Can physicians do as well as orthopaedic surgeons: letting go of the discharge decision.

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What does it mean

The establishment of a multidisciplinary approach to discharge for patients for whom complex planning is not required and who can be classified as requiring a simple discharge

Process of discharging a patient when they meet a predetermined set medical criteria without waiting for medical review

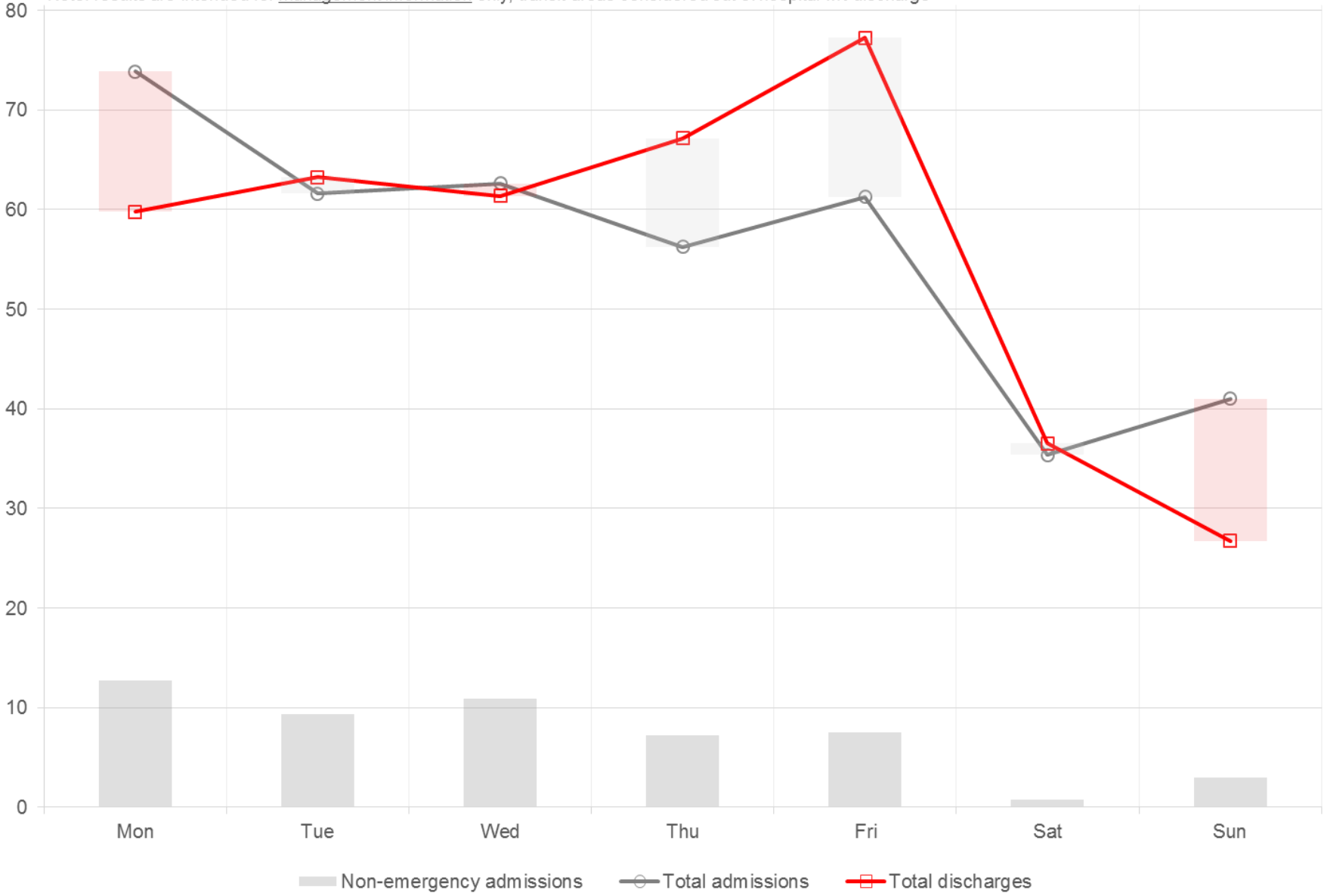
Why might this be important?

- Surely it’s intuitive?
- Is patient experience less if we don’t have criterion led discharge?
- Which groups of staff would have greater satisfaction?
- Nurses are busy enough…..aren’t they?
- Discharging one patient means another one arrives?

daily hospital inpatient arrival and discharge profile, 3 Mar to 27 Apr 2014

Average daily hospital arrivals and discharges (excl. same-day non-emergency admissions and non-admitted ED attendances), by day of week, n

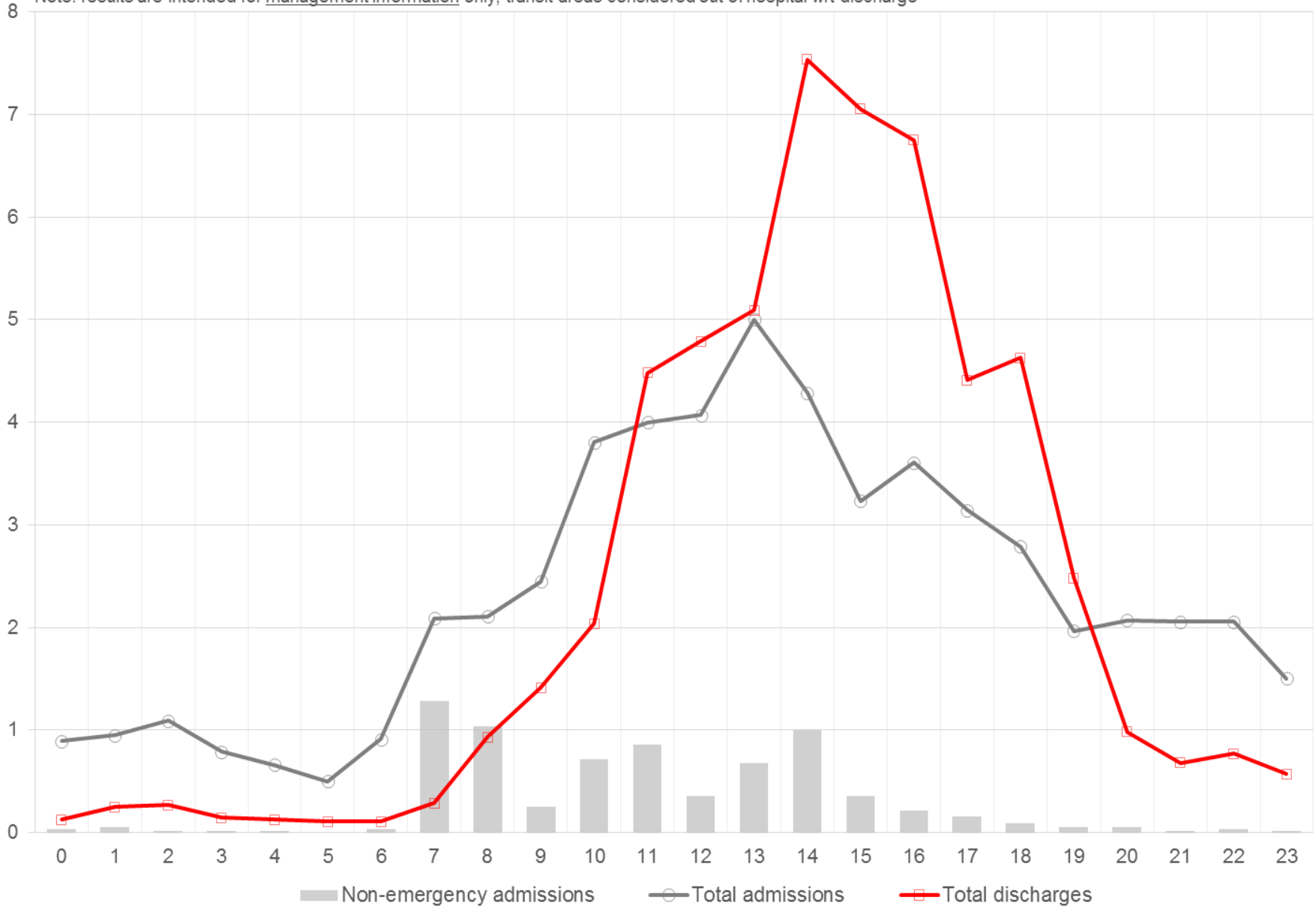
Note: results are intended for management information only; transit areas considered out of hospital wrt discharge



hourly hospital inpatient arrival and discharge profile, 3 Mar to 27 Apr 2014

Average hourly hospital arrivals and discharges (excl. same-day non-emergency admissions and non-admitted ED* attendances), by hour of day, n

Note: results are intended for management information only; transit areas considered out of hospital wrt discharge



What else might matter?

- 4 hour standard is a key safety measure?
- Hospitals are 95% occupied
- Boarding of patients
- Transfer of care

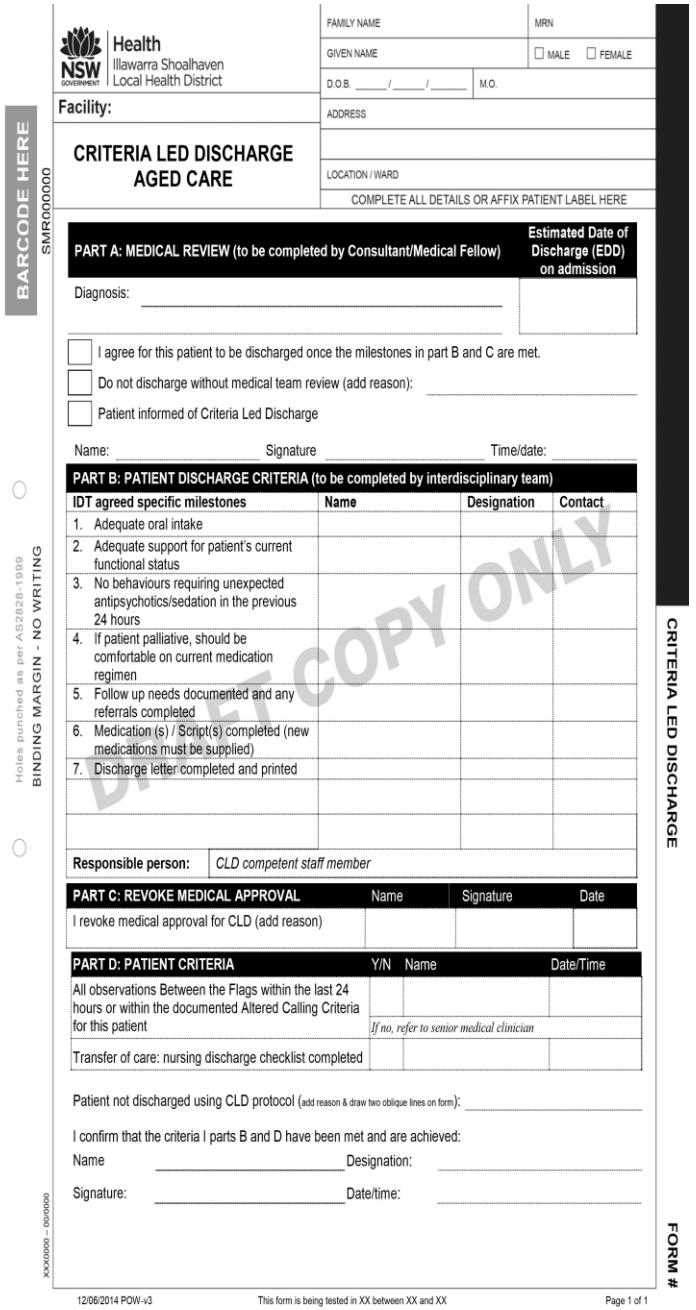
What have we got at the moment?

- EDD's
- Surgical pre-assessment
- Unscheduled medical admissions outnumber surgery, obstetrics and electives added together
- Discharge checklists
- Multi-disciplinary teams
- Electronic GP discharge letters
- Etc etc

How well does it work now?

- EDD's variable, often changed to suit process
- No unscheduled care equivalent of surgical pre-assessment
- Discharge checklists patchy or non-existent
- MDT documentation brief and filed separately
- Unitary records not in use
- Discharge information scanned straight to file
- Integrated care barely underway
- No single assessment

13/3/15
09.30
Cons. W/R
Ready for home
SWW



Health
Illawarra Shoalhaven
Local Health District
NSW GOVERNMENT

Facility:

CRITERIA LED DISCHARGE AGED CARE

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BARCODE HERE
SMR000000

PART A: MEDICAL REVIEW (to be completed by Consultant/Medical Fellow) | **Estimated Date of Discharge (EDD) on admission**

Diagnosis: _____

☐ I agree for this patient to be discharged once the milestones in part B and C are met.
☐ Do not discharge without medical team review (add reason): _____
☐ Patient informed of Criteria Led Discharge

Name: _____ Signature _____ Time/date: _____

PART B: PATIENT DISCHARGE CRITERIA (to be completed by interdisciplinary team)

IDT agreed specific milestones	Name	Designation	Contact
1. Adequate oral intake			
2. Adequate support for patient's current functional status			
3. No behaviours requiring unexpected antipsychotics/sedation in the previous 24 hours			
4. If patient palliative, should be comfortable on current medication regimen			
5. Follow up needs documented and any referrals completed			
6. Medication (s) / Script(s) completed (new medications must be supplied)			
7. Discharge letter completed and printed			

Responsible person: *CLD competent staff member*

PART C: REVOKE MEDICAL APPROVAL	Name	Signature	Date
I revoke medical approval for CLD (add reason)			

PART D: PATIENT CRITERIA	Y/N	Name	Date/Time
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: nursing discharge checklist completed			

Patient not discharged using CLD protocol (add reason & draw two oblique lines on form): _____

I confirm that the criteria I parts B and D have been met and are achieved:
Name _____ Designation: _____
Signature: _____ Date/time: _____

DRAFT COPY ONLY

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

CRITERIA LED DISCHARGE
FORM #

XXX0000 – 00/00000

12/06/2014 POW-v3 | This form is being tested in XX between XX and XX | Page 1 of 1

What advantages are there?

- Increased patient and family satisfaction
- Patients are able to leave hospital earlier
- Patients have more certainty about discharge time
- Empowerment of patients to be part of the discharge process
- Improved bed flow
- Improved confidence of the multidisciplinary team
- Increased productivity in use of clinical staff resources

What has to happen?

- Challenging the status quo
- Protocol, procedure and tool creation
- Clinical consensus
- Education of staff and managers

What is a simple discharge

- Day case hernia
- NSTEMI
- Leg ulcer
- Normal delivery
- Hemicolectomy
- Stroke
- Febrile convulsion

Maybe not condition specific

- NEWS score zero
- Self caring
- Med Rec done

Delayed discharge

- If CLD helps reduce delayed discharge, what is the link
- Start on admission
- Interprofessional communication
- Proactive management
- Patient and carer involvement

Why are discharges delayed

Scenario 1

- Elective hip arthroplasty aged 62
- Cleared on pre op assessment
- Eligible for enhanced recovery
- Lives in bungalow
- Partner retired

Scenario 2

- 84 year old with cognitive impairment
- 4 x daily POC
- Found on floor at home
- NEWS score 4
- Multiple comorbidity
- EDD “unknown”

Scenario 3

- 45 years old, renal transplant
- Admitted from clinic with BP 200/120
- Lives alone
- Alcohol dependence

Scenarios

Scenario	Frequency	Criteria	Chance of CLD
Elective hip	Moderate	Easy	High
Frail elderly	Frequent	Generic	Low
Young complex	Rare	Specific	Medium

What’s in place?

- MDT approach in all areas
- Agreed criteria
- Board policy
- National policy

Settings

- First aid
- Midwives
- ITU
- Acute assessment units
- Community hospitals
- Elective surgery
- District nursing
- Acute DME

Examples

Setting	Volume	NHS acute impact	Risk	Delivery
First aid	High	Nil	Low	Exists
Midwives	High	Low	Medium	Partial
ITU	Low	Low	High	Unlikely
Acute assessment units	High	High	High	Difficult
Community hospitals	Low	Low	Low	Easy
Elective surgery	Moderate	Moderate	Low	Partial
District nursing	High	Low	Low	Exists
Acute DME	Low	Moderate	Moderate	Easy

How will we know it's worked?

- Increased patient and family satisfaction
  Satisfaction surveys
- Patients are able to leave hospital earlier
  Length of stay
- Patients have more certainty about discharge time
  Discharge profile
- Empowerment of patients to be part of the discharge process
  EDD accuracy
- Improved bed flow
  4 hour standard, occupancy
- Improved confidence of the multidisciplinary team
  Readmissions
- Increased productivity in use of clinical staff resources
  Bank and agency use

2004

National Competencies

3. Advanced practitioners (Expert)

Estimating expected date of discharge	
Undertake a full assessment of patient	
Demonstrate excellent knowledge of the clinical condition and interventions required	
Review and revise the EDD based on further assessments & evidence	
Estimate LOS needed to complete treatment to a level where patient is clinically fit for discharge	

What do we need?

- Trust
- Training
- Teamwork
- IT
- Time?