AN ACI RESOURCE FOR IMPLEMENTING CRITERIA LED DISCHARGE - CONSULTATION DRAFT

Project Overview

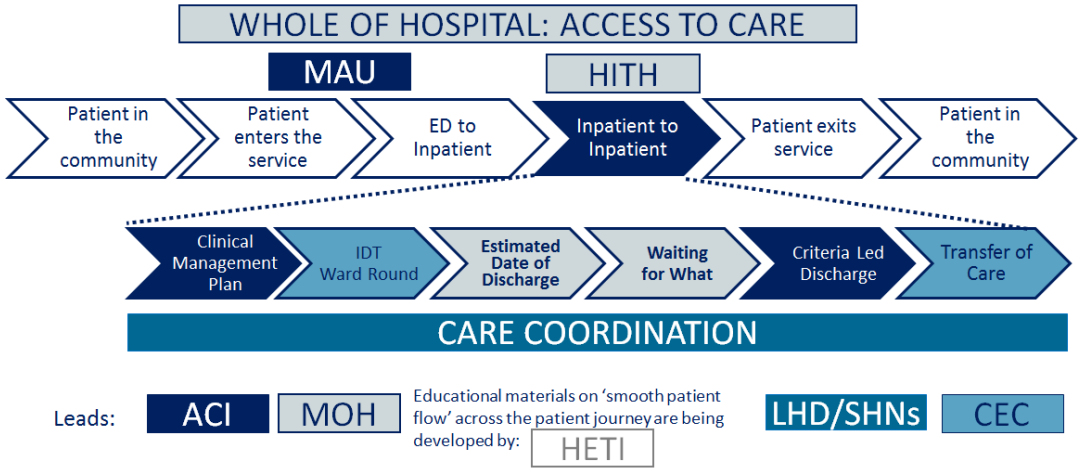
The Acute Care Taskforce (ACT) has been involved in developing solutions for improving the medical patient journey since 2005. This includes work around safe clinical handover, avoidable admissions and the establishment of medical assessment units.

In 2011 the NSW Ministry of Health published a policy directive titled *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.* Acknowledging that patient involvement contributes to positive health outcomes the policy mandated that hospital teams involve patients/carers in care planning. It highlights five important stages to a coordinated inpatient experience: 1.Pre Admission/Admission; 2.Multidisciplinary team review; 3.Estimated date of discharge (EDD); 4.Referrals and liaison for patient transfer of care and 5.Transfer of care (discharge) out of the hospital.

In 2012 the ACT transitioned to the ACI and in order to build upon this important work the ACI brought together a group of clinicians, consumers and managers. Under the guidance of this group the ACT decided it would focus on improving the medical inpatient journey in 2013. Five important elements to improving the inpatient journey were identified with the system lead noted in brackets (Figure 1):

1. A patient flow systems approach to improving the inpatient experience focused on the EDD and waiting for what functions (NSW Ministry of Health and Health & Education Training Institute)
2. Inpatient clinical management plans (Agency for Clinical Innovation - ACI)
3. Ward rounds (Clinical Excellence Commission - CEC)
4. Criteria led discharge (ACI)
5. Transfer of care / discharge (CEC)

Figure 1 Acute Care Taskforce 2013: a collaborative approach to improving the medical inpatient journey



Key

ACI=NSW Agency for Clinical innovation
CEC=NSW Clinical Excellence Commission
HETI=NSW Health Education and Training Institute
LHD/SHNs=NSW Local Health Districts & Speciality Networks
MOH=NSW Ministry of Health
IDT=Interdisciplinary
HITH=Hospital in the Home
MAU=Medical Assessment Unit

Under the guidance of the ACT Executive two working groups were established: one for clinical management plans (CMP) and another concentrating on criteria led discharge (CLD). Following a comprehensive literature review and in consultation with the statewide ACT the clinician led working groups developed a set of tools to assist staff from Local Health Districts and Specialty Health Networks to:

- Improve documentation of the CMP in their wards and facilities, and/or
- Assess the requirements for implementing CLD.

The solutions are designed to assist teams to make changes to improve the way that care is provided while patients are in hospital. These resources acknowledge that the care provided in hospitals can be complex and that the solutions to improving both the patient and staff experience will require an interdisciplinary effort. These changes include better communication of the clinical management plan, a more streamlined approach to planning for transfer of care (discharge) and a more coordinated inpatient journey.

This resource includes the following components key to implementing CLD:

- An overview chapter outlining the case for change and potential approach to implementation, including
  - A Framework for Criteria Led Discharge (p11)
  - Frequently asked questions for implementing CLD (p12)
  - CLD form with guidance (p13)
  - Transfer of care checklist (p15)
  - Patient and staff experience using Patient Experience Trackers (PETs, p16)
  - Protocol/policy for local adaptation (p17)
  - CLD competency set (p22)
  - An implementation checklist (pp23-24)
  - A draft set of orientation/education slides (pp25-35)

A separate resource includes the elements that are fundamental to support the implementation of CMP (http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/clinical-management-plans-resource-feedback).

Criteria Led Discharge

Planning for discharge on admission

(DRAFT FOR DISCUSSION)

Revision History		
Prepared by:	Version:	Date:
Wilson Yeung (CEC)	1.0	16 January 2013
Kate Lloyd (ACI)	1.1	8 May 2013
Kate Lloyd (ACI)	1.2	4 June 2013
Kate Lloyd (ACI)	1.3	11 July 2013
Kate Lloyd (ACI)	1.4	17 July 2013
Kate Lloyd (ACI)	1.5	6 September 2013
Kate Lloyd (ACI)	1.6	2 December 2013

Acknowledgements

Clinical Excellence Commission – initial draft of this document
ACI Acute Care Taskforce
ACI Criteria Led Discharge Working Group
Bega Hospital (Surgical Ward)
Calvary Mater Hospital (Haematology Unit)
Wollongong Hospital (Cardiology Step Down Unit, Neurology Ward)
Auckland District Health Board
Queensland Health
Children's Hospital Westmead, NSW
Royal Children's Hospital Melbourne, VIC
Department of Health / NHS, UK

Contents

The Issue - Increasing demand on our health facilities

In Australia the number of patient admissions continues to increase each year. Table 1 indicates that there was an average 2.6% increase year on year in separations for NSW public hospitals between 2007/08 to 2010/11. Comparing 2007/08 to 2010/11, demand has grown by 8% (116,067 separations) across the state. With an ageing population and issues related to chronic disease affecting members of our community, one would expect that the number of admissions to our health facilities will continue to rise.

Table 1: AIHW NSW Hospital admissions (2007-2011)

2007/08	2008/09	2009/10	2010/11
1,466,737	1,505,969	1,542,968	1,582,804

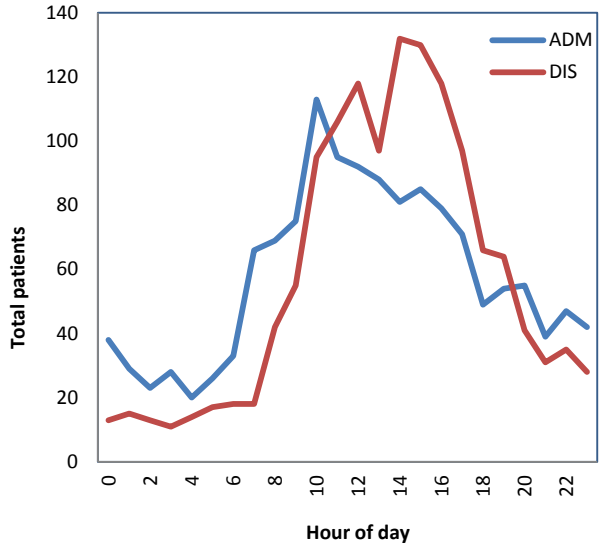
(Source AIHW 2012: Australia Hospital Statistics 2010-11)

Current Situation - Patient transfers of care

Patient transfers of care occur unevenly through the week, with reduced numbers at the weekend and a peak on Mondays with the team playing catch up throughout the week (Figure 2). There is also a mismatch between admission and transfer of care times which has an effect on the required number of inpatient beds which contributes to bed block (Figure 3). This is inefficient and represents an unequal spread of the burden of demand on health resources.

Figure 2: Medical admissions and discharges in NSW Hospital Facility – July 2012

Figure 3: Medical admissions and discharges in NSW Hospital Facility by hour of day – week ending 1 July 2012



Effective transfer of care planning is essential to the efficient use of healthcare resources. It is a key part of care planning for patients and should begin at the patients' admission into hospital as indicated by the Coordination: Planning from admission to transfer of care in NSW public hospitals policy directive PD2011_015. Transfer of care planning should be seen as a product of good care planning and good care delivery. Patients will be ready for transfer as planned, if care is delivered as planned.

It has been well documented that planning for transfers of care with clear dates and times reduces:

- Patient's length of stay
- Emergency readmissions
- Pressure on hospital beds

The specific problem of peaks and troughs in patient transfers of care are connected with peaks and troughs of staff availability, and the peaks and troughs in patient demand. The focus of short to medium term efforts should be on improving the decision making capability of patient care teams, particularly regarding patient care and transfer of care planning.

A Solution - Criteria Led Discharge

One solution that can assist in addressing the demand on beds in our health facilities is to formalise and improve transfers of care. Criteria led discharge will enable the most appropriate healthcare professional to transfer the patient (potentially nursing, allied health or junior medical staff) by providing supportive criteria for the transfer making process and not relying solely on the admitting medical officer to make the decision.

A formalised criteria led discharge process has the potential to:

- **Improve patient experience:** patients are able to get home sooner
- **Enhance patient safety:** criteria led transfers of care through a checklist
- **Reduce unnecessary length of stay:** not being in hospital when patients can actually be transferred
- **Reduce bed days:** elimination of unnecessary days in hospital
- **Minimise waste:** reduction of costs as a result of eliminating unnecessary lengths of stay in hospital
- **Improve staff satisfaction:** not pressured to transfer patients in the "last minute" or experience bed block on Monday due to transfers not occurring over the weekend

While a patient can be identified for criteria led discharge at any point in their inpatient journey the interdisciplinary ward round is an ideal time for the team to discuss eligibility. This planning can commence as early as admission.

NSW Health Patient Flow Systems

A number of initiatives have been implemented across NSW to improve patient flow. One of the key tools is the Patient Flow Portal (PFP) that allows staff to access and plan for the expected availability of beds and staff based on demand.

The Patient Flow Portal supports NSW Health workers to adopt a Patient Flow Systems approach by providing accessible, user friendly tools. The Patient Flow Portal aims to improve patient flow within a hospital or local health district/speciality network assisting staff and improving patient experience. Specifically the PFP included predictive tools to supports staff to:

- plan actions according to expected demand
- identify how patients are being allocated according to an expected date of discharge
- view relative length of stay (LOS)
- have a view across varied frames of how a single ward or entire facility is managing
- understand for what services patients are waiting
- have good information on at risk patients

In addition to the Patient Flow Portal, the NSW Ministry of Health commissioned the University of Tasmania, eHealth Services Research Group to undertake an evidenced based review on Smooth Patient Flow and produce associated education packages. The Ministry commissioned this work so that an independent group could review the available evidence on the essentials for good patient flow and how the required systems for flow can be sustained. The reviewers visited many hospitals around NSW and based their feedback on these visits and the available international good practice.

The authors of this review suggest their work would help our health professionals reflect on: how work practices affect patient flow; recognise how flow relates to quality and safety; and how smooth flow can reduce waste and delays in healthcare.

To complement this review, the Health Education and Training Institute (HETI) is developing educational and training resources on smooth patient flow based on the training materials developed by the University of Tasmania. The education programs will be available by the latter months of 2013 and will provide staff with enhanced understanding of patient flow and the respective responsibilities to assist flow to ensure quality safe care for patients. It will also cover the critical aspects of care planning, transfer practices and other critical enablers to support good patient journeys.

An expert advisory group will be established by HETI to inform the development of these training and educational modules and they will be developed as blended resources with online and face to face content.

Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals

NSW Health currently has the Care Coordination: Planning from admission to transfer of care in NSW public hospitals policy directive PD2011_015 in place which outlines a five stage process to guide staff and patients through their hospital stay which are:

1. Pre Admission/Admission
2. Interdisciplinary Team Review
3. Estimated Date of Transfer (Discharge – EDD)
4. Referrals and Liaison for patient transfer of care
5. Transfer of care out of the hospital

These five stages provide the foundation for CLD which is focused on the improvement of transfer of care. In addition to the Policy Directive the following are supporting documents:

- Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals Reference Manual (including the Transfer of Care Risk Assessment)
- Staff Booklet: The Principles of Care Co-ordination.

The Framework

The framework for criteria led discharge incorporates 5 phases which aligns with the 5 stages from the Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Policy Directive.

Table 2: Mapping the Criteria Led Discharge Framework to the Care Coordination Policy Directive

Criteria Led Discharge Framework	Care Coordination Policy Directive
1. Pre Admission	1. Pre admission/admission
2. On admission	2. Multidisciplinary Team Review
3. During admission	3. Estimated Date of Discharge 4. Referrals and Liaison
4. Planning for discharge	5. Transfer of Care
5. 24 hours before discharge	
6. Day of discharge	

This framework covers the patient journey from pre admission to transfer and includes the patient and carer as part of the planning process and the patient care team. The framework is illustrated in APPENDIX A.

The generic criteria led discharge form can be found at APPENDIX C. A protocol for the application of criteria led discharge is included at APPENDIX D. This protocol outlines to the process and principles for clinicians to undertake criteria led discharge. A competency has been developed for teams wishing to undertake formal assessment of staff (APPENDIX F).

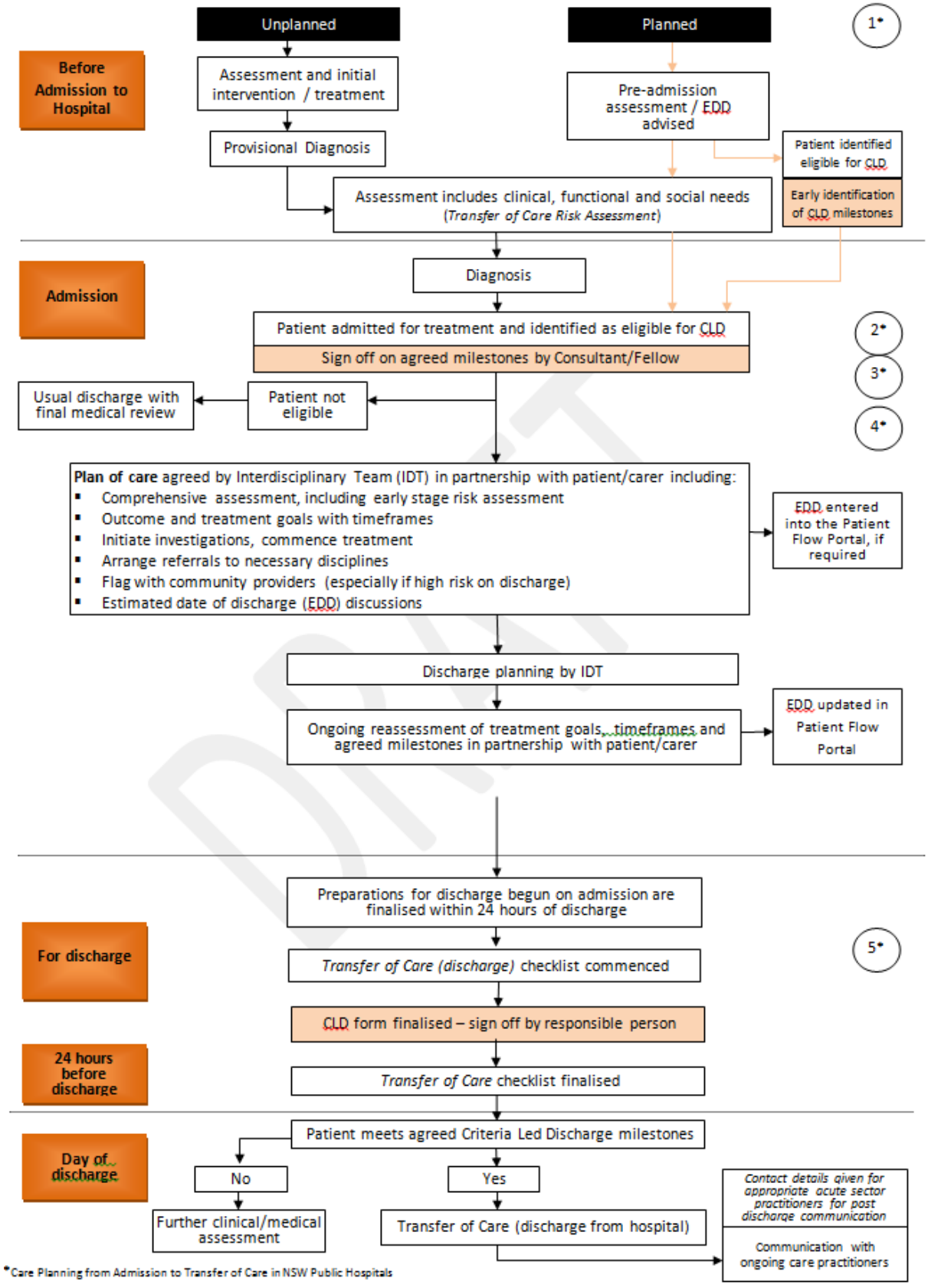
The steps to implementing CLD are*:

1. Analysis of data to determine issues in timely discharge
2. Executive level support
3. Senior medical buy-in and endorsement
4. Agree range of patient groups
5. Clarify roles and responsibilities for interdisciplinary team
6. Review systems, processes and establish an agreed target
7. Identify skills required
8. Adopt policy approach
9. Refine policy approach in response to
    - Feedback from patients and carers
    - Incident reports
    - Audit
10. Capture impact on
    - Patient experience
    - Patterns of admissions and discharges by time of day and week
    - Comparison with estimated date of discharge

*Adapted from *Achieving timely 'simple' discharge from hospital*

A checklist for teams involved in implementing CLD can be found at APPENDIX H.

APPENDIX A: A FRAMEWORK FOR CRITERIA LED DISCHARGE



APPENDIX B: FREQUENTLY ASKED QUESTIONS FOR IMPLEMENTING CLD

The optimal time for patient transfer of care (discharge) is when a patient is medically safe to go home. This is usually when both:

1. the ongoing medical care needs can be equally well provided at home, and
2. when the patient or their carer is confident in their abilities to provide this care.

What is Criteria Led Discharge?

Under Criteria Led Discharge (CLD) the decisions for discharge are made and documented by the senior medical clinician (e.g. Senior Consultant, Medical Fellow, Visiting Medical Officer).
For appropriate patients CLD competent staff (e.g. nursing) can then facilitate the discharge of a patient according to documented criteria. The CLD competent staff member is responsible for monitoring that the CLD criteria have been met.
Criteria Led Discharge is not:

- a substitute for clinical decision making. A patient should still be seen every day by the medical team.
- The nursing (or other staff) independently discharging patients. The CLD competent staff is monitoring that the patient has met the set criteria.

What is the process for Criteria Led Discharge?

The senior medical clinician identifies eligible patients on PART A of the CLD form and documents a set of criteria on PART B of the CLD form. Identification of patients may occur at any point following discussion between the health care team, led by the senior medical clinician. Other team members may add criteria to those set by the senior medical clinician (PART B).
The CLD competent staff member monitors that the patient has met all the criteria and completes PART C of the CLD form.

What is a Criteria Led Discharge competent staff member?

The local team will decide on a process for identifying CLD competent staff. The team should maintain a list of such staff; this list should be reviewed at least annually. Some teams identify this staff member with a badge.
A competency set has been developed to guide this process.

What is best practice for Criteria Led Discharge?

- A patient should be identified as eligible for CLD on admission, or as early as possible.
- The patient must be reviewed every day by the medical team and the set criteria should be updated, if required.
- The criteria and subsequent plan for discharge should be decided in partnership with the entire health care team, including the patient and/or their carer.
- The CLD competent staff member must monitor and record if the patient has met the criteria. **This does not substitute for clinical judgement** and if a patient does not meet the criteria a medical review is necessary.

What are the potential benefits of Criteria Led Discharge?

- **Improve patient experience:** patients are able to get home sooner
- **Enhance patient safety:** criteria led transfer of care (discharge) through a checklist
- **Improve staff satisfaction:** not pressured to transfer patients in the "last minute" or experience bed block on Monday due to transfers not occurring over the weekend.
- **Reduce unnecessary length of stay:** not being in hospital when patients can actually be transferred
- **Reduce bed days wasted:** elimination of unnecessary days in hospital
- **Minimise waste:** best use of time-poor consultants; reduction of costs as a result of eliminating unnecessary lengths of stay in hospital.

Where can I find more information on Criteria Led Discharge?

A set of resources is available at: www.aci.health.nsw.gov.au/cld, these include a/an:

- CLD form with guidance
- suggested transfer of care checklist
- protocol/policy for local adaptation
- competency set
- set of education/orientation slides
- implementation checklist

The ACI contact for CLD is Kate Lloyd, Manager, Acute Care (02 9464 4623 or kate.lloyd@aci.health.nsw.gov.au).
Your local contact for CLD is <insert contact>.

APPENDIX C: A TEMPLATE FOR CRITERIA LED DISCHARGE WITH GUIDANCE ON COMPLETION

BARCODE HERE

SMR000000

NSW GOVERNMENT

Facility:

CRITERIA LED DISCHARGE

MILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PART A: MEDICAL REVIEW (to be completed by Consultant or Medical Fellow)

Diagnosis: _____

Expected Date of Discharge (EDD) on admission

☐ I agree for this patient to be discharged once the milestones in part B and C are met.

☐ Please do not discharge until medical team review for the following reason (s): _____

Name: _____ Signature _____ Time/date: _____

PART B: Specific patient interdisciplinary team (IDT) discharge criteria (to be completed by IDT)

IDT agreed specific milestones	Name	Designation	Contact

Responsible person:	*CLD competent staff member*

PART C: PATIENT CRITERIA	**Y/N**	**Name**	**Signature**
All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient			
	If no, refer to senior medical clinician		
Transfer of care (discharge) checklist completed			

Reason patient not discharged using CLD protocol:

_____

I confirm that the criteria I parts B and C have been met and are achieved:

Name _____ Designation: _____

Signature: _____ Date/time: _____

Holes punched as per AS2828-1999

BINDING MARGIN - NO WRITING

XXXXXXX – 00/0000

CRITERIA LED DISCHARGE

FORM #

Guidance for Criteria Led Discharge for <insert team>

PART A: Documentation of suitability for criteria led discharge

Please ensure PART A of the Criteria Led Discharge form is filled in by <insert senior medical clinician role>.

Expected date of discharge needs to be completed.

PART A: MEDICAL REVIEW (to be completed by Consultant or Medical Fellow)	
GP name _____ GP phone _____ Diagnosis: _____	Expected Date of Discharge (EDD) 1. 2. 3. 4.

☐ I agree for this patient to be discharged once the milestones in part B and C are met.

☐ Please do not discharge until medical team review for the following reason (s): _____

_____

Name: _____ Signature _____ Time/date: _____

PART B: Discharge Criteria

The completion of Part B should be led by the <insert senior medical clinician role>. CLD can be discussed at a team meeting (e.g. rapid round) where nursing and allied health criteria can be added.

PART B: Specific patient interdisciplinary team (IDT) discharge criteria (to be completed by IDT)			
IDT agreed specific milestones	**Name**	**Designation**	**Contact**
Responsible person:			

<insert team> milestones to consider (these may come from an existing pathway):

- 1.
- 2.
- 3.

<insert team name> please ensure:

- <add specific instructions for team, e.g. Script for sublingual anginine is attended>

PART C: Patient Criteria

PART C: PATIENT CRITERIA	Y/N	Name	Signature
All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient			
	If no, refer to senior medical clinician		
Transfer of care (discharge) checklist completed			

Reason patient not discharged using CLD protocol:

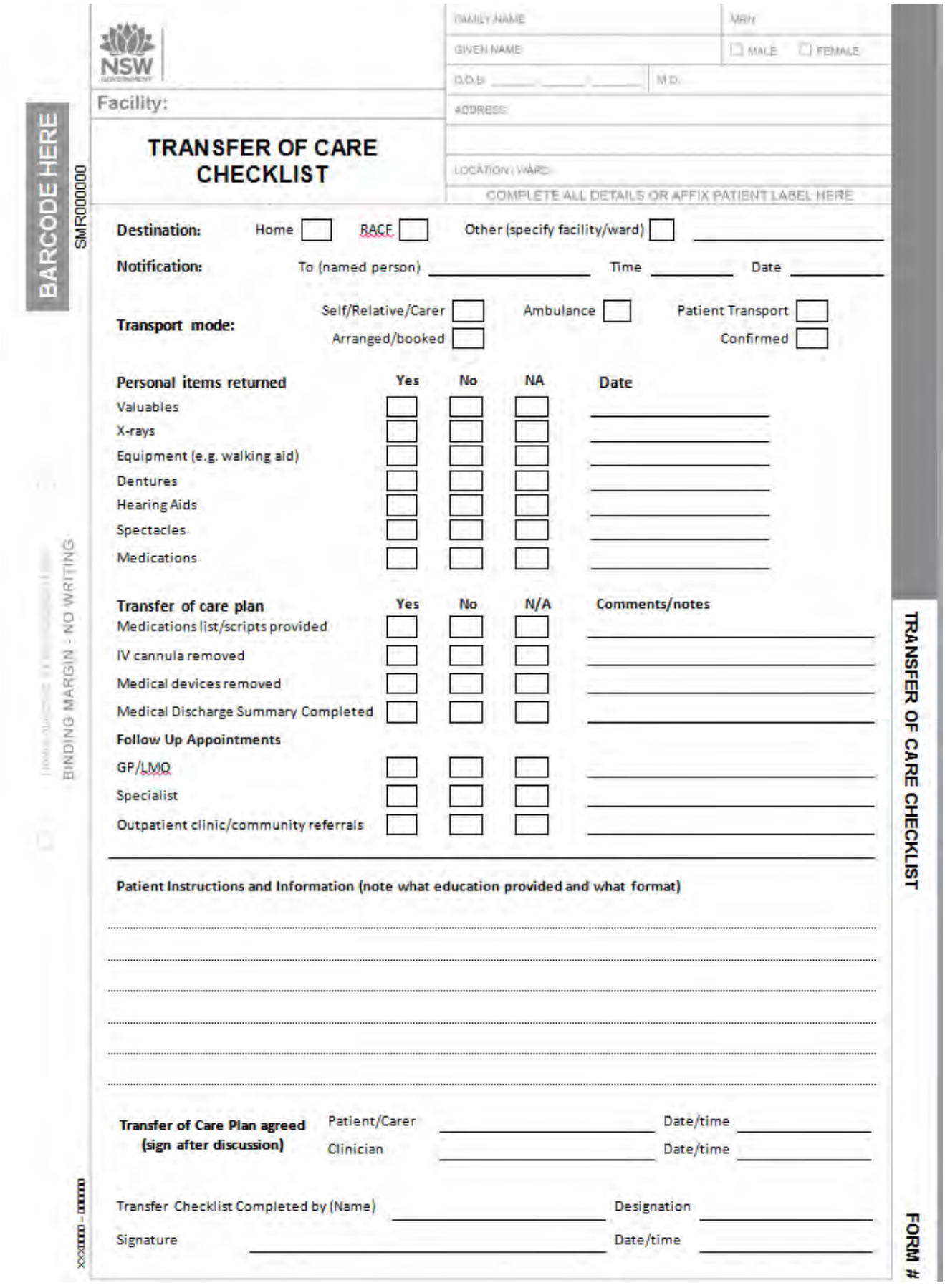
_____

I confirm that the criteria I parts B and C have been met and are achieved:

Name _____ Designation: _____

Signature: _____ Date/time: _____

APPENDIX D: TRANSFER OF CARE CHECKLIST



NSW GOVERNMENT

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B: ___/___/___ | M.D.

ADDRESS:

LOCATION / WARD:

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BARCODE HERE

SMR000000

TRANSFER OF CARE CHECKLIST

Destination: Home ☐ RACF ☐ Other (specify facility/ward) ☐ _____

Notification: To (named person) _____ Time _____ Date _____

Transport mode: Self/Relative/Carer ☐ Ambulance ☐ Patient Transport ☐
Arranged/booked ☐ Confirmed ☐

Personal items returned	Yes	No	NA	Date
Valuables	☐	☐	☐	_____
X-rays	☐	☐	☐	_____
Equipment (e.g. walking aid)	☐	☐	☐	_____
Dentures	☐	☐	☐	_____
Hearing Aids	☐	☐	☐	_____
Spectacles	☐	☐	☐	_____
Medications	☐	☐	☐	_____

Transfer of care plan	Yes	No	N/A	Comments/notes
Medications list/scripts provided	☐	☐	☐	_____
IV cannula removed	☐	☐	☐	_____
Medical devices removed	☐	☐	☐	_____
Medical Discharge Summary Completed	☐	☐	☐	_____
Follow Up Appointments				
GP/LMO	☐	☐	☐	_____
Specialist	☐	☐	☐	_____
Outpatient clinic/community referrals	☐	☐	☐	_____

Patient Instructions and Information (note what education provided and what format)

.....

.....

.....

.....

.....

.....

Transfer of Care Plan agreed (sign after discussion)
Patient/Carer _____ Date/time _____
Clinician _____ Date/time _____

Transfer Checklist Completed by (Name) _____ Designation _____
Signature _____ Date/time _____

BINDING MARGIN - NO WRITING

xxxxxx - xxxxx

TRANSFER OF CARE CHECKLIST

FORM #

APPENDIX E: PATIENT AND STAFF EXPERIENCE - PATIENT EXPERIENCE TRACKERS (PETS)

The Patient Experience Tracker (PET) is a small electronic hand held device that can be used to collect patient and/or staff feedback at the point of care (Figure 4). The device can have up to 5 customised questions with multiple choice answers. Patients and staff can respond to each question by the press of a button. It is fast and effective way to collect patient feedback and measure patient and staff experience. The de-identified data from the devices is collated every day and the reports are sent back via email to nominated staff overnight. The reports are presented in graphical form which is easy to interpret and provides information to act on in 'Real Time'. A weekly and monthly summary report is also available.

Figure 4: ACI Patient Experience Tracker

The CLD working group has devised a set of patient (Table 3) and staff (Table 4) experience questions to be used to measure improvements to documenting the clinical management plan.

Table 3 Clinical Management Plan Patient Experience Questions

No.	Question	Circle the most appropriate answer
1	I know the date I am expected to be discharged from hospital	Yes Unsure No
2	I am aware of what needs to happen before I am discharged from hospital	Yes Unsure No
3	I know who to ask if I have questions about my plan of care	Always Mostly Sometimes Rarely Never
4	I receive daily updates about my plan of care	
5	I am involved in the development of my discharge plan	

Table 4 Clinical Management Plan Staff Experience Questions

No.	Question	Circle the most appropriate answer
1	I understand what is involved with criteria led discharge	Yes Unsure No
2	I involve the patient/family in developing a management plan	Always Mostly Sometimes Rarely Never
3	Our team updates a patient's estimated date of discharge on admission and throughout the hospital stay	
4	I know who to contact if I have concerns regarding a patient's discharge plan	
5	Our team uses a transfer of care checklist when planning for a patients discharge	

APPENDIX F: DRAFT PROTOCOL/POLICY FOR LOCAL ADAPTATION

Local Protocol v2

Criteria Led Discharge – ACI Trial			
Category : Clinical or Corporate	**Version Number** Local Protocol is to be versioned and maintained by the site/facility . **Relates to Policy (NSW MoH or SNSWLHD Policy)** Insert Policy name and version number	**Effective Date** XXXX To be allocated by nominated position at site/facility/service upon endorsement	**Review Date** XXXX To be reviewed in 5 years or earlier as required or on receipt of RCA recommendations. To be allocated by nominated position at site/facility/service upon endorsement

Aim
An interdisciplinary team (IDT) decision making approach is utilised in deciding when a patient is fit for discharge.

Discharge delays are avoided by a competent <insert staff level> authorising discharge based on criteria set by the interdisciplinary team.

Indications
The optimal time for discharge is when the patient is medically ready to go home and carers are confident in the ability to care for the patient at home.

Criteria
<insert local criteria e.g. DRG specific, consultant specific>

Contraindications
Those patients not meeting above criteria.

Alerts/Risks
Nil

Scope
<insert local scope>

- VMO/Staff Specialists
- <specialty> Registrars
- Nurse Managers
- <ward> NUM
- <ward/specialty> CNE
- <ward/specialty> CNS

Local Protocol
A. Equipment & materials

- Template for Criteria Led Discharge
- <transfer of care checklist/discharge planning form>

B. Staff Education
- CLD Process
- On Orientation
- Nurse competency assessment must be completed prior to conducting CLD

C. Patient education
- To participate in decision making regarding discharge criteria during IDT rounds
- To be informed at pre-admission clinic of possibility of CLD

D. Sequence of actions

<local adaptation of 12 steps below>

1. IDT reviews patient and identifies eligibility for CLD during rapid/interdisciplinary rounds. The selection of patients must involve a discussion with the treating medical team.

2. A patient must be deemed eligible as early as possible in the admission.

3. Senior medical officer (VMO or Fellow) signs off eligibility for CLD on CLD form and assigns delegation for discharge to identified staff member (senior nurse).

4. IDT agrees on criteria for discharge; these may be a mix of medical, nursing, allied health and social criteria/milestones for the patient to meet/achieve. Criteria/milestones are clearly documented on the CLD form in front of the patient record and linked to the inpatient management plan to ensure smooth transfer of care.

5. As part of this process the IDT agree on estimated date of discharge (EDD) and document this in the CLD form. This can always be reviewed daily.

6. The medical staff will discuss the criteria led discharge process with the patient/families including the IDT and patient/family expectations for discharge.

7. The criteria for discharge will be monitored by the nurse caring for the patient and once all criteria are met, the patient is reviewed by a nurse who has completed the relevant competency or a member of the medical staff.

8. The medical staff must ensure a discharge summary is completed and scripts available the day before discharge.

9. All patients on CLD must have been reviewed within 24 hours prior to discharge.

10. A full set of observations must be performed and recorded within one hour of discharge. In addition, any nursing observations that have been regularly recorded during the previous 48 hours should also be performed.

11. If the CLD competent nurse is satisfied the observations are within normal limits for the patient, and the patient has met the criteria for discharge, **they may be discharged.**

12. Patient eligible for CLD should ideally targeted to be discharged by 10am which will therefore require engagement by previous evening and night duty nursing staff

Documentation

- EDD and CLD are clearly labelled on patient journey board.
- Parts A, B and C must be completed on the Criteria Led Discharge Form.
- A clear clinical management plan is still required in the patient medical record.
- The CLD form may be used in conjunction with the <e.g. clinical pathways, nursing care maps>.
- <decision on how to track patients who have been involved> e.g. The CLD forms will be collected on the ward and maintained in a folder for purposes of trial evaluation. The CLD forms will remain on the medical record and a book will be kept at the nurse station to track patients who have been discharge using CLD.

Standards

NSQHS Standard 1 – Governance for Safety and Quality in Health Service Organisations
NSQHS Standard 2 – Partnering with Consumers

Safety Considerations

Manual Handling	Hand Hygiene	Spill Hazard	Sharp Hazard
Clinical Competency	Patient Education	Radiation Hazard	Cytotoxic Therapy
Standard Precautions	Electrical Safety		

Responsibilities

- **General Manager/ DoNM**
  Executive and authorising sponsor of the project trial

- **Lead Medical Consultant**
  1. Ensure all <insert ward> medical staff are aware and understand the CLD project and their expectations

- **Nurse Manager**
  2. Ensure all <insert ward> nursing staff are aware and understand the CLD project and their expectations
  3. Ensure NUM, CNE and CNS are deemed competent in CLD

4. Ensure CLD procedure is adhered to

- **NUM / CNE/CNS**
    1. Undertake clinical competency in CLD
    2. Engage all disciplines in CLD during interdisciplinary rounds

- **Staff**
    1. Ensure a basic understanding of CLD and willingly engage and participate in trial

Appendices

1. CLD Form
2. <other forms to be used> e.g. Transfer of Care/Discharge Checklist

Approved by

Title	Name	Signature	Date

Position Responsible for Adherence & Implementation

<Role responsible for ensuring the protocol is implemented and adhered to>

Outcome Measures

Reasonable and achievable

Where appropriate and integral to the implementation of the protocol, an outcome measure will be stated. This could be a measurement process (i.e. compliance) or a measured outcome (i.e. patient outcomes). Where possible, link to existing systems for measuring quality of practice.

Pre and post Patient and Staff Experience collected using Patient Experience Trackers (PETs)

Other data to consider:

- Discharge by Day of Week
- Discharge by Hour of Day
- Ward Length of Stay
- Ward Mortality
- Ward Traffic (Ward discharges in period of time)
- Surgery cancellations
- Re-admission within 28 Days/ Unplanned Readmissions
- MET Calls (Between the Flags)
- Falls
- Pressure Ulcers
- Medication Prescription Errors
- EDD: Estimated Date of Discharge
- EEDD: Expired Estimated Date of Discharge
- Patient Experience (PET)
- Staff Experience (PET)

CLD form Audit

- Utilisation and documentation

- % of completed forms
- % of patients discharged
- % patients not discharged on CLD
- % completed transfer of care checklists
- Comparison with EDD
- Patient discharged with documentation
- Transfer of care checklist used

Terminology
Ex: National Safety and Quality Health Service Standards (NS & QHSS) Please list and describe key words.

Consultation Process / List

Title / Position	Title/Position Responded
GM	
DMS	
VMO	
Fellow	
Patient Flow Project Manager	
Nurse Manager	
NUM	
CNE	
CNS	

Created by
<insert local name?

Acknowledgements
Children's Hospital at Westmead
Nepean Hospital
Director of Nursing and Midwidfery, Bega Valley Health Service, Southern NSW LHD
Patient Flow Project Manager, Bega Valley Health Service
Bega Hospital – Surgical Ward
ACI Manager, Acute Care
Acute Care Taskforce – Improving the Medical Inpatient Journey

Bibliography
To be added

References

APPENDIX G: A Competency Statement for Criteria Led Discharge

The health professional safely and effectively discharges a patient applying a criteria led discharge process.

Competency	CLD 1	CLD 2	CLD 3
Locate and read Criteria Led Discharge protocol			
Discuss the benefits of criteria led discharge			
a. For the patient, their carer and/or family			
b. For the organisation			
Discuss the expectations of the health professional within the criteria led discharge process			
Discuss the required authorisation from medical staff for criteria led discharge to occur and identify where this particular information is documented			
Discuss the medical review requirements for a patient who will have a criteria led discharge			
Demonstrate discussion with the patient, their carer and/or family explaining the criteria led discharge process			
Highlight some of the issues that may need addressing when discharging a patient via criteria led discharge			
Discuss the discharge follow up required and how this is arranged			

I, the undersigned, have demonstrated the necessary knowledge, skills, attitudes, values and/or abilities to be deemed competent in criteria led discharge. I acknowledge that ongoing development and maintenance of competency is my responsibility and will be evidenced in my Professional Practice Portfolio

Health professional

Name _____ Signature _____

Role _____ Date _____

I, the undersigned, have observed the necessary knowledge, skills, attitudes, values and/or abilities for <insert name> to be deemed competent in criteria led discharge.

Assessor

Name _____ Signature _____

Role _____ Date _____

APPENDIX H: A Checklist for Implementing Criteria Led Discharge

Area	Ref	Task	Owner	Timeframe	Status
Governance	1.1	Identify executive lead			
Governance	1.2	Identify clinical lead (s): minimum both medical and nursing			
Governance	1.3	Identify implementation lead			
Governance	1.4	Define, document and agree roles and responsibilities for the clinical leads			
Governance	1.5	Define, document and agree roles and responsibilities for the implementation officer			
Governance	1.6	Finalise local implementation team • Terms of Reference • Regular meeting dates are established			
Governance	1.7	Risk assessment • Identify and manage local implementation risk and issue resolution process • Involve managers and clinicians (unit specific) • Identify any potential barriers and solutions to patient flow			
Governance	1.8	Define and measure implementation and outcome measures (see data set) • What local outcomes will be measured? • At what points of the implementation will you measure outcomes? • How will you track and report the outcomes?			
Operating Design	2.1	Define local protocol (draft available from ACI)			
Operating Design	2.2	Determine changes to local operating models, procedures and clinical guidelines e.g. adapting existing protocols			
Operating Design	2.3	Configure rosters (if required) to accommodate changes brought about by the revised operating model			

Area	Ref	Task	Owner	Timeframe	Status
Operating Design	2.4	Steering Committee sign-off			
Awareness/Training	3.1	Communication plan/ Communication strategy to report achievements			
Awareness/Training	3.2	Create awareness of the Criteria Led Discharge, impact on existing business processes and 'go-live' dates for hospital management			
Awareness/Training	3.3	Schedule orientation and training sessions for identified clinicians			
Awareness/Training	3.4	Ensure patient flow managers are involved in this process			
Data/Evaluation	4.1	Define roles and responsibilities for • IT • Data and planning team			
Data/Evaluation	4.2	**Data set** • Patient and carer experience with patient story gathering • Patterns of admissions and discharges by time of day and week • Compliance with clinician defined estimated date of discharge • Mortality data • Ward data (length of stay, traffic) • Readmission rate • Audit of CLD form o Utilisation and documentation o % of completed forms o % of patients discharged o % patients not discharged on CLD o % completed transfer of care checklists o Comparison with EDD			

LOCAL LHD LOGO

Criteria Led Discharge

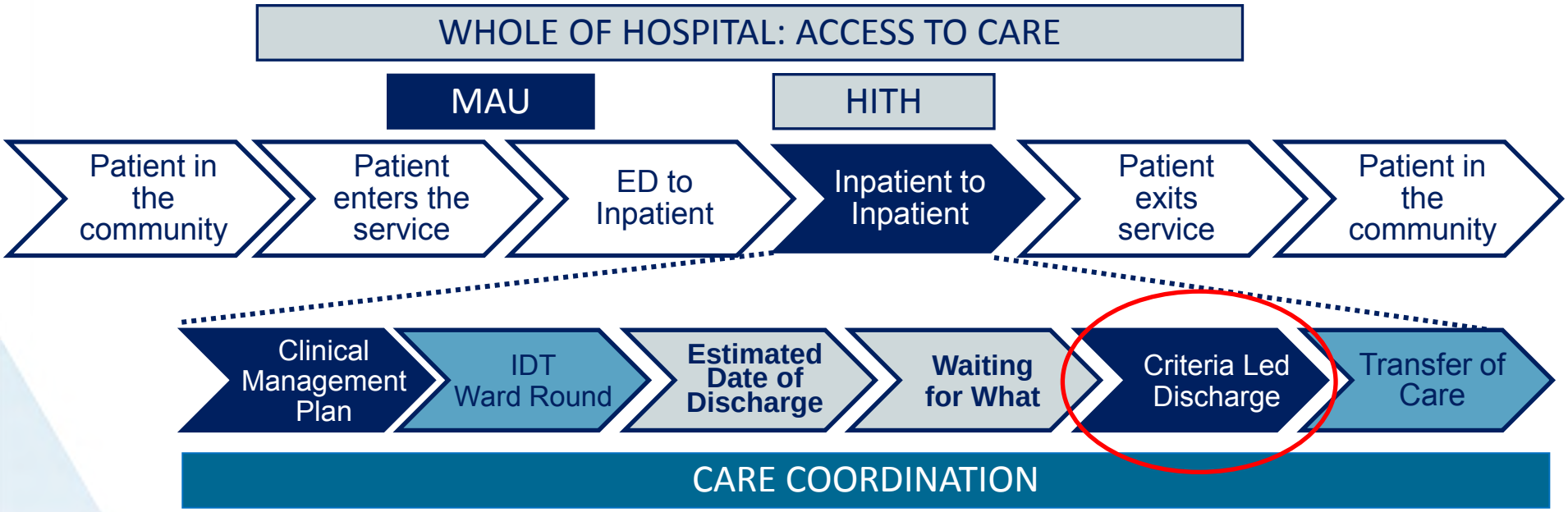
Kate Lloyd
Manager, Acute Care
Agency for Clinical Innovation
Tel 02 9464 4623 | Mob 0467 603 578
kate.lloyd@aci.health.nsw.gov.au

Name
Role
XX LHD
Tel | Mob
email

Overview

- Improving the medical inpatient journey
- Goals of CLD
- CLD form – PART A, B and C
- Protocol
- Competency set
- Implementation team
- Acknowledgments

Improving the Medical Inpatient Journey



Leads: ACI | MOH

Educational materials on 'smooth patient flow' across the patient journey are being developed by: HETI

LHDs | CEC

Key

ACI=NSW Agency for Clinical innovation
CEC=NSW Clinical Excellence Commission
HETI=NSW Health Education and Training Institute
LHDs=NSW Local Health Districts and Speciality Networks
MOH=NSW Ministry of Health
IDT=Interdisciplinary
HITH=Hospital in the Home
MAU=Medical Assessment Unit

LOCAL LHD LOGO

Goals of CLD

- Improve
  - Patient experience
  - Staff experience
  - Patient safety
  - Discharge processes
- Reduce
  - Length of stay / waste
  - Surgery cancellations

CLD Form – PART A

PART A: MEDICAL REVIEW (to be completed by Consultant or Medical Fellow)

Diagnosis: _____

Expected Date of Discharge (EDD) on admission

_____

_____

☐ I agree for this patient to be discharged once the milestones in part B and C are met.

☐ Please do not discharge until medical team review for the following reason (s): _____

_____

Name: _____ Signature _____ Time/date: _____

Senior medical clinician signs of patient as eligible

LOCAL LHD LOGO

CLD Form – PART B

Interdisciplinary team document criteria for patient to meet – **led by Senior Medical Clinician**

PART B: Specific patient interdisciplinary team (IDT) discharge criteria (to be completed by IDT)			
IDT agreed specific milestones	**Name**	**Designation**	**Contact**
Responsible person:	*CLD competent staff member*		

Local protocol identifies which staff are eligible. This is clearly documented on the ward. Individual staff may wear badge to denote they are CLD competent.

LOCAL LHD LOGO

CLD Form – PART C

PART C: PATIENT CRITERIA	Y/N	Name	Signature
All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient			
	If no, refer to senior medical clinician		
Transfer of care (discharge) checklist completed			

Reason patient not discharged using CLD protocol:

I confirm that the criteria I parts B and C have been met and are achieved:

Name _____ Designation: _____

Signature: _____ Date/time: _____

CLD competent staff member monitors milestones have been met in PART B and signs of patient in PART C

LOCAL LHD LOGO

Protocol

- Aim
- Scope
- Responsibilities
- Locally defined protocol

INSERT LHD LOGO

Local Protocol v2

Criteria Led Discharge – ACI Trial			
Category Clinical or Corporate	**Version Number** Local Protocol is to be versioned and maintained by the site/facility **Relates to Policy (NSW MoH or SNSWLHD Policy)** Insert Policy name and version number	**Effective Date** XXXX To be allocated by nominated position at site/facility/service upon endorsement	**Review Date** XXXX To be reviewed in 5 years or earlier as required or on receipt of RCA recommendations. To be allocated by nominated position at site/facility/service upon endorsement

Aim
An interdisciplinary team (IDT) decision making approach is utilised in deciding when a patient is fit for discharge.

Discharge delays are avoided by a competent <insert staff level> authorising discharge based on criteria set by the interdisciplinary team.

Indications
The optimal time for discharge is when the patient is medically ready to go home and carers are confident in the ability to care for the patient at home.

Criteria
<insert local criteria e.g. DRG specific, consultant specific>

Contraindications
Those patients not meeting above criteria.

Alerts/Risks
Nil

Scope
<insert local scope>
- VMO/Staff Specialists
- <specialty> Registrars
- Nurse Managers
- <ward> NUM
- <ward/specialty> CNE
- <ward/specialty> CNS

Local Protocol
A. Equipment & materials

- Template for Criteria Led Discharge
- <transfer of care checklist/discharge planning form>

Competency set

Competency
1. Locate and read Criteria Led Discharge protocol
2. Discuss the benefits of criteria led discharge a. For the patient, their carer and/or family / b. For the organisation
3. Discuss the expectations of the health professional within the criteria led discharge process
4. Discuss the required authorisation from medical staff for criteria led discharge to occur and identify where this particular information is documented
5. Discuss the medical review requirements for a patient who will have a criteria led discharge
6. Demonstrate discussion with the patient, their carer and/or family explaining the criteria led discharge process
7. Highlight some of the issues that may need addressing when discharging a patient via criteria led discharge
8. Discuss the discharge follow up required and how this is arranged

Implementation Team

XX

XX

XX

Kate Lloyd – Manager Acute Care (ACI) 9464 4623, kate.lloyd@aci.health.nsw.gov.au

Add names and contacts for Local implementation team +/- ACI staff

Acknowledgements

- ACI Acute Care Taskforce
- ACI Criteria Led Discharge Working Group
- Bega Hospital (Surgical Ward)
- Calvary Mater Hospital (Haematology Unit)
- Wollongong Hospital (Cardiology Step Down Unit, Neurology Ward)
- Auckland District Health Board
- Queensland Health
- Children's Hospital Westmead, NSW
- Royal Children's Hospital Melbourne, VIC
- Department of Health / NHS, UK