

STANDARDS TO BE MET (refer also to [Appendix 1](#))

1. Responsibilities

- 1.1 All relevant health professionals will be involved with discharge planning and will maintain the required discharge documentation.
- 1.2 The decision to medically discharge a patient is to be made initially by the responsible Consultant or Lead Maternity Carer (LMC) or their delegated authority. The health professionals will document in the health record the patient / client's readiness for discharge.
- 1.3 Parameters for discharge in the form of Criteria Lead Discharge must be written in the patient health record by the Consultant, LMC or their delegated authority. The Criteria Lead Discharge Form (8236) is ordered from Design and Print.
- 1.4 There must be evidence that discharge information has been discussed with patient / client / family / whanau by the relevant health professionals.
- 1.5 The Registered Nurse (RN) who is responsible for the patient / client at the time of discharge, must ensure the discharge process is completed.

2. Medical Discharge Summary

- 2.1 The ultimate responsibility for the discharge documentation rests with the responsible SMO who is responsible for the patient's management and includes the monitoring of the discharge process.
- 2.2 Generally the House Officer is delegated responsibility for providing the patient with a medical Discharge Summary which must be completed and given to the patient on the day of discharge. A copy should be sent to the GP which includes advice to access the house officer or hospital electronic record (CHIP) for further detail if required.
- 2.3 In complex cases and those needing follow up this discharge summary must be discussed with the Responsible Senior Medical Officer (SMO). In some cases it may be necessary to forward a copy to the Responsible SMO for approval.
- 2.4 The Consultant or delegate is responsible for any tests ordered on an inpatient, including results that come in after the patient has been discharged. They must follow up on all results and are responsible for further communication with the GP if required.
- 2.5 The discharge summary sent to the GP is an essential part of the transfer of care and any tests required as a result of details in the discharge summary are deemed to be the responsibility of the patients GP.
- 2.6 Where the GP status is unknown or where uncertainty exists, contact must be made with the assigned care provider e.g. LMC to ensure that the above process is adhered to and that that the patient's discharge details are communicated to the person responsible for their care.
- 2.7 Administration staff are responsible for sending a copy of the discharge letter, if required, to the patient, GP and / or Health Care Provider and a copy entered into the patient's Health Record.

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3. Discharge Planning

- 3.1 Discharge Planning will begin prior to admission when admitted electively, or will be commenced within 24 hours of current admission.
- 3.2 There will be a Discharge Plan formulated in partnership with the patient / client and / or family / whanau.
- 3.3 The Discharge Plan will include evidence of the following:
- a) Assessment of patient / client's needs, post discharge.
 - b) Identification of family / whanau support and other agencies / services already involved.
 - c) Documentation of expected plan / strategies to meet patient / client's discharge needs.
 - d) An indication of anticipated length of stay.
 - e) Medical discharge summary, includes:
 - i. Principal diagnosis – condition found to be primarily responsible for patient's admission to hospital
 - ii. Any secondary conditions that existed at the time of admission for which treatment was given or that arose during the patient's stay, or affected length of stay or treatment / care
 - iii. Principal procedure performed for definitive treatment that required the greatest level of hospital resources or which was performed for treatment of the principal diagnosis
 - iv. Other significant procedures undertaken that were either surgical in nature or carried procedural risk and / or required special equipment only available in the acute care setting
 - v. Specific follow up requirements to support continuity of care once the patient is discharged from hospital
 - vi. That the GP will receive documentation of the up to date medication list
 - f) Discharge summaries must include all changes to a patient's medication – discontinued drugs, new additional drugs and changes in doses. Expected duration of treatment should be indicated where this is time limited.
 - g) Specify information to be given to the patient.
- 3.4 To ensure cultural compliance and by agreement with the patient Maori patients are referred to Regional Maori Health Services.
- 3.5 Referrals will be actioned within 24 hours to the appropriate health professional or other service provider as identified in the initial and subsequent patient assessments.
- 3.6 All complex discharges are actively planned within the multi-disciplinary team (MDT).
- 3.7 Referral needs will be assessed on an ongoing basis.
- 3.8 Staff education in discharge planning processes to be included in ward / service / unit orientation and clearly documented.

4. Before Discharge

- 4.1 Each member of a MDT (when appropriate) must clear the patient for discharge.
- 4.2 All referrals and any discharge equipment will be organised if required and liaison with community providers confirmed.

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- 4.3 Patient education shall be appropriate for the level of understanding of patient / client and / or family / whanau. Evidence of patient education to be documented in the patient's health record.
- 4.4 Discharge documentation e.g. discharge summary, transfer letter if required and the discharge information is explained and given to the patient and / or family / whanau before they leave hospital.
- 4.5 Enhanced communication with GPs must be given when there are new additional treatments with risk attached to them that require specific GP follow up eg warfarin, statin prescriptions.

5. On Discharge

- 5.1 Final discharge tasks completed as detailed in the Admission to Discharge Planner, Part Four – Discharge Planning.
- 5.2 Electronic Discharge summary provided and explained to patient.
 - a) In an acute assessment area the last doctor to treat the patient is responsible for the completion of the electronic acute event summary. This discharge summary will ensure greater communication between multidisciplinary services if the patient is admitted to hospital
 - b) If unable to provide an electronic discharge summary the house officer or person delegated by the consultant may provide a handwritten discharge summary, which is entered into the health record and a follow up letter sent to the GP within three (3) days, if required
- 5.3 Completed Medication reconciliation, if required.
- 5.4 All referrals to community providers are confirmed and explained to patient.
- 5.5 Information required for the patient to manage at home and the planned follow-up arrangements explained and given to patient.
- 5.6 Arrangements should be made so that patients can be discharged from hospital before 1100 hours. In the event that this is not possible, appropriate patients are transferred to the Transit Lounge where their hospital discharge will occur.
- 5.7 Patients who are assessed as vulnerable, e.g. elderly, the very young, and / or without an accompanying support person, should be discharged at a time when there is appropriate access to support services, provisions, family / whanau, community support.
- 5.8 In the event of patient re-admission, consultant, GP, or specialist nursing follow up on discharge is mandatory

6. Post Discharge

- 6.1 Copy of the Discharge Summary is sent to the GP within 24 hours of discharge and follow up letter within three (3) days, if complexity of case requires.
- 6.2 In the event of death of the patient, a discharge summary should be sent to the GP as outlined in 6.6.1 P1 Death of a Patient – Record of Death.

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7. Repeat Admission

- 7.1 Repeat admission may signal that the discharge plan was insufficient for the patient's needs resulting in failed transition to the next setting of care.
- 7.2 Repeat admission is indicated as an icon on the Electronic Hospital Status at a Glance board.
- 7.3 The repeat admission patient assessment tool must be applied to assess for specific patient / client / family requirements of discharge planning.
- 7.4 Place a coloured repeat admission bookmark in the clinical record to flag that the patient has a high risk of further re-admission.

8. Documentation

- 8.1 All Health professionals involved with discharge planning will document in the health record the patient / client's readiness for discharge from Hospital or Inpatient Health Centre.
- 8.2 House Surgeon / Registrar / Consultant completes discharge documentation as per section 4.1 above.
- 8.3 Nursing staff are responsible for ensuring that the discharge summary section of the Admission to Discharge Planner or patient pathway is complete prior to patient discharge.
- 8.4 Administration staff will undertake to forward information in the necessary timeframes (copy to patient, GP and / or Well Child Provider).

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.5.1 Inpatient Discharge Planning
- Bay of Plenty District Health Board policy 6.5.1 protocol 3 Discharge - Self Discharge Planning Process
- Bay of Plenty District Health Board policy 6.5.1 protocol 4 Discharge - Emergency Department Electronic Acute Event Summaries
- Bay of Plenty District Health Board policy 6.5.1 protocol 5 Discharge – Issuing Medical Electrical Equipment to Medically Dependent Electricity Consumers
- Bay of Plenty District Health Board policy 6.5.1 protocol 6 Discharge – Dementia Level Residential Care
- Bay of Plenty District Health Board policy 6.5.1 protocol 7 Discharge – Needing Short Term Services (STS) Procedure
- Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.27 Consumers Absent Without Leave (AWOL)
- Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.31 Discharge from the MHAS
- Bay of Plenty District Health Board Form FM.E4.1 Electrical Equipment – Certificate of Notice of Potentially MDC Consumer Status
- Bay of Plenty District Health Board Form FM.E4.2 Electrical – WINZ Physical Disability Allowance for Electrical Costs
- Bay of Plenty District Health Board Form FM.R10.1 Readmission – High Risk – Patient Assessment Tool

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- Bay of Plenty District Health Board Form FM.R10.2 Readmission – Audit Worksheet of Patient Groups (*fillable*)
- Bay of Plenty District Health Board Form FM.R10.3 Readmission – Audit Worksheet of Patient Groups (*blank for printing*)
- Bay of Plenty District Health Board Form FM.S4.1 Self Discharge
- Bay of Plenty District Health Board Form Criteria Lead Discharge (8236) – *viewable only* – order from *Design & Print Centre*
- Bay of Plenty District Health Board policy 6.9.3 Patient / Client Personal Property
- Bay of Plenty District Health Board policy 2.1.1 Risk Management
- Bay of Plenty District Health Board policy 2.1.3 Hazard Management
- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board Admission to Discharge Planner (7760) – *viewable only* - order from *Design & Print Centre*

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Appendix 1: Discharge Planning Algorithm

Process		Tasks / Standards	Responsibility
Admission & Pre-admission	<i>First contact with hospital</i>	<ul style="list-style-type: none"> • Patient referred to hospital – refer to policy 6.1.2 p2 Admission, Handover of Responsibility & Patient Care Management • Discharge planning to begin prior to admission when admitted electively or within 24 hours of current admission 	Health professionals
	<i>Discharge Plan commenced – Admission to Discharge Planner</i>	<ul style="list-style-type: none"> • Nursing assessment to be completed within 8 hours • Community / voluntary agencies currently providing services to patient notified of admission • Need to referral to Allied Health professional identified and referral(s) sent within 24 hours – reviewed on daily basis • Discharge plan commenced • Expected length of stay discussed with patient / client, family / whanau 	Registered Nurse (RN) or delegated authority
Discharge	<i>Patient Education</i>	<ul style="list-style-type: none"> • Patient education is given and documented by health professionals • Education is targeted to the level of understanding of the patient 	Health professionals / interpreters / Regional Maori Health Services as required
	<i>Set parameters for medical discharge</i>	<ul style="list-style-type: none"> • All patients must be medically discharged • Consultants may set written parameters in health record in the form of Criteria Led Discharge from which their delegated authority or senior RN may discharge patient 	Specialist Consultant / GP / LMC delegated authority
	<i>Make discharge arrangements</i>	<ul style="list-style-type: none"> • Prior to discharge the following needs to occur: • Transport arrangements confirmed • Follow up appointments made between 0800 and 1630 hours Monday to Friday • Written discharge information discussed with patient / client, family / whanau, given to patient / caregiver and documented in health record • Return of patient's own medication documented • Return all patient's property as per policy 6.9.3 Patient Client Personal Property 	RN or delegated authority
	<i>Confirm</i>	<ul style="list-style-type: none"> • Community services home visit (e.g. home support, District Nursing, Occupational Therapy, Physiotherapy) confirmed • Patient / caregiver / family / whanau informed • All documentation given to patient on discharge e.g. prescription, medical certificate • Ensure all issued equipment goes with patient on discharge per policy 6.5.1 protocol 5 Issuing Medical Electrical Equipment to Medically Dependent Electricity Consumers • Outpatient appointments 	Discharge Nurse

Process		Tasks / Standards	Responsibility
Discharge (continued)	<i>Medical Discharge Summary</i>	<ul style="list-style-type: none"> Completed by House Officer and given to the patient on discharge where possible The discharge summary must be completed no later than 24 hours following discharge 	House Officer / Registrar / Consultant
	<i>Nursing Discharge Summary</i>	<ul style="list-style-type: none"> Where applicable, nursing / allied health discharge summary and / or checklist / clinical pathway to be given to patient / client on discharge 	Nursing / Allied Health professionals
	<i>Medical Discharge Letter to GP</i>	<ul style="list-style-type: none"> If required, discharge letter written by Consultant or Registrar to GP within three (3) days of discharge 	Consultant / Registrar
	<i>Arrange follow up appointments</i>	<ul style="list-style-type: none"> Follow up outpatient appointments made and confirmed prior to discharge (0800 to 1630 hours Monday to Friday) 	Administration Support / Nursing staff
	<i>Collate Health Record</i>	<ul style="list-style-type: none"> All health records (current and old) are to be given to ward Administration Support for collation Ward Administration Support will forward to Health Records, or for mental health to Mental Health & Addictions Service 	Nursing staff / Administration Support
Post Discharge	<i>Monitoring and Evaluation</i>	<ul style="list-style-type: none"> Any issues / problems relating to patient / client discharge to be identified and reported using the Reportable Event system, with a copy to relevant Clinical Nurse Manager / Cluster Leader All unplanned re-admissions to be assessed using diagnostic toolkit so that cases of re-admission is understood and appropriate actions taken 	Case Managers / Nurse Educators / Allied Health professionals / District Nurses
		<ul style="list-style-type: none"> Discharge planning feedback from patients / clients through website "Feedback about your Healthcare Experience" 	Via Quality & Patient Safety