Somerset Partnership NHS
NHS Foundation Trust

MULTIDISCIPLINARY MEETINGS FOR COMMUNITY HOSPITALS POLICY

(To be read in conjunction with Handover Policy)

Version:	3
Ratified by:	Senior Managers Operational Group
Date ratified:	August 2015
Title of originator/author:	Clinical Lead for Adult Rehabilitation Community Hospital Matron
Title of responsible committee/group:	Clinical Governance Group
Date issued:	**August 2015**
Review date:	**July 2018**
Relevant Staff Groups:	Registered Nurses, Allied Health Professionals and Medical Staff in Community Hospitals

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference Aug15/MMH	**Version** 3	**Status** Final	**Author** Clinical Lead for Adult Rehabilitation Community Hospital Matron
Amendments	Reflected to be consistent with Admissions, Transfers and Discharge Policy		
Document objectives: This document will ensure throughout the Trust there is a consistent approach to multidisciplinary meetings within all Community Hospitals across Somerset.			
Intended recipients: Registered Nurses, Medical Staff and Allied Health Professionals in Community Hospitals.			
Committee/Group Consulted: Clinical Policy Review Group, Community Hospitals Best Practice Group.			
Monitoring arrangements and indicators: See Section 13			
Training/resource implications: See section 11			

Approving body and date	Clinical Governance Group	Date: August 2015
Formal Impact Assessment	Impact Part 1	Date: TBA
Clinical Audit Standards	NO	Date: N/A
Ratification Body and date	Senior Managers Operational Group	Date: August 2015
Date of issue	**August 2015**	
Review date	**July 2018**	
Contact for review	Clinical Lead for Adult Rehabilitation	
Lead Director	Chief Operating Officer	

CONTRIBUTION LIST Key individuals involved in developing the document

Name	**Designation or Group**
Oonagh Michelmore	Clinical Lead for Adult Rehabilitation
Kathryn Westbury	Matron, Dene Barton Community Hospital
All members	Community Hospital Matrons
All Members	Community Hospitals Best Practice Group
All members	Clinical Governance Group

CONTENTS		
Section	**Summary of Section**	**Page**

Section	Summary of Section	Page
Doc	Document Control	2
Cont	Contents	**3**
1	Introduction	4
2	Purpose & Scope	4
3	Duties and Responsibilities	4
4	Explanations of Terms Used	5
5	Key Duties in the Community Hospital Setting	5
6	Reluctant Discharges	7
7	Monitoring And Recording of Delayed Discharges in Relation to Sitrep Reporting	7
8	Purpose Of The Multidisciplinary Meetings	8
9	Conduct And Procedure For Meetings	9
10	Responsibility of Team Members	9
11	Training Requirements	10
12	Equality Impact assessment	11
13	Monitoring Compliance and Effectiveness	11
14	Counter Fraud	11
15	Relevant Care Quality Commission (CQC) Registration Standards	11
16	References, Acknowledgements and Associated documents	12
17	Appendices	13
Appendix A	Multidisciplinary meeting attendance template – needs updating	14
Appendix B	Feedback Template From MDT	16
Appendix C	Simple Discharge Checklist (Adults) Discharge Plan	17
Appendix D	Complex Discharge Planning	18

1. INTRODUCTION

1.1 This policy is to ensure a consistent approach to multidisciplinary team working across the Community Directorate to ensure robust, consistent and safe discharge planning. The multidisciplinary team meeting is an integral part of the patient's discharge plan it provides a forum for discussion in order to co-ordinate treatment planning of inpatients and a timely and appropriate discharge for patient, It should encourage collaboration in order to ensure effective use of resources and their availability and is a network for communication across Health and Social Care

2. PURPOSE & SCOPE

2.1 To promote a safe and consistent multidisciplinary team approach to active rehabilitation and patient centred discharge planning. To be read in conjunction with:

- Somerset Partnership NHS Foundation Trust Handover Policy;
- Care planning policy.
- Reluctant discharge policy.
- Admission, Transfer & Discharge Policy.

3. DUTIES AND RESPONSIBLITIES

3.1 **The Trust Board** has overall responsibility for procedural documents and delegate's responsibility as appropriate.

3.2 **The Lead Director** with responsibility for Community Hospital MDT Protocol within the Community Health Directorate is the Director of Community Health Services.

3.3 **The Identified Lead (Author)** is the nominated community hospital Matron and Clinical Lead for rehabilitation, who will be responsible for producing written drafts of the document and for consulting with others and amending as appropriate.

3.4 The Community Hospital Best practice Group and the Clinical Governance Group **is responsible for monitoring the effectiveness of this policy:**

- Ensuring there are adequate controls to provide safe admission, transfer and discharge practice in line with national guidelines;
- Advising on training requirement for individual staff groups.

3.5 **Clinical Directors/Service Managers/Heads of Service:** responsibility for implementing this policy is devolved to Clinical Directors, Heads of Service and Service Managers.

3.6 **The Head of Governance** has responsibility for holding the central database of procedural documents including this policy and for providing

review reminders. The team also have responsibility for dissemination of the final documents and archiving old versions.

3.7 **Matrons/Sisters/Charge Nurses/Service Managers** are responsible for ensuring that they have a planned programme of training for staff in their team in accordance with the Trust-wide Staff Training Matrix.

3.8 **All Community Health Staff** including temporary staff are individually responsible for complying with this policy. This includes (a) attending training and updating risk assessment skills as directed by this policy, (b) reporting concerns to their line manager, (c) regularly updating risk related sections within the Patients Healthcare Records and also completing an Untoward Event report form in line with the Trust's Untoward Event Reporting Policy accessible on the Trust Intranet This will all be reported to and reviewed by the Community Hospital's Best practice group.

4. EXPLANATIONS OF TERMS USED

4.1 Reluctant Discharges. Reluctant discharges awaiting placement, patient and family choice.

4.2 Complex discharge plan - Complex discharges are defined as follows

- where the patient requires a high level of nursing care or a large package of care involving different agencies;
- where the patient needs have changed since admission so that several different services need to be coordinated;
- where the family/carer requires intensive input into discharge planning considerations.

4.3 IMCA   Independent Mental Capacity Advocate

4.4 Interim Bed. Interim bed offered whilst awaiting placement

4.5 End of Life Care Co-ordination Centre. Centre for co-ordinating fast track continuing health care

4.6 Delayed discharge

5. KEY DUTIES UNDERTAKEN IN THE COMMUNITY HOSPITAL

5.1 To ensure that all patients, appropriate others or relatives/carers have been given the relevant discharge leaflet on admission to the Community Hospital.

5.2 To ensure that plans for future discharge have been discussed with the patient and their family and /or appropriate others within 24 hours of admission to the Community Hospital. Where there are concerns with capacity a Mental Capacity Assessment must be completed and if the patient lacks capacity a best Interest meeting held with all relevant parties invited to contribute to the discussion

5.3 To ensure that all patients have an estimated date of discharge set on admission in readiness for the first multidisciplinary meeting after the patient's admission to the Community Hospital

5.4 To agree rehabilitation goals for therapy, nursing and treatment required to achieve this estimated discharge date.

5.5 To agree a date for a home visit or access visit if required at the first multidisciplinary meeting after the patient's admission to the Community Hospital

5.6 To ensure that all equipment is ordered following any home visit so that this is available in the home prior to the agreed discharge date.

5.7 If appropriate, to ensure that a referral has been made for assessment by Social Services for care package requirements on discharge. The referral is to be made at the first multidisciplinary meeting after admission of the patient.

5.8 To ensure that the Understanding You process is commenced for all patients with complex care needs within an appropriate timeframe that will allow all professionals to contribute fully and ensure completion well in advance of the estimated discharge date.

5.9 To ensure that a continuing Health Care fast track assessment is completed and referral made to the End of Life Care Co-ordination Centre where appropriate.

5.10 As part of an Understanding You assessment the patient's potential eligibility for NHS continuing healthcare should always be considered by using the CHC checklist.

5.11 Any Safeguarding concerns should be discussed with the line manager and/or the Safeguarding Team who will advise with regard to onward referral to Somerset Direct

5.12 To review all estimated discharge dates at the multidisciplinary meeting to ensure that these are still appropriate. Where the patient is not medically or clinically fit, to agree a revised discharge date following points 5.4 to 5.6, organise plans to achieve this or agree transfer arrangements to an acute trust. The discharge planning assessment will continue once the patient is deemed fit for discharge even though there may be ongoing medical needs.

5.13 To ensure that the reporting for all delayed discharges is reviewed at every multidisciplinary team meeting and agreed by the multidisciplinary team and reported appropriately.

5.14 To ensure timely referral to Somerset Direct. To ensure a safe, well planned discharge taking into consideration the patients preferred place of care

5.15 To ensure timely discussion if change in medication

6. RELUCTANT DISCHARGES

6.1 All reluctant discharges should be managed in accordance with Somerset-wide admissions transfers and discharge policy

6.2 Complete the appropriate multidisciplinary records as outlined in the appendices for all patients at every multidisciplinary team meeting to provide an audit trail for discharge planning for all patients

6.3 Liaise with relevant social worker to record the date that the notification has been sent to patients requiring a nursing or residential home placement.

6.4 Where patients are being discharged to a nursing home and a bed is not available in the home of their choice, record the date that an offer of an interim bed or placement was made by the Social Worker for the patient.

6.5 Where an interim bed is available and this has been declined by the patient the implementation of the Somerset wide admissions transfers and discharge policy should be adhered to .The Community Hospital Matron should be informed so this can be commenced without delay and appropriate Reluctant Discharge letters circulated.

6.6 Review the stage achieved in the Somerset wide admissions transfers and discharge policy at each multidisciplinary team meeting and initiate appropriate correspondence or feedback to appropriate others, families or carers.

7. MONITORING AND RECORDING OF DELAYED DISCHARGES IN RELATION TO SITREP REPORTING

7.1 Ensure that all objectives in Section 5 are followed for all patients.

7.2 Home visits are only recorded as a delay if the date set will delay the discharge of the patient beyond the agreed discharge date when they are medically fit for discharge.

7.3 Equipment ordered does not constitute a delay unless the arrival date in the home will delay the agreed discharge date.

7.4 Completion of the Understanding You assessment process constitutes a delay where the patient is medically fit for discharge and the lack of completion of the assessment has delayed achievement of the estimated discharge date.

7.5 Where the patient’s discharge is delayed whilst waiting for a care home with or without nursing of their choice, this is recorded as a National Health Service delay.

7.6 Where the delay is a direct result of an ongoing Safeguarding concern, this should not be recorded as a delayed discharge.

7.7 In circumstances where there is deemed no vacancy in the patient's first choice of nursing/residential care home, alternative arrangements will be discussed with the patients and carers. The patient either agrees to use an interim bed or the Somerset wide admissions transfers and discharge policy is implemented, but if an interim bed is not available this is recorded as a Social Services delay.

8. PURPOSE OF THE MULTIDISCIPLINARY MEETINGS

8.1 Purpose

- The multidisciplinary team meeting is an integral part of the patient's discharge plan
- The meeting provides a forum for discussion in order to co-ordinate treatment planning of inpatients and to achieve a timely and appropriate discharge for patients
- The meeting encourages collaboration in order to ensure effective use of resources and their availability
- The multidisciplinary team provides a network for communication across Health and Social Care
- The multidisciplinary team is responsible for agreeing the appropriate categories for reporting delayed discharges

8.2 Membership

- The core membership of the Multidisciplinary Team meeting:
- Chair, Sister/Charge Nurse/Matron
- Occupational Therapist, allocated from the Community Hospital
- Physiotherapist, allocated from the Community Hospital
- Social Worker, allocated from Social Services to cover the Community Hospital
- Medical/General Practitioner (GP), in-house or delegated from the GP's covering the Community Hospital
- Nurse representative from each ward
- District Nurses – when required
- Community Matron – when required
- Community CPN – when required
- Other professionals – when required

8.3 Co-opted Members

- If there are complex case conferences other professionals will be involved and also other individuals can be invited to the meeting through the Chair
- Where a core member cannot attend the meeting they must ensure a deputising arrangement is in place;
- Where there are significant safeguarding concerns a member of the safeguarding team should be invited to contribute and the chair of the

MDT meeting should gain assurance that the local authority is aware of the safeguarding issues and is coordinating any safeguarding enquiry.

- The Multidisciplinary meetings will be held weekly and scheduled to meet the individual needs of the hospital. Virtual Multidisciplinary Team meetings can be held as part of the Somerset Partnership NHS Foundation Trust Handover Policy;
- It is intended that the meeting should take no longer than two hours in line with the revised handover Policy guidance, at each handover an update on the patients discharge and care is progressed.

9. CONDUCT AND PROCEDURE FOR MEETINGS

9.1 The meeting will be chaired by a senior member of the nursing staff, preferably a ward sister or a nominated deputy deemed competent to chair. Staff Nurses will only chair these meetings if they have undertaken specific training and development to do this successfully and if is agreed by the Sister in charge.

9.2 The Chair will provide essential information referring to each patient in order that all members of the team have the same information. This information will be in the form of a hand over sheet or similar. Further information may be provided by a member of the meeting having access to up to date RiO notes via an mobile device.

9.3 Each member of the team will have an opportunity to discuss specific patient issues. The team will provide an action plan to support the discharge and submit a target discharge date. The Chair's role is to agree with each team member their responsibility within the action plan and document this in the Patient's RiO notes using the specific patient progress template. This must be undertaken at every meeting until the patient is discharged This will require a member of the MDT meeting to have a mobile device so the members of the meeting can access the patients progress notes to inform the meeting of the patients current situation. (see Appendix B).

9.4 The Chair will ensure the patient and carers are aware of the action planning and decisions and that they are kept up to date.

9.5 The Chair will ensure that each patient has an allocated Social Care representative and confirm this at the meeting, if appropriate. If there is not an allocated Social Worker it is the Chair's responsibility to assess the need for a Social Worker and highlight this at the meeting. Contact Somerset Direct to request an allocation of a Social Worker.

9.6 The Chair will request an agreement from the team on the reporting of the delayed discharge for each specific patient on the delayed discharge list.

10. RESPONSIBILITIES OF TEAM MEMBERS

10.1 The Chair will;

Lead and facilitate the meeting ensuring factual information is obtained by all the team members

- Ensure relevant information and documentation is available to the team at each meeting and that the personalised care plan has been reviewed and a discussion has taken place with patient appropriate other or carer prior to and after the multidisciplinary meeting;

- Ensure the patients multidisciplinary team meeting progress record is updated for every patient on RiO;

- Ensure that the discharge checklist is updated on RiO at each meeting. This will establish when the patient is fit for discharge (Appendix 4);

- Discuss with the delayed discharge and explain why the patient is deemed a delay. For example, if the patient has a home visit set for the following week because this would be the most appropriate time in the patient's pathway then this is not a delay. If the home visit is set for the following week because there is no other time for the Occupational Therapist to go with the patient this will be a delay;

- Ensure that all the patients' documentation is updated after the meeting which will initiate the interventions required for discharge. This will include referrals to other agencies and specialist nurses as agreed at the meeting;

- Ensure that referrals to other agencies are actioned and may delegate to the most appropriate team member to action;

- Ensure that information is communicated to the patient and relatives and the nurse in charge of the next shift and is included on the appropriate handover sheet.

- Ensure that the discharge checklist is completed prior to discharge;

- It is the responsibility of all members to contribute to discussion and use their expert knowledge to ensure all services are provided to ensure a safe and timely discharge of the patients;

- Each team member will ensure that actions delegated to them are undertaken and feedback given at the next meeting;

- All team members must ensure that all required information is available at the meeting and that feedback is given to the team they represent.

11. TRAINING REQUIREMENTS

11.1 The Trust will work towards all staff being appropriately trained in line with the organisation's or local induction programme.

11.2 Senior staff within the Community Hospital's will ensure quality and competency throughout the Multidisciplinary Team, supporting team members in order to achieve a competent level of practice.

11.3 All registered nurses will be encouraged and supported in order to reach an agreed level of competency to Chair the multidisciplinary meeting and take full responsibility for initiating discharge. This will be agreed by the Ward Sister following achievement of agreed level of competency.

12. EQUALITY IMPACT ASSESSMENT

All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

13. MONITORING COMPLIANCE AND EFFECTIVENESS

13.1 Implementation of this policy will be reviewed in all Community Hospitals and local monitoring of compliance with this policy undertaken by Ward Sisters and discussed and reviewed and reported at Community Hospital Best Practice Group and Rehabilitation best practice group. Actions will be addressed at team level.

14. COUNTER FRAUD

14.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

15. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

15.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 12: Safe care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 14: Meeting nutritional and hydration needs
Regulation 15: Premises and equipment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance

Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

15.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 12:	Statement of purpose
Regulation 13:	Financial position
Regulation 14:	Notice of absence
Regulation 15:	Notice of changes
Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents
Regulation 19:	Fees
Regulation 20:	Requirements relating to termination of pregnancies
Regulation 22A:	Form of notifications to the Commission (although this is in Part 5, it relates to regulations in Part 4).

15.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

16. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

References

Department of Health (2004) Achieving Timely Simple Discharge from Hospital, Department of Health, London

Department of Health (2004) KSF

The Somerset Health and Social Care Community Principles of Discharge – Good Practice in Handling Difficult or Reluctant Discharges from hospital care.

High Impact Actions for Nursing and Midwifery 2012, Institute for Innovation and Improvement

Cross reference to other procedural documents

Development & Management of Procedural Documents

Handover Policy

In-patient Admission/Transfer and Discharge Policy

Mandatory Training Policy

Personalised Care Planning Policy

Risk Management Policy and Procedure

Safeguarding Adults at Risk Policy

Staff Training Matrix (Training Needs Analysis)

Training Prospectus

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet (within Policies and Procedures).

17. APPENDICES

Appendix A	Multidisciplinary meeting template
Appendix B	Sticker labels for medical records
Appendix C	Simple Discharge Checklist (Adults) Discharge Plan
Appendix D	Complex Discharge Planning

Somerset Partnership NHS
NHS Foundation Trust

APPENDIX A

MDT meeting attendance sheet **Date: ……………….**

Name	Surname	Designation	Signature

APPENDIX B

FEEDBACK TEMPLATE FROM MDT

Week since admission **date** **Ward**

Estimated Date of Discharge:

Current situation:
Including DoLS authorisation

Mood & Mental state:

Continence:

Physio:

OT:

SALT

Psychology

Nursing

Medical

UY Completed: Yes / No

Discharge plan: Yes / No

Discharge status:

Consultant/GP: **District Nurse:**

CMHT: **Social Worker:**

Follow up: Yes / No **Referral to Safeguarding Yes / No**

Goals discussed

APPENDIX C

DISCHARGE PLAN PART OF MDAR

PLANNED DATE/ TIME OF DISCHARGE:

<table>
<tr><td>Initial Date:</td><td>Change Date:

Reason:</td><td colspan="2">Change Date:

Reason:</td></tr>
<tr><td colspan="4">Planned Discharge Destination:

Home ☐ Nursing Home ☐ Residential Home ☐ Other (please specify)

Care Package ☐ Community Support Team ☐</td></tr>
<tr><td></td><td>Comments Yes / No</td><td>Date</td><td>Signature</td></tr>
<tr><td>Multidisciplinary Team agreement for discharge</td><td></td><td></td><td></td></tr>
<tr><td>All equipment arrangements made Please state:</td><td></td><td></td><td></td></tr>
<tr><td>Social Work agreement to discharge date</td><td></td><td></td><td></td></tr>
<tr><td>Care package in place –
Date and start time:</td><td></td><td></td><td></td></tr>
<tr><td>Patient aware of proposed discharge date</td><td></td><td></td><td></td></tr>
<tr><td>Relatives aware of proposed discharge date</td><td></td><td></td><td></td></tr>
<tr><td>Call required on discharge</td><td></td><td></td><td></td></tr>
<tr><td>Community Services informed
OR
Community Support Team arranged</td><td></td><td></td><td></td></tr>
<tr><td>Telephone contact with District Nurse
Team</td><td></td><td></td><td></td></tr>
<tr><td>Person to receive patient arranged</td><td></td><td></td><td></td></tr>
<tr><td>House keys available</td><td></td><td></td><td></td></tr>
<tr><td>Heating on</td><td></td><td></td><td></td></tr>
<tr><td>Food available</td><td></td><td></td><td></td></tr>
<tr><td>Relatives able to transport patient home</td><td></td><td></td><td></td></tr>
<tr><td>Patient is able to transfer into a car?</td><td></td><td></td><td></td></tr>
<tr><td>Hospital transport booked (please circle)

Car / Ambulance / Sitting / Stretcher</td><td></td><td></td><td></td></tr>
<tr><td>Discharge Medication ☐
Ordered ☐ Received ☐
Consider Compliance Aid</td><td></td><td></td><td></td></tr>
</table>

GP Surgery informed			
Out-patient appointment made / to follow by post			
Referral to Specialist Psychiatric Liaison team / Memory Service, or GP for specialist diagnosis (dementia)			

DISCHARGE PLAN – continued

Day of Discharge Inter-healthcare infection control transfer form to be completed on all relevant discharges	**Tick**	**Discharging Nurse** (Print Name)
GP letter given to patient or sent to GP		
District Nurse referral completed and given to patient		
Discharge medication given and explained to patient		
For all patients receiving anticoagulant therapy, fax INR and medication record to their GP on the day of discharge and update the patients yellow card		
Pad/dressing checked if appropriate		
Pads/ dressings/catheters/stoma supplies given to patient if appropriate		
Check that ALL cannulae have been removed		
Property returned to patient including from the safe e.g dentures, glasses, hearing aid, etc		
Relatives/ carers/ relevant destination informed	**Yes/ No**	
In the event of death, checklist completed	**Yes/ No**	

In the event of a discharge or patient death, form completed and documented in records **Yes / No**

Print Name:..

Signature:...

Date:..

Print Name: Designation:

Signature: Date / Time:

APPENDIX D

COMPLEX DISCHARGE PLANNING

Patient at risk because (tick relevant box)

- ↑ Requires Specialist assessments
- ↑ Already received community services
- ↑ Requires complex package of care
- ↑ Family / Carers / Staff have concerns
- ↑ Dementia
- ↑ Learning Disability

Addressograph

Discharge Leaflet given on Admission: YES / NO

Is SAP required: YES / NO ____

Referral to / request for assessment to	Type of referral Verbal/written Dated completed	Referrer	Name and contact details for assessor	Outcome of referral
Occupational Therapist				
Physiotherapist				
Social Worker				
Specialist Learning Disability Service				
Community Psychiatric Nurse				
District Nurse				
Community Matron or Case manager				
Care Home Matron				
Red Cross 'Home from Hospital'				
Other (eg Dietician, Safeguarding ,				

Use nursing continuation sheet for more detailed comments, ID labelled and attached to this form

Difficult/Reluctant Discharge Policy (refer to policy)

Action	By Whom	Date Issued
Letter 1 issued		
Letter 2 issued		
Letter 3 issued		