Admission to Discharge Care Coordination

Summary Care Coordination is the process whereby patients needs are identified and managed from the point of admission. This Policy outlines the five steps in coordinating patient experience and improve patient flow within the hospital.

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Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Tertiary Education Institutes

Audience All Staff of NSW Health

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

NSW Health

POLICY DIRECTIVE

Admission to Discharge Care Coordination

POLICY STATEMENT

NSW Health organisations have a duty of care to ensure that care coordination provides the care needed to identify and manage safe and appropriate care to all patients within NSW Health. It must ensure all clinical staff are aware of their obligations to coordinate patient care and follow the principals of admission to discharge care coordination.

SUMMARY OF POLICY REQUIREMENTS

NSW Health must comply with admitted patients transitioning through the five stages of care coordination outlined in this Policy Directive.

1. Pre-Admission / Admission
2. Multidisciplinary Team Review
3. Estimated Date of Discharge
4. Referral and Liaison for patient transfer of care
5. Transfer of care out of Hospital

Pre-Admission/Admission must develop and use an admitted patient 'Discharge Risk Assessment' Tool'.

All departments (including the emergency department) must have procedures in place for the care of discharged patients at risk, especially between the hours of 2200hrs and 0800hrs. Where procedures and checklists already exist (including in paediatrics) it must be confirmed that they comply with the requirements of this Policy Directive.

Multidisciplinary team review structured allocates set time, duration and frequency of all multidisciplinary team reviews (Electronic Patient Journey Board MDT rapid huddle) in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.

An Estimated Date of Discharge (EDD) is allocated, documented and displayed near the bedside and on the Patient Flow Portal (PFP) electronic patient management tools (EPJB), and are reviewed for each patient. The patient and carer must be kept informed of the estimated date of discharge during their stay.

Referrals and liaison for patient transfer of care must ensure that the Discharge Checklist or equivalent is completed for all relevant admitted patients before they return to the community.

All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer and appropriate service prior to transfer of care, in plain language

While the five stages will apply to most patients having an inpatient stay, the stages may require adjustment for some patient groups. Patients having scheduled admissions for a course of treatment (e.g. chemotherapy, dialysis or a multi-staged procedure) may not require a review for each admission in the absence of a change in personal/social circumstances or clinical condition. Planned day only or extended day only patients are to have an assessment of their discharge needs and arrangements put in place prior to their admission.

All Local Health Districts and Speciality Health Networks (Districts/Networks) have duty of care to ensure that patients have a safe and appropriate discharge plan.

For those being discharged from Mental Health Inpatient Units this Policy Directive serves as an addition to the overarching principles outlined in NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045).

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2022_012 April 2022	Deputy Secretary, Patient experience and System Performance	Recent coronial inquiries led to further additions to policy directive • Section 5.1 referring to Service Providers. • Referenced new NSW Family Focused Recovery Framework 2020-2025.
PD2011_015 March-2011	Deputy Director – General Health System Quality Performance and Innovation	Updated policy directive
PD2007_092 December-2007	Director General - General	Updated policy directive
PD2007_034 May-2007	Director General - General	Updated policy directive
PD2007_003 January-2007	Director General - General	Updated policy directive
PD2006_054 July-2006	Director General - General	Updated policy directive
PD2005_092 January-2005	Director General - General	New policy directive

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1. BACKGROUND

1.1. About this document

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 discharge.

This Policy Directive applies to clinical staff involved in the care of inpatients across all NSW Health Hospitals. It outlines a five-stage process to inform staff and patients throughout their hospital stay. Implementation of this approach will enhance patient outcomes, safety and experience.

A patient's discharge from hospital demonstrates that a patient's care continues beyond the treatment they receive in hospital as they continue to receive care from another service/facility/or in the community. This could be by a patient's General Practitioner (GP), community health providers, including Aboriginal Community Controlled Health Services (ACCHS), or other organisations by the patient and/or their carer's.

1.2. Key definitions

Multidisciplinary Team (MDT) Care	When professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. *Mitchell G.K., Tieman, J.J., and Shelby-James T.M. (2008), Multidisciplinary care planning and teamwork in primary care, Medical Journal of Australia, Vol. 188, No. 8, p.S63.*
Estimated Date of Discharge (EDD)	The EDD predicts the likely date that a patient will be **clinically ready** to leave the hospital, defined as all members of the treating MDT agree when active care is completed, and the patient will be safe to transition to their next phase of care or discharge home. It provides everyone involved in the patient's care, including the patient and their family/carers, with a date to coordinate the patient's needs and discharge planning.

2. PRE-ADMISSION/ADMISSION

At the time of first contact with the patient (pre-admission clinic or admission to an inpatient ward) a locally developed 'Discharge Risk Assessment' or equivalent must be completed by the treating nurse or midwife. A discharge risk tool is used to identify those patients who may have needs that require further assessment and follow-up before they are discharged home or to ongoing care from the acute hospital service.

Health Services are responsible for ensuring that a discharge risk is completed for all admitted patients. The results from this discharge risk tool are to be used to inform the overall management of the patient. Each Health Service, Hospital, and clinical units must develop a process for flagging those patients who have been identified as having a discharge risk with the multidisciplinary team and to implement procedures for contacting the appropriate health professionals to provide a discharge risk assessment.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) standard has identified that organisations develop electronic discharge tools to mitigate risk. An electronic discharge summary (eDS) must be used where available.

The 'Discharge Risk Assessment' must be used to gather information on all appropriate patients at admission or pre-admission. The key areas to be addressed are:

1. Is the patient likely to have self-care problems?
2. Does the patient live alone, is the patient homeless?
3. Does the patient have responsibilities to care for others?
4. Has the patient used community services before admission?
5. Are there other psychosocial factors that may impact on the patient's recovery?
6. Does the patient usually take three or more medications and have their medications changed in the last two weeks?
7. Is the Patient at risk of/or suffering from a current mental illness?
8. Is the patient of Aboriginal background?

This is important in the context of identifying potential service providers located in an Aboriginal Controlled Community Health Service. This will prompt an immediate inpatient referral to an Aboriginal Hospital Liaison Officer, identifying risk criteria for specific diseases as well as cultural considerations.

The 'Discharge Risk Assessment' must be completed on initial presentation and whenever the patient's clinical or social status changes and whenever further information becomes available.

When a discharge risk is identified by any member of the multidisciplinary team, it must be documented and ensure that procedures are in place to highlight risks to the multidisciplinary team and make referrals to the relevant health professions for further assessments and intervention.

2.1. Pre-admission

For planned admissions, discharge planning must begin before the patient is admitted. The discharge risk assessment is to be conducted during this time.

Patients with an identified risk must be referred early to the relevant inpatient allied health service and/or community teams, including Aboriginal Controlled Community Health Service so planning for transfer can begin. This must include the proposed length of admissions and the goals for admission.

2.2. Planned day-only admission

Discharge planning must occur for patients having day-only procedures. Facilities may nominate their own processes to ensure the discharge risk assessment is completed. For example:

- utilising a pre-admission preparation toolkit,
- nominating staff responsible for assessment of day-only patients, ideally this is to occur prior to the day of their procedure.

2.3. Planned patients

All patients with a planned admission must have their discharge risk assessment completed by the treating clinician at presentation or before admission to hospital, such as at a pre-admission clinic.

Completion of this assessment will allow the identification of discharge risks. The treating clinician is responsible for ensuring that all necessary referrals are made before admission, where possible, and confirmed during the acute phase of care.

2.4. Non-planned patients

For non-planned patients who are admitted to hospital through the emergency department or through direct admission, their discharge risk assessment must be completed within the *first 24 hours* of admission by the inpatient treating nurse or midwife.

2.5. Rural and remote patients

Consideration must be given to time, distance and dislocation involved for rural patients (and their carers / families) when hospitalised in a larger facility a long way from home.

Early identification of rurality or displacement will enable early mobilisation of support for carers and families who are isolated from support networks and are vulnerable. A needs assessment on admission would enable care planning sensitive to rurality to decrease hardship (emotional, social, financial and environmental), increase access to information and improve communication. This includes using telehealth as an option for family involvement in multidisciplinary team rounding and at discharge for follow up appointments and rehabilitation closer to home.

In some rural settings, and with some models of care local medical practitioners and allied health professionals are not always available. Local Health Districts (districts) and Speciality Health Networks (networks) must ensure patients can access these services if they are

required with local processes in place to ensure appropriate input into decision making regarding assessment, treatment and discharge planning.

2.6. Homeless patients

All districts / networks have a duty of care to ensure that patients have a safe and appropriate discharge plan, including discharge to appropriate accommodation.

Where a patient does not have a general practitioner and requires follow up treatment and ongoing management in the community, options of general practitioners and outreach service providers must be given.

For homeless patients or those patients identified as at risk of being homeless, plans need to be put in place prior to discharge to ensure that no patient exits an NSW Health facility into homelessness. Access and referral to specialist outreach services and support information must be provided and can be found at NSW Family & Community Services website (Housing NSW).

3. MULTIDISCIPLINARY TEAM

3.1. Roles and responsibilities

All members of the multidisciplinary team are expected to work collaboratively across disciplines to ensure improved patient outcomes and have defined roles and responsibilities in assisting in the care coordination process.

Health Services, hospitals and departments will need to ensure local procedures are in place to support a designated time for the multidisciplinary team care in inpatient wards/units to meet.

3.2. Team huddles

Multidisciplinary huddles are to take place daily throughout the working week thus ensuring short stay patients' needs are met.

The multidisciplinary team members must agree on the treatment plan, incorporate the discharge risks into the patient care plan, and set or review and update each patient's estimated date of discharge.

In some models of care (particularly in rural settings) regular participation from some members of the multidisciplinary team may be limited. Local processes need to be in place to ensure appropriate input into decision making regarding discharge planning.

Multidisciplinary huddles are a daily action planning tool and *do not* replace patient rounding, or in depth 'case review' meetings, patient rounding in which a patient care and treatment are discussed in more detail and a patient and their family carer are invited to actively participate.

Multidisciplinary huddle stages

Multidisciplinary Huddles	
Start of the day huddle	High level view of the predicted demand for the day, using the information in the Patient Flow Portal (PFP). Average of 30 seconds to share and highlight numbers.
Main body of the huddle	Progression of each patient towards the next transition of care and discharge (average of 30 seconds per patient – note that some patients will take longer than others). Discussing the patient's clinical plan and reviewing and updating the patients EDD is pivotal. To assess the need for Allied Health interventions from Day 1. Any other clinical concerns to be raised.
End the huddle	Raising ward related matters such as staff, any need for escalation of issues e.g. about particular complex patients, and opportunities to bring outliers back to the ward. Average of 30 seconds to close the huddle.
Follow-up	A range of actions after the huddle, such as updating the EPJB, actioning appropriate clinical care and referrals, i.e., allied health, medical consults and updating the patient/carer.

3.2.1. Positive multidisciplinary team huddles

The multidisciplinary team huddle is a quick daily meeting discussing care coordination requirements and discharge decisions. The huddle will discuss every patient on the ward, including outliers where appropriate. The huddle can also be known by other names, such as care coordination rounding, rapid huddle or electronic patient journey board rapid round.

The huddle must have a *forward outlook*, with a focus on the treatment plan and the tasks need for safe discharge, a discussion and amendment of each patient's estimated date of discharge, agreement about what is required next and key actions for team members in the *next 24-48 hours* including confirmation of discharges for today and tomorrow.

It must be led by a senior clinician such as the Nursing Unit Manager, Nursing Team Leader, and/or Senior Allied Health / Medical Consultant to ensure the meetings maintain structure and efficiency and be conducted at the Electronic Patient Journey Board (EPJB) or equivalent.

Patients who have been identified for discharge on the day of the huddle must be prioritised for early review and management.

Detailed clinical discussion about complex patient requirements can occur in case conferencing or handover, rather than in the huddle. Consider developing an 'multidisciplinary team huddle' script / template to provide structure and consistency to the meeting.

3.2.2. Preparation for multidisciplinary team huddles

Team members must decide on key roles to perform within the huddle. This must be established based on the professions involved in the patients care (e.g. Medical, allied health and nursing).

An agreed time must be decided for the huddle, frequency and duration. The duration of the rapid huddle is to be approximately 30 seconds each patient. (e.g. 15mins for 30-bed ward).

Ground rules must be established with the team, thus providing good communication and efficiency.

- Mandatory attendance by these key roles
- Ensure handovers are completed before the huddle, so that the most up-to-date information is provided to the multidisciplinary team.
- Start on time and finish on time
- Turn off phones: minimising interruptions
- Nominate a team member to respond to urgent correspondence
- Discussion centres around the electronic patient journey board (which means the electronic patient journey board must be set up in a way that facilitates meaningful discussion)
- Every member of the huddle has the opportunity to raise quality and safety issues that may affect patient outcomes.
- A nominated person updates the electronic patient journey board during the rapid huddle or afterwards.

4. ESTIMATED DATE OF DISCHARGE

The estimated date of discharge will be set based on the multidisciplinary team plan of care. It must be reviewed and updated as required during the electronic patient journey board rapid multidisciplinary team huddle or equivalent, and communicated to the patient, family/carers and relevant community service providers.

This process of capturing and reviewing a patient's estimated date of discharge is not required for patients admitted in an Emergency Department or an Emergency Department Short Stay Unit (EDSSU).

For many patients, the estimated date of discharge will change due to clinical issues. Discussions with the patient and their family/carer/s, general practitioner's community health and service providers must occur early and updated regularly for effective care planning. The estimated date of discharge is to be reviewed in the multidisciplinary team huddle and updated in the patient flow portal as changes occur.

Any changes to the estimated date of discharge for clinical reasons or delays in transfer beyond the estimated date of discharge are to be recorded and relevant staff informed. In this situation it is necessary to contact any relevant community service providers to advise them of the updated estimated date of discharge.

Hospitals must ensure an agreed local process is developed identifying the clinician/s responsible to ensure that the estimated date of discharge is updated in the patient flow portal or patient administration system (PAS).

- A patient's estimated date of discharge must be visible near their bed, reminding staff of the date they are working towards and informing the patient and their family or carer.
- The estimated date of discharge must be updated in the NSW Health patient flow portal (or PAS) within the first 24 hours of the patient's admission then reviewed and updated daily.
- The multidisciplinary team must use the estimated date of discharge to synchronise referrals to other teams and/or disciplines that are not involved in regular multidisciplinary team reviews.
- The estimated date of discharge is used by patient flow managers and hospital executive teams for predictive planning and management of patient flow.

The patient flow portal reports module provides the hospitals with the tools to review their estimated date of discharge compliance and accuracy for review and management.

Hospitals are to have in place a business continuity plan (BCP) in the unlikely event that the patient flow portal is off-line.

4.1. Inter-ward transfers

In the case of inpatient units such as Intensive Care, Coronary Care, Medical Assessment and Short Stay Units (Surgical Short Stay / 23hr units), the estimated date of discharge will be the predicted date that the patient will be clinically appropriate and ready for an inter-ward transfer to another inpatient unit.

If the patient's clinical plan is to be discharged from any of the units mentioned above (rather than transferred to another inpatient unit) then the estimated date of discharge will be the predicted discharge date for the patient.

4.2. Inter-hospital transfers

Patients awaiting transfer to another facility must have their estimated date of discharge set as the date that the accepting hospitals medical team has accepted care of the patient and the patient is clinically appropriate for safe transfer to the accepting facility.

This includes waiting for a transfer to a Residential Aged Care Facility (RACF), rehabilitation services and respite accommodation.

4.3. Patient detained for involuntary treatment

The estimated date of discharge for patients detained for involuntary treatment is the date that the multidisciplinary team believes the patient will be clinically fit for discharge/transfer from the current inpatient unit.

If the patient has an Involuntary Patient Order (IPO) or dependency certificate any expiry/review dates relating to this order can also be recorded in the patient flow portal.

In line with principles of least restrictive care, the Order expiry date is not the estimated date of discharge for the patient unless the team believe the patient will be clinically fit for discharge on this date.

4.4. Setting and estimated date of discharge for patients with complex needs

When setting and estimated date of discharge for patients with complex clinical needs the following things may help to determine a likely date of discharge/transfer:

- If the patient has had previous admissions how long where they?
- What is the patient's diagnosis and what is the average length of admission for patients with similar diagnosis?
- What is the treatment plan? If commencing/restarting medications how long is anticipated this will have a therapeutic effect
- What is the patient's provisional discharge plan?
- What is likely level of recovery and function for the patient, does their current social circumstance support this?
- What are the patients' goals? Establishing the patients previous baseline function, including their detailed social situation.

The estimated date of discharge for patients with complex needs will usually require assessments by several multidisciplinary team members and therefore the patients estimated date of discharge may require several revisions throughout the patient's admission.

4.5. Non-clinical delays

If a patient is unable to be transferred or discharged due to non-clinical delays then the estimated date of discharge *must not* be changed.

The patients estimated date of discharge will remain as the date that the patient was clinically ready to leave the hospital but was therefore unable to be discharged on their estimated date of discharge. This is primarily due to non-clinical delays such as waiting for a residential aged care facility to have capacity or waiting for a transfer to another hospital etc.

The patients estimated date of discharge days (EDD#) will then display as a negative number, each day the EDD# column will be indicating the number of days that the patients estimated date of discharge has lapsed. This will identify the number of days that a patient has been waiting for discharge/transfer and provides an opportunity for the facilities to identify and understand the non-clinical delays to discharge in their facility.

The patient flow portal 'Waiting for What' tool assists clinicians in identifying the delays to discharge and therefore by definition every patient with an estimated date of discharge in the past must have a non-clinical delay. Therefore, these patients must have an attached 'Waiting for What' (W4W) entry in the NSW Health Patient Flow Portal.

These delays include waits for:

- Out of Hospital Services
- Suitable Accommodation
- Guardianship
- National Disability Insurance Scheme (NDIS)

- Aged Care Assessment Teams (ACAT)
- Residential Aged Care Facilities (RACF)
- Respite service
- Community Service
- Home modification
- Discharge Equipment
- Family / Carer to pick up the Patient
- Inter-Hospital or Inter-ward Transfers and Transport
- Inter Hospital transfer to Tertiary/specialist hospital for acute services
- Return to sender post specialist care
- Waiting for rehabilitation bed
- Waiting for respite bed
- Palliative Care Services
- Community Treatment Orders

The free-text sections in the 'waiting for what' entry can be used to document delayed transfer times e.g. when a bed is ready, or when home modifications are due to be completed.

Facilities and Health Districts must have robust processes in place to open, manage, escalate 'waiting for what' delays and review data trends.

If a patient's condition changes or deteriorates whilst they are waiting for a service, then the estimated date of discharge will need to be revised and updated in the patient flow portal to reflect their new estimated date of discharge.

4.6. Good to Go

The Good to Go (G2G) is used in either the patient flow portal, electronic patient journey board or bed board list to show that a confirmed patient is ready for discharge from the hospital.

Discharge includes transfers to other hospitals and care facilities. A good to go must *not be* used to flag patient ready for transfer within the same hospital (IWTs).

Districts and hospital patient flow teams can see confirmed and potential good to go in the patient flow portal bed board and allocations module to make decisions about capacity and demand planning.

Good to go must be used to flag patient discharges 24/7, 7 days a week, and is the responsibility of the treating Nurse in the following scenarios:

- discharge confirmed - **select G2G 'Yes'** and the likely discharge time.
- discharge is a potential- **select G2G 'Query'** where a final review, test or action is needed before confirmation.

- discharge delayed - **select G2G 'No'** for patients with an estimated day of discharge is delayed (e.g. Transfer W4W or Out of Hospital W4W's).
- patient deemed unsuitable for discharge - - **select G2G 'No'** e.g.
    - previously discharge confirmed update G2G ‘Yes’ to ‘No’
    - previously a potential for discharge update G2G ‘Query’ to ‘No’

Good to go entries on patients who have not been discharged will be cleared at midnight each day.

5. REFERRALS AND LIAISON

5.1. Referring to service providers

Service providers are to be involved in planning for the patient’s transfer from the acute setting. Liaison will need to occur with all appropriate providers including the patient’s general practitioner and any additional health providers the patient currently receives services from.

The needs of the patient’s children and family members must also be considered. All family members’ needs are identified and planned for with appropriate referrals made to care providers to family/dependents (as needed).

Once a patient’s requirements are identified, discussions with the appropriate providers *must occur* using the estimated date of discharge as the start date.

Discussions with providers must occur early to provide enough time to make the appropriate arrangements.

Where the patient’s service provider is located in an Aboriginal Controlled Community Health Care Service (ACCHS) or a general practitioner clinic where the patient may not see the same provider on each occasion, the organisation must be asked to nominate an alternate contact to ensure that transfer /discharge care arrangements are managed appropriately.

During the acute episode of care, it is important to identify what services the patient will require upon discharge. *Each facility is required to develop referral structures to enable staff to easily contact the relevant service providers.*

Multidisciplinary team members are to undertake assessments early in the admission to determine the services required upon discharge. Referral details must be recorded in one place in the patient’s medical record, and on any relevant individual referrals (e.g. general practitioner and community health) and the referral status flagged on your ward’s electronic patient journey board.

It may not be possible to complete a patient assessment in hospital prior to the transfer of care. The multidisciplinary team must look for opportunities for early discharge where acute, rehabilitation and subacute care can continue to be provided in the community.

If a need for services has been identified, a referral to the appropriate community service provider or general practitioner must be made. Follow-up by the organisation with the patient will then take place on their return to the community. This follow up may include the need for a more complete assessment in the home environment.

6. TRANSFERRING HOME

6.1. Discharge checklist

Staff must use their locally developed discharge checklist to meet the needs of patients before leaving the hospital. The nurse unit manager / midwifery unit manager is responsible for ensuring that these details are checked and completed by the treating nurse/ midwife and agreed to by the patient and / or carer before leaving the hospital.

The Discharge Checklist must cover the following information:

- Estimated Date of Discharge
- Destination of Transfer
- Notification/Transport Booked
- Personal Items Returned
- Referral Services Booked
- Care Plan
- Assistive Technology (equipment)
- Patient Educational Resources

Discharge summary provided to patient that includes medication information, community and general practitioner referral information, follow up appointments and patient educational resources. This must be provided in plain language and explained to the patient.

Staff are strongly encouraged to use an electronic checklist if available. Each individual Health Service, Hospital and Clinical Unit are to build on these fundamentals in the checklist to address specific local circumstances.

Shared care roles and responsibilities are to be clearly defined for the various services providers involved in the patient's care. Joint care planning with Community Managed Organisations, National Disability Insurance Scheme (NDIS) and private service providers must be undertaken.

NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045). Provides an example Transfer of Care / Discharge Checklist for those being discharged from Mental Health Inpatient Units.

6.2. Discharge medications

Patients with an identified medication risk as per the check list or advice from the multidisciplinary team are to be prioritised for the pharmacist's review over non-urgent cases.

Each Pharmacy department will need to establish a system to effectively prioritise patients to facilitate safe discharge and meeting the estimated date of discharge.

Patient transport needs are to be considered in the discharge planning processes. This is particularly important in the case of regional or remote patients as some patients may be eligible for subsidies for the cost of long-distance travel.

6.3. Patient transport

The Patient Transport Service (PTS) manages non-emergency patient transport bookings through the patient flow portal. Bookings on the day of Inter Hospital Transfer or day of discharge are only to be made in exceptional circumstances.

Early booking for the next available patient transport service ambulance will prevent patients waiting long periods for the transport to arrive by improving resource management and ensuring appropriate transport is available for patients when required.

7. IMPLEMENTATION

7.1. Health Service Chief Executives are responsible for

Establishing mechanisms to ensure that the essential stages of care coordination are applied in each facility and are sustained as part of the normal care coordination and discharge planning.

7.2. Patient flow systems framework

The Patient Flow Systems Framework was developed through state-wide collaboration that used Redesign Methodology to identify elements that contribute to good patient flow.

The seven key elements, Quality, Standardised Practice, Care Coordination, Demand and Capacity Planning, Variation Management, Demand Escalation and Governance have been developed to enable a system wide approach to identify and resolve delays within the current system to create capacity. Care Coordination has been identified as one of the seven key elements in the patient flow systems framework.

8. FURTHER EDUCATION

The PFP Care Coordination webpage includes advice and direction on how to improve Care Coordination. This includes definition of care coordination, links to policy directives, PDF Care Coordination factsheet for printout and general overview of the importance of care coordination to patient outcomes.

Completing a specific training module is no longer a mandatory requirement however completing the current My-Health Learning module titled *Care Coordination (46356692)* would meet these requirements and will continue to be available.

A link to Care Coordination training resource in My Health Learning will also be available on this page. My-Health Learning module online titled *Care Coordination (46356692)* will be available to support staff with clinical practice requirements.

Please liaise with your line Manager, Clinical Nurse Educator, Midwife or Patient Flow Manager for further education and support.

A number of education materials and resources are also available on the NSW Health PFP to support clinical staff in meeting their obligations under this Policy Directive.

9. REFERENCES

Online resources are available via:

- My-Health Learning module titled Care Coordination (46356692)
- Patient Flow Portal website
- Clinical Care Coordination Rounds: Presentation by A/Prof Golo Ahlenstiel
- Behavioural Insights Unit V1.0 Newsletter April 2016; Ideal Patient Journey
- NHS England » Principle 1: Plan for discharge from the start to setting expected dates of discharge and clinical criteria for discharge
- The NSW Family Focused Recovery Framework 2020-2025: A framework for NSW Health services provides a guide for services to improve support to families where a parent lives with mental health issues and has dependent children through implementing a family focused approach.

10. GLOSSARY OF TERMS

Listed in alphabetical order and in context to this policy document	
Discharge	The relinquishing of patient care in whole or part by a health care provider or organisation.
Discharging clinician	The medical officer, nurse practitioner, midwife or suitably authorised healthcare employee responsible for discharging the patient.
Discharge documentation	Refers to both the discharge summary and the patient directed discharge letter.
Discharge referral	A referral occurring in the context of discharge, see 'referral'.
Discharge report	An additional document to the discharge summary usually completed by Allied Health professionals to provide greater detail on discharge.
Discharge summary	A collection of information about events during care by a provider or organisation as outlined in section 2.
Electronic Patient Journey Board (EPJB)	The Electronic Patient Journey Board (EPJB) is designed to help NSW Health staff to coordinate patient care as part of the Patient Flow Systems Framework. The EPJB is customised for each ward based on their specific needs and provides information about every patient relating to their care coordination and patient flow management.
Estimated date of Discharge (EDD)	The estimated date of discharge (EDD) predicts the likely date that a patient will be clinically ready to leave the hospital, defined as all members of the treating MDT agree when active care is completed and the patient will be safe to transition to their next phase of care or discharge home.

Good to Go (G2G)	Good to Go (G2G) is used in either the PFP EPJB or Bed Board list to show a confirmed patient discharge today from the hospital.
Inter Hospital Transfer (IHT)	An inter hospital transfer (IHT) of a patient from a sending facility to an accepting facility under the care of an accepting Doctor.
Inter Ward Transfer (IWT)	An inter ward transfer (IWT) occurs when a patient is transferred from one ward to another ward within the same facility.
Multidisciplinary team (MDT)	Involves a range of health professionals from different disciplines or organisations working together to deliver comprehensive patient care.
Patient directed discharge letter	A personalised letter or documentation for the patient written in plain English, summarising their hospital admission.
Patient Flow Portal (PFP)	The Patient Flow Portal (PFP) provides access to a suite of modules used by NSW Health Hospital Staff and administration support and executive teams to monitor and manage patient flow.
Presenting problem	Most relevant symptom/s, disorder/s, or concern/s expressed by the patient when seeking care.
Primary care provider	Discharge summary recipient including the patient's nominated General Practitioner (GP), Residential Aged Care Facility (RACF), Aboriginal Medical Service (AMS), Justice Health, agency or community-based clinician or other community-based service provider.
Principal diagnosis	The diagnosis established after study to be chiefly responsible for occasioning the patient's care at the facility.
Residential Aged Care Facility (RACF)	This is the term used to describe a residential aged care facility (RACF) or aged care home operated by an approved provider.
Referral	The communication, with the intention of initiating care transfer, from the provider making the referral to the receiver. Referral can take several forms, most notably: a) Request for management of a problem or provision of a service, e.g. a request for an investigation, intervention or treatment. b) Notification of a problem with hope, expectation, or imposition of its management, e.g. a discharge summary in a setting which transitions care responsibility on the recipient.
Waiting For What (W4W)	Waiting for What (W4W) is used in the PFP to record delays to care or discharge so that they can be fixed and analysed to improve patient care.

11. APPENDIX LIST

1. Implementation / Compliance checklist

11.1. Implementation checklist and compliance self-assessment

Local Health District / Facility:	

Assessed by:	Date of Assessment:		
Development and use of an admitted patient 'Discharge Risk Assessment' Tool'. All departments (including the emergency department) must have guidelines in place for care of discharged patients at risk especially between the hours of 2200hrs and 0800hrs. Where guidelines and checklists already exist (including in paediatrics) it should be confirmed that they comply with the requirements of this policy.	❑	❑	❑
	Notes:		
Structured (set time, duration and frequency) multidisciplinary team reviews (Electronic Patient Journey Board MDT rapid huddle) in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.	❑	❑	❑
	Notes:		
An Estimated Date of Discharge (EDD) is allocated, documented and displayed near the bedside and on the Patient Flow Portal (PFP) electronic patient management tools (EPJB), and reviewed for each patient. The patient and carer must be kept informed of the EDD during their stay.	❑	❑	❑
	Notes:		
Ensuring the Discharge Checklist or equivalent is completed for all relevant admitted patients before they return to the community.	❑	❑	❑
	Notes:		
All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer and appropriate service prior to transfer of care, in plain language.	❑	❑	❑
	Notes:		