South East Coast Ambulance Service NHS
NHS Foundation Trust

Discharge Procedure

Contents

1 Scope

1.1. This document sits under the **Referral, Discharge and Conveyance Policy**

1.2. This document describes the requirements and processes which underpin the safe discharge of patients from SECAmb (The Trust).

1.3. This procedure applies to all clinicians and should be used when attending any incident relating to patient care where it is considered appropriate to discharge the patient from ambulance care, following an appropriate clinical examination.

1.4. Clinical staff working in the “Hear and Treat” setting in the Emergency Operations Centres (EOC) or in Paramedic Practitioner Urgent Care Hubs should follow the governance and procedural documents/arrangements provided for that specific role when completing encounters with patients

1.5. The **Referral, Discharge and Conveyance Policy** describes discharge as follows:

1.5.1. Termination of care or the end of the episode with no follow up for the patient (patients who refuse care/transport and have capacity to do so are deemed to have “self-discharged”).

1.5.2. Self-discharge, which includes refusal of care, requires the patient to be given sufficient details upon with to make an informed decision about their own care.

1.5.3. Self-discharge may take the form of refusal (to one or a combination of),

- giving a history
- being examined
- being treated (specific treatments or all treatments)
- being transported to hospital
- being referred

1.5.4. Self-discharge must only be accepted where the patient has mental capacity (see section on **Mental capacity**), and which is judged not to be fluctuating.

2 Procedure

2.1. Overarching principles

2.1.1. Discharge is the clinical decision that carries most risk. Discharging a patient means that their health problem/condition has been resolved or is deemed to be self-limiting and require no follow-up. The Trust recognises that diagnostic certainty is limited and so patients being discharged must have specific worsening care advice and safety netting in place should they deteriorate. This information should be shared with the patient and/or their family/carers/representative as necessary.

2.1.2. Staff who are not authorised to discharge patients, or where a discharge may have taken place outside of the appropriate clinical scope of practice, incidents will be investigated appropriately. Where an adverse event occurs, the principles associated with the NHS drive for just and learning cultures will be observed by the trust. Accountability for acts and omissions will be objectively applied alongside all other factors present.

2.1.3. Clinicians must be satisfied that the person is not suffering from a life threatening or serious medical problem. Please refer to clinical practice guidance via the JRCALC Plus smart device application.

2.1.3.1. Clinicians are encouraged to seek assistance with clinical decision making from a paramedic practitioner or other suitable clinician (subject to any restrictions in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.1.3.2. The patient's GP or an Out of Hours provider should only be approached where a specific need has been identified which can only be resolved through this route (for example, a specific repeat prescription). Staff should in the first instance request an ECAL and speak to an Urgent Care Hub as this provides the timeliest response to staff on-scene with patients and avoids a potentially long wait for a call back from a GP where this is not necessary.

2.1.3.3. Clinicians must be prepared to convey if required following discussion with a colleague/supervisor.

2.2. The following instructions must be observed in all cases:

2.2.1. Patient Clinical Record (electronic and/or paper)

2.2.1.1. When discharging a patient, all documentation must be sufficiently detailed and accurate, observing the minimum data set and required clinical observations.

2.2.1.2. The details about the discharge must be documented and include the rationale for any clinical decisions made regarding the discharge.

2.2.1.3. If using a paper PCR, the bottom copy of Patient Clinical Record (PCR) must be left with the patient.

2.2.1.4. Staff must remember that "*if it's not written down it did not happen*"[1] and must record all pertinent clinical findings as this is the only documentary evidence of the episode of care. Findings should be related to the chief complaint(s) that the patient has called for. Staff are not required to screen patients for conditions, of which they have no signs and/or symptoms at the time of the clinical encounter.

[1] This quote does not have a specific reliable citation but often appears in professional guidance relating to legal and/or coronial cases (click here for an example)

2.2.1.5. The health record must include the following:

- Consideration of 'red flags' and differential diagnoses
- Documentary evidence of safety netting
- Basis for, and confirmation of, patient's informed consent decision (including assessing mental capacity where appropriate)
- Any clinical advice sought to support the discharge decision
- Worsening care advice - what the patient or carers might expect in the event of deterioration. You should confirm that the patient/carer understands this and is able to detect changes and can act accordingly
- Safety Netting – information on what to do and who to call in the event of deterioration
- "Left in Care of" – who the patient is remaining with (if applicable)

2.2.1.6. Clinicians do not need to complete a non-conveyance form for patients being discharged unless they are refusing care, and have capacity to make an informed decision.

2.2.2. **Clinical Decision Making**

2.2.2.1. Staff must not make assumptions about the progression of any illness or injury encountered. The level of diagnosis made for the patient must be in line with the scope of practice of the clinician, as defined in the **Scope of Practice and Clinical Standards Policy**.

2.2.2.2. All staff are encouraged to seek assistance with clinical decision-making from a Paramedic Practitioner (PP) Urgent Care Hub (following guidance in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.2.2.3. Where there is doubt about the final or working diagnosis/diagnoses, the patient should be referred or consideration given to them being conveyed.

2.2.2.4. The authority within the **Scope of Practice and Clinical Standards Policy** regarding discharge may change for some grades of staff in the future (such as NQPs). Processes to check the safety of discharges which are undertaken without joint decision making may be implemented to support safe care (for example, PP Hubs undertaking Post-Discharge Reviews)

2.2.3. **Collaborative care planning with the patient (shared decision making)**

2.2.3.1. The wishes of the patient must form the basis of any decision to discharge and, where appropriate, patients should be empowered to support their own care.

2.2.3.2. Patients must not be coerced into any decision regarding discharge (be cautious in the use of leading questions, supposition, or directive questions). This is especially relevant for vulnerable patients.

2.3. **Special conditions**

2.3.1. **Children**

2.3.1.1. Only paramedics with specific competencies in paediatric assessment and treatment should consider discharge of children. The Trust has adopted the national position agreed by the National Ambulance Service Medical Directors (NASMed) group regarding the conveyance of children under 1 year of age. Where there is any doubt regarding the care of children, seek clinical support or convey.

2.3.1.2. Where a child is considered for discharge, safeguarding considerations must be given and recorded. Any concerns must be raised in accordance with Trust **Safeguarding Policy and Procedures**.

2.3.1.3. Care must be delivered in line with any relevant and current paediatric and/or obstetric* care policies. (*where the patient is a newborn).

2.3.2. **Mental capacity**

2.3.2.1. Clinicians must be fully aware of the Trust's **Informed Consent and Mental Capacity Act Guidelines** and the requirement to be assured that a patient being considered for discharge has capacity or is left in the care of someone with capacity, to understand instruction and advice pertaining to that discharge, regardless of circumstances (i.e. agreed care plan or refusal of care).

2.3.2.2. Clinicians are encouraged to seek assistance with clinical decision making from a PP Urgent Care Hub (following guidance in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.3.2.3. Where a patient wishes to self-discharge, staff must assess the capacity of the patient to make this decision in accordance with the Trust's **Mental Capacity Act and Informed Consent Guidelines**.

2.4. **General arrangements**

2.4.1. Discharges can only be made according to the non-conveyance rights described in the **Scope of Practice and Clinical Standards Policy**.

2.4.2. Discharges must be fully documented in the PCR and any worsening care advice must be given to the patient. Please refer to the relevant **Health Records Policies and Procedures**

2.5. Patients must give consent to be discharged. Where patients lack mental capacity, a best interest decision can be made to make a discharge for your patient, but the decision must be made according to the guidance in the **MCA and Informed Consent Guidelines**.

2.5.1. Remember that at all times patient safety is paramount. Staff must ensure that patients have the ability and means to summon assistance in the event of them deteriorating.

2.5.2. Staff are encouraged to seek assistance with clinical decision making: this could be via a PP Urgent Care Hub (following guidance in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.5.3. Clinicians must not make an instinctive decision to discharge and must base any decisions on a thorough history and focused assessment before a decision to discharge is considered.

2.5.4. Patients can only be discharged where the clinician is authorised to do so in the **Scope of Practice and Clinical Standards Policy**. Staff not authorised to discharge patients are required to refer patients or seek support from an urgent care hub in order to provide adequate follow up:

2.5.4.1. Follow-up may include notifying a GP, a family member, providing safety net/worsening care advice (see **Definitions** section) or notifying a care-line etc.

3 Definitions

3.1. Hear and Treat – Care given over the telephone

3.2. “Safety netting” – instructions given to the patient on what to do if their condition worsens, such as who to contact

3.3. Worsening care advice: information given to patient relating to signs and symptoms to be aware of.

4 Responsibilities

4.1. The **Chief Executive Officer** has ultimate responsibility for patient referrals.

4.2. The **Consultant Paramedic(s) (Urgent & Emergency Care)** are responsible for managing the procedure.

4.3. **Operations Managers (OUM/OM/OTL)** are responsible for implementing the procedure.

4.4. All clinicians are responsible for following this procedure.

4.5. The **Consultant Paramedic(s) (Urgent & Emergency Care)** are responsible for monitoring and audit of the procedure.

5 Audit and Review (evaluating effectiveness)

5.1. Discharges will be monitored using data collected on non-conveyed incidents. This will be collated into an annual report and presented to the Clinical Governance Group.

5.2. Any Serious Incident (SI) related to discharge of a patient will, where applicable, be investigated using this document and the **Scope of Practice and Clinical Standards Policy**.

5.3. This procedure will be reviewed every three years or sooner if new legislation, codes of practice or national standards are introduced.

6 Equality Analysis

6.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

6.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

7 References

7.1. A Just Culture Guide. NHS England - https://www.england.nhs.uk/patient-safety/a-just-culture-guide/