## Draft “CHOICE” ON DISCHARGE FROM HOSPITAL POLICY & PROCEDURE

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| Author:        | Head of Clinical Site and Operational Safety |
| Sponsor:       | Director of Operations |

### Policy Dissemination
- Corporate To all Medway NHS staff

### Consultation Process

#### Title of Individuals Consulted
- Patient Advocate Liaison Service 21.2.07

#### Name of Committee / Group Consulted
- Collaborative Practice Group 06.03.07
- Senior Delayed Discharge Group (PCT Chaired) 06.03.07
- Heads of Nursing 06.03.07
- Matrons 06.03.07
- Executive Team 06.03.07
- Trust Board

### Approval Signatures

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<tr>
<th>Job Title</th>
<th>Signature</th>
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<td>1. Director of Operations</td>
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<td>2. Director of Nursing</td>
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<td>3. Head of Clinical Site and Operational Safety</td>
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### Corporate Approval

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<td>Trust Risk Management Group</td>
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<td>Review existing Patient Choice Letter Protocol – PROTCPCM002 and update into new format and include policy.</td>
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<td><a href="POLCPCM030">Discharge Policy</a></td>
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Draft “CHOICE” ON DISCHARGE FROM HOSPITAL POLICY & PROCEDURE

1 Introduction

1.1 A proposed discharge date should be agreed on, or shortly following admission and documented by the pre-assessment/admitting nurse.

1.2 The policy of the Trust and overarching aim is that patients will be cared for in a place of safety, following assessment of their needs as an alternative to an acute hospital bed, when they are considered ready for transfer.

1.3 Each patient admitted to the Trust will receive a ‘Moving on from Hospital leaflet’ from the pre-assessment/admitting nurse. This action will be documented within the integrated health care records, signed and dated.

1.4 The Government guidance on this is identified in “NHS Responsibility for Meeting Continuing Health Care Needs” (HSG (95) 8/LAC(95)5). This states:

   1.4.1 “Where a patient has been assessed as needing care in a nursing home or residential care home arranged by a Local Authority, he or she has the right, under the directions of Choice LAC (92) 27 and LAC (92) 18, to choose, within limits on cost and assessed needs, which home he or she moves into. Where however, a place in the particular home chosen by the patient is not currently available and is unlikely to be available in the near future, it may be necessary for the patient to be discharged to another home until a place is available”. (para 26).

   1.4.2 “Where patients have been assessed as not requiring NHS continuing inpatient care, as now, they do not have the right to occupy indefinitely an NHS bed. In all but a very small number of cases where a patient is placed under Part 2 of the Mental Health Act 1983, they do however have the right to refuse to be discharged from NHS care into a nursing home or residential care home (para 27). In such cases, the Social Services Department should work with the hospital and community based staff and with the patient, his or her family and any carer to explore the alternative options (para 28).

1.5 If these options have been rejected, it may be necessary for the hospital, in consultation with the Health Authority, Social Services Department and where necessary Housing Authority to implement discharge to the patient’s home or alternative accommodation, with a package of health and social care within the options and resources available. A charge may be payable by the person to the Social Services department for the social care element of the package (para 29).

2 Aim

2.1 Patients will be cared for in a place of safety, following assessment of their needs as an alternative to an acute hospital bed, when they are considered ready for transfer.

3 Objective

3.1 To ensure the concerns and anxieties of patients and/or carers are discussed and resolved without prejudice or discrimination.
3.2 To ensure that patients and/or carers are invited to be a full participant in the decision making process from the time of admission.

3.3 To ensure that during the patient’s admission and throughout the decision making process, they will continue to receive an appropriate standard of care.

3.4 To ensure the patient’s identified levels of care/need for placement is kept under constant review during their admission.

3.5 To ensure the patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination. Where they are unable, their carer or representative will be consulted.

3.6 To ensure all discussions concerning assessment and the decision making process will be noted in the patient’s integrated health care records.

3.7 To ensure that at all times, Health and Social Services staff will act in the best interest of the patient.

3.8 To ensure that it is rarely in the patient’s best interest to remain in an acute hospital environment for longer than necessary.

3.9 To ensure that essential beds are made available for appropriate patients.

3.10 To ensure that if patients are discharged to an interim placement, (consideration must be given to suitability, visiting distance for relatives, GP accessibility) Social Services will undertake a four week review to ensure that the patient’s needs are being met and to identify any issues that may have arisen. If or when a placement is available in the care home of choice, transfer will be arranged. This will be dependent on the Home Matron’s or Manager’s assessment and date of vacancy. If at this time the patient decides they would like to stay in the interim placement permanently, this can be discussed with the Care Manager. (All placements are agreed dependent on the care home’s assessment and funding agreement).

4 Definitions

4.1 The policy applies to patients awaiting any of the following:

4.1.1 Patients for whom an agreed multidisciplinary assessment has identified where discharge from hospital is appropriate but who require a care home (residential or nursing). This placement will be funded by Social Services, the NHS or the patient, dependent on the outcome of financial and physical assessments.

4.1.2 Patients who have identified a care home of choice, or are having difficulty in identifying a care home of choice.

4.1.3 Patients who are awaiting care packages to be arranged, and/or completion of aids/adaptations to their own home.

4.1.4 Patients who are declared as ‘homeless’.

4.1.5 Patients who have stated that they are unwilling for transfer of care to take place until a bed is available in a care home of their choice.
4.1.6 Patients for whom an interim placement has been identified which meets their assessed physical or mental needs.

4.1.7 Patients whose home address lies outside the Primary Care Trust’s and Social Services’ boundaries of the hospital in which they are a patient.

4.1.8 A patient can be excluded from this procedure at the discretion of the Director of Operations following a case presentation to the Head of Clinical Site and Operational Safety by the Matron.

## Roles & Responsibilities

### 5.1 Director of Operations

5.1.1 The Director of Operations is responsible for approval of the Policy and Procedure. The Director of Operations has the authority to refer cases to the Trust Legal Advisor that are not resolved in the undertaking of this Policy and Procedure and evoke legal proceedings to ensure that the patient is transferred or discharged from an acute hospital bed.

### 5.2 General Managers

5.2.1 The General Manager is responsible for ensuring that all staff within the Directorate are trained in the process of this Policy to ensure equity in the delivery of the aim across the Acute and Primary Care Trust’s Community Hospitals NHS sites.

### 5.3 Trust Legal Advisor

5.3.1 The Trust Legal Advisor is responsible for assisting the Trust via the Director of Operations in the application of legal proceedings to ensure that the patient is transferred or discharged from an acute hospital bed, for the cohort of Patients who have not achieved the aim of this Policy within 28 days of the date activation of the Policy; from the date the first letter was sent.

### 5.4 Discharge Coordinator

5.4.1 The Discharge Coordinator is responsible for assisting the Senior Sister/Charge Nurse in the process of transfer of care/discharge planning. It is the Discharge Coordinator who is a specialist in the subject.

### 5.5 Care Manager

5.5.1 The Care Manager; Social Services is responsible for identification of need via a joint assessment process, clarification of funding streams and identification of placements to the patient and relatives.

### 5.6 Senior Sister/Charge Nurse

5.6.1 The Senior Sister/Charge Nurse is responsible for ensuring that all staff within her area of responsibility are fully trained and comply with the Policy and Procedure. All training events should be recorded in individual training records. The Senior Sister/Charge Nurse will work with the multidisciplinary team to ensure that the
Patients are fit for discharge. The Senior Sister/Charge Nurse will activate the Policy with support from the Discharge Coordinator. The Senior Sister/Charge Nurse is responsible for escalation to the Matron at the appropriate stage in the process.

5.6.2 The Senior Sister/Charge Nurse will ensure that a copy of any correspondence sent within the application of this policy is held as part of the integrated health care records of the patient.

5.7 Matron

5.7.1 The Matron is responsible for ensuring that all staff within her area of responsibility are fully trained and comply with the Policy and Procedure. The Matron is responsible for chairing the second meeting and should the need arise escalating the policy to the Director of Operations via the Head of Clinical Site and Operational safety. Additionally it is the Matron who can present to the Head of Clinical Site and Operational Safety any need for an exception to the Policy and Procedure that will be heard by the Director of Operations.

5.8 Head of Clinical Site and Operational Safety

5.8.1 The Head of Clinical Site and Operational Safety is responsible for collating all information in relation to this Policy. This will cover auditing effectiveness and reporting Risk via the Governance Coordinator to the Trust Risk Management Group as well as a review to the Trust Board annually. The Head of Clinical Site and Operational Safety will be the responsible officer for review of the Policy and Procedure document.

5.8.2 The Head of Clinical Site and Operational Safety is responsible for sharing all audit data with the Directorate Heads of Nursing on a weekly basis.

6 Monitoring & Review

6.1 The Head of Clinical Site and Operational Safety will answer to the Director of Operations in the monitoring and review of the application of this Policy and Procedure Document.

6.2 The Head of Clinical Site and Operational Safety will audit centrally held training records level on a biannual basis and any shortfall in training will be highlighted as a corrective action via the Senior Sister/Charge Nurse with a copy of the report forwarded to the Matron.

6.3 The Head of Clinical Site and Operational Safety will investigate any complaints or IRIS forms raised regarding the application of the Policy and Procedure and will share findings with the Directorate Heads of Nursing.

7 The Patient Considered as a Delayed Transfer of Care

7.1 A patient is considered a delayed transfer of care when:

7.1.1 “A patient is ready for transfer from an ‘acute hospital bed’, but is still occupying such a bed”. A patient is ready for transfer when:
Draft “CHOICE” ON DISCHARGE FROM HOSPITAL POLICY & PROCEDURE

7.1.2 A clinical decision has been made that the patient is ready for transfer/ or discharge

7.1.3 A multi-disciplinary team decision has been made that the patient is ready for transfer/ or discharge. A multi-disciplinary team in this context includes nursing and other Health and Social Care professionals.

7.1.4 A patient is safe to discharge or transfer (DoH, ROCR Steering Committee SITREP definition)

7.2 Once it is agreed that the patient’s medical condition cannot be improved by further inpatient care or by a period of rehabilitation in an identified appropriate setting, and that placement in a care home is the most appropriate option to meet the assessed needs, the following process will be followed. This will be undertaken with the full involvement of the patient or carer.

7.2.1 On admission to the ward and/or referral by the Nurse or Doctor, a Care Manager will be designated to discuss with the patient or carer, their needs, once medically stable, to include notification of proposed discharge date.

7.2.2 All meetings, case conferences, and discussions concerning assessment will be discussed with the patient or carer and documented in their integrated health care records.

7.3 On completion of the joint assessment and once in receipt of an agreed outcome, the patient or carer will be informed of the outcome of such deliberations both verbally and in writing (Letter 1 or 2 and patient information leaflet).

7.4 The Head of Clinical Site and Operational Safety must be notified for audit purposes that the letter has been sent by the Senior Sister/Charge Nurse.

7.5 The letter will confirm that:

7.5.1 The patient is medically fit for transfer or discharge from a hospital setting.

7.5.2 Transfer to a care home is required to meet the patient's needs and maintain safety.

7.5.3 It is expected that a suitable vacancy should be identified within 14 days of receipt of the letter from the Senior Sister/Charge Nurse.

7.5.4 Patients will be given the contact details of the Senior Sister/Charge Nurse and care manager that can advise and assist with any problems or concerns they may have.

7.5.5 Patient will be expected to accept an alternative care home (residential or nursing) from the vacancies available, if the home of their choice does not have a vacancy at that time.

7.5.6 A copy of this Policy is available to the patient or carer and will be given to the patient by the ward manager at the 14 day meeting

8 How do we proceed if a care home has not been identified within the 14 day period?
8.1 On confirmation that the delay is not due to assessment or altered needs and that the patient has refused transfer until a vacancy in the care home of their choice becomes available, the Senior Sister/Charge Nurse will take the following action:

8.1.1 The Senior Sister/Charge Nurse will arrange a meeting with the patient or carer and those members of the multi-disciplinary team who are involved in the patient’s care.

8.1.2 A leaflet will be given informing the patient of the role of the Patient Advice and Liaison Service (PALS), giving them the address and telephone number.

8.2 The Head of Clinical Site and Operational Safety must be notified for audit purposes that a meeting has been arranged by the Senior Sister/Charge Nurse.

9 At the meeting

9.1 The Senior Sister/Charge Nurse and Discharge Co-ordinator will advise the patient that an acute hospital bed is no longer required and that alternative arrangements should be made for transfer or discharge of care.

9.2 The following points will be confirmed at the meeting:

9.2.1 That the patient remains medically fit for transfer or discharge.

9.2.2 That remaining in an acute hospital environment may be detrimental to the patient’s health and well-being and is not an option for their care needs.

9.2.3 There are defined periods of time in which a care home must be selected (14 days) which commenced from the point at which written notification was given, identifying the need for a care home placement to meet the patient’s needs.

9.3 The Senior Sister/Charge Nurse and Discharge Co-ordinator will ensure that:

9.3.1 The patient or carer has received all information and has contact numbers for their allocated Care Manager.

9.3.2 It will be explained that the patient or carer has a further 7 days from the date of this meeting, in which an appropriate selection should be made.

9.3.3 The patient or carer is aware that alternatively, the patient could be discharged home (or to the home of a friend/relative) with a package of Health and Social care within the options and resources available. There would be a charge for the Social element of this package (this will be dependent on the previous financial assessment carried out).

9.3.4 The patient will receive written confirmation of the discussions from this meeting. A copy of this letter will also be sent to the Matron and other professionals present at the meeting, and a copy placed in the integrated health care records.

10 In the event that a care home has not been selected after a further 7 days
10.1 If, after the extended 7 day period, the patient has not been transferred or discharged from an acute hospital bed and there is not a date set for assessment by a care home or transfer to a care home, the following actions will occur:

10.1.1 The Senior Sister/Charge Nurse will escalate the case to the Matron who will inform:

10.1.2 The Director of Operations and the Trust Legal Advisor both via the Head of Clinical Site and Operational Safety

10.1.3 The patient or carer will be invited in writing to a further meeting, within two days of expiry of the extended period (letter 3). This letter will also contain information on how to contact PALS.

10.2 If during the second meeting, it is apparent that the patient or carer does not intend to find an appropriate placement within 7 days, the Matron will:

10.2.1 Advise the patient or carer that the Trust will begin legal proceedings to ensure that the patient is transferred or discharged from an acute hospital bed, to safeguard their health and well being, ensuring that the hospital bed is then made available for other appropriate patients during their acute period of illness.

10.2.2 Ensure that it is clearly stated in this meeting and confirmed in writing that the above action will be taken in line with Government guidance (Page 2) due to the absence of any agreement to accept a placement within a care home with a vacancy.

10.2.3 Ensure that it is reiterated and the patient or carer understands that they have the option of transfer or discharge to their own, a relative or friend’s home with a Health and Social Care package within options and resources available. The Care Manager will be responsible for co-ordinating such a package.

10.2.4 A copy of the detail of this meeting will be sent to all professionals present at the meeting, the Head of Clinical Site and Operational Safety as well as the patient or carer.

10.2.5 A meeting will then be convened (Letter 4) with the following professionals to determine the next course of action:

10.2.5.1 Matron
10.2.5.2 Trust Legal Advisor
10.2.5.3 Director of Operations

11 What about the other categories of reluctant discharge?

11.1 The Senior Sister/Charge Nurse and Discharge Co-ordinator will chair the case conference, which will consist of the patient (where able), next of kin and/or carer, ward nurse, member of the medical team, care manager and any other relevant member of the multidisciplinary team.
11.2 The purpose of the conference is to agree an action plan to move the patient to alternative accommodation as soon as possible.

11.3 A letter which reiterates the agreement reached at the case conference will be sent to the patient/relative within 24 hours of an action plan being formulated.

11.4 If NO agreement is reached the Senior Sister/Charge Nurse will notify the Matron, who will discuss with the Trust’s Legal Advisor and the Director of Operations via the Head of Clinical Site and Operational Safety.
Each patient admitted to the Trust will receive a ‘Moving on from Hospital Leaflet’ from the pre-assessment/admitting nurse. (Documented within the integrated health care records; signed and dated).

Patient determined by MDT to be medically fit for discharge.
JA completed, agreed outcome (Choice discussed at meeting)

Meeting after 7 days
If care not transferred, with Patient/Carer, Care Manager, Matron and Discharge Co-ordinator
(Appendix 3 letter sent to invite by Matron)

Meeting after 14 days
With Senior Sister/Charge Nurse, Care Manager, and Patient/Carer

Choice on Discharge from Hospital Policy activated.
(Appendix 1-2 letter sent by Senior Sister/Charge Nurse)

Meeting for final meeting
If transfer not planned within 7 days with Patient/Carer, Director of Operations and Trust Legal Advisor, to agree way forward.
(Appendix 4 letter sent to invite by Matron)

Requires funding
Self funding

Funding agreed
Dear

I am writing to confirm that the team of professionals looking after you have now completed their assessment of your needs. It is considered that your medical condition no longer requires treatment in hospital, and that placement in a Care Home (Nursing) is now considered to be the best way to meet your care needs.

We recognise that this decision is a major one and that you may require some support. Advice as to which Nursing Homes have vacancies, that can meet your assessed needs will be provided by the Care Manager, on request.

In the event that a vacancy in the Home of your choice does not exist, an interim placement will need to be secured. Please note that this interim vacancy may be outside your area of choice.

If, after 14 days, you have not secured a suitable vacancy or made alternative arrangements, you and/or your representatives will be invited to a meeting by the Ward Manager, so that we can discuss a way forward.

If you have any further queries or concerns please do not hesitate to contact me or Care Manager in the first instance.

Thank you for your co-operation and best wishes for the future.

Yours sincerely

Senior Sister/Charge Nurse

Senior Sister/Charge Nurse................................................. Contact details

Care Manager ...................................................................... Contact details

Cc Head of Clinical Site and Operational Safety (Audit purposes)

Copy to be placed in Hospital Integrated Health Care Records, dated and signed
Dear

I am writing to confirm that the team of professionals looking after you have now completed their assessment of your needs. It is considered that your medical condition no longer requires treatment in hospital, and that placement in a Care Home (Residential) is now considered to be the best way to meet your care needs.

We recognise that this decision is a major one and that you may require some support. Advice as to which Residential Homes have vacancies, that can meet your assessed needs, will be provided by the Care Manager, on request.

In the event that a vacancy in the Home of your choice does not exist, an interim placement will need to be secured. Please note that this interim vacancy may be outside your area of choice.

If, after 14 days, you have not secured a suitable vacancy or made alternative arrangements, you and/or your representatives will be invited to a meeting by the Ward Manager, so that we can discuss a way forward.

If you have any further queries or concerns please do not hesitate to contact me or Care Manager in the first instance.

Thank you for your co-operation and best wishes for the future.

Yours sincerely

Senior Sister/Charge Nurse

Senior Sister/Charge Nurse................................................. Contact details

Care Manager ...................................................................... Contact details

Cc Head of Clinical Site and Operational Safety (Audit purposes)

Copy to be placed in Hospital Integrated Health Care Records, dated and signed.
Ref: Letter 2/Social Services/Nursing – Senior Sister/Charge Nurse

Date:

To: (Patient Name)
   (Relative / Carers)

Dear

I am writing to confirm that the team of professionals looking after you have now completed their assessment of your needs. It is considered that your medical condition no longer requires treatment in hospital, and that placement in a Care Home (Nursing) is now considered to be the best way to meet your care needs.

You and your representatives will now be required to identify a suitable Home. We recognise that this decision is a major one and that you may require some support. Advice as to which Nursing Homes have vacancies may be provided by the Care Manager, on request.

However, whilst a suitable Home of your choice is being found, an interim placement will be provided by Social Services within 14 days of receipt of this letter. Please note that this interim vacancy may be outside your area of choice. *Support with visiting may be provided in special circumstances.*

If you have any further queries or concerns please do not hesitate to contact me or Care Manager in the first instance.

Thank you for your co-operation and best wishes for the future.

Yours sincerely

Senior Sister/Charge Nurse

Senior Sister/Charge Nurse................................................. Contact details

Care Manager ................................................................. Contact details

Cc Head of Clinical Site and Operational Safety (Audit purposes)

Copy to be placed in Hospital Integrated Health Care Records, dated and signed
Ref: Letter 2a/Social Services/Residential – Senior Sister/Charge Nurse

Date:

To: (Patient Name)
   (Relative / Carers)

Dear

I am writing to confirm that the team of professionals looking after you have now completed their assessment of your needs. It is considered that your medical condition no longer requires treatment in hospital, and that placement in a Care Home (Residential) is now considered to be the best way to meet your care needs.

You and your representatives will be required to identify a suitable Home. We recognise that this decision is a major one and that you may require some support. Advice as to which Residential Homes have vacancies may be provided by the Care Manager, on request.

However, whilst a suitable Home of your choice is being found, an interim placement will be provided by Social Services within 14 days of receipt of this letter. Please note that this interim vacancy may be outside your area of choice. Support with visiting may be provided in special circumstances.

If you have any further queries or concerns please do not hesitate to contact me or Care Manager in the first instance.

Thank you for your co-operation and best wishes for the future.

Yours sincerely

Senior Sister/Charge Nurse

Senior Sister/Charge Nurse................................................. Contact details

Care Manager ................................................................. Contact details

Cc Head of Clinical Site and Operational Safety (Audit purposes)

Copy to be placed in Hospital Integrated Health Care Records, dated and signed
Ref: Letter 3 – Matron

Date:

To: (Patient Name) (Relative / Carers)

Dear

Further to your meeting with the Ward Manager (name)……………. dated ................., you and/or your representatives were provided with a further 7 days in which to secure a suitable Care Home vacancy of your choice.

As that period has now expired, it is felt necessary to invite you and / or your representatives to a second meeting, which will take place on ............... the venue for which is:- ...............................................................

Whilst it is appreciated that further support and advice may be necessary, the aim of this meeting will ultimately be to agree an appropriate discharge plan and establish a discharge date.

If you have any further queries please do not hesitate to contact the Matron on .................

You may also contact the Patient Advice and Liaison Service (PALS) on 01643 825004 for support.

Yours sincerely

Matron

Senior Sister/Charge Nurse................................................. Contact details
Care Manager ................................................................. Contact details

Cc Head of Clinical Site and Operational Safety (Audit purposes)

Copy to be placed in Hospital Integrated Health Care Records, dated and signed
Ref: Letter 4 – Director of Operations

Date:

To: (Patient Name) (Relative / Carers)

Dear

Further to previous meetings, the Trust must now inform you that both the 14 day period and the additional 7 day period for identifying a Home of your choice have been exceeded.

A final meeting has been arranged for ....................., which either yourself or your representative are required to attend. The venue for this meeting is: ................................................................. The Director of Operations and a member of the Trust’s Legal Department will be present at this meeting.

If a suitable Home of your choice has not been identified, or if indeed the Home of your choice does not have a vacancy within 48 hours following the above meeting, the Trust will begin legal proceedings to ensure that the patient is transferred or discharged from an acute hospital bed.

If you have any further queries please do not hesitate to contact the Matron on......................... You may also contact the Patient Advice and Liaison Service (PALS) on 01634 825004 for support.

Yours sincerely

Ellen Ryabov
Director of Operations

CC: ...................... – General Manager,
......................... - Trust Legal Advisor

Cc Head of Clinical Site and Operational Safety (Audit purposes)

Copy to be placed in Hospital Integrated Health Care Records, dated and signed