# Departure of Emergency Department Patients

**Summary** This policy outlines the principles for implementing a standardised approach to determining whether a patient is ready for departure from NSW Emergency Departments (EDs) once the ED phase of their care is complete.

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**Applies to** Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Private Hospitals and day Procedure Centres, Public Health Units, Public Hospitals

**Distributed to** Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

**Audience** Administration;Emergency Departments

Secretary, NSW Health

POLICY STATEMENT

# DEPARTURE OF EMERGENCY DEPARTMENT PATIENTS

## PURPOSE

For the purpose of this policy, **'Departure from Emergency Department'** refers to patients leaving the Emergency Department (ED) whether they are to be discharged, admitted or transferred to another facility.

This policy outlines the principles for implementing a standardised approach to determining whether a patient is ready for departure from NSW EDs once the ED phase of their care is complete. These principles are to be implemented by NSW Public Health Organisations.

For information on patients awaiting care or commencement of clinical treatment please see PD2013_047 *'Triage of Patients in NSW Emergency Departments'* and PD2010_075 *'Emergency Department Patients Awaiting Care'*.

## MANDATORY REQUIREMENTS

All NSW Public Health Organisations must:

- Ensure that local processes are in place which comply with this policy and support the four principles of readiness for departure from ED described here
- Confirm that processes are in place in each ED to ensure that all patients are ready for departure from ED upon completion of the ED phase of their treatment and have been authorised as ready to depart. Readiness for departure from ED encompasses the following four principles:
    - The patient is safe for departure from a clinical and functional perspective.
    - The patient has had appropriate risk assessments undertaken prior to departure.
    - Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible.
    - Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred. Patients should be given post-discharge care instructions in plain language which is relevant to the individual and provides information that adequately desc ribes follow up treatment. Communication must be undertaken with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED, particularly if there is a requirement for them to provide patient care or a request to follow up outstanding care requirements.
- Ensure all staff are aware of the 'Departure of Emergency Department Patients' policy and their responsibilities in relation to managing the departure from ED of patients.

- Ensure that the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists are utilised to support implementation of this policy as per NSW Health policy PD2013_049 *'Recognition and Management of Patients who are Clinically Deteriorating*'. If the ED charts specifically are not used, that alternate local processes must be in place which demonstrate all information on the checklist being collected for patients.
- Ensure that local evaluation of compliance with this policy is undertaken. This should include internal review of incidents related to departure of patients from ED and review of consistency of use of the Adult and Paediatric ED Observation chart 'Departure and Discharge from ED' checklists (or equivalent local process).

## IMPLEMENTATION

Local Health District and Specialty Health Network Chief Executives are responsible for:

- Assigning responsibility, personnel and resources to implement this policy
- Establishing mechanisms to ensure that the mandatory requirements are applied, achieved and sustained as usual processes for departure of patients from ED; this should include nomination of an executive sponsor
- Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management and other relevant staff
- Ensuring that hospital and ED processes support the minimisation of delays for patients departing the ED, including limiting delays which may occur as a result of the requirement to complete the ED departure process.

## REVISION HISTORY

| Version | Approved by | Amendment notes |
|---|---|---|
| PD2014_025 (July 2014) | Deputy Secretary, System Purchasing and Performance | New Policy<br>Replaces *PD2005_082, Discharge Policy for Emergency Department at risk patients*. |

## ATTACHMENTS

1. Departure of Emergency Department Patients: Procedures.

# Departure of Emergency Department Patients

NSW GOVERNMENT Health

PROCEDURES

**Issue date:** July-2014

PD2014_025

# CONTENTS

# 1 BACKGROUND

## 1.1 About this document

For the purpose of this policy, 'Departure from Emergency Department' refers to patients leaving the Emergency Department whether it is to be discharged, admitted or transferred to another facility.

This policy directive and procedure replaces PD2005_082 *'Discharge Policy for Emergency Department at risk patients'*, which was developed in recognition that patients being discharged from Emergency Departments (ED) may be at risk of re-presentation or adverse events. The Special Commission of Inquiry, Acute Care Services in NSW Public Hospitals also recommended in 2008 that a checklist be implemented in NSW EDs to communicate the needs of a patient being admitted to an inpatient unit.

This policy and procedure seeks to encompass both of these elements by detailing a standardised approach for all patients who depart the ED. It describes the principles required to minimise the risk of adverse events for patients who have completed the ED phase of their treatment and have been authorised as ready to depart the ED.

In accordance with NSW Health policy PD2013_049 *'Recognition and Management of Patients who are Clinically Deteriorating'* this policy requires use of the NSW Health Standard Adult and Paediatric ED Observation Charts including the checklist for staff to complete for patients prior to leaving ED. If the charts are not used, alternative local processes must demonstrate that the information contained in the checklists is being collected.

This policy is also consistent with the Australian Charter of Healthcare Rights for patients described in NSW Health Policy PD2011_022 Your Health Rights and Responsibilities.

## 1.2 Key definitions

| | |
|---|---|
| **At Risk** | Refers to a patient who has been assessed as having an identified risk which is recognised to contribute to adverse events or readmissions upon leaving the ED. |
| **Clinical Handover** | The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. |
| **Emergency Department Departure** | (ED Departure) refers to the transfer of responsibility and accountability for a patient's care upon leaving the ED. The patient may be admitted to an inpatient ward, be transferred to another facility or be discharged back to the community and their usual place of residence. |
| **Left at Own Risk** | Refers to any person who leaves the ED after treatment has commenced, against advice. The patient's health Care Record will reflect that the patient |

| | |
|---|---|
| | has been seen by Doctor/Nurse/Nurse Practitioner and will have a diagnosis. |
| **Person Responsible** | Refers to someone who has legal authority to make decisions on behalf of someone else who does not have the capacity to consent for themselves.<br><br>A 'person responsible' is not necessarily the patient's next of kin. A 'person r esponsible' is either:<br><br>• a **guardian** (including an enduring guardian) who has the function of consenting to medical, or dental treatment.<br><br>or, if there is no guardian:<br><br>• the most recent **spouse** or **de facto spouse** with whom the person h as a close, continuing relationship. 'de facto spouse' includes same s ex partners<br><br>or, if there is no spouse or de facto spouse:<br><br>• an **unpaid carer** who is now providing support to the person or provi ded this support before the person entered residential care<br><br>or, if there is no carer:<br><br>• a **relative** or **friend** who has a close personal relationship with the pe rson<br><br>• The **NSW Civil & Administrative Tribunal**, **Guardianship Division**<br><br>***Note:*** *The above information has been provided by the NSW Civil & Administrative Tribunal, Guardianship Division*<br><br>In accordance with PD2005_406 Consent to Medical Treatment – Patient Information:<br><br>• A child aged 14 years and above may consent to their own treatment provided they adequately understand and appreciate the nature and consequences of the operation, procedure or treatment |
| **Ready for Departure** | Refers to a patient who has been authorised by senior ED staff as safe to depart the ED in accordance with the principles of this policy. |
| **Risk Assessment** | An activity that identifies risks, estimates their probability and the likely impact of their occurrence particularly in relation to adverse outcomes. |

# 2 PROCEDURE FOR DETERMINING READINESS FOR DEPARTURE OF EMERGENCY DEPARTMENT PATIENTS

## 2.1 The four principles for determining readiness for departure of Emergency Department patients

Determination of a patient being ready for departure is a multidisciplinary process with ultimate responsibility resting with the senior ED medical officer and nurse in charge of shift of the ED or their delegates. Readiness for departure from ED encompasses the following principles:

1. The patient is safe for departure from a clinical and functional perspective.
2. The patient has had appropriate risk assessments undertaken prior to departure
3. Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible
4. Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred; as well as communication with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED.

### 2.1.1 Clinically and functionally safe for departure

When deeming a patient clinically safe for departure the following aspects must be met:

- The patient will be 'between the flags' with respect to recorded observations or there will be documented alterations to calling criteria on the relevant NSW Standard Observation Chart where this is appropriate for the patient. Patients who are leaving the ED for higher level care (e.g. Intensive Care Unit) are often unstable and may not be 'between the flags' – this should not delay departure from ED.
- All appropriate diagnostic tests will be completed or there is a documented plan of who is responsible to follow up outstanding tests and results. A management plan is documented including a provisional or definitive diagnosis and this is communicated to relevant health professionals.
- The patient is departing for a location that has a level of supervision or clinical care consistent with their clinical condition and risk assessment.

### 2.1.2 Risk assessment

There are many health risk assessment tools and guidelines available to clinicians – not all are suitable to be undertaken in the ED. Appropriate risk assessment should be undertaken at the discretion of the treating clinician and according to patient clinical need and local procedures.

In addition to clinical risk identification; mental health, social and cultural aspects that are likely to impact on the patient's readiness for departure from the ED must be considered.

If a patient is determined to be at risk; documentation and a corresponding risk mitigation process should be enacted.

Possible risks include, but are not limited to:

- Level of supervision required for discharge
- Availability and accessibility of competent supervision if required
- Competency to access transport or the provision of own transport
- Ability to comply with discharge instructions including access to other health providers e.g. GPs and pharmacies
- Need for specialist care within an inpatient unit or the requirement for inter-hospital transfer
- Patients with undifferentiated diagnoses
- Evolving or rapidly progressing disease processes
- Indication for additional resources including equipment and personnel that is not currently available.
- Unsafe home environment/circumstances e.g. departure of elderly patients to home at night, known domestic violence situations.
- Complex social situation/circumstances where significant allied health intervention is required e.g. homelessness.

### 2.1.3 Risk mitigation

Not all risks can be mitigated in the ED, however every effort should be made to identify and manage potential risks during assessment and treatment in the ED. Referral to appropriate services to manage identified risks should occur as early as possible, this may include Mental Health Services, Aboriginal Liaison Officers or Allied Health services.

Departure from the ED must not take place if significant risk has been identified and these risks cannot be managed after ED Departure, or if the patient requires the supervision of a responsible adult for appropriate ED Departure and this cannot be ensured. A local facility protocol should identify the process to be undertaken in this situation (e.g. transfer to inpatient unit if appropriate).

### 2.1.4 Communication of the Patient's care needs.

The communication of information to patients, carers and other health professionals about the ongoing care needs of the patient is essential to ensuring continuity of care.

PD2009_060 '*Clinical Handover – Standard Key Principles'* clearly states the requirements for the transfer of information, accountability and responsibility for a patient or group of patients between clinicians. The elements relevant to the clinical handover should be addressed as per the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists.

**Patients departing the ED for inpatient wards**

Patients departing the ED for inpatient wards should have a clinical handover process completed with the relevant ward staff which details the patient's plan of care and any outstanding tests and actions that require follow up.

Documentation is to be complete as per PD2012_069 Health Care Records - Documentation and Management as well as other relevant information to ensure ongoing care of the patient pending review of the inpatient team (e.g. interim orders for analgesia and other medications charted, progress notes completed).

**Patients departing the ED for another facility**

Patients departing ED for another facility must have communication managed as per PD2011_031 *'Inter-facility Transfer Process for Adults Requiring Specialist Care'* and PD2010_031 '*Children and Adolescents – Inter-Facility Transfers'*

Communication for the Transfer of Critically ill patients is as per PD2010_021 *'Critical Care Tertiary Referral Networks & Transfer of Care (Adults)'* and PD2010_030 *'Critical Care Tertiary Referral Networks (Paediatrics)'*

**Patients departing the ED for home or usual place of residence**

Patients departing the ED for home or their usual place of residence require adequate instruction to ensure the patient (and /or family/carer where appropriate) is aware of ongoing care requirements.

Not every patient requires a formally written discharge letter; however information should be given to the patient which adequately describes follow up treatment. This may be verbal instruction, patient fact sheets with information about their condition or details of who to call or follow up with regarding their treatment and any referrals made to other services.

The method of information given should be at the discretion of the treating clinician and take into account the patient's understanding of information and any cultural, language and social requirements to assist with understanding of information. Documentation in the patient's Health Care Record of the method used is appropriate, e.g. if verbal instruction only is given or a copy of the discharge letter.

Efforts should be made to contact Residential Aged Care Facility staff to notify them of the resident's return to the facility.

**Discharge letter**

If further care by another health professional is required, then a discharge letter is appropriate. The letter should include information about the ED treatment, details of test results carried out in the ED or results which require follow up, any changes to medications and any other relevant information required to ensure continuity of the patient's care. A copy of the letter should remain in the patient's Health Care Record.

**Authorisation to depart ED**

All patients leaving the ED require authorisation that they are ready to depart the ED. This is the responsibility of senior medical and nursing staff in the ED (or their delegate) and should be indicated on the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists (or documented as per equivalent local process).

In EDs where there is no senior medical staff on site, delegation of authorisation to depart the ED will be according to locally agreed to and communicated processes.

## 3 PATIENTS WHO 'LEFT AT OWN RISK'

A competent adult patient has the right to refuse medical treatment for themselves or their children/dependents. A person is incapable of giving consent if they are not "competent'. There is no single legal test or definition of competency. However, in order to be competent to consent to or refuse treatment, a patient must be able to comprehend and retain treatment information and consider the information in order to reach a decision.

The Guardianship Act, 1987 provides methods for obtaining consent to treat those persons who are incapable of giving consent. A designated Person Responsible may substitute if the patient is unable to given consent.

All reasonable measures must be undertaken to manage the patient who expresses the wish to leave the ED against medical advice.

This includes ensuring the patient:

- Is counselled by appropriate staff against leaving against medical advice. All attempts to convince the patient to stay should be documented in the patient's Health Care Record.
- Has had the potential consequences of leaving the ED explained in plain language which is relevant to the individual (by the senior doctor/nursing staff or their delegate) including the use of interpreters/ Aboriginal Liaison Officer if necessary. This must be explicitly documented in the patient's Health Care Record.
- Is competent to make the decision to leave.
- Is given advice on follow up options.
- Is given the option to return.
- Is encouraged to call to inform a friend or relative, or allow the ED staff to do so where appropriate.
- If appropriate has consulted with an Aboriginal Liaison Officer to ensure culturally appropriate treatment options.

Should a patient be found to have left the ED without the knowledge of staff and there are concerns for the patient's or other's safety, actions taken will be in consideration of both the patient's level of competence to make the decision as well as the risk (clinical or otherwise) to the patient/others.

**Section 2.5.2** of PD2012_060 Transfer of Care from Mental Health Inpatient Services provides specific detail on Procedures for locating missing patients which can be applied to the ED setting, particularly for patients being detained under the Mental Health Act 2007.

## Attachment 1: Adult ED Observation Chart 'Departure and Discharge from ED' checklists.

NSW Health

Facility: _____

**ADULT EMERGENCY DEPARTMENT OBSERVATION CHART**

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____ | M.O.
ADDRESS
LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE**

**PROVISIONAL DIAGNOSIS:**

Admitting Consultant name:
Delegate name (If applicable):
Accepted Care of patient
Date:
Time:

Clinical Plan explained to patient /carer Yes ☐
Clinical Plan documented in progress notes Yes ☐
**Admission completed by:**
**ED Medical Officer name:**
**ED Medical Officer signature:**

**ED to WARD DEPARTURE CHECKLIST**

**NURSING**

Verified that all documentation is complete
- Admission/Transfer forms/eMR ☐
- Medications charted Yes ☐ N/A ☐
- Analgesia charted Yes ☐ N/A ☐
- IV Fluids charted Yes ☐ N/A ☐
- Fluid Balance up to date ☐
- Progress notes up to date ☐
- Risk assessments completed ☐

Diet: Eat & Drink ☐ Nil By Mouth ☐ IVT ☐ NG ☐
Infection status:
Precautions / Isolation required Yes ☐
Specify: Contact Precautions / Respiratory
Patient belongings sent to ward Yes ☐ N/A ☐
Medication sent to ward Yes ☐ N/A ☐

**Ward accepting care:**
**Ward Nurse accepting care:**
**ED Nurse Transferring name:**
**ED Nurse transferring sign:**

**MEDICAL**

Medical Handover given Yes ☐ No ☐
Outstanding results and actions handed over:
1.
2.
3.
4.
5.

**Medical Officer Accepting Care name:**

**ED Medical Officer providing handover**
**Name:**
**Sign:**
**Date:**
**Time:**

**AUTHORISATION FOR DEPARTURE FROM ED TO WARD**

**NURSING**

Observations within the last hour Yes ☐
Is the patient 'Between the Flags' Yes ☐ No ☐
If not, clinical reason and plan is documented and signed ☐

Alterations to calling criteria charted Yes ☐ No ☐ N/A ☐
Altered frequency for observations charted Yes ☐ No ☐ N/A ☐

**MEDICAL AUTHORISATION**

**Authorised as safe for transfer** Yes ☐
**NUM/ Senior ED Nurse name:**
**NUM/Senior ED Nurse sign:**
**Date:** **Time:**

**Authorised as safe for transfer** Yes ☐
**ED Medical Officer name:**
**ED Medical Officer sign:**
**Date:** **Time:**

**AUTHORISATION FOR DISCHARGE FROM ED TO HOME**

**NURSING**

Cannula / ID Band removed Yes ☐
Discharge / Referral Letter Yes ☐
Discharge Prescription Yes ☐
Fact Sheet Yes ☐
Clothes / Belongings Yes ☐

**ELDERLY:**
Does the patient live alone Yes ☐ No ☐
Time of discharge appropriate Yes ☐ No ☐
NOK/person responsible aware? Yes ☐ No ☐
Nursing Home / Hostel aware? Yes ☐ No ☐

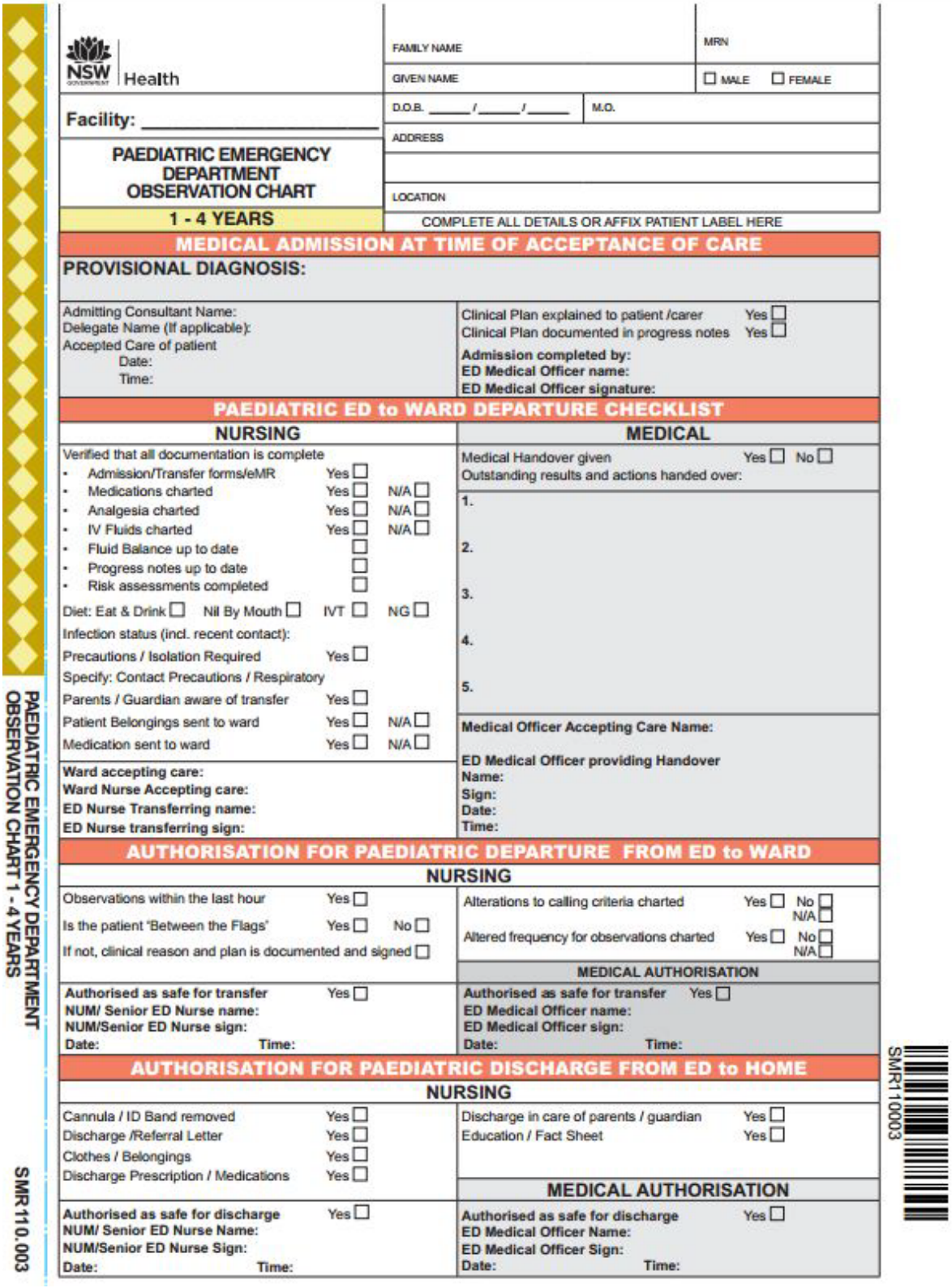
**MEDICAL AUTHORISATION**

**Authorised as safe for discharge** Yes ☐
**NUM/ Senior ED nurse name:**
**NUM/Senior ED nurse sign:**
**Date:** **Time:**

**Authorised as safe for discharge** Yes ☐
**ED Medical Officer Name:**
**ED Medical Officer Sign:**
**Date:** **Time:**

ADULT EMERGENCY DEPARTMENT OBSERVATION CHART SMR040.010

# Attachment 2: Paediatric ED Observation Chart 'Departure and Discharge from ED' checklists



NSW Health

Facility: _____

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART

1 - 4 YEARS

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE**

**PROVISIONAL DIAGNOSIS:**

Admitting Consultant Name:
Delegate Name (If applicable):
Accepted Care of patient
Date:
Time:

Clinical Plan explained to patient /carer Yes ☐
Clinical Plan documented in progress notes Yes ☐
**Admission completed by:**
**ED Medical Officer name:**
**ED Medical Officer signature:**

**PAEDIATRIC ED to WARD DEPARTURE CHECKLIST**

**NURSING**

Verified that all documentation is complete
- Admission/Transfer forms/eMR Yes ☐
- Medications charted Yes ☐ N/A ☐
- Analgesia charted Yes ☐ N/A ☐
- IV Fluids charted Yes ☐ N/A ☐
- Fluid Balance up to date ☐
- Progress notes up to date ☐
- Risk assessments completed ☐

Diet: Eat & Drink ☐ Nil By Mouth ☐ IVT ☐ NG ☐
Infection status (incl. recent contact):
Precautions / Isolation Required Yes ☐
Specify: Contact Precautions / Respiratory
Parents / Guardian aware of transfer Yes ☐
Patient Belongings sent to ward Yes ☐ N/A ☐
Medication sent to ward Yes ☐ N/A ☐

**Ward accepting care:**
**Ward Nurse Accepting care:**
**ED Nurse Transferring name:**
**ED Nurse transferring sign:**

**MEDICAL**

Medical Handover given Yes ☐ No ☐
Outstanding results and actions handed over:

1.
2.
3.
4.
5.

**Medical Officer Accepting Care Name:**

**ED Medical Officer providing Handover**
**Name:**
**Sign:**
**Date:**
**Time:**

**AUTHORISATION FOR PAEDIATRIC DEPARTURE FROM ED to WARD**

**NURSING**

Observations within the last hour Yes ☐
Is the patient 'Between the Flags' Yes ☐ No ☐
If not, clinical reason and plan is documented and signed ☐

Alterations to calling criteria charted Yes ☐ No ☐ N/A ☐
Altered frequency for observations charted Yes ☐ No ☐ N/A ☐

**MEDICAL AUTHORISATION**

**Authorised as safe for transfer** Yes ☐
**NUM/ Senior ED Nurse name:**
**NUM/Senior ED Nurse sign:**
**Date:** **Time:**

**Authorised as safe for transfer** Yes ☐
**ED Medical Officer name:**
**ED Medical Officer sign:**
**Date:** **Time:**

**AUTHORISATION FOR PAEDIATRIC DISCHARGE FROM ED to HOME**

**NURSING**

Cannula / ID Band removed Yes ☐
Discharge /Referral Letter Yes ☐
Clothes / Belongings Yes ☐
Discharge Prescription / Medications Yes ☐

Discharge in care of parents / guardian Yes ☐
Education / Fact Sheet Yes ☐

**MEDICAL AUTHORISATION**

**Authorised as safe for discharge** Yes ☐
**NUM/ Senior ED Nurse Name:**
**NUM/Senior ED Nurse Sign:**
**Date:** **Time:**

**Authorised as safe for discharge** Yes ☐
**ED Medical Officer Name:**
**ED Medical Officer Sign:**
**Date:** **Time:**

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART 1 - 4 YEARS

SMR110003

SMR 110.003