Discharge and Transfer of Care - Adults Policy

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Brief Summary of Document:	This policy provides guidance to all those involved in in-patient care provision and community care and should be adopted for all discharges of care from and transfers between hospitals across Hywel Dda University Health Board.
Scope:	The Discharge and Transfer of Care Policy application is the responsibility of all health care professionals and support staff working in the Hywel Dda University Health Board care environment. The policy covers all clinical environments where inpatient care is received and incorporates the needs of children, young people and adults, but excludes neonates children and young people and any registered professionals caring for the said patient group.
To be read in conjunction with:	141 – Independent Medical Capacity Service Policy 163 - Deprivation of Liberty Safeguards 289 - Record keeping for Nurses and Midwives Policy 295 - Protection of Vulnerable Adults from Abuse Policies & Procedures 309 - Continuing NHS Healthcare (CHC) Operational Policy to support the National Framework for implementation of CHC 341 - Prescription and Administration of Emergency Oxygen in Adults Policy & Procedures

	548 – Care Home of choice policy 811 – Mental Capacity Act Practice Guidelines HDUHB Discharge and Transfer of Care Policy – Paediatrics and Neonates – Draft Status
Patient information:	

Owning Group	Senior Nursing & Midwifery Team (SNMT)

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Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy	16.5.2016
2	Full reviewed	24.10.2019

Glossary of terms

Expected date of discharge	EDD
Multi-disciplinary team	MDT
Length of stay	LOS
Continuing NHS Healthcare	CHC
Do not attempt resuscitation	DNAR
Non emergency patient transport	NEPT
Average length of stay	ALOS
Delayed transfers of care	DTOC
Discharge liaison nurse	DLN
Deprivation of Liberty Safeguards	DOLS
Key performance indicators	KPI
Discharge Support Tool	DST
For the purpose of this policy out of hours refers to between 20.00 hours and 08.00 hours	Out of Hours
Nursing & Midwifery Council	NMC

Keywords	Discharge, Expected Date of Discharge, Transfer of care, Complex discharge, Delayed discharge, Transport, Equipment on discharge, Local discharge, Discharge planning

CONTENTS

1. INTRODUCTION

Hywel Dda University Health Board (HDUHB) is committed to providing safe, evidenced based health care which meets with national standards of best practice.

Discharge is a process not an isolated event (DOH 2003). The Welsh Government Circular 2005/17 – Hospital Discharge Planning Guidance highlights that people being discharged from hospital are entitled to expect and receive a smooth transition from one stage of care to the next. A lack of coordinated and person centred planning for discharge can lead to poor outcomes for patients possibly jeopardising health and safety or leading to inappropriate readmission to hospital

This Policy sets out the strategic direction and detailed procedures for discharge and transfer of care arrangements for hospital inpatients in Hywel Dda University Health Board.

It gives an opportunity to impact on the whole system improving the patient journey and patient experience by re-enforcing what needs to be done to make discharge safe and effective

2. POLICY STATEMENT

This policy clarifies the Health Board's core responsibilities - corporately, clinically, professionally and externally with key partners. It should be read in conjunction with the list of national and local documents as listed on page 1 of this policy. The Acute and Community Services Management Teams, through the Acute and Community Management Structures, are responsible for the development and delivery of the Service Implementation Plans which are the operational vehicles to fulfil this policy and will adhere to the key strategic principles laid out in this policy for discharge and transfer of care for acute and community hospital inpatients.

3. SCOPE

The Discharge and Transfer of Care – Adults Policy application is the responsibility of all health care professionals and support staff working in the Hywel Dda University Health Board care environment. The policy covers all clinical environments where care is received which includes young people between 16-18 years old. For children and young people under 16 years refer to Discharge and Transfer of Care for Paediatrics and Neonatal Policy – Draft Status) . The Policy is the responsibility of all Health Care Professionals and support staff working within the HDUHB environment.

4. AIM

The aim of the policy is to ensure a safe, timely, efficient patient centred discharge and transfer of care.

5. OBJECTIVES

The objective of the policy is to set out the framework to ensure that all individuals and teams are aware of their roles and responsibilities in the implementation and application of this Discharge and Transfer of Care Policy, incorporating the seven core principles as detailed in section 6.

6. THE DISCHARGE AND TRANSFER OF CARE PROCESS

6.1 Key Principles

The following principles are the drivers for delivering effective and timely discharge planning arrangements for acute and community hospital inpatients.

i. **Communication:** Patients and their designated representatives are to be fully involved and engaged in the discharge process at the outset and encouraged to fulfil their responsibility within the process. There must be appropriate consultation and involvement of the patient and their/family/carer/ advocate in the discharge process. Appropriate communication to other professionals involved in the on-going care of the patient following discharge is mandatory.

ii. **Coordination:** The discharge process will be coordinated by a nominated person linking in with the multidisciplinary team as required, and a deputy will be identified when the named person is absent, to ensure continuity of plans.

iii. **Collaboration:** Liaison and communication with and between the multi disciplinary teams/appropriate agencies with patient and family member/carer involvement in order to arrange the provision of appropriate services will take place, including timely referrals and assessments.

iv. **Consideration:** A comprehensive assessment of the patient's home circumstances will take place in line with the principles of the Integrated Assessment, identifying the support required to achieve the best available way of meeting the care needs of the patient. Consideration for the family member/Carer and their needs as well.

v. **Creativity:** Consideration of the range of services that most appropriately meets the patient's needs that will promote and sustain their optimum level of independence.

vi. **Integrity:** Displaying a moral and ethical duty to secure the best possible outcome for the patient and their family member/carer.

vii. **Partnership:** Effective communication and collaboration between Patient/carer or advocate and all agencies, ensuring clear lines of responsibility and accountability for the process.

6.2 Discharge or Transfer from Care

The Department of Health (2003) identifies that a patient is ready to be discharged from hospital care when:

- A clinical criteria for discharge set by the Clinician in charge of care has been made that the patient no longer requires care and is ready for transfer and/or;
- A multi-disciplinary team decision has been made that the patient is ready for discharge/ transfer and;
- The patient is safe to discharge/transfer.

These three criteria are not separate or sequential stages; all three should be addressed at the same time where ever possible and consideration must also be given to family members/carers involvement in the discharge planning arrangements and ability to care for the individual on discharge..

Discharge planning should begin during any needs assessment or following the decision for hospital admission and should consider the whole continuum of care, until such time that the responsibility for health care can be resumed by the primary care team. In complex cases it is a multidisciplinary/inter-agency process that necessitates close liaison between hospital and community based staff. The continuum may include

transfer from acute hospital care to community hospital or from acute hospital to a tertiary or specialist care facility and vice versa with the needs of the patient aligned to the level of care provision within each setting. This will also include Mental Health and Learning Disability inpatient transfers of care to Acute Services

The discharge planning pathway should be commenced from the outset or within 24 hours of admission and be an actively managed process. Wherever the patient is on the pathway and in whichever healthcare environment, discharge planning should be evident and include patient/family/carer/advocate involvement.

Patients who are ready for discharge but cannot be discharged out of an acute hospital setting to their own home; either through choice (this may also link to the family member/carers also unable to cope with the patient on discharge), or a delay in discharge arrangements, will be transferred to an appropriate facility using the principles outlined in the Care Home of Choice Policy. Patients do not have the right to remain in an acute hospital bed while these arrangements are being realised: (ref: Welsh Government (WG) ministerial statement 23rd April 2013).

6.3 Expectations at Acute and Community Services Level:

Acute and Community Directorate Management Teams are responsible for supporting the clinical areas with the implementation of 6.3 and 6.6 below.

Acute and Community Directorate Management Teams have a clinical escalation process in place to support ward/department staff in the event of a failing discharge process.

Each Acute and Community Directorate Management Team should ensure the implementation of the following:

- All patients to have an assessment within 24 hours of arrival, which should include consideration of discharge/transfer processes;
- The expected date of discharge (EDD) as agreed by the Medical Team or transfer will be pro-actively managed against the plan on a daily basis by the Multi-disciplinary Team;
- The plan will be formally reviewed at each multi-disciplinary Board round/meeting;
- Changes to the plan should be agreed by the patient and communicated to the family/carer/or advocate;
- Effective communication processes must be in place between medical staff, the patient and family/carers, nursing and allied health professional staff and all staff involved in the patient's treatment and care;
- Family members and carers play an important part in a patient's continuity of care following discharge from hospital and consideration should be made regarding the patients carers. Therefore it is important that as part of the discharge plan any practical or emotional support they as individuals may require should be addressed and considered actions given for a carer's needs assessment and/or support from the Third Sector. This is particularly pertinent in the event of any major change in the patient's condition to that preceding the need for the individual's hospital admission and may necessitate transfer of care to an alternative care environment, all of which will have an impact on the family member/carer. Coming out of hospital

booklet for Carers: https://www.carersuk.org/help-and-advice/practical-support/coming-out-of-hospital

6.4 Local Discharge Planning at Ward Level:

All wards will have a localised protocol for discharge which will include:-

- The identification of the staff role(s) within the Multi-disciplinary Team that will take the lead for daily review of expected dates of discharge or transfer for individual patients;
- The identification of the staff role(s) within the Multi-disciplinary Team that can make the decision to discharge patients (criteria led discharge according to agreed policy for individual wards including provision for 7 day working);
- Reference to an expected date of discharge for adult patients being set within 24 hours of arrival by the Lead Clinician and the multidisciplinary team in co-production with the Patient/family/carer or advocate for all unscheduled care admissions; and to initiate local procedures that reflect the Welsh Government Guidance relating to choice of accommodation in accordance with WHC (2004)/066 Choice of Accommodation Directions (Social Services Health and wellbeing Act) and communicate all of this to the patient/family/carer/ or advocate;
- The predicted length of stay for elective patients, as determined in their pre operative assessment which includes their discharge plans are to be pre arranged prior to the hospital admission with the patient/family/carer/advocate and consider Care Home of choice policy.
- Reference to the planning of ward rounds (in some areas the board round will also be the Multi-disciplinary Team meeting) scheduled to allow a senior review of all patients at least daily to include the Safer Care Bundle;
- Daily Multi-disciplinary Team Board Rounds to establish progress on the patient's discharge plan and identify any potential difficulties that can be addressed;
- All Inpatient discharges should be planned to occur before 10:00am, on any day of the week, including weekends;
- Patients waiting for transport should be transferred to the discharge lounge before 11.00am;
- Completion of the discharge checklist documentation and discharge plan. The process for patients requiring ongoing health or social care support on discharge from hospital is described in the complex discharge section 6.8 on page 9**;**
- The ongoing care management of each patient should be communicated to the General Practitioner on discharge. Following the introduction of the Medicines Transcribing and e-Discharge (MTeD) process a complete discharge summary will be provided electronically;
- A nursing transfer of care discharge letter must be sent with the patient and/or their carer who requires district nursing input or is returning to, or being placed in residential homes, nursing homes or community hospitals. Refer to discharge protocol;
- The community services will have a discharge protocol in place to guide the discharge process from hospital into the community services;

6.5 Equipment and Environmental Adaptation

Assessment and advice regarding the need for equipment, non-consumables and medical equipment should be available prior to discharge. Supply should be sufficient to meet the risk assessment needs until continual supplies are obtained. Where equipment is essential for safe discharge, but the items are currently unavailable, short term temporary solutions must be considered to prevent a delay in discharge.

Assessment for equipment and/or adaptations should be timely to avoid delaying the discharge process. Where home adaptations are required before a safe discharge can take place, there may be a delay in the patient going directly home. In these cases it may be necessary to transfer the patient to another facility to wait for the work to be completed. This must meet the level of need required which may not necessarily be an NHS facility.

6.6 Nurse/ Therapist Criteria Led Discharge /Transfer

Where relevant clinical management criteria are in place or where medical staff have confirmed that a patient is medically fit for discharge, the decision for date of discharge will be made by a designated nurse or therapist practicing within the agreed criteria in consultation with the patient/family/carer or advocate.

Criteria led discharge will include the following as a minimum:

- There is consensus with the Multi-disciplinary Team that criteria led discharge is appropriate for the individual patient; with acknowledgement of any best interest decision/review process taken in the patient's interest
- The proposed date and time of discharge;
- The lead clinician has signed off the protocol for the individual patient concerned;
- The agreed clinical parameters that will constitute medical fitness for discharge is clearly documented;
- The designation and grade of the practitioner with delegated responsibility for making the decision to discharge is documented;
- Confirmation that all planned discharge arrangements are in place;
- The person responsible for discharging the patient ensures and documents that all communication requirements are met;
- The discharging practitioners contact information is available in any case of queries (Passing the Baton p 64).

6.7 Simple Discharge/Transfer of Care

6.7.1 Criteria for a simple discharge

The patient has one or more of the following:

- Can be discharged to their own home or place of residence (no change to existing nursing / residential placement).
- Has simple ongoing care needs (e.g. Community Nurse/Acute Response Team, Community Children's Nurse) that do not require complex planning and delivery.
- Has capacity to make decisions and does not require multi-disciplinary team involvement / meeting.
- Is identified on assessment with length of stay (LOS) predicted.
- Can be discharged directly from ward areas or assessment units.

- Safer Care Bundle principles must be embedded with discharges aimed to be complete by 11.00am
- Family member/carer is able to care for the patient once discharged.

For simple discharges, an expected date of discharge (EDD) or transfer should be set by the Lead Clinician within 24 hours of admission, based on the predicted length of stay. This should then be communicated to the patient/family or carer and to all staff in contact with the patient.

The EDD must be documented on the Myrddin Patient Administration System and on the 'Patient Status at a Glance Boards (PSAG)' which are wall mounted within the vicinity of the Nurses Station in each ward area. A PSAG board details the patient's journey of care and those involved in that care.

The EDD should be proactively reviewed against the treatment plan on a daily basis by the Ward Sister or designated deputy and the Multi-disciplinary Team, and any changes should be communicated to the patient/ family/carer or advocate. Changes to the EDD must also be noted on Myrddin under the notes section for EDD. (Refer to local protocol)

6.8 Complex Discharge

6.8.1 Criteria for a complex discharge

The patient who:

1. Prior to admission, patient was already in receipt of social care/community services.
2. Has a restart care package of current services;
3. Is being discharged home with paid carers/residential or nursing home support (new placement / arrangements);
4. Has a history of recurrent admission linked to a chronic illness;
5. Has a length of stay (LOS) in hospital which is more difficult to predict;
6. Requires educational input, e.g. management of Insulin administration;
7. Requires rehabilitation, home visits or equipment;
8. Is classified as an adult at risk child or young person, either due to circumstances or diagnosis (refer to the Hywel Dda University Health Board Safeguarding Adults at Risk Interim Policy)
9. Lacks capacity to make decisions
10. Has experienced a recent life changing event/deterioration in functional ability;
11. Is being discharged with an "end of life" priorities package.
12. Has a family member/carer who is able to cope with the care on discharge.

6.9 Continuing NHS Healthcare (CHC)

Comprehensive guidance on assessment and eligibility for continuing NHS Healthcare (CHC), a Decision Support Assessment Tool will assist the decision making process, care planning and provision, dispute resolution and related issues is contained in the publication 'Continuing NHS Healthcare – the National Framework for Implementation in Wales'.

This guidance must be used whenever Continuing NHS Healthcare is being considered as an option for the patient. Again, the objective in these circumstances must be to

ensure a timely discharge to the appropriate care setting. Refer to Hywel Dda University Health Board Policy 309 - Continuing NHS Healthcare Operational Policy.

6.10 Delayed Transfers of Care & Executive Escalation Including Care Home Of Choice Policy

A delayed transfer of care is experienced by a hospital in-patient, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons.

The date on which the inpatient is ready to move on to the next stage of care is the ready-for transfer-of-care date. This is determined by the clinician responsible for the in-patient care, in consultation with colleagues in the hospital multi-disciplinary health care team and all agencies involved in planning the in-patient's transfer of care (both NHS and non-NHS). Thus the inpatient is ready for transfer of care, but the transfer is delayed, for one or more of the following:

- Healthcare reasons;
- Social care reasons;
- Community hospital reasons;
- Patient/carer /family-related reasons;
- To link in with HDUHB Care Home of choice policy
- Lack of essential equipment for support in home environment
- Difficulty in arranging appropriate transport.
- Consider appropriate use of the Discharge Lounge

The 'next stage of care' covers all appropriate destinations within and outside NHS, so delayed transfer of care applies to those inpatients who are unable to be discharged from NHS care, and those who are unable to be transferred within the NHS to a more appropriate bed that meets their level of need.

Delayed transfers of care are the subject of performance review for the Health Board and Local Authority partners. They are measured and reported on a national basis monthly using an agreed set of criteria to identify the delay. Community Management Teams (CMT) must ensure that arrangements are in place for the census to be undertaken on a monthly basis and the outcome validated in collaboration with Local Authority (LA) partners. Community Management Teams must also ensure that they have mechanisms to support and monitor the transfer of care arrangements in order that delays can be managed timely and escalated. CMTs should have guidance through local Accommodation of Choice procedures which reflect the WHC National Assistance Act 1948 (Choice of accommodation Directions) 1993, which was further supported by Supplementary Guidance WHC(2004) 066/NafW 46/2004 Procedures When Discharging Patients From Hospital To A Care Setting.

6.11 Escalation of Discharges

Reasons for the need to escalate a delay in discharge are as follows:

- Delay in treatment, investigation and/or medication;
- Access to care;
- Dispute by patient;
- Dispute by parent/family/carer;

- Dispute by Multidisciplinary Team (MDT);
- Dispute by Agency;
- Delay in assessment by an Allied Health Professional/Social Worker;
- Lack of availability of supportive equipment for home environment;
- Difficulty in arranging appropriate transport.
- Difficulty of out of county repatriations

Local escalation procedures must be followed and documented within the Acute and Community Service Plans.

6.12 Discharge against Medical Advice

If a patient wishes to discharge themselves from hospital, the health professional involved must:

- Establish the reason for this intention;
- Attempt to resolve any issues;
- Advise the patient of the consequences of leaving;
- Encourage the patient to see a doctor;
- Assess the risks to the person and/or others and take any necessary action;
- Document a full account of the events and the relevant discharge plan, together with the patient's responses;
- Encourage the patient to sign a "discharge against medical advice form" located in the designated stationary area generally on the Nurses Station on each ward;
- Inform the patient's GP, Community Nurse and other relevant community services by telephone;
- Complete the Datix incident reporting system.

Where there are reasons to doubt a patient's capacity to make a decision about discharge against medical advice a formal assessment of capacity must be considered in accordance with the Mental Capacity Act. Discharge against medical advice may be viewed as an "unwise decision" but this does not necessarily mean that the patient lacks capacity to make it. As well as a concern about the decisions being made, there *must* be some evidence of impaired or disturbed functioning of the mind or brain (eg stroke, dementia, mental illness, delirium, intoxication, etc.) before a functional assessment of the patient's capacity can be undertaken.

If the patient is found to lack capacity to make a decision about their discharge, the decision will need to be made following the best interests process. If it is concluded that the patient is unable to give valid consent to remaining in hospital an application for authorisation under the Deprivation of Liberty Safeguards must be made".

Further information and advice on assessing capacity, best interests decision-making and Deprivation of Liberty Safeguards can be found on the Health Board's Mental Capacity Act intranet page: http://howis.wales.nhs.uk/sitesplus/862/page/48570 http://howis.wales.nhs.uk/sitesplus/862/page/68864 Also refer to Hywel Dda University Health Board Policy 374 - Mental Capacity Act 2005 and Hywel Dda University Health Board Policy 163 - Deprivation of Liberty Safeguards. The Mental Capacity Act Lead Officer and/or the Deprivation of Liberty Safeguards Coordinator (contact details are available on the webpage) are available for further advice and support.

Discharge Medication

An individual assessment of patients discharging themselves against medical advice should be made. If a prescriber is prepared to prescribe, discharge medication can be dispensed, if clinically appropriate (for example, not diazepam for alcohol detoxification if the patient is likely to drink alcohol again but antibiotics and anticoagulants if required). It should be noted that the patient's own medicines should be returned to them as they are the patient's property (as long as it is clinically appropriate to do so). Patients can wait to have their prescription dispensed or return later to collect it.

6.13 Communication and Information Sharing

Good communication is a pre-requisite for a well co-ordinated patient journey from preadmission through to discharge. Patients and their families/carers/or advocates will be given every opportunity to discuss their care, treatment and transfer/ discharge arrangements.

Information will be given as far as possible, in English or Welsh. Additional communication help is available on request, such as language line, interpreters, advocates and other communication aids for minority populations and patients, families/carers/advocates with special needs.

6.14 Documentation of Discharge and Transfer of Care Process

Documentation provides the evidence of the active process of planning discharges and transfers of care. It must capture all elements of the planning in relation to the discharge/transfer and evidence the multi-disciplinary/inter-agency, partnership working and joint decision making with the patient with their /family and/or an advocate.

Record keeping is an integral part of professional practice and is essential to the provision of safe and effective care and seamless discharge. This must adhere to Hywel Dda University Health Board Policy 289 - Record Keeping for Nurses and Midwives and profession specific record keeping procedures and guidelines. Contemporaneous record keeping, whether at an individual, team or organisational level in relation to discharge planning from hospital care must:

- Demonstrate how decisions related to the discharge process were made.
- Document the delivery of care and discharge.
- Document effective clinical judgements and decisions regarding discharge
- Documents the plans for continuity of care.
- Documents patient/ family/ carers/advocates' involvement and communications regarding the discharge.
- Provides documentary evidence of the care delivered and discharge planning process.
- Document the equipment, medical consumables and other needs.
- Document the transport home arrangements and criteria
- Document the Do Not Resuscitate Status (DNAR)status clearly
- Refer to the DNA CPR Policy.
- Include copies of any documents relating to Lasting Power of Attorney, Deputyship or any advanced decisions
- Refer to the Transfer of Care Document

In addition, accurate, contemporaneous records assist in the investigations of enquiries, complaints and untoward events. Good standards of record keeping at every stage of the discharge process are essential- including individual patient case-notes, records of multi-disciplinary Team meetings, ward rounds and case conferences.

6.15 Medicines Management

Medicines management plays an important role in preparing patients and their families/ carers/advocates for discharges and transfers, which has an impact on the recovery and/or maintenance of their conditions following discharge.

Information regarding medicines must be provided to all patients and their family member/carer on their discharge or transfer by a member of the multi professional team. .

Medication and non-consumables should be arranged in a timely manner. This must be undertaken at an early stage of the discharge process.

A minimum of seven days supply of medication must be given to the patient on discharge. This will allow sufficient time for the patients/carers to obtain further supplies from their GP.

Requests for existing patients who use multi dosage systems (MDS) must be arranged at least 48 hours prior to discharge; however those new patients who require MDS must be referred to their local community pharmacy.

The provision of oxygen on discharge will require advanced planning. Refer to HDUHB Policy 341 - Prescription and Administration of Emergency Oxygen in Adults.

6.16 Non-Emergency Transportation

For patients medically fit for discharge and deemed eligible for ambulance transport the Welsh Ambulance Service Trust (WAST) liaison supervisor is to be contacted in the first instance. Prior to requesting transport a decision will need to be made as to what category of transport will be required:

Ensure that the family /carer/advocate have taken home excess patient's property and the transport will only take one bag on discharge.

T1 - Patient can go by ambulance car (single manned) and patient - walks with minimal assistance;
C1 - Patient can go by ambulance but not by ambulance car – patient walks with minimal assistance.
C2 - Patient can go by double crew;
C3 - Patient in own wheelchair, can be conveyed by single crew;
C4 - Patient in own wheelchair, to be conveyed by double crew;
C5 - Patient in own electric wheelchair, to be conveyed by double crew
C6 - Stretcher case, to be conveyed by double crew.

The WAST liaison supervisor is only available from Monday to Friday 08.30 hrs to - 16.30 hrs, outside these hours transfers should only be undertaken when absolutely necessary. However when deemed necessary alternative transport arrangements will need to be pursued by the clinical site manager and hospital on-call manager.

It is the responsibility of the discharging hospital to deal with any transport requests for patients being discharged or transferred to another hospital. A patient's transport arrangements on discharge should be discussed with the patient upon admission. It is expected that all patients will make their own arrangements unless there is a medical need for non-emergency patient transport. If a patient is being discharged home consideration must be made to accessing the home, especially when there are codes or keys required that the patient does not have.

6.17 Escort Arrangements and Transfer Between Hospitals

6.17.1 Decision To Transfer

Responsibility for assessing and managing the appropriate and safe transfer of patients lies with the nurse in charge of the ward/dept or her deputy and the medical team. An escort checklist must be completed and filed in patient record. (Appendix 2)

The decision to transfer a patient to another ward/unit/department/external clinical environment must be made taking into consideration the potential risks and benefits to the patient.

The decision to transfer patients to another hospital should be made by the Consultant in charge, or in their absence their deputy, and recorded in the medical record.

The decision to transfer patients to Community Hospitals will be in accordance with local transfer arrangements. Staff must make sure that the transfer is in the best interest of the patient.

Out of hours transfers should be undertaken by following the appropriate policies, and in consultation with the site manager. Out of hours between 20.00 hours and 08.00 hours should only be in the patient's best interest and/or in exceptional circumstances. The procedure will, however, remain the same.

The Registered Nurse responsible for the patient must assess to determine that there has been no significant change in the patient's risk category between the time of initial decision to transfer and the time immediately prior to transfer.

Internal transfers include movement of patients from:

- Emergency Department
- Ward to ward
- Assessments/admission units
- Departments to Wards following investigations/ procedures/operations
- Ward to Critical care area
- Critical Care area to wards
- Mental Health and Learning Disability inpatients to acute services

Bed availability and equipment requirements must be confirmed by the receiving unit prior to transfer commencing so that the necessary equipment and resources can be put in place and be functioning ready for the patient's arrival.

** There are occasions when patients are transferred to support the patient flow process and decisions will be undertaken in collaboration with the multi-disciplinary teams and co-ordinated by the patient flow team.*

External transfers include movement of patients to :

- Another Hospital
- Nursing or Residential Homes
- Other health care provider
- Mental Health and Learning Disability inpatient transfer of care to acute Services or other Health provider (Appendix 1)

It also covers:

- Patients attending a department in another hospital/health care provider unit for investigations i.e. bone scan, radiotherapy treatment
- Patients going for investigations in another hospital/health care provider unit where the nurse will remain throughout the procedure

6.17.2 Escort

Responsibility for decisions on the escort requirements lies with the nurse in charge of the clinical area, in collaboration with the medical team as appropriate. This will be dependent on the reason for transfer; the individual patient's acuity level, clinical condition and care requirements during the transfer process; and any specific needs if the patient is a vulnerable adult. Out of hours support with this responsibility is provided by the clinical site manager on duty.

An escort is defined as any member of staff who is involved with escorting patients and who has the relevant knowledge and skills to provide a high standard of care during the transfer and to ensure patient safety is not compromised.

Escort duties can be undertaken by any of the following:

- Registered health care professionals:
  - doctors
  - registered nurses and midwives
  - operating department practitioners
  - paramedics
- Non registered health care support workers, healthcare assistants, Pre registration student nurses, other clinical support workers or other healthcare professionals
- High dependency service ambulance crew
- Patient care services ambulance crew

In the event that the clinical area does not have sufficient staffing resources to allow staff to be released for escort, the Senior Nurse Manager/Clinical Site Nurse or Manager must be contacted and, wherever possible, cover from another area should be provided. If no cover is

available a risk assessment must be undertaken in collaboration with medical staff and transfer arrangements reviewed and decisions documented.

Any member of staff escorting a patient must be competent and able to meet the assessed/predictable needs of the patient and be able to recognise and able to undertake any action needed in the event of, any change in condition of the patient during their absence from the ward/department. In the event of accompanying patients for radioactive procedures, it must be ensured that the escort is not pregnant. In the event of the transfer being likely to take longer than their span of duty, the nurse or health care professional must be willing to undertake the transfer in/work extended hours.

Pre-registration Student Nurses can be involved in on site transfers when accompanying a registered nurse. Pre-registration student nurses must always work under supervision.

The nurse in charge of the patient's care will assess the escort requirements in line with this policy and record any such requirement in the patient care record. The Nurse in charge is accountable for the decision taken in relation to allocation of an appropriate competent escort to meet the patient's acuity level and care needs. The selection of an appropriate staff member to act as escort must be made with due regard for the reason for transfer and any intervention or support likely to be required during the transfer process. (Table 2 & 3).

Before leaving the ward/dept the nurse in charge must check that the bed is still available on the receiving ward/hospital and an effective handover must occur prior to the patient leaving the clinical area; when the patient has arrived at their destination; and when the patient is returned to the original clinical area (if applicable) and at any other time when it may be required. The handover will be verbal and/or written, dependent on the reason for transfer and should follow the Situation Background Assessment and Recommendations (SBAR) principles.

Escorts are required to engage with the patient during the whole transfer process and must maintain the patient's dignity and wellbeing at all times. This will require consideration of such features as the:

- patient and the escort's gender
- the patient's anticipated personal requirements
- appropriate clothing to maintain dignity, warmth and comfort
- the length of journey

For Level 1 patients the escort must:

- Have knowledge of the patient's current medical condition and nursing needs including risk assessments and be available to accurately convey this information to the ward/department that the patient is being escorted to
- Safely maintain all relevant documentation during the transfer
- Ensure that he/she is aware of the patient's resuscitation status and that it is communicated/documented where appropriate
- Ensure that he/she is aware of any procedures relating to the Safeguarding of Vulnerable Adults that apply to the patient and ensure the patient's specific needs are met during the transfer through full risk assessment and handover. (Refer to Wales Interim Policy and Procedures for the Protection of Vulnerable Adults (2010)).

- Maximise patient safety, dignity, comfort and communication by remaining close to the patient, wherever possible, at the head end of the bed or trolley
- Check and be able to manage the patient's analgesia / antiemetic or other drug regimen during the transfer journey
- Check Intravenous infusions, oxygen, drains, etc and any monitoring devices prior to movement of the patient, ensuring that there are sufficient supplies/equipment etc prior to leaving the clinical area
- Be confident that they have the necessary knowledge and skills to deal with any situation that may occur during the escort process and to be fully aware of any actions to be taken in the event of any deterioration in the patient's condition

Table 2: Intra-hospital Transfers

RECOMMENDED GUIDELINES FOR INTRA HOSPTIAL TRANSFER OF PATIENTS	**(Minimum) ACCOMPANYING PERSONNEL /ESCORT**	**SKILLS REQUIRED**	**ESSENTIAL EQUIPMENT**
Level 0	Porter or HCSW or Registered Nurse	Basic Life Support	
***Level 0.5 (eg Elderly/Confused)**	Porter plus HCSW or Registered Nurse	Basic Life Support	
Level 1	Suitably experienced Registered Nurse/HCSW plus porter, appropriate to the needs of the patient	Basic Life Support and Gas Cylinder Training. Appropriate competency in: - Specific Medication Delivery - Recognition of Deterioration - Suction and Tracheostomy Care - Medical/Infusion devices in use	- Oxygen - Suction (if Tracheostomy) - Portable IV stand - Battery operated infusors - Pulse-Oximeter

Table 3: Inter Hospital Transfers

RECOMMENDED GUIDELINES FOR INTER-HOSPITAL TRANSFER OF PATIENTS PATIENT	**(Minimum) ACCOMPANYING PERSONNEL**	**SKILLS REQUIRED**	**ESSENTIAL EQUIPMENT**
Level 0	Ambulance Crew	Basic Life Support	
***Level 0.5**	Ambulance Crew and HCSW/Registered Nurse	Basic Life Support	
Level 1	Registered Nurse or other registered health care professional / PTS / HDS Crew	Intermediate Life Support and Gas Cylinder Training Appropriate competency in: - Specific Medication Delivery - Recognition of Deterioration - Suction and Tracheostomy Care	- Oxygen - Suction (if Tracheostomy) - Portable IV stand - Battery operated infusors - Pulse-Oximeter

		- Medical/Infusion devices in use	

The same criteria for exact 'decision-making' must be applied when using private ambulance services or other statutory agency transport arrangements. e.g. Local Authority transport,.

For external transfers, the nurse in charge must ensure that the necessary arrangements for the **return** journey of the escort are made **prior** to the transfer commencing. This should be clearly communicated and arrangements agreed with the escort and also passed on to the ward based nurse in charge during shift handover as appropriate.

6.17.3 Patient Preparation For Transfer

The nurse in charge who is responsible for arranging the transfer must ensure that the patient is aware of the reason for transfer. The patient's next of kin must be notified of the transfer **as soon as possible** once a decision to transfer the patient is taken, to enable suitable arrangements to be made e.g to travel to the receiving hospital at same time etc, and also to minimise distress associated with transfers perceived to be urgent/rushed. (This may not be necessary in the case of transfers/investigations **within** one hospital site).

Ensure receiving clinical area is notified of expected transfer/time of arrival so that appropriate equipment can be prepared for the patient, if required.

Ensure that all the necessary transportation equipment is present, in full working order and that batteries are fully charged. Ensure also that there is enough oxygen to last during transfer and that the escort is fully competent in the use of all these items of equipment

Ensure that the patient's notes, and blood results and radiological reports are taken with the patient to their destination. If the transfer is external, follow the Health Board's Medical Records Policy relating to transfer of notes (photocopies of notes are required) and x-rays if applicable.

In the event of a Mental Health or learning Disability inpatient transfer to acute services or another Health provider a transfer of care SBAR (Appendix 1) must be completed for patients with a Learning Disability and used in conjunction with a Health Passport.

Collect and check all the patient's medications that are required for transfer. If medication or intravenous infusions require disconnecting for transfer this should be clearly documented and explained to the patient. All medications must be stored appropriately during the transfer as per Health Board policy.

If the patient is to be transported in a wheelchair, ensure that the patient's feet are on the foot rest. Use the appropriate manual handling techniques for patient transfer. All monitors and infusion devices should be secured appropriately and not resting on the trolley or the patient.

To promote patient dignity appropriately check that the patient is dressed and covered prior to transfer. Ensuring adequate warm clothing/ covers are available.

If appropriate, ensure analgesia is offered prior to transfer.

If the transfer journey is expected to be lengthy or during a mealtime period, arrange for a packed lunch to be made available for the patient (if appropriate) from the Catering Department. The needs of the escort must also be considered and arrangements made accordingly.

Ensure that all of the patient's property/valuables are documented and packed securely in hospital property bags or in patient's own luggage and in accordance with Health Board policy and Welsh Ambulance Service protocols and guidance for patient transport. Be mindful that there is a limit on the number of property bags that can be transported with the patient.

All patient property including valuables handed over to the receiving area must be, checked listed and signed for by a member of staff from the receiving clinical area and by the patient (or a second member of staff if the patient is unable to sign).

If the patient is transferred to another ward within the same hospital the receiving ward should also complete a property sheet. This should be signed by the patient and by a member of staff from the receiving ward/area of the ward receiving the patient.

If the patient is transferred to another hospital the receiving ward/area will treat the patient as a new admission by completing the patient's property book

Should the patient decide not to hand over any property/valuables for safekeeping during their transfer, then this must be noted in the patient care record and included in the handover. If required the patient must be informed of the need to sign a disclaimer notice in accordance with the Heath Boards Property Procedure.

Any care delivered during the patient's transfer and any observations recorded must be documented and reported as Handover.

On arrival at the destination ensure that there is formal handover report to the receiving team. Assist in settling the patient and ensure all equipment is transferred and the correct flow rates of infusions etc are checked.

6.17.4 Conveyance

The Welsh Ambulance Service uses a range of vehicles, each staffed and equipped to deliver a specific level of care which needs to be matched with the needs of the individual patient.

It is **vital** that the right type of ambulance is requested. Inappropriate requests for Paramedic Ambulances adversely affect the ability of the ambulance service to provide its emergency service and can lead to unacceptable delays in attending life threatening calls in the community.

It is expected that all planned, inter-hospital transfers can be undertaken by either a High

Dependency Ambulance crew or via the routine Patient Care Service. Paramedic crews should only be requested where the patient may require immediate advanced life support during the journey.

The ambulance service will require information from the nurse in charge or his/her deputy in order to determine transport requirements with regards to the patient's individual needs.

Arrange an ambulance ensuring that all other necessary preparations are made prior to requesting. Ensure that decisions are based on the individual patient's needs, including the reason and time of transfer. (See Table 4)

Out of area, non urgent transfers may require more than 24hrs notice for an ambulance to be booked. Bed/Clinical Site Managers are best placed to liaise with accepting Health Boards/organisations with regards to the bed availability in order to ensure that transport arrangements do not need to be cancelled on the day of planned transfer.

Table 4

TYPE OF AMBULANCE	CREW LEVEL	REQUEST MECHANISM	SUITABILITY
Paramedic	Advanced Paramedic Practitioner Service	Via 999 or emergency ambulance control	**EXCLUSIVELY FOR:** situations where **immediate life saving** treatment is required during the journey.
High Dependency Unit	BLS including oxygen and defibrillation	Via emergency ambulance control	Stable patients requiring oxygen or the presence of a defibrillator during transfer
Patient Care Services	Non emergency but can provide first aid and oxygen therapy.	Via Paramedic Practitioner Service booking system or hospital ambulance liaison officer	Routine transfers

* There are occasions when a patient may be transferred by car e.g twilight service

6.17.5 Infection Prevention and Control

It is the responsibility of all staff members involved in the decision making and implementation of the transfer arrangements to ensure that infection control requirements are fully considered and implemented during the transfer as per HDUHB Infection Prevention and Control Policies. The Infection Prevention and Control Department should be contacted for advice on the transport of patients with infectious conditions as appropriate.

The Transport Department / Ambulance control must be informed of any infectious conditions/infection prevention and control considerations when booking the transport and definitely prior to the transportation taking place.

6.17.6 Equipment

All regular transfer equipment e.g. infusion pumps should be kept fully charged ready for transfer

Prior to transfer it should be checked that all equipment is in full working order and that batteries are charged. If possible a spare battery should be taken on the transfer.

On return to the originating clinical area, the escort nurse should check that all equipment is returned to the correct ward / department or the Equipment Library; that it is decontaminated beforehand; and that equipment requiring charging is re-charged.

6.18 Adult Safeguarding

All staff within health services have a responsibility for the safety and wellbeing of patients.

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well-being.

Safeguarding adults is about the safety and well-being of all patients but providing additional measures for those least able to protect themselves from harm or abuse. Consideration should be given to the patients circumstances to ensure that their discharge is safe. Where there are concerns that an 'adult at risk' may be at risk or experiencing abuse or neglect then a referral needs to be made to the relevant Local Authority Adult Safeguarding Team and a plan agreed to ensure that discharge is safe.

Definition of an adult at risk:

The Social Services and Well Being (Wales) Act 2014 defines an "adult at risk of abuse and or neglect" as an adult who:

- Is experiencing or is at risk of abuse or neglect.
- Has needs for Care & Support (whether or not the Local Authority is meeting any of those needs). and;
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk thereof.

The inclusion of 'at risk' within the Welsh Government definition enables early intervention to protect an adult at risk and prevent escalation. The decision to act does not require actual abuse or neglect to have taken place. The aim is to protect people who need it and to help them prevent abuse or neglect happening.

All agencies are expected to report concerns to the Local Authority if they have reasonable cause to suspect that an adult is at risk of abuse or neglect. Concerns may become apparent via a variety of means including during the admission assessment, during the inpatient stage, as a consequence of concerns raised by family or friends, or as a result of observations of interactions between the patient and visitors. 'Adults at risk' may not be able to alert health professionals to their situation as a consequence of physical or cognitive incapacity, failure to recognise what is happening to them is abuse or neglect or being afraid to speak out.

Abuse and Neglect is defined as follows:

Abuse means physical, sexual, psychological, emotional or financial abuse. Neglect means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being.

The Social Services and Well-Being Wales (Wales) Act 2014 also ensures that 'carers' are entitled to an assessment of their needs. Carers should be made aware of this entitlement and assisted to access this if required. Or referred to the local Carers Information Service.,

Whilst all agencies are expected to report concerns to the Local Authority if they have reasonable cause to suspect that an adult is at risk of abuse or neglect, as defined by the Social Services and Well Being (Wales) Act 2014, those employed within Health have a legal duty to do so.

Wherever possible, you must gain consent of the individual and seek their views unless doing so is likely to increase the risk to them or put others at risk. Information should be presented to the individual in such a way that there is informed consent. If consent is not given to sharing information including raising a safeguarding concern then alternative action should be taken to reduce the risk to the adult. A lack of consent does not negate the need to take preventative action if and when appropriate.

Where the adult lacks capacity then a referral should be made taking into the considerations of the Mental Capacity Act (2005).

When an adult with capacity to make an informed decision about their own safety does not want any action taken, this does not always override a professional's responsibility to raise a safeguarding concern with the Police or Local Authority. In circumstances where others are at risk, including children or a crime may have been committed, or the adult is being coerced, controlled and intimidated, a safeguarding concern should be raised.

Cases of self-neglect in an adult who is deemed to have capacity can often be complex and whilst they may not fit the criteria to be referred to Safeguarding may still require a multi-agency response.

The Health Board Adult Safeguarding Team operate an advice and support desk, Monday to Friday 9-5pm, accessible via phone Tel. 01437 772516 or email: Adult.SafeguardingTeam.Hdd@wales.nhs.uk. There is also a Safeguarding intranet site available.

Additional information can be sort from the Safeguarding Adults at Risk Interim Policy (098). It is anticipated that the New All Wales Safeguarding Procedures will be completed in July 2019.

6.19 Adults with Dementia

In-patients with a diagnosis of dementia, specific considerations are required due to the detrimental impact 'change' has on patients with such disabling conditions; resulting in destabilisation and deterioration of their condition and a likely delay in their planned hospital discharge or transfer.

It is beneficial to the care of such patients that moves or transfers of care are kept to a minimum and the National Audit of Dementia Care in General Hospitals Report December (2011) recommends:

- People with dementia should be moved only for reasons pertaining to their care and treatment.
- The move should take place during daytime.
- Relatives and carers should be informed of any move and given adequate notice.

6.20 Adults with Dementia – Advocacy

Advocacy issues are around capacity which is a legal not mental health construct
Advocacy has developed in the United Kingdom over the past twenty years. Advocacy in all its forms seeks to ensure that people are able to speak out, to express their views and defend their rights.
Having a mental health problem or experiencing stress and distress can sometimes mean people feel that their opinions and ideas are not taken seriously or that they are not offered the opportunities and choices they would like.

In its simplest form advocacy can mean just listening respectfully to someone.

Advocacy is a process of supporting and enabling people to:

- express their views and concerns;
- access information and services;
- defend and promote their rights and responsibilities;
- explore choices and options.

Formal Advocacy (Independent Mental Health Advocacy IMHA)

An individual will be entitled to the support of an advocate as soon as they are admitted to hospital and will continue to be eligible for that support for as long as they are being assessed or receiving treatment as an inpatient. If further support were required following discharge, the patient would be referred on to existing non-statutory advocacy services. The support provided would only be in relation to issues connected to care and treatment of the patient's mental health disorder. This applies even where the primary purpose for the individual's hospital admission was not for a mental health condition.
By expanding statutory advocacy services to ensure that access is available to all inpatients receiving treatment for mental ill-health, whether subject to compulsion or not, the Mental Health Measure (Wales 2010) seeks to ensure that the rights of this vulnerable at risk group of patients are safeguarded. Statutory advocacy will assist inpatients in making informed decisions about their care and treatment, and support them in getting their voices heard.

- **Independent Mental Health Advocacy (IMHA)**

An **IMHA** is an independent advocate who is trained to work within the framework of the Mental Health Act to support people to understand and uphold their rights, to obtain relevant information, to participate in decisions about their care and treatment, to explore options and their consequences, to support people to have their views and wishes heard and to promote self-advocacy. An **IMHA** is independent of all services, professionals, family and carers involved in the care of an individual.
Contact details relating to IMHA are:-
01267 223197 Ty Carwyn 3 St. Peter's Street Carmarthen SA31 1LN

The Independent Mental Capacity Advocate (IMCA) Service

- **IMCA** is a type of advocacy introduced by the Mental Capacity Act 2005 ("the Act"). The Act gives some people who lack capacity a right to receive support from an **IMCA** in relation to important decisions about their care.

An IMCA can only be involved when there is no family/friends or when family/friends are not appropriate

- **IMCA** services are free and provided by organisations that are independent from the NHS and local authorities.

Contact details relating to IMCA are**:- 01437 762935**
A 24 hour answer phone is in operation. Calls will be returned within 72 hours.

6.21 Concerns

If a concern is raised by a patient/family/carer or advocate in relation to the discharge planning process, the concern should be dealt with using the guidance 'Putting Things Right' – Raising a concern about the NHS (2011). In the first instance, all efforts to resolve the issue should be made immediately, however if this does not resolve the issue, refer the complainant to the Concerns Team.
If a patient is under the DoLS Framework and if there are concerns about discharge plans then the DoLS Team need to be informed

7. RESPONSIBILITIES

7.1 Chief Executive

The Chief Executive Officer and Board hold ultimate responsibility for assurance, safety and improvement within the Health Board and have a duty for setting Health Board priorities and requirements.

7.2 Executive Director of Nursing & Midwifery and Patient Experience

The Executive Director of Nursing, Midwifery & Patient Experience will take the lead responsibility on behalf of the HDUHB for the strategic direction and development of the Discharge & Transfer of Care – Adults Policy. She/he will also work with education and training providers to influence the development of appropriate training programmes to ensure professionals are competent and safe to practice.

7.3 Deputy Chief Executive / Director of Operations - Acute Services /County Directors of Community Services & Commissioning

The Director of Operations - Acute Services and the County Directors of Community Services and Commissioning will be responsible for the localised implementation of the discharge and Transfer of Care – Adults Policy by working with consultant colleagues, nursing teams and therapy leads to influence practice and improve processes to maximise bed capacity and reduce avoidable delays.

The Director of Operations - Acute Services and County Directors of Community Services & Commissioning are also responsible for the development of the service structures to direct both financial and human resources to support the Discharge & Transfer of Care – Adults Policy through the Service Delivery and Senior Nurse Managers

They will be responsible for ensuring that the Discharge & Transfer of Care Policy is fully implemented within their areas of responsibility. The Heads of Adult Mental Health Services, Heads of Therapies and Clinical Support Services will work in partnership

with the Service Delivery and Senior Nurse Managers to ensure that the said policy is operationalised.

The Unscheduled/Scheduled Care/Hospital Site General Managers have overall responsibility for the monitoring of performance associated with the discharge and transfer of patients, how it impacts upon reducing average length of stay (ALOS), delayed transfers of care (DTOC), bed capacity and patient flow.

They will also be responsible for the full implementation of Estimated Date of Discharge (EDD), and for creating an environment in which multi-agency and partnership working flourishes to assist the process and patient experience.

7.4 Discharge Liaison Nurses

The Discharge Liaison Nurse (DLN) role is designed to support both patients and ward staff in the application of discharging patients with complex health and social care needs. The DLNs are responsible for providing effective communication between all members of the multidisciplinary team and associate departments and are responsible for identifying complex discharge issues and delays in the entire diagnostic, treatment and care process whilst being proactive in generating solutions which meet both the patients, family members/carers needs in order to facilitate a safe discharge from hospital.

7.4.1 The Hospital DLNs provide a service in the Acute General Hospitals across Hywel Dda University Health Board

The Discharge Liaison Nurse should:-

- Co-ordinate discharge planning for patients with complex needs in consultation with the patient/family/carers and advocates
- Liaise with other relevant internal/external agencies to ensure optimum progression of care, completing assessments in a timely way;
- Work within the guidance of the Health Board's Discharge and Transfer of Care Policies;
- Work efficiently in coordination with the Hospital Bed Management Team in order to have effective patient flow and timely discharges;
- Attend multidisciplinary team meetings as required to progress complex discharge plans for the patient;
- Undertake audit and research as required in relation to the discharge planning process.
- Participate in and provide direct teaching in relation to the discharge process to multi professional groups;
- Chair discharge planning meetings as required;
- Be accountable for the accuracy of information collated and disseminated to the multidisciplinary team;
- Act as a resource point and role model for providing knowledge and advice to all staff working within the Health Board in relation to discharge planning;
- Be proficient in the assessment of patients for continuing health care applications;
- Be proficient in supporting staff in implementing local procedures relating to choice of accommodation as reflected in the WHC National Assistance Act 1948 - Choice Accommodation Directions 1993 and subsequent Supplementary guidance WHC 2004

Procedures when discharging patients from hospital and in providing relevant documentation /information to families;

- Be proficient in the assessment of patients for Reablement services and inputting data accurately onto the Share Point System.

7.4.2 Discharge Liaison Nurses – Community In-reach Service Model

The Community In reach service model is designed to support both patients and ward staff in the application of discharging patients with complex health and social care needs. The community team will work with the ward staff to assist with any complex discharge issues identified in order to facilitate a safe discharge from hospital.

The Community In-Reach Team should:

- Be informed of any patients to be discharged with complex needs;
- Work within the guidance of the Health Board Discharge and Transfer of Care Policies;
- Work efficiently in coordination with the Hospital Site/Bed Management Team in order to have effective patient flow and timely discharges;
- Attend multidisciplinary team meetings as required to progress complex discharge plans for the patient to be discharged safely into community;
- Work in collaboration with the ward staff promoting good communication and information sharing to ensure timely safe discharge;
- Be proficient in the assessment of patients for continuing health care applications;
- Co-ordinate discharge planning for patients consultation with the patient/family/carers and advocates

7.5 Medical Consultant /General Practitioner

Overall legal responsibility for a patient's medical care remains with the named consultant during admission, inpatient stay and discharge. On discharge the patient's care returns to the patient's General Practitioner.

However, the Consultant can delegate responsibility to an appropriately qualified health professional. When a task is delegated the consultant/lead clinician assumes responsibility for delegating appropriately.

The Consultant should:

- Support the Expected Date of Discharge;
- Ensure that every patient has an EDD and discharge plan;
- Give due consideration to any Best Interest Decisions
- Set clear goals of the discharge criteria for the MDT to follow.

8. MONITORING - KEY PERFORMANCE INDICATORS FOR DISCHARGE AND TRANSFER OF CARE

All Acute Service Hospitals / Directorates and Community Teams are required to provide evidence through key performance indicators (KPI's) that patients are receiving appropriate care. The KPI's include:

- Reducing the average length of stay;
- Reducing the delayed transfers of care;

- Increasing the percentage of wards using expected dates of discharge;
- Increasing the percentage of patients having an EDD in place within 24 hours of admission;
- Increasing the percentage of patients discharged before 1100Hrs, consider use of Discharge Lounge
- Percentage of patients discharged to usual place of residence;
- Reducing the hospital readmission rates within 28 days of discharge.

Completeness and timeliness of discharge letters are regarded as quality indicators.

9. TRAINING

The Hywel Dda University Health Board will ensure that all frontline staff has access to appropriate training in the management of patient discharge and transfer. This will be addressed through wide availability of the policy and through various training opportunities for example:-

- Internal training programmes;
- Ward based Induction and orientation;
- Access to the Effective Discharge Planning Module (University of Wales Swansea).

10. IMPLEMENTATION

The Acute Hospital Services / Directorates and Integrated County Community Teams will set out the implementation process of the Discharge and Transfer of Care Policy within their respective areas.

11. REFERENCES

- CCQI/Royal College of Psychiatrists/ Royal college of Physicians (2011) Report of the National Audit of Dementia Care in General Hospitals.DOH (2010)

- Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care.

- The General Medical Council (2013) Delegation and Referral LHDS://www.gmc-ukorg/ethical-dugiance-for-doctors/delegation-andreferral/delegation-and-referral

- The General Medical Council Documentation Standards file:///C:/Users/je024794/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/generic-medical-record-keeping-standards%20(1).pdf

- A Clinician's Guide to Record Standards https://www.rcoa.ac.uk/sites/default/files/FPM-clinicians-guide1.pdf

- Health & Care Professional Council - Standards of conduct, performance and ethic https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf

- DOH Continuing NHS Healthcare National Programme, (2010). 10High Impact Changes for Complex Care. NLIAH, Cardiff.
- Continuing NHS Health Care, The National Framework for Implementation in Wales (2014)
- NLIAH (2008) Passing the Baton. A practical guide to effective discharge planning.
- Hywel Dda Health Board Safeguarding Adults at Risk Interim Policy
- Welsh Health Circular WHC (2005)035: Hospital Discharge Planning Guidance
- WHC (2006)059: Emergency care – A report from the Delivery & Support Unit
- WHC (2004)066: Guidance on National Assistance Act 1948) Choice of Accommodation Directions 1993
- WHC (2004)024: NHS Funded Nursing Care in Care Homes Guidance
- WHC (2004)054: Continuing NHS Health Care: Guidance and Framework for Implementation in Wales
- HDUHB Care Home of Choice Policy (2019)
- Part 7 – Social Services and Wellbeing Act (2014)
- HIW Review of Adult Protection Procedures in Wales (2010)
- All Wales Child Protection Procedures
- www.wales.nhs.uk
- www.publichealthwales.org
- **Carers Wales have produced a fact sheet called Coming out of hospital for Carers see link: https://www.carersuk.org/help-and-advice/practical-support/coming-out-of-hospital**

12. APPENDIX 1- MENTAL HEALTH AND LEARNING DISABILITY INPATIENT TRANSFER OF CARE HANDOVER TO ACUTE SERVICES

Mental Health and Learning Disability Inpatient Transfer of Care Handover To Acute Services

Procedure Number:	Issued following approval	Supersedes:		Classification	Clinical

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
1	NA	Tabled for final approval at The Written Control Document Group	Tabled for 03.12.18	Projected for 17.12.18	15.12.19

To be read in conjunction with:	370 - Discharge and Transfer of care policy 141 - Multi Agency Policy of the Independent Mental Capacity Advocate Service 163 - Deprivation of Liberties Safeguards Policy 196 - Escort Policy for Adult In-patients Policy 374 - Mental Capacity Act (2005) Policy 289 - Record keeping for Nurses and Midwives Policy 295 - Protection of Vulnerable Adults from Abuse Policies & Procedures 309 - Continuing NHS Healthcare (CHC) Operational Policy to support the

To be used EVERY TIME ANY PATIENT RECIEVING CARE FROM MENTAL HEALTH AND LEARNING DISABILITY SERVICES is transferred to another service whether this is within the Health Board or to another provider. This is to be used with the Health Passport for patients with a Learning Disability.

Brief Summary of Document:

This document provides the framework for the collection and transfer of the right information about the patient being transferred, from the right staff to the right receiving staff.

Mental Health and Learning Disability teams in Hywel Dda University Health Board are subject to the guiding principles of their professional body as well as the service aims, values and principles.

The information collected will form the front sheet of the essential information required to provide a safe, systematic and meaningful handover of care from one area of care to another. All boxes are required to be completed and a signatory obtained from both the transferor and receiver that a safe and adequate transfer has been achieved.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Mental Health & Learning Disability SBAR Handover for Transfer of Care

(For completion on transfer from in-patient mental health areas to acute inpatient areas)

First Name	Surname	Date of Birth	NHS number	Preferred Name
		/ /		

Home address:	Postcode		
Next of Kin/ Emergency contact Name: Tel No		NOK/ Carer/ Family: aware / not aware of transfer	
Transferred from		Transferred to	
Tel No		Tel No	

S — **Situation** (Presenting complaint & reason for transfer)

Responsible Consultant Psychiatrist	

B — **Background**

History of presenting complaint:

Concerns with cognitive function	Legal status	DOLS	Expiry date of Section 17 leave agreement / /

Summary of RISK and updated management plan.
Include:

- Risk of self-harming
- Risk to others
- Risk of Suicide

Advanced directives (if yes, copy in notes)	**Lasting Power of attorney(LPoA) YES / NO** **Name of LPoA ?** **Where is a copy of the document?**

Does the patient have a valid DNACPR form in place? **Copy in the patient notes** □

Allergies (include reaction type, if they have an epi pen)

A

Assessment (treatment so far)

BP:	**HR:**	**Resps:**	**Temp:**	**BP:**	NEWS Score:

GCS: Copy observations chart given □

Mental Health Observations that have been in place on the Mental Health unit – (give rationale)

Confirm handover of the following:
Falls risk □
Nutrition Risk Score □
Communication / sensory loss concerns □
Mobility difficulties
Current prescribed medication □

Other documents in use
Printed copies of CTP/WARRN/PBIS plan

R	**Recommendations (plan of care)**
	Specify level of observation required: (specify if enhance support needed) in the general ward /accepting ward consider ligatures/staffing skills/disruption to person being transferred.

	Transferring Registered Nurse	Receiving Registered Nurse
Print Name		
Signature		
Date & Time		

HYWEL DDA UNIVERSITY HEALTH BOARD

THE SBAR FOR EMERGENCY SITUATIONS IS TO ACCOMPANY THIS FORM FOR ANY TRANSFER TO AN EMERGENCY DEPARTMENT IN ACUTE HOSPITAL SERVICES

HYWEL DDA UNIVERSITY HEALTH BOARD

13. APPENDIX 2 - PATIENT ESCORT CHECKLIST

Patient ID:	Ward/Clinical Area: Date of Transfer: Time of Transfer:	Transfer to:	Is the patient returning to the ward Yes [ ] No [ ] If Yes, have the return journey arrangements been made Yes [ ] If Yes, has this been communicated during shift handover – Yes [ ] NA [ ]

TO BE FILED IN PATIENT RECORD

Reason For Transfer:				
Decision To Transfer By:	Documented in Medical Record: Yes [ ] No [ ] Please comment if No:			
Discussed With Patient: Yes [ ] No [ ] Please Comment If <u>No:</u>	Relatives Informed: Yes [ ] No [ ] Please Comment If <u>No:</u>			
Liaised with receiving area: Yes [ ]	***Escort Requirements (see tables overleaf) :***			
Equipment required prepared: Yes [ ] NA [ ]	Normal Ward Care		Learning Difficulties	
Tick all that apply: Notes [ ] X ray [ ] Medication [ ]	Confused		Mental Health Illness	
Valuables property packed: Yes [ ] Property list completed: Yes [ ] No [ ] - If No, disclaimer must be signed	Communication Difficulties		Defined As A 'Vulnerable Adult'	
Escort Arranged: Tick all that apply Porter [ ] HCSW [ ] Registered Nurse [ ] Ambulance crew [ ] Other [ ] (please specify):	At Risk Of Their Condition Deteriorating		Recently Relocated From Higher Levels Of Care	
	Level of Care: Level 0 [ ]		Level 0.5 [ ] Level 1 [ ]	
Signature of Nurse completing the form :	**Signature Registered Nurse in charge of the ward:**			

Level 0	Applies to patients whose needs can be met through normal ward care in an acute hospital.

*** Level 0.5**	Applies where some additional support is required for eg elderly or confused, or those with communication difficulties, learning difficulties, mental health illness or defined as a 'vulnerable adult' (Refer to the HB Interim Policy for the Protection of Vulnerable Adults (2010) and the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults (Nov 2010) (See Appendix 1 for definition of vulnerable adult)
Level 1	Applies to patients at risk of their condition deteriorating, and/or those recently relocated from higher levels of care.

RECOMMENDED GUIDELINES FOR INTRA-HOSPTIAL TRANSFER OF PATIENTS	**(Minimum) ACCOMPANYING PERSONNEL /ESCORT**	**SKILLS REQUIRED**	**ESSENTIAL EQUIPMENT**
Level 0	Porter or HCSW or Registered Nurse	BLS	
***Level 0.5 (eg Elderly/Confused)**	Porter plus HCSW or Registered Nurse	BLS	
Level 1	Suitably experienced Registered Nurse/HCSW plus porter, appropriate to the needs of the patient	BLS and Gas Cylinder Training. Appropriate competency in: - Specific Drug Delivery - Recognition of Deterioration - Suction and Tracheostomy Care Medical/Infusion devices in use	- Oxygen - Suction (if Trache) - Portable IV stand - Battery operated infusors - Pulse-Oximeter

RECOMMENDED GUIDELINES FOR INTER-HOSPITAL TRANSFER OF PATIENTS PATIENT	**(Minimum) ACCOMPANYING PERSONNEL**	**SKILLS REQUIRED**	**ESSENTIAL EQUIPMENT**
Level 0	Ambulance Crew	BLS	
***Level 0.5**	Ambulance Crew and HCSW/Registered Nurse	BLS	
Level 1	Registered Nurse or other registered health care professional / PTS / HDS Crew	ILS and Gas Cylinder Training Appropriate competency in: - Specific Drug Delivery - Recognition of Deterioration - Suction and Tracheostomy Care Medical/Infusion devices in use	- Oxygen - Suction (if Trache) - Portable IV stand - Battery operated infusors - Pulse-Oximeter