INFORMATION
for clinicians

Comprehensive Care Standard

Transition of care - discharge from an acute facility

Part of delivering comprehensive care is planning for transition from the health service organisation to home or another service. Discharge planning is the development of a personalised plan for a patient leaving a health service organisation. Discharge should not be considered the end of care. It is a transition point along the patient's health journey.

The aim of discharge planning is to:

- Ensure appropriate post-discharge care or support
- Improve the co-ordination of services following discharge from hospital
- Improve patient experience of care
- Reduce hospital length of stay and unplanned readmission to hospital.

Discharge planning includes identifying any services, equipment or follow-up that may be needed to safely transition the patient home or elsewhere. Processes must be in place to ensure that follow-up arrangements are made before the patient leaves the health service, and that any required referrals are dealt with promptly. The person, and their family and carers, should be engaged in the transition of care from the beginning of the healthcare episode.

The value of discharge planning

There is some evidence that discharge planning may reduce hospital length of stay and unplanned readmission rates in elderly people with a medical condition. Individualised discharge plans may also reduce delayed transition due to non-medical factors, contain costs, and improve patient outcomes.

Patient participation in discharge planning improves their experience and can result in better health outcomes. Discharge planning can also positively affect clinician satisfaction.

NSQHS Standards

The NSQHS Standards have actions that directly relate to transitions of care including discharge planning:

Item	Action
Designing systems to deliver comprehensive care	5.4 The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive care plans for patients' care and treatment c. Ensure timely referral of patients
Developing the comprehensive care plan	5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: d. Commences discharge planning at the beginning of the episode of care
Predicting, preventing and managing self-harm and suicide	5.32 The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts
Provision of a medicines list	4.12 The health service organisation has processes to: c. Provide patients on discharge with a current medicines list and the reasons for any changes
Clinical handover	6.8 Clinicians use structured clinical handover processes that include: f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Tips for transitions of care and discharge planning

Things you can do, as a clinician, to encourage and support successful transitions of care include:

- Taking a multidisciplinary approach to transitions of care with all members of the healthcare team providing input
- Communicating openly with patients, their carer and family, and sharing care decisions
- Designating a care co-ordinator who knows the patient
- Ensuring the discharge summary contains correct and relevant information to facilitate continuity of care after transition from the service
- Providing discharge information that is appropriate to the patient's circumstances and level of health literacy
- Providing patient education tailored to their comprehensive care plan
- Organising home-based interventions, such as home nursing, Hospital in the Home or Meals on Wheels, to commence without delay
- Performing a medication reconciliation, providing the patient with an up-to-date medication list and an adequate supply of discharge medications
- Ensuring discharge requirements are documented and met
- Ensuring that the receiving clinician(s) receive the discharge summary in a timely fashion to prevent treatment delays and eliminate the risk of adverse events occurring due to missing information.

Further information and resources about discharge planning

Hospital discharge planning: information for consumers **https://www.healthdirect.gov.au/hospital-discharge-planning**

Discharge planning research **https://www.unisa.edu.au/research/Health-Research/Research/Allied-Health-Evidence/Projects/Quality-Care1/DCP/**

Questions?

For more information, please visit:
safetyandquality.gov.au/our-work/comprehensive-care

You can also contact the Comprehensive Care project team at: **mail@safetyandquality.gov.au**