The Federal Democratic Republic of Ethiopia

Ministry of Health

The National Admission and Discharge Protocols for Ethiopian Hospitals

November 2012

Ethiopian Hospital Management Initiative

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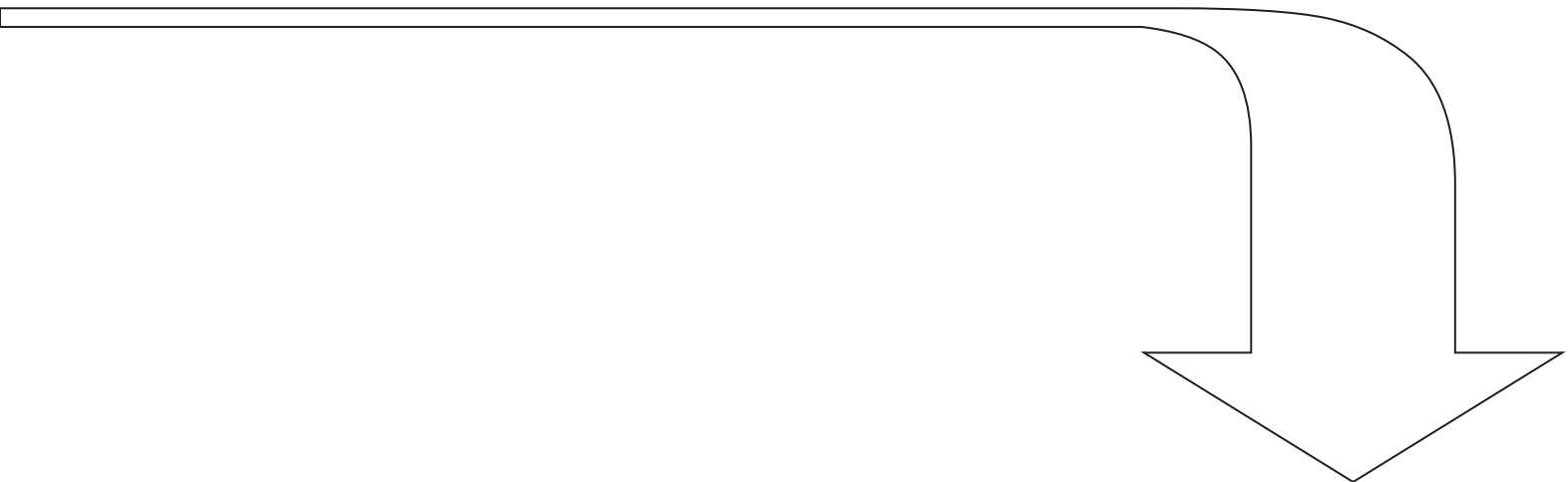

Foreword

It gives me great pleasure to launch the National Admission and Discharge Protocols for Ethiopian Hospitals.

The Federal Ministry of Health has been leading a sector-wide reform effort aimed at significantly improving the quality and accessibility of services at all levels of the country's decentralized health system. As part of this reform, health facilities throughout the country have been streamlining their operational processes and building their capacities with a view to making their services more effective and efficient.

The Ethiopian Hospitals Reform Implementation Guidelines provides a framework for achieving these objectives within Hospitals. The Patient Flow Chapter of these guidelines requires each hospital to have a comprehensive written Admission and Discharge Protocols that is well communicated, understood and followed by all relevant staff.

Where such protocols exist there are often great variably in their standard and content between hospitals and, in general there is significant room for improvement in these protocols. This results in great variations in the timeliness of admissions, inappropriate admissions and discharges, the level and quality of care, efficiency, length of stay and bed occupancy.

These National Admission and Discharge Protocols address these issues. They were produced after wide consultation on Draft Admission and Discharge Protocols in October and November 2011. The Consultation Draft was developed by a Technical Working Group established by the Medical Services Directorate of Ministry of Health. In so doing, they considered international best practice and adapted these, where appropriate, to fit the Ethiopian context

In the consultation we sought and received comments on the document, its contents, how the protocols might be best deployed in the work environment. This initiative was wholeheartedly welcomed. The major challenge that was presented by the vast majority of responders was that there should be a good awareness program and, that adequate support should be provided to hospitals with effective and timely implementation of the protocols. We will endeavor to provide you with that support.

I thank all of you who provided valuable comments that have enriched this document. I also thank the Members of the Technical Working Group for their sterling efforts and, the Clinton Health Access Initiative for providing Technical and other support.

Our task now is to implement a better A&D system based on this document guidance. In so doing you will all make a lasting and significant difference to the quality, efficiency and effectiveness of the care that we provide to Ethiopians in all of our hospitals.

Dr Abraham Mengistu Endeshaw

Director

FMOH

Executive Summary

We have sought and received your views via consultation, on the Draft National Admission and Discharge protocols. We have considered your views and reflected them, where appropriate, in these National Admission and Discharge Protocols. The result is these National Admission and Discharge Protocols that are in line with international best practice.

In adopting and implementing these protocols, hospitals will have satisfied a key requirement of The Ethiopian Hospital Reform Implementation Guidelines. That is the requirement that each hospital should have written and well communicated good practice protocols that are adhered to by all staff.

These protocols do not include protocols for Mental Health as they will be developed with Amanuel Hospital at a later date.

The protocols document consists of a core protocols followed by an appendix comprising of tools, case studies, and fact sheets that can be of assistance to hospitals and staff when implementing the protocols, followed by references.

The document is divided into clear sections. Section A-D sets out the context for the development of the protocols and their scope and application. In addition it defines the key terms of "clinical stability" and "fit for discharge" and clearly states that it is the responsibility of all hospital staff to abide by the protocols within the document

Admissions in general are then addressed in Section E. Here objectives, eligibility, common principles and processes are proposed and, protocols recommended for medical determination for admissions together with contra indications for admission.

Protocols for Emergency Admissions and Elective (planned) admissions are separately set out in sections F and G respectively. In each case the protocols are set out under the common sub-headings of:

- Principles
- Process
- Medical Determination
- Contra-indications

A number of tools that can aid staff in the admission and discharge process are set out in the appendices – pages 33 to 57

Protocols for Discharge are set out in section H under the headings of:

- Principles
- Processes
- Medical Determination
- Patient Death

A number of tools that can be used in the discharge process are set out in the appendices. For example, the General Discharge Score card (appendix 4) provides a methodology based on clinical criteria, for determining whether or not a patient is "fit for discharge"

Such good practice tools are used in many foreign hospitals. They facilitate the safe devolvement of discharge by junior doctors and nurses. There are also case studies of how this has worked in other hospitals and the resulting benefits.

These protocols demonstrate the Federal Ministry of Health's commitment to taking forward the Government reforms that will help us to save more lives and deliver better, more timely and appropriate patient care, more efficiently and more effectively.

FMOH/MSD

Acknowledgement

The Federal Democratic Republic of Ethiopia Ministry of Health (FMOH) would like to thank the Clinton Health Access Initiative (CHAI) Ethiopian Hospital Management Initiative (EHMI) for providing technical and other support. In addition FMOH would like to acknowledge the following individuals and their organizations for their participation in the technical working group, the development workshop and for their contribution to the development of this document to date

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Acronyms

AAU/BLH	Addis Ababa University/Black Lion Hospital
AARHB	Addis Ababa Regional Health Bureau
CHAI	Clinton Health Access Initiative
CRCPO	Curative and Rehabilitative Core Process Owner
EAU	Emergency Admission Unit
ED	Emergency Department
EDD	Expected Date of Discharge
ER	Emergency Room
ESoS	Ethiopian Society of Surgery
FMOH	Federal Ministry of Health
HO	Health Officer
ICU	Intensive Care Unit
MAU	Medical Assessment Unit
MD	Medical Director
MDT	Multidisciplinary Team
MSD	Medical Services Directorate
ORHB	Oromia Regional Health Bureau
RHB	Regional Health Bureau
SMT	Senior Management Team
SNNPR	Southern Nations Nationalities and Peoples Region
TA	Technical Advisor
TTO	Transobturtor Tape
TWG	Technical Working Group

Definitions

Boarder infant:

Any infant still in hospital after the mother's discharge for any reason, even if temporary.

'Clinical stability':

The term 'clinical stability' refers to a condition, where, the patient's vital signs are found to be within an acceptable/normal range after blood tests and further investigations are performed.

Elective Admissions:

Admissions for medical interventions that are planned or scheduled in advance because the illness or condition does not pose an immediate risk to the person's life or long term health

Elective Patient:

A patient who attends hospital for a planned procedure

Emergency Admissions:

Admissions not planned or scheduled in advance but are at short notice, for an immediate intervention to preserve life or long term health

Emergency Patient:

A patient who attends hospital for immediate treatment in order to preserve life or long term health

'Fit for discharge':

The term 'fit for discharge' refers to when a patient is deemed to be: physiologically, socially, functionally, and psychologically stable after such investigations have been taken into account through multi-disciplinary assessments, where appropriate. In short, it is safe for the patient to be discharged or transferred from the hospital to their home or another setting.

A patient is 'fit for discharge' if he/she no longer requires the services of emergency care or specialist staff within a secondary care setting, as an inpatient, and where:

- review of the patient's condition can be shared with the appropriate health professional including adjustments to medication;
- ongoing general, nursing, and rehabilitation needs can be met in another setting at home, in those cases where applicable, or through primary/community/ intermediate/social care services, and;
- additional tests and interventions can be carried out in an outpatient or ambulatory care setting.

Liaison Officer:

A person, often with a nursing or other health qualification whose main duties are effecting referrals, bed management and coordinating admissions and discharges of patients

Non-Physician Clinician:

Health professionals who are not physicians but can make clinical decisions in the absence of a physician (e.g. health officer, midwives, emergency nurse professional)

Observation Services

Patient Waiting Area

A patient waiting area is a place where patients can wait for either admission or discharge. Similar to an airport, the patient waiting area is a 'holding area' for patients who are either on their way into or out of the inpatient wards.

Pediatric Age Group:

Those whose ages range from birth to 16 years

Semi-elective:

An intervention to preserve the patient's life that does not need to be done immediately

Social Services:

Services and activities aimed at supporting or improving an individual's well being. Often an organized public service department as in Ethiopia that can play an important role before admission but even more so in helping to ensure that patients in hospital and being discharged have their psychosocial needs assessed, planned for and addressed. In some countries, social workers are also deployed within the hospitals.

Transobturtor Tape:

A narrow strip of mesh, made up of synthetic material, which is placed in the vagina to support the weak muscles and tissue that make up pelvic floor. The weak muscles result in urinary incontinence.

Table of Contents

A. Introduction

The development and provision of an equitable and acceptable standard of health services to all segments of the population of Ethiopia has been a major policy objective of the government since the issuance of the 1993 Health Policy.

In, addition, the Federal Ministry of Health (FMOH) has been leading a sector-wide reform aimed at significantly improving the quality and accessibility of services at all levels of the country's decentralized health system. As part of this reform, health facilities throughout the country have streamlined their operational processes and are continually building their capacities to increase the effectiveness and efficiency of services provided.

The Ethiopian Hospital Reform Implementation Guidelines (EHRIG) provide a framework for achieving these objectives within hospitals. Chapter 2 of the EHRIG guidelines, Patient Flow, requires that each hospital have a comprehensive Admission and Discharge Protocols developed and in practice by all relevant staff at health facility level.

In support of these efforts, the Medical Services Directorate (MSD) established a Technical Working Group (TWG) to support best practice development of Admission and Discharge Protocols that were used for consultation with wider stakeholders.

General Objectives

The purpose of this protocols document is to provide health facilities with best practices, processes, and guidelines to deliver both effective and efficient admission and discharge processes

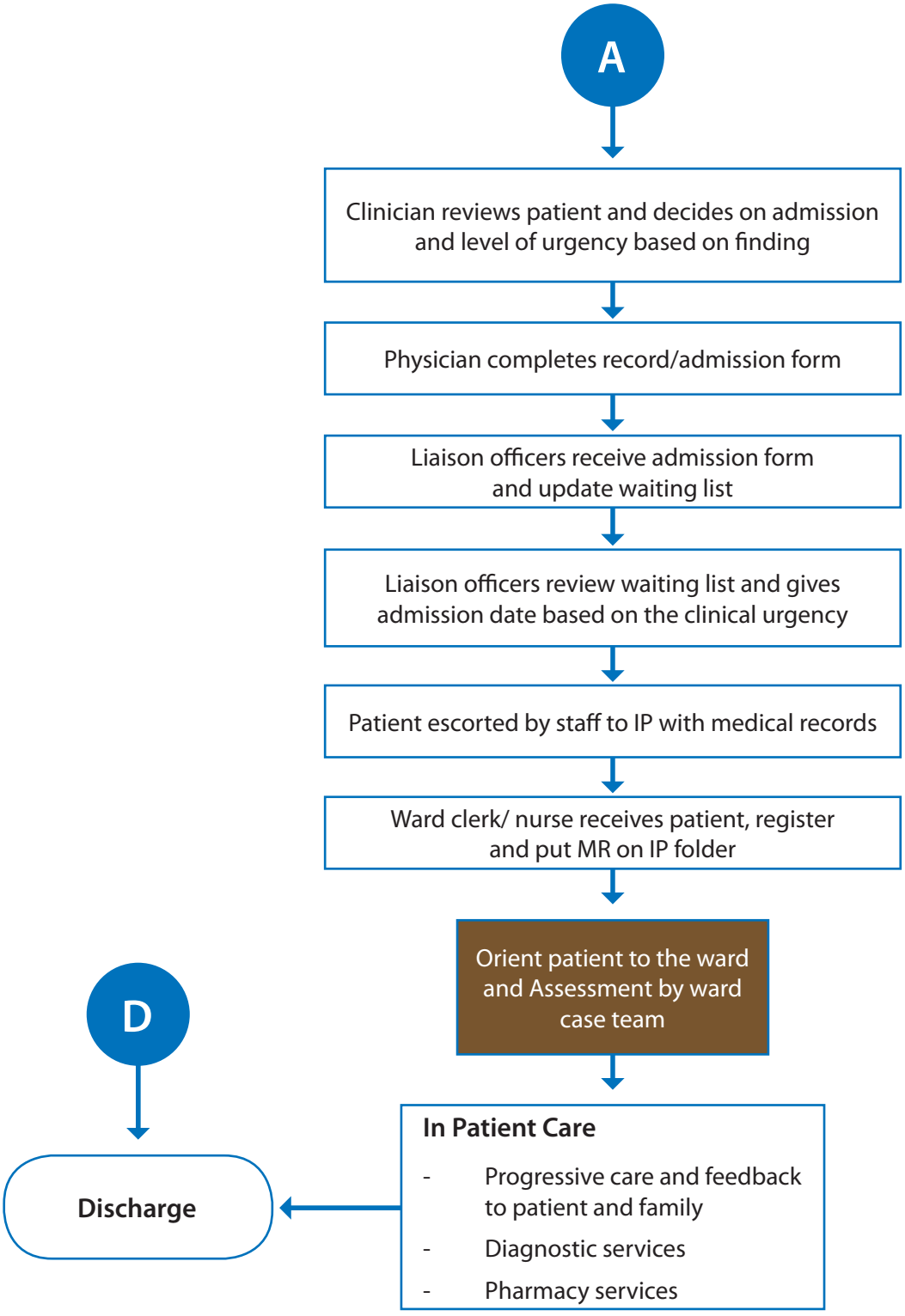
In addition they provide a basis from which other hospitals can develop further protocols for their own use and circumstances, while adhering to the core principles of these protocols.

Specific Objectives

1) To Share international Best Practice and adapt them to the Ethiopian context.
2) To show standardized processes for admission and discharges that should be adhered to by all hospitals.
3) To provide technical guidance that can be used for training and development of relevant staff particularly the liaison officers.
4) To provide guidance for managers on the monitoring and evaluation of the admission and discharge process.
5) To ensure elective admissions are prioritized and affected on the strict basis of clinical need.
6) To support the improvement of bed management in hospitals.

B. Application

These Procedures are to be followed by all clinical staff at all hospitals in Ethiopia, excluding Mental Health Services. Protocols for Mental Health will be developed with Amanuel Hospital.



C. 'Clinical stability' and being 'Fit for discharge'

Two key terms used in relation to admission and discharges are: 'Clinically stable' and 'fit for discharge'. These terms are described in the definitions section of the document.

D. Roles and Responsibilities

For the purposes of these protocols all hospital staff are obliged to abide by these protocols:

I. FMOH

a) The FMOH will provide both technical and supportive supervision support to Regional Health Bureaus and hospitals.

b) It will have sole authority for approving any amendments to these protocols.

II. RHBs

a) Disseminate these protocols and any related materials to hospitals and all other relevant stakeholders.

b) Facilitate implementation of these guidelines in hospitals.

c) Assign a Focal Person at Regional Health Bureau Level to co-ordinate facility level implementation.

d) implementation of A&D protocols (likely to be the referral focal person).

e) Incorporate A&D Protocols in the Agenda of the Regional Review Meetings and Carry out periodic Evaluations of the implementation progress and impact of A&D Protocols implementation in the region.

f) Plan for and facilitate Scale-up of good practices observed from regional development or elsewhere.

g) conduct regular supportive supervision.

III. Hospital SMTs

a) Ensure that there is facility - wide communication and awareness of the A&D protocols.

b) Using these protocols and principles, develop tailored protocols for the hospital

c) Establish a team or broaden the scope and membership of an appropriate existing team to develop and drive the implementation of the protocols within the hospital.

d) Ensure training is given to relevant staff.

e) Avail necessary inputs for implementation.

f) Carryout periodic monitoring and evaluation of the proper application of the A&D Protocols.

g) Ensure that discharges are carried out seven days a week.

h) Receive and review regular reports on bed occupancy and bed management improvement processes.

IV. Medical Directors

a) Champion the implementation of the A&D Protocols.

b) Discuss A&D protocols with doctors in the "morning sessions".

c) Ensure that all Case Team Leaders and those admitting and discharging patients are thoroughly familiar with the protocols.

d) Review and discuss monitoring and evaluation reports with the Hospital liaison service and make recommendations for improvement.

V. Liaison officers

a) Update the elective admissions waiting list.

b) Assign an admission date to patients based on the urgency of the clinical need as date indicated by the physician in the patient notes.

c) Secure a bed for the patient.

d) Maintain good communications with inpatient case teams and the wards.

e) Ensure that the patient receives proper directions to the ward.

f) In collaboration with ward staff, play a leading role in the co-ordination of discharges.

e) Ensure regular bed census is carried out, reported and used to update and manage the bed resources.

VI. Admitting Physicians

a) Adhere to hospital guidelines when deciding on admitting a patient.

b) Indicate the level of urgency for admission based on the urgency of clinical need. As a Guide.

- Emergency – immediate admissions
- Non emergency but priority: within two weeks
- Non emergency: two weeks or more

These indicative timelines can vary from hospital to hospital. The important thing is that they are known to all admitting health professionals and, consistently applied.

c) Ensure that these protocols and existing national guidelines relating to children, birthing mothers and major diseases are followed during admission.

d) Ensure that an estimated length of stay, where possible, is placed in the patients notes.

VII. Ward Nurses

a) Welcome and familiarize the patient with the ward surroundings.

b) Review notes and ensure all requirements are met/planned to be met.

c) Assess the patient and prepare the nursing Care Plan, involving the patient, and relevant others, and place in the patient medical record within 24 hours of admission.

d) Follow the guidance set out for admissions and discharges.

e) Maintain good communication with the Liaison Office particularly in relation to emergency admissions, pending and actual discharges, and bed status reports.

VIII. Discharging Physicians

a) Adhere to the hospitals' discharge protocols or these set out in this document.

b) Wherever possible do ward rounds early in the day and discharge early in the day.

c) Has responsibility for correctly completing all the relevant documentation.

d) Discharging at weekends when the facilities are availed by the SMT.

E. ADMISSIONS

Two key terms used in relation to admission and discharges are: 'Clinically stable' and 'fit for discharge'. These terms are described in the definitions section of the document.

1. Objectives

The key objectives underpinning an effective and coherent admissions and discharge policy for emergency and elective patients are:

- The provision of an integrated personal health and social services as per the hospital guideline/ practice/ implemented through social worker.
- The utilization of resources to maximize clinical and organizational effectiveness and outcomes.
- The establishment of fully integrated networks (within or between the facilities) of emergency care which are accessible to each person.
- The provision of levels of local access to emergency care while simultaneously ensuring high quality clinical care.
- The acquisition of clinical admissions data to assist service planning and monitoring.

2. Eligibility for Free Services

2.1 The eligibility for free health care in Ethiopia is based on Federal and Regional Health Care Financing Reform Proclamations. These Proclamations must be adhered to.

2.2 Eligibility is not an automatic right of Ethiopian citizenship. Each adult has to demonstrate eligibility in their own right. This is normally demonstrated by the possession of a Fee Waiver letter.

2.3 In addition, according to Ethiopian law, there is a minimum list of exempt services which all Ethiopians are entitled to receive, free of cost. Furthermore, some regions provide additional exempted services. Where this is the case, patients in those regions are entitled to receive those services free as well.

2.4 Only persons who meet the eligibility criteria, as defined by the Ethiopian Government can receive publicly-funded (i.e. free or subsidized) health and disability services.

2.5 Individuals who meet a minimum of one of the criteria are said to be eligible.

2.6 Individuals who are not eligible to receive publicly-funded health services or use a public health service in Ethiopia will be charged for the full cost of the services.

2.7 The eligibility criteria in no way interfere with the FMOH/health professional ethical obligation to provide necessary emergency services to individuals regardless of eligibility status.

3. Principles

3.1 Emergency Department (ED) admissions

The principles of emergency department admissions are discussed in Section F.

3.2 Elective admissions

The principles of elective admissions are discussed in Section G.

4. Process

4.1 Introduction

4.1.1 All admissions should be arranged through the Liaison Service following the process described below:

Upon arrival on the ward, the nurse should receive the patient to initiate admission process and give orientation and instruction about facilities (such as toilet and showers) to the patient and care-givers etc.

4.1.2 The patient should be assessed by a medical doctor upon arrival on the ward and a History and Physical Examination Assessment should be completed. This should include the immediate management plan for the patient.

4.1.3 Additionally, a Nursing Assessment should be completed within 24 hours of admission and a Nursing Care Plan developed.

4.1.4 All emergency patients who require admission to Hospital (as assessed by an appropriate health professional) will be admitted under the care of an appropriate senior physician /Midwife/an appropriate health professional The decision as to whether to admit the patient is to be made on clinical grounds.

4.1.5 Patients who require hospital admission but where the hospital does not have adequate services to meet their needs are to be transferred to a more appropriate hospital (as per the requirements of the Inter-Facilities Transfer of Patients Procedure).

4.2 Admission to Hospital Pediatric Unit

4.2.1 All children admitted to a hospital are to be admitted to a Pediatric Unit, and are to remain there for the duration of their hospital stay, unless there are specific exceptional circumstances which warrant a shift to another ward.

4.2.2 Children requiring intensive monitoring are to be admitted to the Intensive Care Unit (ICU) at the hospital.

4.2.3 A sick mother with a 'boarder infant' may be admitted to a Pediatric Unit, provided that:

i) the mother's illness is of short duration;

ii) the mother is not an isolation patient, and;

Iii) In the absence of the mother, nursing staff should ensure that all of the baby's needs including nutrition, are fully met.

4.2.4 Sick adults are not to be admitted to the Pediatric Unit, unless there are specific exceptional circumstances which warrant such an admission.

4.2.5 Conditions of existing patients are to be taken into account when well children are accompanying a sick mother into the Pediatric Unit.

4.2.6 The nurse in charge of Pediatric Unit, in consultation with the ward doctor, is responsible for making the decision regarding the admitting of a sick mother and a well child into the Pediatric Unit.

4.3 Precautions and Considerations

4.3.1 All emergency patients who require admission to hospital (as assessed by a Doctor) will be admitted under the care of an appropriate health professional.

4.3.2 Elective admissions are undertaken on the basis of a referral from health facilities to a hospital.

4.3.3 All children admitted to Hospital are to be admitted to Pediatric Ward.

4.3.4 Hospitals operate a policy where no patient is refused admission, but the admission may be delayed and managed according to the individual health facilities waiting list guidelines and requirements.

5. Medical Determination for Admission

To support the medical necessity of an inpatient admission, the doctor must adequately document (in the patient's medical record) that a provider with applicable expertise expressly determined that the patient required services involving a greater intensity of care that could be provided safely and effectively in an outpatient setting. Such a determination may take into account: the amount of time the patient is expected to require inpatient services, but must not be based solely on this factor. The decision to admit is a medical determination that is based on factors, including but not limited to the:

1. patient's medical history;
2. patient's current medical needs;
3. severity of the signs and symptoms exhibited by the patient;
4. medical predictability of an adverse clinical event occurring with the patient;
5. results of outpatient diagnostic studies;
6. types of facilities available to inpatients and outpatients, and;
7. Ethiopian Inpatient Hospital Admission Guidelines.

6. Contra Indications for Admission

The aim of the following guidelines is to describe admissions that generally are not medically necessary. This is not an all-inclusive list. FMOH, or its agent, may also determine that other admissions not characterized in this list are medically unnecessary on an inpatient basis. This should be the responsibility of the admitting physician. A summary of the general type of cases are set out below.

The admission occurs following observation services, and the admitting hospital has not documented at in the medical record at the time of the decision to admit, that there is clear detritions in the patient's clinical statutes and that there are interventions that can be managed in a outpatient or health centre setting.

6.1 The patient's condition has been improving substantially and is approaching either normal clinical parameters or the patient's baseline.

6.2 The admission is for monitoring, observation or other interventions that have to date been successfully delivered outside of a hospital setting.

6.3 The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.

6.4 The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s).

6.5 The admission is primarily due to the:

1. amount of time a patient has spent as an outpatient in a hospital or other outpatient setting;
2. need for diagnostic testing or obtaining consultations;
3. services;
4. age of the patient, and;
5. convenience of the physician, hospital, patient, family, or other medical provider.

6.6 Example of clinical conditions

Clinical conditions accepted for admission into the ICU at a hospital include:

1. Acute Chest Pain
2. Acute Myocardial Infarction
3. Arrhythmias
4. Insertion of Temporary Pacemaker
5. Pulmonary Embolism (requiring high level support)
6. Inotropic Treatment
7. Intensive Airway Management
8. Ventilator Care
9. Trauma
10. Overdose
11. Ketoacidosis
12. Eclampsia
13. Unconscious/semi-conscious

6.7 Documentation (Example Only)

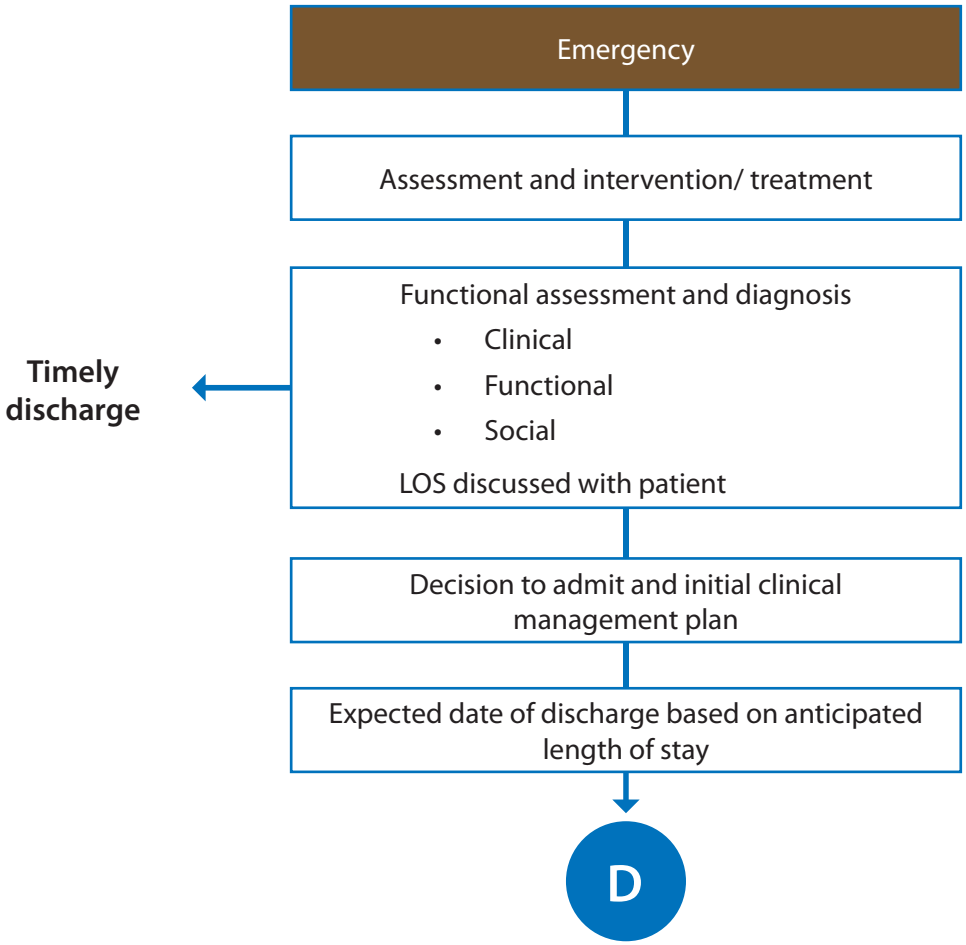
1. The Liaison Officer (during working hours) or after-hours the Operator, will process the admission and send all paper-work and patient medical records to the Ward on completion. The exception to this is where during working hours where the Ward Clerk has chosen to do the emergency admissions and arranged admissions.
2. When a patient arrives directly at a ward, as a transfer from another Hospital or on referral from a GP, the ward is to inform the Liaison Officer that the patient has arrived, and then send down a completed Manual Data Sheet for admissions so it can then be processed. There should also be a process for documentation of admissions in the ER and the ICU.

7. Refusal for Admission

Each hospital must have a policy whereby the decision to admit a patient is made on clinical grounds, but this admission may be delayed and/or managed according to the Hospital Waiting List guidelines and requirements.

F. Emergency Admissions

A typical emergency pathway is shown in figure on below.



1. Principles

Emergency Department (ED) admissions

Only emergency patients should be admitted to the hospital through the Emergency Department. This may require a subtle shift of emphasis from 'semi elective' admission to more rigorous assessments to ensure the appropriateness of hospital admissions and maximize the number of available beds for elective admissions.

2. Process

2.1 Emergency Resuscitation and Rehabilitation Unit in ER

Short Stay observation wards or Resuscitation and Rehabilitation Units (RRUs) are advocated in emergency patient care. Such units should be directly adjacent to the Emergency Department and should be supervised by specialists in Emergency Medicine. The length of stay should not be greater than 24 hours.

2.2 Transfer to ward for proper admission

A. If the patient is to be admitted as an emergency, a clinical member of the relevant Case Team should contact the Liaison Service providing, as a minimum, the following information:

- Patient name and medical record number;
- Summary of clinical history and reason for admission;
- Case team to which patient should be admitted (for example surgical case team, internal medicine case team etc), and;
- Urgency of admission.

B. When a request for admission is made, the Liaison Officer should follow the steps below:

1. Is a bed immediately available in the relevant inpatient case team/ward?

   If yes ➔ admit patient.

   The Liaison Officer should inform the attending clinician of the admission, the patient should be transferred to the ward, and any necessary administrative tasks carried out with the assistance of a runner.

   If no ➔ the Liaison Service should consider finding a bed in another facility.

2. Is there any patient in the relevant case team/ward due to be discharged that day?

   If yes ➔ confirm that patient will be discharged. Identify and address any factors that are delaying discharge. Consider moving patient to Transit Lounge (if available) or another waiting area. In this way the bed can be freed and the new patient can be admitted.

   If no ➔ the Liaison Service should consider finding a bed in another facility.

3. Is a bed available within another case team/ward?

   If yes ➔ discuss with Director of Inpatient Services, and if appropriate, admit patient to that bed and inform the Leader of the Inpatient Case Team that is responsible for the patient where the patient is located. Ensure that the patient is transferred to 'correct' case team bed/ward as soon as a bed there becomes available.

   If no ➔ the Liaison Service should consider finding a bed in another facility.

4. Is there an elective admission that could be cancelled to make a bed available for the patient?

   If no ➔ the Liaison Service should consider finding a bed in another facility.

As far as possible, planned admissions should not be cancelled. However depending on the priority it may be necessary to do so. Factors to be considered are:

- The clinical urgency of both the planned admission and the emergency patient requiring admission should be performed within 5 minutes;
- The time on waiting list, distance travelled and other pertinent social circumstances of the elective case, and;
- The availability of a bed in another facility for the emergency patient requiring admission, and the distance to reach that facility.

If a bed can be made available by any of the steps above then the patient should be admitted. If a bed is not available or if the required service is not available at the hospital then the patient should be referred to another facility. Communication and coordination should be developed and dependable as well as in line with national referral guidelines.

C. What are the important factors influencing patient admission from the Emergency Department (ED) to inpatient services?

1. Extended access to rapid assessment clinics and outpatient imaging, pharmacy, and basic laboratory services.
2. Rapid assessment and extended access to diagnostics (unnecessary delays in admitting and/or discharging patients from hospital may arise from avoidable delays in patient assessment by specialists, duplication of tests or the absence of high or low dependency beds).
3. Early Senior Medical decision making available at the point of admission.
4. Close multi-disciplinary team work.
5. Nationally agreed standardized triage processes to ensure clinical prioritization of patients on their arrival in the Emergency Department and to ensure timely and appropriate care is delivered.
6. Prioritization should be based on the clinical background and should be decided by the treating physician.
7. Care pathways to minimize delays in the Emergency Department if admission is definite. These pathways should be developed in consultation with the relevant professionals and stakeholders.
8. Rapid access facilities such as Medical Assessment Units (MAU) and Surgical Assessment Units (SAU) requiring robust, specific and auditable operational policies.
9. Protocols for transfer of patients within and between regional areas and tertiary units to continue to be developed and implemented with pre-hospital emergency care, trauma teams and other relevant parties.
10. Case Team led services.

11. Information Systems should be used to provide comprehensive comparable and reliable data on activity and waiting times.

12. There should be regular and influential audit of clinical activity.

13. The critical role of Support Staff should be acknowledged with appropriate support for professional development and influence in decision making at all levels.

3. Emergency obstetrics

3.1 Birthing mother only to be admitted if in active labor.

3.2 Birthing Mothers should be transferred immediately to the delivery ward.

3.3 A rapid assessment for any complications or abnormal risks should be made and plan and actions addressing these put in place.

4. Maternity Admissions

4.1 An assessment of the risk of delivery must be carried out before admission during antenatal care.

4.2 Mothers should be directed, or escorted when necessary, to the delivery ward.

4.3 High risk and complicated cases must be clearly identified and arrangements put in place to reduce the risk and facilitate safe delivery in complex cases.

4.4 In caesarian cases and in other low risk non-complex cases an expected length of stay should be given to the mother and placed on the patient notes.

4.5 On admission, care should be provided according to existing national standards and guidelines.

4.6 After normal delivery, the mother should be kept under observation for six hours by the ward doctor or other appropriate health professional. This must be planned for on admission.

4.7 Complex and high risk cases must be transferred to the maternity ward and care provided according to existing national standards and guidelines.

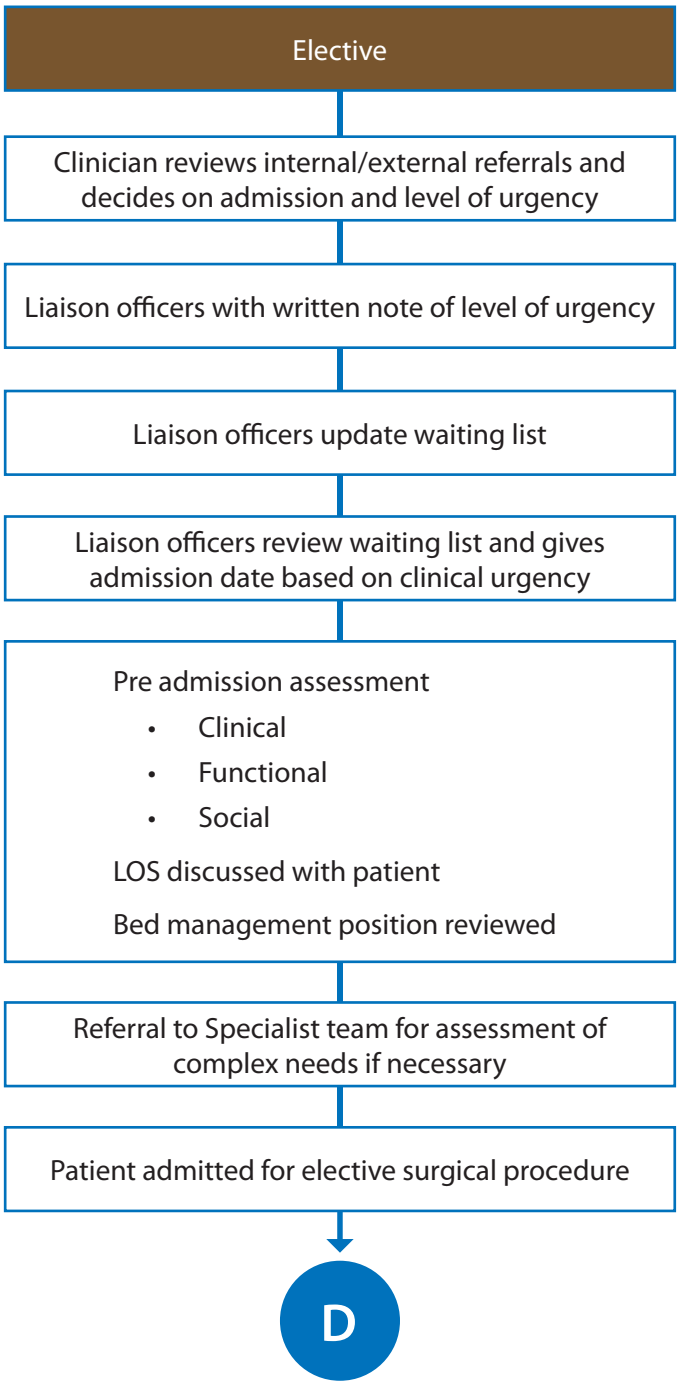
5. Medical Determination for Admission.

See Section E. 5

6. Contra Indications for Admission

See Section E. 6

G. Elective Admissions



1. Principles

1.1 A patient's episode of care should be planned before his/her admission and should take account of the entire pathway up to and after discharge from hospital. Patients and their caregivers should be partners in this planning. Bed management should be overseen by the Liaison and referral service who has the authority to implement the bed management policy and to co-ordinate the bed management team.

1.2 The bed management service should operate on a permanent basis, i.e. for 24 hours on every day of the year. The Liaison Officer reports to a senior member of management. Part of the Liaison Officer's role would include continuous analysis and the provision of reports and forecasts.

1.3 The process of allocating beds to patients should be centralized and the hospital Liaison Officer should have authority over hospital bed access. The hospital Liaison Officer should work within the notional allocation of beds to each Case Team to ensure that patients are accommodated in the most appropriate bed available at the time of their admission, and to ensure that patients are cared for by staff with the appropriate expertise.

1.4 There should be a network information service which proceeds elective admission after an appointment for admission has been made and the waiting list is checked.

2. Process

2.1 Elective admissions may be booked by the liaison officer. When a patient requires elective admission the patient is sent to the Liaison Officer with adequate information reflecting:

- Patient name and medical record number;
- Summary of clinical history and reason for admission;
- Case team to which patient should be admitted (for example surgical case team, internal medicine case team etc), and;
- Urgency of admission (set criteria related to: pathology of the disease, socio-economic status of the patient, and distance of the patient's residence).

2.2 The Liaison and Referral Service should book the admission date, the bed and give an appointment card to the patient.

2.3 On the day of admission, the Liaison Officer should submit the medical records of the patient to the admitting clinician on the day of the admission.

2.4 On a daily basis, the Liaison Officer should inform each Inpatient Case Team of any elective admissions for the following day to ensure that the required service is available and allow the Case Team to make all necessary preparations for the admission.

2.5 The following key requirements have been identified to facilitate effective elective admission practices:

1. All patients should have a treatment plan within 24 hours of admission.
2. Centralized waiting list management.
3. Agreement on the parameters for scheduling operation theatre lists with the OR team.

4. Pre-admission assessment as a standard requirement for all elective admissions to ensure appropriate planning of the entire patient journey. Diagnostics such as pathology and imaging should be done in advance upon multidisciplinary team decision.

5. The anticipated Length of Stay (LOS) for elective admissions indicated as early as possible by the physician and communicated to the Liaison Service to facilitate scheduling.

6. Increased day surgery can also be supported by pre-admission assessment to ensure appropriate scheduling and to minimize time transfer to inpatient beds.

7. Length of Stay (LOS) after admission should be monitored to minimize hospital acquired infections, cost for the patients, and appropriately manage bed occupancy.

3. Medical Determination for Admission

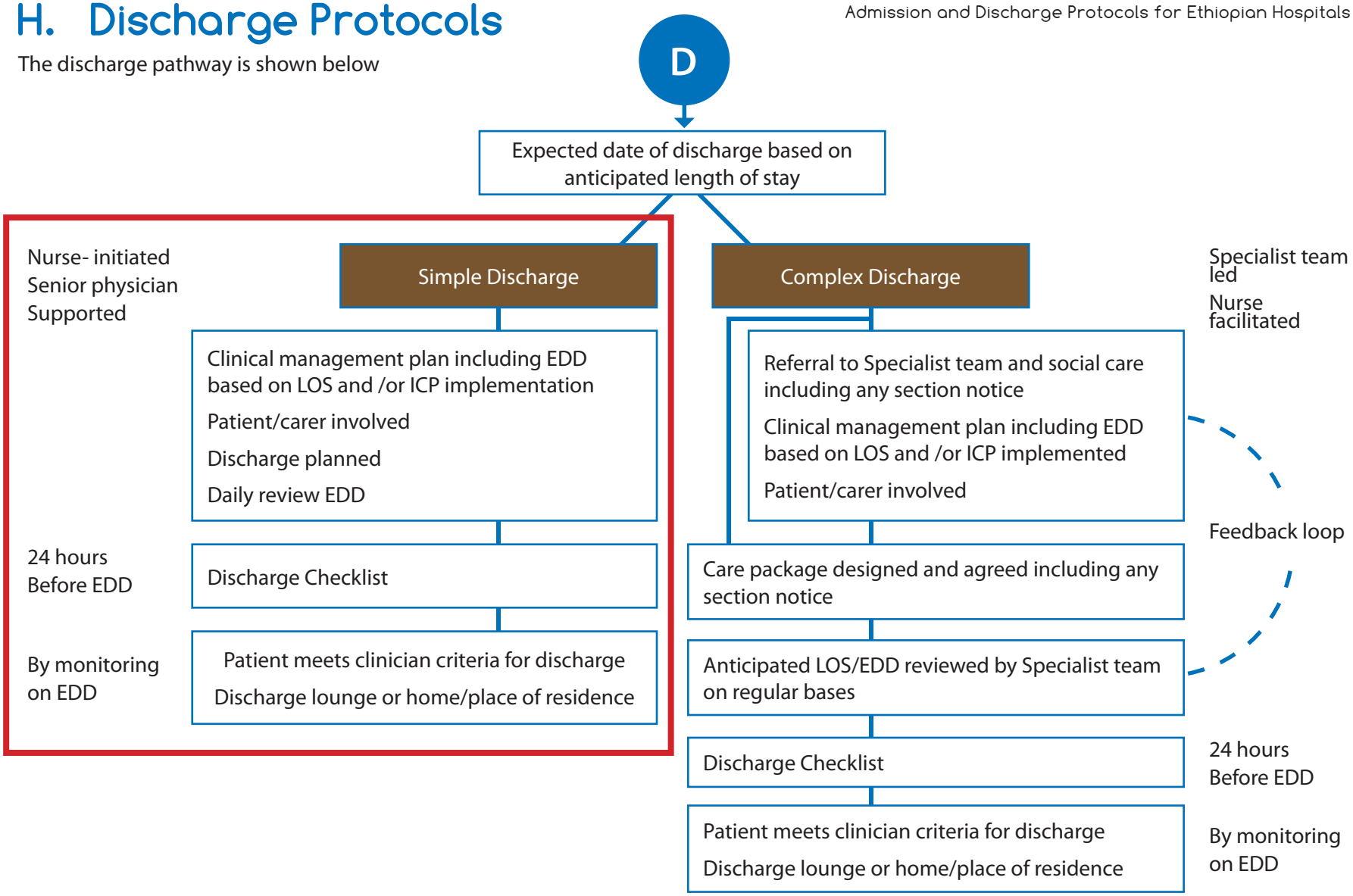
See Section E. 5

4. Contra Indications for Admission

See Section E. 6

H. Discharge Protocols

The discharge pathway is shown below



1. Principles

The core principles for effective discharge planning provide that:

1. A patient's use of a hospital bed and their discharge should be planned before their admission, where possible.
2. The estimated date of discharge should be documented and communicated to the patient and relevant personnel within 24 hours of admission.
3. Discharge should be "streamlined" e.g. prescriptions and letter should be completed in a timely manner; transport booked and test results made available promptly.
4. Patients who were seriously ill should be regularly discussed by the MDT to facilitate timely discharge.

2. Process

2.1 The decision for discharge should be made by a physician who should complete a discharge summary for the patient. A copy of the discharge summary containing medical history should be given to the patient and a second copy filed in the Medical Record. If a patient was referred from another facility the discharging physician should also complete the feedback section of the Referral Form.

The processes required for effective discharge planning provide that:

1. There should be an organization led commitment to manage all hospital beds.
2. Resources such as a discharge coordinator should be available to ensure delays are minimized and extensive patient and family involvement in decision making processes.
3. Referrals to physiotherapy, occupational therapy, and psychosocial support should be identified as early as possible to access aids and appliances as appropriate.
4. Discharge documentation should be audited to ensure compliance with hospital protocols.
5. Analysis of trends and data should be undertaken by the discharge coordinator/ Liaison Officer and communicated to hospital senior management.
6. Multidisciplinary teamwork is the key to success with discharge planning. A patient's discharge plan should be coordinated by a nominated member of the multidisciplinary case team.
7. Appropriate bodies within the attending case team should be involved in the discharge planning process.
8. Patients and their caregivers should be partners in the discharge planning process.
9. Discharge planning should be continually updated and improved.

10. A&D case team should be established to identify and resolve bed management problems with the support of the hospital Senior Management Team.

11. There should be early involvement of Pharmacy to increase compliance with medication.

12. Patients (or parents, caregivers, surrogate, or guardians) should co-sign the patient's discharge letter ensuring that the discharge instructions have been clearly explained to them.

13. An expected date of discharge should be set within 24 hours of admission or in many cases before admission for elective patients and communicated to the patient and all staff in contact with the patient.

14. The expected date of discharge should be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes communicated to the patient.

15. Ward rounds should be scheduled in a way that it allows a review at least daily of all patients by a senior clinical staff member.

16. Inpatient case teams can make significant improvements by:

    - identifying anticipated length of stay and expected date of discharge on admission;
    - using a Discharge Predictor as a core tool for effective bed management;
    - providing an updated list of expected discharges on a shift basis;
    - discharging patients in the morning on the day of discharge, and;
    - discharging patients over the weekend and holidays.

2.2 Key Steps in Timely Discharge

- Expected date of discharge is identified early as part of patient's assessment within 24 hours of admission (or in pre-assessment for elective patients). It is based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge.
- The patient and caregiver are involved and informed about the clinical management plan and the expected date for discharge.
- In parallel, all the necessary arrangements are put in place to optimize the (simple) discharge including Discharge Summary, outpatient appointment, hospital sick leave completed, any medicines to be taken away, and patient transport arrangements confirmed.
- Daily review of the patient's condition and response to treatment will determine if the expected date of discharge needs to be revised.
- Review of planned/actual discharge date. Did it go according to plan? Complete audit on a regular basis.

2.3 The Purpose and Timing of Ward Round Reviews

2.3.1 The ward round is seen as the time when the main decisions about the patient's care are made including the decision to discharge the patient. This will work if ward rounds happen on a regular basis and patients are assessed daily. However, in reality ward rounds in many specialties happen only once or twice a week. The ways to avoid delays due to the timing of ward rounds could include:

- Early identification of patients that could be discharged (before ward rounds or reviews) so that these patients can be seen first.
- Regular senior reviews outside the ward round including the prescription of treatment to takeouts on the day prior to discharge.
- Progress monitoring and interpretation of test results.
- Expansion of the scope of practice of nurses and Non-Physician Clinicians (NPCs) with the appropriate knowledge, skills and competencies to review the patient and initiate discharge including to the GP. In the absence of the GP, nurses and NPCs can also complete the hospital sick certificate. This may be supported by agreed protocols, guidelines, or criteria documented within the patient record.
- Expanding the scope of practice of clinical pharmacists to include the review of medications and transcribing of TTOs (Transob Turtor Tape).

2.4 Discharge Process & Information Needs

2.4.1 Regardless of how patient discharge is organized within individual units, the actual discharge process should create a climate in which patients and their caregivers understand their roles and responsibilities in ongoing care. This should promote confidence in the discharge of the patient. In general, avoidance of early discharge usually ensures that any essential discharge criteria are met. Preparation of specific discharge information should be collected and readied for each patient so discharge is as smooth and unrushed as possible. The communication skills of nurses in coordinating this process are therefore of utmost importance.

2.4.2 With the possible exception of a diagnosis, none of the information provided during the discharge process should be new. Wherever possible, the patient's identified caregiver should be involved in all pre-discharge assessments and information given. Nursing staff must ensure that they assess both patients and caregiver understanding of their ongoing care responsibilities through structured questioning. As a general guide, procedure specific information should encompass:

- Medication - specific instructions regarding prescribed analgesia, antiemetic or antibiotics.
- Wound care & when patient is able to bathe or shower.
- Arrangements for dressing renewal and suture removal (if appropriate).
- Resuming normal activities.

- What 'normal' symptoms may be expected and their duration.
- What would be abnormal symptoms and what to do if they occur.
- Contact telephone numbers for information or in an emergency.
- Arrangements for follow-up (telephone and out-patients).

3. Maternity Cases

The following should be observed

3.1 The mother MUST be assessed on 6 hours or shortly after.

3.2 After assessment the doctor or any appropriate professional makes the decision to discharge.

3.3 All Relevant documentation filled out.

3.4 Mother discharged and directed to finance to settle any outstanding bills.

4. Medical Determination for Discharge

4.1 Every patient should be seen following their operation by the anesthetist and surgeon involved in their care. Assessment of when the patient is clinically stable or ready for discharge can and should be performed by the treating physician with the involvement of the nursing staff. Each Case Team needs to identify clear discharge criteria as part of a written policy for staff to follow. These need to consider social factors as well as a medical assessment of sufficient recovery for discharge. All guidelines should address the following areas; however, the list is not intended to be all-inclusive:

- Vital signs must be stable and consistent with age and the clinical baseline correct orientation as to time, place and person.
- Adequate pain maintenance and has supply of oral analgesia.
- Understands how to use oral supplied analgesia and has been given written information about these.
- Ability to dress and walk where appropriate.
- Minimal nausea, vomiting or dizziness.
- Has at least taken oral fluids.
- Minimal bleeding or wound drainage.
- Has passed urine (if appropriate).
- Has a responsible adult to take them home.
- Written and verbal instructions given about postoperative care.
- Knows when to come back for follow up (if appropriate).
- Emergency contact number supplied.

If one or more of these set discharge criteria is not met, then a discharge must not be made until that criteria is fulfilled, documented, and a discharge approved by an appropriate staff member. Also, individual case teams may choose to expand upon the criteria from the list above.

4.2 A scoring system that is extensively used in other countries to aid in the assessment of recovery and suitability for discharge is set out in Appendix 4. Hospitals may wish to review this and consider its application.

5. Patient death

If a patient dies in the hospital, the death should be confirmed by a physician or NPC in the absence of a physician. A death summary should be completed and documented in the patient's medical record. If it is necessary to confirm the cause of death, a post mortem examination form should be completed and the body should be transferred to the pathology case team for post mortem examination. When all necessary medical examinations are complete the body should be stored in the hospital morgue until collection by the patient's relatives or other responsible person. If the patient does not have a next of kin, the local authority is responsible for collecting the body. All unexpected deaths should be reported to, and investigated by an appropriate hospital committee, where such exists.

I. Monitoring and Evaluation

1. General

Monitoring and evaluation of the implementation of the A&D protocols should be carried out at both the RHB and hospital level.

I. Ministry

1) Incorporate Patient flow on National review meetings.

II. RHB

1) Incorporate A&D protocols on the regional review agenda.
2) Conduct regular supportive supervision of the A&D protocols development and implementation regional public hospitals. Where ever possible insure that this is integrated with other supportive supervision.

III. Hospital

1) Conduct periodic audits of the A&D protocols(at least 6 monthly) using the audit/ framework and checklist.
2) Review findings by the A&D protocols team and make recommendations for improvement to the SMT.
3) SMT consider recommendations of the protocols team, address issues and share development and issues with RHB at regional review meetings or, in "one to one" meetings if the issues are highly sensitive.
4) SMT should get regular reports on bed management and monitor the results.

2. Audit framework and checklist

The audit of the admission and discharge protocols is a key process in ensuring that staff are aware of them, and that they are implemented, adhered to by every hospital and should therefore carry out a periodic audit of the A&D process.

Senior management may use two approaches in audit:

1) A systematic sample approach.
2) A target approach where there is identified or suspected issue.

This framework covers the systematic sample approach.

3. Auditing checklist

Sample Approach

- The audit should be conducted using a sample of cases. The cases should be the same for both the admission and discharge elements of the protocols.
- The sample should be made up of both emergency and elective cases and should cover all of the major clinical areas. Medical, Surgical, Obs & Gyne, Pediatrics.
- The split between the number of emergency cases and elective cases in the sample should be the proportion of the total number admission in the quarter (3month period) proceeding the month in which audit is being conducted.

For example

- There are100 cases in the period of which 20 are elective and 80 are emergency, the sample would be made up of 80% emergency cases and 20% elective cases.
- The responsibility for conducting the audit should be clearly assigned, perhaps to the Quality Team. Each person taking part in the audit should be oriented on the purpose, process and tools of the audit.

An audit plan should be prepared before each audit setting out the key activities, documents to be reviewed, arrangements for sharing of findings and recommendations.

Key documents and considerations for audit include:

1) The patient notes.
2) Waiting list.
3) That elective admissions are in accordance with the clinical priority stated in the noted by the doctor.
4) That there is general consistency in the assignment of clinical priority for the same conditions.
5) Using the admission checklist look for evidence of compliance with the checklist. Review discharge information in the liaison office ascertain whether or not discharge are occurring seven days.
6) Using the discharge checklist, look for evidence of compliance with the checklist. Note any non compliance.
7) Review, note the trends and obtain explanations for significance increases or decreases the following KPIs:-
    a. KPI 8 - ER length of stay >24hours
    b. KPI 13 – delay for elective surgery
    c. KPI 14 – Bed occupancy rate
    d. KPI 15 – average length of stay
8) There is evidence of continuous orientation and training on the protocols for new staff.

J. List of Appendices

1. Sample Admission Checklist.
2. Sample Discharge Decision Checklist.
3. Assessment Tools for Monitoring A&D process: Fact Sheets.
    1. Organizational barometer.
    2. Development 'health check' progress tool.
    3. Developing a Non physician clinician-initiated discharge policy.
    4. Example of discharge checklist.
    5. Matrix of training competencies for timely discharge.
4. Criteria for Discharge of Patient.
5. Sample Admission Urgency Notification Card.

Appendix 1

Sample Admission Checklist

	Yes	No	N/A
1. Has the patient information been collected?	☐	☐	☐
2. Has the clinician seen the patient and decided on admission?	☐	☐	☐
3. If birthing mother, has risk and other antenatal assessment been done?	☐	☐	☐
4. Has the clinician filled out the admission form and notes?	☐	☐	☐
5. Are the following shown?			
• Clinical priority	☐	☐	☐
• Estimated length of stay	☐	☐	☐
6. Has the liaison officers received the admission form?	☐	☐	☐
7. Has the waiting list been updated?	☐	☐	☐
8. Has the clinical, functional and social pre admission assessment been done?	☐	☐	☐
9. Has the liaison officers discussed the admission with the Patient and relatives where relevant?	☐	☐	☐
10. Has the bed been allocated in a timely manner?	☐	☐	☐
11. Is the patient eligible for free service?	☐	☐	☐
12. If no, has all financial issues been settled?	☐	☐	☐

Appendix 2

Sample Discharge Decision Checklist

		Yes	No	N/A
1.	Has a date of discharge been estimated and documented?	☐	☐	☐
2.	Has the patient been involved or informed?	☐	☐	☐
3.	Is the patient clinically stable and fit for discharge?	☐	☐	☐
4.	Has medications been dispensed and purpose, regime explained to patient?	☐	☐	☐
5.	Is the discharge summary and any other relevant information included for the receiving facility?	☐	☐	☐
6.	Outpatient appointments made and given to patient?	☐	☐	☐
7.	Patient given information about self-care and who to contact if symptoms return?	☐	☐	☐
8.	Has the patient been given a hospital sick certificate if required?	☐	☐	☐
9.	Has the patient settled all financial issues?	☐	☐	☐

Appendix 3

Assessment Tools for Monitoring A&D Process

The series of factsheets in this section are intended to support the stages of the discharge process. They can be used and adapted to your practice to continue to improve the discharge process. The factsheets include:

Factsheet 1 (Liaison Office)

Organizational barometer

Use this to identify where you are in relation to the key steps to implement timely patient discharge.

Factsheet 2 (Liaison Office)

Development 'health check' progress tool

Use this checklist to establish how close you are to implementing timely patient discharge and to identify the steps you still need to take.

Factsheet 3 (Supplementary, NPC)

Developing a Non-physician Clinician-initiated discharge policy

It includes the elements that a policy should address. Use this to develop your policy.

Factsheet 4 (Can be synched with the previous checklist in Appendix 2)

Example of discharge checklist

An example developed for an emergency assessment which demonstrates patient involvement. Use this to develop your local checklist.

Factsheet 5 (Supplementary)

Matrix of training competencies for timely discharge

Use this matrix to identify training needs among members of the multidisciplinary team.

Factsheet 1

Organizational barometer

Use this barometer to identify where you are in relation to the key steps to implement timely patient discharge. When you have read the toolkit, reflect on your current practice in the clinical team and see where you are.

Where is your organization positioned on the line?

What have you achieved so far?

What will you need to do to make it happen in your organization?

What do you think is stopping you?

Who are your allies and champions who will support you in making this happen?

Who are the stakeholders/people you need to influence/persuade that this is a positive direction to take?

What are your next steps?

Factsheet 2

Developmental 'health check' progress tool

Use this check list to establish how close you are to implementing timely patient discharge and to identify the steps you still need to take.

1. Willingness to try

- Have you started to review the discharge process through process mapping? Yes No
- Have you started to discuss timely discharge within the multi-disciplinary team? Yes No
- Have you approached the information manager to look at current pattern of discharges? Yes No

2. Support

- Do you have support from the lead consultant, clinical director, and senior manager? Yes No
- Have you started to discuss timely discharge with the director of operations executive lead? Yes No
- Have you gained support and agreement with the director of nursing and medical director to begin nurse-initiated discharges earlier in day and at weekends? Yes No
- Have you identified your allies and champions who will support you? Yes No
- Have you referred to the DH workbook 'Discharge Planning - pathway process and practice'? Yes No

3. Discharge pathway

Have you agreed the elective or emergency pathway and patient group? Yes No

Referral routes established (access to pathway) Yes No

Scope of pathway decided: Yes No

- Pre-operative or pre admission Yes No
- From point of admission Yes No
- At point of medical stability (clinical stability) Yes No
- On day of discharge Yes No
- Post discharge Yes No
- Exit route(s) established Yes No

Checklists

Discharge checklist developed? Yes No

Nurse or AHP led discharge checklist? Yes No

Decision when checklist is to be used (48hr/24hr/ON DAY) Yes No

Patient focus (involvement) considered? Yes No

4. Clarify roles and responsibilities

- Have you identified the members of the team who are involved in the discharge process? Yes No
- Have you mapped the discharge process with the roles and responsibilities of members of the clinical team? Yes No
- Could you clarify the roles and responsibilities? Yes No
- Could you change the roles and responsibilities so that it improves the discharge process? Yes No

5. Estimated date of discharge (acute)

Estimated date of discharge (EDD) process in place? Yes No

Endorsed by consultant teams and junior doctors? Yes No

Agreements with labs and X-ray for turnaround times of tests etc? Yes No

Implemented consistently at post take ward rounds or MDT meetings? Yes No

Estimated date of discharge (rehab)

Supported by regular multi-disciplinary team input Yes No

Links from EDD and nurse initiated discharge established? Yes No

Wider consideration of 'number of contacts' required by AHP Yes No

Estimated date of discharge (primary/intermediate)

Considers primary care perspectives (e.g. district nursing input) Yes No

Considers intermediate care service input/assessment/availability Yes No

6. Training(knowledge, skills and competencies

Skills/competencies required, are clearly identified (matrix)? Yes No

Supporting nurse initiated assessments are developed? Yes No

Training and work-based learning needs identified Yes No

Supervision and assessment in carrying out nurse-initiated discharge in place Yes No

7. Policy

Have you reviewed your hospital discharge policy? Yes No

Nurse initiated discharge as part of policy? Yes No

Nurse initiated discharge policy links with Trust discharge policy? Yes No

Written in collaboration with multi-disciplinary team including social services? Yes No

Written in collaboration with primary and intermediate care services Yes No

Signed off by legal team / clinical governance approval? Yes No

Policy indicates scope of nurse initiated discharge from secondary care, primary care, intermediate care and nursing /residential settings

8. Protocols/guidelines

Individual condition based protocols developed with lead consultants?	Yes No
Exclusion/inclusion criteria decided (to assess suitability for NID)?	Yes No
Screening tools written in conjunction with physician or surgeons?	Yes No

Protocol clear about when transfer of care from medical profession to nurse or AHP protocols is to happen?

- Protocols signed off by relevant professionals with implementation and review date
- Clinical governance aspects of protocols are agreed by trust clinical risk departments, legal advisers

9. Outcome measures

Agreed measures before and after new process in place?	Yes No
Audit mechanism in place?	Yes No
Established as a pilot project?	Yes No
Agreement about how to disseminate best practice or lessons learned?	Yes No

Factsheet 3

Developing a Non-physician clinician-initiated discharge policy

The following elements can be included in a nurse/allied health professional-initiated discharge policy. Examples are included under each heading.

Statement of philosophy

- Patients and caregivers are involved in making decisions and kept informed of their discharge plans
- Plans allow for flexibility, accessibility and individual choice
- Early planning for discharge through multi-disciplinary working
- Non-discriminatory practice
- Includes directives for the safe and effective provision of nurse/allied health professional discharge

Strategic intention or aim

Organizational

The aim will determine the key drivers underpinning the policy, such as:

- Percentage of discharges aimed for
- explicit links to reducing the length of in-patient stay
- links to preoperative assessment and suitable patient groups

Professional

- To extend or formalize current practice
- To assist in delivering the working hours directive
- To promote confidence in the discharge process
- To assist with the development of new roles

Objectives

- To ensure more timely discharges occurs and reduces the discharge delays
- To promote independence for the professional carrying the discharge
- To ensure practice is safe and does not put the patient at risk
- To provide continuity of care, through effective communication across all professionals and teams irrespective of setting

Definition of a nurse/allied health professional-initiated discharge

- Interfaces with other professional roles to support discharge planning
- Part of a process, to secure safe timely discharge
- Can be supported by condition specific protocols

Scope of the policy

- Medicine
- Surgery
- Where does it start? Where does it finish? Pre-admission to post discharge
- Agreements with intermediate care and outreach teams
- Primary care provision to support the policy?
- Integration with PCT commissioning processes?

Areas of special concern

Highlight the categories of patient who need particular attention and who should not be excluded on an age or condition related basis, provided they are medically stable:

- People who live alone
- People who are elderly
- People who are frail irrespective of age
- Terminally ill patients
- People with chronic conditions who may return to Hospital for further treatment.
- People living in sheltered accommodation

Authorized responsibilities

- Level of health professional
- Core team to support health professional
- Length of time need to be qualified.
- Role of MDT and support provided by named team members

Education and training

- Core discharge skills analysis to determine areas of training required
- Competency assessment
- Competency based training and declaration of competence

Legal liability

- Undergone preparation and training for the role
- Deemed competent to undertake the role
- Authorized framework has been developed
- Supporting protocols, criteria where appropriate

Professional accountability process

- Suitability of patient selection
- Links with appraisal process
- Recorded onto a local database for named nurses competent to initiate discharge
- Job descriptions need to reflect the additional role dimension

Patient responsibility in the process

- Giving consent
- Learning self-care (if required to facilitate discharge planning)
- Involving their family/caregivers

Audit and evaluation framework

- What framework will be employed? What are the key measures?
- How will you measure patient's satisfaction?
- Who is signing this document off?
- Has it been presented at a clinical risk or governance group?

Factsheet 4

Example of discharge checklist

This example of a discharge checklist is used in partnership by the patient, who fills in the first section, the nurse and the ward clerk. It is an example of patient involvement in the discharge process in action.

Patient section

Please complete these questions and the nurse will collect the form from you.

Your Name:

Date:	
Is this the first time you have attended the Department?	☐ Yes ☐ No
Do you understand your diagnosis?	☐ Yes ☐ No
Has a clinic appointment been made for you?	☐ Yes ☐ No ☐ Not sure
Have further investigations been arranged for you?	☐ Yes ☐ No ☐ Not sure
Do you understand your medications?	☐ Yes ☐ No ☐ Not sure
Have you been prescribed any medications?	☐ Yes ☐ No

Thank you for completing this, please hand this to the nurse looking after you.

Nurses to complete

Medically fit for discharge (in notes)	☐
Venflon removed	☐
Discharge discussed with patient	☐
GP discharge letter given to patient	☐
Drugs to take home supplied and explained	☐
Any patient's own drugs returned	☐
Dressings and equipment supplied	☐
District Nurses contacted	☐

Follow up call indicated	☐ Yes ☐ No
Notified patient about follow up call	☐ (time) _____

Clerical staff

Do you understand your medications?	☐ (time) _____
Have you been prescribed any medications?	☐ (time) _____ (how) _____
Other follow up arranged	☐ _____

Discharging signature _____ (time) _____

Factsheet 5

Matrix of training competencies for timely discharge

The competency framework has been designed so that any member of the multi-disciplinary team can assess their own knowledge and skills, these can be discussed with the team leader, and training needs can be identified for individual staff and for the team as a whole.

You and your team will need to agree the level of practice, supervision and assessment needed by each member of the team. You will also need to agree roles, responsibilities, and contributions individual team members will make to discharge decisions and the co-ordination of the discharge process. This may help you to identify training needs and support you in designing local education and training. For example, the team may include:

- ward clerks and administrative assistants
- newly qualified professional staff
- more experienced staff including staff nurses, allied health professionals, junior doctors and social workers
- expert practitioners including consultants practitioners including doctors, nurses and allied health professionals, specialist registrars, ward sisters, matrons, nurses, social services managers and allied health professionals with specialist interest.

It will also help you to plan the rotas to ensure that staffs with the appropriate knowledge, skills and competencies are available to follow through clinical management plans and discharge criteria so that patients continue to be discharged over the weekend.

We suggest that individuals must achieve an expert level of competence before taking full accountability for initiating discharge.

The competency framework will allow self-assessment and peer review of the range of knowledge and skills required. It is suggested that you identify your level of competence for each section or elements within each section. You may be fully competent in some areas, but only partially competent and need further training and supervision in other areas.

The competency framework is a suggested guide and can be adapted to ensure it is consistent with your usual approach to education, training and assessment of competence.

Use the boxes to assess your competence:
C = Competent **P** = Partially competent **N** = Not yet had experience

	Multi-disciplinary team working	Estimating expected date of discharge	Development, implementation and review of clinical management plan
Advanced Practitioners (Expert) **Able to make decisions independently**	Able to: • Lead a team effectively • Demonstrate collaborative working and has trust of senior colleagues • Communicate effectively with team/other HCP/patients and carers • Develop/implement clinical management plan • Identify and achieve shared goals	Able to: • Undertake full assessment of the patient including physical, physiological, social and functional • Demonstrate excellent knowledge of the clinical condition and the investigations/ interventions required • Estimate the length of stay needed to complete treatment to a level where the patient is clinically fit for discharge • Review and revise EDD based on further assessment/data	Able to: • Develop clinical management plan based on full assessment • Implement and review CMP developed by another member of MDT • Review patient progress and adjust the plan in response to assessment and test results • Identify EDD within the plan • Demonstrate ability to make effective discharge decisions
Practitioners (Experienced) (Completed foundation years) **Able to present all information needed for decision making but requires support in making decision**	Able to: • Demonstrate good understanding of individual roles within MDT and their contribution to discharge • Communicate effectively with members of MDT/patients/carers • Anticipate information needed by MDT in order to make decisions • Demonstrate high level of knowledge of discharge process	Able to: • Undertake partial assessment of the patient including physical, physiological, social and functional • Use protocols/guidelines/ ICPs to support planning and implementation of care • Prompt MDT to estimate EDD and document in patient record • Prompt review of EDD based on assessment of patient	Able to: • Implement aspects of the CMP and co-ordinate care around the patient • Assess the patient (clinical condition specific) for discharge using criteria or protocols developed by MDT • Identify when patient's condition has deteriorated and are no longer suitable for discharge
Newly qualified Practitioners (Novice) (During foundation years) **Able to demonstrate an understanding of discharge process**	Able to: • Demonstrate an awareness of individual roles within MDT • Understand the importance of effective and timely communication	Able to: • Carry out basic components of assessment • Follow instructions and report any variances to team leaders • Demonstrate awareness of importance in discharge model	Able to: • Demonstrate understanding of elements of CMP • Implement aspects of the plan under supervision • Demonstrate understanding of importance of effective documentation and communication

Making referrals	Interpretation of test results and investigations	Patient decides to self discharge against healthcare professional advice
Able to: • Demonstrate excellent ability to identify when a referral is needed • Initiate referral to other members of MDT • Follow up actions and results from referrals • Co-ordinate and run MDT review of patient • Use outcome of MDT review to adopt CMP and EDD	Able to: • Refer and interpret test results • Adjust CMP in response to the results of tests and investigations • Identify when future discussion and review by medical colleagues and other members of MDT • Take responsibility for discharge decision based on clinical assessment and best results	Able to: • Attempt to persuade patient to remain in hospital if this is in the clinical interest of the patient • Explain the risks and potential consequences of self discharge to the patient and carers • Rapidly co-ordinate care package if accepted by the patient • Document events accurately within patient record • Communicate with GP including discharge letter
Able to: • Recognise when referral to MDT may be needed • Make referrals based on guidance from others • Co-ordinate actions and results from referrals • Demonstrate understanding of MDT review and implications for CMP and EDD	Able to: • Proactively chase test results • Understand the significance of test results • Communicate abnormal test results effectively and in timely manner to appropriate member of MDT	Able to: • Explore reasons for self discharge • Inform patient's consultant or senior medical team of patient's intention • Ensure all relevant documentation is completed
Able to: • Follow instructions and plans developed by other members of MDT • Document when referrals have been made in patient record	Able to: • Accurately record and document test results • Demonstrate an awareness of normal and abnormal test results	Able to: • Demonstrate awareness of the risks and potential consequences of self discharge for patient • Demonstrate awareness of the policy and procedures/documentation required

Appendix 4

Criteria for Discharge of Patient

General Discharge Score Card

	Score
Activity	
Able to move 4 extremities voluntarily or on command	2
Able to move 2 extremities voluntarily or on command	1
Unable to move extremities voluntarily or on command	0
Respiration	
Able to breathe deeply and cough freely	2
Dyspnoea or limited breathing	1
Apneic	0
Circulation	
BP ± 20% of pre anaesthetic level	2
BP ± 20 to 49% of pre anesthetic level	1
BP ± 50% of pre anesthetic level	0
Consciousness	
Fully awake	2
rousable on calling	1
Not responding	0
Oxygen saturation	
Able to maintain saturation >92% on room air	2
Needs oxygen to maintain saturation >90%	1
Saturation <90% even with oxygen	0
Dressing	
Dry and clean	2
Wet but stationary or marked	1
Growing area of wetness	0
Pain	
Pain free	2
Mild pain handled by oral medication	1
Severe pain requiring parenteral medication	0
Ambulation	
Able to stand up and walk straight	2
Vertigo when erect	1
Dizziness when supine	0
Fasting-feeding	
Able to drink fluids	2
Nauseated	1
Nausea and vomiting	0

Urine output	
Has voided	2
Unable to void but comfortable	1
Unable to void and uncomfortable	0

Another more recent system is the Post anesthesia Discharge Scoring System (PADSS) developed by Marshall and Chung. The total possible score is 10 and patients scoring 9 or above are fit for discharge.

		Score
Vital signs:	Vital signs must be stable and consistent with age and preoperative baseline.	
	BP and pulse within 20% of preoperative baseline	2
	BP and pulse within 20-40% of preoperative baseline	1
	BP and pulse >40% from preoperative baseline	0
Activity level:	Patient must be able to ambulate at preoperative level.	
	Steady gait, no dizziness (or meets preoperative level)	2
	Requires assistance	1
	Unable to ambulate	0
Nausea and Vomiting:	The patient should have minimal nausea and vomiting prior to discharge.	
	Minimal: successfully treated with oral medication	2
	Moderate: successfully treated with intramuscular medication	1
	Severe: continues after repeated treatment	0
Pain:	The patient should have minimal or no pain prior to discharge. The level of pain that the patient has should be acceptable to the patient. Pain should be controllable by oral analgesics. The location, type and intensity of pain should be consistent with the anticipated postoperative discomfort.	
	Acceptability: Yes	2
	No	0
Surgical Bleeding	Postoperative bleeding should be consistent with expected blood loss for the procedure.	
	Minimal: does not require dressing change	2
	Moderate: up to two dressing changes required	1
	Severe: more than three dressing changes required	0

Appendix 5

Sample Admission Urgency Notification Card

Date _____

Name of the department issuing admission _____

Name of the patient _____

Card number _____

Name and signature of the physician approving admission

_____

Urgency of the admission

Emergency (immediate admission) _____ ☐

Non emergency but priority (admission within two weeks) _____ ☐

Non emergency (admission in two weeks or more) _____ ☐

Name and signature of the Liaison officer accepted admission

_____

Date of patient appointment for admission _____

K. References

1. Ethiopian Hospital Reform Implementation Guideline (EHRIG)

2. Admission and Discharge Guidelines: Health Strategy Implementation 2003. Retrieved from http://www.dohc.ie/issues/health_strategy/action84.pdf?direct=12.

3. Achieving Timely 'Simple' Discharge from Hospitals. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4088367.pdf

4. British Association of Day Surgery, Handbook Series Guidelines about the discharge process and the assessment of fitness for discharge. Retrieved from http://www.daysurgeryuk.net/bads/joomla/files/Handbooks/badsdischargecriteria.pdf