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Discharge from Hospital Procedure

Introduction and Aim

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

Objectives

The objectives of the Discharge from Hospital Procedure are to :

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

Scope

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

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

	Accountable Executive or Clinical Board Director Author(s)	Chief Operating Officer		Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board
		Head of Integrated Care		

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Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1			<i>new document</i>
2			Review of Document, update to include most recent legislation.

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1. Introduction

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

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

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

2. Statement

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

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

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

Central to the policy and procedure are these principles:

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

Consideration of capacity and the principles and requirements of the Mental Capacity Act 2005, the Mental Health Measure 2010 and the All Wales Safeguarding Procedures for Children and Adults at Risk of Abuse and Neglect (2020) must underpin the application of this policy which will include recognition of those who hold a Lasting Power of Attorney, a Court appointed Deputy and verification of an Advanced Decision to refuse treatment.

All patients should receive a leaflet with necessary information, detailing the discharge planning processes. This "Planning your Discharge" information leaflet can be found at

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http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRA_NET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/PLANNING%20DISCHARGE%20BOOKLET%20-%20DEC%202012.PDF

3. Objectives

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

4. Responsibilities

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

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

The Clinical Boards have operational responsibility to implement effective and efficient systems and processes to ensure that all patients receive evidence based person-centred care and treatment within the available resources. This will include ensuring that discharge planning is organised and managed so that patients get the right clinical care under the right clinical teams at the right time, and that they are supported to be discharged from hospital when they are fit for discharge.

5. Patient Experience

- The wishes of patients should inform the development of care plans and the discharge process.
- The patient and their family/representative (with the patient's consent) should be engaged at every stage of the discharge planning process and this should be recorded on the discharge plan.

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- Every effort should be made to take into account cultural, religious, or language differences and sensory disabilities. All staff should be sensitive to special needs arising from these differences.

6. Legal context

- Where there is doubt about a patient's decision making abilities in relation to discharge destination, the Mental Capacity Act 2005 must be followed. <https://www.gov.uk/government/statistics/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-2015-to-2016>
- Patients who are subject to the Mental Health Act 1983, must have a robust management plan in place prior to discharge. <http://www.legislation.gov.uk/ukpga/1983/20/contents>
- If there are any concerns that the patient may be an 'Adult at Risk' as defined under the Social Services and Wellbeing (Wales) Act 2014, the assessing professional must follow local safeguarding procedures in line with the All Wales Safeguarding Procedures for Children and Adults at Risk of Abuse and Neglect (2020). If a patient requires care and support at home every effort will be made to carry out the assessment in the patient's own home.
- Must be compliant with Human Rights Act Articles 5 (Right to liberty) & 8 (Right to respect for private and family life).

7. Safety

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

8. Effectiveness

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

9. Timeliness

- Discharge planning should commence on admission in collaboration with the patient and their family with the patient's consent.
- Arrangements for discharge from hospital should ensure there is seamless care, so the person does not experience a gap in care due to hand over from hospital to home.
- Where arrangements for ongoing care are not in place and interim arrangements are made this should not disadvantage the person being discharged, such as where a

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person agrees to move to temporary accommodation while awaiting grant work in their own property.

- Equipment required for discharge should be identified early in order to be in place when the person is discharged.
- An assessment of the person's needs should be carried out as early as possible and consideration of eligibility for Continuing NHS Health Care should be done by MDT as part of the discharge planning process.
- Patients identified as requiring a Fast Track Discharge, the ward MDT/Palliative Care Team must have early discussions with the patient and their families/carers and a referral to the Discharge Liaison Nurse to support the discharge plans.

10. Roles

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

A. Ward Nurses – Care Coordinator

- Act as care co-ordinator for own group of patients on each shift.
- Discharge plans (including Planned Date of Discharge) are discussed with patient and family/carer at intervals throughout their stay in ward area and written discharge information is provided.
- Coordinate proportionate, integrated and specialist assessments where appropriate.
- Discharge documentation (including Integrated Assessment/ Care Plans / Continued Health Care) is legible; outcomes and recommendations are documented and completed in a timely way as a part of the MDT assessment process.
- Ensure assessments and decision making documents provide evidence of needs and risks that inform discharge plan.
- Identify constraints in the patient's discharge plan and escalate as appropriate to Ward Sister / Charge Nurse or Deputy.
- Ensure reasons for delays or failure in meeting the Planned Date of Discharge are recorded on clinical information systems.
- Recording exact time of discharge on Clinical Information systems within 10 minutes of patient being discharged from the ward.
- Ensure all the relevant information is available at the Board Round.
- Early identification of equipment needs and discussion with appropriate therapist including alternatives for support on discharge e.g. Community Resource Team (CRT/VCRS) and anticipated delivery date of any equipment required.
- Ensure Discharge Planning Checklist is completed for **all** discharges.
- Ensure transport arrangements are discussed with family and where necessary book ambulance transport 24 – 48 hours prior to discharge. Transport arrangements must not delay discharge.
- Ensure take home medication is requested 24 – 48 hours prior to discharge.
- Effective use and early transfer to Discharge Lounge where appropriate.

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B. Sisters/Charge Nurses

- Are responsible for the organisation and management of care provided to patients on their ward. This will include the co-ordination of care to ensure that all patients get the right care by the right professionals at the right time. In so doing they will ensure:
- That all patients have a CELOS/PDD set within 48 hours of admission and that this is recorded on the Clinical Work Station (CWS) and noted on the board round board.
- That all patients have a care, treatment and discharge plan that is reviewed daily so that patients and their families are kept fully up-to-date as equal partners on all aspects of their care.
- That efficient and effective multidisciplinary (MDT) board rounds are held every day, care plans for all patients are discussed and actions such as tests, treatments, assessments and referrals are carried out and all delays chased up.
- That every patient has a clear discharge plan that is reviewed daily and all delays escalated appropriately.
- That the **Choice of Accommodation Protocol** is properly implemented for **all** patients being discharged to a Care Home.
- That all formal MDT meetings are properly co-ordinated and managed so that all information to inform effective decision-making is presented and agreed actions documented and followed up.
- There is effective liaison between the ward and Integrated Discharge Service.
- That a 'live' bed state is maintained on the CWS at all times so that the Patient Access Team are able to co-ordinate the admission of new patients to the most appropriate ward.

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

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

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

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

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- E. The responsible Consultant** (or their delegated deputy) will attend the daily board round to discuss all clinical plans with the MDT and ensure all decisions / changes to the plan are effectively communicated and acted upon and will also ensure that:
- All 'to take home' (TTH) medicines, etc, are completed in good time to enable early discharges - for example blister packs for medications are ordered a week prior to discharge.
 - Discharge documentation (including Integrated Assessment / Continued Health Care) is legible; outcomes and recommendations are documented and completed in a timely way as a part of the MDT assessment process.
 - Electronic discharge summaries are completed on day of discharge.
 - A clear plan, including any follow-up care, is in place for patients who are likely to be discharged over the weekend.
 - Where a person is not returning to the care of their previous GP the doctor has a responsibility to ensure the receiving GP is provided with appropriate information to provide ongoing care.
- F. Allied Health Professionals**, eg Occupational Therapists, Physiotherapists, Dieticians, Pharmacists will:
- Attend the daily board rounds to give professional input and participate in MDT discussion on individual Clinical Plans to ensure timely discharge.
 - Provide advice, support and training to MDTs in planning safe and timely discharge of patients.
 - Work with the CRTs to identify patients who can be 'discharged to assess'.
 - Provide teaching, training and supervision to achieve best practice in discharge planning.
 - Participate in CHC assessment processes and provide expert advice.
 - Escalate any discharge delays to the appropriate level.
 - Ensure that the ward clinical work station is maintained up-to-date so that the Integrated Discharge Service (IDS) and the CRTs are accurately informed about patient progress.
- G. Directorate Managers /Lead Nurses** – will ensure that the Policy and this Procedure are fully implemented within their area of responsibility. This will include:
- Monitoring performance associated with discharge, freeing up bed capacity, reducing length of stay (LOS) and delayed transfers of care (DTOC).
 - Ensuring that the ward clinical work stations are kept up-to-date at all times so that IDS and CRT are accurately informed about patient progress.
 - Escalating any untoward patient delays that are likely to impact on patient flow issues to the appropriate level.
- H. Clinical Board Management Teams** - are responsible for ensuring that the Policy and Procedure are properly implemented within their Clinical Board. This includes ensuring that:
- All staff are made aware of their responsibilities within the Policy and Procedure.
 - Adequate training and support is provided to facilitate adequate understanding and implementation of the Policy and Procedure.
 - Effective systems are established to monitor the impact of the Policy and Procedure and the discharge planning processes.

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11. Integrated Discharge Service IDS

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

The IDS Team will:

- Use a [Standard Operating Procedure](#) as a framework for a work plan
- Act as a resource to all members of the multi-disciplinary team, to provide expert discharge planning advice.
- Provide teaching and training, both formal and informal, at ward and departmental level to improve discharge planning.
- Support ward teams in the long-term placement assessment process.
- Act as a liaison point between ward teams and other agencies.
- Escalate any discharge delays appropriately.
- Ensure that the IDS activity on the ward clinical work station is maintained up-to-date so that the IDS and the CRTs are accurately informed about patient progress.

12. Discharge Documentation

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

13. Discharge Information for Patients and their Families

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

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

14. Discharge Summary / Communication with General Practitioners

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

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

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

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15. Discharge against Clinical Advice

There are occasions when patients will want to discharge themselves against clinical advice. In these circumstances the ward staff must endeavour to establish the reason for the self-discharge. Where there is no reason to doubt a patient's capacity to make this decision, the ward team must respect the right of the individual to leave the hospital, ensuring that where possible they have been provided with sufficient information to make a fully informed decision. The 'Discharge Against Clinical Advice' procedure must be followed.

http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_I_NTRANET/TRUST_SERVICES_INDEX/EMERGENCY_UNIT_CP/UHW%20EMERGENCY%20UNIT%20DOCUMENTS/CLINICAL%20GUIDANCE/DACA%20PROCEDURE.PDF

16. Refusal to Leave Hospital/ Reluctant Discharges

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

17. Continuing NHS Healthcare (CHC)

For those patients with complex needs their on-going care will be determined following the completion of an 'Integrated Assessment' and, if necessary, the completion of the Decision Support Tool (DST), in accordance with the Continuing National Health Service Care guidance (2014).

http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_I_NTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/CHC%20-%20NATIONAL%20FRAMEWORK%20FOR%20IMPLEMENTATION%20IN%20WALES.PDF

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

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

18. Fast Track Continuing Health Care Discharge [Integrated Discharge Service](#)

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

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information to support the rapid approval and arrangement of an appropriate package of care.

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

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

It is essential that a timely discussions and decisions are made by the Ward MDT and Palliative Care Teams in order that the patient receives their care in a setting which they and their families request as long as it can meet their identified needs. Early referrals to the Discharge Liaison Nurse to support the discharge plan is essential.

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

19. [Choice of Accommodation Protocol](#)

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

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

20. Vulnerable Groups

Some individuals may require additional support when planning their ongoing care arrangements and may include individuals with a learning disability; people who are homeless; those who have a physical or sensory disability; people who have a mental illness, including dementia; and those who are old with frailty. There should also be due consideration of those adults and children who have existing safeguarding plans in place. Any safeguarding concerns identified must be raised in line with the All Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020).

21. Carers

The Social Services and Well-being (Wales) Act 2014 came into force on the 6th April 2016. The Act in Wales applies to people in need, of any age and introduces equivalent rights for

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carers to those they care for. A carer's need assessment should be triggered if there appears that the carer needs support or if they are likely to need support in the future. Carers are legally entitled to a carer's need assessment regardless of the amount of care they provide or their financial means or the level of support they may need, this includes young carers. All carers are entitled to an assessment in their own right regardless of their age, care for someone who is disabled, ill or elderly. There must not be an assumption that carers are willing and able to meet the needs of the individual without having a conversation with the carer.

Young Carers

Young Carers are children under the age of 18 years old, with caring responsibilities. They will be assessed under the Social Services and Well-being Wales Act.

Assessment is the first stage in helping a child and their family. There must be particular considerations applied to the needs of the children.

Refusal of an assessment must be overridden, where there is a refusal this would be inconsistent with a child's well-being and referral to the local safeguarding team. Any safeguarding concerns identified must be raised in line with the All Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020).

22. Performance Measures

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

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

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

23. Review of Policy

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

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

24. References

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

25. Glossary of Terms

Planned Date of Discharge (PDD)

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

Ready for Transfer (RT)

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

Discharge Fit (Fit for Discharge)

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

Care Plan

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

Plan of Care and Support (POC)

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

26. Other sources of information can be found at IDS web site [Integrated Discharge Service](#).

1. Standard operating procedure for Integrated Discharge Service
2. Choice Protocol
3. Simple/Supported/Complex Matrix
4. Clinical Workstation Operating Procedure
5. Ticket Home
6. Discharge Checklist (Draft)
7. Provision of Equipment
8. Procedure for requesting Non-Standard CHC Funded Equipment
9. Procedure for requesting CHC Equipment
10. The Discharge Pathway
11. Discharge Lounge Service
12. Pharmacy
13. CHC Fast Track Discharge
14. Hospital discharge for patients of no fixed abode