SESLHD GUIDELINE COVER SHEET

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SUMMARY	To provide guidance to South Eastern Sydney Local Health District (SESLHD) staff in relation to the escalation process for effective patient discharges/transfers of care from acute facilities.

Feedback about this document can be sent to SESLHD-ExecutiveServices@health.nsw.gov.au

SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

Management of Complex Discharges / Escalation Guidelines

Section 1 - Background

Care coordination describes the process where patient care needs are identified and managed from the point of admission in order to enhance patient outcomes, safety and experience, and to improve patient flow within the hospital.

The essential stages of care coordination are outlined in NSW Health Policy Directive PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.

Care coordination should commence at the time of the patient's admission (or at pre-admission, in the case of a planned admission) to inform the management of the patient, and to facilitate the effective transfer of care of the patient to another facility, health service or into the community.

Effective care coordination should involve members of the multidisciplinary care team, the patient, and their family/carer/s/ representative and is based on clear and effective communication between the patient, family / carers / representative and the care team.

1.1 Introduction

This guideline has been developed to support Hospital personnel who are arranging a patient's discharge or transfer of care where the patient / carers / representative are not supporting or in agreement with the proposed plans and an escalation process needs to be enacted.

The term **'Discharge'** in this guideline includes plans for discharge home or transfer of care to another facility, including other hospitals within Sydney Eastern Sydney Local Health District (SESLHD).

The term **'Representative'** in this guideline refers to the person responsible for making decisions about the patient's care. Ideally one person should be identified as the key contact person, however it is acknowledged that this is not always possible.

1.2 The aims/expected outcome of this guideline

This guideline is designed to provide a framework that supports those staff responsible for arranging and planning patient discharges and aims to promote effective communication between hospital staff and the patient /carers / representative to achieve a safe and timely transfer of care/discharge.

This guideline is to be used in conjunction with admission, discharge and transfer processes as defined by NSW Health and SESLHD.

For some patients and families, the discharge process may be complicated, for example as a result of complex clinical conditions or if there is difficulty in identifying a suitable discharge destination. Often, such discharges require sensitivity and should always occur with full consideration given to the patient's/ families and / or representatives wishes.

Section 2 - Principles

2.1 Scope

This guideline applies to all patients where the recommended discharge plan is complex in nature, including if the patient / family / representative disagrees with the Expected Discharge Date (EDD) or the recommended discharge destination set by the multidisciplinary team (MDT) supporting the patient. The MDT must follow admission, transfer and discharge processes and determine what is required for the patient.

Examples of when these Guidelines may be applicable include:

- The clinical team has determined that a patient no longer requires acute hospital care, but they and/or their family / representative do not agree with a decision around the date of discharge, or may not be willing to engage in discussions regarding a plan for discharge.

- Patients who are being discharged to another facility such as a Rehabilitation Facility/Aged Care Facility / Hospice, and do not choose to engage in a discussion to consider the alternative option, either on a temporary or permanent basis.

2.2 Process

It is important that the discharge process in relation to all patients commences as soon as possible, and that this occur in a sensitive manner inclusive of the wishes of the patient and carers.

In alignment with **SESLHD Policy SESLHDPR/265 – Arranging Accommodation in Residential Aged Care Facilities,** the following process guidelines should be followed to ensure that patients with complex discharge or transfer requirements are identified early and escalated to appropriate staff at a senior level in SESLHD hospitals.

Prior to any escalation the following should be completed and documented as this is standard practice for all patients.

As per NSW Health *PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*

- Admission and Discharge Risk Assessment form completed by nursing staff within 24 hours of admission to ward
- Risks identified from the admission assessment to be referred to allied health professionals for further assessment eg, those risks identified in the section Transfer of Care Risk Screen and changes in mobility, functional status or cognition
- Patient and family have been informed of EDD and EDD documented in patient health care record /admission form
- Intended/proposed discharge plan discussed with patient/ family/representative. Plan and discussion are documented in patient health care record

- Issues with capacity of patient to make decisions identified early
- Correct person responsible (representative) details are recorded on front sheet
- If multiple relatives/friends involved, **one person** is nominated as the contact person.

For some patients, the Guardianship Division of NSW Civil and Administrative Tribunal (NCAT) may need to be engaged to appoint a guardian with the authority to make decisions on the patient's behalf.

All of the above needs to be clearly documented in the patients' clinical record.

Triggers/flags for early identification of potential delays or complex discharges:

Stage One applies to all cases.

Stage Two is divided into two scenarios:

- Aged care and residential placement
- Cases other than the above

Stage Three is the final stage of escalation.

2.2.1 STAGE ONE

Issues:

- Unable to contact family
- No family or family not available
- Family not attending scheduled meetings/alternatives, e-mail contacts
- Frequent changes to discharge plan, either by family/ representative or treating team
- Lack of flexibility by family/representative in which facility patient may be placed
- Lack of suitable options for patient due to highly complex needs
- Requirement for particularly culturally sensitive discharge plan or placement
- Approaching EDD with no discharge plan in place
- Identified complex home environment
- Difficulty accessing equipment or arranging services
- Multiple patient moves through wards that creates a communication gap
- Delay in progress toward discharge due to staffing.

Note: Specific arrangements may need to be considered for patients placed under Guardianship arrangements.

Staff response to these triggers

- Inform Nurse Unit Manager / Midwifery Nurse Manager (NUM / MUM)
- Inform relevant Senior Nurse Manager (or equivalent senior staff) eg, Service Line Manager
- Notify relevant staff – Patient Access / Complex Discharge Coordinator/ Discharge Planner, Medical, Allied Health and document in patient health care record that they are involved

- The staff member who will be co-coordinating/case managing the patient should be identified in the patient health care record with the proposed discharge plan and the role of the coordinator
- Develop plan to manage situation with a timeframe for outcome to be reached or for escalation to Stage Two.
- Document the following in the patient health care record – senior staff member notified, contact details given to patient / family / representative.

2.2.2 STAGE TWO

Escalation plan
An escalation plan should be actioned if Stage One has been completed and the discharge continues to be delayed or is likely to be delayed.

For Aged Care and residential placements:

- Patient is medically appropriate for discharge
- Allocated Social Worker has discussed discharge plan with patient/family
- Case conference held where the Nursing Unit Manager (NUM), Clinical (Care) Coordinator, Social Worker, Discharge Clinical Nurse Consultant (CNC) Complex/Discharge Coordinator or Occupational Therapist, Physiotherapist, Speech pathologist, Medical Officer present as appropriate for the patient's situation at the facility
- Case Conference documented to support the decisions for placement:
    - Patient/family/ representative aware that alternate/residential accommodation is appropriate for care needs and patient is no longer acute
    - **One** designated contact person for family with contact details, mobile phone etc documented in patient health care record.
- Transfer to Residential Aged Care Facility information pack including suitable accommodation across the district, is given to the patient/family/representative by the Social Worker
- Patient/family/representative to be given information by the Social Worker on the procedure to find and transfer to another facility and informed they will not be able to stay in the acute hospital
- Patient/family/representative to be informed of the financial issues and process for finding a facility
- If patient/family/representative refuse to discharge patient to appropriate facility and community services cannot provide suitable care at home due to patients care needs, then the family are to be informed by NUM/ MUM or Senior Nurse Manager (or equivalent) that the only option is for them to take the patient home. The MDT will provide patient/family with assistance to make the discharge as safe as possible. The family/representative will be provided with additional information on private services and equipment needs
- At this stage there is no need for another review of the case unless the patient's condition has improved or changed significantly
- If the family/representative agree to placement in a RACF, the Social Worker is to ensure contact person is aware of requirement to visit available homes within 24 hours of being notified of a vacancy. If no return call after this 24 hour period is received from

the contact person, Social Worker to immediately initiate follow up contact and if no response or significant delay by family/ representative, alert NUM/MUM (or equivalent) to situation

- Inform Senior Nurse Manager (or equivalent) for relevant clinical area and head of Social Work and other staff members as indicated
- Inform Director of Nursing (DON) for relevant site for action and involvement of Director Clinical Services (DCS) (or equivalent) if required.

For all other patients

- Patient is medically appropriate for discharge to appropriate destination, such as home/friend/relative
- Case conference held where the Nursing Unit Manager, Clinical (Care) Coordinator, Complex / Discharge Coordinator, Social Worker, CNC, Occupational Therapist, Physiotherapist, Medical Officer (or equivalent present as appropriate)
- Recommendations from Allied Health made including services, modifications and equipment
- Risks identified and explained to patient/family/representative and documented in the patient health care record
- The patient/family/representative informed they will not be able to stay in the acute sector
- If patient /family/ representative refuse to accept recommendations, appraise the Allied Health Head of Department, Senior Nurse Manager (or equivalent) for clinical area
- Appraise Director of Nursing (DON) for relevant site for action and involvement of Director Clinical Services (DCS) or equivalent if required
- At this stage the Senior Nurse Manager, DCS or DON (or equivalent senior managers) need to take over management of the case
- Prior to escalation, the case manager must summarise events and actions taken in the patients' health care record and to whom they have escalated the issue. Outcome of escalation is discharge within an agreed timeframe.

2.2.3 STAGE THREE
Escalation plan

A Stage Three escalation plan should be actioned if Stage One and Stage Two have been completed and the discharge continues to be delayed or likely to be delayed**.**

If agreement regarding the discharge plan is not achieved in Stage Two, the Senior Nurse Manager and DCS/Service Line Manager, NUM/MUM/Complex / Discharge Coordinator and AMO or delegated registrar must review all the documentation relating to the patient's admission to ensure that all issues and concerns in relation to the discharge have been resolved as far as they can be.

If all the issues and concerns have been addressed and the patient and/or representative are still not supporting the agreed discharge plan, the Senior Nurse Manager and DCS/Service Line Manager and the delegated Hospital Executive should escalate the issue to the General Manager/Director.

The General Manager/Director of the Service must review the case and provide a written summary to the patient/family/representative outlining the Hospital's position.

The General Manager/Director of the Service must provide an internal briefing to the Director Programs and Performance outlining the outcome of Stage Three, including recommendations for the way forward.

The Director Programs and Performance must provide advice to the Chief Executive as required.

Section 3 - Definitions

Definitions:

The following terms and acronyms are used within the document:

Carer	Is an individual who provides personal care, support and assistance to another individual who needs it because that other individual: (a) has a disability (b) has a medical condition (including a terminal or chronic illness) (c) has a mental illness (d) is frail and aged.
Representative	A substitute decision maker eg, guardian, power of attorney, enduring guardian or person responsible can make decisions, depending on what that decision is. An informal decision maker may also make decisions if they do not have a formal decision maker in place.
Discharge	Transfer of Care to another health service or into the community
EDD	Estimated Date of Discharge
MDT	Multi-Disciplinary Team. For example, Health care professionals from a range of disciplines who work together to deliver comprehensive care that addresses as many of the patient's needs as possible.
NUM	Nursing Unit Manager
MUM	Midwifery Unit Manager
AMO	Admitting Medical Officer

Section 4 - Responsibilities

Responsibility for ensuring the safe, effective and timely transfer of care of an admitted patient rests with the Consulting Medical Officer, Multidisciplinary Team and the relevant NUM/MUM.

The patient and their carer/s should be involved in discussions around transfer of care at the earliest opportunity, and throughout the duration of the admission. These discussions must be conducted sensitively and reflect patient and carer wishes.

All stages of the communication process should be recorded within the patient's health care record.

Support from the Nursing and Medical Co-Director/Nurse Manager and Complex/ Discharge Coordinators is available at all stages. With good communication and early identification of the situation, the majority of plans not supported by the patient and/or carer/s can be avoided and no further action will be required beyond Stage One.

References

NSW MOH PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals

IB2016_036, 2016/17 Service Agreement Key Performance Indicators and Service Measures Data Dictionary, Service Access and Patient Flow targets

NSW Ministry of Health PD2011_015, Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.

NSW Ministry of Health PD2011_031, Inter-facility Transfer Process for Adults Requiring Specialist Care

PD2016 024 Health Services Act 1997 – Scale of fees for Hospital and Other Services

SESLHD Policy 265 – Arranging Accommodation in Residential Aged Care Facilities

SESLHDPR/410, Escalation Process and Expectations of Patient Flow coordinators, After Hours Nurse Managers and District Executive Officers On-Call for SESLHD

PD2016_039 Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care

Revision and Approval History

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