Health, Our Care, Our Say: A new direction for community services

Department of Health (2006) Reviewing the Care Programme Approach
www.nimhe.csip.org.uk/cpa

Leaving Hospital and Minds: Briefing on discharge from Inpatient mental health services December 2017
https://www.mind.org.uk/media-a/4376/leaving-hospital-minds-good-practice-briefing.pdf

Mental Capacity Act and Code of Practice 2006 Advance Directives
http://www.dca.gov.uk/legalpolicy/mentalcapacity/guidance.htm

Mental Health Act 1983 and 2015 Code of Practice
http://mhact.csip.org.uk/

Transition between inpatient mental health settings and community or care home settings. NICE guideline [NG53] Published date: 30 August 2016 https://www.nice.org.uk/guidance/ng53/resources/transition-between-inpatient-mental-health-settings-and-community-or-care-home-settings-pdf-1837511615941

Transition between inpatient mental health settings and community or care home settings. Quality standard [QS159] Published date: 12 September 2017 https://www.nice.org.uk/guidance/qs159

15 Contact Details

Title	***Name***	***Phone***	***Email***
Nurse Consultant	Adelaide Chibanda	0114 3050743	adelaide.chibanda@shsc.nhs.uk

Appendix A

Equality Impact Assessment

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**	**No**	**No**
Disability	**No**	**No**	**No**
Gender Reassignment	**No**	**No**	**No**
Pregnancy and Maternity	**No**	**No**	**No**
Race	**No**	**No**	**No**
Religion or Belief	**No**	**No**	**No**
Sex	**No**	**No**	**No**

Sexual Orientation	**No**	**No**	**No**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended

Impact Assessment Completed by: Adelaide Chibanda
Name /Date July 2020

Appendix B. Discharge Best Practice guidance

Discharge Checklist
Identify discharge planning needs at MDT in collaboration with patient and set estimated date of discharge
Discharge collaborative care plan to be completed in collaboration with service user, carers and other healthcare or service providers as appropriate.
Contact with or referral to services and agencies which will be involved with ongoing care and support after discharge;
Review social care assessment requirement, including confirmation of continuing or newly funded service provision;
Review need for functional assessment either on wards or in the community.
Review any finance and benefits needs and refer to advocacy or discharge co-ordinators or facilitators as needed.
Professionals meetings and complex cases arrange meetings or escalate concerns in a timely manner
Consider and make arrangements for the management of any physical health conditions or needs
Consider and make arrangements for the management of risk and any community safety concerns
Consider and make arrangements for the management of the risks of substance misuse
Any issues relating to children who may normally live with the service user or for whom the service user has parental responsibilities;
Ensuring that accommodation is appropriate at the time of the discharge e.g. utilities connected;
Ensure discharge medication and compliance aids are ordered from Pharmacy within recommended timescales
The provision of information in an appropriate format outlining the care plan, information about medication, and information necessary to enable the service user or carers to attend future appointments or otherwise access the services;
Information for the services user and their carers or relatives to access help and support in the event of crises
Ensure follow up appointments are booked
Communicating the discharge plan to others, including accommodation providers, primary care staff, community support, or other services or agencies;
Make arrangements for transport where appropriate.
The return of valuables, possessions, and monies held for safe keeping during
Complete e-discharge summary and send off within 24hours of discharge.
Inform HTT and Flow co-ordinators of discharge