Adult Discharge and Transfer of Care Policy

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<td>Inclusion of a section relating to assessment of escort need, exemptions where they apply and Appendix 16 which is the documentation to be used for appropriate inter-department transfers.</td>
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Equality Impact

Bolton NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare Bolton NHS FT aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Assessment (EIA).
Adult Discharge & Transfer of Care Policy
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1. **Purpose & Scope**

This is the jointly agreed policy for Bolton NHS Foundation Trust and the Adult Social Care Department at Bolton Metropolitan Borough Council.

This policy applies to all adult in-patients in the Trust, which includes Accident & Emergency, all Adult Acute wards, all Elective Care wards, the Gynaecology ward and Darley Court.

For the purpose of this policy adult care is defined as anyone over the age of sixteen. There are separate discharge policies for the Family Care Division.

2. **Introduction**

2.1. Admissions to and transfer from hospital can be a distressing time for individuals, their families and friends. For most people, however, treatment will be successful and they will return to their usual way of life very quickly, but some people will need additional help to enable them to do so over and above their medical treatment. These needs can be varied and cannot be met by the NHS alone.

2.2. Effective discharge and transfer of care can only be achieved when there is good joint working between the NHS, local authorities, housing organisations, and the independent and voluntary sectors.

3. **Background & Policy Context**

3.1. The Community Care Delayed Discharge Act (2003) introduced statutory legislation on how hospitals and local authorities should work together to avoid unnecessary hospital admissions or delayed discharges.

3.2. Other relevant policies and legislation such as Carers Recognition and Services Act (2000), National Framework for NHS Continuing Health Care & NHS Funded Nursing Care (2009), Mental Capacity Act (2005) and NHS Act (2006) give consistent and strong messages of the need for statutory and independent agencies to work together with their local communities to plan, commission and deliver services.

3.3. Equally there is a clear expectation that those individuals, who require services and their carer’s will be actively and fully, informed participants in the assessment, planning and delivery of health and social care.

3.4. Although patient choice is considered extremely important, patients who have been assessed as not requiring NHS in-patient care, do not have the right to occupy, indefinitely, an NHS bed (with the exception of a very small number of cases where a patient is being placed under Part II of the Mental Health Act 1983).

4. **Aims of the Policy**

4.1. This policy sets standards which are based on the principle that discharge and transfer of care is a planned process carried out in a multi-disciplinary setting in which the patient is central. The policy aims to reduce unnecessary delays in discharge and transfer of care as
well as supporting patient’s, their carer’s and staff in setting realistic expectations for hospital and intermediate care stay and improving communication of relevant information to patients and carers.

5. **Key Principles**

5.1. Discharge and transfer of patients from services is a process, not an isolated event. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital or intermediate care to an appropriate setting. The individuals concerned and their carer(s) should be involved at all stages and kept fully informed by regular reviews and updates of the care plan.

5.2. The process of discharge should be co-ordinated by a named person usually a nurse who has responsibility for coordinating all stages of the patients progress. This involves liaison with those involved in the individuals care and those who need to be involved in the future at the earliest opportunity and agree the transfer of those responsibilities.

5.3. Planning for discharge and transfer of care is part of an ongoing process that should start prior to admission for planned admissions, and as soon as possible for all other admissions to services.

6. **Involving Patients & Carers**

6.1. Patients and their carer(s) should be actively involved in the discharge and transfer of care planning, and be given an estimated date for this.

6.2. Patients should be given written information on diagnosis, treatment, and any support arrangements in place on transfer.

6.3. Patients should have a named person to contact for any support and advice with details of contact numbers. This will usually be the social worker.

6.4. Patients should be given information on eligibility criteria for NHS Continuing Health Care.

6.5. Patients should be given a copy of the transfer of care letter (if appropriate) on the day of discharge and a copy of the Trusts Leaving Hospital Information Leaflet (Appendix 1).

7. **Definitions**

7.1. To enable practitioners to ensure safe and timely effective discharge and transfer of patients, the following definitions have been agreed:

Simple discharge/transfers include patients who have simple ongoing care needs which do not require complex planning and delivery, for example:

- Require no support on discharge/transfer
- Going home with no ongoing support/informal support
- Need time limited support from one agency
- Are returning to same level of support and have not been in hospital for more than three
days
Do not need care in a residential setting.

Complex discharge/transfers include patients who

- Have complex ongoing health and social care needs which require detailed assessment, planning and delivery by the MDT
- Need ongoing support from Multi-disciplinary team on discharge
- Have NHS Continuing Health Care needs
- Newly assessed as needing care in a residential/nursing setting
- Need stepping up in the level of intensity of care (i.e. residential to nursing home or significant increases to care packages in the community)
- On the End of Life Care Pathway (LCP) discharges.
- Overseas visitors

7.2 The definition of medically safe is as follows:

A hospital inpatient is medically safe to discharge when they are clinically ready to move on to a more appropriate care setting. This is determined by the consultant/clinical specialist responsible for the inpatient medical care in consultation with all agencies involved in planning the patients discharge. The team must be satisfied that it is safe and reasonable to discharge the patient.

7.3. A patient who continues to occupy a hospital bed after he/she is ready for discharge after the agreed discharge date and during the same inpatient episode is a delayed discharge.

7.4. Patients with simple discharge needs will be assessed as medically safe by the medical team caring for the patient and this should be documented in the patient’s medical notes.

7.5. For patients with complex discharge or transfer of care needs decisions of medically safe for discharge must be a consensual decision with other members of the multi-disciplinary team and must incorporate the timescales required to complete any assessments and arrangements required to set up support packages for discharge. This should be recorded in the patient’s medical record.

7.6. All patients with complex discharge of care needs must be considered for screening for eligibility for NHS Continuing Health Care prior to any plans. Please complete NHS Healthcare Checklist available from Discharge Coordinators. The screening checklist should be completed as early as possible in the patient’s journey. The appropriate social worker must be involved in the screening process.

7.7. The definition of the Multidisciplinary Team (MDT) is as follows:

The MDT comprises a range of health and social care professionals involved in an ongoing process and continuous cycle of collecting information to inform the discharge process. Effective MDT working will prevent some of the problems experienced by patients and their carers when being transferred from services.
7.8. The nurse should refer patients to the relevant MDT members to facilitate timely and effective discharge planning.

8. **Patients with Special Needs**

**Patients with physical disabilities**

8.1. If a patient is admitted to hospital or community bed based services with a physical disability the nurse should ensure a referral to the appropriate social worker is made.

8.2. The nurse should liaise with community health and social care colleagues known to the patient regarding management of the patient whilst in their care. When preparing for discharge the Occupational Therapist will refer any appropriate patients to the Community Disability Team for any equipment needed.

**Patients with Learning Disabilities**

8.3. Patients with Learning Disabilities may have particular needs and will need additional help and support when planning for discharge. Where possible a pre-discharge planning meeting should be arranged with the appropriate community staff.

8.4. The hospital based Learning Disability Liaison Nurse should be contacted for advice and to provide support for individual patients in hospital and where possible should be involved in the transfer planning process. For community service patients refer to Adult Social Care Team.

**Patients with mental health problems**

8.5 Patients admitted to A&E with acute mental health needs should be referred to the on call Mental Health Team. For inpatient wards including assessment wards staff should contact the on call psychiatrist.

8.6. For elderly patients with complex mental health needs consider referral to the Mental Health Liaison Service. The Mental Health Liaison Nurse can be contacted for advice/support and will assist with planning packages of care and referral of patients to the Liaison Psychiatrist.

8.7. Patients who may need a Community Psychiatric Nurse (C.P.N.) assessment to establish if they require EMI nursing care will be referred by the social worker.

**Patients with Palliative Care needs**

8.8. Patients should be referred to the Palliative Care Team if they need specialist support such as symptom control or pain management as early as possible.

8.9. Patients with palliative care needs should be screened for NHS Continuing Health Care prior to any plans for discharge or transfer. For patients who need to be fast tracked home on the NHS Continuing Care Pathway a discharge planning meeting must be arranged involving the relevant District Nursing Team / District Nurse Liaison Team.
8.10. Patients with progressive, life-threatening illness often have complex needs. The information, support and care needs of the patient and the family/carer should be continually reviewed and form an integral part of the discharge planning process.

**Patients with Dementia**

8.11. People with dementia respond best in environments that are familiar with the least disruption to their usual routines. Admission to hospital or intermediate care services should be avoided unless absolutely necessary.

8.12. Transfers should be kept to the absolute minimum and where possible should only happen when this is appropriate to the care of the person with dementia e.g. for assessment and not for organisational reasons.

8.13. Any moves should be identified in a timely manner, and not in response to a bed crisis. The move should take place during the day, preferably late morning and not between 8pm and 8am. Patients with dementia should not be discharged back to care homes later than 9pm.

**Homeless People or No Fixed Abode**

8.15. If a patient is homeless or living in temporary accommodation and they are likely to need community support on discharge they should be referred to the social work team immediately.

8.16. For these individuals admission to hospital presents an opportunity to deal with underlying medical, social and mental health problems and address accommodation needs.

8.17. On admission ask every patient for their address, and whether this is the address they expect to return to. Check if the patient comes from Greater Manchester and why they may be homeless. If the patient has no accommodation, or it is not clear that they can return to the address they gave, ask the following questions before deciding what to do next:

- Does the patient come from Greater Manchester or wish to be in Greater Manchester?
- If they had a home before coming into hospital, why are they not able to go back there?
- If the patient is homeless and needs help to find somewhere in Greater Manchester, contact the Social Worker.

**Asylum Seekers/Refugees**

8.18. Asylum seekers who have not yet got their refugee status sorted out are accommodated by a range of providers. The best contact point is the Asylum Support Service on 0845 602 1739.

8.19. Asylum seekers whose application for asylum has failed cannot be housed through council or other public sector housing. Families are supported by Asylum Support but single people may have no accommodation. Contact either Refugee Action, Greater Manchester: 0161 831 5420 [http://www.refugee-action.org.uk/manchester/default.aspx](http://www.refugee-action.org.uk/manchester/default.aspx) or Social Services for advice.
8.20. Asylum seekers who are unaccompanied minors are looked after by the relevant Social Services Unaccompanied Minors or go
http://www.refugeeaction.org.uk/manchester/default.aspx

8.21. Refugees are entitled to apply for housing in the same way as any other households. They may be supported through Refugee Action on 0161 831 5420 or by visiting the website http://www.refugee-action.org.uk/manchester/default.aspx or by the relevant Housing Options Service.

**Patients who lack mental capacity to make safe discharge decisions**

8.22. If a patient is unable to make decisions with regards to their discharge, an assessment of the patient’s capacity must be undertaken. (Refer to Trust Mental Capacity policy).

**9. Referral Procedures**

9.1. The three discharge pathways (Appendix 2,3,4) with the relevant timescales have been agreed to simplify the process for practitioners, and assist them with identifying the appropriate discharge planning practices for patients with simple, complex and NHS Continuing Health Care needs.

9.2. The Community care and Delayed Discharges Act (2003) placed certain statutory duties on Acute Hospital Trusts in relation to hospital discharges. Hospital Trusts are required to make two notifications to any local authority adult social services.

9.3. The first, a Section 2 notification / referral (Appendix 5) giving notice of the patient’s possible need for community care support. The second, a Section 5 (Appendix 6) giving notice to social services of the discharge date for patients who require community care support.

9.4. For a section 2 notification / referral, the minimum timescale is three days and starts on the day the notification is given to the Local Authority if this is done before 2pm.

9.5. For a section 5 notification the minimum notice period is 24 hours. A delay is not reportable as a reimbursable delay until the day after the confirmed discharge date on the Section 5. As soon as a discharge date has been identified a section 5 notification should be sent to the relevant adult social services department to formally notify them of the date.

9.6. There are locally agreed timescales for Local Authorities to complete an assessment of patients’ needs and put services in place for discharge. From receipt of the Section 2 notification / referral for a simple discharge the assessment must be complete and services in place in a minimum of three days up to a maximum of five days depending on individual circumstances. For a complex discharge the agreed timescale is a minimum of seven days up to a maximum of fourteen days. For patients assessed as needing residential care on discharge it is agreed that the maximum of 14 days to complete the assessment and arrange the service will be required. These timescales must be considered when discussions are held within the MDT to agree the patient’s discharge date.

9.7. A patient can only be identified as being a delayed discharge when the Local Authority has
not been able to make available community care services which are essential to enable a safe discharge or they have not undertaken an assessment of need within the statutory time frame.

9.8 The period of delayed discharge will end on the day that the Local Authority has completed the assessment of community care need and the identified community services are in place.

9.9. This is part of the required NHS formal process. If the planned discharge date has to be amended a Section 5 withdrawal notification must be completed (Appendix 6). A new section 5 notification must then be issued when the new planned discharge date is agreed.

10. **NHS Continuing Care**

10.1. An eligibility meeting should be arranged (this should be set for a maximum of seven days from the completion of the screening checklist) for those patients who are likely to have NHS Continuing Health Care Needs. The MDT should ensure that all relevant assessments are completed prior to the eligibility meeting. Where possible, the Discharge Coordinator should attend and chair the meeting. The purpose of the meeting is to identify the ongoing health needs of the patient and will involve District Nurse / District Nurse Liaison.

10.2. The meeting should be used as a forum for the team to complete the NHS Continuing Care Decision Support Tool to determine if the person is eligible for continuing health care and should be chaired by a senior member of the nursing staff. At the end of the meeting a discharge plan must be agreed by the team with an agreed date. Where ever possible patients and their carers should attend eligibility meetings. If the patient is likely to be transferred home the relevant District Nurse / District Nurse Liaison Team must be involved and invited to the eligibility meeting.

11. **Case Conference**

11.1. Case conferences should be used when difficulties and disputes arise with patients and their families concerning the discharge arrangements for patients or if the MDT have concerns for the welfare of a vulnerable adult. All relevant professionals involved with the care of the patient and the appropriate family members should attend the case conference. Where possible the patient should also be included.

11.2. The case conference should be chaired by a senior member of the social work team. The case conference should be used to discuss all the concerns in relation to the proposed discharge and explore all the options. It is important that staff identify these cases as early as possible to avoid any unnecessary delays or complaints. A summary of the discussions, agreed outcomes and plan of care should be recorded with an agreed discharge date and a list of the names designation of all the attendees.

11.3. Once all options have been explored and there is still no agreement, the Trust may have to implement discharge arrangements by consulting with the Trust legal team.
12 Planning Discharge

Intermediate Care

12.1. Intermediate Care services can avoid admissions to hospital or reduce prolonged and unnecessary stays in hospital. They provide rehabilitation, assessment and recuperation for people needing help to regain their former level of independence or assessment of future care needs where the discharge destination or care needs are unclear. The ward teams are responsible for referring patients to Intermediate Care and need to include relevant medical, nursing and therapy information in order to ensure placement in the appropriate intermediate care setting.

12.2. Patients from A & E who live in Bolton should be referred to B1 Frailty Unit, if Intermediate Care is considered appropriate.

12.3 Each borough has different services and admission criteria and ward teams will need to contact the relevant department.

Arranging Transport

12.4. When a patient is deemed fit for discharge, the nurse in charge of their care should, wherever possible, encourage the patient and their relative or carer to arrange their own transport home.

12.5. If staff deem the patient unsuitable to be transported home in private or public transport, they can book an ambulance or ambulance car. Wherever possible, this should be booked the day prior to the discharge.

13. Discharge / Transfer of Care process

The decision to transfer a patient is usually for one of the following reasons:
- Transfer to another department for reasons of admission and assessment (such as from A&E to assessment ward)
- Transfer to a specialist ward from an assessment ward or clinic
- Transfer to another department or unit for specialist treatment/therapy or diagnostic investigations
- Transferred to an outlying ward for extreme capacity issues
- Transfer from acute to community care within own Trust
- Transfer of care between hospital to hospital for specialist treatment or repatriation

Assessment of Escort Need

It is recognised that the nurse/midwife in charge of the patient’s on-going care must decide on the level of escort for patients leaving her/his area of responsibility. Where doubt exists the ultimate decision should rest with the consultant.

If there are issues in relation to providing escort for patients who are identified as requiring
them this must be escalated to the Matron/ Professional Lead.

All hospital in-patient assessments for an escort need to be completed on the appropriate document (appendix 16). The completed Patient Assessment for Transfer Form to accompany patient on transfer and post transfer be filed with the patients nursing records.

Exemptions to this exist for the Emergency Department, Theatres, Darley Court and Maternity services. The emergency department documentation includes assessment for an escort which takes into consideration the acuteness of the patients in the department. Theatre areas go and collect patients for bringing to theatre and patient is accompanied on return to the ward. Darley Court processes include nurse escort on transfer where applicable and all transfers are conducted by an ambulance crew. Maternity services work towards their own transfer policy.

If any member of staff is independently escorting a patient then they must consider what level of risk this may pose and take all necessary precautions to protect themselves and others.

**Accident & Emergency**

13.1. Where a patient is identified (ideally at triage, or immediately afterwards), as having social care needs but is safe for discharge without requiring hospital admission, the patient must be referred to Bolton Community Unit. Frail vulnerable patients with complex care needs who live alone should not be discharged unless the appropriate support is in place and any family/ carers are fully informed.

**Out of hours transfers**

13.2. For patients who are discharged in the evening, at night and weekends, staff should ensure that all planned community support is in place. Frail vulnerable patients with complex care needs who live alone should not be discharged unless the appropriate support is in place and any family/ carers are fully informed.

**Transfer back to the community**

13.3. The safe transfer of patients is an essential component of good MDT planning. Careful consideration needs to be given when transferring vulnerable patients with complex care needs. Patients who are being discharged to care homes or Intermediate Care services should be transferred as early as possible during the day and no later than 9pm, involving District Nurse Liaison where appropriate.

13.4. Essential information for the Community Teams taking over the care of the patient must be completed and forwarded to the appropriate agency. The Transfer of Care form (Appendix 7) must be completed the day before or on the morning of discharge. If community services are to provide care on the day of transfer then every effort must be made to forward the Transfer of Care information before the transfer. A copy should accompany the patient on the day of discharge. All NHS Continuing Healthcare patients need to be referred to District Nurses on discharge.

**Hospital to Hospital Transfers**
13.5. Transfers from hospital to hospital are sometimes necessary. These must be arranged by a direct referral from the Consultant in charge of the patients care directly to the receiving Consultant. On the day of transfer, staff should complete an Inter-Hospital Transfer form (Appendix 8) and photocopy and send the current inpatient records. The exception to this would be patients undergoing Cardiology procedures, in which case the specific proforma should be used.

**Internal transfers / handover**

13.6. If patients are being transferred from Accident and Emergency (A/E) to an assessment ward (D1, D2, F3) within the hospital, A/E must complete an SBAR on Extramed prior to transfer that ward staff MUST read before patient arrives. For transfers from Accident and Emergency to any other ward nursing staff from A/E MUST provide a verbal handover to the nursing staff. The receiving ward nurse must complete and retain an SBAR (appendix 15) to support the capture of relevant clinical information pertaining to the patient.

13.7. Patients moving from Accident and Emergency to any ward must be transferred with a photocopy of all the current attendance records and any other relevant information. This process should be followed for all patients at all times, including weekends, evenings and nights.

13.8. If patients are being transferred within the hospital wards, the transferring ward must contact the receiving ward and provide a verbal handover. The nursing assessment front sheet must be completed indicating whether an escort is required and that the relevant information has been handed over (Appendix 9). A handover SBAR sheet (Appendix 15) should be used by the receiving ward to ascertain the relevant clinical information and retained with the patients notes when completed.

13.9. The ward staff should update the electronic bed management (Extramed) system which includes detailed clinical information. This process should be followed for all patients at all times, including weekends, evenings and nights.

13.10. Transferring patients to outlying wards should only occur when extreme capacity issues prevail. Patients with complex needs, dementia or frail vulnerable patients with cognitive problems should not be transferred following initial transfer from A&E or assessment unit, unless their clinical condition indicates need to transfer to another ward/department. The same process for safe transfer must be followed for all patients.

13.11. Patients who are moving to the community bed based unit (Darley Court) must be transferred with the complete set of medical records. The unit should be contacted prior to transfer to provide a brief verbal handover.

**Transfer from Intensive Care / High Dependency Care**

13.12. If a patient is transferred from intensive care to another hospital the critical care transfer form (Appendix 10) and the blue discharge summary/management plan (Appendix 11) should be completed and transferred with the patient to the receiving hospital.

13.13. For all internal transfers from intensive care / high dependency to the wards the blue discharge summary/management plan should be completed and accompany the patient to the
ward.

13.14. If a patient is to be discharged home directly from critical care, please follow normal discharge planning arrangements. Please complete Transfer of Care form (Appendix 7).

14. Discharge against Medical Advice

14.1. If a patient takes their own discharge against medical advice the nurse in charge of the patient’s care must inform the ward manager or nurse in charge of the ward. The ward nurse should ascertain if the patient understands the risks they are taking in discharging themselves

14.2. The patient should be offered the opportunity to have a relative/carer or advocate present with whom they can discuss their decision. The nurse in charge of the patient’s care must contact a doctor, from the consultant’s team responsible for the patient, or the doctor on call.

14.3. The doctor responsible for the patient will ascertain that the patient is capable of making the decision to take their own discharge. The doctor will ensure the patient is aware of the consequences of discharge against medical advice and document this in the patient’s medical notes

14.4. In the event of a discharge against medical advice the nurse/doctor will contact the patient’s General Practitioner and any other relevant primary/community services involved as soon as possible. This may initially be by telephone but must be followed up in writing.

15. Patients going to a Care Home

15.1. If admission to a care home is agreed as the best option the social worker / discharge coordinator will give the family/carer information on homes and issue them with a letter which outlines the timescales within which to find a suitable home and that they must choose a home with vacancies (Appendix 12).

15.2. For patients who are NHS Continuing Care funded and are being placed out of area, contact the Bolton Continuing Care office on 01204 462293 or 01204 462291.

15.3. If the family fail to adhere to the agreed timescales and do not have justified reasons for doing so the Trust will write to them explaining the importance of seeking a suitable home and agreeing a timescale for this.

16. Roles and Responsibilities

Medical Staff

16.1. Responsibility for discharge rests with the Consultant responsible for the patients care. Patients should not be discharged without the authority of the Consultant or deputy. Delegation of this authority must be clearly understood by all concerned

16.2. Medical staff responsibilities:
   - Predicting possible discharge date
Review progress with MDT & record decisions made
Agree discharge date and follow up arrangements and communicate plans with patient and relatives / carers
- Complete the medical assessment section of NHS Continuing Care document as required
- Record the agreed date medically safe for discharge in patient’s notes.
- Confirm on the day of discharge that the patient is medically fit to be discharged.
- Complete Discharge Summary (ASCRIBE) 24 hours prior to discharge and write the discharge prescription when the date agreed
- For patients who are likely to be discharged at the weekend or on a Monday morning, complete the ASCRIBE prescription on Friday if possible.

Nursing Staff

16.3. Nursing staff responsibilities:
- Completion of baseline nursing assessment within 24 hours of admission.
- Establish any current support and existing community services.
- Assess if patient or carer is likely to need new or different services that are essential for discharge and complete section 2 notification / referral and document date sent in patient’s notes. (Appendix 5). For out of area referrals fax to the relevant social services.
- Keep patient and carers informed of plans for discharge arrangements.
- Complete discharge planning checklist (Appendix 13).
- Inform social worker if there any concerns with regards to vulnerable patient.
- For patients with complex health and social care needs complete NHS Continuing Care checklist as soon as possible ideally after first ward round in conjunction with the social worker.
- Arrange eligibility meeting to complete NHS Continuing Care Decision Support Tool (within seven days of completion of NHS screening tool).
- For patients who live in supported housing contact the manager and inform them of planned discharge.
- Complete referrals to District Nursing Service for patients who are housebound (these are collected twice a day from wards). Outside daytime working hours referrals should be faxed to the District Nurse Evening Service.
- NHS Continuing Care patients who are being discharged to their own home will need the Care Plan completed by the District Nursing Liaison Team.
- If District Nurse is required to administer medications, a copy of the completed Ascribe document with the administration dosage and duration details must be sent with the referral which has been signed by the prescriber.
- End of life patients need to have the medication prescribed on a Community Medication Administration record which is available in the folders on the wards with the District Nurse contact details, which should be sent home with the patient.
- As soon as discharge date is agreed issue a section 5 notification giving a minimum of 24 hours notice (Appendix 6).
- Inform pharmacy when discharge medication is prescribed as early as possible (medication compliance aids must only be ordered if ward pharmacist has assessed the patient as requiring it).
- Arrange transport as required.
- Patients who are ambulant and need simple dressings/removal of sutures should
contact treatment room via the Central Booking Number on 01204 462626. Patients are responsible for making their own appointments.

- Supply patients with first five days supply of any wound / stoma dressings, incontinence pads catheter bags etc.
- Ensure that drugs given to patients are checked and correct before discharge this includes patient’s own medication from bedside cabinets.
- Complete Transfer of Care document and send with the patient (Appendix 7).
- Inform patients/carer of any follow up appointments.
- Complete leaving hospital leaflet (Appendix 1)
- Inform bed manager as soon as beds become available, vacant beds must not remain unreported and update EXTRAMED.
- Complete weekly delayed discharge report on Thursday of each week and send to Matron/Departmental Manager. (Appendix 14)

**Social Worker**

16. **4. Social worker responsibilities**

- Undertake initial assessment of social care needs and ascertain eligibility for a service, if eligible, complete full assessment of patient or carer needs.
- Contact the designated nurse (or their deputy) and the patient within 48 hours of receipt of section 2 notification / referral (Appendix 5). Note Sundays and Bank Holidays are excluded.
- Complete NHS Continuing Care Checklist with ward nurse
- Attend eligibility meetings to complete NHS Decision Support Tool for NHS continuing care.
- Agree with the MDT when the patient is safe to discharge
- Ensure anyone with reablement potential has access to reablement on discharge
- Devise an independence plan and complete a risk assessment which sets out how needs will be met and how the risks will be managed on discharge.
- Provide a copy of the independence plan to the patient or carer.
- Arrange funding to purchase services to meet the ongoing care needs of the patient and commission services to meet these needs in time to meet the agreed discharge date.
- Keep nursing staff and the MDT up to date on discharge arrangements and record this in medical notes.

17. **Delayed Discharge Problems**

17.1. When a delayed discharge issue arises it is essential that the relevant MDT team arrange an initial meeting with the appropriate members of the team, the patient, relative/carer and/ the appropriate social worker and discharge coordinator.

17.2. A record of the issues discussed and actions agreed need to be documented and confirmed in writing to the patient / carer. If the MDT is unable to resolve the delay / dispute the ward manager/ discharge coordinator should inform the appropriate Divisional Manager.

17.3. A further formal meeting with the patient and appropriate relative/carer and senior manager from the hospital and social work department will be organised. The purpose of the meeting is to identify problems and seek confirmation on the reasons for delay / dispute. The senior managers from the trust and social work department will discuss the options for care
and explain the planned discharge arrangements with patient/relatives/carer.

17.4. The meeting should agree a plan of care, and a proposed discharge date with appropriate community support. It may be necessary depending on the situation to seek legal advice prior to the meeting.

17.5. A written record of the meeting and agreed plans must be made and confirmed in writing to the patient and family members by the relevant Divisional Manager.

17.6. Proceed with the proposed discharge plan and prepare for any possible media coverage. Monitor and review discharge plan. In exceptional circumstances, should the patient/relative continue to refuse to cooperate it may be necessary to evict them from the hospital. This should only happen when all reasonable steps to resolve the dispute have been taken and the Trust has sought legal advice.

18 Community Care and Delayed Discharges Act Disputes Procedure

18.1. The Strategic Health Authority is required under the legislation to set up a Disputes Panel to assist in the resolution of disputes between the NHS and Social Services Authorities about the need for Community Care Services on discharge or about the liability for reimbursement.

18.2. The Panel may be used either for disputes about individual patient delays or issues of the broader disagreement between partner organisations in relation to the management of the reimbursement provisions.

18.3. The Panel will include an Independent chair, a Local Authority Representative, and a PCT representative (not involved with the dispute). The Department of Health regards recourse to the formal disputes mechanism as a measure of failure in collaborative working.

18.4. Local health and social care organisations have a joint responsibility for solving problems and addressing disagreements purposefully and constructively before they invoke the dispute process and should have local arrangements in place to resolve any disputes.

19 Out of Area Information

Wigan and Leigh Patients

19.1. All section two and section five referrals for Wigan residents should be faxed direct to the Social Work Team based at Wigan and Leigh Hospital, on 01942 264600. For patients who need NHS Continuing Health Care assessment the ward staff should complete the Wigan referral form and fax this to 01942 482788.

Salford Patients

19.2. All section two and section five referrals for Salford residents should be faxed to Salford Social Services on 0161 909 6520. For patients who need screening or assessment for NHS Continuing Health Care ward staff should contact the continuing care team via telephone on 0161 212 4184.
Bury Patients

19.3. All section two and section five referrals for Bury residents should be faxed to Bury Social Services on 0844 873 2211. For patients who need screening or assessment for NHS Continuing Health Care ward staff should contact the continuing care team via telephone on 0161 762 3133.

Other Out of Borough Residents

19.4. Any section two or section referrals for patients who reside in other Boroughs should be faxed to the appropriate Social Services Department in the relevant Borough. For patients who need screening or assessment for NHS Continuing Health Care in other Boroughs ward staff should contact the Discharge Co-ordinators.

Exclusions

19.5. For the purpose of the Delayed Discharges Act, patients ordinarily resident in Scotland, Wales or Northern Ireland are excluded from the Community Care Delayed Discharge Legislation. For further information refer to the Department of Health guidance on Ordinary Residence (2010) guidance.²

No Fixed Abode

19.6. Following reasonable checks by the nurse in charge of the patient’s care, if it is apparent that a patient has no address, please complete section 2 notification / referral (Appendix 5) and forward to hospital social work department.

20. Education & Training

20.1. Ward /Unit managers are responsible for ensuring that all staff are familiar with this policy. All new staff will be briefed on the policy on induction to their ward / department.

20.2. Regular training sessions will be offered to staff from across both health and social care organisations to ensure the policy is implemented effectively.

21. Monitoring & Evaluation

21.1 Monitoring of discharge practice is essential to identify delays in system, and to ensure improvements are sustained. This should be a joint activity with all disciplines and agencies involved in the process. The table below summarises the monitoring and reporting arrangements for this policy.

21.2 The policy will be reviewed in three years or earlier in line with any National guidance.
### Monitoring and reporting arrangements for this Adult Discharge and Transfer of Care Policy.

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Process for monitoring e.g. audit</th>
<th>Responsible individual/group/committee</th>
<th>Frequency of monitoring</th>
<th>Responsible individual/group/committee for review of results</th>
<th>Responsible individual/group/committee for development of action plan</th>
<th>Responsible individual/group/committee for monitoring of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual audit of compliance with the policy.</td>
<td>The audit will consist of a retrospective review of patients’ records to monitor use of the documentation.</td>
<td>Professional Advisory Group</td>
<td>Annually</td>
<td>Governance and Assurance Committee</td>
<td>Professional Advisory Group</td>
<td>Professional Advisory Group</td>
</tr>
</tbody>
</table>
Appendix 1
Leaving Hospital

Patient Name:

Ward:

Information for patients and Carers

When you are admitted to hospital

From the time you come into to hospital, your Doctor and other members of the Multi-disciplinary Care Team, will be planning your discharge with you and try to give you a date when you are likely to be well enough to go home.

This date will be reviewed constantly by the team looking after you, and they will discuss the plans with you to find out what support, if any, you might need on leaving hospital.

The staff involved in your care will involve you as much as possible in any decisions about your care and treatment. Please ask if you have any concerns.

Current Support

So that we can give you the best possible assistance, please tell us about any help or care you are currently receiving. This will help the team plan for your discharge home.

Managing at home
If you think you will be unable to manage at home after leaving hospital, please ask a member of the nursing team. The team caring for you can talk to you about some of the support that can be arranged.

Who decides that I am ready to leave hospital?

This decision will be made by the team of doctors, nurses and therapists looking after you and in discussion with you and your carer.

The nurse will explain what your medication is for, how and when to take it and any side effects to watch out for and any new medicines that you have to take. If you are unsure about anything please ask.

Your Doctor or nurse will explain your diagnosis and treatment if you have any concerns please ask.

You will have been able to discuss your discharge and know what to do and who to contact in an emergency.

What if I have any worries or concerns?

If there is anything that you do not understand about the care you receive, please do not go home and worry, but ask us about it before you leave.

Nobody will mind, most problems can be solved by talking to ward staff before you go home. If you are concerned about your healthcare once you get home, you will need to speak to your GP.

Things to think about before going home

- Do you have a key or someone to let you in?
- Do you have clothes, shoes and a coat to go home in that is suitable for the weather?
- Will there be any food in the house and will the house be warm enough?
- Do you have any relatives, or friends who can help?

Ask one of the nurses, in advance, for any medical certificates you may need, e.g. private insurance/health insurance claim forms.
Things to check before leaving hospital, a member of staff will go through this with you.

<table>
<thead>
<tr>
<th>Before you go home you should know or ask about the following</th>
<th>Name of Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Any changes made to your medicines have been explained.</td>
<td></td>
</tr>
<tr>
<td>2 Someone has discussed with you potential side effects of your medicines.</td>
<td></td>
</tr>
<tr>
<td>3 Someone has gone through with and checked the medicines you are to go home with.</td>
<td></td>
</tr>
<tr>
<td>4 You or your carer have had the opportunity to discuss your discharge and have got all the information that you need.</td>
<td></td>
</tr>
<tr>
<td>5 Any Support Services such as District Nurse Arranged has been explained</td>
<td></td>
</tr>
<tr>
<td>6 Any services that have been arranged have been explained</td>
<td></td>
</tr>
<tr>
<td>7 Any equipment arranged has been explained</td>
<td></td>
</tr>
<tr>
<td>8 Any follow up appointments have been explained</td>
<td></td>
</tr>
<tr>
<td>9 Any transport arrangements following your discharge from hospital.</td>
<td></td>
</tr>
<tr>
<td>10 Who to contact if you are worried about your condition and treatment after you leave the hospital.</td>
<td></td>
</tr>
</tbody>
</table>

**The Discharge Lounge**

If you are not able to collect from the ward before 11.00 hours, we will arrange for you to wait in our Discharge Lounge. You will be able to relax away from the business of the ward until you can be collected.
Appendix 2
Pathway 1 – Simple Discharge

On admission/or first ward round agree predicted discharge date

Community care needs on discharge

No
Proceed with discharge – no section 2 required

Yes
Send section 2 with predicted discharge date

Allow minimum 3 days and maximum 5 days for social worker assessment and plan

Complete all relevant assessments

Agree final discharge date at next ward round/MDT

Should not exceed 5 days except for medical reasons

Issue section 5 confirming discharge date
Appendix 3
Pathway 2 - Complex Discharge

Earliest ward round/MDT meeting agree predicted discharge

Consider if continuing healthcare applicable

- Yes
  - Follow continuing care pathway
  - Intermediate care – yes refer

- No
  - Agree plan of care and issue section 2
  - Home with support
    - Complete all assessments
    - Agree final discharge date
    - Issue section 5
    - Public funded await confirmation from social worker
  - Residential home
    - Social worker does assessment informs family & gives letter to family
    - Home identified
      - For self funders arrange date
Appendix 4
Pathway 3 – NHS Continuing Care

Earliest ward round/NDT meeting consider continuing care

Complete screening tool with allocated social worker

Issue section 2 referral

All relevant disciplines to complete assessments (include district nurse) set date for eligibility meeting

Maximum of seven days

Eligibility meeting complete decision support tool agree discharge plan and set discharge date

Maximum of 2 weeks

If continuing care recommended send papers to twice-weekly panel/relevant PCT

PCT verified yes

Arrange discharge date
Appendix 5
REFERRAL FOR ASSESSMENT TO SOCIAL SERVICES and SECTION 2 NOTIFICATION

Complete sections A to H for all referrals.

Place the original (for Bolton LA patients) in the social worker tray for collection. Forms will be collected at 2pm weekdays Monday to Friday.

For out of area patient fax both sides to the relevant social services contact number.

| Has patient consented to referral to social worker | Yes □ No □ |
| If patient lacks capacity is relative/carer aware of referral | Yes □ No □ |

| A. Referred by: .................. | Date .................. | Time .................. am/pm |

NB COMMENCEMENT OF NOTIFICATION

| Ward/department | Tel. No .................. |

Patient/Carer: Aware: YES □ NO □ Agree: YES □ NO □

| B. Patient details: |
| Addressograph label/ details: |
| Name: |
| Address: |
| D.O.B |

| Admission date: .................. | Home telephone number: .................. |

First Language: .................. GP name: ..................

| Address: .......................... |

GP telephone number: ..................

Religion: .........................
**Next of Kin Details:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Postcode:</th>
<th>Contact Tel No:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main contact if different: Name</th>
<th>Address</th>
<th>Contact Tel. No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Key holder:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Postcode:</th>
<th>Contact Tel No:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**C. Reason for referral:**

- **Already has services:**
  - YES □  NO □  Details:

- **Problems with self care:**
  - YES □  NO □  Details:

- **Problems with mobility:**
  - YES □  NO □  Details:

- **Is at risk of abuse:**
  - YES □  NO □  Details:

- **Is a carer / or risk of carer stress:**
  - YES □  NO □  Details:

- **Other reason:**
  - Details:

  ..........................................................................................................................
Proposed length of stay……………………..or Provisional discharge date……………………

Or proposed discharge date if known………………………………………………………………………………

D: This section is to be completed at preoperative assessment only.

Planned admission date ……………………………………………………Ward ……………………………………………

Day case or overnight stay only Yes ☐ No ☐

If yes, proposed discharge date ………………………………………………………………………………………

(This constitutes a section 5 notification when completed at preoperative assessment only).

E. Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>White or White British</th>
<th>Black or Black British</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White Irish</td>
<td>Caribbean</td>
</tr>
<tr>
<td></td>
<td>African</td>
<td>Asian or British Asian</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>Pakistani</td>
</tr>
<tr>
<td></td>
<td>Bangladesh</td>
<td>Chinese</td>
</tr>
<tr>
<td></td>
<td>Mixed</td>
<td>White &amp; Black African</td>
</tr>
<tr>
<td>Other ethnic group: Details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F. Accommodation type

<table>
<thead>
<tr>
<th></th>
<th>House</th>
<th>Caravan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground floor flat</td>
<td>Bed sit</td>
<td>Caravan</td>
</tr>
<tr>
<td>Upper floor flat</td>
<td>Nursing home</td>
<td>Mobile home</td>
</tr>
<tr>
<td>Bungalow</td>
<td>Residential home</td>
<td>Hostel</td>
</tr>
<tr>
<td>Long stay hospital</td>
<td>No fixed abode</td>
<td></td>
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</table>

G. Tenure type

<table>
<thead>
<tr>
<th></th>
<th>Council Tenant</th>
<th>Sheltered Accommodation</th>
<th>Lodger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Association</td>
<td>High Dependency Unit</td>
<td>Living with relative</td>
<td></td>
</tr>
<tr>
<td>Owner occupier</td>
<td>Privately rented</td>
<td>Squat</td>
<td></td>
</tr>
</tbody>
</table>

H. Household composition:-

<table>
<thead>
<tr>
<th></th>
<th>Living with partner</th>
<th>Living Alone</th>
<th>Group living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two parent family</td>
<td>Living with relatives</td>
<td>Foster Family</td>
<td></td>
</tr>
<tr>
<td>Single parent family</td>
<td>Living with friends</td>
<td>Adult living with parents</td>
<td></td>
</tr>
</tbody>
</table>

(Social Services to complete):-

Referral received by………………………………………………Designation………………………………………..

Date…………………… Time………………am/pm
Appendix 6
SECTION 5 (Notification of Planned Discharge Date)

PLEAS note:
If out of area – FAX to
O.O.A. Fax

Addressograph Label:

Agreed Discharge Date ..............................................
Ward ...........................................................................

Name (print)................................................... Signature .......................... Date ..............
Received by (print) ................................. Signature ................................. Date ..............

COMPLETED FORM TO BE COPIED/COLLECTED BY SOCIAL WORKER

NOTIFICATION OF WITHDRAWAL OF SECTION 5

Addressograph Label:

Date of Withdrawal ...................................................

Name (print)................................................... Signature .......................... Date ..............
Received by (print) ................................. Signature ................................. Date ..............

NEW PLANNED DISCHARGE DATE ..........................................

(PLEASE NOTE: New Section 5 required for new discharge date)
## Appendix 7

**Transfer of Care Form Hospital to Community & care homes to Hospital**

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Discharge / Transfer Address (if different): ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: __________________________</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Postcode: __________________________DOB: ______</td>
<td>Postcode: __________________________Tele No: __________________________</td>
</tr>
<tr>
<td>NHS No: ___________________________Television: ___________________________</td>
<td>GP &amp; Practice: (check if GP needs changing on discharge)</td>
</tr>
<tr>
<td>Access or Key holder: ___________________________</td>
<td>Date of Admission: ___________________________</td>
</tr>
<tr>
<td>Next of Kin: ___________________________</td>
<td>Date of Transfer/discharge: ___________________________</td>
</tr>
<tr>
<td>Ward: ___________________________Telephone number: ___________________________</td>
<td></td>
</tr>
</tbody>
</table>

**District Nurse Required (N.B District Nurses only visit housebound patients). □ Date of first visit**

**CLINICAL DETAILS:** Consultant: ___________________________

Reason for admission: ___________________________

Diagnosis: ___________________________ Date of Operation

Additional Information: (consider medical information, patient wishes for ongoing care, social care)

DNR Status; Infection Control Status; MRSA/CDIF/Others - Details: □

Is there an outbreak of infection from transferring facility: No □ Yes □ Details:

Prognosis/Diagnosis known to □ Patient □ Relatives □ Both

**NURSING CARE:** (e.g. Dressing change, continence support, administer medication, (Ensure prescription faxed to District Nurse), pressure relief, and provide detail on skin integrity. Please complete body map on day of discharge with details of any wounds / bruises & send copy on transfer

□

First dressing □ change supplied □ Catheter & drainage bag supplied Date Catheter Change

Patient is on □ Gold Standard Framework □ End of Life Care Plan □

**EQUIPMENT ARRANGED FOR DISCHARGE/TRANSFER (e.g. commode, hoist)**

Arranged by Occupational Therapy □ Needs to be arranged by district nurse □ Syringe driver

**DETAILS OF ADDITIONAL SERVICES (e.g. stoma care, palliative care)**

Follow up appointment: Yes □ No □ State Date of appointment

Follow up appointment to be sent to patient: Yes □ No □ N/A □
**SUMMARY OF CURRENT ACTIVITY LEVELS:**

### Mobility:
- [ ] With stick
- [ ] With crutches
- [ ] With Zimmer
- [ ] < 10 metres
- [ ] < 20 metres
- [ ] Independent
- [ ] Supervision required
- [ ] Assistance of 1
- [ ] Assistance of 2

### Transfers Chair/bed/ toilet
- [ ] Independent
- [ ] Supervision required
- [ ] Assistance of 1
- [ ] Assistance of 2

**Comments:**

Send walking aids with patient on transfer/discharge.

Is the patient at risk of falls Yes/No

### Washing and dressing:
- [ ] Independent
- [ ] Supervision required
- [ ] Assistance of 1
- [ ] Assistance of 2

**Comments:**

### Elimination:
- [ ] Continental
- [ ] Incontinent
  - [ ] Catheterised: Date of insertion _________ Size _________
  - [ ] Long term
  - [ ] Short term

**Comments:**

### Eating:
- [ ] Independent
- [ ] Supervision required
- [ ] Assistance of 1

### Drinking:
- [ ] Independent
- [ ] Supervision required
- [ ] Assistance of 1

### Enteral Feeding:
- [ ] Nasogastric tube
- [ ] Gastrostomy tube
- [ ] Jejunostomy
- [ ] Combination

**Date of insertion _________**
**Type of feeding tube _________________**
Please send spare feeding tube
**Time of last meal/drink**

- [ ] Meals on wheels: State frequency

**Comments:**

### Cognitive Function:
- [ ] No problems
- [ ] Short term memory impairment

**Comments:**

### Communication (comments)
- [ ] Interpreter needed

### Hearing (details)

### Sight (details)

### Speech (details)

**Medication Arrangements:**
- [ ] Independent
- [ ] Family support
- [ ] Carer Support

**Time last medications given;**

**Comments:**

**FORM COMPLETED BY:**
- Name: ____________________________
- Signature: ________________________
- Profession: ________________________

**COPIES OF FORM TO:**
- Name: ____________________________
- Service: __________________________
- Date sent: _________________________

**Form Completed by:** Name & Signature

**Date:** __________________________

**Verbal Handover Given Yes/No**

**Date &Time:** ____________________
**Name & Signature**
Appendix 8 – Hospital to Hospital Transfer
Date of transfer: ……………….. Form completed by: …………………. Designation: ………………….

<table>
<thead>
<tr>
<th>Transferring Trust:</th>
<th>Receiving Trust:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital:</td>
<td>Hospital:</td>
</tr>
</tbody>
</table>

Patients Details:

<table>
<thead>
<tr>
<th>Patient’s last name:</th>
<th>Hospital Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

Title  Mr  Mrs  Miss  Ms
Sex:  M  F

Marital status: (circle one)  Single / Married / Divorced / Separated / Widow

<table>
<thead>
<tr>
<th>Address:</th>
<th>Next of Kin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home telephone number:</td>
<td>Relation:ship:</td>
</tr>
</tbody>
</table>

Address: (if different)

<table>
<thead>
<tr>
<th>Home telephone number: Notified of transfer:</th>
<th>Y  N</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no, action taken:</td>
<td></td>
</tr>
</tbody>
</table>

Reason for admission and Continuing Care:

Transfer Details:

<table>
<thead>
<tr>
<th>Reason for transfer: (Tick appropriate box and state rationale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher level care  ☐  Speciality care  ☐  Other  ☐  state</td>
</tr>
</tbody>
</table>

Rationale:

Transferring Ward/Unit

|-------|----------|

Sending Consultant:

Receiving Ward/Unit

|-------|----------|

Receiving Consultant:

Receiving Ward/Unit ready to receive patient: Y ☐

No ☐

Documentation

<table>
<thead>
<tr>
<th>Written order for transfer in medical notes:</th>
<th>Y  N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Written order patient stable for transfer:</th>
<th>Y  N</th>
</tr>
</thead>
</table>

Copy of medical notes:  Y ☐  N ☐

Copy of X-rays  Y ☐  N ☐

Copy of medical notes:  Y ☐  N ☐

Medical letter:  Y ☐  N ☐

Mode of Transfer

<table>
<thead>
<tr>
<th>Ambulance:</th>
<th>Private Care</th>
<th>Other</th>
<th>Escort required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>Y ☐  N ☐</td>
</tr>
</tbody>
</table>

Rationale:

Equipment required for supporting patient during transfer:

<table>
<thead>
<tr>
<th>Oxygen:</th>
<th>Y ☐  N ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, Oxygen percentage:</td>
<td></td>
</tr>
</tbody>
</table>

Infusion devices:  Y ☐  N ☐

If Yes, state:

Other:

MRSA Status: +ve ☐  -ve ☐  Unknown ☐  Date of last screening:  

Receiving Ward/Unit aware:  Y ☐  N ☐

Nursing intervention required for MRSA/Infectious condition:

Other infectious condition:

Vital signs: time of transfer / last recording:  

<table>
<thead>
<tr>
<th>T</th>
<th>BP</th>
<th>P/HR</th>
<th>SaO2 if oxygen required:</th>
</tr>
</thead>
</table>

Neuro Status:  Alert and orientated:  Y ☐  N ☐  If No, state current neuro status:
<table>
<thead>
<tr>
<th>Personal Care</th>
<th>Items</th>
<th>Unable to perform task</th>
<th>Attempts task but unsafe</th>
<th>Moderate help required</th>
<th>Minimal help required</th>
<th>Fully independent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Hygiene</td>
<td></td>
<td></td>
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<tr>
<td>Bathing Self</td>
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<tr>
<td>Feeding</td>
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<td>Toilet</td>
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<td>Stair Climbing</td>
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<tr>
<td>Dressing</td>
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<td>Bowel Control</td>
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<td>Bladder Control</td>
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<tr>
<td>Ambulation (Wheelchair)</td>
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<td>Chair – Bed Transfers</td>
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<tr>
<td>Medication:</td>
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<tr>
<td>Latest medication chart or copy transferred with patient:</td>
<td>Y □  N □</td>
<td>Medication last administered:</td>
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<tr>
<td>Medication transferred with patient:</td>
<td>Y □  N □</td>
<td>Past medical history / Specialist requirements:</td>
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<td>Relevant past medical history:</td>
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<td>Special Nursing Care:</td>
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<tr>
<td>Diet/Therapies:</td>
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<tr>
<td>Nutrition score if applicable:</td>
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<tr>
<td>Skin Assessment: (including invasive lines)</td>
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<tr>
<td>Glasses:</td>
<td>Y □  N □</td>
<td>Hearing Aid:</td>
<td>Y □  N □</td>
<td>Dentures:</td>
<td>Y □  N □</td>
<td>Cane/Crutches/Zimmer</td>
<td></td>
</tr>
<tr>
<td>Pressure Area Care, provide detail on skin integrity. Please complete body map on day of discharge with details of any wound/bruses &amp; send copy on transfer.</td>
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<tr>
<td>Risk Assessment and Management (e.g. Falls assessment, MH assessment)</td>
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<td>Assessed Risk:</td>
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<td>Multidisciplinary Referrals</td>
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<td>Team:</td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>Social Worker</td>
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<tr>
<td>MacMillan Nurse</td>
<td></td>
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<tr>
<td>Patient Property</td>
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<tr>
<td>Valuables transferred with patient:</td>
<td>Y □  N □</td>
<td>Property list attached:</td>
<td>Y □  N □</td>
<td>Patient has no property:</td>
<td>Y □  N □</td>
<td>Verbal Handover given Yes/No  Date &amp; Time  Name &amp; Signature</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 9

**Assessment & Care Document**  
All sections MUST be completed

<table>
<thead>
<tr>
<th>Patients Name:</th>
<th>Admission Ward:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Number:</td>
<td>Admission Date &amp; Time:</td>
</tr>
<tr>
<td>NHS Number:</td>
<td>Consultant:</td>
</tr>
</tbody>
</table>

#### TRANSFERS: Complete for each transfer. This document must be used to handover to receiving ward.

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Consultant</th>
<th>Ward transferring to</th>
<th>Relatives informed</th>
<th>Nurse Handover Given</th>
<th>Escort Required</th>
<th>Medication Transferred</th>
<th>Signature &amp; Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td></td>
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<td></td>
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<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
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<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
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<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>

#### DISCHARGE DATE:

<table>
<thead>
<tr>
<th>Planned discharge:</th>
<th>Revised discharge:</th>
<th>Actual Discharge:</th>
</tr>
</thead>
</table>

#### STANDARD WORK: ON ADMISSION

- Patient demographic detail record (R276a) must be completed and filed in medical note  
  - On admission
- Assessment and Care Document (R276) must be completed in full within 6 hours of admission  
  - Within 6 hours
- A complete set of clinical observations (as outlined in patient observation policy) must be completed  
  - On admission
- MRSA Screen, Waterlow and VTE assessment must be completed.  
  - Within 6 hours
- Further assessments must be completed in accordance with findings from initial assessment e.g. nutritional assessment, manual handling risk, and oral hygiene assessment.  
  - Within 6 hours
- A plan of care must be devised based on any assessments with involvement of the patient/relative or carer  
  - Within 12 hours
- All documentation must conform to Trust policy for Record Keeping and professional standards.  
  - Ongoing

#### STANDARD WORK: ONGOING ASSESSMENT & CARE

- A full set of clinical observations must be recorded in accordance with the patient observation policy.  
  - Ongoing care
- Review and update care plan daily  
  - Ongoing care
- Assign each care plan with its own number and evaluate/ record variances on a shift basis in collaborative notes  
  - Ongoing care
- On patient transfer the patient details must be updated on the front sheet of the Assessment document (R276) by the transferring nurse. The receiving nurse must review the assessment and plan of care  
  - On transfer
Appendix 10
Critical Care Transfer Form

![Critical Care Transfer Form Image]

### Patient Details
- **Name:**
- **Age:**
- **Sex:** Male / Female
- **Address:**
- **Postcode:**

### Transfer Details
- **Transferring Unit Name:**
- **Recipient Unit Name:**
- **ICU:**
- **HDU:**
- **Date of Admission to Hospital:**
- **Date of Transfer:**
- **Time of Transfer:**

### Pre Sedation GCS
- **Diagnosis and brief summary of clinical findings:**

### Stabilisation Time
- **Time commenced:**
- **Time ready to transfer:**

### Ambulance Details
- **Incident No.:**
- **Time arr. on Scene:**
- **Time left Scene:**
- **Arrived ICU:**

### Staff Arranging Transfer
- **At Preparing Hospital:**
  - **Name:**
  - **Grade:**
  - **Spec:**
  - **Consultant in charge:**

### Escorting Personnel
- **At Preparing Hospital:**
  - **Name:**
  - **Grade:**
  - **Spec:**
  - **Consultant in charge:**

### At Recipient Unit
- **Name:**
- **Grade:**
- **Spec:**
- **Consultant in charge:**

### Ventilation During Transfer
- **Mode of ventilation:**
- **Ventilator:**
- **Tidal volume:**
- **Peak inspiratory pressure:**
- **PEEP:**
- **PAP:**
- **Respiratory rate:**
- **PaCO2:**
- **PaO2:**

### Monitoring
- **Heart Rate:**
- **Systolic BP:**
- **Diastolic BP:**
- **Pulse Ox:**
- **Core Temp:**

### Risk appropriate devices
- **ECG:**
- **NIBP:**
- **SpO2:**
- **ETCO2:**
- **Arterial Line:**

### Drug

### Transfer notes comments

### Signature of escorting doctor:

### Instructions:
- The **WHITE COPY** of this completed form should be handed to the patient's relatives or the recipient hospital.
- The **YELLOW** and **GREEN** copies should be returned by ICEMS Manchester, M1 5BR.
- Pre-addressed envelopes are available in NHW Region Critical Care Units.
Appendix 11
Critical Care Discharge Summary/Management Plan
Appendix 12
Information on choosing a Care Home

Dear Patient,

Information on choosing your Care Home

I understand that you have now completed your treatment and are ready to be discharged from the Royal Bolton Hospital, and that it has been agreed with you and your family that you will be moving to a care home. We want the best possible care home that will meet your needs, and your social worker will help you through this process.

In the first instance you will be advised to look for a home which has vacancies. This does not prevent you from looking for somewhere else in the longer term if you should choose to do so, or remaining on a Waiting List elsewhere.

This letter is to inform you that you will need to find a suitable home with vacancies within seven (7) days. Staying in hospital, when this is no longer appropriate, it not good for you, as you need to be in a more suitable care environment. Staying in hospital may put you at risk of catching infections from other patients, and remaining in hospital longer than appropriate may be preventing someone more ill from using your bed.

Your social worker will be able to advise you and your relative which homes have current vacancies, and also explain to you relevant financial issues.

If you need more information, or would like to discuss your situation, please speak to your social worker, or the nurse in charge of your care, at the earliest opportunity.

May I wish you well for your move into your new home.

Yours sincerely

Social Worker
### Discharge Plan/Checklist

**Patient’s Name**

**Discharge Date**

<table>
<thead>
<tr>
<th>Discharge plan</th>
<th>Date</th>
<th>N/A</th>
<th>Summary of Actions/progress</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments/equipment needs identified and date of discharge confirmed with relevant healthcare professionals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
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<tr>
<td>Specialist nurse/services</td>
<td></td>
<td></td>
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<tr>
<td>Social worker</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Patient and or carers/relatives aware of discharge date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check access to house, keys available and basic provisions, heating etc</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Transport arrangements confirmed</td>
<td></td>
<td></td>
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<tr>
<td>Transfer of care/District Nurse form/Health Centre referral completed</td>
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<tr>
<td>Discharge prescription complete and discharge medications obtained</td>
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<tr>
<td>Patient/carer informed of follow up appointments</td>
<td></td>
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<tr>
<td>Anticoagulant appointment arranged</td>
<td></td>
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<tr>
<td>Transport arranged for follow up &amp; details given:</td>
<td></td>
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<tr>
<td>Infection control precautions discussed with patient/carer/care home e.g. MRSA</td>
<td></td>
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<tr>
<td>On day of Discharge</td>
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<tr>
<td>Venflon removed prior to discharge</td>
<td></td>
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<tr>
<td>Medication checked, explained and given to patient</td>
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<tr>
<td>-Check each drug against prescription</td>
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<tr>
<td>-Ensure names correspond</td>
<td></td>
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<tr>
<td>Patient has equipment to take home</td>
<td></td>
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<tr>
<td>Property/valuables packed/returned to patient</td>
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<tr>
<td>Discharge follow up arrangements discussed and understood</td>
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<tr>
<td>Discharge letter sent to GP</td>
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<tr>
<td>Patient discharge leaflet given</td>
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<tr>
<td>Patient education/information leaflets given</td>
<td></td>
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</tbody>
</table>
Appendix 14
Delayed Discharges/Transfers

Please Fax to the Information Dept on 5947

Must be a delay on the Thursday to be reported

Ward…………………… Date Completed Thursday for Friday…………………………

<table>
<thead>
<tr>
<th>PMI No</th>
<th>Date of admission</th>
<th>Predicted discharge date</th>
<th>Agreed date for discharge/Transfer</th>
<th>Discharge Destination</th>
<th>Date referred to Social Services (Section 2)</th>
<th>Date Section 5 sent to social services</th>
<th>Letter 3 date if looking for RH/NH</th>
<th>Borough of Residence (Town)</th>
<th>Reasons for Delay</th>
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<tbody>
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</table>

Reportable Delays please use codes a-q as appropriate

(a) Awaiting Completion of assessment e.g. OT Physiotherapy or social services assessment
(b) Awaiting Public Funding e.g. All patients with completed assessment but delayed due to social services funding/disputed funding
(c) Awaiting Further NHS Care e.g. All patients with completed assessment waiting further NHS care this includes intermediate care/NHS continuing care
(d) Awaiting Residential/Nursing Home Placement e.g. patients delayed due to insufficient places not funding
(e) Awaiting Domiciliary Package All patients with completed assessment delayed due to waiting for care package or equipment/adaptations
(f) Patient/Family exercising choice All patients with completed assessment delayed due to patient/family exercising choice re care homes
(g) Housing Issues i.e. patients with completed assessment delayed due to housing but not eligible for community care services (not awaiting care package or equipment)

Signed Name…………………………… Designation………………………………
## PATIENT HANOVER PROMPT

<table>
<thead>
<tr>
<th>S</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handover Ward from</td>
<td>Patient Name / Age</td>
</tr>
<tr>
<td>Allergies / Resus</td>
<td>Infection Status</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Past Medical History</td>
<td></td>
</tr>
<tr>
<td>Treatment received</td>
<td></td>
</tr>
<tr>
<td>e.g. IVI</td>
<td></td>
</tr>
<tr>
<td>NBM</td>
<td></td>
</tr>
<tr>
<td>Investigations</td>
<td></td>
</tr>
<tr>
<td>Home circumstance</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Activities of daily living</td>
<td></td>
</tr>
<tr>
<td>e.g. Pressure areas</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
</tr>
<tr>
<td>History of falls</td>
<td></td>
</tr>
<tr>
<td>Mental state – Confusion</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td></td>
</tr>
<tr>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>NOK informed of transfer</td>
<td></td>
</tr>
<tr>
<td>Additional Information</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 16

Patient Assessment for Escort

If patients are being transferred inter-departmentally you **MUST** assess their individual need for an escort prior to them leaving the ward / clinical area.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Patient requires transfer from: ..................................</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMC:</td>
<td>Patient requires transfer to: ...................................</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

**General points:**

- If DNARCPR completed this **must** accompany the patient on transfer
- Ensure patients medical and nursing notes including drug chart and transfer letter are complete and are transferring with the patient for Ward to Ward transfers
- Ensure medication is sent with the patient and indicate time next medication due within SBAR handover / collaborative records
- Complete patient transfer section within nursing and assessment of care document
- Ensure portable box of essential equipment is transferring with the patient who has a tracheostomy or laryngectomy
- Ward to ward transfers between 22:00 – 06:00 must be avoided

**This assessment form supports but does not replace clinical judgement.**

**Any concerns in decision making should be discussed with the Nurse in Charge, Matron and/or Consultant**
PATIENT ASSESSMENT FOR ESCORT

- Patient is medically stable and has capacity
- Patient complies with request and procedure/transfer
- Patient expresses no concerns in relation to transfer without escort

- Patient is medically stable but requires assistance with aspects of care (e.g., manual handling, emotional support)
- Patient at risk of falls/injury
- Patient has communication or language problems

- Patient has IV drugs or fluids via infusion pump
- Medical devices in situ (e.g., PCA, McKinley syringe driver)
- Any clinical concern on the NEWS
- Patient requiring oxygen therapy
- Patient with confusion/delirium
- Patient with tracheostomy or airway adjunct
- Patient with decreased level of consciousness

Member of staff who has completed this assessment prior to the patient leaving the ward area:

Name: ........................................ Signature: ........................................
Designation: ........................................
Date of assessment: ............................. Time: .................

Member of staff who has completed this assessment prior to the patient leaving the clinical area:

Name: ........................................ Signature: ........................................
Designation: ........................................
Date of assessment: ............................. Time: .................

Document to accompany patient on transfer; on return form to be filed within collaborative records.
If an inpatient has an existing outpatient appointment exercise professional judgement to decide if the patient can attend or contact the department to request a review on the ward.
Appendix 17

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the document/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Gender (including gender reassignment)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Religion or belief</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Sexual orientation</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?</td>
<td>No</td>
</tr>
<tr>
<td>4.</td>
<td>Is the impact of the document/guidance likely to be negative?</td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td>If so, can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>What alternative is there to achieving the document/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Co-ordinator, together with any suggestions as to the action required to avoid/reduce this impact.
# Appendix 18

## Document Development Checklist

<table>
<thead>
<tr>
<th>Type of document</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead author:</td>
<td>Nashaba Ellahi</td>
</tr>
<tr>
<td>Is this new or does it replace an existing document?</td>
<td>Replaces existing policy</td>
</tr>
<tr>
<td>What is the rationale/ Primary purpose for the document? [Motivation for developing the document]?</td>
<td>Joint document relating to safe transfer and discharge of patients in and out of the organisation</td>
</tr>
<tr>
<td>What evidence/standard is the document based on?</td>
<td>Joint working with Bolton Council around safe transfer of care in and out of hospital</td>
</tr>
<tr>
<td>Is this document being used anywhere else, locally or nationally?</td>
<td>Locally used with care homes, IMC and Bolton Hospital</td>
</tr>
<tr>
<td>Who will use the document?</td>
<td>All staff involved in transfer and discharge of care</td>
</tr>
<tr>
<td>Has a pilot run of the document taken place (optional)</td>
<td>N/A</td>
</tr>
<tr>
<td>Has an evaluation taken place? What are the results (optional)</td>
<td>N/A</td>
</tr>
<tr>
<td>What is the implementation and dissemination plan? [How will this be shared?]</td>
<td>Altered document to be shared at Professional Advisory Group (PAG) and a PINUP to support the key changes in the policy to be circulated widely via Intranet and through divisions.</td>
</tr>
<tr>
<td>How will the document be reviewed? [When, how and who will be responsible?]</td>
<td>Will be reviewed 3 yearly with joint review linked form hospital and social care.</td>
</tr>
<tr>
<td>Are there any service implications? [How will any change to services be met? Resource implications?]</td>
<td>None</td>
</tr>
<tr>
<td>Keywords [Include keywords for the document controller to include to assist searching for the policy on the Intranet]</td>
<td>Discharge, transfer, care, adult, section 2, referrals, disputes</td>
</tr>
<tr>
<td>Staff/Stakeholders Consulted:</td>
<td>PAG, Clinical Governance and Quality Assurance</td>
</tr>
<tr>
<td>EIA:</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Signed and dated</td>
<td></td>
</tr>
<tr>
<td>By validator</td>
<td></td>
</tr>
<tr>
<td>By ratifying officer</td>
<td></td>
</tr>
</tbody>
</table>
References


