HM Government

NHS

Hospital Discharge and Community Support: Staff Action Card

How your role helps to implement best practice outlined in the Hospital discharge and community support guidance.

Key messages for all staff

- Early discharge planning is required from admission (for emergency admissions) and prior to admission (for elective admissions). This enables people and their family members/carers to ask questions and receive timely information to support them in discussions and decisions about their discharge. For those likely to require health and/or social care and support post-discharge, early discharge planning must involve the person and any unpaid carers (including young carers), where appropriate, as per the duty in the Health and Care Act 2022.
- All people who no longer meet the clinical criteria to reside for inpatient care in acute hospitals or who no longer need inpatient care in community hospitals should be discharged **as soon as it is possible and safe**. Local areas should adopt discharge processes that best meet the needs of the local population. This could include the Discharge to Assess model and Home First approach.
- Every local health and social care system based around an acute hospital site should have a Single Coordinator, reporting to an Executive Lead, to lead and drive the discharge agenda across the system.
- Where Discharge to Assess is implemented, discharge home should be the default pathway (Pathways 0 & 1). People may also be transferred to non-acute settings (Pathways 2 & 3). A Case Manager may be assigned to all those requiring health and/or social care and support post-discharge to aid their recovery prior to any assessments of ongoing needs (Pathways 1, 2 & 3). A Transfer of Care Hub based around an acute hospital site should link services to coordinate care and support to aid discharge, recovery and admission avoidance.
- People should be discharged as soon as it is possible and safe following a medical decision to discharge. People on all pathways should be discharged as early in the day as possible, ideally before 5pm, as agreed with people and their family members/carers and any providers of onward care and support.
- Staff training is available via the Home First Act Now eLearning Programme. For the latest information on COVID-19 requirements for people discharged to care homes, please see Infection prevention and control in adult social care settings and Infection prevention and control in adult social care: COVID-19 supplement.

MEDICAL STAFF (DOCTORS)

All people who no longer meet the clinical criteria to reside for inpatient care in acute hospitals should be discharged home or to a non-acute setting as soon as it is possible and safe to do so.

Reviews and discharge coordination

- Ensure twice daily multi-disciplinary review (consultant review at least daily) of all people in acute beds. Agree who no longer meets the clinical criteria to reside for inpatient care and therefore should be discharged.
- Ensure clear clinical plans in medical notes to enable criteria-led discharge.
- Request immediate arrangements for discharge with a plan for virtual follow-up where needed.
- People should be discharged when clinically ready in a safe and timely manner. If a person ready for discharge requires onward care and support, it is best practice for them to receive a short period of post-discharge rehabilitation and/or reablement prior to any assessments of ongoing care and support needs (if required). This is to ensure accurate assessments of longer-term needs.
- The multi-disciplinary team should clearly describe the function and needs of people ready for discharge. They should not prescribe the exact post-discharge care and support needed.
- Ensure e-discharge summaries shared with GPs contain pertinent information from the hospital episode, and the discharge details and plan, including any medication instructions and safety netting arrangements.

Safety netting

- Conduct patient-initiated follow-up. Give people the direct number of the ward they are discharged from to call back for advice. Do not suggest going back to their GP or going to the emergency department.
- If required, telephone people the day after discharge to check on them.
- If required, call people after discharge with the results of investigations and their management plan.
- Manage people virtually in outpatient clinics under the care of the same team / speciality.
- Request community nursing and/or GP follow-up where appropriate.

Criteria-led discharge

- For each person selected for criteria-led discharge, document clear clinical criteria for safe discharge that can be enacted by an appropriate junior doctor, nurse or allied health professional without further consultant review. These may be used alongside the clinical criteria to reside in acute hospitals.
- Ensure arrangements are in place to contact the consultant directly for clarification about small variances from the documented clinical criteria.