**Canberra Health Services**

**Procedure**

**Admission to Discharge Procedure (adults and children)**

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| Purpose |

To facilitate safe and effective processes to manage patients requiring admission to, or discharge from Canberra Health Services (CHS).

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| Alerts  |

Staff requesting or receiving any admission must update the Patient Journey Board (PJB) to ensure its accuracy at all times. If it is not possible for staff to update the PJB, staff should contact the Patient Flow Unit to ensure a complete and accurate picture of bed availability 24 hours per day.

**Note**:

PJB is a term to refer to the collective modules of the digital patient journey system.

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| Scope |

This procedure applies to all CHS staff involved in the admission and discharge of patients.

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| Section 1 – Patient Admission |

A patient’s admission may be classed as non-elective or elective. See Patient Admission Flowchart at Attachment 1:

* Non-elective patients require admission to hospital for treatment and the admission is not planned. Emergency admissions are included in this category.
* Elective patients are booked for a planned procedure or treatment.

**Note**:

Minimum safe staffing levels must be maintained at CHS as per the ACT Public Sector Nursing and Midwifery Enterprise Agreement 2020-2022 and the ACT Public Sector Nursing and Midwifery Enterprise Safe Care Staffing Framework. If a ward is unable to accept an admission due to unsafe staffing levels, this should be escalated to the CHS Patient Flow team as per the CHS Capacity Escalation Procedure.

## 1.1 Non-elective patient admissions

Non-elective patient admissions may occur via the Emergency Department (ED), outpatient clinics, community programs, General Practitioners (GP), Justice Health Services, or Consultant rooms for a time critical service.

Non elective patient admissions can occur direct to ICU via Capital Region Retrieval Service (CRRS).

Once the admission has been accepted by the specialty as per below, all requests for beds must be processed through the Patient Flow Unit or the After Hours Hospital Manager (AHHM). The following phone numbers are to be used 24 hours, 7 days**:**

* Patient Flow 5124 2654 or 5124 3247
* AHHM 5124 2560

### 1.1.1 Emergency Department

Patients presenting to the ED who require admission are allocated to the appropriate inpatient medical team as per the CHS *Admission from the Emergency Department to the Ward procedure* and triaged according to the Transfer Urgency Rating Scale at Attachment 2.

Admitted patients are booked on the ED Patient Information System (EDIS) under an admitting consultant, as per the Emergency Department and Mental Health Interface procedure. The Patient Flow Unit or AHHM will allocate an appropriate bed within the hospital.

The Emergency Medicine Unit (EMU) at Canberra Hospital is a short stay unit, with a defined maximum length of stay of 24 hours. Patients admitted to this unit receive short duration emergency medical and nursing care under an Emergency Medicine Specialist. Patients who primarily require care by a specialty team should not be admitted to the EMU.

### 1.1.2 Outpatient clinics and services (including Justice Health)

Outpatients may require admission to the hospital. It is the responsibility of the consultant/registrar requesting the admission to complete the Planned Hospital Admission Booklet for Surgical and Medical Care (‘**Admission Booklet**’), contact Patient Flow or AHHM and request the bed.

### 1.1.3 Consultant and GP rooms

Patients seen at specialist consultant or GP rooms who require urgent treatment may be referred to the ED for further assessment and possible admission. Before sending the patient to CHS the consultant or GP must notify the ED admitting officer (AO).

### 1.1.4 Direct Ward Admissions

Direct admissions to the ward are **only** permitted if the admitting consultant or registrar has assessed the patient as appropriate for an inpatient admission. This assessment must ensure that the patient is not admitted unnecessarily, pre-emptively to await diagnostics or in anticipation of a procedure, unless urgent inpatient care is also required. Hospital in the Home (HITH) should be considered as an alternative.

The patient must have a Modified Early Warning Score (MEWS) of four (4) or less, or an acceptable result under an equivalent interstate observation system as assessed by the admitting medical team at Canberra Hospital and in consultation with the referring team. If the patient requires urgent treatment/assessment or deteriorates on route they should be admitted via the ED (AO must be notified) unless specific arrangements have been made; e.g. direct to operating room or, cardiac catheter laboratory. If direct admission to a ward is requested the accepting specialist consultant/registrar must contact the Patient Flow Unit or AHHM to request a bed and complete an Admission Booklet.

### 1.1.5 Time critical services

The CHS Unit receiving a direct admission from a time critical service must complete the PJB, where this is not possible staff should inform Patient Flow /AHHM of the admission as soon as possible. A time critical service is defined by requiring admission in less than 24 hours.

### 1.1.6 Capital Region Retrieval Service (CRRS)

If an adult patient from the ACT or the surrounding region requires urgent medical triage/advice/treatment and transport they are referred to the CRRS who will provide coordination and retrieval services.

* The service works in collaboration with the ACT Ambulance Service and Toll NSW Ambulance Rescue helicopter service.
* The CRRS may conduct transfer to or from CHS.
* The service coordinates with the Adult Medical Retrieval Service (AMRS) regarding sourcing beds for patients and transferring patients to other facilities.

### 1.1.7 ST Elevation Myocardial Infarction (STEMI) Pathway

Any Southern NSW Local Health District and/or Ambulance Service NSW patient identified as having a STEMI will proceed to either the Canberra Hospital ED or the Cardiac Catheter Laboratory. The Clinical Nurse Consultant (CNC) or team leader of Coronary Care Unit (CCU) is to notify the Patient Flow or AHHM about STEMI patients as soon as possible. See the *ST Elevation Myocardial Infarction (STEMI) Pathway*.

### 1.1.8 NSW Newborn and Paediatric Emergency Transport Service (NETS)

NSW NETS coordinate the retrieval and transfer of paediatric patients less than 16 years of age. Please see the following procedures for further detail:

* *Patients Requiring Referral, Stabilisation and Transfer to ICU*.

*Neonatal Emergency Transport Service Elective Transfer & Retrieval*

### 1.1.9 Obstetric Emergency or Labouring Women

Women in labour or experiencing an Obstetric emergency should present directly to the Centenary Hospital for Women and Children and are admitted to the Birthing Suite or Birth Centre. The Clinical Midwife Consultant (CMC) or team leader of Birthing Suite or Birth Centre must complete the Patient Journey Board, or notify the Patient Flow Unit or AHHM as soon as possible.

Where an obstetric patients has presented to the CHS Emergency Department the Obstetric Registrar on-call will be informed and a transfer to Women’s, Youth and Children will be arranged by the AHHM or Bed Management.

## 1.2 Elective patient admissions

All elective patients require a Request for Admission form to be completed prior to admission that is located in the Planned Hospital Admission Booklet For Surgical and Medical Care. The Request for admission informs the Patient Flow Unit as to the type of admission required and whether they are placed on the direct admit lists.

### 1.2.1 Interhospital Transfer list

Elective patients are placed on the Hospital Transfer List. This list is triaged by a medical team to determine their admission date. Admission can occur at the triage time or at a future date depending on clinical need and bed availability.

### 1.2.2 Transfers to CHS from other health facilities or services

Patient transfers are managed by the Patient Flow Unit or AHHM to ensure the appropriate bed is allocated with consideration of patient care needs and staffing requirements. Transfer from other facilities must be accepted by a consultant. Once a consultant has accepted a transfer, the patient is included on the bed management interhospital transfer list and triaged for an admitting date as per medical team. The mode of transfer can be by air or road retrieval.

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| Note: Admission to Acute Mental Health Inpatient Unit is coordinated by the Territory Wide Mental Health Bed Access CoordinatorAdmission to Women Youth and Children is coordinated by the Access and Operations Coordinator |

Acceptance of a patient from other facilities must be for services that can only be provided at CHS, noting the demand on beds.

This process involves:

* The Patient Flow Unit of the referring facility being notified when a bed becomes available by CHS Patient Flow Unit.
* The transferring facility organising transport to CHS ED or to a nominated inpatient area at CHS.
* Where possible, the patient’s admission / transfer should be planned to occur within business hours to ensure safe and timely transfer of care.

### 1.2.3 Day Procedures

Patients having day procedures in the Gastroenterology and Hepatology Unit (GEHU), Cardiac Catheter Laboratory and Medical Imaging are admitted by the admitting officer of that unit. If a patient requires an admission post-procedure the relevant unit must notify the Patient Flow Unit as soon as possible.

### 1.2.4 Elective Surgery list

When added to the elective surgery list, a patient is allocated a planned future admission date, subject to availability as determined by the Surgical Bookings Please refer to the CHS *Elective Surgery Access Policy*.

Patients booked for elective same day surgery may require admission to hospital post-procedure. Patient Flow is to be informed as soon as this is known. If the Extended Day Surgery Unit (EDSU) is unable to accommodate the patient, the Patient Flow Unit will find another clinically appropriate bed in the hospital.

EDSU is unsuitable for patients who are:

* Expected to stay longer than 23 hours
* Under 15 years of age
* Non-surgical patients who have not undergone a Medical Imaging Procedure
* Diagnosed with an infectious disease/Multi Resistant Organism
* Requiring extra support for activities of daily living with a complex medical history
* Pre-operation with a lower limb fracture
* Under guard/requiring extra security
* Diagnosed with a mental health condition not suitable for the open environment
* A bariatric patient over 140kg
* Requiring a carer to stay or have special one-on-one nursing.
* Patients with intellectual disability

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| Section 2 – CHS requirements when admitting a patient |

## 2.1 Patient admission location: home ward and outliers

The Patient Flow staff will allocate beds on the following priority order:

1. Bed available in the home ward.
2. Bed available in the home division.
3. Transfer of outliers to a home ward or division to create capacity.
4. Allocate a bed with staff who have the appropriate skillset for their admission.

**Note**:

Considerations for the need for a single room or particular equipment may override the above.

If the patient has multiple care requirements the decision as to where the patient is best placed will be based on clinical assessment

## 2.2 Medical admission

Patients will be assessed and admitted on the ward/unit by a medical officer (or delegate) from the admitting team within two (2) hours. Patients must have advanced care directives discussed and documented within 2 hours of admission, by the medical officer that completes their admission

The ward/unit nursing team will notify the medical officer when the patient arrives. The patient’s plan for care must be documented in the clinical notes and communicated to the patient and their family.

## 2.3 Estimated Date of Discharge

An Estimated Date of Discharge (EDD) is the predicted date when the patient will be ready to be safely discharged from CHS to their next destination. It is a requirement that an EDD is determined within 12 to 24 hours of admission.

The EDD is to be documented in the patient’s clinical notes, and on the CHS Comprehensive Care Plan – Part 2 Adult Care Plan (along with a statement of having informed the patient/family/carer/s), on the PJB and on the patient’s bedside board (where available).

Where a patient is expected to die during this admission, no EDD is recorded. The end of life icon should be used in the Alerts for these patients, refer to the CHS *Alerts Management Procedure.*

## 2.4 Identification, alerts and allergies

Each patient is to be provided with an identification wrist band on admission. If the patient has allergies they must have a red wrist band. Refer to the CHS *Patient Identification and Procedure Matching Procedure.* This must also be documented in the Alerts Management System on Clinical Portal, which informs ACTPAS and the PJB. Alerts include children at risk, Advance Care Plans, Apprehended Violence Orders etc. The clinical team is responsible for completing the clinical alerts through Clinical Portal.

Check and record if the patient identifies as Aboriginal and/or Torres Strait Islander, including in the ACTPAS patient alerts screen. Where appropriate referral to Aboriginal and Torres Strait Islander liaison officer should be made.

## 2.5 Room boards and bedside whiteboard

The room board, or where no room board is available the bedside white board, in each patient bed area is to be completed by nursing staff caring for the patient with the following information:

* EDD
* Which medical and nursing staff are looking after the patient, the bedside whiteboard must be updated to reflect the staff member/s looking after the patient each shift.
* What is the patient waiting for, e.g. planned activities, tests, and discharge activities.

## 2.6 Orientation to ward

The nurse who admits the patient is responsible for actioning the following with the patient/family/carer:

* **Interpreter** – Should an interpreter be required the interpreter service is to be contacted as soon as possible and appropriate arrangements made, refer to the CHS *Language Services - Interpreters and Translated Materials* procedure for more information.
* **Risk of Harm -** Discuss with the patient how to minimise the risk of harm during their stay including falls, pressure injuries and infection prevention and provide appropriate written information.
* **Visiting hours** **and visitor numbers -** Provide orientation to bathrooms, call bells, bedside whiteboard, ward specific patient/family areas (e.g. kitchens or play rooms), staff roles and identifying uniforms. Provide the patient the *Patient’s Right and Responsibilities Pamphlet.*
* **CARE for Patient Safety Program** - Explain the program and provide the patient/their family/carer with the supporting hospital pamphlet.
* **Patient valuables** – Discuss with patients that they are strongly advised against bringing valuables or surplus clothing into the Hospital. Any property brought into the Hospital is at their risk and under their control; CHS will not accept liability for loss or damage to such property. Valuables can be secured in the hospital safe. Two nurses list and place item(s) in a sealed bag. The patient receives a receipt and two copies placed within the sealed bag. Security staff collect the sealed bag from the nursing staff and it is secured in the hospital safe. The patient requires a receipt to claim the sealed bag.
* **No smoking policy** –Smoking is not permitted within any CHS facility. Patients who smoke are to be offered Nicotine Replacement Therapy. See CHS *Managing Nicotine Dependence* procedure for more information.
* **Legal documents and directives** – If the patient has any directives or legal documents they are to be copied and placed in the patient’s clinical notes. If a patient wishes to discuss a directive such as an Advance Care Plan refer to the CHS *Advanced Care Planning (Adults)* guidelineor contact the Respecting Patient Choices team on 5124 3344.
* **Food Service** – Contact the Nutrition Team on admission, via phone on Ext 42567, to arrange meal services including identifying cultural, allergy and dietary requirements which are entered by the nutrition team into the appropriate food services system at TCH or UCH.
* **Comfort Care Pathway** – Patients admitted on a Comfort Care Pathway are to be provided information on the pathway. This includes the following brochures *Comfort at end of life* and *Comfort Care information for family member/friend.*

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| Section 3 – Risk Screening and Care Planning |

## 3.1 CHS Comprehensive Care Plan Part 1 - Risk Screening Adult

The CHS Comprehensive Care Plan Part 1 - Risk Screening Adult is available on the Clinical Forms Register and is to be used for all adult patients, excluding Maternity, admitted to CHS. Risk screening should commence at the entry point of admission irrespective of location – Emergency Department, direct admission to ward or other (i.e. Day of Surgery Admission, Outpatient Clinic, Rapid Assessment Unit).

In the Emergency Department, risk screening is required for all patients admitted or requiring admission and for those patients identified as higher risk including:

* Age of 65 years and older; or 45 years and older for Aboriginal and Torres Strait Islander people,
* Complex care needs,
* With clinical conditions, co-morbidities and social circumstances that suggest a level of risk of harm.

The complete risk screening is to be commenced within four (4) hours and completed within 24 hours from the decision to admit. Nursing staff are to follow-up on relevant actions and assessments, and referrals to medical and allied health teams for further assessment and actions.

## 3.2 CHS Comprehensive Care Plan Part 2 – Adult Care Plan or Comfort Care Plan

The CHS Adult Care Plan or Comfort Care Plan is available on the Clinical Forms Register and has been developed to meet the individual patient’s needs. Through appropriate screening and clinical assessment along with discussions with the patient and their support person, completion of the *Patient Goals of Care form* and the actions that are planned to meet those goals are determined and the appropriate CHS Care plan identified.

### 3.2.1 CHS Adult Care Plan

The CHS Adult Care Plan informs and records the delivery of multidisciplinary team (MDT) clinical care and interventions. All members of the MDT should document on the Care Plan where appropriate. The CHS Adult Care Plan is reviewed every 24 hours with the patient and or support person and progress against each of the care goals is documented on the care plan.

The CHS Adult Care Plan serves as the primary source of documentation for nursing actions and interventions. Additional actions or nursing interventions that are not described in the care plan are to be recorded in the patient’s progress notes.

### 3.2.2 CHS Comfort Care Plan

The CHS Comfort Care Plan is to be used in place of the CHS Adult Care Plan where a patient is identified to have goals of optimal comfort treatment and on the Comfort Care Pathway, or receiving active ward based treatment with symptom and comfort care and on a Comfort Care Pathway.

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| Section 4 – Ward Clerk Responsibilities |

At the time of admission it is the responsibility of the admitting administrative staff to:

* Check all patient details and update as required.
* Check if the patient has private health insurance and if they are under a NOOPEX (no out of pocket expenses) Doctor.
* Ask the patient the best way to contact them once discharged.
* Ensure the patient/guardian has signed the relevant election forms and general Conditions of Admission form.
* Update ACTPAS with the following:
* Referrals
* National E-Health Record consent
* Message authorisation
* Changes to personal details/personal contacts
* GP admit notification

Check patient alerts including Respecting Patient Choices and Advanced Care Plan/Power of Attorney. If the patient has one of these documents it must be printed and placed in the patient’s clinical record. If new POA/Guardianship, Ward Clerk takes copy and sends to Health Information Services to update alerts.

* Check the financial status of the patient. For any Medicare non-eligible, third party insurance or Veterans Affairs patients double check they are signed in correctly.
* Use the Elective Surgery Waiting List Referral Source for elective surgery admissions

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| Section 5 – Discharge |

## 5.1 Discharge Planning

Planning for achieving the EDD must commence on admission. This includes:

* Early referral to and review by allied health, residential aged care liaison, and/or discharge liaison nurses who may be able to assist with readiness for discharge,
* Regular discussions with the patient and carers,
* Prompt referral for services such as Aged Care Assessment Team (ACAT) and community based services,
* Post-discharge/follow up appointment requirements,
* Timely completion of a discharge summary,
* Medication reconciliation.

The Comprehensive Care Plan must be completed and always updated to reflect goals of care, plans for each day and intended discharge. Note there is a requirement to use a different plan for particular patient cohorts including paediatrics, end of life and critical care patients. Any patients who deviates from their expected course of recovery should be reviewed by the medical team including the medical consultant.

### 5.1.1 Inter-hospital transfers from CHS

Patients (adult, paediatric or neonate) may be transferred to another health care facility. This will be coordinated by NSW NETS and NETS ACT, CRRS, the Patient Flow Unit or AHHM. See the *Patients Requiring Referral, Stabilisation and Transfer to ICU procedure* for more information on transferring patients requiring intensive care.

The staff in the Patient Flow Unit are responsible for arranging the following transport:

* By road Ambulance Transport (ACT and NSW)
* between Calvary Public Hospital Bruce and CHS using a Patient Transport Vehicle
* By Air ambulance.

**Note**:

NSW regional patient transfers are arranged by the receiving hospital/Local Health District.

If the Patient Flow Unit is not directly involved in organising a patient’s transfer to another healthcare facility they must be made aware of any inter-hospital transfers as soon as possible.

### 5.1.2 Discharge

A patient should not be discharged where there are concerns about the appropriateness or safety of their discharge location.

### 5.1.3 Discharge Requirements

Patients are discharged from CHS at the direction of the treating team and the following best practice principles should be applied:

* Planned Discharge Date
* Using a multidisciplinary approach to determine a realistic set of criteria for discharge and an estimated day of discharge (EDD). This should be clearly communicated to all members of the multidisciplinary team, the patient and carer each day.
* Communication
* Discuss with the patient and or carer the proposed criteria for discharge and EDD to allow early arrangements for transport and accommodation to be made.
* Update the bedside whiteboard regularly.
* Patients should be advised that on discharge, the primary care team (e.g. GP) is responsible for ongoing care and management. An appointment should be made to visit the GP following discharge.
* Requirements for follow up appointments with CHS should be clearly communicated to the patient.
* Discharge Medications
* Medical teams should complete discharge medication prescriptions and orders in the afternoon before the planned discharge date. The ward pharmacist should complete a medication reconciliation and educate the patient on new and or changed medication regimes prior to discharge by an agreed time. This will ensure discharge medications are delivered to the patient the next morning on the first pharmacy round of the day to facilitate safe and timely discharge.
* Discharge Pathology Testing
* Blood tests ordered by the medical team on the discharge date should be stamped with the “discharge priority” stamp. Requests are to be placed on a 06:00 bloods hook (or night staff collection point). This will allow for the specimens to be collected and results to be ready for morning rounds, to enable confirmation of discharge.
* Documentation
* As early as possible in the patient admission, the medical team should commence the discharge documentation including the discharge summary. The multidisciplinary team should ensure patients/carers are aware of ongoing care plans/providers/appointments and provide a clinical handover to the primary care team.
* Patients/carers should be provided a copy of all discharge documentation, relevant appointment details and follow up interventions on discharge from the service.
* Where patients are on a comfort care pathway and returning to an Residential Aged Care Facility (RACF) or other health setting, the Comfort Care Pathway, CHS Comfort Care Plan and any updated Advance Care Plans, Enduring Power of Attorney (EPOA) etc should be photocopied and provided with the patient to the RACF and faxed to the nominated GP.
* The decision to discharge a patient must be based on clinical assessment or clinical criteria set by the admitted medical team, in collaboration with patient, their family/carer or substitute decision maker and the MDT.
* Where criteria have been established for discharge and criteria led discharge is in place a criteria led discharge trained staff member for example a senior nurse can determine and document that the patient meets these criteria and is safe for discharge. In this case the patient does not need to be seen by medical staff to confirm discharge.
* Discharge should be planned for as early as possible each day, with at least one patient per ward identified for a pre-09:00 discharge.
* For neonates being discharged/transferred from the Neonatal Intensive Care Unit and Special Care Nursery, the discharge/transfer requirements found on the Neonatal Admission Assessment, Care Plan and Discharge Planning form must be followed and completed prior to discharge and/or transfer

For a patient to be discharged the following criteria must be met:

* Patient is clinically stable,
* There are no outstanding tests required as an inpatient, and important investigation results have been reviewed by the treating team,
* Patient and their family/carer or substitute decision maker have been involved in the decision to discharge,
* Discharge destination is appropriate,
* Discharge medications are available,
* Transport to the discharge location is available,
* All relevant members of the multidisciplinary team are aware of the discharge, and discharge paperwork, including plans for follow-up are planned to be completed within expected timeframes..

### 5.1.4 Discharge Lounge

When the patient is clinically stable on the planned day of discharge, but one or more of the above criteria are pending, the patient may be suitable for transfer to the Discharge Lounge as per *Transfer from Inpatient Ward to Discharge Lounge Procedure* or ward patient lounge.

### 5.1.5 Post-Discharge Requirements

Where patients have post-discharge appointments or ongoing care requirements (Community Care, Chronic Care Program, Outpatient appointments, referrals, etc.) ensure the patient/carer fully understands the expectations and processes for follow up. Where possible make appointments for the patient prior to discharge and communicate these clearly to the patient/carer.

### 5.1.6 Transport

If a Patient Transport Vehicle (PTV) is required, this is arranged through the Patient Flow Unit, via the PJB, or by the ward. Community transport is arranged by the ward/unit. Noting the demand for PTV, ensure other appropriate options have been explored first.

### 5.1.7 Ward Clerk duties on discharge of patient

Following discharge the ward clerks are to:

* Check the patient discharge time and destination,
* Ensure that the discharge time and destination, as well as any other relevant information, is entered in ACTPAS as soon as practicable,
* Write the discharge time on the identification sheet (10200) in the patient’s clinical record,
* Enter date a patient clinical record is sent to Health Information Services in the patient record and on ACTPAS.

**Note**:

Statistical discharges and ward transfers should be entered at the time they occur.

## 5.2. Leave pass

Leave passes for patients are only granted in the following circumstances:

* A patient may take a leave of absence for a defined period of time if the admitting consultant (or their delegate) provides their permission,
* The appropriate part of the General Conditions of Admission Form is signed by both the patient and medical officer,
* The nurse caring for the patient informs the ward clerk who ensures the information is entered in ACTPAS.

## 5.3. Discharge against Medical Officer’s advice

If a patient wishes to be discharged against medical officer’s advice staff are to attempt to identify and remedy the problem if possible.

The staff will:

1. Notify the CNC/team leader and treating team medical officer,
2. The CNC/CMC/team leader and/or medical officer will inform the patient of the implications of self-discharge,
3. Request the patient signs the Release and Acceptance of Responsibility for Discharge section of the General Conditions of Admission Form.

**Note**:

If the patient refuses to sign the Release and Acceptance of Responsibility for Discharge section, do not attempt to detain the patient.

1. Document the incident with a witness signature in the patient’s clinical record,
2. Inform the Patient Flow Unit or AHHM of patient’s departure,
3. Inform the ward clerk of discharge time and destination.

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| Evaluation  |

**Outcome**

* The Comprehensive Care Plan will be completed on admission for patients meeting the screening criteria
* All discharge summaries will be completed within the 48 Hours KPI

**Method**

* Comprehensive Bedside Audit will be reviewed by the Executive Leadership team every 6 months
* Discharge Summary Completion is review monthly by the Community for Safety Committee and the Discharge Summary Working Group
* The Relative Stay Index will be reviewed and compared to length of stay data by the Executive Leadership team every 6 months

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* ACT Language Services
* Elective Surgery Access

**Procedures**

* Admissions from the Emergency Department to Ward
* Alerts Management
* Capacity Escalation
* Clinical Handover
* Emergency Department and Mental health interface
* Language Services – Interpreters and Translated Materials
* Neonatal Emergency Transport Service (NETS) Elective Transfer and Retrieval
* Patients Requiring Referral, Stabilisation and Transfer to ICU procedure
* ST Elevation Myocardial Infarction Pathway
* Transfer from Inpatient Ward to Discharge Lounge
* Managing Nicotine Dependence

**Guidelines**

* Advanced Care Planning (Adults)
* Fasting Guidelines for Patients Requiring Sedation and Anaesthesia
* ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework

**Consumer Handouts**

* Comfort at the end of life
* Comfort Care information for family member family

**Forms**

* Neonatal Admission Assessment, Care Plan, and Discharge Planning Booklet

**Legislation**

* *ACT Health Records (Privacy and Access) Act* 1997
* *Health Records (Privacy and Access) Act* 1997
* *Human Rights Act* 2004
* *Public Sector Management Act* 1994
* *Territory Records Act* 2002
* *Work Health and Safety Act* 2011
* *ACT Public Sector Nursing and Midwifery Enterprise Agreement, 2020-2022.*

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| --- |
| Search Terms  |

Leave Pass- For the purpose of this procedure leave pass is defined as temporary absence from the hospital with the intent to return for further treatment.

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| Search Terms  |

Admission, Discharge, Patient, Care, elective, non-elective, request for admission, RFA, transfer, inter-hospital

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| Attachments |

Attachment 1 – Patient Admission Flowchart

Attachment 2 – Transfer Urgency Rating Scale

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*Policy Team ONLY to complete the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval*  |
| *22 October 2021* | *Complete Review*  | *Cathie O’Neill,* *Chief Operating Officer* | *CHS Policy Committee* |
| *21 March 2022* | *Nursing Ratio updated* | *Karen Grace ED NMPSS* | *CHS Policy Committee Chair* |

*This document supersedes the following:*

|  |  |
| --- | --- |
| *Document Number* | *Document Name* |
| *CHHS17/263* | *Admission to Discharge – Canberra Hospital and Health Services* |
|  |  |

## Attachment 1 – Patient Admission Flowchart



## Attachment 2 – Transfer Urgency Rating Scale

|  |  |  |  |
| --- | --- | --- | --- |
| Rating  | Case Group (example Only) | Timeframe | Action |
| Emergent / Emergency | Severely unwell, requiring support or potential support of:* Airway, breathing, circulation, disability

**Immediate risk to life or limb without definitive management** | Immediately  | Call AMRS or CRRSretrieval service consultant on**1300 873 711** |
| Interhospital Transfer**Priority 1** | **Potential risk of deterioration or adverse outcome without timely investigation or definitive management.**For example:* Undifferentiated condition
* Obstructed ureter
* Bowel obstruction
* Intervention needed e.g., orthopaedic, abdominal etc
 | within 6 hours | Discuss with Admitting Officer/treating team at receiving site:* Timing of transfer and patient condition
* Updates on condition at mutually agreed times
* Any alteration of condition

Source a bed through relevant bed management unitArrange transfer* Contact appropriate Ambulance Service
* Clinician to arrange appropriate transport

Referring hospital continual observation of clinical conditionNB: Not to be a direct inpatient admission if clinically unstable. |
| Interhospital Transfer**Priority 2** | **Potential risk of deterioration or adverse outcome without timely investigation or definitive management within the 6-12hrs timeframe.**For example:* Undifferentiated condition
* Obstructed ureter
* Bowel obstruction

Intervention needed e.g., orthopaedic, abdominal etc | within 6-12 hours |
| Interhospital Transfer**Priority 3** | Discussed with accepting teams and triaged appropriately for 24hrs. | within 24 hours | Suitable for direct admission to inpatient ward. |
| Interhospital Transfer**Priority 4** | Discussed with accepting teams and triaged appropriately for 48hrs. | within 48 hours | Suitable for direct admission to inpatient ward. |
| Interhospital Transfer**Priority 5** | Discussed with accepting teams and triaged appropriately for 72hrs. | within 72 hours | Suitable for direct admission to inpatient ward. |
| Interhospital Transfer**Priority 6** | **No risk of deterioration**Can safely wait for interventional procedure | non-urgent & timed admission | As per agreement between receiving and referring Senior Doctor. |