The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Discharge Policy

Author and Contact details:	[redacted]	
Responsible Director:	**Director of Nursing**	
Approved by and date:	**Patient Safety Group**	**June 2019**
Document Type:	**POLICY**	**Version 3.0**
Target Audience:	All trust employees.	
Document Approval, History/Changes	**See Appendix 7.** For further information contact the Governance Department on [redacted]	

Think of the environment…Do you have to print this out this document? **You can always view the most up to date version electronically on the Trust intranet.**

Executive Summary

The Trust is committed to ensuring well planned discharge, recognising that discharge is a process and not an isolated event. Effective communication with patients, relatives and carers and between members of the multidisciplinary team is essential in facilitating timely patient flow from admission to discharge.

The policy is based on the principle that discharge is a planned process, carried out in a multi-disciplinary setting in which the patient is central. The policy has the aim of reducing unnecessary delays in patient flow, having a beneficial effect on individual patients and their carers, as well as benefits to the health and social care system in respect of access to services.

Contents

1. Introduction

This policy and procedure sets out standards of acceptable practice, to support staff, patients and their relatives/carers in setting realistic expectations of hospital stays. The standards apply to all elective and emergency adult services provided within the Trust and follows guidance set out in the 'Discharge from Hospital; Pathway, Process and Practice 'document (DOH 2003).

The standards are based on the principle that discharge or handover of care is a planned process, carried out in a multi-disciplinary setting in which the patient is central. The policy has the aim of reducing unnecessary delays in patient flow, having a beneficial effect on individual patients and their carers, as well as benefits to the health and social care system in respect of access to services.

1.1. Objectives

1.1.1 To achieve a safe, standardised approach and practice towards discharge planning across the Trust by:

- ensuring patients are always treated as individuals, taking account of special needs
- ensuring safe discharge of patients from hospital by ensuring timely and effective communication with the relevant health and social care services
- ensuring the patient and all appropriate carers receive timely assessments, clear information and instructions and are involved in the discharge process, either before or from the date of admission
- Minimising inappropriate length of stay
- reducing the risk of readmission following discharge
- reducing delays in discharge and support optimal bed management
- ensuring timely access for elective and emergency admissions
- ensuring proactive discharge planning at the earliest opportunity resulting in safe and appropriate discharge of patients

1.2. Effective Discharge Co-ordination

The aims of effective discharge co-ordination should:

- promote good clinical outcomes which include that patients, social emotional and psychological needs are met
- promote good care management of individuals and establish care pathways across service boundaries
- encourage the patient/carer to take responsibility for their health needs/recovery, promoting independence where possible
- ensure that the patient/carer is fully involved in the decision-making processes
- provide effective and efficient systems for inter-professional referral, assessment, treatment, and support
- ensure acute hospital facilities and community resources are used appropriately
- promote timely and appropriate discharge, preventing unnecessary stays in acute inpatient facilities

2. Scope

2.1. This policy applies to in-patient admissions to The Walton Centre from the community it serves, and all staff involved in the admission, assessment, planning of patient care and discharge. Patients ready to leave hospital from the Critical Care Unit within the Walton

2.2. Centre will be managed under the Trust Transfer Policy to support specific on-going needs.

2.3. The Trust applies the process of multi-disciplinary working.

2.4. The Trust acknowledges that discharges of vulnerable adults and certain other patient groups thought to need protection such as those with acquired brain injuries, capacity issues, learning disabilities need more specific guidelines when being discharged. Separate guidelines have been produced in line with the most up to date legislation.

2.5. The policy should be read in conjunction with 'Cheshire & Merseyside SHA Eligibility Criteria for NHS Funded Continuing Healthcare' (Revised 2006) and the 'Joint Protocol for Transfer of Care from an Acute Hospital Bed' (2003).

3. Definitions

- **Self-Discharge** - relates to patients wishing to discharge themselves against medical advice. Details should be recorded in the patient's notes and on the Patient Information System. The nurse looking after the patient should make every effort to inform the next of kin having established the patient's consent
- **Intended Date of Discharge (IDD)** - an identified target date by the medical staff as an indication when the patient will be fit for discharge. This date is dependent upon patient needs
- **To take out' Medication (TTO'S)** - medicines which the patient takes away with them when they are discharged from hospital
- **Equality and Human Rights** - the Trust has a commitment to providing equality for all and to breaking down all barriers of discrimination, prejudice, fear or misunderstanding, which can damage service effectiveness for service users and carers (see Equality and Human Rights Policy)

4. Duties

4.1. Trust Board is:

- ultimately accountable for ensuring effective controls are in place to support safe discharge practices

4.2. Executive Nurse and Medical Director are accountable:

- to the Trust Board for ensuring compliance with these standards in all parts of the Trust

4.3. Divisional Clinical Directors / Divisional Lead Nurses are responsible:

- to the Executive Nurse and Medical Director for ensuring these standards are implemented within their nursing and medical teams by:
  - ensuring nursing and medical staff are aware of the standards
  - monitoring and audit of practice relating to the standards

4.4. Divisional Directors of Operations are responsible:

- to the Director of Operations for ensuring this policy is implemented within own teams by:
  - ensuring all line managers are aware of the standards
  - identifying training needs
  - check with Intranet that this printed copy is the latest issue

4.5. Ward / departmental Line Managers are responsible

- to the Lead Nurses/Service Managers for implementing, monitoring, and evaluating compliance with the standards

4.6. The Bed management Team

- assist the clinical teams with co-ordination to ensure safe and effective discharges
- ensure every effort is made to minimise delayed discharges and update Trust records for reporting, escalate problem areas and manage through the Trust daily bed management meeting.
- Report on a regular basis to The Director of Operations for higher level matters
- work closely with the Discharge Planner to utilise appropriate beds in the community
- assist with the monitoring of compliance of the discharge policy

4.7. The Discharge planner

- Completing complex assessments for patients requiring intermediate care/ continuing healthcare funding act as a mediator between the wards and relevant external agencies/commissioning authorities.
- apply for specialist rehabilitation funding (IFR)
- working in partnership with other disciplines such as the bed management team, ward managers, therapists, and ward coordinators
- ordering of any necessary nursing equipment to support the patient at home also to confirm equipment is in place prior to discharge
- Help to minimise delays by identifying potential issues before IDD- these can be identified to discharge planners at the ‘10am bed management meeting’
- Support with section 2 referrals to social services which are made via EP2.
- Discharge Planner is available to offer support and advice to all members of the MDT. Contact [redacted]

4.8. Multi-Disciplinary Team

The multi-disciplinary team should assess, plan, coordinate and evaluate patient-focused, evidence based and cost-effective care for patients, ensuring that they are discharged from hospital in a timely manner to a safe and clinically appropriate environment.

4.9. All Staff

It is the responsibility of all staff within the Trust to ensure that the standards are implemented. They are also responsible for identifying areas of practice where further training is required, informing their managers and attending training.

4.10. Safeguarding

There is clear guidance as to the discharge of children for whom there are child protection concerns:

- no child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child, this plan must include follow up arrangements and involve partner agencies as required
- the need to safeguard a child should always inform the timing of their discharge, so that the likelihood of harm can be assessed while he or she is in hospital
- Please liaise with Safe Guarding Matron for any further support and guidance

5. Discharge requirements for all patients

5.1. The discharge requirements for all patients are included in the Discharge Checklist which can be found EP2.

5.2. Discharge must be planned for at the earliest opportunity between the Trust and social care organisations, ensuring that patients and their carers understand and are able to contribute to care planning decisions as appropriate.

5.3. Discharge planning must take into consideration, patients with special requirements, such as sight, hearing impairments, cognitive impairments, patients who have learning difficulties, cultural or whose first language is not English. Staff must ensure appropriate patient representation is available e.g. interpreters (from recognised Trust providers), IMCA for patients who do not have an appropriate advocate and carers to ensure patients and their families are fully involved in the discharge process and can contribute to the discharge plan.

5.4. The process of discharge planning should be co-ordinated by a named Nurse who has the responsibility for co-ordinating all stages of the patients progress. This involves liaison with those involved in the patients care and those who need to be involved in the future, at the earliest opportunity.

5.5. The admitting nurse/nurse responsible for patients care will commence the discharge planning checklist within six hours of admission to issue any potential issues for longer stay patients or sooner for patients of shorter stay and ensure patient, relative/carer receive appropriate initial discharge information and the “Leaving Hospital” Discharge Leaflet - these are located in each ward location..

5.6. The consultant team responsible for the patient will identify and document when the patient is medically fit for discharge.

5.7. The Nurse responsible for the patient’s care will progress the discharge plans, once the patient is deemed medically fit, the date should be entered onto the IPAD. (EP2/CRU)

5.8. All patients, (relatives/carers where appropriate) being discharged following an inpatient admission, or day case episode must receive appropriate information, either verbally and/or written. The nurse responsible for the patient discharge must document the information given in the patient record.

5.9. Where relevant this may include, discharge medications and instructions, discharge leaflet, condition related information, OPD appointment, and copy of the discharge summary for the patients GP.

5.10. Nurse-led discharge will be undertaken in agreed suitable clinical areas within the Trust.

5.11. All patients must be discharged on the Patient Administration System (PAS) as part of the discharge process, as they are leaving the ward.

5.12. All patients will be offered a copy of their discharge medication letter and a copy for their GP. A formal Discharge summary will be forwarded to the patients GP and the patient.

6. Medications on Discharge

6.1.1 All patients must be supplied with discharge paperwork (including brief summary of reason for admission) written, even if no medication supply is required. For those patients requiring supply of medication the prescription must be sent to Pharmacy (via the ward pharmacist where available) for verifying and dispensing. Prior to discharge all medication must be checked against the discharge prescription by 2 trained members of staff; this MUST be recorded on the discharge checklist.

7. Rapid Discharge Pathway for the Care of the Dying Patient from Hospital to Home

7.1.1 If a dying patient and/or family/carer express the wish to die at home, the Rapid Discharge Pathway is a coordination tool that should be used to expedite this request safely.

7.1.2 Please see Appendix 2 for Rapid Discharge algorithm – Contact Discharge Planner and the Palliative Care Team (PCT) for advice.

7.1.3 Contact No's [redacted]

8. Discharge Out of Hours

8.1.1 On occasion patient discharge may occur out of hours. Where patients are discharged out of hours, staff must ensure the same Discharge procedure and standards are applied as at other times to ensure safe discharge.

9. Self-Discharge

9.1.1 In the case of self-discharge, the patient MUST be given sufficient information about the risks of self-discharging.

9.1.2 The senior doctor on duty should be made aware of the patient's wish to self-discharge and the patient should be seen by a doctor who should fully document the discussion with the patient.

9.1.3 The Consultant in charge of the patient's care should be advised of the patient's self-discharge as soon as is practically possible.

9.1.4 Where the patient has taken their own discharge the patient's GP should be made aware of the situation and receive a written medical report as soon as possible, unless it is considered a breach of the patient's confidentiality the patient's next of Kin or significant other should be advised of the patient's self-discharge.

9.2. When a Patient Refuses to Leave Hospital

9.2.1 If a patient refuses to leave the hospital, once medically discharged by the Consultant, nursing staff will contact the team to speak to the patient again, to resolve any issues, if the patient still refuses to leave, the matter will then be escalated to the relevant Matron/General Manager.

9.2.2 Discharge of Patients into the Prison Service/ Police Custody

Patients admitted from the local prison service or in police custody will have prison/ police staff in attendance at all times, in accordance with the Trust policy.

Prisoners/ Patients under arrest will be discharged using the operational procedures within this policy, whilst taking into consideration the following:

- Communication about the patient should always be directed through the prison service / police staff.
- No information should be passed to friends or family. Any enquiries about the patient from an outside source should be directed to the escorting staff, as per the above policy.

At the time of discharge, all items of property belonging to the patient, including any equipment or medications issued by the Trust, will be handed to the escorting staff and not the patient.

All the above guidance is in accordance with the above policy.

9.2.3 Discharge of patients with Safeguarding Adult Issues (formerly known as Adult Protection)

- If a patient is the subject of a Safeguarding Adults investigation, or it is felt that discharging the patient may put him at risk, discharge should not be considered.
- If there is a Social Worker or Safeguarding involved with the patient, he or she should be kept informed at each stage of the planning process.
- Where there has been no previous social work involvement, there should be discussions with the patient's local social care team regarding who would be the most appropriate agency to investigate and decision make.
- It may not be appropriate for the patient to remain in an acute hospital setting; therefore, a transfer to intermediate care, or a non-acute area, may be considered.
- Short term or temporary placement in a Care Home should be considered until the Safeguarding Adult procedures are resolved.
- Contact Trust Safeguarding Lead

All actions in respect of Safeguarding Adults should be in accordance with the Documents; Liverpool Inter-Agency Safeguarding Policy and Procedure 2015 https://www.liverpool.gov.uk/media/8902/liverpool-inter-agency-safeguarding-adults-policy-and-procedure.doc

9.2.4 Discharge of patients who are being deprived of their Liberty

In accordance with the Deprivation of Liberty Code of Practice, it is possible for a patient to be discharged from hospital, even if he is being deprived of his liberty whilst he is in hospital. This is irrespective of whether discharge is to either to his home address, or another hospital or a care home,

As soon as a discharge date is established, a notification email should be sent to the Deprivation of Liberty Administration office, informing them of the intention to discharge.

This can be done in liaison with the Trust's Lead for Safeguarding Adults

10. Process for Cheshire and Merseyside Rehabilitation Patients.

Patients who are suitable for rehabilitation will be assessed by the Cheshire and Merseyside Rehabilitation Team, and referred if appropriate, to further care facilities. See appendix 5.

11. Training

11.1.1 All staff involved in the assessment of discharge needs must ensure they are aware of:

- The Continuing Health Care Eligibility Criteria.
- Mental Capacity Assessment
- Deprivation of Liberty Assessment (DOLS)
- How to access and complete the electronic discharge checklist
- How to Discharge and Transfer patients from the PAS system

12. Monitoring

The Bed Management Team will present an annual audit to the Patient Safety Group. (Remove)

13. References

13.1. Supporting policies/documents

- Safeguarding Children and Adults Policies
- DoLS Policy
- Equality and Human Rights Policy

14. Homeless

The Homelessness Reduction Act 2017, which introduced the duty to refer, came into force 3 April 2018 and introduced new duties for local housing authorities to help prevent the homelessness of all families and single people, regardless of priority need. Under the new duties in the Act, local housing authorities will now offer individuals who are homeless or threatened with homelessness a greater package of advice and support. The Act should mean more people get the help they need earlier, to prevent them from becoming homeless in the first place.

14.1. Duty to Refer

Specified public services now have a legal duty to refer service users they consider may be homeless or threatened with homelessness to a local housing authority. For health services the impact will be on NHS trusts and foundation trusts in the provision of any of the following NHS health services:

- accident and emergency services in a hospital
- urgent treatment centres
- in-patient treatment (**of any kind**)

The referring service must have the person's consent.

- The Faculty for Homeless and Inclusion Health in consultation with health providers have developed a downloadable example referral form for hospitals to use. This should be used alongside the duty to refer health services checklist.
- Provides an overview of the duty to refer for NHS staff, including how to make a referral to a local authority. https://www.pathway.org.uk/wp-content/uploads/Standards-Appendix-1-HRA-Referral-Form-v02-August-18.docx
- https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff (Appendix 3) (Appendix 4)

Appendix 1 - SOP Rapid discharge

1. Introduction

The aim of the rapid discharge SOP is to facilitate a safe, smooth and seamless transition of care from hospital to community for patients with a terminal illness who wish to be cared for in their own home for the last days or weeks of their life.

The procedure relies on:

a. Hospital staff recognising the priority of the discharge therefore minimising any potential delays

b. Patient/carer/significant other being aware of care plan and are involved in care plan

c. The district nursing service being key in the discharge process

d. Secondary care prescribing for s/c administration of any regular or anticipatory medications for community use until GP can visit

This SOP should be used if:

a. A patient who is in the dying phase of a terminal illness chooses to die at home

b. The family/carer/significant other support patient decision

c. Patient / family / carer/significant other have discussed the option for continued hospital support

d. The multi-professional team must support the patient decision and make every effort to accommodate this request communicating any concerns they may have regarding discharge

e. GP supporting the discharge

2. Scope

This SOP is for use by the Registered Nurse responsible for co-ordinating the patient discharge, assisted by the Discharge Planner/ Palliative Care Team as required. Delegation of these responsibilities is at the discretion of the senior nurse on duty.

3. Patient Group

Patients who are recognised to have a terminal illness and are in the last days or weeks of life and who wish to be cared for in their own home.

4. Process

- Discharge planning team informed of discharge and coordinates discharge.
- Care package arranged as required by discharge planning team.
- Required equipment in place prior to discharge arranged through discharge planning team.
- Contact numbers for 24 hour DN cover available to family/carers/significant other.
- District nurse visit arranged immediately following discharge.
- GP has been spoken to and GP supports discharge process.
- Out of Hours GP service aware of discharge if discharge takes place at weekend.
- GP visit planned within 24 hours of discharge.
- Current medication assessed by medical staff and non-essential medication is discontinued.

- PRN subcutaneous medication prescribed by medical staff for pain/nausea/vomiting/agitation and chest secretions as per protocol on district nurse prescribing form and faxed to appropriate DN service.
- If syringe driver in place district nurse prescribing form completed by medical staff and faxed to relevant DN service.
- TTO medication prescribed for 48 hours until review by GP. This should include syringe driver medication if appropriate and PRN subcutaneous medication as above.
- If syringe driver in use replenish just prior to discharge. Discharge with hospital syringe driver in situ and ask district nursing team to return to Walton Centre within 24 hours.
- If oxygen is required medical staff to complete HOOF form and ward staff to ensure oxygen in place prior to discharge.
- Urgent paramedic ambulance booked.
- The Nurse responsible for booking the ambulance informs the ambulance control of the patients DNAR orders as documented in the patient's case notes. The top copy of the unified DNAR Form (lilac border) must accompany the patient. (A photocopy is not acceptable to ambulance staff) Depending upon the patient's clinical condition the patient/ family / carer/significant other should be informed about the procedure should death occur during the journey home

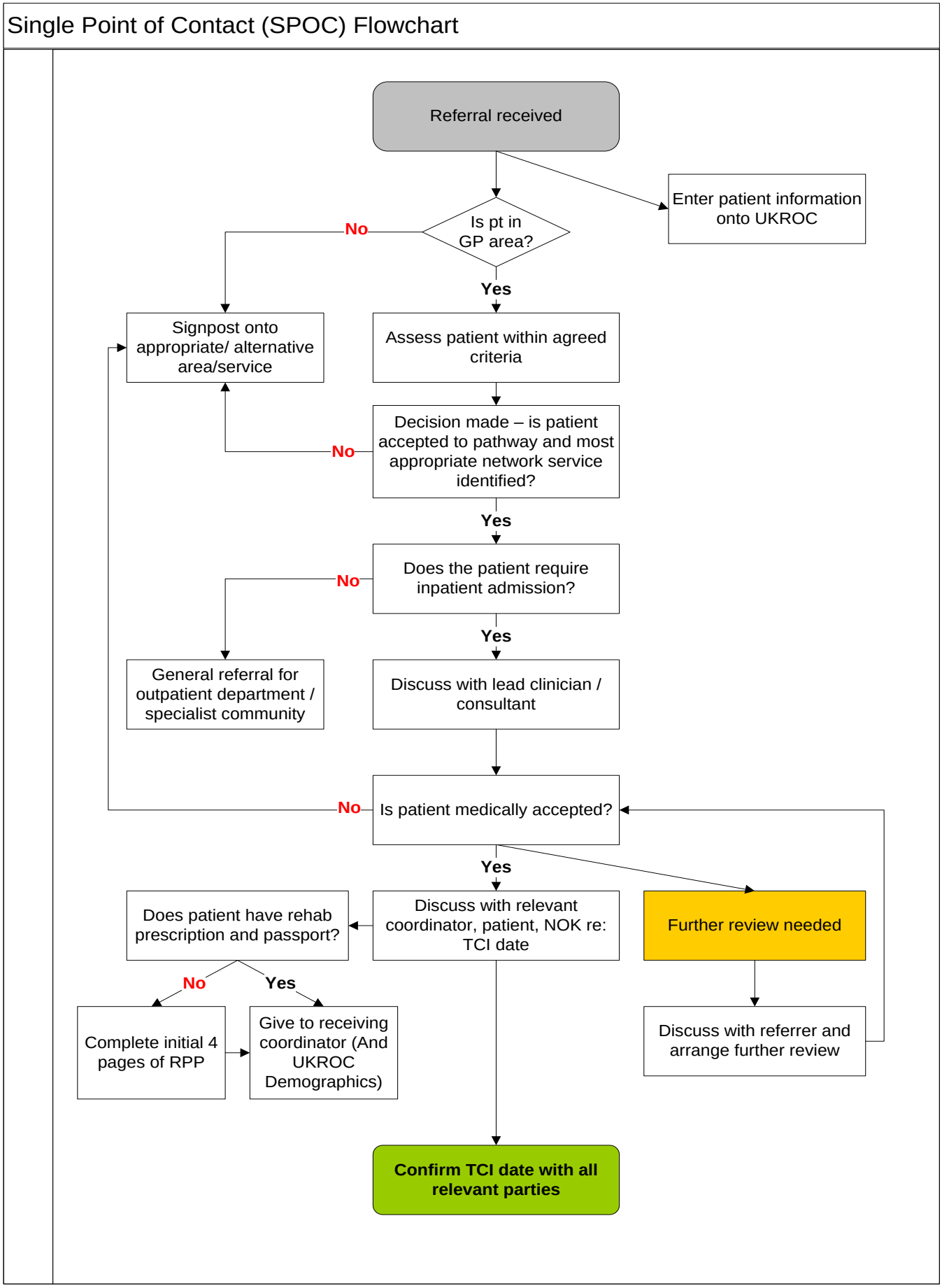
5. Supporting/documentation

- Discharge Policy

6. References

- End of Life Care Strategy: Quality Markers and Measures for End of Life Care in Acute Hospitals (3.5 and 3.6)

Appendix 2 - Single point of contact flow chart for rehab patients



Appendix 3 - Homeless Duty to Refer Checklist

<u>This is not a definitive list</u>

Health services already support and refer individuals who are homeless or at risk of homelessness, as part of their safeguarding responsibilities and normal daily work. The duty to refer seeks to extend the good practice that already exists in many local areas across England and aims to ensure services are working together.

The Ministry of Housing, Communities and Local Government have asked every local authority to create an email address using the format [redacted] to facilitate referrals from public service professionals who may not know contact details for services.

Every Local Authority will have their own protocol for making housing referrals. Therefore, please check with your Head of Unit or the chosen Local Authority.		
1	**Before completing the referral form, please check if the patient or hospital has been in contact with a Local Housing Authority previously about the patient's homeless status?**	
2	Patient Ward Location?	
3	Has the patient provided written/verbal consent for the referral?	
4	Has the patient provided contact details?	
5	Has the patient confirmed why they need to be referred, for instance: • They are living in over-crowded accommodation • They are suffering domestic abuse • They are in rent/mortgage arrears • They have been threatened with eviction • Currently sofa-surfing (staying with friends) • They have been asked to leave their current accommodation	
6	Has the Local Housing Authority been informed of the Patient's discharge date? • **The earlier the Local Housing Authority are informed the more likely a successful referral**	
7	Does the patient have links to the local area?	
8	Has the patient confirmed what type of accommodation they are currently living in?	
9	Does the patient have dependent children?	
10	Is the patient content to provide medical details? • **The more information the local authority has, the more effective the referral.**	
Please ensure a copy of the referral form is filed with the hospital notes with receipt of confirmation from the Local Housing Authority.		

Appendix 4 - Duty to refer referral form

Please insert the name of the local housing authority that the service user is being referred to.	
NOTE: Service users can chose which local housing authority they wish to be referred to. However, it is advisable for them to choose a local authority with which they have a local connection. In general, a service user is likely to have a local connection to an area if they live or have lived there, wok there or have a close family connection. However, a service user should not be referred to an area where they would be at risk of violence. A guide to the duty to refer includes advice on the duty to refer and local connection.	
(1A) Written Consent to share information I agree to the information on this form being shared with _____ Council. I understand that the Council may use this information to contact me, and to help assess my needs for assistance with housing and that I am not making a homelessness application. I have read _____ privacy notice and understand how my data will be processed. Signed: _____ Date: _____ NOTE: The service user must give consent to the referral. Referrers are advised to obtain signed consent to the referral; however, oral consent can be provided. The referrer must therefore complete box 1B.	
(1B) Oral Consent to share information Having discussed the accommodation status of _____ (*insert service user name)* the service user, I can confirm that they provided me with oral consent to refer their case to _____ Council. I explained to the Service User that the Council may use this information to contact them and to help assess their needs for assistance with housing and that this is not a homelessness application.	

Signed	**Public authority**	**Date**

Core information Please note that sections 2 – 4 must be filled in.	
(2) About the referring professional (to be completed by the professional)	
Public authority referring (e.g. prison, hospital, etc.)	
Role of person referring (e.g. social worker)	
Name of referrer	
Address of referrer	
Email address of referrer	
Phone number of referrer	
Name and contact details of any other person who could be contacted for further information, if not the referrer (e.g. a support provider)	
(3) Information and contact details for the service user being referred	
Name	
Household composition (e.g. single person, couple, family with X children/X adults)	
Current address (if applicable)	
Home telephone number	
Mobile number	

Email address	
Gender	
Date of birth	
Language and communication needs (identify any assistance the service user will need for an assessment to be completed)	
(4) Main reason for referral	
What is the main reason you are referring the individual?	I believe they are homeless / I believe they are threatened with homelessness
Please explain your answer (e.g. “they are facing eviction from their home”)	
Additional information Please provide any additional information you are aware of which may help housing options officers support the individual.	
(5) Current accommodation	
What type of accommodation is the individual currently living in?	
If the service user is threatened with homelessness, on what date are they likely to become homeless?	
If the service user is due to leave prison or hospital, or is leaving the armed forces, with no accommodation available, please state when the release/ discharge will take place.	
(6) Are there any additional needs/risks to be aware of?	
Additional needs/risks might include: • previous history of sleeping rough • lack of support from family/friends • history of substance misuse • risk of domestic or other abuse	
(7) Relevant medical information	
Please provide information on any physical or mental health needs that the service user has, and any treatment that they are receiving	
(8) Other information	
Please provide any additional information. In particular, are there any known risks to staff visiting the service user at home or any other issues that we need to be aware of prior to initial contact?	

Appendix 5 - Equality Impact Assessment (EIA) Form

The Walton Centre NHS Foundation Trust

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part 1

1. Person(s) Responsible for Assessment: [redacted] 2. Contact Number:

3. Department(s): Bed Management/Discharge Planner/Matron 4. Date of Assessment: June 2019

5. Name of the policy/procedure being assessed: Discharge Policy

6. Is the policy new or existing?

New Existing

7. Who will be affected by the policy (*please tick all that apply*)?

Staff Patients √ Visitors Public

8. How will these groups/key stakeholders be consulted with? Intranet

9. What is the main purpose of the policy? To ensure a safe discharge pathway.

10. What are the benefits of the policy and how will these be measured? Benefits will be to assist in discharge planning. Reviewed when changes are made.

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? *Safeguarding Children and Adults Policy, DOL, Equality and Human Rights Policy.*

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics?

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation/adjustments already put in place
Age			√		
Sex			√		
Race			√		
Religion or Belief			√		
Disability			√		
Sexual Orientation			√		
Pregnancy/maternity			√		
Gender Reassignment			√		
Marriage & Civil Partnership			√		
Other					

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? *See Guidance for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal).*

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Safeguarding Matron for further support.

Action	Lead	Timescales	Review Date

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: [redacted] Date: [redacted]

Signed:

Appendix 6 - Policy approval checklist

The Discharge Policy is presented to the Patient Safety Group for Approval.

In order for this policy to be approved, the reviewing group must confirm in table 1 below that the following criteria is included within the policy. Any policy which does not meet these criterion should not be submitted to an approving group/committee, the policy author must be asked to make the necessary changes prior to resubmission.

Policy review stage

Table 1

The reviewing group should ensure the following has been undertaken:	**Approved?**
The author has consulted relevant people as necessary including relevant service users and stakeholders.	Yes
The objectives and reasons for developing the documents are clearly stated in the minutes and have been considered by the reviewing group.	Yes
Duties and responsibilities are clearly defined and can be fulfilled within the relevant divisions and teams.	Yes
The policy fits within the wider organisational context and does not duplicate other documents.	Yes
An Equality Impact Assessment has been completed and approved by the HR Team.	Yes
A Training Needs Analysis has been undertaken (as applicable) and T&D have been consulted and support the implementation	Yes
The document clearly details how compliance will be monitored, by who and how often.	Yes
The timescale for reviewing the policy has been set and are realistic.	Yes
The reviewing group has signed off that the policy has met the requirements above.	Yes

Reviewing group chairs name: [redacted]	**Date: June 2019**

Policy approval stage

☐ **The approving committee/group approves this policy.**

☐ **The approving committee/group does not approve the policy.**

Actions to be taken by the policy author:

Approving committee/group chairs name: [redacted]	**Date: June 2019**

Appendix 7 - Version control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
1.0	All	Revision at review date.	May 2015	[redacted]
2.0	4.6 final bullet	Insertion in - The Discharge planner - All section 2 referrals to social services are made via E patient on the IPAD.	June 2015	[redacted]
2.1	4.9	Insertion of safeguarding section.	June 2015	[redacted]
2.2	6.0	Insertion of Rapid Discharge Pathway for the Care of the Dying Patient from Hospital to Home.	June 2015	[redacted]
2.3	9.0	Insertion of process for Cheshire and Merseyside Rehabilitation Patients.	June 2015	[redacted]
2.4			June 2015	[redacted]
2.5	Appendix 3	Removal of existing Patient Information Leaflet	June 2015	[redacted]
2.6	Appendix 5	Insertion of process map.	June 2015	[redacted]
3.0	All	Full review at expiry date	May 19	[redacted]
	4.6	Remove final bullet monitor IDD through the Bed Management system	May 19	[redacted]
	5.2	Change reference from Discharge Checklist in Appendix 2 to signpost form in EP2	May 19	[redacted]
	5.6	An intended discharge date (IDD) Take Out will be allocated by the admitting consultant team within the first 48 hours of admission or sooner for shorter stay patients, unless the patient's clinical condition dictates otherwise.	May 19	[redacted]
	6.0	Section updated by Pharmacy	Jun 19	[redacted]
	9.2.2	Following bullets points updated • Communication about the patient should always be directed through the prison service / police staff. • No information should be passed to friends or family. Any enquiries about the patient from an outside source should be directed to the escorting staff, as per the above policy.	May 19	[redacted]
	9.2.3	Update to section - Discharge of patients with Safeguarding Adult Issues (formerly known as Adult Protection)	May 19	[redacted]
	9.2.4	Update to section - Discharge of patients who are being deprived of their Liberty	May 19	[redacted]
	13.0	Inclusion of section on the homeless	May 19	[redacted]
	13.1	Update to section - Discharge of patients who are being deprived of their Liberty	May 19	[redacted]
	Appendix 1	Remove Nursing Transfer Letter	May 19	[redacted]

		removed as this form is held on EP2		
	Appendix 2	Patient Discharge Checklist removed as this form is held on EP2	May 19	[redacted]
	Appendix 3	Patient discharge Leaflet removed as this form is held on EP2	May 19	[redacted]

Translation Service

If you require this in any other language or format, please contact the [redacted] stating the leaflet name, code and format you require.

Arabic
اذا كنت بحاجة إلى هذه النشرة بأي لغة أو تنسيق آخر، فيرجى الاتصال بفريق متابعة تجارب المرضى على الرقم [redacted]
موضحاً اسم النشرة، والرمز، والشكل الذي تطلبه.

Chinese **如果你想索取本**传单的任何其他语言或格式版本，[redacted]说明所需要的传单名称、代码和格式。

Farsi
[redacted]ی لطفا با تیم تجرب[redacted]
[redacted] یا۳۰۹۳ یا با ایمیل زیرتماس بگیرد
با ذکر نام بروشور ، کد و قالب مورد نیاز خود

French
Si vous avez besoin de ce dépliant dans une autre langue ou un autre format, veuillez contacter Patient Experience Team (équipe de l’expérience des patients) au [redacted], ou envoyez un e-mail à [redacted] en indiquant le nom du dépliant, le code et le format que vous désirez.

Polish Jeśli niniejsza ulotka potrzebna jest w innym języku lub formacie, należy skontaktować się z zespołem ds. opieki nad pacjentem (Patient Experience Team) pod numerem telefonu [redacted], podając nazwę ulotki, jej kod i wymagany format.

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਕਿਤਾਬਚਾ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਪੇਸ਼ੈਂਟ ਐਕਸਪੀਰਿਅੰਸ ਟੀਮ ਨਾਲ [redacted]ਤੇ ਈਮੇਲ ਕਰੋ ਅਤੇ ਪਰਚੇ ਦਾ ਨਾਮ, ਕੋਡ ਅਤੇ ਆਪਣਾ ਲੋੜੀਂਦਾ ਫਾਰਮੈਟ ਦੱਸੋ।

Somali
Haddii aad u baahan tahay buug-yarahan oo luqad kale ku qoran ama isaga oo qaab kale ah, fadlan Kooxda Waayo-arragnimada Bukaanka kala soo xiriir [redacted] sheeg magaca iyo summadda buug-yaraha iyo qaabka aad u rabtid.

Urdu
یا [redacted]
پر رابطہ کریں، یا کتابچے کا نام، کوڈ اور اپنی مطلوبہ شکل کا ذکر کرتے ہوئے [redacted]
پر ای میل کریں۔

Welsh Pe byddech angen y daflen hon mewn unrhyw iaith neu fformat arall, byddwch cystal â chysylltu gyda’r Tîm Profiadau Cleifion ar [redacted] nodi enw’r daflen, y cod a’r fformat sydd ei angen arnoch.