Reference Number: UHB 373 **Version Number:** 1	**Date of Next Review:** 6TH Dec 2020 **Previous Trust/LHB Reference Number:** N/A

Discharge from Hospital Procedure

Introduction and Aim

The Hospital Discharge procedure is a document which is intended to support the Cardiff and the Vale UHB Discharge from Hospital Policy.
The aim of the Procedure is provide direction, support and guidance to the Policy and is to be utilised by ward based multidisciplinary teams when planning discharge.
The Procedure aims to ensure that each member of the Team has a clear understanding of their contribution to the effective, timely discharge and that staff recognise the importance of Patients and /or Carer engagement at the earliest possible opportunity.

Objectives

The objectives of the Discharge from Hospital Procedure are to :

- Identify the key principles of discharge and understand the links with other policies and how they impact upon the discharge process
- Clarify roles and responsibilities of key staff associated with the discharge process
- Promote a co-ordinated multidisciplinary team approach to discharge and care planning
- Promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place
- Support good communication between clinical teams across the health community, patients and their families/carers
- Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented in a safe and co-ordinated manner
- Promote IM&T communications i.e. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems
- Encourage a strengths based approach to the assessment of need ; and
- Provide key performance indicators

Scope

This procedure applies to all of our staff including those with honorary contracts involved in the discharge of patients from hospital sites of Cardiff and the Vale UHB. The procedure also provides advice on how other statutory organisations support the Discharge Policy.

Equality and Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed and found there to be a positive impact
Documents to read alongside this Procedure	Discharge from Hospital Policy Choice of Accommodation Protocol for Inpatients
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Chief Operating Officer
Author(s)	Head of Integrated Care

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	06/12/17	12/12/17	new document

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1. Introduction

This Discharge from hospital Procedure reflects the principles identified in the Social Services and Well-being Act 2014 (the Act) which was implemented in April 2016. It will ensure that staff actively work towards a strengths based assessment of care needs recognising the importance of an integrated health and social care approach to discharge planning

Supporting the Act's principles is the local Strategy of the Cardiff and Vale University Health Board (UHB): 'Caring for People, Keeping People Well'. This procedure has been developed to provide the framework within which the UHB will support patients to be discharged from hospital at the earliest opportunity and in accordance with their individual ongoing needs as identified on the assessment document. It will include guidance to staff to provide a standardised approach to discharge planning.

The principle of making suitable information, assistance and advice available to patients, and their carers/families at the earliest opportunity is central to the discharge planning process. This should include information in relation to financial assessments and charging for social services and /or accommodation.

2. Statement

A safe discharge is one where the risks associated with the person's ongoing needs are identified and recorded. The UHB cannot prevent or reduce all risks but will work with patients and their families to make the discharge as safe as possible. All risks and discussions about risks should be recorded for those who may be involved in ongoing care.

Working in tandem with social care colleagues, Cardiff and Vale UHB will take all reasonable and practicable steps to provide a mutually agreed safe, effective and timely discharge service for people based on their assessed needs.

This procedure sets out Cardiff and Vale UHB's approach to working with patients, their families and partner organisations to support a patient's safe and timely discharge from hospital.

Central to the policy and procedure are these principles:

- Patients and/or their representative are involved
- Patients are informed
- Using strengths based approach
- Discharges are safe
- Discharges are timely
- Discharges are co-ordinated

Consideration of capacity and the principles and requirements of the Mental Capacity Act 2005, the Mental Health Measure 2010 and the Safeguarding Adult

Procedures must underpin the application of this policy which will include recognition of those who hold a Lasting Power of Attorney, a Court appointed Deputy and verification of an Advanced Decision to refuse treatment.

All patients should receive a leaflet with necessary information, detailing the discharge planning processes. This "Planning your Discharge" information leaflet can be found at
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/PLANNING%20DISCHARGE%20BOOKLET%20-%20DEC%202012.PDF

3. Objectives

- To identify the key principles of discharge and understand the links with other policies and how they impact upon the discharge process
- To clarify roles and responsibilities of key staff associated with discharge
- Promote a co-ordinated multidisciplinary team approach to discharge and care planning
- To promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place
- Support good communication between clinical teams across the health community, patients and their families/carers
- Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented in a safe and co-ordinated manner
- To promote IM&T communications ie. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems
- Strengths based approach and key performance indicators

4. Responsibilities

The consequences of delayed discharges are well referenced, especially in respect of older people with frailty who are vulnerable to:

- Loss of muscle strength
- General decline
- Loss of confidence and mobility
- Delirium and deterioration of cognitive function
- Increased risk of falls and hospital acquired infections

The Clinical Boards have operational responsibility to implement effective and efficient systems and processes to ensure that all patients receive evidence based person-centred care and treatment within the available resources. This will include

ensuring that discharge planning is organised and managed so that patients get the right clinical care under the right clinical teams at the right time, and that they are supported to be discharged from hospital when they are fit for discharge.

5. Patient Experience

- The wishes of patients should inform the development of care plans and the discharge process
- The patient and their family/representative (with the patient's consent) should be engaged at every stage of the discharge planning process and this should be recorded on the discharge plan
- Every effort should be made to take into account cultural, religious, or language differences and sensory disabilities. All staff should be sensitive to special needs arising from these differences

6. Legal context

- Where there is doubt about a patient's decision making abilities in relation to discharge destination, the Mental Capacity Act 2005 must be followed. https://www.gov.uk/government/statistics/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-2015-to-2016
- Patients who are subject to the Mental Health Act 1983, must have a robust management plan in place prior to discharge. http://www.legislation.gov.uk/ukpga/1983/20/contents
- If there are any concerns that the patient may be an 'Adult at Risk' as defined under the Social Services and Wellbeing (Wales) Act 2014, the assessing professional must follow local safeguarding procedures. If a patient requires care and support at home every effort will be made to carry out the assessment in the patient's own home
- Must be compliant with Human Rights Act Articles 5(Right to liberty) & 8(Right to respect for private and family life)

7. Safety

- All staff should be aware of the increased risks to patients associated with an extended hospital stay
- A Discharge Planning Checklist must be completed for every patient, with information provided, re: follow up appointments, on-going care of wounds, drains, vascular lines, catheter care, continence aids, gastrostomies and NG tubes

8. Effectiveness

- Clinical Expected Length of Stay (CELOS) should be set within 48 hours of admission, and discussed with the patient and their family
- Decisions in relation to the discharge of patients should be made each day during ward Board Rounds
- Discharges should be planned to take place every day of the week.
- All staff in contact with patients should be clear to explain to patients and their families that once a patient is 'medically fit' i.e. no longer requires an acute hospital bed, they do not have the right to occupy that bed

9. Timeliness

- Discharge planning should commence on admission in collaboration with the patient and their family with the patient's consent.
- Arrangements for discharge from hospital should ensure there is seamless care, so the person does not experience a gap in care due to hand over from hospital to home.
- Where arrangements for ongoing care are not in place and interim arrangements are made this should not disadvantage the person being discharged, such as where a person agrees to move to temporary accommodation while awaiting grant work in their own property.
- Equipment required for discharge should be identified early in order to be in place when the person is discharged.
- An assessment of the person's needs should be carried out as early as possible and consideration of eligibility for Continuing NHS Health Care should be done by MDT as part of the discharge planning process.

10. Roles

Cardiff and Vale UHB through the Chief Executive as the 'Accountable Officer' **-** The Accountable Officer is responsible for setting the strategic direction and the policy framework. As part of the strategic direction and the policy framework, care will be provided using collaborative working arrangements across all the agencies responsible for the provision of health and social care for the population served, within Cardiff and Vale UHB.

a. Ward Nurses – Care Coordinator

- Act as care co-ordinator for own group of patients on each shift
- Discharge plans (including Planned Date of Discharge) are discussed with patient and family/carer at intervals throughout their stay in ward area and written discharge information is provided
- Coordinate proportionate, integrated and specialist assessments where appropriate
- Ensure assessments and decision making documents provide evidence of needs and risks that inform discharge plan

- Identify constraints in the patient's discharge plan and escalate as appropriate to Ward Sister / Charge Nurse or Deputy
- Ensure reasons for delays or failure in meeting the Planned Date of Discharge are recorded on clinical information systems
- Recording exact time of discharge on Clinical Information systems within 10 minutes of patient being discharged from the ward
- Ensure all the relevant information is available at the Board Round
- Early identification of equipment needs and discussion with appropriate therapist including alternatives for support on discharge e.g. Community Resource Team (CRT) and anticipated delivery date of any equipment required
- Ensure Discharge Planning Checklist is completed for **all** discharges
- Ensure transport arrangements are discussed with family and where necessary book ambulance transport 24 – 48 hours prior to discharge. Transport arrangements must not delay discharge
- Ensure take home medication is requested 24 – 48 hours prior to discharge
- Effective use and early transfer to Discharge Lounge where appropriate

Sisters/Charge Nurses - are responsible for the organisation and management of care provided to patients on their ward. This will include the co-ordination of care to ensure that all patients get the right care by the right professionals at the right time. In so doing they will ensure:

- That all patients have a CELOS set within 48 hours of admission and that this is recorded on the Clinical Work Station (CWS) and noted on the board round board
- That all patients have a care, treatment and discharge plan that is reviewed daily so that patients and their families are kept fully up-to-date as equal partners on all aspects of their care
- That efficient and effective multidisciplinary (MDT) board rounds are held every day, care plans for all patients are discussed and actions such as tests, treatments, assessments and referrals are carried out and all delays chased up
- That every patient has a clear discharge plan that is reviewed daily and all delays escalated appropriately
- That the **Choice of Accommodation Protocol** is properly implemented for **all** patients being discharged to a Care Home
- That all formal MDT meetings are properly co-ordinated and managed so that all information to inform effective decision-making is presented and agreed actions documented and followed up
- There is effective liaison between the ward and Integrated Discharge Service

- That a 'live' bed state is maintained on the CWS at all times so that the Patient Access Team are able to co-ordinate the admission of new patients to the most appropriate ward

b. Senior Nurses **–** in relation to discharge planning, senior nurses will ensure that this policy is implemented within their area of responsibility. This will include ensuring that:

- There is an effective board round regularly to assure that all patients are reviewed on a daily basis and meaningful decision are made and executed
- Any discharge delays that cannot be resolved at ward level are escalated to Lead Nurse
- They attend at multiagency weekly DTOC meetings to identify and escalate constraints
- They act on escalated constraints to discharge

c. Senior Medical Staff **–** are responsible for ensuring that there is a clear documented Clinical Plan that has been discussed with the patient, for all patients under their care. The Clinical Plan will include:

- Differential diagnosis
- Investigations to confirm / rule out a diagnosis and how to act on results
- Immediate treatment plans
- Treatment to be started based on results
- Any further functional assessment required
- Anticipated need for therapies input
- Anticipated need of social input
- Clinical Expected Length of Stay (CELOS)
- Post-hospital management plan
- Relapse signatures and crisis management plan (for Mental Health)

d. The responsible Consultant (or their delegated deputy) will attend the daily board round to discuss all clinical plans with the MDT and ensure all decisions / changes to the plan are effectively communicated and acted upon. S/he will also ensure that:

- All 'to take home' (TTH) medicines, etc., are completed in good time to enable early discharges - for example blister packs for medications are ordered a week prior to discharge
- Discharge documentation (including Integrated Assessment / Continued Health Care) is legible; outcomes and recommendations are documented and completed in a timely way as a part of the MDT assessment process
- Electronic discharge summaries are completed on day of discharge
- A clear plan, including any follow-up care, is in place for patients who are likely to be discharged over the weekend
- Where a person is not returning to the care of their previous GP the doctor has a responsibility to ensure the receiving GP is provided with appropriate information to provide ongoing care

e. Allied Health Professionals, eg Occupational Therapists, Physiotherapists, Dieticians, Pharmacists will:

- Attend the daily board rounds to give professional input and participate in MDT discussion on individual Clinical Plans to ensure timely discharge
- Provide advice, support and training to MDTs in planning safe and timely discharge of patients
- Work with the CRTs to identify patients who can be 'discharged to assess'
- Provide teaching, training and supervision to achieve best practice in discharge planning
- Participate in CHC assessment processes and provide expert advice
- Escalate any discharge delays to the appropriate level
- Ensure that the ward clinical work station is maintained up-to-date so that the Integrated Discharge Service (IDS) and the CRTs are accurately informed about patient progress

f. Directorate Managers /Lead Nurses **–** will ensure that the Policy and this Procedure are fully implemented within their area of responsibility. This will include:

- Monitoring performance associated with discharge, freeing up bed capacity, reducing length of stay (LOS) and delayed transfers of care (DTOC)
- Ensuring that the ward clinical work stations are kept up-to-date at all times so that IDS and CRT are accurately informed about patient progress
- Escalating any untoward patient delays that are likely to impact on patient flow issues to the appropriate level

g. Clinical Board Management Teams - are responsible for ensuring that the Policy and Procedure are properly implemented within their Clinical Board. This includes ensuring that:

- All staff are made aware of their responsibilities within the Policy and Procedure.
- Adequate training and support is provided to facilitate adequate understanding and implementation of the Policy and Procedure.
- Effective systems are established to monitor the impact of the Policy and Procedure and the discharge planning processes.

11. Integrated Discharge Service IDS

The Integrated Discharge Service, supported by the Head of Integrated Care, will work with clinical teams to support discharge planning processes for people with complex ongoing health and social care needs.
The IDS Team will:

- Use a Standard Operating Procedure as a framework for a work plan
- Act as a resource to all members of the multi-disciplinary team, to provide expert discharge planning advice

- Provide teaching and training, both formal and informal, at ward and departmental level to improve discharge planning
- Support ward teams in the long-term placement assessment process
- Act as a liaison point between ward teams and other agencies
- Escalate any discharge delays appropriately
- Ensure that the IDS activity on the ward clinical work station is maintained up-to-date so that the IDS and the CRTs are accurately informed about patient progress

12. Discharge Documentation

All discharge arrangements should be recorded on the patient's own medical record **and** on the Health Board clinical information systems. If appropriate an accurate contemporaneous record will be available on Social Services client information systems.

13. Discharge Information for Patients and their Families

Patients and their families (where appropriate) will be engaged as equal partners in all aspects of care throughout the in-patient period. On discharge, individual members of the MDT will provide a written summary of the care and treatment while in hospital, including any changes to medication and any further tests, investigations and outpatient clinic appointments, which may be needed.

The patient and their family (where appropriate) will also be provided with any other appropriate information/ contact details relevant to their ongoing care and /or condition.

14. Discharge Summary / Communication with General Practitioners

The patient's Consultant will ensure that an electronic discharge summary is completed for all patients on their day of discharge and forwarded to the patient's GP. The discharge summary will include; the patient's diagnosis and treatment plan and any advice on on-going patient management and follow-up arrangements, details of medication particularly any changes in medication, and the date of discharge.

Where there is a radical change in treatment or medication or where there are complex issues in relation to the ongoing medical care the patient's Consultant is responsible for ensuring the patient's GP is informed by telephone.

A comprehensive discharge summary will be sent to the General Practitioner within 14 working days of the patient's discharge by the patient's consultant.

Discharge against Clinical Advice

There are occasions when patients will want to discharge themselves against clinical advice. In these circumstances the ward staff must endeavour to establish the reason for the self-discharge. Where there is no reason to doubt a patient's capacity to make this decision, the ward team must respect the right of the individual to leave the hospital, ensuring that where possible they have been provided with sufficient information to make a fully informed decision. The 'Discharge Against Clinical Advice' procedure must be followed.
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/EMERGENCY_UNIT_CP/UHW%20EMEREGENCY%20UNIT%20DOCUMENTS/CLINICAL%20GUIDANCE/DACA%20PROCEDURE.PDF

15. Refusal to Leave Hospital

If for any reason a patient refuses to leave hospital, every effort will be made to facilitate the discharge to the patient's place of choice. Where difficulties are experienced in transferring care of the patient to the care home of choice , the Multidisciplinary Team will work with the patient and their family/or representative to secure a suitable alternative. This will be done in accordance with the Choice of Accommodation Protocol. Where there are unresolved issues the case should be escalated for consideration to the Clinical Board.

16. Continuing NHS Healthcare (CHC)

For those patients with complex needs their on-going care will be determined following the completion of an 'Integrated Assessment' and, if necessary, the completion of the Decision Support Tool (DST), in accordance with the Continuing National Health Service Care guidance (2014).
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/CHC%20-%20NATIONAL%20FRAMEWORK%20FOR%20IMPLEMENTATION%20IN%20WALES.PDF

If patients are deemed eligible for CHC or a joint package of care, the patient will be assessed by the MDT supported by the IDS Team and the package of care will be planned and implemented accordingly.

If a patient requires a bespoke/specialist piece of equipment there may be delays in the provision of this equipment so every effort must be made to order this as early as possible. While delays should always be minimised, they should however, be taken into account when planning the discharge and transitional placements used where appropriate.

17. Fast Track Continuing Health Care Discharge Integrated Discharge Service

The 2014 Continuing NHS Healthcare, National Framework for Implementation requires the UHB to have in place a fast track processes aimed at supporting individuals with a rapidly deteriorating condition who are entering a terminal phase of their disease and be in the last weeks or days of life. The fast track process enables them to be supported in their preferred place of care. All staff must ensure that this streamlined process provides enough information to support the rapid approval and arrangement of an appropriate package of care.

All staff involved in the Fast Track process must read the guidance notes carefully and have a clear understanding of the requirements for this process including the need for the Fast Track Care Plan.

Patients and their recognised carers will have provided informed consent to share information about them with community staff who will be providing their care. Patients and their families will be provided with contact details of their Community Key Care Co-ordinator prior to discharge.

It is essential that a timely decision is made in order that the patient receives their care in a setting which they and their families request as long as it can meet their identified needs.

Where a person's home is a residential care home in usual circumstances they would not be able to return with nursing needs however if this is a placement they have been in for some time consideration will be given by the UHB for a return there for end of life care with support from primary care. It is essential that Primary Care services continue to oversee the clinical care and District Nurses are invited to participate in decision making to assure a safe discharge.

18. Choice of Accommodation Protocol

The Protocol sets out the process for the safe and permanent placement of patients in an appropriate care setting and in a manner which reflects their right to choose their accommodation. This is a significant decision and requires careful consideration by the patient (or their Lasting Power of Attorney, (if applicable), their advocate and their family and/or carers. Obtaining good advice from health care and social care professionals is essential, to ensure that the process is done effectively and efficiently.

Each stage of the discharge planning process should be approached in a supportive manner. The patient (or their LPA where applicable) and their family/carer/advocate should be offered explanations verbally and in writing, there should be counselling and further support throughout the process.

19. Vulnerable Groups

Some individuals may require additional support when planning their ongoing care arrangements and may include individuals with a learning disability; people who are homeless; those who have a physical or sensory disability; people who have a mental illness, including dementia; and those who are old with frailty. There should also be due consideration of those adults and children who have existing safeguarding plans in place.

20. Performance Measures

Compliance with this Discharge Policy and Procedure will be monitored as part of Cardiff and Vale UHB's operational performance management process to include:

- Reduction in number of delayed transfers of care
- Reduction in number of bed days lost
- Reduction in number of complaints associated with the discharge process
- Achievement of expected Date of Discharge
- Increased number of discharges achieved before noon
-

The Clinical Boards are accountable for enforcing and supporting this Policy and Procedure and performance of Directorates will be reviewed at Operational Performance Group meetings.

21. Review of Policy

The Policy will be reviewed every three years and will include:

- Regular audit of compliance
- Monitoring of complaints and reported incidents and areas of consistent difficulties
- Feedback from key stakeholders including patients/carers/advocates

22. References

This document needs to be read in conjunction with other resources/ polices. The appropriate links have been made on the electronic version but in the written document they are referred to in the index.

23. Glossary of Terms

Planned Date of Discharge
This is a date identified by the admitting ward team, based on information gained during admittance assessment, as to when the patient is likely to be discharged.

Ready for Transfer

Ready for transfer of care date is the date on which a hospital inpatient is ready to move on to the next stage of care. This is determined by the clinician responsible for the inpatient care, in consultation with the multi-disciplinary team and all agencies involved in planning the patient's discharge or transfer to a more appropriate NHS care setting. A patient who continues to occupy a hospital bed after his/her ready for transfer of care date during the SAME inpatient episode experiences a delayed transfer of care

Discharge Fit (Fit for Discharge)

- Is when the patient no longer benefits from on-going hospital based inpatient services, within a tertiary / secondary care setting and where:
- on-going care and social needs have been agreed and can be met in another setting, home or through primary, community, intermediate care or social services.
- on-going care and social care needs can be met more appropriately in a secondary or community care setting closer to the patients' home.
- additional tests and interventions can be carried out in an outpatient or ambulatory setting.

Care Plan

Where hospital staff provide a plan of care that documents the care a person requires how often and the risks to the person if care is not provided in order that all staff responsible for the patient's care are able to provide it consistently and identify any changes in needs.

Plan of Care and Support (POC)

- The documentation the local authority requires to be completed by the social care worker to ensure ongoing care. This is usually commissioned by a local authority.

24. Other sources of information can be found at IDS web site

Integrated Discharge Service

1. Choice Protocol
2. Simple/Supported/Complex Matrix
3. Clinical Workstation Operating Procedure
4. Ticket Home
5. Discharge Checklist (Draft)
6. Provision of Equipment
7. Procedure for requesting Non-Standard CHC Funded Equipment
8. Procedure for requesting CHC Equipment
9. The Discharge Pathway
10. Discharge Lounge Service
11. Pharmacy
12. CHC Fast Track Discharge

Hospital discharge for patients of no fixed abode

APPENDIX 1

CARDIFF AND THE VALE INTEGRATED DISCHARGE SERVICE JUNE 2017 STANDARD OPERATING PROCEDURE

The Integrated Discharge Service (IDS) brings together experienced professionals from health and social care into one hospital based team that can support and advise individuals and professionals in non mental health beds of Cardiff and Vale UHB.

Ward teams are required to identify discharge planning for all patients as simple supported or complex. The simple, supported, complex matrix is built in to the clinical workstation (CWS) and there is a requirement for ward teams to update the CWS regularly. The Integrated Discharge Service will support ward teams with discharge planning differently in each category (refer to simple supported complex matrix)

Category	Integrated Discharge Service
Simple Discharge	Support ward team with sign posting to community services that may support the person following discharge Age Connects Discharge Support Officers can spend time with patients and their families discussing their wishes and concerns regarding discharge from hospital and providing a consistent point of contact for families ward team The responsibility for discharge and decision making remains the responsibility of the ward team and the ward need to identify a named coordinator for the discharge planning.
Supported Discharge	A named person from the IDS team will work with the MDT to plan a person's discharge from hospital. This may be • A discharge support officer to work with and support communication with families • A contact officer to work with ward and care agency to restart a care and support package • A social work assistant to restart or amend a care and support package The responsibility for discharge and decision making remains the responsibility of the ward team and the ward still need to identify a coordinator on the ward for IDS to liaise with
Complex Discharge	A named person from the IDS team will work with the MDT and coordinate a person discharge from hospital. The IDS coordinator will work with the ward coordinator for each patient to arrange meetings and ensure • A comprehensive assessment is completed • Discharge planning involves patients and their families • Meetings are action focused, recorded accurately and provide rationale for decision making • Transfers of Care are completed in a safe and timely manner so that there is continuity in the care and support a person receives wherever they may be discharged to • facilitate and support CHC assessments

Access to the Integrated Discharge Service

Board Rounds will be attended regularly by a member of the IDS team to provide immediate advice and prompt focus of the board round on discharge planning. Where agreed with Multi disciplinary team the IDS representative will present cases to the IDS team briefing and liaise between IDS and ward team.

Discharge Support Officers Each ward has a named Discharge Support Officer and that Discharge Support Officer will attend each ward at least twice weekly

- to visit patients and families offer information and sign posting as first point of contact
- to liaise with and answer questions any staff may have
- to ensure people referred to CRT are aware of referral and have information about the service

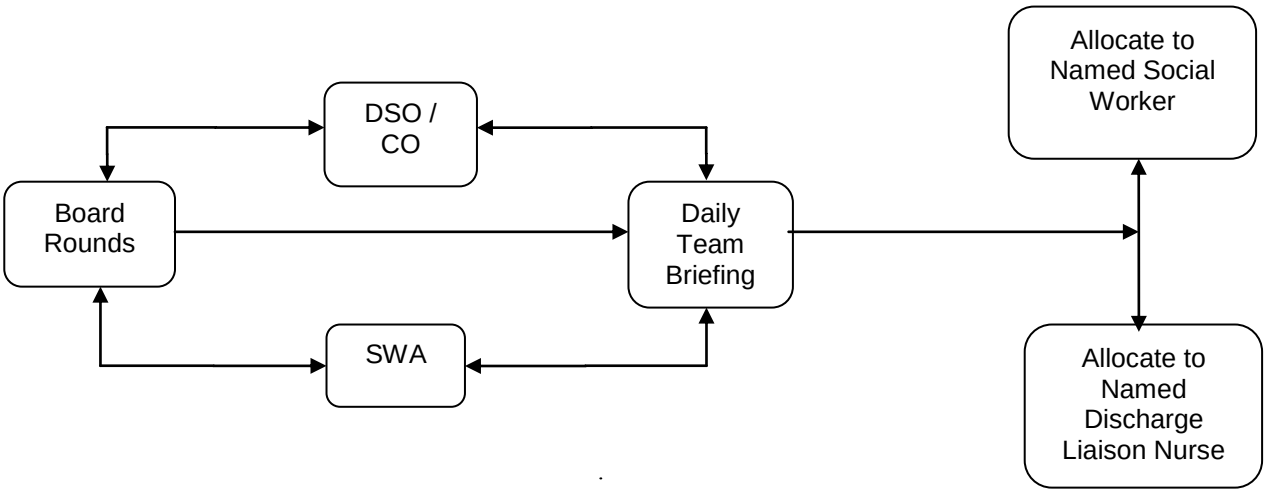
Phone call to Integrated Discharge Service Anyone can ring the IDS department and ask for advice, the only information required is the patients name and ward and what advice is required. The Admin team will direct the request to the relevant IDS team who will respond within next working day.

IDS UHW Tel 029 20742768 or 029 20742098 (discharges from UHW)
IDS Llandough Tel 029 20715522 (discharge from Llandough or Barry)
St David's Hospital please Ring UHW for Hamadryad and Rhydlaver
Ring Llandough for Lansdowne ward

Hours of service: Monday to Thursday 0900 and 1700. Friday 0900 and 1630.

Out of hours Cardiff and Vale Emergency Duty Team. Tel 029 20788570
Mobile 07812230073
Fax 029 20226640
email edt@cardiff.gov.uk

Workflow Integrated Discharge Service



The IDS team is divided into 5 sub team for working and case load management (see Ids team structure) Each team is made up of contact officers(CO's), discharge support officers (DSO), housing support officers (HSO), social work assistants (SWA), social workers and discharge Liaison nurses. The IDS team will decide which is the appropriate person to work with each patient.

Each day the sub team will have a short tem briefing to review new cases for allocation and action and escalation of existing cases for support from within team. At times of absence of any member of the sub team any other member of the team should be able to liaise with ward and patient or relatives.

Escalation of Constraints and delays to Discharges

DSO, CO, SWA and HSO can escalate delays and difficulties via the daily team briefing for action and to address.
Where each sub team are unable to progress and resolve delays then they should escalate to their respective team managers
Ward teams can escalate delays via their senior nurses

Regular meetings

Daily team Briefing
Weekly DTOC meeting is a forum to identify and share delays in transfers of care and action to avoid delays
Weekly Quality Assurance meeting to present cases complex cases where there is consideration of Continuing NHS Healthcare, joint funding of packages of care or disagreements
Monthly DTOC meeting to review and agree delays reported to Welsh Government prior to submission of DTOC report.