The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- **service redesign and evaluation** – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services
- **specialist advice on healthcare innovation** – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- **initiatives including guidelines and models of care** – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- **implementation support** – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
- **knowledge sharing** – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- **continuous capability building** – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

Acknowledgements

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
- Prince of Wales Hospital South East Sydney Local Health District
- Dubbo Hospital (Western NSW Local Health District)
- Concord Hospital (Sydney Local Health District)
- Northern Sydney Local Health District
- 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 and 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).

The 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
**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>A formal process, and follows a decision made by a medical officer, that a patient needs to be admitted for appropriate management or treatment of their condition, or for appropriate care or assessment of needs. Separation is the term used to refer to the episode of admitted patient care.</td>
</tr>
<tr>
<td>Bed block</td>
<td>A situation in which a patient stays in hospital because there is no other suitable place for them to go. This also means that other patients cannot enter the hospital when they need to because no beds are available for them.</td>
</tr>
<tr>
<td>CLD-trained</td>
<td>A junior medical officer or registered staff member who has attended training on the principles of CLD and is able to discharge a patient once they have met their CLD criteria.</td>
</tr>
<tr>
<td>Discharge</td>
<td>See transfer of care.</td>
</tr>
<tr>
<td>Interdisciplinary</td>
<td>This document uses the terms interdisciplinary and multidisciplinary to mean the same thing. This resource recognises that a multidisciplinary team has a tendency to utilise the skills and experience of individuals from different disciplines, with each discipline approaching the patient from their own perspective. An interdisciplinary team approach attempts to integrate separate discipline approaches into a single method.</td>
</tr>
<tr>
<td>Multidisciplinary</td>
<td>See interdisciplinary.</td>
</tr>
<tr>
<td>Separation</td>
<td>Separation is the term used to refer to the episode of admitted patient care. A separation, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</td>
</tr>
<tr>
<td>Transfer of care</td>
<td>This term is used interchangeably with discharge. It involves 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.</td>
</tr>
<tr>
<td>Criteria</td>
<td>The collection of individual milestones.</td>
</tr>
<tr>
<td>Milestones</td>
<td>The measures an individual needs to meet to be eligible for discharge. Milestones may be a mix of physical (medical requirements), psychological or social measures.</td>
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**Acronyms**

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<td>ACI</td>
<td>NSW Agency for Clinical Innovation</td>
</tr>
<tr>
<td>CEC</td>
<td>Clinical Excellence Commission</td>
</tr>
<tr>
<td>CLD</td>
<td>Criteria Led Discharge</td>
</tr>
<tr>
<td>EDD</td>
<td>Estimated Date of Discharge</td>
</tr>
<tr>
<td>HETI</td>
<td>Health Education Training Institute</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
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<tr>
<td>LOS</td>
<td>Length of stay</td>
</tr>
<tr>
<td>PET</td>
<td>Patient experience tracker</td>
</tr>
<tr>
<td>PFP</td>
<td>Patient flow portal</td>
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<td>Speciality Health Network</td>
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Section 1

Introduction

Criteria Led Discharge

Care coordination is the process where patient care needs are identified and managed. The patient/carers must be involved in care planning from admission through to transfer of care. Criteria Led Discharge (CLD) is one approach to improve communication within the team regarding discharge planning. It is a tool to ensure the entire team, including the patient, is aware of what needs to happen before a patient can leave the hospital. As one of the important aspects in the coordination of the inpatient journey, CLD streamlines the transfer of care from the beginning of their inpatient journey. The approach involves the multidisciplinary team and ensures the discharge process is not solely reliant on the final review by the admitting medical officer.

The 2014 NSW adult admitted patient survey results provide an insight into the current patient experience of hospital transfers of care (discharge), results show that 95% of those completing the survey reported that they would like to be involved in discharge decisions. CLD incorporates the patient and carer/family in planning for discharge and in identifying milestones.

CLD aims to deliver increased capability in the healthcare system by providing benefits for patients and staff and contributing to the healthcare triple aim:

- better health outcomes
- improved experience of care
- reduced per capita cost of care.

CLD has the ability to improve:

- the coordination of patient care
- communication across the team, including patients and carers
- patient flow within a ward and across the hospital
- patient experience and outcomes
- staff experience
- reduce unnecessary length of stay and bed days
- time efficiency.

---

1 Based on the Institute for Healthcare Improvement (IHI) Triple Aim Framework. This Framework was developed by the IHI in Cambridge, Massachusetts (www.ihi.org).

2
Under CLD (on a patient’s admission) a number of clinical criteria for their discharge are set by the senior medical clinician/s in collaboration with the multidisciplinary team. The setting of criteria occurs as part of team’s initial review of the patient and occurs simultaneously with the setting of the patient’s estimated date of discharge (EDD). Although the setting of criteria occurs on admission, the process is flexible to allow for criteria to be amended during the patient journey, as appropriate to their condition.

While the patient remains under the clinical management of the medical staff, the process of discharge itself can be undertaken by a CLD-trained junior medical officer and nursing or allied health staff. CLD-trained staff have the necessary skills and knowledge to review patients and facilitate their discharge once the patient has met their individualised predetermined clinical criteria, as well as to escalate issues or concerns if the criteria are not met.

During their regular review of the patient, the multidisciplinary team is able to plan care and monitor the patient’s progress against their clinical criteria which may also include some social or community needs for discharge. If a patient does not meet any of the criteria by their EDD they are unable to be discharged using CLD and will require a senior medical review.

All patients are potentially suitable for CLD, as there is flexibility to set criteria appropriate to the complexity and individual needs of every patient.
This toolkit describes the resources available to assist sites to:

- assess their readiness for CLD implementation (Appendix 1)
- create a governance structure
- plan implementation (Appendix 3)
- create CLD resources
- train staff (Appendix 6 and Appendix 8)
- educate patients (Appendix 9a-e)
- collect indicators (Appendix 11)
- assess outcomes.
Assess readiness for implementation

Change does not occur in isolation and it is important to assess the readiness of the environment to be able to manage and adapt to change. There are many competing priorities within healthcare and clinical areas are often overwhelmed with many “new and improved” ways of doing things at the same time or within close succession. Wards often experience change fatigue, trying innovations whilst continuing to maintain patient care.

Several approaches to assessing readiness for change are available. ACI has developed a fit for purpose sustainability and change readiness survey for CLD (Appendix 1) to assist managers and clinicians embarking on a change project for discharge using CLD. It is vital that sites seek opportunities to prepare teams within the organisation for change using the information collected in the readiness assessment. As well as identifying if a site is ready to implement CLD, the readiness assessment will assist teams to identify key areas to target to make implementation more likely to be successful and sustainable.

Create a governance structure

The processes for decision making and escalation along with financial and professional support are important for any change to succeed. Sponsorship at all levels is essential. The executive team, project sponsors, managers, and clinical leads all have a governance role across the project. Hospital and ward/department managers, clinicians and staff all play a role in reinforcing and communicating the key messages.

It is important to create a stakeholder map and to outline the roles and responsibilities of all individuals. A local protocol should identify these roles, and responsibilities for the implementation of CLD; a template protocol is available at Appendix 2a and 2b for local adaption.
Implementation

Steps to consider when implementing CLD

1. Define the aim, objectives and scope of implementation.
2. Build a local case for change to support the need to change existing discharge processes.
3. Develop executive sponsorship and governance systems for implementation.
4. Establish a project team including roles and responsibilities to drive implementation.
5. Determine stakeholders and assess their readiness to be involved.
6. Begin to gather baseline data (see indicators and evaluation).
7. Develop a comprehensive project plan including approach to communication to guide implementation.
8. Develop site specific resources.
9. Prepare staff through education and training.

An example of a CLD implementation checklist can be found at Appendix 3.

CLD documentation

The flexibility of CLD ensures that this approach to discharge planning is suitable for all patients regardless of their complexity, or the severity of their condition. Depending upon the clinical situation it may be appropriate to:

- use pre-set criteria for discharge (e.g. for elective surgery, maternity or standard admissions such as community-acquired pneumonia Appendix 4a)
- use pre-set criteria for discharge with the addition of individualised criteria based on clinical need (e.g. for transient ischaemic attack – TIA Appendix 4b)
- set individualised criteria for discharge based on clinical complexity and need (e.g. for patients with multiple complex health needs)

Further examples of CLD documentation can be found at Appendix 4c and 4b.

In order to assist with care-coordination, the transfer of care checklist should be completed to meet the needs of patients before leaving the hospital.

The transfer of care checklist must cover the following information:

- estimated date of transfer
- destination of transfer
- notification/transport booked
- personal items returned
- referral services booked
- care plan
- transfer of care summary provided to patient that includes medication information, community and GP referral information and follow up appointments.

This should be provided in plain language and explained to the patient. This form should be adapted for local requirements (Appendix 5).
Section 5

Education and training

There are two important aspects of education and training for CLD: one is focused on staff and the other on patients, families and carers.

**Staff training**

Staff need to be involved in the implementation of CLD from the beginning, to assist with planning as well as for ongoing education and training. When strategies to enable and reinforce changes in clinical practice are used together with education sessions for staff, outcomes for patients are more positive. Staff education and training is most effective when formal teaching is interactive and combined with practice-based examples and reinforcing strategies such as modelling and case-based discussions.

It is recommended that all sites have a training approach in place. To ensure staff are CLD-trained, ACI has developed a number of resources to support the education and training of staff.

An adaptable presentation for staff outlining the principles and processes for CLD can be found at Appendix 6.

A one page summary for staff outlining frequently asked questions about the CLD process can be found at Appendix 7a and 7b. These can be adapted to fit your local needs.

An example of a worksheet to be used post training to consolidate staff learning is available at Appendix 8.

**Patient and carer/family education**

Including patients, carers and family members in the CLD process is one of the key principles of CLD. Information for patients and families about CLD is an important aspect that needs to be addressed early on in the implementation. Together with discussing CLD with the patient and their family, written information provided in the CLD patient leaflets can assist in outlining the process and answering questions. Draft versions of the CLD patient/consumer leaflets can be found at Appendix 9a and 9b together with some examples from other sites who have had further consumer input and testing into these documents (Appendix 9c,d and e).
Monitoring and evaluation is an important part of any project to ensure that implementation has occurred, is sustained and that the expected outcomes are being achieved. Collecting baseline data is vitally important for evaluations to be able to measure change.

**Patient experience trackers**

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. Patients and staff can respond to each question by the press of a button. It is a fast and effective way to collect measure patient and staff experience. The CLD PETs have five questions to explore the patients’ and staff experiences, these are:

### Table 1: Criteria Led Discharge patient experience questions

<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 2: Criteria Led Discharge staff experience questions

<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>Yes / Unsure / No</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 patient’s discharge</td>
<td></td>
</tr>
</tbody>
</table>

The de-identified data from the devices is collated daily and reports can be 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 near or “real time”. Weekly and project summary reports can also be generated, an example of the reports generated can be found at Appendix 10.
Suggested data measures

Measures to assess the effectiveness of CLD may include:

- estimated date of discharge
- length of stay
- number or percentage of weekend discharges
- time of discharge with a view to increasing pre-10:00 am discharges and pre-midday discharges
- readmission rates
- patient outcomes

At the beginning of the implementation some sites have found it useful to manually collect data (example at Appendix 11).


5. NSW Agency for Clinical Innovation. ACI Aged Health Network Key Principles for Care of Confused Hospitalised Older Persons. 2014.

Appendices

Appendix 1  CLD site readiness survey
Appendix 2a  CLD protocol template
Appendix 2b  Mental health inpatient template
Appendix 3  CLD implementation checklist
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Appendix 9e  Concord Hospital consumer leaflet
Appendix 10  Patient and staff experience tracker information report
Appendix 11  Western NSW – Data collection template
Appendix 1 – CLD site readiness survey

The proposed change: Criteria Led Discharge

The optimal time for patient transfer of care (discharge) from hospital 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.

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). PART A and B on the CLD form.

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

This survey is a tool to recognise and understand key barriers to implementing criteria led discharge (CLD) and also to identify strengths in sustaining improvement around CLD. It asks questions across three domains:
1. Process
2. Staff
3. Organisation
## Your Processes

### 1. Benefits beyond helping patients
- In addition to helping patients, are there other benefits?
- For example, does the change reduce waste or avoid duplication?
- Will it make things run more smoothly?
- Will staff notice a difference in their daily working lives?

Select the answer that comes closest to your situation.

- We can demonstrate that the change has a wide range of benefits beyond helping patients, for example by reducing waste, creating efficiency or making people’s jobs easier.
- We can demonstrate that the change has some benefits beyond helping patients such as reducing waste and making jobs easier, but not a wide range.
- We can demonstrate that the change has one or two benefits beyond helping patients.
- The benefits that we have identified are only directly related to helping patients. We have not identified any other benefits that this initiative could bring.

### 2. Credibility of the benefits
- Are benefits to patients, staff and the organisation visible?
- Do staff believe in the benefits?
- Can all staff clearly describe the a full range of benefits?
- Is there evidence that this type of change has been achieved elsewhere?

Select the answer that comes closest to your situation.

- Benefits of the change are widely communicated, immediately obvious, supported by evidence and believed by stakeholders. Staff are able to fully describe a wide range of intended benefits for this initiative.
- Benefits of the change are not widely communicated or immediately obvious even though they are supported by evidence and believed by stakeholders.
- Benefits of the change are not widely communicated or immediately obvious even though they are supported by evidence. They are not widely believed by stakeholders.
- Benefits of the change are not widely communicated, they are not immediately obvious, nor are they supported by evidence or believed by stakeholders.
3. Adaptability of improved process

- Can the new process overcome internal pressures, or will this disrupt the change?
- Does the change continue to meet ongoing needs effectively?
- Does the change rely on a specific individual or group of people, technology, finance etc, to keep it going?
- Can it keep going when these are removed?

Select the answer that comes closest to your situation.

- The improved process can adapt to link in with and even support other organisational changes. It would not be disrupted if specific individuals or groups left the project. Its focus will continue to meet the improvement needs of our organisation.
- The improved process can be adapted to support wider organisational change but it would be disrupted if specific individuals or groups left the project. Elements of this work will continue to meet our organisation’s improvement needs.
- It would be difficult to adapt the new process to other organisational changes. It would cause disruption if specific individuals or groups left the project.
- The new process could not adapt if there was any other organisational change happening and it would be disrupted if specific individuals or groups left.

4. Effectiveness of the system to monitor progress

- Does the change require special monitoring systems to identify and continually measure improvement?
- Is there a feedback system to reinforce benefits and progress and initiate new or further action?
- Are mechanisms in place to continue to monitor progress beyond the formal life of the project?
- Are the results of the change communicated to patients, staff, the organisation and the wider healthcare community?

Select the answer that comes closest to your situation.

- There is a system in place to provide evidence of impact, including benefits analysis, monitor progress and communicate the results. This is set up to continue beyond the formal life of the project.
- There is a system in place to provide evidence of impact, including benefits analysis, monitor progress and communicate the results. This is not set up to continue beyond the formal life of the project.
- There is a system in place to provide evidence of impact and monitor progress. However none of this information is communicated more widely than the core project team. The measurement system is not set up to continue beyond the formal life of the project.
- There is only a very patchy system to monitor progress and this will end at the same time as the project. There is no system to communicate the results.
This section assesses training and involvement, behaviours, senior leads and clinical leaders to sustain change.

5. Staff involvement and training to sustain the process

- Do staff play a part in innovation, design and implementation of the change?
- Have they used their ideas to inform the change process from the beginning?
- Is there a training and development infrastructure to identify gaps in skills and knowledge and are staff educated and trained to take the change forward?

Select the answer that comes closest to your situation.

- Staff have been involved from the beginning of the change process. They have helped to identify any skill gaps and have been able to access training and development so that they are confident and competent in the new way of working.
- Staff have been involved from the beginning of the change process and have helped to identify skills gaps but they have not had training or development in the new way of working.
- Staff have not been involved from the beginning of the change but they have received training in the new way of working.
- Staff have not been involved from the beginning of the change process and have not had training or development in the new way of working.

6. Staff behaviours toward sustaining the change

- Are staff encouraged and able to express their ideas regularly throughout the change process and is their input taken on board?
- Do staff think that the change is a better way of doing things that they want to preserve for the future?
- Are staff trained and empowered to run small-scale tests (PDSA) based on their ideas, to see if additional improvements should be recommended?

Select the answer that comes closest to your situation.

- Staff are able to share their ideas regularly and some of them have been taken on board during the project. They believe that the change is a better way of doing things and have been empowered to run small scale test cycles (Plan, Do, Study, Act).
- Staff are able to share their ideas regularly and some of them have been taken on board during the project. They believe that the change is a better way of doing things. Staff do not feel empowered to run small scale test cycles (Plan, Do, Study, Act).
- Staff are able to share their ideas regularly but none seem to have been taken on board during the project. They don’t think that the change will be a better way of doing things. They don’t feel empowered to run small scale test cycles (Plan, Do, Study, Act).
- Staff do not feel they have been able to share their ideas. They do not believe that the change is a better way of doing things and they have not been empowered to run small scale test cycles (Plan, Do, Study, Act).
7. Senior leadership engagement and support

- Are the senior leaders trusted, influential, respected and believable?
- Are they involved in the initiative, do they understand it and do they promote it?
- Are they respected by their peers and can they influence others to get on board?
- Are they taking personal responsibility to help break down barriers and are they giving time to help ensure the change is successful?

Select the answer that comes closest to your situation.

- Clinical leaders are highly involved and visible in their support of the change process. They use their influence to communicate the impact of the work and to break down any barriers. Staff regularly share information with and actively seek advice from clinical leaders.
- Clinical leaders are highly involved and visible in their support of the change process. They use their influence to communicate the impact of the work and to break down any barriers. Staff typically don’t share information with, or seek advice from clinical leaders.
- Clinical leaders are somewhat involved but not highly visible in their support of the change process. They use their influence to communicate the impact of the work but cannot be relied upon to break down any barriers if things get difficult. Staff typically don’t share information with, or seek advice from clinical leaders.
- Clinical leaders are not involved or visible in their support of the change process. They have not used their influence to communicate the impact of the work or to break down any barriers. Staff typically don’t share information with, or seek advice from clinical leaders.
This section assesses the organisation's infrastructure and the change's fit with goals and culture.

8. Fit with the organisation's strategic aims and culture
   • Are the goals of the change clear and shared?
   • Are they clearly contributing to the overall organisational strategic aims?
   • Is improvement important to the organisation and its leadership?
   • Has the organisation successfully sustained improvement in the past?

Select the answer that comes closest to your situation.

☐ The goals of the change are clear and have been shared widely. They are consistent with and support the organisation’s strategic aims for improvement. The organisation has demonstrated successful sustainability of improvements before and has a ‘can do’ culture.

☐ The goals of the change are clear and have been shared widely. They are consistent with and support the organisation’s strategic aims for improvement. The organisation has not demonstrated success in sustaining previous improvements and does not have a ‘can do’ culture.

☐ The goals of the change are clear and have been shared widely. They have not been linked with the organisation’s strategy so we don’t know if they support any organisational aims for improvement. The organisation has not demonstrated success in sustaining previous improvements and does not have a ‘can do’ culture.

☐ The goals of the change are not really clear and they have not been shared widely. They have not been linked with the organisation’s strategy so we don’t know if they support any organisational aims for improvement. The organisation has not demonstrated success in sustaining previous improvements and does not have a ‘can do’ culture.

9. Infrastructure
   • Are the staff fully trained and competent in the new way of working?
   • Are there enough facilities and equipment to support the new process?
   • Are new requirements built into job descriptions?
   • Are there policies and procedures supporting the new way of working?
   • Is there a communication system in place?

Select the answer that comes closest to your situation.

☐ Staff are confident and trained in the new way of working. Job descriptions, policies and procedures reflect the new process and communication systems are in place. Facilities and equipment are all appropriate to sustain the new process.

☐ Staff are confident and trained in the new way of working. However, job descriptions, policies and procedures do not reflect the new process. Some communication systems are in place. Facilities and equipment are all appropriate to sustain the new process.

☐ Staff are confident and trained in the new way of working. However, job descriptions, policies and procedures do not reflect the new process and there are no communication systems to adequately support the new process. Facilities and equipment are not appropriate to sustain the new process.

☐ Staff have not been trained in the new process and are not confident in the new way of working. Job descriptions, policies and procedures do not reflect the new process and there are no communication systems to adequately support the new process. Facilities and equipment are not appropriate to sustain the new process.

This survey has been adapted from the NHS Sustainability Model and Guide. The guide was developed by the NHS Institute for Innovation and Improvement and it can be found online at: http://www.qualitasconsortium.com/index.cfm/programs-services/sustainability/sustainability-model-and-guide/.
Appendix 2a – CLD protocol template

| Criteria Led Discharge Protocol – DRAFT v1 | Mandatory compliance is required for all Local Protocol | Page 17 |

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 consumers 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 CLD Form
  - The CLD form may be used in conjunction with clinical pathways
  - 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
  2. Ensure all nursing and allied health staff are aware and understand the CLD project and their expectations
  3. 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
  4. 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
- EEED: 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

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

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Position responsible for adherence and 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

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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:
   - 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.

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Appendix 2b – Mental health inpatient template

Criteria Led Discharge – mental health protocol

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**Aim**

A multidisciplinary team (MDT) decision making approach is utilised in deciding when a patient is ready for discharge.

Discharge delays are avoided by a <insert role e.g. Nurse, Allied Health professional or Junior Medical Officer> who has been assessed as competent, monitoring criteria set by the multidisciplinary team and approved by the patient’s Consultant Psychiatrist (Visiting Medical Officer Staff Specialist).

**Indications**

The optimal time for discharge is when the consumer is medically ready to go home their mental and physiological health and psychosocial needs can safely be provided for in the community setting and the consumer and carers have been involved in discharge planning and are in agreement with the discharge plan.

**Criteria**

The criteria for discharge will be determined by each implementing team and approved by the consumer’s Consultant Psychiatrist (Visiting Medical Officer /Staff Specialist Fellow). These will be individualised for each patient.

**Contraindications**

Those consumers not meeting above criteria or deemed not appropriate by the Authorised Medical Officer.

**Audience**

- Visiting Medical Officers (VMO)/Staff Specialists
- Authorised Medical Officers (AMO) under the Mental Health Act 2007
- Psychiatry Registrars
- Nurse Managers
- Nursing Unit Manager (NUM)
- Nurse Practitioners/Clinical Nurse Consultants (NP/CNC)
- Clinical Nurse Educators (CNE)
- Clinical Nurse Specialists (CNS)
- Registered Nurses (RN)
- Allied Health staff <insert roles>.
Requirements

Equipment, materials and documentation

- Form: Criteria Led Discharge (draft at Appendix A)
  - Parts A, B C and D must be completed on the CLD form
  - The CLD form may be used in conjunction with clinical pathways
  - 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.

- Estimated date of discharge (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> (draft at Appendix B)

- A completed discharge summary available prior to the patient leaving the unit and sent to the clinician/service receiving care. A copy of the discharge summary should also be provided to the consumer.

Staff education

- CLD process

- Staff competency assessment must be completed prior to conducting CLD (Appendix C).

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

Consumer education

- Discussion with consumer and carer about CLD

- To participate in decision making regarding discharge criteria during clinical review

- For planned admissions to be informed of possibility of CLD

- Information to be provided in written and verbal form (Appendix D)

Procedure

A draft procedure is included at Appendix E. Each implementing team should have a process for signing off discharge criteria.

Responsibilities

- **Director of Clinical Services**
  
  Executive and authorising sponsor

- **Lead Medical Consultants**

  Ensure all medical staff are aware and understand the CLD project and their expectations

- **Nurse Manager / Allied Health Team Lead**

  Ensure all nursing and allied health staff are aware and understand the CLD project and their expectations

  Ensure staff roles (e.g. Nurse Unit Manager (NUM), Clinical Nurse Consultant (CNC) Clinical Nurse Specialist (CNS), complete the competency assessment in CLD

  Ensure CLD procedure is adhered to.

- **NUM /NP/CNC/CNS/RN**

  Undertake clinical competency in CLD

  Engage all disciplines in CLD during interdisciplinary rounds and/or clinical reviews

- **All clinical staff**

  Have a basic understanding of CLD and willingly engage and participate in trial.
Outcome measures
Pre (baseline) and post implementation consumer, carer and staff experience collected using Patient Experience Trackers (PETs). Questions have been determined and these are available from the NSW Agency for Clinical Innovation.

Suggested minimum dataset:
- Consumers discharged via CLD (numerator) vs Consumers discharged without CLD (denominator)
- Discharges by day of week
- Length of stay for consumers discharged using CLD
- Consumer experience
- Staff experience
- Readmission within 28 days of consumers discharged using CLD
- % discharge summaries completed received by ongoing service provider (with timeframe?) (e.g. Community Mental Health, General Practitioners)

CLD form audit
- % of completed forms
- Number of patients discharged on CLD
- Number patients not discharged on CLD
- Number completed transfer of care checklists
- Comparison of actual discharge time with EDD
- Consumer/carer discharged with documentation

Appendices
A. CLD Form
B. Transfer of care (discharge) checklist
C. Staff competency
D. Consumer education material
E. Protocol

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

Safety considerations
- Clinical competency consumer education
- Clinical risk assessment (to include risk of harm to self/others, risk of absent without leave (AWOL), risk of misadventure, exploitation, vulnerability and ability to self care).
- When assessing for suicide risk a comprehensive mental health assessment should be conducted. Risk management checklists or tools should not be used in isolation to determine treatment decisions (including readiness for discharge)
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Terminology

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Created by

<Insert name, role, Facility>

Acknowledgements

Acute Care Taskforce – Improving the Medical Inpatient Journey
ACI Manager, Acute Care Taskforce
Whole of Health Program- Mental Health Project
Mental Health and Drug and Alcohol Office, NSW Ministry of Health
Nursing & Midwifery Office, NSW Ministry of Health
Children’s Hospital at Westmead
Nepean Hospital
Bega Valley Health Service: Director of Nursing and Midwifery, Patient Flow Project Manager, and Surgical Ward

References

Mental Health Act 2007 No 8
NSW Health PD2012_060 Transfer of Care from Mental Health Inpatient Services
The guideline for the Physical Health Care of Mental Health Consumers (GL2009/007)
<Insert references e.g.>
APPENDIX E

Criteria Led Discharge – procedure

1. A patient must be deemed eligible as early as possible in the admission and the CLD process commenced. CLD should not to commence on the day of discharge.

2. The multidisciplinary team (MDT) reviews patient and identifies eligibility for CLD during multidisciplinary team meeting. The selection of patients must involve a discussion with the treating medical team.

3. The patient’s Consultant Psychiatrist (Visiting medical officer / staff specialist) signs off on the CLD form that the patient is eligible for CLD and assigns delegation for discharge to identified staff member <insert roles>. Review by the consultant psychiatrist is required 24-48 hours prior to discharge, as per the Transfer of Care Policy (PD2012_060). This can be undertaken either face to face or via telepsychiatry.

4. The following pre-set criteria have been agreed by the team:
   - <insert pre-set criteria if applicable>; (example provided below)
   - Independent with activities of daily living (ADL), signed off by the MDT. Support organised, if required.
   - If caring for children or others that these needs have been addressed.
   - Has safe, accessible accommodation
   - No significant deterioration in mental state since last MDT review or when reviewed for CLD by Consultant Psychiatrist
   - No increase in clinical risk assessment since last MDT review
   - Follow up needs documented, including contact by Mental Health Service within seven days of discharge
   - Medication(s) / script(s) completed
   - Completed discharge summary available at the time of discharge

These may be included in your local transfer of care checklist.

5. MDT may agree on additional criteria for discharge; these may be a mix of medical, nursing, allied health and social criteria for the patient to meet/achieve. Criteria are clearly documented on the CLD form in the 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 MDT agree on estimated date of discharge (EDD) on admission and document this on the CLD form. This can always be reviewed daily and updated in the patient administration system (PAS).

7. The medical staff will discuss the CLD process with the consumer/carer and collaborate with the consumer/carer to agree to consumer specific criteria and expectations for discharge. The consumer will be offered the opportunity to sign the CLD form.

8. If a consumer initially refuses to sign or be involved in CLD continued engagement to discuss the process and criteria for discharge must continue to ensure a collaborative discharge process.

9. 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 reached the consumer is reviewed by a CLD competent team member.

10. The medical staff must ensure a discharge summary is completed and sent to the service receiving care provider/s prior to discharge, otherwise discharge must not proceed.

11. All consumers on CLD must have had a clinical risk assessment completed and documented prior to discharge from the ward. This risk assessment must be completed by a Medical Officer or CLD competent clinician. Any increase in risk should instigate further review prior to discharge/leave.
12. Where physical observations are clinically indicated, these must be completed on the day of discharge or as directed in the guideline for the Physical Health Care of Mental Health Consumers (GL2009/007).

13. If the CLD competent clinician 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.

14. If at any point criteria for discharge are not met, the reasons/issues should be escalated, staff need to take action as required.

15. Patients eligible for CLD require engagement by Evening and Night Duty Nursing Staff the day before discharge to ensure that discharge occurs in a timely manner.

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# Appendix 3 – CLD implementation checklist

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<td>implementation officer</td>
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<tr>
<td>Governance</td>
<td>1.6</td>
<td>Finalise local implementation team</td>
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<td></td>
<td></td>
<td>• Terms of reference</td>
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<td></td>
<td></td>
<td>• Regular meeting dates are established</td>
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<tr>
<td>Governance</td>
<td>1.7</td>
<td>Risk assessment</td>
<td></td>
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<td></td>
<td></td>
<td>• Identify and manage local implementation risk and issue</td>
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<td></td>
<td>resolution process</td>
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<td></td>
<td></td>
<td>• Involve managers and clinicians (key role map for specific unit)</td>
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<td></td>
<td></td>
<td>• Identify any potential barriers and solutions to patient flow</td>
<td></td>
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<tr>
<td>Governance</td>
<td>1.8</td>
<td>Define and measure implementation and outcome measures (see data set)</td>
<td></td>
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<td></td>
<td></td>
<td>Collect baseline data</td>
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<td></td>
<td></td>
<td>• What local outcomes will be measured?</td>
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<td></td>
<td></td>
<td>• At what points of the implementation will you measure outcomes?</td>
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<td></td>
<td></td>
<td>• How will you track and report the outcomes?</td>
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<tr>
<td>Operating design</td>
<td>2.1</td>
<td>Define local protocol (draft available from ACI)</td>
<td></td>
<td></td>
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<tr>
<td>Operating design</td>
<td>2.2</td>
<td>Determine changes to local operating models, procedures and clinical</td>
<td></td>
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<td></td>
<td></td>
<td>guidelines e.g. adapting existing protocols</td>
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<tr>
<td>Operating design</td>
<td>2.3</td>
<td>Configure rosters (if required) to accommodate changes brought about</td>
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<td>by the revised operating model</td>
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<tr>
<td>Operating design</td>
<td>2.4</td>
<td>Steering Committee sign-off</td>
<td></td>
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<tr>
<td>Awareness/training</td>
<td>3.1</td>
<td>Communication plan/</td>
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<td></td>
<td></td>
<td>Communication strategy to report achievements</td>
<td></td>
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<tr>
<td>Data collection</td>
<td>3.2</td>
<td>Collection baseline patient and staff experience data (trackers</td>
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<td></td>
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<td>available from ACI)</td>
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<tr>
<td>Awareness/training</td>
<td>3.3</td>
<td>Create awareness of Criteria Led Discharge, impact on existing</td>
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<td></td>
<td></td>
<td>business processes and ‘go-live’ dates for hospital management</td>
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<tr>
<td>Awareness/training</td>
<td>3.3</td>
<td>Schedule orientation and training sessions for identified clinicians</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td>Awareness/training</td>
<td>3.4</td>
<td>Ensure patient flow managers are involved in this process</td>
<td></td>
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<tr>
<td>Data/evaluation</td>
<td>4.1</td>
<td>Define roles and responsibilities for</td>
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<td>• IT</td>
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<td>• Data and planning team</td>
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<tr>
<td>Data/evaluation</td>
<td>4.2</td>
<td>• Patient and carer experience with patient story gathering</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patterns of admissions and discharges by time of day and week</td>
<td></td>
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<td></td>
<td></td>
<td>• Compliance with clinician defined estimated date of discharge</td>
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<td>• Mortality data</td>
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<td>• Ward data (length of stay, traffic)</td>
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<td>• Readmission rate</td>
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<td>• Audit of CLD form (available from ACI):</td>
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<td></td>
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<td>○ Utilisation and documentation</td>
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<td>○ % of completed forms</td>
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<td>○ % of patients discharged</td>
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<td></td>
<td></td>
<td>○ % patients not discharged on CLD</td>
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<tr>
<td></td>
<td></td>
<td>○ % completed transfer of care checklists</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>○ Comparison with EDD</td>
<td></td>
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</tr>
</tbody>
</table>
### Appendix 4a – CLD respiratory pre-set criteria

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

**Diagnosis:**

*Insert diagnosis here*

- I agree for this patient to be discharged once the milestones in part B and C are met.
- Do not discharge without medical team review (add reason):
- Patient informed and consented to Criteria Led Discharge

**Name:**

**Signature:**

**Time/date:**

#### PART B: PATIENT DISCHARGE CRITERIA (to be completed by interdisciplinary team)

1. Off IV medications
2. Temp between ______ and ______
3. Oxygen saturation on room air ______
   - Oxygen saturation _____ LPM ______
4. Independent with ADLs, signed off by IDT.
   - Support organised, if required.
5. Referrals made (Y, in progress - IP, not needed - NA) and completed (C)
   - Physio: NA, Y, IP, C
   - OT: NA, Y, IP, C
   - SW: NA, Y, IP, C
   - RCCP: NA, Y, IP, C
   - Other: NA, Y, IP, C
6. Follow up needs documented
7. Medication(s) / Script(s) completed

**Responsible person:**

**CLD competent staff member**

#### PART C: REVOKE MEDICAL APPROVAL

**Name:**

**Signature:**

**Date:**

I revoke medical approval for CLD (add reason)

#### PART D: PATIENT CRITERIA

**Y/N**

**Name**

**Date/Time**

All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient

- If no, refer to senior medical clinician

Transfer of care: nursing discharge checklist completed

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

**Name**

**Designation:**

**Signature:**

**Date/time:**
### Appendix 4b – CLD TIA pre-set criteria

**CONCORD REPATRIATION GENERAL HOSPITAL**

**CRITERIA LED DISCHARGE**

**TRANSIENT ISCHAEMIC ATTACK**

<table>
<thead>
<tr>
<th>Part A: Medical Review (Consultant/ Advance Trainee/ Senior Registrar to complete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I agree for this patient to be discharged once the milestones in Part B and C have been met</td>
</tr>
<tr>
<td>☐ Please do not discharge until medical team review for the following reason/s:</td>
</tr>
<tr>
<td>Name: __________________________ Signature: __________________________ Date: / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part B: Specific patient interdisciplinary team (IDT) discharge criteria (to be completed by IDT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke Workup completed</td>
</tr>
<tr>
<td>Symptoms Resolved</td>
</tr>
<tr>
<td>Imaging of neck vessels show no evidence of significant stenosis (i.e. CTA/MRA or Carotid Doppler NAD)</td>
</tr>
<tr>
<td>No New AF</td>
</tr>
<tr>
<td>Discharge summary, discharge medications and follow up appointments completed</td>
</tr>
</tbody>
</table>

**Responsible Person:** CLD competent staff member

<table>
<thead>
<tr>
<th>Part C: Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient</td>
</tr>
<tr>
<td>If no, refer to senior medical clinician</td>
</tr>
<tr>
<td>Transfer of care (discharge) checklist completed on Adult Admission &amp; Discharge Assessment Form (AMR606.001)</td>
</tr>
<tr>
<td>Reason patient not discharged using CLD protocol:</td>
</tr>
<tr>
<td>I confirm that the criteria in Part B and C have been met and achieved:</td>
</tr>
<tr>
<td>Name: __________________________ Designation: __________________________</td>
</tr>
<tr>
<td>Signature: __________________________ Date: / / Time: __________</td>
</tr>
</tbody>
</table>

**Holes Punched as per AS2828.1: 2012**

**CONCORD REPATRIATION GENERAL HOSPITAL**

**CRITERIA LED DISCHARGE**

**TRANSIENT ISCHAEMIC ATTACK**

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
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</thead>
<tbody>
<tr>
<td>GIVEN NAME</td>
<td>☐ MALE ☐ FEMALE</td>
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<tr>
<td>D.O.B. _____ / _____ / _____ M.O.</td>
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<tr>
<td>ADDRESS</td>
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<tr>
<td>LOCATION / WARD</td>
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</tbody>
</table>

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

**CRITERIA LED DISCHARGE**

**TRANSIENT ISCHAEMIC ATTACK**

**FAMILY NAME**

<table>
<thead>
<tr>
<th>MRN</th>
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<tbody>
<tr>
<td>MR012012</td>
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</table>

**GIVEN NAME**

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<tr>
<th>MRN</th>
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</thead>
<tbody>
<tr>
<td>MR012012</td>
</tr>
</tbody>
</table>

**D.O.B.**: _______ / _______ / _______ **M.O.**

**ADDRESS**

**LOCATION / WARD**

**MR012.012**

**NO WRITING**
Appendix 4c – CLD form generic

CRITERIA LED DISCHARGE

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

Diagnosis: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ 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Appendix 4d – POW CLD form generic

CRITERIA LED DISCHARGE

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

Diagnosis: __ __ __ __ __ __ __ __ __ __

☐ I agree for this patient to be discharged once the milestones in part B and C are met.
☐ Do not discharge without medical team review (add reason): __ __ __ __ __ __

Name: __ __ __ __ Signature __ __ __ __ Time/date: __ __ __ __

PART B: PATIENT DISCHARGE CRITERIA (to be completed by interdisciplinary team)

IDT agreed specific milestones Comments Name Designation
1. Pre-set criteria 1. __ __ __ __ __ __ __ __ __ __
2. Pre-set criteria 2. __ __ __ __ __ __ __ __ __ __
3. Pre-set criteria 3. __ __ __ __ __ __ __ __ __ __
4. Pre-set criteria 4. __ __ __ __ __ __ __ __ __ __
5. Referrals made (Y, in progress - IP, not needed - NA) and completed (C)

Physio __ OT __ S/W __ RCCP __ Other __
NA __ Y __ IP __ C __

Responsible person: __ __ __ __ CLD competent staff member

PART C: REVOKE MEDICAL APPROVAL

I revoke medical approval for CLD (add reason & draw two oblique lines on form):

Name __ __ __ __ Signature __ __ __ __ Date __ __ __ __

PART D: PATIENT CRITERIA

Y/N Name Date/Time

All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient __ __ __ __ __ __ __ __ __ __

If no, refer to senior medical clinician __ __ __ __ __ __ __ __

Transfer of care: nursing discharge checklist completed __ __ __ __ __ __ __ __ __ __

Patient not discharged using CLD protocol (add reason & draw two oblique lines on form): __ __ __ __ __ __ __ __ __ __

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

Name __ __ __ __ Designation: __ __ __ __ __ __ __ __

Signature: __ __ __ __ __ __ Date/time: __ __ __ __ __ __ __ __
### Appendix 5 – Transfer of care checklist

#### Destination
- Home
- RACF
- Other (specify facility/ward)

#### Transport mode
- Self/Relative/Carer
- Ambulance
- Patient Transport

#### Notification
- To (named person)
- Time
- Date

#### Personal items returned
- Yes
- No
- NA
- Date

#### Transfer of care plan
- Medications list/scripts provided
- IV cannula removed
- Medical devices removed
- Medical Discharge Summary Completed
- Resuscitation plan
- Follow Up Appointments
  - GP
  - Specialist
  - Outpatient clinic/community referrals
- Transfer of care plan
  - Patient/Carer
  - Clinician

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

Transfer Checklist Completed by (Name & sign)  
Discharged by (name & sign)
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
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

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

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

**Responsible person:** CLD competent staff member

---

**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.**
CLD Form – PART C

CLD competent staff member monitors milestones have been met in PART B and signs of patient in PART C

Information Sheets

FOR HEALTH CARE TEAMS

• 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

<table>
<thead>
<tr>
<th>Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Locate and read Criteria Led Discharge protocol</td>
</tr>
</tbody>
</table>
| 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 |
Implementation Team

- XX
- XX
- XX
  - Anthea Temple – Manager Acute Care (ACI) 9464 4623, anthea.temple@aci.health.nsw.gov.au

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
One important aspect in the coordination of the inpatient journey is Criteria Led Discharge (CLD). CLD maximises the multidisciplinary team to streamline transfer of care by making the discharge process not solely reliant on a final review by the admitting medical officer.

The purpose of CLD is to formalise and coordinate transfers of care to:

- improve the patient experience and outcomes,
- reduce unnecessary length of stay and bed days, and
- minimise waste and enhance staff experience.

The setting of criteria occurs as part of the team’s initial review of the patient and occurs simultaneously with the setting of the patient’s estimated date of discharge (EDD). Whilst the setting of criteria occurs on admission, the process is flexible to allow for criteria to be amended during the patient journey, as appropriate to their condition.

During their regular review of the patient, the multidisciplinary team are able to plan care and monitor the patient’s progress against their clinical criteria for discharge. If a patient does not meet any of the criteria by their EDD they are unable to discharged using CLD and will require a medical review.

There is flexibility to set criteria appropriate to the complexity and individual needs of each patient.

For more information contact Anthea Temple
Anthea.temple@health.nsw.gov.au

CLD has been implemented in 15 hospitals in NSW in over 18 specialities. ACI are aware of a further ten hospitals who are in the process of, or considering, implementation. CLD has been successfully implemented across a number of conditions including: COPD, pneumonia, TIA, orthopaedic surgery, short stay surgery and MAU, in both adult and paediatric settings.

In August 2015 the NSW Minister for Health discussed a number of strategies employed within NSW Health to improve patient flow, together with the Peak Activity Team (PAT) Initiative the priority is for further implementation of CLD to avoid unnecessary delays in discharging patients, particularly at the weekend.
The optimal time for consumer 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:

- the ongoing mental health and psychosocial care needs can be provided at home, and
- when the consumer and their carer are 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 consumer’s Consultant Psychiatrist.

For appropriate consumers CLD competent staff (e.g. nursing, allied health, Authorised Medical Officer) can then facilitate the discharge of a consumer 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 and risk assessment decision making.
- nursing (or other staff) independently discharging patients. The CLD competent staff is monitoring that the consumer has met the set criteria.

What is the process for CLD?
The Consultant Psychiatrist approves eligible consumers on PART A of the CLD form and signs off the criteria on PART B of the CLD form. Identification of consumers may occur at any point following discussion between the health care team, including the consumer and their carer, led by the Consultant Psychiatrist. Other team members may, in consultation with the Consultant Psychiatrist, the consumer and carer, add criteria to those set and approved by the Consultant Psychiatrist (PART B).

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

What is a CLD competent staff member?
The local team will decide on a process for identifying CLD competent staff. The mental health service/inpatient unit should maintain a list of CLD competent staff; this list should be reviewed at least annually by the Nurse Unit Manager or delegate. The ACI has developed a competency set to guide this process.
What is the best practice for CLD?

- A consumer should be identified as eligible for CLD on admission, or as early as possible.
- The consumer must be reviewed every day by their health care 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 consumer and their carer.
- The CLD competent staff member must monitor and record if the consumer has met the criteria. This does not substitute for clinical judgement and if a consumer does not meet the criteria a clinical review is necessary.
- A transfer of care (discharge) checklist should be completed; this should include a section on the consumer education that has been provided.

Where can I find more information on CLD?

A set of resources is available at: www.aci.health.nsw.gov.au, 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 consumer and staff experience data using Patient Experience Trackers.
- CLD should be implemented in conjunction with the Transfer of Care Policy PD2012_060.

What are the potential benefits of CLD?

- **Improve consumer experience:** consumers are more involved in discharge planning and able to leave the hospital sooner
- **Enhance consumer safety:** criteria led transfer of care (discharge) through a checklist
- **Improve staff satisfaction:** not pressured to transfer consumers at 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 consumers can safely be discharged
- **Minimise waste:** best use of time-poor consultants; reduction of costs as a result of minimising unnecessary lengths of stay in hospital.

---

**ACI CONTACT FOR CRITERIA LED DISCHARGE**

Craig Martin  
Manager, ACI Mental Health Network  
Phone: 02 9464 4680  
Email: craig.martin@aci.health.nsw.gov.au

Your local contact for CLD is <insert contact>

Phone:  
Email:
On completion of this worksheet, the individual will be assessed as being competent to complete the Criteria Led Discharge Form within a nominated department.

Name: ____________________________________________
Department/ Ward: __________________________________
Position: __________________________________________

Date worksheet submitted: ____________________________
Name of Assessor: __________________________________
Results of Knowledge Assessment (please circle): Satisfactory/ Not Satisfactory
Signature of Assessor: ________________________________

1. List and describe 4 benefits of Criteria Led Discharge (CLD)?

2. When can a patient be put onto a CLD pathway?

3. Identify which clinicians can complete Part A of the CLD Form.

4. Which clinicians can add criteria to Part B of the CLD form?
5. Can any staff member approve a patient for discharge once all the criteria are met?

6. What additional documentation must be completed on discharge in conjunction with the CLD form?

7. Identify what you would do if all the criteria were met, yet the patient did not want to be discharged.

8. Identify what you would do it all the criteria were met, however you had some concerns with the patient being discharged from the hospital.
INFORMATION

Criteria Led Discharge

ACI Acute Care Taskforce

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

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 health care 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.

The estimated date you will leave the hospital is:

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.

The process

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

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.
Appendix 9b – CLD consumer information (ACI)

CONSUMER INFORMATION

Criteria Led Discharge

ACI Acute Care Taskforce

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

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 consumers a great deal of worry and stress.

Criteria Led Discharge is a process about working together with your care team to make 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 well enough. It has many benefits:

- it clearly outlines how you will be involved in your recovery planning with your healthcare team during your hospital stay
- you spend less time in hospital because decisions about your transfer are made earlier in your stay
- working in collaboration with your healthcare team in goal setting means less time is wasted waiting for the decision to let you go home.

What will happen under Criteria Led Discharge?

You and your healthcare team agree on a set of goals (milestones) for you to meet before you can be discharged. Your milestones might include a combination of clinical goals such as having a reduction in symptoms or improved mood, wellbeing and recovery planning and social (physical) goals for example having somewhere safe to go home. These milestones will be documented in your medical notes to ensure everyone is on the same page. The team will work with you to meet these milestones so that you can go home 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.

The Estimated Date You Will Leave the Hospital Is:

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 goals prior to discharge including your senior doctor. A senior staff member will work with you to confirm that these agreed milestones. You will be discharged once your agreed milestones have been reached.

BEFORE you leave the hospital, please make sure you:
- Understand your wellness care plan for you to manage at home (e.g. medications, follow-up appointments)
- Ask about medical certificates, letters and return of personal property/valuables
- Ask your doctor about any GP, community mental health or specialist follow-up requirements
- Understand any home based support services or community based support that may be available
- Have a clear plan of who to contact if you become unwell or in an emergency e.g. Mental Health Line: 1800 011 511.

The process

<table>
<thead>
<tr>
<th>TALK WITH YOUR DOCTOR</th>
</tr>
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<tbody>
<tr>
<td>Your doctor will discuss Criteria Led Discharge with you to make sure you both agree to the process</td>
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<table>
<thead>
<tr>
<th>DEVELOP CRITERIA</th>
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<tbody>
<tr>
<td>You and your team agree on a set of goals (milestones) to achieve prior to your discharge</td>
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<tr>
<th>PROGRESS MONITORED</th>
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<tr>
<td>A senior staff member monitors that the agreed milestones have been met</td>
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<table>
<thead>
<tr>
<th>DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are able to leave the hospital without having to wait to see your doctor</td>
</tr>
</tbody>
</table>

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
XXXXXXX
ACI Acute Care Taskforce

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 REACH service on 0417 983 199 for a clinical review or the After Hour Nurse Manager on 0429608181, and their office is located in the Emergency Department.

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 in the criteria agreed.

PROGRESS MONITORED

A senior staff member monitors that the agreed milestones have been met and you are safe to leave hospital.

CRITERIA LED DISCHARGE

You are able to leave the hospital without having to wait to see your doctor.

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

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.

What is Criteria Led Discharge?

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
- You spend less time in hospital for the benefit of your health
- Your planning should start early for transport home
- Discuss transport or home care difficulties with your care team
- IPTASG travel claims may be available if you have travelled more than 100km. Freecall 1800 473 227

PLEASE NOTE: on your Doctor’s advice you may be transferred to another health facility for ongoing medical management.

REMEMBER... Hand washing

All patients, visitors and staff need to clean their hands with soap and water or alcohol-based rubs to help reduce the spread of infections in health facilities.

As a patient, you should clean your hands:

- Entering and leaving the ward
- After coughing, sneezing & using tissues
- After using the toilet
- Before eating and drinking

It is important to remind relatives and friends to clean their hands before and after they visit you.

Don’t be afraid to ask visitors and staff if they have cleaned their hands before coming to you.

The estimated date you will leave the hospital is ____________

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.

SOME SUGGESTIONS YOU MAY LIKE TO CONSIDER TO BE PREPARED

- Put an In Case of Emergency number or ICE in your mobile phone. An ICE number in your phone helps emergency services
- Arrange with a friend to have access to your house so that you can leave the hospital as quickly and safely as possible
- Put an In Case of Emergency number or ICE in your mobile phone. An ICE number in your phone helps emergency services
- Keep a bag at the ready in the car boot to cover this and other possible emergencies
- Keep a list of key family/friends phone numbers in your car (or a list of who to call if they are in your phone) to cover you needing them wherever you are
- Keep your pension card/watch/ATM card handy at all times
- Keep your medications and medication conditions/details with the name of your medical practitioner (e.g. GP) in your wallet
- Keep your My Health Record (Red Book) updated

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

AFTER you leave the hospital:

The hospital cannot pay for any of your needs after you are discharged. You become totally responsible for yourself for:

- your travel
- Accommodation, if you cannot go straight home
- clothing and shoes
- food; and
- all of your expenses.

DUNBBO HOSPITAL

Criteria Led Discharge

Patient Leaflet

To improve our service to patients we have established a discharge process that is led by your recovery. This is called ‘Criteria led discharge’ and means that discharge is dependent on a set of clinical criteria (milestones) you must meet before going home.

IMAGES: Courtesy of Clinical Excellence Commission, Hand Hygiene Program
CRITERIA LED DISCHARGE – PATIENT INFORMATION

What is Criteria Led Discharge?
Criteria Led Discharge is a process where the healthcare team work with you to ensure your timely discharge from hospital is safe. Discharge from hospital happens when you are medically ready to go and agreed goals for your healthcare are met.

Your planned date to go home is: ____________________

CRITERIA LED DISCHARGE PROCESS

Talk with your doctor
A doctor will discuss Criteria Led Discharge with you to make sure you both agree to the process

Develop criteria
You and your healthcare team will agree on a set of criteria (recovery goals) in order for you to leave hospital

Progress monitored
A senior staff member monitors that the agreed recovery goals are met

Discharge
You will be able to leave the hospital without having to wait to see your doctor

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

The Criteria Led Discharge Process
• The process clearly outlines what both you and your healthcare team need you to accomplish during your hospital stay.
• You spend less time in hospital because decisions about your discharge are made before admission and early during your stay.
• You spend less time waiting for decisions to be made regarding your discharge as all required recovery goals are outlined.

Criteria Led Discharge recovery goals may include:
• Ability to mobilise safely.
• Your blood pressure and temperature are within the required range.
• Your home environment is ready for your discharge.
When the goals are reached they will be documented in your medical record.

How will you know you have met the recovery goals related to your care?
• A senior healthcare staff member will confirm that you have met all the agreed recovery goals.
• 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 your discharge.

Will my hospital doctor be involved in decisions about my care?
• Yes. Your hospital doctor will continue to see you regularly throughout your hospital stay.

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

What should you do if you want to discuss any aspect of your care in hospital?
Please ask to speak to the nurse in charge or the Nursing Unit Manager of your ward.
If you do not feel that they are addressing your issues please contact the Consumer Relations Co-ordinator Manly Hospital by email:
NBHSC ConsumerRelations@health.nsw.gov.au or by phone on 9998 0295.
Criteria Led Discharge
Patient Information

Concord Repatriation General Hospital
June 2015

What is ‘Criteria Led Discharge’?

Criteria Led Discharge is a process used by the hospital staff to outline what goals/milestones need to be achieved before you can be discharged.

The objective of Criteria Led Discharge is to ensure your discharge from hospital is not delayed, and that you can be safely discharged from the hospital setting.

Criteria Led Discharge 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 care 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?

• Your healthcare team will agree on a set of milestones with you to meet during your admission to hospital
• Milestones can include clinical criteria (e.g. normal temperature, controlled pain, etc.) and social criteria (e.g. being able to live safely where you normally live).
• All milestones are documented in your medical record.
• Your healthcare team will work with you to meet these milestones.
• Once these milestones are met and there are no outstanding requirements a senior staff member can discharge you.
• If there are any concerns, the staff will contact the doctor to review you before you leave.
Does this mean I 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 any private X-Rays
- Ask your doctor about any GP or specialist follow-up requirements
- Understand any home based-support services or community based support that may be available
- Discharge time is 10am
- Please ensure your arrangements for transport are organized before you come into hospital
- If you are unable to be collected from the ward by 10am, it will be necessary to transfer you to the discharge lounge to wait for your transport to arrive.

**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 9767 7488 and their office is located in the Executive Unit, Ground Floor, Building 5.
Appendix 10 – Patient and staff experience tracker information report

Example of PET report

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: I know the date I am expected to be discharged from hospital</td>
<td>33.3</td>
<td>Yes, 7, 29%</td>
<td>No, 15, 62%</td>
<td>Unsure, 2, 8%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q2: I am aware of what needs to happen before I am discharged from hospital</td>
<td>47.9</td>
<td>Yes, 8, 33%</td>
<td>No, 9, 38%</td>
<td>Unsure, 7, 29%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q3: I know who to ask if I have questions about my care in hospital</td>
<td>70.8</td>
<td>Always, 7, 29%</td>
<td>Rarely, 2, 8%</td>
<td>Mostly, 8, 33%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4: I receive daily updates from the team about my care in hospital</td>
<td>81.2</td>
<td>Always, 12, 50%</td>
<td>Sometimes, 4, 17%</td>
<td>Mostly, 7, 29%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q5: I am involved in the development of my discharge plan</td>
<td>39.6</td>
<td>Yes, 5, 21%</td>
<td>No, 10, 42%</td>
<td>Unsure, 9, 38%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Overall Feedback Score: 54.6
Day on Day Change: N/A
Number of Surveys: 24
Day on Day Change: N/A
## Appendix 11 – Western NSW – Data collection template

### Criteria Led Discharge

**Month:** ____________________  

**Facility:** ____________________

<table>
<thead>
<tr>
<th>Date</th>
<th>MRN</th>
<th>Condition (Eg TURP, ankle, hernia)</th>
<th>Discharged using CLD (Yes or No)</th>
<th>Reason for NOT discharged using CLD (medical reason)</th>
<th>Comments (Further information if relevant)</th>
<th>Unplanned Re-admission (Date, reason)</th>
<th>Name, Signature and Date</th>
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ACI Acute Care Taskforce – Criteria Led Discharge Toolkit – A resource to support the implementation of CLD
<table>
<thead>
<tr>
<th>Date</th>
<th>MRN</th>
<th>Condition Eg TURP, ankle, hernia</th>
<th>Discharged using CLD (Yes or No)</th>
<th>Reason for NOT discharged using CLD (medical reason)</th>
<th>Comments Further information if relevant</th>
<th>Unplanned Re-admission (Date, reason)</th>
<th>Name, Signature And Date</th>
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