East London NHS
NHS Foundation Trust

Community Health Newham Directorate

Transfer and Discharge Protocol for Community Health Services

Version:	1.0
Ratified by:	Community Health Newham Quality and Assurance Group
Date Ratified:	20th July 2012
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Name of responsible committee/individual:	Community Health Newham Quality and Assurance Group
Circulated to:	Heads of services, clinical managers and clinical staff
Date issued:	July 2012
Review Date:	July 2015
Target audience:	Clinical managers and clinical staff

Version	Date	Author	Status	Comment
1.0	June 2012	Petra Nittel, Governance Manager	Final	This protocol meets the requirement for the NHSLA risk management standards relating to the transfer and discharge of patients.

Contents

1. Executive Summary

Transfer and Discharge of patients brings specific risks and issues that require careful consideration and planning in order to minimise and manage risks effectively and ensure continuity of care.

General principles relating to communication, planning and implementation of care apply to both transfer and discharge of care happening across all Community Health Newham services. Specific considerations may be required depending upon the setting from which a patient's care is transferred or discharged to and from and may vary depending upon the patient group.

Procedures and interventions described in this protocol will also be found in more detail and specific related documents. This protocol aims to provide an overarching approach to the variety of transfers and discharge that happen routinely within Community Health Newham services.

2 Introduction

2.1 Admissions and discharge from community teams to prevent unnecessary hospital Admissions requires effective discharge procedures to ensure timely transfer of information and prevent unnecessary distress.

2.2 Patients and their carers must be involved at all stages of the process and kept fully informed of their care plans at regular multi-disciplinary reviews and updates. Assessments and care planning must continually engage patients and their carers, providing information in a manner which helps them to make unprejudiced decisions about care.

2.3 It is important to ensure that the patient is always treated as an individual and continuity of care is provided from one setting to another.

2.4 Failure in communication between staff in different services can increase the difficulty experienced by patients in response to transfer and discharge and also compromise the safety and quality of care.

2.5 In order to ensure a smooth and safe transition between various services, it is important to set out clear arrangements in terms of the process together with information requirements and timescales.

3 Purpose

The purpose of this protocol is to ensure that appropriate arrangements are in place when those receiving care and treatment from Community Health Newham are either transferred between services that the Community Health Newham provides or are discharged from the Community Health Newham which may involve the transfer of care elsewhere. It aims to draw attention to the potential risks involved in transfer and discharge and to emphasise the need for adequate planning in order that those risks are minimised and that continuity of care is provided.

4 Duties

4.1 The Trust Board
Has a responsibility to ensure there is a framework in place to promote the effective management of the problems and risks associated with the transfer and discharge of patients.

4.2 Directorate Management
Community Health Newham Heads of Services are responsible for ensuring that all operational managers are aware of this protocol, understand its requirements and support its implementation with relevant staff.

4.3 Clinical Team Managers
Are responsible for ensuring their clinical staff have a good working knowledge of this protocol and that the principles and standards within it are adhered to by their clinical staff. Team managers should have good clinical systems in place for effectively managing the transfer and discharge of patients and support adherence to this protocol.

4.4 Clinical Staff
Clinical staff have a responsibility to ensure they have a good working knowledge of the principles and standards contained within this protocol and that they comply with the requirements of this and associated policies with regards to the transfer and discharge of patients.

5 Principles of Transfer and Discharge

5.1 Where transfer or discharge is being considered, the patient's level of need should be assessed and referrals made to other services in a timely manner as appropriate. This will include social care and physical health needs.

5.2 Assessment and planning associated with transfer or discharge should always incorporate thorough risk assessment and planning. Consideration should be given as to the risks involved in escorting patients as part of a transfer and the necessary level of skill mix required.

5.3 It is important that patients are involved in the planning and decision-making about the transfer or discharge of their care and that this should take account of any preferences the patient may have.

5.4 Patients should be given adequate notice, where possible, about transfer and discharge arrangements and given clear information about support options available following transfer or discharge, in order that joint and informed choices can be made.

5.5 Patients and carers should be provided with clear information about how they can access the service again, if arrangements following transfer or discharge do not work out or things deteriorate.

5.6 Patients and carers should have clear information provided about the referral pathways and processes for any services they are being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, time-scale of intervention).

5.7 It should be acknowledged with patients, that discharges and transfers are often an anxiety provoking time. Patients should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of treatment and transition from one service to another may evoke strong emotions and

reactions and staff should ensure that such changes are discussed carefully with the patient beforehand and are structured and phased.

5.8 Family and carers should have the opportunity (with the agreement of the service user) to be involved in the planning of transfers or discharge, where appropriate.

5.9 Involved family and carers should be notified before the service user is transferred or discharged.

5.10 Planning with regards to transfer and discharge should be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the arrangements and refer to these when needed.

5.11 Clinical staff should engage with and communicate effectively and timely with others involved in the transfer and discharge process. This will include Trust staff, staff from other agencies i.e. social care or NHS bodies, patients, their family and/or carers. Key information should be given to those who become responsible for treatment and care following transfer or discharge.

5.12 In many circumstances, transfer and discharge will follow similar procedures and general principles will apply to each activity.

6 Transfer

6.1 This protocol applies to patients being transferred to other inpatient or outpatient services while the 'bed' is kept open for the patient's return (East Ham Care Centre and Virtual Ward).

6.2 The planning of all transfers to and from an acute hospital should incorporate detailed planning of both mental and physical health care needs and treatment and a detailed plan of care should always accompany the patient and a verbal handover provided at the point of handing over the patient to the receiving care providers.

6.3 Documentation to accompany the patient on transfer

As a minimum the following records should accompany any internal or external transfer:

- Healthcare records
- Drug charts
- Care plan
- X-rays or other diagnostic records as appropriate

6.4 Out of hours transfer arrangements

Transfer of patients out of hours is sometimes necessary but where possible transfer should happen during normal office hours. Any out of hours transfers should pay special regards to safe escort arrangements, prior risk assessment and adequate supporting documentation to accompany the transfer.

6.5 Infection Control

When planning transfers, discharges or re-admission of any suspected or confirmed infectious service user, advice must be sought from the Infection Control Nurse and Physical Healthcare Lead to ensure that risks of cross infection are assessed and minimised.

7 Discharge

For the purpose of this protocol, discharge will refer to patients discharged from all services

7.1 Discharge from East Ham Care Centre and the Virtual Ward

The discharge process for all patients should begin at the point of admission and in the majority of cases is planned, following a multi-disciplinary care planning/review meeting actively incorporating the views of patients, their family and carers and any voluntary or independent sector agencies providing care or support to the service user. Exceptions to this may occur when discharge is at short notice or is against medical advice.

7.1.1 Patients should be offered a copy of their care plan and give consent as to who else may have a copy.

7.1.2 Appropriate discharge information, including medication needs should be provided to GPs or other agencies that may be providing any ongoing care to patients. A final care plan should be produced and with the patient's agreement, circulated appropriately, indicating that discharge has taken place and is with GPs within two working days.

7.1.3 Staff must comply with the Trust's Medicines Policy in respect of discharge medication and the information that should be given to patients when they are discharged.

7.2 Discharge from the outpatient based services

Appropriate discharge information including medication needs should be provided to GPs or other agencies that may be providing any ongoing care to patients.

8 Implementation, Monitoring and Review

Clinical staff should be made aware of the requirements of this policy and associated policies, procedures and guidance by their line managers. All related policies and guidance should be readily available to staff via the Trust's website and or intranet site. This protocol will be reviewed every three years unless it is deemed necessary to do so sooner.

Lead	Tool	Frequency	Reporting Arrangements	Actions on recommendations and leads	Change in practice and lessons to be shared
Associate Medical Director for Primary Care	Health care records audit	annual	The Deputy Director of Nursing receives the audit report	The Associate Medical Director for Primary Care will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit	The Clinical Effectiveness Sub Committee will receive and discuss the report and monitor the action plan within six weeks of the audit
Associate Medical Director for Primary Care	CQUIN report Healthcare records audit	annual	The Deputy Director of Nursing receives the CQUIN report	The Associate Medical Director for Primary Care will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit	The Clinical Effectiveness Sub Committee will receive and discuss the report and monitor the action plan within six weeks of the audit

9 Associated Documentation

8.1 Admission and Discharge Policy
8.2 East Ham Care Centre Operational Policy
8.3 Virtual Ward and Extended Primary Care Team Operational Policy
8.4 Service specific documentation

10 References

9.1 NICE (02/2012) Patient experience in adult NHS Services: Improving the Experience of Care for People Using Adult NHS Health Services. NICE Clinical Guideline 138. London: NICE