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.

MATRON, WARD MANAGER (NURSE IN CHARGE)

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.

What do I need to do?

- 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 every person has a clearly written plan which includes clear clinical criteria by which a person no longer meets the criteria to reside. Make sure the plan is communicated to all multi-disciplinary team members, the person and their carers, family and friends. A patient leaflet is available to give to people on admission.
- For those likely to require health and/or social care and support following discharge, you must ensure that the person and any unpaid carers (including young carers) are involved in early discharge planning conversations, where appropriate, as per the duty in the Health and Care Act 2022.
- The MDT should clearly describe the function and needs of people ready for discharge, e.g. where someone would need help for daily activities such as preparing meals. They should not prescribe the exact post-discharge care and support needed.
- Where Discharge to Assess is implemented, liaise with managers of the discharge or relevant team in relation to people on Pathway 0 (those discharged home without formal care and support).
- For discharges to care homes, ensure the results of COVID-19 testing within 48 hours prior to discharge are shared with individuals themselves, their family members/carers and relevant care providers in advance of discharge.
- Ensure staff nurses are engaged in good discharge practice, e.g. utilising the Home First Act Now eLearning Programme.
- During every ward round, board round or case discussion ask the following:
    - Does the person require the level of care that they are receiving, or can it be provided in another setting?
    - What value are we adding for the person staying in the acute hospital balanced against the risks of them being discharged?
    - What do they need next and what action is required?
    - ‘Why not home, why not today?’ For those who have not reached a point where long-term 24-hour care is required.
    - ‘If not for discharge today, then when?’ Ensure there is an expected date of discharge.
    - Can a nurse or allied healthcare professional discharge the patient without a further review if documented clinical criteria are met?