



Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard

This Clinical Practice Standard **does not include**:

- **Inter-hospital transfers**, refer to the:
 - WACHS [Assessment and Management of Inter-hospital Patient Transfers Policy](#)
 - WACHS [Inter-hospital Transfer of the Mental Health Patient Guideline](#)
- **Discharge against medical advice**, refer to the:
 - WACHS [Discharge Against Medical Advice Policy](#)
 - WACHS [MR36 Discharge Against Medical Advice Form](#)

1. Purpose

The purpose of this policy is to establish minimum practice standards for the care and management of admission, discharge, and intra-hospital transfer of patients throughout the WA Country Health Service (WACHS).

This policy is to be used in conjunction with:

- WACHS Assessment and Management of Inter-hospital Patient Transfers Policy
- WACHS Inter-hospital Transfer of the Mental Health Patients Guideline
- WACHS Mental Health Patients in Emergency Departments and General Wards Policy
- WACHS Adult Psychiatric Inpatient Services – Referral, Admission, Assessment, Care, Treatment and Discharge Policy

Further information relating to specialty areas including Mental Health, Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WHNS) can be found via [HealthPoint](#) if not covered in this policy.

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

Further information may be found via [HealthPoint](#) or the [Australian Health Practitioner Regulation Agency](#) as appropriate.

3. Procedural Information

- Patients require confirmation of at least three core patient identifiers whenever admission, clinical handover, patient transfer or discharge occurs or related documentation is generated as per the WACHS Patient Identification Policy.

- There should be evidence that discharge planning mechanisms are in place and that patient records include relevant discharge plans.
- All admissions require a discharge summary to be completed by the MO responsible for care – Refer to WA Health Clinical Handover Policy MP0095 (refer to [Appendix 2](#) for exclusions to this requirement)
- Security of tenure exists for inpatients of public hospitals that are also residents of aged care facilities OD0214/09 Security of Tenure for Residents of Aged Care Facilities.
- A standardised approach to assessing frail older people for permanent and respite residential care prior to admission to a Multipurpose Service – refer to the WACHS Residential Aged Care Services Policy.

4. Considerations

- Clinical staff are to meet the requirements of the MP0095 Clinical Handover Policy at the time of care change.
- By law, a WACHS site is deemed to be a custodial place. Prisoners attending a WACHS site must be escorted by the agency/service that is legally responsible for them. Where a patient is under escort by the WA Police, the same conditions apply to them as for prisoners. Refer to the WACHS Care and Discharge of Persons in Custody Policy.

5. General Information

This policy outlines the basic principles of admission, transferring a patient between wards and departments in the same hospital, and discharging a patient. Discharge and intra-hospital transfer procedures may differ between sites in WACHS. This document is to be read in conjunction with the existing site based documents to ensure the safe and timely intra-hospital transfer and discharge of patients from WACHS hospitals.

6. Admission Principles

To ensure that patients receive comprehensive care (a coordinated delivery of the total health care required or requested) the admission process needs to identify:

- the patient's expressed goals of care and healthcare needs
 - For adults refer to the MR00H.1 State Goals of Patient Care Summary and the WACHS Goals of Patient Care Guideline for additional information
 - For paediatric/neonates refer to the MR39 Not for Cardiopulmonary Resuscitation – Paediatrics Form (refer to the WACHS Paediatric-Neonate Not for Cardiopulmonary Resuscitation Policy for additional information)
- the impact of health issues on the patient's life and wellbeing
- any risk of specific harm by applying screening and assessment processes.

The admission process includes the integrated screening and assessment processes in collaboration with the patient, carer and family to develop goal-directive comprehensive care plans. Comprehensive care planning requires:

- timely screening to identify risks related cognitive, behavioural, mental and physical conditions including harm related to the following:
 - pressure injury and wounds
 - falls
 - nutrition and hydration
 - delirium and cognitive impairment
 - self-harm and suicide
 - aggression and violence
 - restraint and seclusion
 - social and circumstantial risks that may compound these risks.
- timely clinical assessment of risks identified through screening processes
- identification and communication of any identified Clinical Alerts. A Clinical Alert has the potential to be of critical importance to a patients' management during the first 24 hours of their admission to hospital and assumes that the patient is not always capable of communicating such information. Refer to MP0053/17 WA Clinical Alert (MedAlert) Policy
- clinicians to use shared (multidisciplinary) decision making to plan individualised care.

A number of WACHS forms ensure the admission principles are met to develop comprehensive care plans. See [Section 13 Related Forms](#).

Note: Please refer to individual WACHS policy documents on HealthPoint for expected timeframes for screening and assessment of risks.

7. Planning for Discharge

Discharge planning commences on admission or in the preadmission service to facilitate a safe and timely transition to an appropriate discharge/transfer destination. Discharge planning is to have a patient-centred approach, which takes into account the patient's (and their family/carers) circumstances and needs, involves them in planning and decision making, and provides them with appropriate information and education.

In the acute care adult setting, a [Blaylock Discharge Assessment](#) is to be completed on the MR111 WACHS Nursing Admission, Screening and Assessment Tool – Adults as part of the admission process to guide discharge planning.

In the maternity setting discharge planning checklists are provided in the newborn and maternity care plans (see [Section 13 Related Forms](#)).

Certain requirements for effective discharge can be routinely anticipated depending on the unit/service area (e.g. discharge medications, home oxygen, transport arrangements, follow-up appointments, and discharge summary).

Existence of co-morbidities may increase the complexity of the discharge plan. Early identification and appropriate action to support a complex discharge is essential to reduce the likelihood of readmission and improve patient outcomes.

8. Staffing Requirements

In order to facilitate safe and effective discharge planning and achieve seamless care, all staff are to have a clear understanding of the roles and responsibilities of multi-disciplinary team members.

Typical roles are listed below but sites will vary.
Not all roles will be required for all intra-hospital transfers and discharges.

Roles and Responsibilities

Discharge Coordinator/ Nurse Facilitator	<ul style="list-style-type: none"> • Advises and plans the care that a patient may require on discharge. • Liaises with the bed manager to: Organise a bed at the receiving ward, establish a time of bed availability, waitlist patients as required. • Liaises between areas to confirm details of the transfer/discharge. • Liaises with ward staff to make complex transport arrangements involving: mode of transport, equipment required, need for an escort, travel arrangements for the patient/escort and necessary paperwork. • Role may be undertaken by the Bed Manager or A/H Clinical Nurse Manager at some sites.
Bed Manager/ Patient Flow Coordinator	<ul style="list-style-type: none"> • Liaises with clinical areas about bed availability and facilitates patient transfer. • Informs receiving areas of patients requiring special precautions / needs. • Liaise with facilities outside the hospital as appropriate. • Role may be undertaken by the A/H Clinical Nurse Manager at some sites.
Ward Clerk	<ul style="list-style-type: none"> • Records an anticipated discharge date in webPAS. • Prepares and maintains the patient health record, transmits information to the receiving health providers (if applicable), assists preparation of discharge information. • Transmits medication information to community pharmacies as required. • Assists with arranging transport as appropriate. • Informs the bed manager of patient transfer / discharge. • Enters transfer and discharge information in webPAS.
Medical Officer	<ul style="list-style-type: none"> • Discusses anticipated discharge date with the ward staff, patient and significant other(s). • Completes discharge / transfer documentation. May liaise with the bed manager. • Completes medication prescriptions and liaises with ward staff, patient and significant other(s) to ensure they are transmitted to the appropriate health care providers.
Nurse/ Midwife/Shift Coordinator	<ul style="list-style-type: none"> • Liaises with the multi-disciplinary team to complete the risk assessments and ensure safe and effective transfers / discharges. • Liaises with MO to confirm the need for patient escort.
Allied Health Staff	<ul style="list-style-type: none"> • Liaises with the multi-disciplinary team to complete the risk assessments and plan for discharge. • Coordinates requirements for discharge including training and resources.

Note: Not all health services in small rural/remote communities have a designated discharge planning coordinator. This may be the ward manager or a general practitioner (GP).

9. Clinical Communication

- Adequate transfer of clinical information must occur to ensure ongoing clinical care.
- A discharge summary must be completed on the day of discharge or transfer to another health facility.

Clinical Handover

Information exchange is to adhere to WA Health MP0095 Clinical Handover Policy using the iSoBAR framework.

The discharge summary is to be faxed/or sent via secure electronic messaging service to the relevant GP within 24 hours of discharge. If the GP has not enrolled for secure electronic messaging or fax, hard copies must be posted as soon as possible.

Where transfer/escort duties are performed by non-clinical workforce (e.g. orderlies, AINs), continuity of care must be maintained by ensuring adequate documentation, transfer forms and telephone handovers are supplied.

Critical Information

Critical information, concerns or risks about a patient are communicated in a timely manner to clinicians who can make decisions about the care. This includes the presence of an Advanced Health Directive.

In regard to the patient's expressed goals of care refer to and ensure use of:

- For adults the WACHS Goals of Patient Care Guideline and the MR00H.1 State Goals of Patient Care Summary
- For paediatric/neonates the WACHS Paediatric-Neonate Not for Cardiopulmonary Resuscitation Policy and the MR39 Not for Cardiopulmonary Resuscitation – Paediatrics Form

Documentation

Failure to accurately and legibly document, and understand what is recorded, in patient health records contribute to a decrease in the quality and safety of patient care.

Adequate transfer of clinical information must occur to ensure ongoing clinical care, this includes where an admission document has not been completed, document in the progress notes and provide clinical handover to staff member taking over care.

Refer to WA Health Admission Policy MP 0058/17, WA Health Clinical Handover Policy MP0095 and WACHS Documentation Clinical Practice Standard.

Consumer information

There are a number of ways consumers can obtain specific information relating to hospital admissions, transfers and discharge from hospital. Relevant documents can be located via:

- [Patient First resources](#)
- [“What Matters to You” Leaflet](#)
- [Procedure Specific Information Sheets \(PSIS\)](#)
- [Patient Medicines Information](#)
- [Information leaflets for patients about medicines used in mental health](#)
- [Emergency Discharge Information Sheets, WA Health](#)

10. Compliance Monitoring

Evaluation, audit and feedback processes are to be in place to monitor compliance. Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the [Integrity Policy Framework](#) issued pursuant to section 26 of the [Health Services Act 2016](#) (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

Heads of Departments are required to:

- ensure that appropriate training and education are provided regarding accurate documentation and completion of discharge summaries; and
- monitor discharge summary completion rates to ensure compliance within their department.

WACHS staff are reminded that compliance with all policies is mandatory.

11. Relevant Legislation

(Accessible via: Government of Western Australia ([State Law Publisher](#) or [ComLaw](#)))

- *Carers Recognition Act 2004*
- *Children and Community Services Act 2004*
- *Civil Liability Act 2002*
- *Criminal Code Act Compilation Act 1913*
- *Disability Services Act 1993*
- *Equal Opportunity Act 1984*
- *Equal Opportunity Regulations 1986*
- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Mental Health Act 2014*

- *Occupational Safety and Health Act 1984*
- *Occupational Safety and Health Regulations 1996*
- *Privacy Act 1988*
- *Public Sector Management Act 1994*
- *State Records Act 2000*

12. Relevant Standards

[National Safety and Quality Health Services \(NSQHS\) Standards](#)

Clinical Governance Standard: 1.7, 1.16 and 1.17

Partnering with Consumers Standard: 2.3 – 2.7, and 2.10

Comprehensive Care Standard: 5.3 – 5.14

Communicating for Safety Standard: 6.3 – 6.11

13. Related Forms

[MR00H.1 State Goals of Patient Care Summary](#)

[MR111 WACHS Nursing Admission, Screening and Assessment Tool – Adults](#)

[MR111P WACHS Paediatric Nursing Admission / Discharge Assessment Form](#)

[MR115 WACHS Paediatric Short Stay Medical Admission](#)

[MR25 Medical Discharge Summary](#)

[MR29 WACHS Referral Record and Leaving Hospital Checklist - Adults](#)

[MR36 Discharge Against Medical Advice Form](#)

[MR39 WACHS Not for Cardiopulmonary Resuscitation Form Paediatric - Neonate](#)

[MR59 WACHS Cancer Service – Cancer Coordination Admission Form](#)

[MR59C WACHS Cancer Services – Cancer Treatment Nursing Assessment and Care Plan](#)

[MR70a WACHS Antenatal Inpatient Care Plan](#)

[MR75 WACHS Newborn Care Plan](#)

[MR80 WACHS Vaginal Birth Care Plan](#)

[MR80A WACHS Maternity Inpatient Risk Assessment](#)

[MR81 WACHS Caesarean Postnatal Care Plan](#)

[RC 5 WACHS Resident Admission Assessment](#)

14. Related Policy Documents

[Adult Psychiatric Inpatient Services – Referral, Admission, Assessment, Care, Treatment and Discharge Policy](#)

[Advance Health Directive and Enduring Power of Guardianship Guideline](#)

[Assessment and Management of Inter-hospital Patient Transfers Policy](#)

[Care and Discharge of Persons in Custody Policy](#)

[Care of the Deceased Policy](#)

[Discharge Against Medical Advice Policy](#)

[Documentation Clinical Practice Standard](#)

[Goals of Patient Care \(Adults\) Guideline](#)

[Inter-hospital Transfer of the Mental Health Patients Guideline](#)

[Management and review of ‘Did Not Wait’ Patients that Present to Emergency Services Policy](#)

[Mental Health Patients in Emergency Departments and General Wards Policy](#)

[Paediatric - Neonate Not for Cardiopulmonary Resuscitation Policy](#)
[Residential Aged Care Services Policy](#)

15. Related WA Health System Policies

MP 0058/17 [Admission Policy](#)
MP0095 [Clinical Handover Policy](#)
OD 0214/09 [Security of Tenure for Residents of Aged Care Facilities](#)
MP0053/17 [WA Clinical Alert \(MedAlert\) Policy](#)
MP0122/19 [Clinical Incident Management Policy 2019](#)

16. Policy Frameworks

[Clinical Governance, Safety and Quality Policy Framework](#)
[Clinical Services Planning and Programs Policy Framework](#)
[Information Management Policy Framework](#)

17. Acknowledgement

Acknowledgment is made of the previous South Metropolitan Health Service (SMHS) / WACHS site endorsed work used to compile this Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard.

18. References

1. Australian Commission for Safety and Quality in Health Care, National Health and Medical Research Council. [Australian Guidelines for the Prevention and Control of Infection in Healthcare](#) Canberra, ACT: NHMRC; 2019: [Accessed 11 May 2020].
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3. Xue Y. Patient: Discharge from hospital. Adelaide, SA: The Joanna Briggs Institute; 2012. Accessed 4 April 2013.
4. Department of Health WA. [Admission Policy](#). Perth, WA: DoH WA; 2019: [Accessed: 11 May 2020].
5. Ip HY, Chung F. Escort accompanying discharge after ambulatory surgery: a necessity or a luxury? *Current opinion in anaesthesiology*. Dec 2009;22(6):748-754.
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8. Dougherty L, Lister S, editors. The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Seventh Edition. Oxford: Blackwell Publishing; 2008.

9. Australian Commission for Safety and Quality in Health Care. [National Safety and Quality Health Service Standards Second Edition](#). Sydney, NSW: Australian Commission for Safety and Quality in Health Care; 2017.

19. Definitions

Carer	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carers Australia, 2015).
Discharge	Discharge is the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care.
Patient	A person who is receiving care in a health service organisation.

20. Appendices

- Appendix 1: [Admission and Discharge Procedures](#)
 Appendix 2: [Discharge Summaries for patients discharged from inpatient same-day, short-stay emergency admissions or multi-day stays](#)
 Appendix 3: [Intra-hospital transfers \(between wards and units at the same hospital\)](#)
 Appendix 4: [Discharge Transportation Options](#)

**This document can be made available in alternative formats
on request for a person with a disability**

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Appendix 1: Admission and Discharge Procedures

The aim of admission, screening and assessment is to provide a consistent, timely, informed approach to patient-centred care during a hospital admission through to discharge.

Discharge planning is commenced prior to admission for booked admissions and on presentation for unplanned admissions. It is the responsibility of all health professionals involved in the patient's care.² This will facilitate a clear patient-centred admission, safe and timely transition to an appropriate discharge/transfer destination.

The inpatient length of stay is only to last as long as the patient's need for hospital based care. Consider alternatives such as Hospital in the Home (HITH), Silver Chain, or other community based services where clinically indicated.

Specific admission, screening, assessment, and discharge planning documents are to be completed - see [Section 13 Related Forms](#)..

Admission Procedure

Notes:

- The order of the below will vary depending on clinical presentation and patient needs.
- The admission procedure and documentation is commenced at the time of either planned (pre-admission setting or Emergency Department) or actual admission.

On arrival:

- Greet the patient and any family, carers or support persons, introduce yourself.
- Check the patients' identity with the details in the medical record and ID band identification (or other approved method of identification as applicable). Refer to WACHS Patient Identification Policy.
- Explain the admission procedure to the patient/family/carer. Ensure the patient understands the reason for admission.
- Orientate the patient to the ward layout and provide information:
 - The function of the handset; bathroom facilities
 - Meal times, visiting hours and the rest period
 - Locked drawer and valuables
 - Television use
 - Mobile phone use
 - Patient rights
 - Consumer information as appropriate
 - Explain Care and Respond Early (CARE) process for patient, family and/or carer escalation
 - Fire exits.

- If the patient is being transferred from another area of the hospital receive a detailed clinical handover (in the ISoBAR format) from the accompanying staff member. See WA Health Clinical Handover Policy.
- Check if the patient has any special requirements e.g. cultural and communication needs.
- Record clinical alerts as relevant. A clinical alert is a diagnosis which has the potential to be of critical importance to a patients' management during the first 24 hours of their admission to hospital and assumes that the patient is not always capable of communicating such information. There are four classifications of clinical alerts:
 - anaesthetic alerts
 - medical condition alerts (including presence of an **Advance Health Directive**). See WACHS Advance Health Directive and Enduring Power of Guardianship Guideline
 - food alerts
 - medication (drug) alerts (including Adverse Drug Reactions).
- Perform and record observations on the observation and response chart.
- Attend to immediate nursing/midwifery care needs as required.
- Inform the patient that we have a Smoke Free Organisation.
- Ensure consent has been gained/completed (where applicable).
- Notify the MO of the patient's arrival and any abnormalities detected.

Undertake integrated screening and assessment (in collaboration with the patient, carer and family) to develop an individualised, goal-directed comprehensive care plan, and a plan for discharge. This is to include:

- admission history and assessment including current condition and any chronic conditions, as well as any past medical / surgical/mental health history
- home and family assessment including accommodation type, support system (family / friends), transport and community resources available
- identifying other alerts for the patient (e.g. allergies, high risk medications, behaviour, infection control)
- skin assessment and pressure injury screening within 8 hours of presentation
- cognitive impairment and delirium screening
- nutrition and hydration screening
- mobility and falls screening and assessments
- mental health screening and assessment including risk of self-harm and suicide; and aggression and violence
- social and circumstantial risk assessments (e.g. family and domestic violence, substance use).

Any incomplete admission documentation must be handed over to the next shift for completion and continuity of care.

The admission screening and assessments should guide the multi-disciplinary team to ensure the following:

- Identification of services which may be required on discharge.
- Referrals to allied health staff are made as clinically indicated.
- Timely referral to clinical specialties, considering whether they can be completed on an outpatient basis.

- Referrals to a social worker or discharge coordinator where complex needs are expected.
- Consider the use of video-conferencing resources for complex transfers to regional and remote areas.
- Update the patient health care record.

Multi-disciplinary meetings are to be attended by the senior medical officer (MO), relevant allied health and clinical ward lead. They should focus on discharge planning, with the outcome documented by the MO in the patient health record. Consider discharge to Hospital in the Home (HITH) / Rehabilitation in the Home (RITH) on each ward round.

Discharge plans and the estimated date of discharge are to be reviewed following multi-disciplinary meetings or a change in the patient’s clinical condition and communicated to significant other(s) / next of kin (NOK).

Blaylock Risk Assessment Screening Score

In the acute care adult setting, a Blaylock Risk Assessment Screening Score must be completed on the MR111 WACHS Nursing Admission, Screening and Assessment Tool – Adults. The Blaylock Risk Screening Score predicts length of hospital stay and the need for comprehensive discharge planning at the time of admission.

This assists nurses with identifying issues which may affect a patient’s readiness for discharge and/or the need for additional services.

There are various sections of the Blaylock Risk Assessment which need to be completed and scored according to the patient and their circumstances and allocated number (i.e. score):

Indicators	Refers to MR111 section
Age	Specific age groups, with modification to suit an Australian context
Living Situation / Social Support	Home and Family Risk Assessment (page 2)
Previous Admissions/ED Visits	in the last 3 months
Active Medical Problems	Past Medical / Surgical / Psychiatric History (page 1)
Number of Drugs	Medication (page 2)
Cognition	Neurological (page 4) (spheres: person, place, self, time)
Functional Status	Disability and Activities of Daily Living (page 3)
Behaviour Pattern	Neurological (page 4)
Mobility	Disability and Activities of Daily Living (page 3).
Sensory Deficits	Cultural and Communication Needs (page 1) and Disability (page 3)

Total - is the sum of all numbers (scores) for relevant item(s) in each section of the tool of '0-9', '10-19' and '>20' and, relate to the recommended actions. A higher score indicates a potential increased length of stay in hospital.

The MO responsible for patient care is to:

- review and clear the patient for discharge prior to 10am on the day of discharge where possible or to have completed the appropriate criteria led discharge documentation
- organise outpatient follow up appointments where clinically indicated
- complete the patient transfer summary letter for transfers and/or electronic discharge summary and medical certificate as required
- contact the general practitioner by telephone where major new diagnoses or changes in management have occurred, or prompt follow-up is required after discharge
- ensure the patient health record is updated.

Discharge Procedures from inpatient same-day or multi-day beds

Ensure the patient, family, carer is involved in discharge planning.

For patients who choose to leave the hospital and / or are removed by their parent / carer/ responsible person before the completion of treatment against the advice of the treating clinician, or those who leave prior to receiving advice or refuse to wait to receive advice – refer to Discharge Against Medical Advice Policy and the MR36 Discharge Against Medical Advice Form

72 hours prior to discharge

- Clinical staff are to begin coordination of the patient's discharge requirements. This should be related to the Blaylock Risk Assessment Screening Score, where applicable.
- Criteria-based discharge should be discussed with the treating team for use where appropriate.

48 hours prior to discharge

- Allied health interventions should be complete.
- Referrals to community services and/or outpatient services completed as appropriate.
- Transport arrangements for discharge are to be finalised.
- Begin liaising with the patient's discharge destination, if applicable.

24 hours prior to discharge and day of discharge

- Patients must be medically stable for discharge. The treating medical team is to make the decision to discharge in consultation with the multi-disciplinary team as clinically indicated.
- The discharge plan is to be documented in the patient health record.

- Ensure discharge medications are ordered and prepared. If pre-packed (Webster) medications are required, the patient's own pharmacy is to receive the prescription the day prior to discharge.
- Permission may be required to dispose of patient owned medications if clinically appropriate.
- Ensure referrals to community services are completed.
- The MO is to ensure completion of the discharge summary.

The allocated nurse / midwife and shift coordinator are to:

- ensure the patient, family, carer are involved in discharge planning²
- notify the receiving destination of pending discharge
- assess transport needs and clarify transport arrangements with the family
- liaise with senior nursing staff and social work as appropriate
- liaise with the MO regarding medication administration prior to long journeys
- supply items required for transit for long journeys e.g. dressings, fluids and toiletries
- ensure discharge medications are issued and prescriptions are communicated to the patient's regular pharmacy / discharge facility
- educate the patient / carer about medications unless transferring to another facility
- ensure that patient / carer education is complete including provision of written information
- confirm patient / carer understanding of discharge medications and education
- remove invasive devices unless needed after discharge e.g. dialysis lines, peripherally inserted central catheters (PICC)
- ensure patient has all equipment required for discharge e.g. mobility aids, oxygen, feeds and equipment, dressing supplies
- return all personal property to the patient e.g. valuables, own medications and equipment. Refer to site based procedures for the safe-keeping of patient valuables
- ensure pre-admission support services are recommenced
- complete discharge documentation, nursing discharge checklist as appropriate
- include transfer forms for post discharge destination/ services e.g. HITH, Silver Chain
- liaise with the MO regarding follow up appointments.
- liaise with allied health and specialist nurses regarding outpatient appointments if indicated
- ensure a discharge summary, medication list and other information is provided to the patient
- consider transfer to transit or discharge lounge (where available) as clinically indicated
- update the patient health record
- provide options for providing feedback on the care they received.

Discharges from Emergency Department and short stay units

Discharge is only to be actioned after the decision to discharge has been made by the treating medical team, in conjunction with allied health (if appropriate).

Ensure the patient and significant other(s) are involved in discharge planning.

For patients who choose to leave the hospital and / or are removed by their parent / carer/ responsible person before the completion of treatment against the advice of the treating clinician, or those who leave prior to receiving advice or refuse to wait to receive advice – refer to WACHS Discharge Against Medical Advice Policy and the MR36 WACHS Discharge Against Medical Advice Form

For patients who present to a WACHS Emergency Service and do not wait to be treated after triage (refer to WACHS Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy)

Ensure the following:

- A full set of observations has been performed and documented prior to discharge. **Note:** Patients with abnormal observations are not to be discharged without a medical review and a discharge plan for follow up.
- All invasive lines are removed unless required after discharge e.g. HITH patient.
- Discharge medications are ordered and prepared.
- Prescriptions are communicated to the patient's regular pharmacy / discharge facility where applicable.
- Referral documentation is complete. Include transfer forms for post discharge destination / services e.g. HITH, Silver Chain.
- Transport needs are assessed and arrangements clarified with the patient and significant other(s) / NOK. Liaise with senior nursing staff and social work.
- The patient/carer are educated about medications.
- Other education of the patient and carer is complete including provision of written information (including [Emergency Discharge Information Sheets](#), where applicable).
- The patient has all equipment required for discharge e.g. mobility aids, dressing supplies.
- All personal property is returned to the patient e.g. valuables, own medications and equipment. Refer to site based procedures for the safe-keeping of patient valuables.
- Discharge documentation is complete including the electronic discharge record.
- The patient health record is updated.

Discharges from Day Surgery / Short Stay surgical units

For patients who choose to leave the hospital and / or are removed by their parent / carer/ responsible person before the completion of treatment against the advice of the treating clinician, or those who leave prior to receiving advice or refuse to wait to receive advice – refer to WACHS Discharge Against Medical Advice Policy and the MR36 WACHS Discharge Against Medical Advice Form

Ensure the following:

- Post anaesthetic discharge scoring system (PADSS) of 9-10.

Post Anaesthetic Discharge Scoring System (PADSS)	Vital Signs		Ambulation		Nausea/Vomiting		Pain		Surgical Bleeding	
	2	Within 20% pre-op values	2	Steady gait, no dizziness	2	Minimal	2	Minimal	2	Minimal
1	20-40%	1	With assistance	1	Moderate	1	Moderate	1	Moderate	
0	>40%	0	None, dizziness	0	Severe	0	Severe	0	Severe	

- Post procedure physiological observations are stable for at least 1 hour and consistent with pre-operative observations.
- The patient is alert, orientated to time, place and person, or at admission status.
- The patient is tolerating oral diet and fluids.
- Intravenous lines are removed.
- Minimal bleeding or wound drainage.
- Patients at significant risk of urinary retention have passed urine.
- Patients are to be advised that they should not drive a car, operate machinery, sign legal documents, make important decisions or drink alcohol for 24 hours following general anaesthetic.
- Patients are advised not to drive after conscious sedation until they have had a normal night's sleep.
- Patients having eye blocks cannot drive until cleared by their ophthalmologist.
- A responsible adult is transporting the patient to their discharge destination if the patient has undergone sedation.⁵
- A responsible adult is able to stay with the patient for 24 hours.
- Consider if the patient needs to stay within an hour of the hospital for 24 hours.
- The patient/caregiver has a functioning home or mobile telephone.
- Written and verbal instructions for post anaesthetic and procedure specific information are supplied to the patient/caregiver. Document in the patient health record.
- The patient is informed by the MO of the result of the procedure if appropriate e.g. endoscopy.
- Outpatient reviews or appointments are clarified.
- Analgesia is discussed/supplied according to site based protocols.
- Other regular medications are discussed as necessary.

- Hospital contact numbers are given to the patient if appropriate to the site / procedure.
- In cases where the patient does not have a carer organised:
 - notify the treating MO
 - refer to the [WACHS Discharge Against Medical Advice Policy](#) and the MR36 WACHS Discharge Against Medical Advice Form, if applicable
 - arrange patient transport to the discharge destination
 - assess if inpatient bed available.

Appendix 2: Discharge Summaries for patients discharged from inpatient same-day, short-stay emergency admissions or multi-day stays

The discharge summary is the primary document communicating a patient's care plan to GPs and other health care professionals taking over the care of the patient following hospital discharge. It should be clear, concise and fully completed with the patient's diagnoses, symptoms, treatment and plans for follow up care / management. They contribute to the continuity of care and safe transition between the hospital and the community.

The discharge summary also provides the basis for classification by clinical coders into Diagnosis Related Groups (DRG) and is used for Activity Based Funding (ABF) to individual health services. It is essential that all relevant conditions, procedures, complications of treatment or surgery are documented in the discharge summary to ensure the health service is correctly funded.

Inpatients

Discharge summaries are to be completed prior to the time of discharge for all inpatients including patients:

- who are being discharged home
- transferred to another external health care facility
- transferred to an internal or external Hospital in the Home (HITH) program (e.g. Silver Chain). An additional discharge summary will be required once the patient has been discharged from HITH
- who have outstanding test results still require a discharge summary (the summary may require updating once these test results are known)
- who have died in hospital. Refer to the WACHS Care of the Deceased Policy.

Exceptions

Discharge summaries are not required for:

- patients transferred (on leave) to another health care facility with an expected return
- same day elective (booked) procedures (e.g. endoscopy), where the operation report provides the necessary clinical details, copies of which are to be sent to the GP. This includes elective patients without complications who stay overnight but are discharged <24 hours
- day only patients admitted (where no complications arise, no other treatment is provided and the record creation is automated) for:
 - haemodialysis
 - chemotherapy
 - radiotherapy
 - intravenous therapy
- patients with recurring same day care episodes (e.g. same day infusions, transfusions, dialysis, hyperbaric therapy) receiving a course of treatment of the same condition over weeks or months. A single global discharge summary covering all episodes is sufficient

- healthy (unqualified) newborns (babies in their birth episode, with no peri-natal morbidity)
- statistical discharges for an episode of care change such as from acute care to rehab require a progress (not final) discharge summary.

When a discharge summary is not required, the minimum information recorded on the patient's health / medical record is to include the diagnosis and procedure, care or treatment provided and any proposed recurrent care. These patients may receive other documentation, for example a transfer letter.

Mechanisms are to be in place to provide timely information to GPs for exception-type patients to inform of procedures, findings, aftercare and follow-up; especially for investigative procedures such as endoscopy and angiography.

Progress Discharge Summary

A progress discharge summary is useful to handover care internally and/or update the GP for longer-stay patients, and at a minimum is required for:

- patients with an acute episode of care change with an internal transfer to subacute care for ongoing management e.g. rehabilitation.
- transfers to other hospitals where the patient is expected to be transferred back to the original site for further care. All other transfers to other hospitals require a full discharge summary to be completed.

Completion of Discharge Summaries

The primary purpose of a well-documented discharge summary is to support the provision of high quality and safe patient care. A Discharge Summary must be completed on the day of discharge or transfer to another health facility.

The consultant and clinical team that discharge a patient are responsible for the completion of the discharge summary. If the consultant in charge is not available to complete the discharge summary, the next most appropriate clinician in the team will be responsible for completing it.

For maternity patients who meet the criteria for midwife-led discharge, the midwife is responsible for completing the discharge summary.

Where a printed discharge summary is generated in a secure Electronic Discharge Summary System with appropriate user credentialing, e.g. NaCS or Stork, and the clinician completing the discharge summary is clearly identified on the printed discharge summary, there is no additional need for a written signature.

Copies of the discharge summary are to be provided as follows:

- One copy to the patient.
- One copy for the patient's health record.

One copy is sent to the patient's usual GP and referring doctor if different from the usual GP.

- Additional copies as required for ongoing care management (e.g. private specialist, another hospital, aged care facility, Silver Chain, nursing post).
- Where relevant, copies to organisations involved in transporting the patient (e.g. St John Ambulance Australia, Royal Flying Doctor Service).
- One copy to the parent of children/adolescents, at the discretion of medical staff.
- Where technology allows, uploaded to the patient's My Health Record where the patient has one and has not requested that the summary be withheld.

Communication

The discharge summary is to be faxed/or sent via secure electronic messaging service to the relevant GP within 24 hours of discharge. If the GP has not enrolled for secure electronic messaging or fax, hard copies must be posted as soon as possible.

Handwritten discharge summaries are only to be used if electronic discharge summary software is not operational.

The MO is to consider phoning the GP if the patient requires significant follow up or for any major diagnosis.

Clinical Coding / Activity Based Management (ABM)

Activity Based Management (management and funding based on types of patient) is reliant on the accuracy in the application of the WA Health Admission Policy MP0085/17 and the appropriate classification for all episodes of care.

A timely and accurate discharge summary is integral to the data generated through the clinical coding process. Where inconsistencies between the reconciliation of discharge summary and inpatient notes are encountered the clinical coder will communicate with the responsible clinician or clinical team for review.

Therefore accuracy of the discharge summary is vital to ensure reliability of data on first capture.

Elements of a Good Discharge Summary

The key elements relating to the completion of a good discharge summary include:

- content: information should be accurate and comprehensive
- clarity: information should be clear and concise
- sequencing: information should be structured in a logical and helpful way to ease communication.

The components of a good discharge summary include as follows:

- A single principal diagnosis.
- Additional diagnoses / comorbidities.
- Complications arising e.g. infection, adverse reaction, allergies.
- Past history.
- Operations/procedures.
- Presenting problem.
- Relevant investigation results.

- Treatment and progress.
- Medications.
- Future plan of management.

Discharge summaries are to include copies of:

- primary and secondary diagnoses
- treatment course to date, including relevant procedures and dates performed
- relevant diagnostic test results and test results pending
- discharge medications (reconciled)
- outstanding outpatient and medical appointments
- ongoing and follow-up plans, with responsibilities assigned to specific professions, e.g. “General Practitioner to...”

MR29 Referral Record and Leaving Hospital Checklist – Adults

The MR29 Referral Record and Leaving Hospital Checklist – Adults is designed to be printed (both sides) and a photocopy of the record is given to the patient (or carer) on leaving hospital for their information and to facilitate interagency communication with other professionals / services.

The consumer is encouraged to give the form to their general practitioner (GP), remote area community nurse/health centre or Aboriginal Medical Service (AMS) as appropriate. Alternatively, with permission from the patient (or carer), the form can be faxed through to these services by the hospital.

Appendix 3: Intra-hospital transfers (between wards and units at the same hospital)

- The shift coordinator is to be involved in the decision to transfer patients from the ward/unit.
- For transfers to another ward / unit, the MO is to confirm acceptance by the destination medical team and document in the patient health record.
- Ensure the bed manager (where applicable) has approved the transfer.
- Liaise with all involved members of the multi-disciplinary team.
- The nurse responsible for transferring the patient is to be familiar with the patient's condition and have the necessary skills and knowledge for patient care requirements.
- Provide clinical handover to the destination ward / unit and confirm the time of transfer, transport requirements and any additional precautions required.
- Organise a nurse / midwife and/or medical escort as indicated. Refer to [Intra-hospital transfer of patients requiring an escort](#).
- Assess for and obtain equipment required to transfer the patient.
- Liaise with the ward clerk confirming transfer details and transport requirements, additional precautions and personal protective equipment (PPE) that may be required.
- Ensure medical records and x-rays accompany the patient where required.
- Ensure patient belongings, valuables, prosthesis, equipment and medications are transferred with the patient as applicable.
- Inform the significant other(s) / NOK of the transfer where applicable.
- Complete transfer documentation.
- Update the patient health record.
- On arrival at the destination ward / unit, provide a clinical handover to receiving staff and assist to establish / orientate the patient.
- Return any equipment to the ward/unit of origin as required and organise cleaning according to site based infection control procedures.

Intra-hospital Transfer of patients requiring an escort

The member of staff escorting the patient must have the appropriate level of expertise to manage both the level of patient acuity and any equipment required during the transfer.

Patients with the following criteria require an appropriately skilled clinician escort:

- Intubated patients or potential for airway compromise.
- Requiring continuous oxygen saturation monitoring, acutely unstable or with high acuity.
- Cardiac monitoring, external cardiac pacing.
- Infusions via syringe or volumetric pump.
- Intravenous or intramuscular sedation or narcotic in the 30 minutes prior to departure or sedation score of greater than 1 after receiving sedation.
- Altered conscious state i.e. confused, agitated, post-ictal, unconscious
- Acute spinal injury on full spinal precautions.
- Obstetric patients in active labour.

- Acute psychosis or on forms under the *Mental Health Act 1996*.
- Paediatric patients under 16 years old.
- After upper or lower intestinal bleeding episode or scoping.

Completion of Escort

- The escort is to ensure the receiving nurse / midwife or shift coordinator is aware of patient arrival.
- Provide handover documentation and verbal clinical handover.
- Ensure equipment that is to return to originating ward / unit is prepared and cleaned as applicable.
- Ensure details of the transfer are documented in the patient health record.

Intra-hospital Transfer of neonates and paediatric patients

Newborns and Neonates

- Follow the WACHS Patient Identification Policy in relation to ID bands.
- Neonates are to be transported in a cot / resus cot or incubator unless in a wheelchair / trolley with the mother from the labour ward or theatre.
- The baby must be covered to be kept warm.
- The midwife must also accompany the mother and baby.

Infants and Children

Paediatric patients must be transferred with oxygen, suction and an appropriately sized mask for mask and bag ventilation when:

- sedated to undergo procedures in other departments
- returning from recovery room.

This includes infants being carried in parent's arms.

Appendix 4: Discharge Transportation Options

Transport options for discharge and in order of preference:

Significant other(s), next of kin, friend, community service provider
Public transport

- Patients with no other means of transport / insufficient funds.

Hospital Transport

- May be used to transport a patient home, to another hospital/facility or to connecting transport.
- Volunteer transport may be used to transport eligible outpatients to and from appointments at the hospital.
- Consider assessment by social worker or other allied health as clinically indicated to assess transport needs e.g. for voluntary transport.

Patient Taxi

- If other means of transport are unsuitable, in extreme financial difficulties or no family is available.

Note: Department of Veteran's Affairs patients are entitled to a taxi fare from hospital.

Ambulance

- For patients being transferred between hospitals and home or nursing homes where a stretcher is required.
- Clinical assessment must be used to determine the need for ambulance transport.
- Costs may apply for transfers residential care facilities or home.

Flights

- Patients may be eligible for a charter flight or Royal Flying Doctor Service where clinically indicated, where other forms of transport are unsuitable or they are not medically cleared to fly by commercial flight. Patients are to be waitlisted for RFDS but must be ready to leave the hospital at short notice.
- Patients being transferred by commercial flight require suitable clothing and footwear and means of identification.

Refer to the WACHS [Patient Assisted Transport Scheme \(PATS\) User Manual](#) to identify if the patient is eligible for subsidised travel or accommodation assistance, as required.