

Purpose:

To ensure patient discharge involves the patient/whānau is a coordinated and collaborative multi-disciplinary approach from consultation for surgery to transition home/community care post-surgical admission.

Policy Applies to: All Mercy Hospital staff

Cultural Considerations

Appropriate referral to other agencies e.g. Māori Health Providers in consultation with patient/whānau.

Related Standards:

- New Zealand Standard; Health & Disability Services (core) Standards 8134.1.3: 2008, Standard 3.10
- New Zealand Standard Day-stay Surgery & Procedures 8164: 2005 Standards 4.5 & 4.6
- Australian Council on Healthcare Standards.
- EQUIP 6 - Standard 1.1.5

Rationale:

To facilitate a smooth discharge from care in hospital to home and or care in the community, there must be a partnership between the patient, their whānau/family, healthcare professionals and when necessary, community agencies. Refer Appendix 1: Discharge planning flowchart.

Definitions:

Discharge: The end of a patient's current episode of care at Mercy Hospital and the completion of the discharge process.

Discharge Planning: A dynamic process requiring collaboration between the patients, their whānau/family and health care team to anticipate and respond to changes in health care needs beyond hospitalisation.

Simple Discharge: Patient is discharged home with whānau/family support and requires minimal or no additional health care or personal care services.

Complex Discharge: Patient has increased health and/or social care needs or requires a temporary or permanent change of residence.

Nurse Initiated Discharge: Applies to selected patients in Coolock DSU & Manaaki and requires the patient to meet specified clinical criteria.

Discharge Summary: An electronic or written summary of care provided to the patient during the admission episode, and details of follow-up and or advice post-discharge.

Emergency Discharge: The safe discharge of as many patients as possible to accommodate a sudden influx of patients as the result of a local or regional emergency.

Self-Discharge: Patients who wish to discharge themselves from Mercy Hospital against the advice of clinical staff, or a legal guardian(s) who wishes to remove a patient from the hospital against the advice of clinical staff.

Vulnerable or "at risk" patients: Patients who are elderly & /or debilitated, living in challenging social situations, alcohol or drug dependent or those with physical or mental disabilities. Patients with pressure injury, phlebitis, post-op complication or delayed surgical recovery.

Implementation:

Credentialed specialists are encouraged to initiate discharge planning especially when there is the likelihood of a complex discharge. Nursing staff will liaise with the patient's credentialed specialist to ensure a multi-disciplinary approach to the coordination of a patient's discharge-Refer Appendix 2: Complex patient preadmission process.

Evaluation

Evaluation shall occur in the following ways:

- Patient feedback
- Patient complaint process
- Incident reporting system
- Stakeholder feedback

Associated Documents

Internal:

- Patient Assessment Policy
- Clinical Records Management Policy
- Complaints Policy
- Venous Thromboembolism (VTE) Policy
- Transfer Policy
- Mercy Hospital Emergency Management Plan
- MDRO Policy
- Discharge Planning Flow Chart- Appendix 1
- Complex patient admission –Appendix 2
- Vulnerable or ‘At Risk’ patient post-surgical phone call process-Appendix 3
- Patient Self discharge from Hospital Checklist- Appendix 4

References:

- Lippincott on line procedure manual:
<https://procedures.lww.com/lmp/view.do?pld=729075&disciplineId=493>
- Centre for Allied Health Evidence: Discharge Planning. www.unisa.edu.au/cahe

Discharge Planning Process

An effective discharge strategy uses a systems based approach and incorporates four stages:

- **Assessment:** The early identification of patients with complex needs or those “at risk” of adverse outcomes associated with discharge from hospital or transfer to another health care provider.
- **Planning:** Identifying and documenting discharge strategies and developing a discharge plan which involves the patient and whānau/family.
- **Implementation:** Collaboration between the patient, whānau/family and members of the multi-disciplinary team to ensure the patient is safe and ready for discharge by the predicted date /time.
- **Evaluation:** Means of ensuring the discharge process was implemented as planned.

Assessment

Initial pre-operative assessment is undertaken in the surgeon’s rooms or for SDHB patients, at a SDHB pre-assessment clinic. The needs of the patient on discharge including carer support, health related and social support should be considered at this time and the pre-admission nurses notified of issues which may impact on the patient’s discharge from hospital. The patient and whānau/family should also be made aware of the expected length of stay and any limitations the patient may have following discharge. Referrals for pre-operative occupational therapy assessments and/or post-operative equipment (if required) will be actioned through the surgeon’s rooms and sent to the Mercy Occupational Therapist.

All patients are required to complete a health questionnaire which provides details of their health history, current health status, home circumstances and discharge arrangements. This forms part of the nursing assessment and discharge plan for each patient.

Two to three days prior to admission, the pre-admission nurses will telephone all patients to complete a nursing assessment that supplements information provided on the paper health questionnaire or via Personify. Patients unable to be contacted will have a nursing assessment undertaken on admission.

Planning

Effective discharge planning relies on accurate assessment and commences prior to or on admission. The pre-admission nurse or admitting nurse shall provide appropriate information, advice and guidance to the patient regarding discharge planning and length of stay.

Written information condition specific should also be provided on admission not on day of discharge.

Discharge planning occurs in consultation with the patient and their whānau/family. The plan will be documented on the clinical pathway / clinical notes (Appendix1 and Appendix2) and:

- Identify an estimated discharge day /date or length of stay.
- Confirm the discharge destination.
- Identify actions to address positive responses to any of the risk screening questions.
- Identify and address patients learning needs relevant to their surgery
- Identify input required from other health professionals e.g. dietician; stoma therapist.

Plans for complex discharges identified by preadmission nurses and/or Nurse Practitioner, will be communicated via email to the Clinical Nurse Manager, Associate Charge Nurse and Nurse Practitioner prior to the arranged admission-Appendix 2. The plan will be documented in the patient's clinical record.

Implementation

Implementation is closely linked to planning and there may be considerable overlap between the two phases.

- The Pre-Admissions nurse, DSU/inpatient nurse shall liaise to co-ordinate implementing the discharge plan in collaboration with the patient, the patient's whānau/family, credentialed specialists and community agencies if required.
- The estimated date of discharge shall be confirmed by the surgeon and agreed to by the patient and their whānau/family.
- The ability of the patients whānau/family, GP or community services to meet the post discharge needs of the patient may be taken into account when determining the date and time of discharge.
- Written referrals for post-surgical community supports shall be made on the appropriate referral form and shall be completed in full including the name and designation of the person making the referral.
- The date and time of notification is documented in the clinical pathway / clinical notes.
- Where electronic discharge summaries have not yet been implemented, a written discharge summary is completed by credentialed specialists and nursing staff involved in the patient's care. Two copies are usually given to the patient; one copy to be retained by them and the second copy to be forwarded to their GP. At the request of the surgeon, the GP copy may be posted by the hospital.
- The patient and their whānau/family members receive additional verbal and or written information as appropriate for their surgery including medication schedules and side effects, dietary and activity advice, prevention of complications such as constipation and VTE, and when and where to seek follow up care or advice.

Evaluation

Evaluating the patient's response to the discharge planning process is a means of ensuring the phases of discharge have been completed. This is best done once the patient has left the hospital to reduce the potential for bias. It is also likely that the patient will be aware of their limitations and that any community services required will have been implemented. Evaluation shall occur in the following ways:

Online

- The online (Cemplicity) feedback form is emailed or sent via SMS to all patients (Mercy Cancer Care patients receive a survey or surveys dependent upon length of treatment) post discharge, a reminder to complete is also sent.

Post-op phone call follow-up

- Follow up phone call post discharge for in-patients identified as vulnerable/or "at risk" post-surgery. Refer Appendix 3: Vulnerable or "at risk" patient post-surgical phone call

Post-surgical follow-up phone calls to surgery specific patients

- Breast surgery patients receive follow up from the Breast Care Nurse
- Cardiac intervention patients receive a secondary prevention follow-up call (4-6 weeks post-surgery) from a Day surgery unit nurse.

Self-Discharge

From time to time a patient may choose to discharge themselves from hospital against the advice of a clinician. A patient has the right to self-discharge at any time unless they are:

- Detained under the Criminal Justice Act 1985 or
- Detained under the Compulsory Assessment and Treatment Act 1992 (Mental health refer EPS).

If a patient wishes to discharge themselves or a legal guardian wishes to discharge a patient:

- Ascertain the reason for their decision
- Notify the patient's surgeon of their wish to self-discharge
- Explore other options that may be acceptable to the patient and staff / surgeon

A Credentialed Specialist or delegated member of the health care team shall:

- Request appropriate support from whānau/family members and other health care team members as necessary e.g. Clinical Charge Nurse Manager, ACN, On-call Nurse
- Inform the patient of:
 - Possible clinical risks and consequences of self-discharge
 - Health care needs following discharge
 - How to access health care services in the event of complications or emergency
- Complete the 'Self-Discharge from Hospital against Medical Advice' form refer appendix 4.

- Ask the patient to sign the form and obtain the signature of a witness, either the Surgeon / Credentialed Specialist or a Registered Nurse.
- Complete a discharge summary and provide a copy for the patient. Scan and email a copy of the discharge summary to the patient's General Practitioner immediately or within 1 working day if out of hours.
- Complete an Incident form giving appropriate information.
- Document the event in the progress notes, including the reason for self-discharge and file the completed 'Self-Discharge from Hospital against Medical Advice' form in the patient's clinical record.
- A Registered Nurse shall phone the patient the following day to assess their condition.

Emergency Discharge

Emergency discharge may result from a sudden influx of patients following a local or regional emergency.

In the event of an external or internal emergency which necessitates the discharge or transfer of patients to another facility, the CIMS Controller/Senior Nurse will allocate resources as they become available, to ensure patient safety is maintained at all times.