Criteria Led Discharge (CLD)

Planning for discharge on admission

A RESOURCE DEVELOPED BY THE ACI ACUTE CARE TASKFORCE TO SUPPORT IMPLEMENTING CRITERIA LED DISCHARGE
ACKNOWLEDGEMENTS

The Agency for Clinical Innovation (ACI) is the lead agency in NSW for promoting innovation, engaging clinicians and designing and implementing new models of care. All ACI models of care are built on the needs of patients, and are underpinned by extensive research conducted in collaboration with leading researchers, universities and research institutions.

The ACI acknowledges that we operate and function on the lands of the Cammeraigal people of the Eora Nation. We acknowledge and pay respect to the ancestors that walked and managed these lands for many generations. We pay respect to Elders past and present and extend that respect to other Aboriginal peoples present here today. We acknowledge elders who are the knowledge holders, teachers and pioneers. We acknowledge the youth who are the hope for a brighter future and who will be the future leaders.

For further details on the ACI, visit: www.aci.health.nsw.gov.au

The ACI acknowledges the large number of people involved in the development of this resource for CLD, in particular:

- ACI Acute Care Taskforce
- ACI Criteria Led Discharge Working Group
- Auckland District Health Board
- Bega Hospital (Surgical Ward)
- Calvary Mater Hospital (Haematology Unit)
- Children’s Hospital Westmead, NSW
- Clinical Excellence Commission – initial draft of this document
- Department of Health / National Health Service, UK
- Queensland Health
- Royal Children’s Hospital Melbourne, Victoria
- The Nursing and Midwifery Office at the NSW Ministry of Health
- Wollongong Hospital (Cardiology Step Down Unit, Neurology Ward)
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<table>
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Background

The Acute Care Taskforce (ACT) has been involved in developing solutions for improving the medical patient journey since 2005. This includes work around safe clinical handover, avoidable admissions and the establishment of medical assessment units.

In 2011 the NSW Ministry of Health published a policy directive titled Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals. Acknowledging that patient involvement contributes to positive health outcomes, the policy mandated that hospital teams involve patients/carers in care planning. It highlights five important stages to a coordinated inpatient experience:

1. Pre Admission/Admission
2. Multidisciplinary team review
3. Estimated date of discharge (EDD)
4. Referrals and liaison for patient transfer of care
5. Transfer of care (discharge) out of the hospital

In 2012 the ACT transitioned to the NSW Agency for Clinical Innovation (ACI) and in order to build upon this important work the ACI brought together a group of clinicians, consumers and managers. Under the guidance of this group the ACT decided it would focus on improving the medical inpatient journey in 2013.

Five important elements to improving the inpatient journey were identified with the system lead noted in brackets ():

1. A patient flow systems approach to improving the inpatient experience focused on the estimated date of discharge (EDD) and Waiting for What? functions (NSW Ministry of Health – MOH and Health & Education Training Institute - HETI)
2. Inpatient clinical management plans (ACI)
3. Ward rounds (Clinical Excellence Commission - CEC)
4. Criteria led discharge (ACI)
5. Transfer of care / discharge (CEC)

Under the guidance of the ACT Executive, two working groups were established: one for clinical management plans (CMP) and another concentrating on criteria led discharge (CLD). Following a comprehensive literature review and in consultation with the statewide ACT the clinician led working groups developed a set of tools to assist staff from Local Health Districts and Specialty Health Networks (LHD/SHNs) to:

- Improve documentation of the CMP in their wards and facilities, and/or
- Assess the requirements for implementing CLD.

This resource is focused on CLD.

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**Figure 1 Acute Care Taskforce 2013: a collaborative approach to improving the medical inpatient journey**
The tools are designed to assist teams to make changes to improve the way that care is provided while patients are in hospital. This resource acknowledges that care provided in hospitals can be complex and that the solutions to improving both the patient and staff experience will require an interdisciplinary effort. These changes include better communication of the clinical management plan; a more streamlined approach to planning for transfer of care (discharge)* and a more coordinated inpatient journey.

This resource includes the following components key to implementing CLD:

− a framework for CLD (Figure 4)
− frequently asked questions for implementing CLD (Appendix A)
− patient information leaflet (Appendix B)
− a CLD form (Appendix C) with guidance (Appendix D)
− a suggested transfer of care checklist (Appendix E)
− guidance on collecting patient and staff experience using Patient Experience Trackers (PETs) (Appendix F)
− a protocol/policy for local adaptation (Appendix G)
− a CLD competency set (Appendix H)
− an implementation checklist (Appendix I)
− a draft set of orientation/education slides (Appendix J)

The Context for Change

**Increasing demand on our health facilities**

In Australia the number of patient admissions continues to increase each year. Table 1 indicates that there was an average 3.2% increase year on year in separations for NSW public hospitals between 2007/08 to 2010/11. Comparing 2007/08 to 2011/12, demand has grown by 12% (193,865 separations) across the state. With an ageing population and increasing numbers of people with advanced chronic disease who have multiple comorbidities, one would expect that the number of admissions to our health facilities will continue to rise.

**Patient transfers of care**

Patient transfers of care from hospital occur unevenly through the week, with reduced numbers during the weekend and peaks on Mondays, resulting in the team playing catch up throughout the week (Figure 3). There is also a mismatch between admission and transfer of care times which has an effect on the required number of inpatient beds (Figure 2). This in turn contributes to bed block. This inefficiency poses a burden of demand on health resources.

The specific problem of peaks and troughs in patient transfers of care are connected with peaks and troughs in staff availability, as well as the peaks and troughs in patient demand. The focus of short to medium term efforts should be on improving the decision making capability of patient care teams, particularly regarding patient care and transfer of care planning.

**Table 1: AIHW NSW Hospital Separations (2007-2012)**

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>1,466,737</td>
<td>1,505,969</td>
<td>1,542,968</td>
<td>1,582,804</td>
<td>1,660,602</td>
</tr>
</tbody>
</table>

* For the purposes of this resource the terms discharge and transfer of care are used interchangeably to reflect the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group on a temporary or permanent basis.
Transfer of care planning is essential to the efficient use of healthcare resources. It is a key part of care planning for patients and should begin at the patients’ admission into hospital as indicated by the NSW Health care coordination policy directive. Transfer of care planning should be seen as a key component of good care planning and care delivery. In short, patients will be ready for transfer as planned, if care is delivered as planned.

In addition, the NSW Adult Admitted patient survey results provide an insight into the current patient experience of hospital transfers of care (discharge). NSW hospital patients reported that:

- they would like to be involved in decisions about their discharge (95%)
- they were not always as involved in discharge decisions as they would like to be (41%)
- services were needed after discharge (72%)
- their discharge was delayed on the day they left hospital (28%)

A Solution – Criteria Led Discharge

One solution that can assist in addressing the demand on beds in our health facilities is to formalise CLD.

CLD will enable the most appropriate healthcare professional to transfer the patient (potentially nursing, allied health or junior medical staff) by providing set criteria for the transfer making process. Under CLD the decisions for discharge are made and criteria are documented by the senior medical clinician (e.g. Senior Consultant, Medical Fellow, Visiting Medical Officer). The CLD competent staff member (e.g. nursing, allied health, junior medical officer) can then facilitate the discharge of a patient according to the documented criteria. The staff member is then responsible for monitoring that the CLD criteria have been met. If a patient does not meet the agreed criteria they should not be discharged using CLD. The reason should be documented on the CLD form and a medical review will be necessary.
A number of initiatives have been implemented across NSW to improve patient flow. The Patient Flow Portal (PFP) supports NSW Health workers to adopt a Patient Flow Systems approach by providing accessible, user-friendly tools. Specifically, the PFP includes predictive tools to support staff to:

- plan actions according to expected demand
- identify how patients are being allocated according to an expected date of discharge
- view relative length of stay (LOS)
- have a view across varied frames of how a single ward or entire facility is managing
- understand what services patients are waiting for
- have good information on at risk patients

In addition to the PFP, the NSW Ministry of Health commissioned an evidenced based review on Smooth Patient Flow (SPF). To complement this review, the Health Education and Training Institute (HETI) has developed educational and training resources on patient flow. SPF is a learning program divided into three stages.

The objectives of this learning program are to:

- Name the seven elements of the Patient Flow Systems Framework
- Name the five stages of care coordination and identify the key features of each stage
- Explain the seven primary benefits for patients, staff and the organisation that come from using a systematic approach to managing SPF
- Explain how each of the four main functions of the PFP can be used to ensure the systematic management of patient flow
- Analyse a scenario, with a given set of simple data, and determine which interventions, from a selection, would be the most appropriate/effective for improving patient flow for the scenario

It is recommended that the program be completed as follows:

1. Stage 1 - Self-Directed Learning
2. Stage 2 - eLearning module. Depending on your location using either HETI online or moodle.
3. Stage 3 - Continuous Improvement Activities. This stage may be done individually or in local teams and involves a number of activities aimed at reinforcing the principles of smooth patient flow using real world examples.
The Criteria Led Discharge Framework

The NSW Health policy directive on care coordination in public hospitals, Care Coordination: Planning from admission to transfer of care in NSW public hospitals (PD2011_015) which outlines a five stage process to guide staff and patients through their hospital stay. These are:

1. Pre Admission/Admission
2. Interdisciplinary Team Review
3. Estimated Date of Transfer (Discharge – EDD)
4. Referrals and Liaison for patient transfer of care
5. Transfer of care out of the hospital

In addition to the Policy Directive, there are supporting documents for staff:

- Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals Reference Manual (including the Transfer of Care Risk Assessment)
- Staff Booklet: The Principles of Care Coordination

The five stages of care coordination provide the foundation for CLD (Table 2).

Table 2: Mapping the Criteria Led Discharge Framework to the Care Coordination Policy Directive

<table>
<thead>
<tr>
<th>Care Coordination Policy Directive</th>
<th>Criteria Led Discharge Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pre admission/admission</td>
<td>1. Pre Admission</td>
</tr>
<tr>
<td>2. Multidisciplinary Team Review</td>
<td>2. On admission</td>
</tr>
<tr>
<td>3. Estimated Date of Discharge</td>
<td>3. During admission</td>
</tr>
<tr>
<td>4. Referrals and Liaison</td>
<td>4. Planning for discharge</td>
</tr>
<tr>
<td>5. Transfer of Care</td>
<td>5. 24 hours before discharge</td>
</tr>
<tr>
<td></td>
<td>6. Day of discharge</td>
</tr>
</tbody>
</table>
Figure 4 Framework for criteria led discharge

**Pre-admission**
- **Planned**
  - Pre-admission assessment / EDD advised
  - Early identification of CLD milestones
  - Patient identified and signed off by Fellow/Consultant as eligible for CLD in PART A
  - YES
  - Usual care with discharge that includes final medical review

**Unplanned**
- Assessment and initial intervention/treatment
- Provisional Diagnosis
- Assessment including clinical, functional and social needs
  - Transfer of Care Risk Assessment

**Admission**
- **Planned Admission**
  - Clinical management plan agreed by Interdisciplinary Team (IDT) in partnership with patient/carer including:
    - A single comprehensive assessment, including an early stage risk assessment
    - Outcome and treatment goals with timeframes
    - Estimated date of discharge (EDD) that is communicated to patient and entered into the patient flow portal
    - Initiation of investigations, commencement of treatment
    - Referrals to necessary disciplines
    - Communication with community providers (especially if high risk on discharge)
    - Interdisciplinary family conferences, where indicated
  - Diagnosis / Provisional Diagnosis

- **Unplanned Admission**
  - Patient identified and signed off by Fellow/Consultant as eligible for CLD in PART A
  - YES
  - Consultant/Fellow signs off patient eligible in PART A / team documents milestones in PART B

**Discharge planning**
- Ongoing reassessment of treatment goals, timeframes and agreed milestones in partnership with patient/carer
- Discharge planning by team
- Milestones in PART B monitored by CLD competent staff member

**24 hours before discharge**
- Transfer of care (discharge) checklist finalised, including:
  - Personal items returned
  - Medications/scripts provided
  - Discharge summary completed and provided
  - Follow up appointments made, as necessary
  - Patient education completed
  - YES
  - NO

**Day of discharge**
- Transfer of care (discharge) ensuring:
  - Contact details given to patient for appropriate acute sector practitioners for post discharge communication
  - Communication with patient’s ongoing care practitioners
  - YES
  - NO

- Patient remains eligible for CLD
  - YES
  - NO

- Further clinical / medical review
- CLD form finalised. Part C signed off by CLD competent staff member
  - YES
  - NO

- Further clinical / medical review
Implementing Criteria Led Discharge

CLD may be incorporated into the delivery of usual patient care by hospital teams. While CLD is not a project in itself, the implementation of CLD should be managed as a project with a clear project plan and project team.

CLD can be implemented in many ways. The identification of implementing teams will be a local decision. Some hospitals may wish to implement hospital wide; others may wish to implement across wards. To implement CLD you will need, at a minimum:

1. Executive support
2. A co-leadership approach between nursing and medical clinicians, with senior staff leading the implementation
3. An interdisciplinary team approach

In addition then key considerations to implementing CLD are:

- Ensure executive level support
- Analyse data to determine relevant patient population
- Work with clinicians to gain senior medical buy-in and endorsement
- Work with interdisciplinary team to develop a co-leadership model, with senior medical, nursing and allied health (as relevant) buy-in
- Agree range of patient groups with interdisciplinary team and relevant managers
- Clarify roles and responsibilities for interdisciplinary team
- Review systems, processes and establish an agreed target
- Identify skills and training required
- Adopt policy approach, adapting draft protocol for local needs
- Measure baseline patient and staff experience, using the Patient Experience Trackers

- Refine policy approach in response to
  - Feedback from patients and carers
  - Feedback from staff
  - Incident reports
  - Audit
- Capture impact on
  - Patient experience (APPENDIX F)
  - Staff experience (APPENDIX F)
  - Patterns of admissions and discharges by time of day and week
  - Comparison with estimated date of discharge
  - Key quality and safety metrics e.g. length of stay, readmissions

These steps have been adapted from the UK approach\[1\]. A full checklist for teams involved in implementing CLD can be found at APPENDIX I.

Supporting Documentation

A series of documentation is included to support the implementation of CLD. These documents can be adapted according to the needs of each local team.

They are outlined in detail at Table 3 and include:

- frequently asked questions for implementing CLD (Appendix A)
- a CLD information leaflet (Appendix B)
- a CLD form (Appendix C) with guidance (Appendix D)
- a suggested transfer of care checklist (Appendix E)
- guidance on collecting patient and staff experience using Patient Experience Trackers (PETs) (Appendix F)
- a protocol/policy for local adaptation (Appendix G)
- a CLD competency set (Appendix H)
- an implementation checklist (Appendix I)
- a draft set of orientation/education slides (Appendix J)
### Table 3: Supporting documentation for implementing CLD

<table>
<thead>
<tr>
<th>TOOL</th>
<th>FUNCTION</th>
<th>APPENDIX</th>
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<tbody>
<tr>
<td>Frequently Asked Questions</td>
<td>A one page information sheet for teams implementing CLD</td>
<td>A</td>
</tr>
<tr>
<td>Patient Information Leaflet</td>
<td>A one page information leaflet for patients who are part of a CLD process in hospital</td>
<td>B</td>
</tr>
<tr>
<td>Generic CLD Form</td>
<td>A draft form that can be used by local teams and may require local forms committee approval. It is not the intention to create a statewide form in the initial phase of this project. The Senior Medical Clinician is required to sign off that the patient is eligible for CLD. The form also provides a space for noting why the patient was not deemed eligible for CLD. The milestones for the patient to meet should also be documented under the guidance of the Senior Medical Clinician, with the interdisciplinary team, in partnership with the patient and/or their carer. Other team members may add criteria to those set by the senior medical clinician. This may include both nursing and allied health staff (e.g. social workers, pharmacists and physiotherapists).</td>
<td>C</td>
</tr>
<tr>
<td>Guidance on Completing the CLD Form</td>
<td>This guidance can be adapted depending on the local rules for CLD.</td>
<td>D</td>
</tr>
<tr>
<td>Suggested Transfer of Care (Discharge) Checklist</td>
<td>This provides a best practice guide for the structure and a template to develop a local tool for supported transfers of care. It is not intended to replace existing local checklists that are already in place and functional. Implementing teams may wish to audit their existing transfer of care (discharge) checklists against the best practice template provided.</td>
<td>E</td>
</tr>
<tr>
<td>Patient and Staff Experience Questions</td>
<td>A short series of questions have been developed for measuring patient and staff experience. Baseline data should be collected prior to implementation to measure the impact on the ward of CLD. Daily reports are presented in graphical form which are easy to interpret and provide information to act on in real-time.</td>
<td>F</td>
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<tr>
<td>Draft Protocol/Policy for the Application of CLD</td>
<td>This protocol/policy is designed for local adaptation. The final version should be signed off by the team and outline the locally determined process and principles for clinicians to undertake CLD. The local protocol should also outline how staff are identified as competent to perform CLD.</td>
<td>G</td>
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<tr>
<td>Competency Set</td>
<td>This has been developed for teams wishing to undertake formal assessment of staff competency prior to completing CLD. The full competency pack includes case studies to support the examination of staff competency. The specific staff eligible to perform CLD will be a local decision and may include allied health staff, junior medical officers and/or nursing staff.</td>
<td>H</td>
</tr>
<tr>
<td>Implementation Checklist</td>
<td>A suggested checklist for teams involved in implementing CLD.</td>
<td>I</td>
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<tr>
<td>Draft Orientation/Education Slides</td>
<td>A draft presentation has been developed to educate and orientate new staff regarding the operation of CLD in the local team</td>
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</table>
References


4. NSW Health Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospital - Staff Booklet 2011.


6. NSW Health Care Coordination Patient Brochure 2011.


CRITERIA LED DISCHARGE – Frequently Asked Questions

The optimal time for patient transfer of care (discharge) is when a patient is medically stable to leave the hospital and any social and functional issues have been addressed. This is usually when both:

1. the ongoing medical care needs can be provided at home, and
2. when the patient or their carer is confident in their abilities to provide this care.

WHAT IS CRITERIA LED DISCHARGE?

Under Criteria Led Discharge (CLD) the decisions for discharge are made and documented by the senior medical clinician (e.g. Senior Consultant, Medical Fellow, Visiting Medical Officer).

For appropriate patients CLD competent staff (e.g. nursing, allied health, junior medical officer) can then facilitate the discharge of a patient according to documented criteria. The CLD competent staff member is responsible for monitoring that the CLD criteria have been met.

Criteria Led Discharge is not:

- a substitute for clinical decision making. A patient should still be seen every day by the medical team.
- The nursing (or other staff) independently discharging patients. The CLD competent staff is monitoring that the patient has met the set criteria.

WHAT IS THE PROCESS FOR CRITERIA LED DISCHARGE?

The senior medical clinician identifies eligible patients on PART A of the CLD form and documents a set of criteria on PART B of the CLD form. Identification of patients may occur at any point following discussion between the health care team, led by the senior medical clinician. Other team members may add criteria to those set by the senior medical clinician (PART B).

The CLD competent staff member monitors that the patient has met all the criteria and completes PART C of the CLD form.

WHAT IS A CRITERIA LED DISCHARGE COMPETENT STAFF MEMBER?

The local team will decide on a process for identifying CLD competent staff. The team should maintain a list of such staff; this list should be reviewed at least annually. Some teams identify this staff member with a badge. A competency set has been developed to guide this process.

WHAT IS BEST PRACTICE FOR CRITERIA LED DISCHARGE?

- A patient should be identified as eligible for CLD on admission, or as early as possible.
- The patient must be reviewed every day by the medical team and the set criteria should be updated, if required.
- The criteria and subsequent plan for discharge should be decided in partnership with the entire health care team, including the patient and/or their carer.
- The CLD competent staff member must monitor and record if the patient has met the criteria. This does not substitute for clinical judgement and if a patient does not meet the criteria a medical review is necessary.
- A transfer of care (discharge) checklist should be completed, this should include a section on the patient education that has been provided.

WHAT ARE THE POTENTIAL BENEFITS OF CRITERIA LED DISCHARGE?

- Improve patient experience: patients are able to get home sooner
- Enhance patient safety: criteria led transfer of care (discharge) through a checklist
- Improve staff satisfaction: not pressured to transfer patients in the “last minute” or experience bed block on Monday due to transfers not occurring over the weekend.
- Reduce unnecessary length of stay: not being in hospital when patients can actually be transferred
- Reduce bed days wasted: elimination of unnecessary days in hospital
- Minimise waste: best use of time-poor consultants; reduction of costs as a result of eliminating unnecessary lengths of stay in hospital.

WHERE CAN I FIND MORE INFORMATION ON CRITERIA LED DISCHARGE?

A set of resources is available at: www.aci.health.nsw.gov.au/cld, these include a/an:

- CLD form with guidance
- suggested transfer of care checklist
- protocol/policy for local adaptation
- competency set
- set of education/orientation slides
- implementation checklist
- guidance for collecting patient and staff experience data using Patient Experience Trackers

The ACI contact for Criteria Led Discharge is Kate Lloyd, Manager, Acute Care 02 9464 4623 or kate.lloyd@aci.health.nsw.gov.au.

Your local contact for CLD is <insert contact>.

Acknowledgments: Qld Health, The Royal Children's Hospital Melbourne
What is Criteria Led Discharge?
Many people find hospital a worrying and confusing time. Not knowing when they will leave the hospital (discharge) causes many patients a great deal of stress.

Criteria Led Discharge is a process that makes sure your discharge from hospital is not delayed and that you can safely transition home or to another care setting as soon as you are medically ready. It has many benefits:

• it clearly outlines what both you and your healthcare team need to do during your hospital stay
• you spend less time in hospital because decisions about your transfer are made earlier in your stay
• you spend less time waiting for the decision to let you go home

What will happen under Criteria Led Discharge?
You and your team agree on a set of milestones for you to meet. Your milestones might include a combination of clinical criteria such as having a normal temperature or not needing a drip, and social (physical) criteria for example being able to be independent where you normally live. These milestones will be documented in your medical record. The team will work with you to meet these milestones so that you can leave the hospital as quickly and safely as possible.

How will you know you have met the milestones?
A senior staff member will confirm that you have met all of the agreed milestones. If there are no outstanding issues, you will be able to leave the hospital without seeing your doctor for a final time. If there are any concerns the team will contact the doctor to review your health before going home.

Does this mean you will not see a doctor at all?
No. A doctor will continue to see you regularly throughout your hospital stay. Criteria Led Discharge means that you and the team have agreed on a set of milestones. These decisions have been led by the senior doctor. A senior staff member will monitor that these have been met. You will not be discharged before your milestones have been reached.

BEFORE you leave the hospital, please make sure you:
• Understand your care plan for you to manage at home (e.g. medications, follow-up care and appointments)
• Ask about medical certificates, letters and return of private x-rays
• Ask your doctor about any GP or specialist medical follow-up requirements
• Understand any home based support services or community based support that may be available

What should you do if you experience problems or are unhappy with your care?
If you are unhappy with any aspect of your care, please ask to speak to the nurse in charge of your ward.
If you do not feel that they are addressing your concerns, ask to speak to the Patient Representative in the hospital. They can be contacted on XXXX-XXXX and their office is located XXXXXXX.

Benefits for you
• You’ll know what needs to happen before you can leave the hospital
• You won’t need to stay in hospital any longer than necessary
• You and your family can plan well ahead for leaving the hospital

The estimated date you will leave the hospital is

CRITERIA LED DISCHARGE – PATIENT LEAFLET

TALK WITH YOUR DOCTOR
Your doctor will discuss Criteria Led Discharge with you to make sure you both agree to the process.

DEVELOP CRITERIA
You and your team agree on a set of criteria (milestones) that you will need to meet in order to leave the hospital.

PROGRESS MONITORED
A senior staff member monitors that the agreed milestones have been met.

DISCHARGE
You are able to leave the hospital without having to wait to see your doctor.
Appendix C: Criteria Led Discharge Template
Appendix D: Guidance on Criteria Led Discharge Form

Criteria Led Discharge for <insert team>

PART A: Documentation of suitability for criteria led discharge

Please ensure PART A of the Criteria Led Discharge form is filled in by <insert senior medical clinician role>.

Expected date of discharge needs to be completed.

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Expected Date of Discharge (EDD) on admission</th>
</tr>
</thead>
</table>

☐ I agree for this patient to be discharged once the milestones in part B and C are met.
☐ Please do not discharge until medical team review for the following reason (s):

Name: ___________________ Signature ___________________ Time/date: __________

PART B: Discharge Criteria

The completion of Part B should be led by the <insert senior medical clinician role>. CLD can be discussed at a team meeting (e.g. rapid round) where nursing and allied health criteria can be added.

<table>
<thead>
<tr>
<th>IDT agreed specific milestones</th>
<th>Name</th>
<th>Designation</th>
<th>Contact</th>
</tr>
</thead>
</table>

Responsible person: ___________________

<insert team> milestones to consider (these may come from an existing pathway):
1.
2.
3.

<insert team name> please ensure:
- <add specific instructions for team>, e.g. Script for sublingual anginine is attended

PART C: Patient Criteria

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Name</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

I confirm that the criteria in parts B and C have been met and are achieved:

Name: ___________________ Designation: ___________________ Date/time: __________

<table>
<thead>
<tr>
<th>Observation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Appendix E: Transfer of Care Checklist

TRANSFER OF CARE (DISCHARGE) CHECKLIST

Destination: Home [ ] RACF [ ] Other [ ]
Transport mode: Self/Relative/Carer [ ] Ambulance [ ] Patient Transport [ ]
Arranged/booked [ ] Confirmed [ ]
Notification: To [ ] Time [ ] Date [ ]

Personal items returned
- Valuables [ ] Yes [ ] No [ ] NA [ ] Date [ ]
- Medical Imaging (e.g. films/CDs) [ ] Yes [ ] No [ ] NA [ ] Date [ ]
- Equipment (e.g. walking aid) [ ] Yes [ ] No [ ] NA [ ] Date [ ]
- Dentures [ ] Yes [ ] No [ ] NA [ ] Date [ ]
- Hearing Aids [ ] Yes [ ] No [ ] NA [ ] Date [ ]
- Spectacles [ ] Yes [ ] No [ ] NA [ ] Date [ ]
- Medications [ ] Yes [ ] No [ ] NA [ ] Date [ ]

Transfer of care plan
- Medications list/scripts provided [ ] Yes [ ] No [ ] N/A [ ] Comments/notes [ ]
- IV cannula removed [ ] Yes [ ] No [ ] N/A [ ]
- Medical devices removed [ ] Yes [ ] No [ ] N/A [ ]
- Medical Discharge Summary Completed [ ] Yes [ ] No [ ] N/A [ ]
- Resuscitation plan [ ] Yes [ ] No [ ] N/A [ ]

Follow Up Appointments
- GP [ ]
- Specialist [ ]
- Outpatient clinic/community referrals [ ]

Patient Instructions and Information (note what education provided and what format)

Transfer of Care Plan agreed (sign after discussion) Patient/Carer

Clinician

Date/time

Transfer Checklist Completed by (Name & sign) Date/time

Designation

Discharged by (name & sign) Date/time

This form is being retained in XX between XX and XX

Page 1 of 1
Appendix F: Patient and Staff Experience – Patient Trackers (PETS)

PATIENT AND STAFF EXPERIENCE - PATIENT EXPERIENCE TRACKERS (PETS)

The Patient Experience Tracker (PET) is a small electronic hand held device that can be used to collect patient and/or staff feedback at the point of care (Figure 1). The device can have up to 5 customised questions with multiple choice answers. Patients and staff can respond to each question by the press of a button. It is a fast and effective way to collect patient feedback and measure patient and staff experience. Patients who are cognitively impaired or not competent to answer the questions may have their identified carer complete the survey.

The de-identified data from the devices is collated every day and the reports are sent back via email to nominated staff overnight. The reports are presented in graphical form which is easy to interpret and provides information to act on in ‘Real Time’. A weekly and monthly summary report is also available.

Figure 1: ACI Patient Experience Tracker

The CLD working group has devised a set of patient (Table 1) and staff (Table 2) experience questions to be used to measure pre and post experience for implementing CLD.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I know the date I am expected to be discharged from hospital</td>
<td>Yes / Unsure / No</td>
</tr>
<tr>
<td>2</td>
<td>I am aware of what needs to happen before I am discharged from hospital</td>
<td>Yes / Unsure / No</td>
</tr>
<tr>
<td>3</td>
<td>I know who to ask if I have questions about my plan of care</td>
<td>Always / Mostly / Sometimes / Rarely / Never</td>
</tr>
<tr>
<td>4</td>
<td>I receive daily updates about my plan of care</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I am involved in the development of my discharge plan</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I understand what is involved with criteria led discharge</td>
<td>Yes / Unsure / No</td>
</tr>
<tr>
<td>2</td>
<td>I involve the patient/family in developing a management plan</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Our team updates a patient’s estimated date of discharge on admission and throughout the hospital stay</td>
<td>Always / Mostly / Sometimes / Rarely / Never</td>
</tr>
<tr>
<td>4</td>
<td>I know who to contact if I have concerns regarding a patient's discharge plan</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Our team uses a transfer of care checklist (discharge) when planning for a patients discharge</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G: Draft Protocol/Policy For Local Adaptation

<Insert Facility-LHD/SHN> Protocol

<table>
<thead>
<tr>
<th>Category</th>
<th>Version Number</th>
<th>Effective Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>xx</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td></td>
<td>Relates to Policy (NSW MoH or SNSWLHD Policy)</td>
<td>To be allocated by nominated position at site/facility/service upon endorsement</td>
<td>To be reviewed in 5 years or earlier as required or on receipt of RCA recommendations. To be allocated by nominated position at site/facility/service upon endorsement</td>
</tr>
</tbody>
</table>

**Aim**

An interdisciplinary team (IDT) decision making approach is utilised in deciding when a patient is fit for discharge.

Discharge delays are avoided by a competent <insert role e.g. Senior Nurse, Allied Health professional or Junior Medical Officer> monitoring criteria set by the multidisciplinary team and approved by the senior medical clinician (Consultant/Fellow).

**Indications**

The optimal time for discharge is when the patient is medically ready to go home and carers are confident in the ability to care for the patient at home.

**Criteria**

The criteria for discharge will be determined by each implementing team and approved by the senior medical clinician (Consultant/Fellow). These may be pre-determined and/or individualised for each patient.

**Contraindications**

Those patients not meeting above criteria.

**Alerts/Risks**

Nil

**Scope**

- Visiting Medical Officers (VMO)/Staff Specialists
- Registrars
- Nurse Managers
- Nursing Unit Manager (NUM)
- Clinical Nurse Educators (CNE)
- Clinical Nurse Specialists (CNS)
- Allied Health staff <insert roles>

**Local Protocol**

A. Equipment, materials and documentation
   - Form: Criteria Led Discharge
     - Parts A, B and C must be completed on the Criteria Led Discharge Form.
     - The CLD form may be used in conjunction with clinical pathways

Criteria Led Discharge Protocol
Draft v1
Page 1 of 6
Mandatory compliance is required for all Local Protocol
The CLD forms will remain in the medical record and a record of MRNs will be kept at the nurses’ station to track patients who have been discharged using CLD.

- EDD and CLD are clearly labelled on patient journey board.
- A clear clinical management plan is still required in the patient medical record.
- Form: <Insert name of Transfer of Care (Discharge) Checklist>

B. Staff Education
- CLD Process
  - In Orientation
  - Staff competency assessment must be completed prior to conducting CLD

  Competency will be assessed by <insert title of person conducting competency assessment>.

C. Patient education
- To participate in decision making regarding discharge criteria during IDT rounds
- For planned admissions to be informed at pre-admission clinic of possibility of CLD

D. Sequence of actions

A draft sequence of actions is included at Appendix A. Each implementing team should have a process for signing off their own actions.

Responsibilities
- **Director of Clinical Services (Nursing)**
  Executive and authorising sponsor of the project trial

- **Lead Medical Consultants**
  1. Ensure all medical staff are aware and understand the CLD project and their expectations

- **Nurse Manager / Allied Health Team Lead**
  1. Ensure all nursing and allied health staff are aware and understand the CLD project and their expectations
  2. Ensure staff roles(e.g. Nurse Unit Manager (NUM), Clinical Nurse Education (CNE) Clinical Nurse Specialist (CNS), and Allied health are deemed competent in CLD
  3. Ensure CLD procedure is adhered to.

- **NUM / CNE/CNS / Allied Health Staff**
  1. Undertake clinical competency in CLD
  2. Engage all disciplines in CLD during interdisciplinary rounds

- **Staff**
  1. Ensure a basic understanding of CLD and willingly engage and participate in trial

Outcome Measures

Pre (baseline) and post Patient and Staff Experience collected using Patient Experience Trackers (PETs). Questions have been determined and these are available from the NSW Agency for Clinical Innovation.

Minimum dataset:
• Discharge by Day of Week (% of weekend discharges)
• Discharge by Hour of Day
• Ward Length of Stay
• Ward Mortality
• Ward Traffic (Ward discharges in period of time)
• Surgery cancellations
• Re-admission within 28 Days/ Unplanned Readmissions
• MET Calls (Between the Flags)
• Falls
• Pressure Ulcers
• Medication Prescription Errors
• EDD: Estimated Date of Discharge
• EEDD: Expired Estimated Date of Discharge
• Patient Experience (PET)
• Staff Experience (PET)

CLD form Audit
• % of completed forms
• % of patients discharged
• % patients not discharged on CLD
• % completed transfer of care checklists
• Comparison with EDD
• Patient discharged with documentation
• Transfer of care (discharge) checklist used

Appendices
  1. CLD Form
  2. Standards

Standards
NSQHS Standard 1 – Governance for Safety and Quality in Health Service Organisations
NSQHS Standard 2 – Partnering with Consumers

Safety Considerations
Manual Handling  Hand Hygiene  Spill Hazard  Sharp Hazard
Clinical Competency  Patient Education  Radiation Hazard  Cytotoxic Therapy
Standard Precautions  Electrical Safety

Approved by

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Position Responsible for Adherence & Implementation
<Role responsible for ensuring the protocol is implemented and adhered to>

Terminology
Ex: National Safety and Quality Health Service Standards (NS & QHSS) Please list and describe key words.
## Consultation Process / List

<table>
<thead>
<tr>
<th>Title / Position</th>
<th>Title/Position Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Operations</td>
<td></td>
</tr>
<tr>
<td>Director of Clinical Services (Medicine)</td>
<td></td>
</tr>
<tr>
<td>Director of Clinical Services (Nursing)</td>
<td></td>
</tr>
<tr>
<td>Director of Allied Health</td>
<td></td>
</tr>
<tr>
<td>Patient Flow Manager</td>
<td></td>
</tr>
<tr>
<td>Allied Health Team Leader</td>
<td></td>
</tr>
<tr>
<td>Nurse Manager</td>
<td></td>
</tr>
<tr>
<td>Nursing Unit Manager (NUM)</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Educator (CNE)</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Specialist (CNS)</td>
<td></td>
</tr>
</tbody>
</table>

### Created by

<Insert name, role, Facility>

### Acknowledgements

Acute Care Taskforce – Improving the Medical Inpatient Journey  
ACI Manager, Acute Care  
Children’s Hospital at Westmead  
Nepean Hospital  
Bega Valley Health Service; Director of Nursing and Midwifery, Patient Flow Project Manager, and Surgical Ward

### References

<Insert references e.g. >
Appendix A

Criteria Led Discharge – Sequence of Actions for <insert ward/team>

1. A patient must be deemed eligible as early as possible in the admission. For a planned admission this could happen during the pre-admission process.

2. The interdisciplinary team (IDT) reviews patient and identifies eligibility for CLD during rapid/interdisciplinary rounds. The selection of patients must involve a discussion with the treating medical team.

3. Senior Medical Officer (VMO or Fellow) signs off that the patient is eligible for CLD on CLD form and assigns delegation for discharge to identified staff member (senior nurse).

4. The following pre-set criteria have been agreed by the team:
   - <insert pre-set criteria e.g. for respiratory here>
   - Off IV medications
   - Afebrile >24/24
   - Oxygen Saturation > , on room air
   - Independent with Activities of Daily Living (ADL), signed off by IDT. Support organised, if required.
   - Patient accepted by RCCP (strike out if not relevant)*
   - Follow up needs documented
   - Medication(s) / Script(s) completed

*Insert Respiratory Coordinated Care Program (RCCP) acceptance criteria here and process for this to occur

5. IDT agrees on additional criteria for discharge; these may be a mix of medical, nursing, allied health and social criteria/milestones for the patient to meet/achieve. Criteria/milestones are clearly documented on the CLD form in front of the patient record and linked to the inpatient management plan to ensure smooth transfer of care.

6. As part of this process the IDT agree on estimated date of discharge (EDD) on admission and document this in the CLD form. This can always be reviewed daily and updated in the patient administration system (PAS).

7. The medical staff will discuss the criteria led discharge process with the patient/families and patient/family expectations for discharge.

8. The criteria for discharge will be monitored by the CLD competent staff member <insert roles eligible on this ward> caring for the patient and once all criteria are met, the patient is reviewed by a nurse who has completed the relevant competency or a member of the medical staff.

9. The medical staff must ensure a discharge summary is completed and scripts available the day before discharge.

10. All patients on CLD must have had a medical review within 24 hours prior to discharge.
11. A full set of observations must be performed and recorded within one hour of discharge. In addition, any nursing observations that have been regularly recorded during the previous 48 hours should also be performed.

12. If the CLD competent nurse is satisfied the observations are within normal limits for the patient, and the patient has met all of the criteria for discharge, they may be discharged.

13. Patients eligible for CLD should ideally targeted to be discharged by 10am which will therefore require engagement by previous evening and night duty nursing staff.

<table>
<thead>
<tr>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
</tr>
<tr>
<td>&lt;Medical Clinician&gt;</td>
</tr>
</tbody>
</table>

Mandatory compliance is required for all Local Protocol
APPENDIX H: A Competency Statement for Criteria Led Discharge

A Competency Set for Criteria Led Discharge

The health professional safely and effectively discharges a patient applying a criteria led discharge process.

<table>
<thead>
<tr>
<th>Competency</th>
<th>CLD 1</th>
<th>CLD 2</th>
<th>CLD 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locate and read Criteria Led Discharge protocol</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Discuss the benefits of criteria led discharge</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>a. For the patient, their carer and/or family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. For the organisation</td>
<td></td>
<td></td>
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<tr>
<td>Discuss the expectations of the health professional within</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the criteria led discharge process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss the required authorisation from medical staff for criteria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>led discharge to occur and identify where this particular information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss the medical review requirements for a patient who will</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>have a criteria led discharge</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Demonstrate discussion with the patient, their carer and/or family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>explaining the criteria led discharge process</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Highlight some of the issues that may need addressing when discharging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a patient via criteria led discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss the discharge follow up required and how this is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>arranged</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

I, the undersigned, have demonstrated the necessary knowledge, skills, attitudes, values and/or abilities to be deemed competent in criteria led discharge. I acknowledge that ongoing development and maintenance of competency is my responsibility and will be evidenced in my Professional Practice Portfolio

Health professional

Name ___________________________ Signature ___________________________

Role ___________________________ Date ___________________________

I, the undersigned, have observed the necessary knowledge, skills, attitudes, values and/or abilities for <insert name> to be deemed competent in criteria led discharge.

Assessor

Name ___________________________ Signature ___________________________

Role ___________________________ Date ___________________________
APPENDIX I: A Checklist for Implementing Criteria Led Discharge

<table>
<thead>
<tr>
<th>Area</th>
<th>Ref</th>
<th>Task</th>
<th>Owner</th>
<th>Timeframe</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>1.1</td>
<td>Identify executive lead</td>
<td>Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1.2</td>
<td>Identify clinical lead(s): minimum both medical and nursing, consider allied health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td>Medical lead:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td>Nursing/Midwifery lead:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td>Allied Health lead:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1.3</td>
<td>Identify implementation lead</td>
<td>Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1.4</td>
<td>Define, document and agree roles and responsibilities for the clinical leads</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1.5</td>
<td>Define, document and agree roles and responsibilities for the implementation officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1.6</td>
<td>Finalise local implementation team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Terms of Reference</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Regular meeting dates are established</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1.7</td>
<td>Risk assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify and manage local implementation risk and issue resolution process</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Involve managers and clinicians (key role map for specific unit)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Identify any potential barriers and solutions to patient flow</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Governance</td>
<td>1.8</td>
<td>Define and measure implementation and outcome measures (see data set). Collect baseline data.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What local outcomes will be measured?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• At what points of the implementation will you measure outcomes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Design</td>
<td>2.1</td>
<td>Define local protocol (draft available from ACI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Design</td>
<td>2.2</td>
<td>Determine changes to local operating models, procedures and clinical guidelines e.g. adapting existing protocols</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Design</td>
<td>2.3</td>
<td>Configure rosters (if required) to accommodate changes brought about by the revised operating model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Design</td>
<td>2.4</td>
<td>Steering Committee sign-off</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness/Training</td>
<td>3.1</td>
<td>Communication plan/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication strategy to report achievements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>3.3</td>
<td>Collection baseline patient and staff experience data (trackers available from ACI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness/Training</td>
<td>3.2</td>
<td>Create awareness of the Criteria Led Discharge, impact on existing business processes and 'go-live' dates for hospital management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness/Training</td>
<td>3.3</td>
<td>Schedule orientation and training sessions for identified clinicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness/Training</td>
<td>3.4</td>
<td>Ensure patient flow managers are involved in this process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data/Evaluation</td>
<td>4.1</td>
<td>Define roles and responsibilities for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Data and planning team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data/Evaluation</td>
<td>4.2</td>
<td>• Patient and carer experience with patient story gathering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patterns of admissions and discharges by time of day and week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Compliance with clinician defined estimated date of discharge</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Mortality data</td>
<td></td>
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<td>o Utilisation and documentation</td>
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<td>o Comparison with EDD</td>
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APPENDIX J: A set of education/orientation slides for CLD
Overview

- Improving the medical inpatient journey
- Goals of CLD
- CLD form – PART A, B and C
- FAQ and Patient Information
- Protocol
- Competency set
- Implementation team
- Acknowledgments
Improving the Medical Inpatient Journey

WHOLE OF HOSPITAL: ACCESS TO CARE

Patient in the community ➔ Patient enters the service ➔ ED to Inpatient ➔ Inpatient to Inpatient ➔ Patient exits service ➔ Patient in the community

PATIENT FLOW
- Estimated Date of Discharge
- Waiting for What
- Bed management
- Interdisciplinary Ward Round
- Clinical Management Plan
- Criteria Led Discharge
- Transfer of Care

Leads: ACI, MOH, LHDs, CEC, HETI

Educational materials on ‘smooth patient flow’ across the patient journey:

Key:
- ACI=NSW Agency for Clinical Innovation
- MOH=NSW Ministry of Health
- LHDs=NSW Local Health Districts
- CEC=NSW Clinical Excellence Commission
- HETI=NSW Health Education and Training Institute
- MAU=Medical Assessment Unit
- HITH=Hospital in the Home
- LHDs=NSW Local Health Districts and Speciality Networks

LOCAL LHD LOGO
Goals of CLD

- Improve
  - Patient experience
  - Staff experience
  - Patient safety
  - Discharge processes

- Reduce
  - Length of stay / waste
  - Surgery cancellations
CLD Form – PART A

PART A: MEDICAL REVIEW (to be completed by Consultant or Medical Fellow)

Diagnosis: ____________________________

Estimated Date of Discharge (EDD) on admission

☐ I agree for this patient to be discharged once the milestones in part B and C are met.

☐ Please do not discharge until medical team review for the following reason(s): ____________________________

Name: __________________ Signature: ________________ Time/date: ________________

Senior medical clinician signs of patient as eligible
CLD Form – PART B

Interdisciplinary team document criteria for patient to meet – led by Senior Medical Clinician

Local protocol identifies which staff are eligible. This is clearly documented on the ward. Individual staff may wear badge to denote they are CLD competent.

PART B: Specific patient interdisciplinary team (IDT) discharge criteria (to be completed by IDT)

<table>
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<tr>
<th>IDT agreed specific milestones</th>
<th>Name</th>
<th>Designation</th>
<th>Contact</th>
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Responsible person: CLD competent staff member

LOCAL LHD LOGO
# Information Sheets

**FOR HEALTH CARE TEAMS**

- 1 page
- Frequently Asked Questions
  - What is CLD
  - What is the process?
  - Best practice
  - Potential benefits
  - Where can I find more information?

**FOR PATIENTS**

- Information leaflet
  - What is CLD?
  - Why was CLD developed? (benefits)
  - What will happen?
  - How will you know you are ready?
  - Will you still see the doctor?
Protocol

- Locally adapted protocol
- Aim
- Scope
- Responsibilities
## Competency set

1. Locate and read Criteria Led Discharge protocol
2. Discuss the benefits of criteria led discharge
   a. For the patient, their carer and/or family
   b. For the organisation
3. Discuss the expectations of the health professional within the criteria led discharge process
4. Discuss the required authorisation from medical staff for criteria led discharge to occur and identify where this particular information is documented
5. Discuss the medical review requirements for a patient who will have a criteria led discharge. This should include a discussion of when a patient may not be suitable for CLD or when the estimated date of discharge (EDD) may change.
6. Demonstrate discussion with the patient, their carer and/or family explaining the criteria led discharge process
7. Highlight some of the issues that may need addressing when discharging a patient via criteria led discharge
8. Discuss the discharge follow up required and how this is arranged
Criteria Led Discharge (CLD) : Planning for discharge on admission

Implementation Team

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Add names and contacts for Local implementation team +/- ACI staff
Acknowledgements

- ACI Acute Care Taskforce
- ACI Criteria Led Discharge Working Group
- Bega Hospital (Surgical Ward)
- Calvary Mater Hospital (Haematology Unit)
- Wollongong Hospital (Cardiology Step Down Unit, Neurology Ward)
- Auckland District Health Board
- Queensland Health
- Children’s Hospital Westmead, NSW
- Royal Children’s Hospital Melbourne, VIC
- Department of Health / NHS, UK