TECHNICAL BULLETIN

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TITLE : **DISCHARGE POLICY IN WA HOSPITALS**

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1. Purpose

The purpose of this bulletin is to outline the policy for discharge guidelines to operate in hospitals in Western Australia.

2. Background

In recent years, there have been changes in the length of time individuals remain in hospital for the treatment of many different medical conditions or when they are admitted for operative procedures. Some of the factors which have led to shorter hospital admissions are;

- changes in clinical practice;
- increases in the types of services provided in community settings;
- increased provision of day hospital facilities;
- the preference of some patients to convalesce in their own homes;
- the belief that home care will prevent many patients from developing nosocomial or post operative infections; and
- the introduction of casemix funding.

The introduction of casemix funding has led to increased monitoring of the length of stay of admitted patients and greater scrutiny of episodes patients which are allocated the same DRG (that is patients treated for the same diagnoses and who use the same amount of resources). However casemix funding methods should not drive clinical care.

The belief that patients are discharged 'quicker and sicker' and without suitable support services (as espoused by some opponents of the current funding method) can not be substantiated by results of patient satisfaction surveys. The majority of patients leaving hospital in WA believe that they were kept in hospital for an appropriate time and that there was sufficient preparation time before they were discharged from hospital.

Definition of Discharge Planning
Discharge planning is an important part of admitted patient care as it ensures continuity of care leading to an effective post hospital recovery and greater patient satisfaction. All phases of patient care should be planned and managed by those involved in providing the care with active input from the patient and/or the patient's family.

Every patient who receives medical treatment in hospital will make at least one transition during care, from acute care to home care, for example. Others may have several transitions between different levels of acuity of hospital care followed by the final transition to home care or further institutional placement.

There are particular groups of patients for whom very significant discharge arrangements are required and for whom early planning is essential. These include;

- those with severe physical, mental or emotional problems;
- those living alone or with an elderly infirm partner;
- those without relatives; and
- those who are dependent.

Where the initial assessment indicates that rehabilitation or placement arrangements will be required, referrals, for example, to a specialist geriatrician or social worker should take place soon after admission. In other words the discharge process begins soon after assessment.

Whilst most hospitals practise discharge planning, there is not always clear evidence that the process took place. There is recognition that a quality admitted patient service will have a formal discharge planning process. Accreditation of health services and quality assurance programs require discharge plans and other relevant documentation to be filed in the medical records to enable independent verification of the discharge planning process.

The major benefit of good discharge planning process is the provision of a more effective health service with increased patient satisfaction, decreased lengths of patient stays in hospital, increased hospital throughput and decreased unplanned readmission to hospital.

3. Generic Discharge Planning Guidelines

Hospital specific discharge planning guidelines may be developed and used in different hospitals. Teaching hospitals providing a more complex mix of services and who have specified staff monitoring bed allocation and patient discharge may have more specific guidelines than smaller metropolitan or rural hospitals. The following generic guidelines apply to all hospitals in Western Australia.

Note also that hospitals with a large proportion of same day patients may not formally have to undertake the discharge planning process for same day patients. The doctor should have discussed with the patient that the admission and discharge will occur on the same day prior to the admission and arrangements for follow up and any post procedural care will usually have been arranged before admission.

The following points should be noted.

- A discharge plan should be prepared for all patients.

- For scheduled admitted patients the discharge planning process commences before admission.

- For emergency patients the planning process commences at admission.

- The discharge plan is governed by factors such as ;
    - diagnosis;
    - expected length of stay;
    - acuity of care requirements/changes in episode of care;
    - need for placement or management in another institution;
    - availability of community supports and social factors such as carer availability or otherwise.

- The discharge plan should be recorded in the progress notes or on the *Patients Admitting Advice* form by the medical officer responsible for care. Interventions pertinent to nursing staff should be reflected in the Nursing Care Plan. Pertinent interventions and treatments by allied health professionals should also be recorded.

- The discharge planning process has multidisciplinary participation. However, in most health services the nursing staff are the co-ordinators of the process.

- The patient and/ or the patient's carer should be included in the discharge planning process.

- Complications of conditions and treatments may lead to revisions of the discharge plan.

- There are groups of patients for whom significant discharge arrangements will be required and for whom early, more comprehensive, planning may be needed.

  This includes patients who :

    - have severe physical, mental or emotional problems ; and /or

    - require different levels of acuity during a hospital stay.

  (This may include portions of the acute hospital care in an intensive care unit with the remainder of the acute care in a general ward followed by rehabilitative, palliative or non acute care in hospital and finally, continuing care in the community. The changes to the different levels of care and change in episode of care (See Technical Bulletin 26/2)should be recorded on discharge plans)

- While hospitals are encouraged to analyse information about their patients, analysis of DRG information is not a part of the discharge planning process.