Discharge Planning Procedure

TABLE OF CONTENTS

TARGET AUDIENCE and SETTING

This procedure is applicable to all clinical staff involved in patient discharge planning for inpatients.

PURPOSE

This procedure guides multidisciplinary ward-based care teams to plan a safe, efficient and effective discharge for all inpatients.

It applies to all inpatients being discharged from Monash Health into the community, residential care or to another health service's inpatient unit.

It also applies for transfers from Monash Health acute campuses to sub-acute.

EQUIPMENT

EMR Medical Discharge Summary for the clinical area to be completed by the discharging doctor.

EMR Nursing Discharge Checklist (Confirmed Discharge Powerform) for the clinical area to be completed by the bedside nurse. This assists with identifying and completing outstanding tasks prior to discharge.

EMR Patient Discharge Information for the clinical area to be completed by the bedside nurse. This document collates information from the medical record, including diagnosis, procedures and advice to the patient. It is to be printed from the EMR and forms the basis for a discussion with the patient to ensure they are leaving hospital will all the information they need. It replaces 'My Passport'.

This document is not a discharge summary and is not sent to the patient's GP.

EMR Discharge Medication list to be completed by Ward Pharmacist.

SMR eReferral to be completed by Medical Staff of discharge unit where Monash Health Specialist Consulting appointments are required.

STANDARD REQUIREMENTS

It is expected that staff are familiar with the relevant procedures and know when to undertake each step.

- Introduce yourself, discuss the procedure with the patient and obtain consent.
- Check patient identification. Refer to the Patient Identification procedure.
- Perform routine hand hygiene. Refer to the Hand Hygiene procedure.
- Document in the relevant health record.

PROCEDURE

Discharge planning is the responsibility of the multidisciplinary team caring for the patients.

On admission:

Plan for discharge from the day of admission in conjunction with the patient and their support person:

- Determine Estimated Date of Discharge (EDD) within 24 hours of admission
- Determine likely discharge destination and transport arrangements
- Determine the patient's and family's expectations of their care
- Identify any barriers to discharge that may prevent discharge once the medical reason for admission has been resolved
- Ensure plans to address social issues are implemented early
- Ensure referrals to specialist consulting teams and allied health are made early
- Ensure medications are reviewed and medication management plans developed

Individual team members' responsibilities are detailed under "Staff responsibilities at Discharge".

During inpatient stay:

On the ward round and PM huddle

- Review potential need for Advance Care Planning and document in the EMR 'Early Discharge Planning' Powerform
- Regularly review the EDD
- Review progress of management plan daily
- Ensure regular communication with consulting teams
- Keep patient and support person informed of diagnosis, treatment, medications and discharge plans
- Where available, the patient bedside communication board is to be updated to include information on patient's discharge
- Ensure understanding of discharge planning using teach back
- Complete planning and referrals for equipment, specialist ongoing treatment/ therapy and services required after discharge
- Commence preparation for discharge prescriptions and discharge summary early

During last 24 hours of patient stay:

- Confirm intention to discharge
- Confirm discharge destination

- Once discharge confirmed, place 'Discharge Patient' order on the EMR, which will subsequently place a black door icon on the EMR Clinical Leader Organiser to inform the team that the patient is confirmed for discharge
- Inform patient of the time and plan of discharge
- Complete discharge summary (medical and allied health if required), Patient Discharge Information (nursing), discharge prescriptions
- Provide patient with discharge documentation and discharge education using teach back to ensure understanding
- Provide written information as relevant
- Provide equipment if required
- Confirm follow up services and specialist appointments and inform patient and support person about them
- Confirm patient's transport arrangements and ensure there is a plan to safely escort the patient to their form of transport

Individual Staff responsibilities at discharge

Medical staff responsibilities:

1.1 Confirm Estimated Date of Discharge (EDD) with the consultant on day of admission and review EDD every day. Communicate EDD to bedside nurse and ensure this is documented on the EMR 'Early Discharge Planning' Powerform.

1.2 Ensure patient and support person are involved in decisions about their discharge and understand their diagnosis, treatment, medication and discharge plans.

1.3 Prepare a discharge prescription for the patient using the 'Discharge Medication Reconciliation' function in the EMR. Refer to Discharge Medication Reconciliation (including Discharge Prescriptions) EMR Quick Reference Guide.

1.4 Ensure the appropriate EMR Medical Discharge Summary is completed prior to discharge and includes the following information:

- Patient name, UR number, date of birth and home address;
- Hospital name, campus, unit, treating clinician name and contact information;
- Admission and discharge/death date and time, discharge destination;
- Brief note on patient's progress, complications and morbidity during admission;
- Surgical or other procedures undertaken;
- Co-morbidities/Pre-existing conditions including relevant past history, in particular conditions, which affected the management or length of stay of the patient;
- Relevant investigations and results – unreported results (e.g. pathology, radiology) must be indicated with appropriate phone numbers for follow up;
- Medications including discharge medications, changes to regime and rationale, and any suspected adverse drug reaction;
- Relevant clinical risks including risk of falls, pressure injuries, infection and adverse medication reactions;
- Any Patient Clinical Alerts, ensuring that any alerts that may be of a sensitive nature are edited appropriately

1.5 If Medical Discharge Summary is completed by an intern, ensure that it is reviewed and electronically countersigned by the Registrar.

1.6 Upon signing in the EMR, the Medical Discharge Summary will automatically be sent to the patient's GP (if the patient has a GP nominated in iPM) via HealthLink or InterFax. A copy of the Discharge Summary can be printed for the patient (if requested) or for Specialists/Specialist clinics/private rooms/community services as relevant.

1.7 See EMR EMR Discharge Workflow Quick Reference Guide for EMR workflow.

Deceased patients:

- Where possible always telephone the relevant treating clinicians. This is professional courtesy and allows the treating clinician the opportunity to obtain further information.
- Complete an EMR Deceased Patient discharge summary outlining pertinent information, including family present, notified, clinical determinations and other pastoral elements. Refer to the Verification and Notification of Death procedures for additional legal requirements regarding deaths).

Bedside nurse / Midwife / Associate Nurse Manager Responsibilities:

2.1 Enter EDD into the EMR 'Early Discharge Planning' Powerform within 24 hours and subsequently with any change. This will automatically feed into Patient Flow Manager.

2.2 Provide patient with a comprehensive explanation of care and follow-up at discharge.

2.3 Document relevant post discharge care recommendations within the 'Advice to Patient' section of the EMR nursing workflow (Discharge page). This will feed into the EMR 'Patient Discharge Information' form and provide patient/family with the completed document. Use teach back to ensure patient understands the information.

2.4 Complete the Nursing Discharge Checklist in the EMR 'Confirmed Discharge' Powerform to coordinate the discharge plan. Identify and complete outstanding tasks.

2.5 Ensure appropriate equipment, transport and services as per patient's needs have been arranged.

Responsibilities of Nurse / Midwife Manager

3.1 Ensure all relevant documents are completed and staff have communicated the post discharge care recommendations with the patient and support person, and that the patient and support person understand the instructions. Rounding on a sample of patients ready for discharge may assist in this.

3.2 Escalate to Consultant/Department Head if the EMR Medical Discharge Summary has not been completed despite attempts by the Ward Clerk/Bedside Nurse/Midwife.

3.3 Ensure appropriate processes exist for **out of hours** discharges.

Responsibilities of Unit Heads

4.1 Ensure Junior Medical Staff routinely communicate the care/discharge plan with the patient and support person and the EMR Medical Discharge Summary is accurately completed prior to discharge.

4.2 Monitor quality and timeliness of EMR Medical Discharge Summaries.

Allied Health Responsibilities

5.1 Communicate specific discharge information to patient and support person and document within the 'Advice to Patient' section within their EMR workflow page, which will flow into the 'Patient Discharge Information' form.
5.2 Ensure specific discharge information for health care providers taking over care is communicated to medical staff to document in the EMR Medical Discharge Summary.
5.3 Arrange appropriate equipment and follow up services/ ongoing treatment as required for patient and inform patient about these.

Pharmacist Responsibilities

6.1 Profile prescription once received to ensure accuracy and open the 'Pharmacy Medication Management Plan' Powerform to document all medication changes using the approved template in the 'Medication Management Plan for discharge' field.
6.2 Select the 'Prescription received' and 'Prescription profiled and Medication Management Plan for discharge field complete' radio button in the 'Prescription Status' field of the 'Discharge Checklist' and sign the form. Refer to Reviewing and Editing the Pharmacy Medication Management Plan (MMP) on Discharge QRG
6.3 Provide any discharge medications and medication list to the patient/carer.
6.4 Provide medication counselling to the patient/carer using teach back to ensure understanding, communication and explaining any medication changes and any medication management follow up required.
6.5 Provide a full medication list and communicate any changes to patient's local pharmacy provider and GP if required.
6.6 Select the 'Patient Ready for Discharge (Pharmacist discharge complete)' radio button in the 'Prescription Status' field of the 'Pharmacy Medication Management Plan' PowerForm, to indicate prescription dispensed and patient/carer has received any medication counselling required. Refer to Reviewing and Editing the Pharmacy Medication Management Plan (MMP) on Discharge QRG

Responsibilities of Ward Clerks

7.1 Ensure a copy of EMR Medical Discharge Summary is provided to the patient if they request a copy.
7.2 Where the patient cannot nominate a General Practitioner (GP) or GP Clinic, a copy of the EMR Medical Discharge Summary must be handed to the patient to give to the relevant treating clinician at their next visit.
7.3 Incomplete (i.e. saved but not signed) EMR Medical Discharge Summaries must be referred to the Nurse Unit Manager to follow up with medical staff.

KEY STANDARDS, GUIDELINES OR LEGISLATION

Standard 6: Communicating for Safety

KEYWORDS

Discharge, Multidisciplinary Team

Document Governance	
Supporting Policy	Clinical Communication (Operational)
Executive Sponsor	Chief Medical Officer
Committee Responsible	Standard 6: Communicating for Safety
Document Author	Chair, Standard 6: Communicating for Safety