

Appendix I Nine step checklist

Figure III: the nine key steps in effective discharge and transfer of care from hospital to community

Yes	No
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Step 1, Page 15
Begin planning for discharge or transfer before or on admission

<ul style="list-style-type: none"> Pre-admission assessments conducted for planned admissions to hospital e.g. elective procedures, or alternatively at first presentation to the hospital for unplanned admissions. 		
<ul style="list-style-type: none"> Most accurate pre-admission medication list should be identified prior to administration of medication in the hospital. 		
<ul style="list-style-type: none"> Prior history of colonisation with a multidrug resistant organism (e.g. MRSA) or healthcare associated infection should be recorded in healthcare record and healthcare staff informed as per local hospital policy. 		
<ul style="list-style-type: none"> Timely referrals are made to multidisciplinary team and receipt of referrals recorded on integrated discharge planning tracking form within 24 hours of receiving referral. <i>NOTE: this includes referrals from hospital to primary care services (homelessness services where relevant).</i> 		
<ul style="list-style-type: none"> Each service user should have an Estimated Length of Stay/ Predicted Date of Discharge (ELOS/PDD) identified within 24 hours of admission and documented in the healthcare record related to the estimated length of stay required (SDU, 2013). 		

Step 2, Page 19
Identify whether the service user has simple or complex needs

<ul style="list-style-type: none"> The service users needs are assessed either prior to admission or on first presentation and indicates whether the service user has simple or complex needs. 		
<ul style="list-style-type: none"> The ELOS/PDD is determined by whether the service needs are simple or complex. 		
<ul style="list-style-type: none"> The service user is placed on an appropriate clinical care programme care pathway relevant to the service users diagnosis to support seamless care and management. 		

Step 3, Page 21
Develop a treatment plan within 24 hours of admission

<ul style="list-style-type: none"> All service users have a treatment plan documented in their healthcare record within 24 hours of admission, which is discussed and agreed with the service user/carers and family. 		
<ul style="list-style-type: none"> The treatment plan includes a review of pre-admission against admission medication list with a view to reconciliation. 		
<ul style="list-style-type: none"> Changes to the treatment plan are communicated to the service user and relevant primary care services as appropriate and documented in the healthcare record. 		

Step 4, Page 23
Work together to provide comprehensive service user assessment and treatment

<ul style="list-style-type: none"> The multidisciplinary team comprises of the appropriate healthcare professionals to proactively plan service user care, set goals and adjust timeframes for discharge where necessary. 		
<ul style="list-style-type: none"> Regular multidisciplinary team meetings or case conferences for complex care cases, are held where appropriate. 		
<ul style="list-style-type: none"> Roles and responsibilities for proactive management of discharge are clarified. 		

Appendix I: Nine step checklist

Step 5, Page 28
Set an ELOS/PDD/transfer within 24-48 hours of admission

	Yes	No
<ul style="list-style-type: none"> The ELOS/PDD is identified by the admitting consultant in conjunction with the multi-disciplinary team, during pre-assessment, on post admission ward round or within 24 hours of admission to hospital (for simple discharges) and 48 hours (for complex discharges) and documented in the healthcare record. 		
<ul style="list-style-type: none"> The ELOS /PDD is agreed by specialty and proactively managed against a treatment plan by a named accountable person (SDU, 2013). 		
<ul style="list-style-type: none"> The ELOS/PDD is displayed in a prominent position. 		
<ul style="list-style-type: none"> Changes to the treatment plan and ELOS/PDD are documented in the healthcare record (SDU, 2013). 		

Step 6, Page 30
Involve service users and carers so they make informed decisions and choices

<ul style="list-style-type: none"> The treatment plan is shared with the service users and they are encouraged to ask questions about the plan. 		
<ul style="list-style-type: none"> Develop information pack for service user/carer/family e.g. medications list, care of any indwelling devices such as intravascular lines or urinary catheters, wound care and instructions for the service user to share with their GP, community pharmacist and other relevant healthcare provider. 		
<ul style="list-style-type: none"> Counsel and educate the service user, considering the needs of service users with poor vision, hearing difficulties, cognitive deficits, cultural and language barriers. 		

Step 7, Page 33
Review the treatment plan on a daily basis with the service user

<ul style="list-style-type: none"> Practitioners talk to the service user daily about progress. 		
<ul style="list-style-type: none"> The treatment plan is monitored, evaluated and updated (where necessary) and changes to the treatment plan and ELOS/PDD are documented in the healthcare record (SDU, 2013). 		
<ul style="list-style-type: none"> Any problems or actions required are identified and are escalated or resolved as necessary. 		

Step 8, Page 34
Use a discharge checklist 24-48 hours before discharge

<ul style="list-style-type: none"> The carers/family, Primary Care Team /GP, PHN and other primary and community service providers are contacted at least 48 hours before discharge to confirm that the service user is being discharged and to ensure that services are activated or re-activated. 		
<ul style="list-style-type: none"> Discharge arrangements are confirmed 24 hours before discharge (SDU, 2013). 		
<ul style="list-style-type: none"> Clinical teams conduct discharging ward rounds at weekends (SDU, 2013). 		
<ul style="list-style-type: none"> Process in place for delegated discharging to occur between clinical teams or to other disciplines, within agreed parameters (SDU, 2013). 		

Step 9, Page 36
Make decisions to discharge/transfer service users each day

<ul style="list-style-type: none"> Each service user discharge is effected no later than 11am on the day of discharge (SDU, 2013). 		
<ul style="list-style-type: none"> Discharge medication reconciliation and development of the discharge medication communication takes place in a planned and timely fashion, preferably on the day before the service user leaves the hospital. 		
<ul style="list-style-type: none"> Primary Care services and homelessness services should be notified when a service user who is homeless or living in temporary or insecure accommodation is due for discharge. 		