

**Purpose:**

To ensure that patients and their whanau/family experience well-organised, safe and timely discharge from hospital with an agreed, smooth transfer to primary health services, home and / or community agencies.

**Policy Applies to:** Mercy Hospital nursing staff in pre-admissions, Coolock DSU, McAuley Ward and Manaaki.

**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 5 - Standard 1.1.5

**Rationale:**

Hospital discharge describes the point at which inpatient hospital care ends, with ongoing care transferred to other primary, community or domestic environments. 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 whanau / family, healthcare professionals and when necessary, community agencies.

The process of discharge planning is coordinated by nursing staff in conjunction with credentialed specialists and begins at the first patient contact to enable patients and their whanau/families to understand and contribute to care planning decisions. To facilitate this, patients will be given an estimated discharge date and or time prior to or within 48 hours of their admission.

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.

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

## 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 family/whanau and health care team to anticipate and respond to changes in health care needs beyond hospitalisation.

**Simple Discharge:** Patient is discharged home with family/whanau 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 Led 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 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.

**"At Risk" patients:** Patients who are elderly & /or debilitated, alcohol or drug dependent or those with physical or mental disabilities.

## Objectives:

- To ensure clinical outcomes which meet the needs of the patient and their family/whanau.
- To provide efficient and effective referral systems for the transfer of care to other agencies including the patient's family doctor.
- To ensure discharge occurs in a timely manner.

## Implementation:

- Policy is available on Sharepoint and on the Mercy Hospital website.
- Nursing staff are required to read the policy and sign off as having done so.

- 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 surgeon.

### **Evaluation**

Evaluation shall occur in the following ways:

- Patient feedback
- Patient complaint process  
Incident reporting system
- Stakeholder feedback e.g. Credentialed Specialists; GP's
- Feedback from Care Coordination Centre staff

### **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

#### **External:**

New Zealand Standard; Health & Disability Services (core) Standards 2008

New Zealand Standard Day-stay Surgery & Procedures 8164: 2005

**References:**

- Lees, L. (2013). The key principles of discharge planning; *Nursing Times*, 109 (3) [www.nursingtimes.net/vol109no3](http://www.nursingtimes.net/vol109no3)
- Rudd, C. & Smith, J. (2002), Discharge planning; *Nursing Standard* 17(5) p.33-37
- Shepperd, S., Parkes, P., McClaran, J. & Phillips, C. (2007). Discharge planning from hospital to home; *Cochrane Collaboration*
- Watts, R. & Gardner, H. (2005). Nurses perceptions of discharge planning; *Nursing & Health Sciences*, 7, p. 175-183
- Centre for Allied Health Evidence: Discharge Planning. [www.unisa.edu.au/cahe](http://www.unisa.edu.au/cahe)
- Performance indicators for effective discharge (2000); Acute Health Division, Department of Human Services; Melbourne, Victoria

## Process

### Discharge Planning

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 family/whanau.
- **Implementation:** Collaboration between the patient, family/whanau 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. 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 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.

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-three days prior to admission, the pre-admission nurses shall telephone all patients (with the exception of dental, paediatric day surgery and outpatients) to complete a nursing assessment that supplements information provided on the health questionnaire. The remaining patients will have a nursing assessment undertaken on admission.

In assessing the patient's preparedness for discharge, the following questions should be asked of all inpatients, and day surgery patients where relevant. Answers shall be documented on the nursing assessment form or in the electronic health record where this is available.

- Does the patient live alone?
- Does the patient provide care for other dependents?
- Does the patient currently use any community health services?
- Has the patient received a visit or phone call from an occupational therapist with regard to equipment? (if applicable).
- Has the patient arranged transport for the day of discharge?
- Will the patient have any self-care problems following discharge from hospital?
- Does the patient feel safe going to their home environment?
- Does the patient have a history of any multi drug resistant organisms (MDRO) that need to be communicated to other health care providers following discharge?

### **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.

Discharge planning occurs in consultation with the patient and their whanau / family. The plan shall be documented on the clinical pathway / clinical notes 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; stomal therapist.

Plans for complex discharges identified by preadmission nurses, will be communicated to the Clinical Coordinators via email and 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 and the ward/ DSU nurse shall liaise to coordinate implementing the discharge plan in collaboration with the patient, the patient's family/whanau, 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 family/whanau.
- The ability of the patients family / whanau, 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.
- SDHB Care Coordination Centre (for District Nursing) or Community Health Services for personal cares/ home help), or other referral agencies are notified in a timely manner either by phone or fax depending on the agency.
- Written referrals 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.
- In Coolock DSU and Manaaki, nurse led discharge may be considered for patients that meet specific clinical criteria.
- 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 receives additional verbal and or written information as appropriate for their surgery.
- The patient receives an appropriate post-discharge contact to answer queries and address concerns.

## **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:

- Patient feedback form
- Follow up phone call of most day case patients the day following their surgery (exceptions are endoscopy patients and cataract patients who are given the Specialist's contact number or are reviewed by the surgeon the following day).
- Monitoring "advice after discharge calls"
- Follow up phone call 2-3 days post discharge for in-patients.
- Additional follow up phone calls to identified patient groups by specialist / resource nurses i.e. breast patients receive follow up from the Breast Care Nurse and cardiac surgery patients receive a phone call from the Cardiac Resource Nurse.
- Periodic follow up of selected patient groups

## **Self-Discharge**

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

A credentialed specialist or delegated member of the health care team shall:

- Request appropriate support from family members and other health care team members as necessary e.g. Clinical Coordinator, 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



- Document the above information in the clinical notes together with a timed and dated statement saying that the patient is discharging themselves against medical advice, and that they understand the risks.
- Ask the patient to sign the statement and obtain the signature of a witness, preferably the patient's consultant.
- Complete a discharge summary and provide a copy for the patient. Fax 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.
- A Registered Nurse shall phone the patient the following day to assess their condition.

### **Emergency Discharge**

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.