Guideline for Nurse/Midwife Facilitated Discharge Planning

June 2009

Changing practice to support service delivery

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the
Nursing Services Director

Developed by:

Dr. Mary Boyd, Director of Nursing, Cork University Hospital.

Mr. Eddie Byrne, Director of Nursing, Cavan and Monaghan Hospital Group.

Ms. Ann Donovan, Director of Nursing, Adelaide & Meath Hospital Dublin incorporating the National Children's Hospital.

Ms. Joan Gallagher, Professional Development Officer, Nursing and Midwifery Planning and Development Unit, HSE South.

Ms. Joan Phelan, Area Director, Nursing and Midwifery Planning and Development, HSE South and Chair of the Guideline Development Group.

Ms. Anne Keating, Bed Manager, Cork University Hospital.

Ms. Virginia Pye, Director of Public Health Nursing, Longford Westmeath Local Health Office.

In consultation with the HSE National Integrated Discharge Planning Steering Committee.

Feedback received from:

Members of the HSE National Integrated Discharge Planning Steering Committee

Directors of Nursing, Dublin Academic Teaching Hospitals

Nurse and Midwife Focus Group Participants (x7 sites nationally)

Irish Hospital Consultant Association

Irish Nurses Organisation

A&E Forum

Irish Patients Association

Approved by:

Name Title Date:

_____ ___*08/06/2009*__

Dr. Siobhán O'Halloran, Nursing Services Director, HSE.

_____ ___*08/06/2009*__

Mr. John O'Brien Chair, National Integrated Discharge Planning Steering Committee.

This document must be read and used in conjunction with:

Health Service Executive (2008) Code of Practice for Integrated Discharge Planning. Health Service Executive.

Health Service Executive (2007) National Hospital Office Code of Practice for Healthcare Records Management. Health Service Executive.

An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework. An Bord Altranais, Dublin.

An Bord Altranais (2000) Code of Professional Conduct. An Bord Altranais, Dublin.

An Bord Altranais (2001) Guidelines for Midwives. 3rd Edition. An Bord Altranais, Dublin.

An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais, Dublin

Any other locally approved guidelines relating to integrated discharge planning.

Guideline for Nurse/Midwife Facilitated Discharge Planning

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Abbreviations

A&E	Accident and Emergency
ABA	An Bord Altranais – *Irish Nursing Board*.
CAP	Community Assessment Process
CEO	Chief Executive Officer
CSAR	Community Summary Assessment Record
ELOS	Estimated Length of Stay
GP	General Practitioner
HSE	Health Service Executive
IDP	Integrated Discharge Planning
JIG	Joint Implementation Group – *role defined on p10 of the guideline.*
NHO	National Hospital Office
ONSD	The Office of the Nursing Services Director in the HSE
PCCC	Primary Community and Continuing Care
PHN	Public Health Nurse

1. Introduction

Integrated discharge planning (IDP), as a process, commences prior to admission for a planned admission and on admission for all other patients. Nurses and midwives collectively provide care to patients on a 24 hour 7 day basis and are key in facilitating effective discharge planning. In supporting the implementation of the HSE Code of Practice for Integrated Discharge Planning (2008) this guideline outlines core elements for nurse/midwife facilitated discharge planning. The decision to admit and discharge remains the responsibility of the patient's consultant/medical team. The guideline is intended to support and formalise existing discharge planning practice while providing a template for local guidelines. Local policies and guidelines relating to nurse/midwife facilitated discharge planning will be approved by the Joint Implementation Group (JIG) and should reflect the core elements of this guideline.

Implementation of the HSE Code of Practice for Integrated Discharge Planning (2008) is overseen locally by the JIG. As a controlled document the HSE Code of Practice for Integrated Discharge Planning (2008) may be subject to change at any time. Elements relating to nurse/midwife facilitated discharge planning within the Code will be revised in line with the content of this guideline.

Nurses and midwives engage in the discharge planning process at three levels:

1. Discharge planning is an element of the domains of competency in the undergraduate nursing curriculum and nurses and midwives continue to develop this competency in daily practice. The nurse/midwife role in the discharge planning process includes:
    - collaborative input into determining the patient's estimated length of stay (ELOS);
    - collaborative input to the discharge plan;
    - tracking the progress of the discharge plan against the ELOS;
    - inclusion of progress of the discharge plan at each handover;
    - completion of relevant discharge documentation.
2. Criterion based patient discharge refers to patient discharge by a nurse or midwife when specific clinical criteria have been achieved e.g. no raised temperature for 24 hours, wound healed, mobilising safely or no evidence of respiratory distress. The consultant/medical team will have documented discharge criteria or targets in the patient's healthcare record. The patient's consultant/medical team agree that the patient is fit for discharge once the patient has achieved these discharge criteria. Criterion based patient discharge by a nurse or

midwife must be supported by local guidelines agreed with the medical team and specific to the specialist area of practice.

3. Nurse/Midwife led discharge – The nurse/midwife has the authority and responsibility to agree an expected date of discharge and to state the patient is clinically fit for discharge. Collaboratively agreed protocols and guidelines between the nurse/midwife, the consultant and other members of the multidisciplinary team are required to govern discharge practices. The nurse/midwife will have completed further education and competency development in the area of assessment, diagnosis and discharge of patients/clients.

This guideline primarily relates to nurse/midwife involvement in the discharge planning process at level 1 and level 2 described above.

An integrated discharge planning e-learning programme will be available online from the HSE Learning and Development website www.hseland.ie. It is recommended that all nurses and midwives complete this programme.

2. Rationale

Multidisciplinary and multi-agency working is essential in achieving integrated discharge planning. The Code of Practice for Integrated Discharge Planning (HSE 2008) requires that "*a staff member should be identified as responsible for ensuring all aspects of integrated discharge planning have been addressed by the time of discharge* (p11). The patient's medical consultant is the person who decides to admit and discharge a patient and the nurse/midwife is involved in the planning and management of the discharge process. Feedback during the guideline development consultation process confirmed that discharge planning is a core responsibility of the nurse/midwife.

The benefits of integrated discharge planning in supporting optimal patient care are well documented. These include:

1. seamless transition from one stage of care to the next (Hill and Macgregor 2001, NSW Department of Health 2006, Kripalani et al. 2007);
2. increased satisfaction with healthcare services (Preen et al 2005, Hill and Macgregor 2001);
3. reduced length of stay (Stewart 2000, Blue et al. 2001, Koelling et al. 2005, Tarling and Jaffeur 2006);
4. prevention of unplanned admissions (Anthony and Hudson-Barr 1998, Stewart 2000, Holzhausen, 2001).

3. Purpose

This guideline aims to:

3.1 Provide clear, evidence based guidance to nurses and midwives on the provision of safe and effective nurse/midwife facilitated discharge planning of patients**.**

4. Scope

The scope of this guideline applies to:

4.1 All registered nurses and midwives working in the HSE and in any facility providing services on behalf of the HSE.

4.2 People affected by the guidelines are patients, the public and employees of the HSE.

5. Definitions

5.1 Integrated Discharge Planning is a process that encompasses the key elements of discharge: written discharge information, provision of a discharge plan and an estimated length of stay (ELOS). Integrated discharge planning includes the patient and as appropriate, the family/carer in the development and implementation of the patient's discharge plan and ensures that steps are taken to address necessary linkages with other healthcare providers in order to achieve a seamless transition from one stage of care to the next, in accordance with patient need.

5.2 Nurse/Midwife Facilitated Discharge Planning refers to the nurse/midwife's role in the discharge planning process, where the nurse/midwife, assigned to the care of the patient, sources and co-ordinates patient information and links with families, carers, primary care teams, community care teams and voluntary agencies where appropriate (HSE 2008 p54). In consultation with the relevant multidisciplinary team members the nurse/midwife completes a discharge plan and implements the plan to facilitate the transfer/discharge of the patient from the hospital setting to an appropriate community setting. Nurses/Midwives should only discharge/transfer patients from the hospital to another setting where it is has been documented that the patient is deemed clinically fit for discharge/transfer by the patient's medical Consultant/team.

5.3 Nurse/Midwife Criterion Based Patient Discharge refers to patient discharge by a nurse or midwife when specific, collaboratively agreed clinical criteria have been achieved e.g. no

raised temperature for 24 hours, wound healed, mobilising safely or no evidence of respiratory distress. The consultant/medical team will have documented the discharge criteria or targets in the patient's healthcare record indicating that the patient is fit for discharge once these criteria have been achieved. Criterion based patient discharge by a nurse or midwife must be supported by local guidelines agreed with the medical team and specific to the clinical area of practice.

5.4 Estimated Length of Stay (ELOS) is based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge. This is seen as a dynamic process subject to ongoing review (HSE 2008 p58). In line with the HSE Code of Practice for Integrated Discharge Planning, the ELOS should be identified during pre-assessment or on the post-take ward round and documented within 24 hours of admission to hospital.

5.5 Fit for discharge is when the patient is deemed as clinically fit to leave the hospital setting or requires no further medical review prior to discharge/transfer. In the unlikely event of an unavoidable delay in discharge, this allows for repeat patient reviews.

5.6 Facilitate is to 'make easy, help or expedite' (Collins English Dictionary).

5.7 Discharge is the decision made by the patient's consultant/medical team when the patient is deemed fit to leave the hospital/healthcare facility. It also refers to the event of the patient leaving the hospital/healthcare facility.

5.8 Discharge Plan refers to the documentation in the patient's healthcare record that demonstrates the key tasks from patient assessment to discharge. Services may have already included a discharge plan in the patient's healthcare records. The documentation recommended in the HSE Code of Practice for Integrated Discharge Planning and in the appendices of this guideline are elements of a discharge plan and may be incorporated into local care planning documentation as required.

6. Roles and Responsibilities

6.1 The Nurse/Midwife is responsible for maintaining his/her ability to assess and make critical decisions regarding patient discharge planning which is a generic competency and core clinical responsibility of all registered nurses/midwives (ABA 2005, HSE 2007). Nurses/Midwives must at all times practice within their scope of practice. Key responsibilities of the nurse/midwife include: keeping up to date with the patient's discharge plan; contributing to the determination of

the patient's ELOS; tracking progress against the ELOS; communicating progress at each handover; checking completion of relevant discharge documentation including the discharge checklist (Appendix 2) and engaging in continuing professional development to maintain competence necessary for professional practice.

6.2 Line Manager - The line manager or a designate is responsible for assigning the registered nurse/midwife to patient care and thus to undertake nurse/midwife facilitated discharge planning at ward/department level.

6.3 Multidisciplinary Team – each member of the multidisciplinary team is responsible for the implementation of the national HSE Code of Practice for Integrated Discharge Planning. Effective multi-agency and multidisciplinary working is essential to effectively manage the patient's discharge from hospital.

6.4 The Director of Nursing/Midwifery is responsible for facilitating all identified requirements to support integrated discharge planning within the nursing and midwifery portfolio and in their role as a member of the local Joint Implementation Group.

6.5 The Chief Executive Officer (CEO)/**Manager** (i.e. hospital CEO/manager or local health office manager) through the senior management team is responsible for ensuring that there are effective local arrangements for integrated discharge planning (HSE Code of Practice for Integrated Discharge Planning (2008 Part 2 –Standards)) in their area of responsibility.

6.6. The Medical Consultant is responsible for the decision to admit or discharge a patient. The Consultant or designated member of his/her medical team, should document in the patients healthcare record when they are satisfied that patient discharge can occur i.e. the patient is fit for transfer/discharge.

6.7 Joint Implementation Group (JIG) is an essential component of the implementation of the HSE (2008) Code of Practice on Integrated Discharge Planning. The JIG includes local staff from the National Hospital Office (NHO) and Primary Community and Continuing Care (PCCC) who collaboratively oversee and monitor the effective implementation of the HSE Code of Practice.

7. Nurse/Midwife Facilitated Discharge Planning (Level 1) Guidance

Integrated discharge planning (IDP) starts prior to admission for a planned admission and on admission for all other patients.

7.1 Where pre-assessment occurs, the estimated length of stay (ELOS) should be agreed at this stage.

7.2 Within one hour of admission to the ward a nurse/midwife will be assigned to the care of the patient to include patient discharge planning.

7.3 Within twenty four hours of admission, the consultant/medical team, in conjunction with the multidisciplinary team and assigned nurse/midwife will identify and document the patient's estimated length of stay (ELOS).

7.4 As part of the routine nurse/midwife admission of the patient to the ward/department, the nurse/midwife will identify and record factors that may affect the patient's ELOS, discharge and any known issues that may require referral to other members of the multidisciplinary team.

7.5 The nurse/midwife may, as agreed with the patient's consultant/medical team, inform the patient and family/carer of the estimated length of stay (ELOS).

7.6 The nurse/midwife will inform, as appropriate and in line with local communication practices and eligibility criteria, the relevant community services/Liaison Pubic Health Nurse (PHN) (where present) of the patient's admission to hospital and the patient's ELOS.

7.7 If the ELOS is not set and documented in the patient's healthcare record within 24 hours, reasons for this should be documented in the patient's healthcare record.

7.8 In the management of the patient pathway against the ELOS, it is important that all patient tests that are ordered are carried out in a timely fashion and that the test results have been obtained. If this does not occur, the medical team will be informed by the nurse/midwife. It is the responsibility of the medical team that results are sourced and acted on appropriately. Processes to support this include structured ward rounds and utilisation of a discharge tracking form (Appendix 3).

7.9 On the day before discharge, the nurse/midwife will check that all aspects of the discharge checklist have been completed (Appendix 2). This checklist is a guide for nurses and midwives and may be enhanced locally by the documentation subgroup of the local JIG. This document may also be amended for use as a discharge tracking form.

7.10 The relevant family/carers, GP, PHN, members of the multidisciplinary team, Liaison PHN and other primary community and continuing care (PCCC) service providers will be contacted by the nurse/midwife in line with the patient's eligibility. This should occur as soon as possible and at least two days prior to patient discharge (for patients who are in-patients for five days or longer) to confirm that the patient is being discharged and to ensure that relevant services are activated or re-activated where required.

7.11 As part of the discharge plan, the nurse/midwife should ensure that the common assessment process (CAP) and common summary assessment record (CSAR) are completed for eligible patients who will require access to long term residential care (HSE 2008).

7.12 The information and education provided to the patient and the family/carer should be provided in the appropriate language. This information should include a copy of the relevant discharge/transfer documentation as agreed by the local JIG (see Appendix 4 for a sample discharge/transfer document) and any other requirements, e.g. medication prescription, information on medication, the use of aids and equipment, CAP or CSAR documents and relevant follow-up appointments.

7.13 On the day of discharge, the nurse/midwife will confirm with PCCC services/Liaison PHN, where appropriate that the patient has left the hospital and that the required service provision needs to commence. The format of this communication should be agreed locally. This is documented in the discharge plan section on the transfer/discharge communication record.

7.14 If the patient is transferred to another ward or healthcare facility, the nurse/midwife who is facilitating discharge planning for the patient will provide a formal transfer of responsibility to the nurse/midwife who is facilitating discharge planning in that ward or healthcare facility.

7.15 At all stages during the inpatient period, the progress of the discharge plan will be communicated at handover. It is the responsibility of each nurse/midwife on any specific inpatient day to be fully aware of the progress of the discharge plan of patients in their direct care. The discharge checklist or key tasks of a standard discharge in the HSE Code of Practice for Integrated Discharge Planning can be used as a guide or as a tracking form for this purpose. It is in the remit of the local JIG documentation subgroup to adopt and amend if necessary, the templates provided by the HSE Code of Practice.

7.16 The discharge plan will track and indicate all stages and progress in relation to a patient discharge. The ELOS is an integral part of the patient's treatment and care plan and will be

actively managed. Progress of the discharge plan will be discussed with the multidisciplinary team and PCCC services where required/appropriate.

7.17 The nurse/midwife should ensure that decisions for discharge planning take cognisance of patient choice and involvement/participation.

7.18 The guideline acknowledges that pre-admission is a crucial part of the integrated discharge planning process and recommends the nurse/midwife refers to local service guidelines for this aspect of care, as well as the tasks on pre-admission in the HSE Code of Practice for Integrated Discharge Planning.

7.19 The guideline acknowledges the availability of different patient information resources (such as the leaflet in Appendix 5) specific to the different organisation and /or conditions. All patient/carer information, either written or verbal, should be timely, repeated and checked with the patient and family/carers, where relevant to ensure they understand the information. The needs of patients with poor vision, cognitive deficits, cultural and language barriers should be considered. Where deficits in communication and information provision exist within an organisation/service, development of appropriate communication systems/documents should be addressed through the local JIG, in consultation with the relevant service and patient representative/advocate.

8. Nurse/Midwife Criterion Based Patient Discharge (Level 2) Guidance

8.1 The guideline supports the local development of criterion based patient discharge guidelines whereby nurses/midwives discharge patients in specific clinical areas. Such guidelines should be agreed locally by medical and nursing/midwifery staff, in consultation with other relevant members of the multidisciplinary team and in partnership with relevant stakeholders. The patient's consultant/medical team agree that the patient is fit for discharge once the patient has achieved these discharge criteria.

8.2 **N**urse/Midwife criterion based patient discharge guidelines should:

- be reflective of best practice in the clinical area and the principles of integrated discharge planning in the HSE Code of Practice for Integrated Discharge Planning;
- clearly identify the patients/patient groups for inclusion and exclusion in the nurse/midwife criterion based discharge guideline;

- detail the procedures of:
    i) identifying patients suitable for criterion based discharge
    ii) documentation of the agreed criteria including timeframes for attainment where appropriate
    iii) the patient discharge by a nurse/midwife;
- identify the required education preparation and competency development requirements of a nurse/midwife facilitating criterion based discharge in a specific clinical area.

8.3 Nurse/midwife criterion based patient discharge may also occur for individual patients where specific collaboratively agreed discharge criteria/targets are documented in the patient's healthcare record. In this case the patients treating consultant/medical team, in consultation with the nurse/midwife will agree and document the necessary discharge criteria/targets for the patient to achieve prior to discharge (e.g. no raised temperature for 24 hours, wound healed, mobilising safely, no evidence of respiratory distress). These and/or similar criteria must be within the nurse/midwife's ability and scope of practice to assess and agree. Both the nurse/midwife and the patient's consultant/medical team must be satisfied that the nurse/midwife can safely assess the patient's achievement of the criteria/targets. The patient's consultant/medical team must also be satisfied that once these documented criteria have been achieved that the patient is fit for discharge, without further medical review.

8.4 Before discharge, the nurse/midwife will carry out a holistic assessment of the patient (referring to the discharge checklist and tracking form). If the nurse/midwife is concerned that the patient has not fully achieved the pre-set discharge criteria or that there is delay in the patient achieving their individual discharge criteria, the nurse/midwife must contact the patient's consultant/medical team and others members of the multidisciplinary team as appropriate.

8.5 Prior to making a decision to facilitate criterion based patient discharge, nurses/midwives must be satisfied that they are working within their scope of practice. To this end, they must:

- Ensure that they have the ability to assess the discharge criteria;
- Practice within the parameters of local guidelines/protocols or individual documented instructions for nurse/midwife criterion based patient discharge;
- Have the support of their nurse/midwife manager, medical consultant and other multidisciplinary team members to discharge a patient based on collaboratively agreed criteria;

- Be familiar with and comply with legislation, regulation and HSE or organisational policies concerning patient discharge and discharge planning;
- Engage in audit of nurse/midwife criterion based discharge in their clinical areas, as required by their employers;
- Participate in the evaluation of integrated discharge planning and nurse/midwife criterion based patient discharge;
- Engage in continuing professional development on an ongoing basis.

8.6 The educational preparation and competency development of a nurse/midwife to undertake nurse/midwife criterion based patient discharge will be dependent on the clinical area and the discharge criteria agreed for inclusion. It is recommended that:

- the match of the discharge criteria and nursing/midwifery team skills are agreed at local level by the nurse/midwife manager in charge and the patient's consultant;
- local guidelines detail the education preparation (clinical and academic) required of a nurse/midwife to facilitate criterion based patient discharge in their clinical area;
- the specific competencies required of the nurse/midwife should also be detailed.

9. Documentation

9.1 The discharge plan should be documented in the healthcare record, reviewed daily and updated in response to changing needs. An associated discharge tracking form is recommended. This can be developed by the local JIG documentation subgroup and reflect the guidance provided in the discharge checklist and key tasks for a standard discharge as outlined in the HSE Code of Practice. A sample patient discharge tracking form is included in Appendix 3.

9.2 The estimated length of stay should be recorded in the patient's healthcare record.

9.3 Relevant internal referrals (diagnostics, health and social care professionals, specialist nursing services, liaison services, etc) should be made to the various members of the multidisciplinary team on standard referral forms.

9.4 Referrals should be documented on a discharge planning tracking form in the patient's. healthcare record within 24 hours of referral.

9.5 The progress of the discharge plan should be communicated at all patient handovers. Communication with patient, family/carer, PCCC and other services as appropriate should be clearly documented in the patient's healthcare record.

9.6 A discharge checklist (Appendix 2) should be completed by the nurse/midwife 24 hours before discharge.

9.7 The discharge plan section on the transfer/discharge communication record (Appendix 4) must be completed by the nurse/midwife caring for the patient and signed by the nurse on duty on the day of discharge.

9.8 Each health care professional has individual responsibility for their record keeping.

9.9 Where deficits in documentation exist within an organisation/service, development of appropriate documents should be addressed through the local JIG, in consultation with the relevant services and patients.

10. Implementation

10.1 This guideline for nurse/midwife facilitated discharge planning will be disseminated through the Office of the Nursing Services Director (ONSD) and the HSE National Integrated Discharge Planning Steering Committee to all HSE services and any facility providing services on behalf of the HSE. It is available to download from the HSE Nursing Services webpage: www.hse.ie/eng/About_the_HSE/Nursing_Services/

10.2 As part of the implementation of the national HSE Code of Practice for Integrated Discharge Planning, Joint Implementation Groups (JIGs) have been established locally to examine documentation, audit, education and training needs of all staff in relation to integrated discharge planning.

10.3 A specific e-learning education programme on Integrated Discharge Planning has been developed by the National Integrated Discharge Planning Support Team for all relevant staff. This package will be available in 2009. It is recommended that all nurses and midwives complete the e-learning programme and staff who have completed the programme are recorded locally. Focus groups held with nurses and midwives in seven sites nationally to determine the educational requirement of nurses and midwives indicated a need for multidisciplinary education on the HSE Code of Practice for Integrated Discharge Planning mainly through induction and onsite briefing sessions. To support the implementation of Guideline for Nurse/Midwife Facilitated Discharge Planning, educational material/templates on the guideline have been developed for use by individual organisations/JIGs. This information will be available to download from the HSE Nursing Services webpage: www.hse.ie/eng/About_the_HSE/Nursing_Services/ and the HSE Learning and Development website (www.hseland.ie).

10.4 Integrated discharge planning and nurse/midwife facilitated discharge planning should be supported by specific locally agreed policies, procedures and guidelines for all of the key elements of integrated discharge planning as outlined in the HSE Code of Practice for Integrated Discharge Planning (HSE 2008 p29). Appendix 1 is a sign off sheet for nurses/midwives. It is recommended that this be used to monitor dissemination of this guideline at local level.

11. Audit and Evaluation

11.1 Audit of discharge practices will occur as part of the implementation of the national HSE Code of Practice for Integrated Discharge Planning (HSE 2008 Part 4).

11.2 This associated guideline is for review in one year from approval or earlier if required. Audit of staff views and experience of the guideline will inform any required changes.

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13. Appendices

Appendix 1: Sign off Sheet for Nurses/Midwives

The information contained in the attached document must be read and fully understood by all staff.

Please print and sign your name below when you have done so.

DATE	*PRINT NAME*	*SIGNATURE*

Appendix 2: Discharge Checklist

Discharge checklist

Please note that this is not an exhaustive list

General *	Yes (Y)/No (N)/Not Applicable (NA)
☐ A discussion with the patient has taken place regarding their treatment plan	
☐ Observations within normal limits	
☐ Pain control satisfactory	
☐ Adequate nutrition and fluid intake	
☐ Passed urine	
☐ All dressings checked	

**A medical review of the patient prior to discharge is required if the answer to any of the above questions is 'No'*

Personal items returned to patient	Yes (Y)/No (N)/Not Applicable (NA)
☐ Own medications (once reiewed)	
☐ Own equipment	
☐ Own X-Rays	
☐ Valuables	

PCCC Services Referred to/Arranged	Yes (Y)/No (N)/Not Applicable (NA)
☐ Contact made with Public Health Nurse	
☐ Home Help	
☐ Meals on Wheels	
☐ Occupational Therapist	
☐ Physiotherapist	
☐ Speech & Language Therapist	
☐ Community Pharmacist	
☐ Carer identified	
☐ Other (please specify)	

Items arranged for/provided to patient	Yes (Y)/No (N)/Not Applicable (NA)
☐ Transfer/Discharge communication	
☐ Medications and medication list—explained to patient/carer, as appropriate	
☐ Follow-up appointment	
☐ Information pack	
☐ Aids and appliances	
☐ Wound care information	
☐ Common Summary Assessment Record (CSAR) completed	
☐ Home oxygen	

Transport	Time Booked (24 hour)
☐ Relative/friend	
☐ Taxi	
☐ Ambulance	
☐ Community transport provider	
☐ Other (please specify)	

Follow up appointments	Yes (Y)/No (N)/Not Applicable (NA)
☐ General Practitioner (GP)	
☐ OPD (please specify)	
☐ Medical specialist/other hospital (please specify)	
☐ Other (please specify)	

Signature/Printed Name	Date	Time (24 hour)

Appendix 3: Sample Patient Discharge Tracking Form

Sample Patient Discharge Tracking Form

Name: _____ Hospital No.:_____

This sample form aims to assist the implementation of the discharge plan, track the patient's ELOS against the patient's treatment plan and support communication of the patient discharge plan at handover.

Action	Status	Date and Time	Signature (Print name & title if not on ward signature bank)
Assessment of the Patient's Discharge Needs			
Discharge Plan Commenced			
Discharge Plan Completed			
Patient's ELOS Documented			
Please document actual ELOS	ELOS (dd/mm/yy)		
Discharge Arrangements Confirmed with Patient/Family/Carer/Other			
Transport Arrangements Confirmed			
Discharge Checklist Completed			
Discharge/Transfer Summary Record Completed			
Medication Management Discussed			
Patient Education (Other) Completed			
Medical (Sick) Certificate			
Information Pack Provided			
Communication with PCCC services patient discharge (see referrals section also)			
Follow-up Arrangements Confirmed			

Referrals Section

Internal Referrals Made

Name of Referral Type Made	Date & Signature of the Person who made Referral.	Received by Signature and Date	Status Awaiting In progress Complete

External (PCCC) Referrals Made

Name of Referral Type	Date & Signature of the Person who made Referral.	Mode of referral Phone, Letter, Fax etc

Appendix 4: Discharge/Transfer Communication Record

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NAME OF HOSPITAL

ADDRESS: _____

TEL: _____ **FAX:** _____

TRANSFER / DISCHARGE COMMUNICATION Date: Time:

Healthcare Record No: _____
Title: _____
Forename: _____
Surname: _____
Alias: _____
Mother's Maiden Name: _____
Age: _____ Date of Birth: _____
Gender: _____
Occupation: _____
Home Address: _____

Current Address: *(If different)* _____

Discharge Address: *(If different)* _____

Patient's Contact Telephone Numbers:
Landline: _____ *Mobile:* _____
Medical Card Holder: ☐ Yes ☐ No
If yes, Medical Card Number: _____
Medical Insurance: ☐ Yes ☐ No
If yes, Medical Insurance Number: _____

Mode of arrival: ☐ Ambulance ☐ Self ☐ Other
Referral Source: _____
Accompanied by: _____
Spoken Language: _____
Interpreter Required: ☐ Yes ☐ No
Religious Preferences: _____
Nationality: _____
Ethnicity: _____
School: _____
Next of Kin / Emergency Contact / Guardian: _____
(Name, Address and Relationship to patient)

Phone Nos.: *Landline:* _____ *Mobile:* _____
Patient's own GP: *(Name, Address and Phone Nos.)*

Referring Doctor: *(Name, Address and Phone Nos.)*

PHN: *(Name, Address and Phone Nos.)*

Admitted under the care of: *(Name, Address and Phone Nos.)*

DIAGNOSES ON DISCHARGE (including problem list)

ALLERGIES

INFECTION STATUS

MMSE SCORE **BARTHEL SCORE**

PRESENT PROBLEM / COMPLAINT (include current diagnoses)

Appendix 4 Contd.: Discharge/Transfer Communication Record

NAME OF HOSPITAL

ADDRESS: _____

TEL: _____ **FAX:** _____

Please affix patient label here

Labels should contain the following information:

- Name
- Address
- Date of Birth
- Healthcare Record Number

PROCEDURES & INVESTIGATIONS

RESULTS OF INVESTIGATIONS

RELEVANT FINDINGS ON SYSTEMS REVIEW / EXAMINATION FINDINGS AND SUMMARY OF MANAGEMENT CARE PLAN

FUNCTIONAL STATE ON DISCHARGE (Self-care / baseline mobility / walking aids & appliances)

MEDICATIONS AND DIETS (Including nutritional supplements and relevant information on administration of medicines)

TRANSFER / DISCHARGE COMMUNICATION SIGNED BY:
(Name / Signature / Grade / Contact Details)

DISCHARGE PLAN (Please complete / tick relevant sections)

DEPARTURE FROM WARD _____

Ward contact details: _____

Nurse (or HSCP / other) contact details: _____

Date: _____ **Time:** _____

Tick relevant sections

- ☐ Accompanied
- ☐ Alone
- ☐ Own Transport
- ☐ Public Transport
- ☐ Hospital Taxi
- ☐ HSE Ambulance
- ☐ Private Ambulance
- ☐ IV Line(s) Removed
- ☐ ECG Electrodes Removed
- ☐ HSCP Arranged _____
- ☐ Relatives Informed
- ☐ CSAR completed (copy attached)

☐ **HOME**

Follow Up

- ☐ Nil Required
- ☐ By GP in _____ Days
- ☐ By PHN in _____ Days
- ☐ By HSCP
- ☐ OPD Date _____
- ☐ Other _____

☐ **TRANSFER**

Transfer To: _____

Date: _____

Time: _____

TRANSFER CHECKLIST

- ☐ Inter-healthcare infection control transfer form
- ☐ Property / Valuables with patient
- ☐ Property / Valuables in store
- ☐ Identity Band / Bracelet applied
- ☐ Own Medications with patient (if unchanged)
- ☐ Patient's healthcare record
- ☐ Patient's X-Rays
- ☐ Investigation Results
- ☐ Transfer / Discharge communication

INFORMATION GIVEN TO PATIENT

- ☐ Transfer / Discharge communication
- ☐ Medication Information
- ☐ Details about follow-up appointments
- ☐ Information pack
- ☐ Wound care information
- ☐ Information regarding aids and appliances
- ☐ Advice booklet _____
- ☐ Other _____

DISCHARGE PLAN COMPLETED BY:
(Name / Signature / Grade / Contact Details)

RECEIVING CLINICIAN (in the case of a transfer):
(Name / Title)

Appendix 5: Patient Information Leaflet on Going Home from Hospital

Things to do before you go home

Speak to at least one hospital member about how long it might be before you will be feeling better and can expect to resume usual activities.

If your physical abilities have changed as a result of your illness, **make sure you understand** about what you can and can't do when you go home.

Ask staff questions about what has happened to you, and what changes you can expect in your health and daily activities when you return home.

If you have any questions after you leave hospital, you may wish to contact **your GP or Public Health Nurse (PHN)**.

Multidisciplinary team

The staff involved in your care are known as the multidisciplinary team and may include the following:

- Medical Staff (Consultant, Registrar)
- Nursing Team
- Discharge Co-ordinator
- Community Services Discharge Liaison Officer
- Dietician
- Physiotherapist
- Occupational Therapist
- Speech & Language Therapist
- Pharmacist
- Social Worker
- Public Health Liaison Nurse
- Chaplain / Spiritual Advisor

Hospital/Local Health Office (LHO) Name Here

Phone: 555-555-5555
Fax: 555-555-5555

E-mail: someone@example.ie

Patient information brochure

Hospital/Local Health Office (LHO) Name Here

Planning your transition from hospital to home

Introduction

- Many people require no special services after they have been discharged home.
- If you require some extra assistance then hospital staff, your GP and primary, community and continuing care (PCCC) staff will help you to plan ahead so that the appropriate arrangements can be made before you are discharged.
- This brochure is to prompt you (the patient) and your carer, family and friends to consider a range of practical aspects about your return home from hospital.

Your discharge plan

- From the day you are admitted to hospital, a number of different staff involved in your care (the multidisciplinary team) will work with you, your relatives and carers to plan your discharge.
- Your length of stay will depend on your condition. The date of your discharge will be agreed and discussed with you by the consultant and the multidisciplinary team.
- Please advise your nurse, as early as possible in your stay, if you think you will have any problems with going home.
- On the day of your discharge please make arrangements to be collected no later than **12 midday.** This is necessary to make way for other patients who are being admitted to hospital.

Questions you need to ask about your care

- ☐ How long will I be in hospital?
- ☐ What can I expect to happen to me during my time in hospital?
- ☐ When I leave hospital, will I be able to go directly home?
- ☐ How soon should I feel better after leaving the hospital?
- ☐ If I need help and care at home after I leave hospital, who will help me to arrange it?
- ☐ Are there any special instructions for daily activities?
- ☐ Will I need any special equipment at home? Who will help me to arrange this? Is this equipment covered by my insurance or medical card?
- ☐ Will I need to have other treatment following my time in hospital?, (e.g. physiotherapy). Are there any exercises that I need to do? *(If so, ask for written instructions).*
- ☐ Will there be any follow-up appointments?
- ☐ Do I need to have follow-up tests? Who should I follow-up with to get the test results?
- ☐ Do I need to schedule any follow-up visits with my doctor?
- ☐ When can I expect to return to work?
- ☐ Will I be able to walk, climb stairs, go to the bathroom, prepare meals, drive, etc.
- ☐ Who can I call if I have any problems after leaving the hospital?

Questions you need to ask about your medicines

- ☐ What medicines will I need to take at home? *Get a complete list of all your medicines at discharge, including any changes made while you were in hospital. Take this list with you when you leave the hospital.*
- ☐ Can I get written instructions about my medicines? *Ask any questions before you leave the hospital.*
- ☐ Are there any drugs (including non-prescription drugs) or vitamins that I should not take with my medicines?
- ☐ Are there any food or drinks that I should avoid while taking my medicines?

After you leave the hospital

- The hospital staff will let your GP/Public Health Nurse (PHN) know when you are leaving hospital.
- When you leave the hospital, hospital staff will prepare a discharge communication (a summary of medical information about your treatment in hospital and ongoing services that have been arranged for you). This communication will be given to you and a copy will be sent to your GP.
- You may wish to make an appointment to see your GP following discharge.
- If you feel that you are not well and/or are not managing at home, contact your GP and/or PHN.