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Department of Human Services

**Effective Discharge Patient
Record Audit - Final report**

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1 Executive summary

1.1 Introduction

The Department of Human Services (DHS) engaged KPMG Consulting to:

- review medical records to collect data on current discharge performance of hospitals, some for information only and some to rank discharge performance in hospitals;
- provide rankings of the discharge performance of 139 sites in the public health system based on an audit of a sample of 12,205 patient records relating to separations during the period 1 July to 31 December 1998;
- analyse data collected during the audit; and
- provide advice on the indicators, which could be used in the future to allocate discharge performance bonuses.

Note that, for the purposes of this report, all references to “hospitals” include public hospitals, Aged Care funded sub-acute units in public hospitals (aged care services), and extended care services and Multi-Purpose Services (MPS).

1.2 Discharge performance findings

Whilst the majority of hospitals have developed a range of processes and structures to facilitate effective discharge planning and processes, there is considerable scope for improvement. This is evident from the views of hospital administrators regarding weaknesses of their current discharge systems and procedures and is corroborated by the audit findings.

The patient record audit assessed that 16% of facilities audited had high compliance with the discharge standard developed for this audit. A further 26% were assessed as achieving medium compliance and the remaining 58% were assessed with low compliance.

The major contributing factors to this low level of compliance of documentation with the standard are the insufficient evidence of:

- estimation and review of discharge date (18% of records reviewed) and discharge destination (19%). In most hospitals, the performance score was around one quarter of the maximum possible. The better performers were the aged and extended care services and the rehabilitation centres;
- assessment and review of post-discharge needs. In most hospitals, the score was around one-half of the maximum possible. The better performers were the aged care services, the rehabilitation centres and large rural hospitals.

The areas where the hospitals scored best, and where the performance was similar across hospital categories, were:

- providing medical review of the patient prior to discharge (81% of records);

- providing written authorisation of discharge (77%); and
- maintaining discharge documentation that is accessible (89%) and comprehensive (30% fully and 53% partly).

These results should be interpreted in the context that the audit period preceded a period when substantial activity is being undertaken to improve discharge performance. We would expect therefore to see improvement in subsequent audits. On the other hand, a number of areas of discharge were excluded from the calculation of performance ratings, partly because of the view that these areas were less developed and are unlikely to be documented. These included the use of risk screening tools (present in 41% of reviewed records), follow-up with external service providers to ensure implementation of the discharge plan (40% of records where post discharge arrangements were initiated), follow-up with patients and carers (5%) and evaluation of the effectiveness of the discharge plan (very few records).

In general, audit results show:

- aged care services and rehabilitation centres had a higher level of compliance than acute and MPS facilities;
- the discharge process for patients with intensive post discharge needs is better documented than for other patients;
- hospitals with a higher proportion of intensive post discharge needs patients have higher documentation compliance;
- hospital size is inversely proportional to documentation compliance, with smaller hospitals performing better;
- discharge documentation is slightly better for planned admissions than others;
- there is no significant difference between the documented discharge performance in the audit of:
 - metropolitan and rural hospitals. There are varying levels of compliance in metropolitan and rural areas;
 - hospitals with Post Acute Care projects and those without;
 - hospitals with aged care wards and other hospitals, indicating that the better practice of aged care wards is not disseminated throughout the hospital;
 - hospitals with or without a dedicated discharge coordinator, possibly indicating that this role has not resulted in evidence of superior discharge related documentation in patient records.

1.3 Future actions to improve and measure discharge performance

The capacity of this project to inform the Department and hospitals of the effectiveness of patient discharge is limited by:

- the short time-frame in which the audit tool was developed. It has not been validated, although the criteria incorporated into the tool are consistent with the literature regarding 'best practice' discharge systems. The audit tool will require further development following the experience of this audit;
- its analysis of patient records related to admissions before the Effective Discharge Strategy was initiated. This means that the audit results will not reflect any improvements flowing directly from the Effective Discharge Strategy, but will provide a baseline from which it could be expected that agencies will show substantial improvement in future; and
- the audit has relied upon evidence observed in the patient record. To ensure inter-rater reliability and consistency, auditors operated under the general rule that if it was not documented it was not done. However, it is acknowledged that patient records can only provide information on how the discharge process is documented and does not necessarily indicate that the process documented occurred or that it was 'effective' in achieving the desired patient outcomes. Nevertheless, it may be reasonable to assume that there is a relationship between the quality of documented evidence in the patient records and the quality of the process being documented. In the short term, therefore, documented evidence is considered sufficient for the purpose of providing base-line information on the discharge process. Future work by the Department is expected to include the development of performance indicators and methodologies that will yield more direct measures of patient discharge.

However, the audit has identified considerable scope for improvement in discharge practice. It is recommended that hospitals give consideration to the following actions, which may improve documented discharge performance:

- exploring the potential for using a risk screening tool to focus discharge planning activity;
- implementation of formal on-going training of medical and other clinical staff to ensure their understanding of discharge planning policies and requirements;
- enhanced accountability for and resourcing of discharge planning, including establishing formal mechanisms to monitor, plan and improve discharge processes (for example, Discharge coordinator and discharge committee);
- development of formal guidelines for staff to ensure follow-up of actions recommended in discharge assessments;
- formalisation of arrangements with a range of external service providers that are integral to effective discharge planning and the development of internal databases of provider options that link patient needs with provider services and contain information about eligibility criteria, assessment documentation and service availability;

- provision of adequate systems to support staff in discharge processes, including for example on-line access for appointments with internal and external service providers and more comprehensive, and perhaps computerised, medical record forms; and
- on-going review by hospitals of their own performance against their own policies and protocols. This should include improved follow-up with external service providers and patients and carers to facilitate improved outcomes for individual patients and to inform discharge processes generally.

Given the wide variation in compliance with the criteria assessed in this audit and that hospitals openly acknowledge that there is room for development, it is timely that the Department undertakes a review of best practice policies, procedures and systems, including a review of the benefits of systems such as those mentioned above, as part of the Effective Discharge Strategy.

To measure performance into the future, performance indicators of effective discharge should be developed. The Department is initiating a project to establish performance indicators for discharge. The process will include broad consultation and field testing. Given that this project is unlikely to be finalised within a year, it may be necessary to repeat a process similar to the current audit to measure progress and provide a basis for distribution of incentive funds for 1999/2000. In the longer term, the measurement of any performance indicators is likely to require some form of independent audit process. Given the experience with this audit, we recommend a rolling cycle of compliance audits to rank the discharge performance of hospitals. Specifically, those hospitals ranked as highly compliant might be re-audited every three years, those with a moderate ranking every two years and those with a low compliance - annually.

The audit tool developed for this assignment could be further refined in the light of this audit's results. A small expert group could test the validity of the aspects of discharge identified in the tool and the weightings and scores attached to rankings. The refined tool, containing only questions, which are auditable, could then be used to measure compliance with discharge standards as a proxy for discharge performance.

There are a number of other measures of effectiveness of discharge performance, which did not form part of this audit, but which could be analysed in conjunction with its findings. These include analyses comparing health outcomes for comparable hospitals and DRGs using indicators such as length of stay, rates of unplanned readmission and benchmarking of patient, carer and community based provider satisfaction.

2 Introduction

2.1 The project

Effective discharge is a process which involves assessing patient needs and developing and implementing a plan for providing information and services to patients following an admitted patient episode of care to:

- help patients make a smooth, timely and safe transition from hospital to home or another care facility;
- meet recuperative needs associated with the acute health episode of care; and
- assist patients to independently, or with appropriate community supports, attend to their physiological, psychological, social and cultural needs.

The Department of Human Services engaged KPMG Consulting to undertake an audit of patient records to assess the effectiveness of patient discharge practices in Victoria. The purpose of the audit was to identify recorded evidence of discharge activities at all sites responsible for the provision of acute health services in Victoria, including public hospitals and Aged Care funded sub-acute units in public hospitals (aged care services), extended care services, and Multi-Purpose Services (MPS). Note that, for the purposes of this report, all references to "hospitals" include public hospitals, Aged Care funded sub-acute units in public hospitals (aged care services), extended care services and Multi-Purpose Services (MPS).

This audit will inform future decision making and planning by the Acute Health and Aged Community and Mental Health Divisions of the Department by:

- providing an indication of the existing processes and level of documentation used for discharge processes by agencies and an assessment of the capacity of patient records to provide important information about discharge procedures. The audit also provides information about the ease with which this information can be retrieved;
- informing future performance indicator development upon which performance bonuses will be paid to agencies; and
- providing the basis upon which retrospective bonuses can be calculated and paid for 1998/99 to the best performing agencies.

2.2 The process

The process for the patient record audit consisted of three components:

- development of the methodology for assessing discharge performance of agencies, as set out in Section 3. This required an examination of current policies, procedures and documentation relating to discharge processes to assist development of the audit tool. The audit questions were the subject of comment from agencies prior to finalisation;
- assessment of each facility (including each campus of multi-campus agencies) against the agreed set of audit questions over the period from 19 April to 12 May 1999. The total

sample of 12,205 patient records was drawn from the 139 public hospital sites, aged care, extended care services and MPS in Victoria. The sample of patient records excluded same day and same day plus one separations, unqualified neonates, deaths, and separations against medical advice;

- analysis of documentation and data, and providing a report of the results to the Department of Human Services, to:
 - inform on existing processes and documentation used for discharge purposes;
 - provide an assessment of the relative performance of hospitals, upon which financial bonuses will be distributed; and
 - inform the development of performance indicators for effective discharge.

The audit assessed documented evidence of discharge policies, practices and activities relating to the transition from one care setting (acute, aged care, extended care or MPS) to another (the patient's home or another care facility). Hospital documentation and patient records were examined for the following elements:

- *Assessment of the patient's post-discharge needs* in relation to their medical and clinical status, functional status, home environment and social support network, and cultural and linguistic needs.
- *Post-discharge arrangements initiated.* For example, notification to GP and other community providers of patient's admission and anticipated discharge date and time, application for aids and equipment, referral arranged to RDNS, etc.
- *Communication with, and information to, providers in the community.* For example, discharge summary to GP, referral information to RDNS and other community providers, information provided to carer/family.

3 Audit process

3.1 The approach

The audit was conducted within a timeframe of 16 weeks from early March to mid June 1999. The approach involved four stages:

- project design;
- development of audit methodology and tools;
- hospital data collection; and
- analysis and reporting.

Each of these stages is discussed in detail in the following sections.

3.2 Project design

The audit process was developed in consultation with the Department and its Patient Record Audit Steering Committee and involved:

- clarification of audit aims, timelines and activities;
- consideration of ethical issues and the arrangement of an exemption from Section 141 (3)(h) of the Health Services Act, which prohibits disclosure of information, to enable the release of patient records to auditors for assessment;
- review of documentation relating to the Effective Discharge Strategy and existing data collections; in particular, retrieval of relevant data from the VIMD for sample design;
- identification of key contacts for each hospital; and
- request for, and receipt of, hospital discharge documentation.

3.3 Development of audit methodology and tools

The project required an agreed methodology to enable the ranking of hospitals for the purposes of performance payments, as well as for future development of performance indicators. This required the development of appropriate audit tools, which captured the relevant information with respect to both the policies and procedures in place and the audit items.

3.3.1 Audit tools

Given that this audit is the first Statewide study that has been conducted to assess the effectiveness of patient discharge processes, the audit tools have been designed to gather a wide range of information to inform the Department and hospitals of the nature of discharge processes across the system and to provide the Department with information to assist in the

future development of robust and realistic performance indicators. The data used to assist in the determination of performance ratings was derived from the evidence collected in the patient record audit, only some of which was auditable (the remainder being for information only). The audit issues and tools are summarised below and detailed in Appendix 1.

Table 3.1: Audit issues and data sources

Audit issue	Data source				
	<i>VIMD</i>	<i>Documen- tation review</i>	<i>Site inter- view</i>	<i>Patient record audit</i>	<i>Stake- holder consult- ations</i>
1. What are the policies, protocols and processes in place in hospitals? Description only.		X	X		X
2. How is the hospital's discharge infrastructure organised to ensure effective patient discharge? Description only.		X	X		X
3. Does the patient record provide evidence of discharge planning and implementation?	X			X	

There are three aspects of effective discharge:

- the policies, protocols and processes that the hospital has in place to guide discharge. The audit tool gathered and synthesised information from the documentation provided by hospitals and advice given at interview regarding:
 - availability, level of endorsement and responsibility for development and review of policies, protocols and processes;
 - procedures for measurement and benchmarking of performance;
 - obstacles, strengths and deficiencies of the current discharge system;
- the discharge infrastructure, which determines where and how discharge processes are undertaken in the hospital. As above, the audit tool gathered and synthesised information from the documentation provided by the hospitals and advice given at interview regarding:
 - organisational arrangements in the hospital for discharge (for example, the level of centralisation of responsibility for discharge and the tools used to facilitate discharge such as care maps and discharge plans);
 - means of maintaining the relationship with the external service providers;
 - facilitation of the process of discharge through information provision and training;
 - role of internal systems (such as information systems and medical records forms and processes); and

- implementation of discharge for individual patients including consideration of the issues set out in the following table and detailed in Appendix 1. Some of these issues were “auditable” and formed part of the audit measurement of hospitals’ performance, while others provided important information to feed back to participating facilities and to inform the future development of performance indicators. Note that the patient record audit relies on documentary evidence in the patient record. It therefore has an underlying assumption that what is not recorded is not done. The auditable issues were also given a weighting of high, medium or low importance in current discharge practice, as determined by the Patient Record Audit Steering Committee

The draft audit tools were provided to each hospital for comment, in the form of a report and at a forum. Following the receipt of comments, the Audit Steering Committee agreed to the final version of the audit process and tool presented in this report.

Table 3.2: Patient record audit questions

<i>A</i>	<i>Patient data</i>		
A1- A15	Patient characteristics from VIMD		
<i>B</i>	<i>Assessment</i>	<i>Auditable?</i>	<i>Weighting?</i>
B1	Was an estimated date of discharge identified?	Yes	High importance
B2	If yes, when was this date identified?	No	na
B3	If yes, was the estimated date of discharge reviewed?	Yes	Medium importance
B4	If yes, when did the review occur?	No	na
B5	If yes, who was involved in this review?	No	na
B6	Was an expected discharge destination identified at date of admission?	Yes	Medium importance
B7	If yes, what was the expected discharge destination?	No	na
B8	If yes, was the expected discharge destination reviewed?	No	na
B9	If yes, when did the review occur?	No	na
B10	Was the patient screened for risk of failing to adequately recuperate following discharge?	No	na
B11	Did this risk screening include specified risk factors?	No	na
B12	Was an assessment of the patient’s discharge needs made?	Yes	High importance
B13	If yes, when was the first assessment made?	Yes	High importance
B14	If yes, did this first assessment include evidence of assessment of a range of factors?	Yes	High importance
B15	If yes, who was the first assessment undertaken by?	No	na
B16	If yes, where was the evidence of the first assessment found?	No	na
B17	Were there subsequent reassessments of the discharge needs of the patient?	Yes	Low importance
B18	If yes, how often?	No	na
B19	If yes, when was the last assessment made	Yes	Low importance
B20	If yes, did this last assessment include evidence of assessment of a range of factors?	Yes	Low importance
B21	If yes, who was the last assessment undertaken by?	No	na
B22	If yes, where was the evidence of the last assessment found?	No	na

Table 3.2: Patient record audit questions (cont.)

<i>C</i>	<i>Discharge arrangements initiated</i>		
C1	Was the patient reviewed by a medical officer prior to discharge?	Yes	High importance
C2	If yes, when was this review conducted?	Yes	Medium importance
C3	If yes, who was the review conducted by?	No	na
C4	Who was involved in the decision to discharge?	No	na
C5	Was there written authorisation in the record of the decision to discharge?	Yes	High importance
C6	Was a person or team identified to manage the discharge process?	No	na
C7	If yes, who was identified?	No	na
C8	Were post-discharge arrangements initiated?	Yes	High importance
C9	If yes, what did these include?	Yes	High importance
C10	If yes, when were the specified actions taken?	Yes	High importance
C11	Was there involvement of the patient in preparing for discharge?	Yes	High importance
C12	If yes, what did it include?	No	na
C13	Was there involvement of the carer/family in preparing for discharge?	Yes	Medium importance
C14	If yes, what did it include?	No	na
<i>D</i>	<i>Communication with, and information to, post-discharge providers</i>		
D1	Were external service providers involved in consideration of options and decision making for discharge?	Yes	High importance
D2	If yes, who was involved?	Yes	High importance
D3	Was information provided to initiate post-discharge care?	Yes	High importance
D4	If yes, did the information provided give adequate guidance on post-discharge requirements?	No	na
D5	If yes, when was the information provided?	Yes	High importance
D6	Was there follow-up to ensure implementation of the discharge plan?	No	na
D7	If yes, when did this follow-up occur?	No	na
D8	Was there follow-up with the patient and/or carer/family to ensure implementation of the discharge plan?	No	na
D9	If yes, when did this follow-up occur?	No	na
D10	Was there evaluation of the effectiveness of the discharge plan and its implementation?	No	na
D11	If yes, did evaluation include feedback from key stakeholders?	No	na
<i>E</i>	<i>Documentation</i>		
E1	Was the documentation relating to discharge readily accessible?	Yes	Medium importance
E2	Was the documentation comprehensive (ie., containing all information expected, given hospital's policies and documentation requirements)?	Yes	Medium importance
E3	Where was the discharge documentation contained?	No	na

3.3.2 Data sources

There were five data sources accessed in the project. These are set out below.

3.3.2.1 VIMD and sample of patient records

The Victorian Inpatient Minimum Database (VIMD) was used to:

- analyse patient characteristics, including their demography, AN-DRG and length of stay. The VIMD was accessed for all patient separations over the period 1 July 1998 to 31 December 1998, with the exception of:
 - same day and one day plus overnight separations;
 - unqualified neonate separations;
 - acute psychiatric separations;
 - deaths; and
 - patients who leave against medical advice;
- select a sample of separations for review of patient records. A sample of 13,868 patient records was required, with random samples being drawn separately for two groups:
 - patients who have intensive post-discharge needs and are likely to form part of the patient population in most hospitals; and
 - the remainder.

If we were unconstrained by data availability, intensity of post-discharge needs could be categorised for example as follows:

- *high intensity* – the process of discharge required a multidisciplinary approach to the process of discharge and resulted in at least three of the following assessments - clinical, social, functional, home, carer involvement in the process of discharge and referrals to agencies providing care in the home; and
- *low intensity* – the process of discharge required a specialist clinical assessment on or prior to day of discharge and post discharge instructions for care by general practitioner.

However, we are limited to proxy definitions that can be measured through the VIMD and which also are represented at the majority of sites under audit. The intensive post-discharge needs group was defined to be patients with the following common characteristics which may lead to intensive post-discharge needs, and could be identified using the VIMD:

- aged 80 years or more;
- funded through aged care;
- being treated for the following:

- cerebrovascular accident (stroke)
- diabetes mellitus
- fractured neck of femur
- neoplastic disease (cancer)
- chronic obstructive airways disease
- acute myocardial infarction
- congestive cardiac failure
- asthma
- dementia.

For the purposes of sample size estimation, the statistical task to be performed was essentially the estimation of the proportion of patients for whom discharge records contain documented evidence of particular discharge activities having been carried out. A stratified sampling procedure was used where the strata were defined by hospital type and patient type (those with intensive post discharge needs and others). This estimation was carried out for the two complementary patient populations within each nominated hospital site. In calculating sample size requirements for estimation of proportions using simple random sampling, without replacement, from a given (finite) population, there are three pieces of information required:

- the size of the population of interest;
- the proportion with which the characteristic of interest occurs within the population; and
- the maximum standard deviation desired for the resulting estimate.

The first of these was known, the second was unknown and the third was selected on the basis of accuracy requirements.

The total sample of 13,868 patient records, identified by the UR number of the patient, was drawn from the VIMD for 1/7/98 to 31/12/98 as follows:

- two random samples - intensive post discharge needs patients (as defined above) and the remainder – were drawn randomly from the VIMD using the random sample generator of the SPSS statistics computer program, with samples stratified in proportion to the separations recorded on the VIMD for each site;
- sampling varied according to hospital site size, on the basis that we can expect the smaller sites (with their more limited range of services and fewer numbers of staff and patients) to exhibit greater consistency in discharge practice:
 - Category C, D, E, G hospitals and aged and extended care services and MPS were sampled according to an expectation that the proportion of patients for whom discharge records contain documented evidence of particular discharge

activities being carried out is 80% and that the standard deviation around this estimate is 8%; and

- Category A and B hospitals were sampled according to an expectation that the proportion of patients for whom discharge records contain documented evidence of particular discharge activities being carried out is 60% and that the standard deviation around this estimate is 4%.

The sampling approach results in a range of records selected for audit from 17 (Monash aged care ward) to 291 (Royal Melbourne Hospital), as set out in Appendix 2.

3.3.2.2 Documentation review

The Department provided the consultants with documentation relating to the Effective Discharge Strategy and this was reviewed along with literature on effective discharge to develop the audit process and tool.

Hospitals were requested to provide the consultants with documentation relating to their own discharge policies, protocols and processes in use during the period of the audit (1 July to 31 December 1998) and currently. If no documentation existed, hospitals were requested to provide a description of the policies, protocols and processes in place during the audit period. This documentation was reviewed to assist the conduct of the audit and to provide advice to the Department on the nature of discharge policies, protocols and processes within hospitals.

3.3.2.3 Site interview

At each site, an interview was conducted with the hospital's nominated contact person and any other staff deemed appropriate by the hospital. The interview enabled the auditor to clarify any issues from the documentation provided previously and to gather extra documentation and information regarding the nature of patient records in the hospital.

3.3.2.4 Patient record audit

The patient record audit examined a specified number of patient records at each site (selection of the sample is discussed above in Section 3.3.2.1) using a computer audit tool. The required UR numbers and relevant separation date were provided by facsimile to hospitals about one week prior to the intended site visit. Hospitals were requested to make all the specified records available for review in a quiet and secure office space, and to tag those parts of the record relating to the episode being audited.

Twenty-five clinically trained and experienced site auditors, some with experience in the conduct of similar audits, were selected through Healthstra Nursing Services (three in a supervisory capacity). The auditors received two half days training on 13 and 16 April, prior to the commencement of the site audits. The auditor reviewed each patient record according to the audit tool set out in Appendix 1.

Maximum consistency in interpretation and minimum bias between auditors was assured through:

- developing an audit tool which is very specific with limitations on the degree of subjectivity involved;
- piloting the tool by using it to assess a small sample of patient records;
- engaging very experienced auditors with multiple qualifications and experience at management level in hospitals, ensuring that auditors have a high level of understanding of the audit objectives and requirements;
- providing quality control by clinically trained senior staff of Healthstra (in consultation with the KPMG team), and a Helpline for auditors to discuss any concerns regarding interpretation; and
- direct supervision through quality checks conducted for each auditor. The checks involved the attendance of a supervisor on site and the parallel audit and comparison of three (3) randomly selected records. Feedback was provided to the auditor to ensure consistency in interpretation and to reduce any bias. The checks were held at one site early in the involvement of each auditor (preferably in their first site visit, although this was not possible if a rural visit was first) and then randomly thereafter. Auditors were also encouraged to compare interpretations with their peers and to contact the supervisors with any queries.

3.3.2.5 Stakeholder consultations

Consultations with stakeholders occurred through:

- input from the Expert Advisory Group of the Effective Discharge Strategy, which comprises broad representation of the field, including the Department, acute health, aged care, consumers, local government, general practice and other community based services;
- input from the Patient Record Audit Steering Committee, which includes representatives of the Department, hospitals and aged care services;
- a limited number of consultations with facilities to assist in the development and testing of the audit tools;
- provision of a report setting out the audit process and tools to facilities subject to audit for their comment directly to the consultant or at a forum held for all facilities;
- the forum, which provided an opportunity to inform hospitals of the nature and process of the patient record audit, and to receive their comments.

3.4 Hospital data collection

Following the finalisation of the audit process and tools, the consultants undertook an analysis of the VIMD, the site auditors analysed the documentation provided by each hospital and hospitals were contacted to arrange a site visit to occur between 19 April and 12 May. The site visit included:

- a site interview on arrival;
- the audit of the pre-advised sample of patient records against the audit tool in Appendix 1; and
- where required, a final interview to clarify any issues outstanding from the patient record audit.

The site auditors undertook the audits of the sample of patient records directly into laptop PCs loaded with a specifically developed computer program in a Microsoft Access Database. This ensured consistency in the data collected and rapid analysis of the results of the audits.

Inter-auditor comparability has been assessed as good. The results of the direct supervision of auditors (as described in Section 3.3.2.4) are set out in Table 3.3:

Table 3.3: Assessment of auditor comparability

Number of auditors	22
Number of records supervised	68
Number with stated level of agreement between auditor and supervisor in application of the audit tool	Total: 42 Most: 26 Some: 0 Little: 0
Comment	Level of agreement was generally high, with minor differences in assessments made.

The number of sites and records to be audited over the 3 ½ week audit period required tight scheduling, long hours for some auditors and a high level of cooperation from the hospitals. In general this cooperation was provided, although in some cases hospitals were poorly prepared in the following ways:

- documentation had not been provided to the auditor in advance;
- records had not been selected out with the correct episode tagged;
- an appropriate, quiet space for the auditor was not provided or the space was only available during business hours.

As enumerated in Appendix 2, in not all cases was it possible to audit the full number of records specified in the sample. Twelve percent of records were excluded from the audit as a result. Some records were in use and so could not be accessed by the auditors. Given the tight timeframe for the conduct of the audit, a decision was made not to seek substitutes on site for those records, which were not available. In a small number of hospitals, the poor quality of the documentation made it difficult for the auditor to audit the full sample of records in the time scheduled for the audit. As far as possible either extra time was allocated or additional auditors assigned to ensure that as many records as possible were completed. However, given the tight schedule, it was not always possible to complete the audit of all the patient records provided by the hospital. Whilst the final sample size for some hospitals differed from the optimum sample size required to meet all of the parameters set at the beginning of the audit, overall the sample sizes were adequate to conduct both program-wide and aggregated analyses.

The following table shows the high level of comparability between the characteristics of the audited sample and the VIMD data. The high proportion of intensive post discharge needs patients in the audited sample is intentional, resulting from the separate sampling of this group of patients. The DRG composition of the sample is also affected by this, with those DRGs designated as representing intensive post discharge needs comprising a higher proportion of the audited sample than in the VIMD.

Table 3.4: Comparison between the audited sample and the VIMD, % of population

Characteristic	Audit population	VIMD population
Gender		
Male	41	42
Female	59	58
Intensity of post discharge needs		
Intensive	46	24
Non-intensive	54	76
Admission source		
Maternity	10	14
Emergency admission	52	51
Planned admission	34	32
Other	4	3
Top 5 DRGs in sample		
674 - Vaginal delivery w/o complicating diagnosis	4.5	6.7
941 - Rehabilitation	4.1	3.7
177 - Chronic obstructive airways disease	4.1	2.5
252 - Heart failure and shock	3.4	2.0
170 - Respiratory infection/inflam age >54 w/o cc	1.9	1.6
Discharge destination		
Home without support arranged	74	77
Transfer to other acute facility	9	7
Other	17	16
Intention to readmit		
No plan to readmit	79	79
Plan to readmit	21	21

3.5 Analysis and reporting

3.5.1 Ranking hospital performance

The Department required an Audit Performance Assessment Report covering the audit performance scores and relative rankings for all facilities to be provided by 17 May 1999. Widely accepted standards for the provision of effective discharge, and a mechanism for ranking the performance of hospitals against each element of the discharge process, do not exist. However, there is a degree of consistency in the literature regarding what constitutes reasonable discharge practices and this was used as the basis for the audit tool. There is substantial variability between hospitals in their discharge processes and, in many cases, hospitals have only recently developed comprehensive protocols and documentation for discharge processes and any documentation that exists can be scattered across the patient record and is not quantitative in nature. The audit has also had to rely on the evidence observed in the patient record.

The project had to develop a mechanism for the ranking of hospital discharge performance that is appropriate and transparent. The mechanism involves:

- collection from patient records of auditable information about core discharge activities;
- allocation of performance points to this information. Data collected mostly comprised Yes/No responses and some of the items provided descriptive (eg involvement of different professions in the discharge process) rather than compliance (was a specified process undertaken) data. The resulting data are ordinal in nature and it was necessary to quantify these responses. Performance points were allocated for responses to the 23 auditable questions, as follows:
 - for the 13 Yes/No questions, 2 points for Yes and 0 points for No;
 - for the 10 questions with multiple responses, 2 points for high compliance, 1 point for medium compliance and 0 points for low compliance, where the level of compliance was assessed by the auditors;
- weighting of these points to reflect the most important aspects of effective discharge. As set out in Table 2, three groups were considered:
 - *High importance* – without which discharge outcomes are likely to be rendered ineffective – 14 questions given a weighting of 3 points each;
 - *Medium importance* – without which discharge outcomes could be compromised – 6 questions given a weighting of 2 points each; and
 - *Low importance* – add value to discharge process but, if not fulfilled, poses minimal risk to discharge outcomes – 3 questions given a weighting of 1 point each;
- calculation of a performance score for each patient record based on the sum of the performance points by the weighting for each question. Given the above allocation of performance points and weightings, the maximum score for each patient record is 114

points. This method of determining the performance score for each record effectively allocates the following level of importance to ten aspects of the discharge process:

Table 3.5: Ten aspects of discharge, audit questions and points

Aspects of discharge	Questions	Max. Points
1. Estimation and review of the date and destination of discharge	High importance: B1 Medium importance: B3, B6 Information only: B2, B4, B5, B7, B8, B9	14
2. Timely and appropriate assessment and review of discharge needs	High importance: B12, B13, B14 Low importance: B17, B19, B20 Information only: B10, B11, B15, B16, B18, B21, B22	24
3. Timely medical review prior to discharge	High importance: C1 Medium importance: C2 Information only: C3	10
4. Written authorisation in the record of the decision to discharge	High importance: C5 Information only: C4	6
5. Initiation of timely and appropriate post discharge arrangements	High importance: C8, C9, C10 Information only: C6, C7	18
6. Involvement of the patient and carer in preparing for discharge	High importance: C11 Medium importance: C13 Information only: C12, C14	10
7. Involvement of appropriate external service providers in consideration of options and decision making	High importance: D1, D2	12
8. Provision of timely information to initiate post-discharge care	High importance: D3, D5 Information only: D4	12
9. Follow up to ensure implementation and evaluation to ensure effectiveness of the discharge plan	Information only: D6, D7, D8, D9, D10, D11	0
10. Maintenance of accessible and comprehensive discharge information in the patient record	Medium importance: E1, E2 Information only: E3	8
Total		114

- aggregation of these performance scores (expressed as a proportion of the maximum possible number of performance points) for all records audited in the hospital. The score for each hospital is a weighted average derived from the average score for each sub-population (intensive post-discharge care needs and other), where the weight for each sub-population is derived from the sampling fraction for that population. A weighted average is required as a stratified sampling procedure was used to calculate the sample size for each population that resulted in a different sampling fraction for each sub-population;
- the weighted average score was then used to derive a three point performance rating for the hospital as a whole. Any finer distinction has the risk of providing the appearance of specious accuracy, which would be subject to challenge. The performance rating is expressed in the following terms:

- *high compliance*, which requires a weighted average score of 84 or more out of a maximum of 114 points or 73% of maximum score. This is equivalent (see note below) to a hospital having fully satisfied all of the 'high importance' criteria;
- *medium compliance*, which requires a weighted average score of between 66 and 83 inclusive (or a minimum of 58% of maximum score). This is equivalent (see note below) to a hospital having rated at least a moderate compliance with all of the 'high importance' criteria;
- *low compliance*, which requires a weighted average score of less than 66. This is equivalent (see note below) of a hospital not having complied with at least one of the 'high importance' criteria and not rating at all with any of the criteria of less importance.

These performance ratings can be interpreted as follows. A hospital may have been given a medium rating if it scored sufficient points for 'medium' or 'low' importance criteria to make up for any short fall in criteria deemed of 'high importance'. Similarly, a hospital may have been given a high rating if it scored sufficient points for 'medium' or 'low' importance criteria to make up for any short fall in criteria deemed of 'high importance'. A hospital that satisfied criteria of medium or low importance and with an overall rating of low compliance would have failed multiple 'high importance' criteria. In effect there are three ratings, separately calculated for each hospital: the hospital as a whole, the intensive post-discharge needs group and the other group; and

- ranking of the performance of the hospital compared to like hospitals. This ranking is determined by comparing the performance ratings for the 139 sites in the following eleven categories:
 - acute hospitals (108 sites), grouped into 8 categories, as set out in Appendix 3:
 - Metro 1 – tertiary and specialist hospitals (12 sites);
 - Metro 2 – metropolitan community hospitals with greater than 20,000 separations (5 sites);
 - Metro 3 – small metropolitan community hospitals with less than or equal to 20,000 separations (8 sites);
 - Rehabilitation centres (2 sites);
 - Rural 1 – regional referral hospitals with greater than 20,000 separations (3 sites);
 - Rural 2 – base and sub-regional referral hospitals with 4,000 – 20,000 separations (21 sites);
 - Rural 3 – district hospitals with 1,000 – 3,999 separations (29 sites);
 - Rural 4 – small rural hospitals with less than 1,000 separations (28 sites);

- aged care services (12 sites);
- extended care services (11 sites); and
- Multipurpose services (8 sites).

3.5.2 Analysing the audit responses

The project collected information relating to hospital discharge policies, protocols and processes and infrastructure. The responses to the audit tool were analysed and documentation provided by hospitals was assessed to identify examples of good practice.

The patient record audit gathered information about 10 aspects of discharge through 50 questions from 12,205 records. The responses to these questions were analysed in tabular and graphical form.

The consultants then explored some hypotheses relating to effective discharge, to establish whether hospitals with given characteristics or practices were more likely to have high levels of documentation compliance. The hypotheses were those suggested by the Patient Record Audit Steering Committee and the Effective Discharge Strategy Expert Advisory Committee, and it was recognised that there are many more which might be explored.

3.5.3 Reporting

The preceding stages of activity are documented in this report which sets out:

- the audit methodology and audit items in this section;
- the relative performance of each site within its category (without identifying individual sites) in Section 4;
- the findings from the audit, including a description of current discharge policies, protocols, processes and infrastructure in Section 5, analysis of the audit responses in Section 6 and testing of some hypotheses in relation to discharge in Section 7; and
- recommendations for the Department on how the audit can inform the development and monitoring of performance indicators in Section 8.

The draft report was the subject of discussion and fact verification with the Steering Committee on 1 June 1999. This final report was prepared following consideration of the issues raised.

4 Hospital performance rankings

The hospital performance rankings were calculated and compared within the eleven categories set out in Section 3.5.1. The rankings of individual hospitals are confidential and have been used to determine the level of performance bonus paid to hospitals under the Effective Discharge Strategy. However, Table 4.1 provides a perspective on the spread of hospitals within each category.

Table 4.1 Hospital performance ranking by category and level of compliance

Category	Total number of sites (some aggregated)	High compliance	Medium compliance	Low compliance
Acute	95	11 (12%)	21 (22%)	63 (66%)
- Metro 1	10	0	2 (20%)	8 (80%)
- Metro 2	5	0	2 (40%)	3 (60%)
- Metro 3	8	0	4 (50%)	4 (50%)
- Rehab	2	1 (50%)	1 (50%)	0
- Rural 1	3	1 (33%)	1 (33%)	1 (33%)
- Rural 2	17	3 (18%)	2 (12%)	12 (71%)
- Rural 3	25	4 (16%)	4 (16%)	17 (68%)
- Rural 4	25	3 (12%)	4 (16%)	18 (72%)
Aged care services	12	4 (33%)	4 (33%)	4 (33%)
Extended care services	11	4 (36%)	5 (45%)	2 (18%)
Multipurpose services	6	1 (17%)	2 (33%)	3 (50%)
Total	124	20 (16%)	31 (26%)	72 (58%)

The major findings were:

- significant variability (at 1% level using Chi squared test) between sites, from low to high compliance;
- superior compliance in aged care and extended care services, with a higher proportion of these services having medium or high compliance;
- for acute hospitals and multipurpose services, only a small number of hospitals in the high compliance group, with most in the low compliance group – consistent with this being a base line audit. The large metropolitan teaching/specialist hospitals had particularly low compliance;

- as measured by the agreed instrument, a small proportion of hospitals (16%) have discharge planning processes that meet all of the requirements of an effective approach to discharge planning;
- overall, compliance is significantly higher (at 1% level using Spearman's rho) for intensive post-discharge needs patients. However, generally each facility exhibits similar compliance for both types of patients, indicating a generic approach to discharge planning within any one facility. That said, hospitals with a higher proportion of intensive needs patients have higher documentation compliance, as shown in the following table.

Table 4.2 Hospital performance ranking by intensity of patient post discharge needs and level of compliance

Category	Total number of sites	High compliance	Medium compliance	Low compliance
High intensity (50-100% of patients with intensive post discharge needs)	38	10 (26%)	14 (37%)	14 (37%)
Medium intensity (25-49% of patients with intensive post discharge needs)	59	5 (8%)	16 (27%)	38 (64%)
Low intensity (1-24% of patients with intensive post discharge needs)	42	6 (14%)	10 (24%)	26 (62%)

Note: no aged care services, and only two extended care services, have non-intensive patients.

In general, while most hospitals have developed and established a range of processes to facilitate effective discharge, there are a large number of hospitals with low to medium compliance that have scope for significant improvement. To understand from where that improvement might come, we considered (see Table 4.3) the components of the scores allocated to records, which derive from each of the aspects of the discharge process:

- the areas where hospitals scored least well were:
 - the estimation and review of the discharge date and destination. In most hospital categories, the score was around one quarter of the maximum possible. The better performers were the aged and extended care services and the rehabilitation centres;
 - the assessment and review of post-discharge needs. In most hospital categories, the score was around one-half of the maximum possible. The better performers were the aged and extended care services, the rehabilitation centres and large rural hospitals;
- the areas where the hospitals scored better, and where their performance was uniformly good across hospital categories, were:
 - providing medical review of the patient prior to discharge;

- providing written authorisation of discharge; and
- maintaining accessible and comprehensive discharge documentation.

Table 4.3: Components of performance scores by intensity of post discharge needs and hospital category

Legend I - patients with intensive post discharge needs, NI - non-intensive post discharge needs patients, AG - Aged care funded sub-acute units in public hospitals, E - extended care services, M - Multi-Purpose services.

Category	Sub-category of Acute	Post Discharge needs	Estimation/review date and destination		Assess/review discharge needs		Medical review		Written authorisation		Initiation of post DC arrangements		Involvement of patients and carer		Involving ESP		Timely information of post DC care		Accessible/comprehensive information		Total	
			Raw	%	Raw	%	Raw	%	Raw	%	Raw	%	Raw	%	Raw	%	Raw	%	Raw	%	Raw	%
Total possible			14	12%	24	21%	10	9%	6	5%	18	16%	10	9%	12	11%	12	11%	8	7%	114.0	100%
Acute	Metro 1	I	2.4	2%	14.3	13%	7.7	7%	4.8	4%	12.4	11%	5.0	4%	3.6	3%	5.6	5%	6.1	5%	61.9	54%
		NI	2.8	2%	12.1	11%	7.4	7%	4.6	4%	12.0	11%	4.9	4%	3.1	3%	5.3	5%	5.9	5%	58.0	51%
	Metro 1 Total		2.6	2%	13.0	11%	7.6	7%	4.6	4%	12.2	11%	4.9	4%	3.3	3%	5.4	5%	6.0	5%	59.6	52%
	Metro 2	I	2.9	3%	16.7	15%	9.5	8%	5.6	5%	13.1	11%	5.6	5%	5.5	5%	6.0	5%	6.1	5%	70.9	62%
		NI	3.1	3%	12.5	11%	9.0	8%	5.1	5%	12.3	11%	3.9	3%	4.1	4%	5.1	4%	5.4	5%	60.6	53%
	Metro 2 Total		3.0	3%	14.5	13%	9.2	8%	5.3	5%	12.6	11%	4.7	4%	4.8	4%	5.5	5%	5.8	5%	65.3	57%
	Metro 3	I	3.2	3%	17.3	15%	9.2	8%	5.2	5%	13.2	12%	5.5	5%	6.6	6%	6.2	5%	6.0	5%	72.2	63%
		NI	2.8	2%	10.8	9%	8.1	7%	4.7	4%	12.7	11%	5.5	5%	4.9	4%	4.9	4%	5.7	5%	60.1	53%
	Metro 3 Total		3.0	3%	13.5	12%	8.6	8%	4.9	4%	12.9	11%	5.5	5%	5.6	5%	5.4	5%	5.8	5%	65.2	57%
Rehab	I	I	3.8	3%	17.7	15%	7.7	7%	5.7	5%	12.2	11%	3.9	3%	5.3	5%	5.2	5%	7.7	7%	69.0	61%
		NI	5.8	5%	20.1	18%	9.4	8%	5.2	5%	14.2	12%	5.7	5%	4.7	4%	5.9	5%	7.7	7%	78.7	69%
	Rehab Total		5.1	5%	19.3	17%	8.8	8%	5.4	5%	13.6	12%	5.1	4%	4.9	4%	5.7	5%	7.7	7%	75.6	66%
Rural 1	I	I	4.2	4%	20.6	18%	9.0	8%	4.7	4%	13.8	12%	5.6	5%	7.2	6%	7.0	6%	6.3	6%	78.6	69%
		NI	4.4	4%	19.5	17%	8.9	8%	4.7	4%	13.1	11%	4.9	4%	6.0	5%	5.8	5%	6.2	5%	73.4	64%
	Rural 1 Total		4.3	4%	20.0	18%	8.9	8%	4.7	4%	13.4	12%	5.2	5%	6.6	6%	6.4	6%	6.2	5%	75.8	67%
Rural 2	I	I	2.9	3%	15.2	13%	8.3	7%	4.7	4%	12.1	11%	4.3	4%	4.7	4%	5.6	5%	6.1	5%	63.8	56%
		NI	2.6	2%	11.8	10%	7.4	7%	4.1	4%	12.2	11%	3.9	3%	4.3	4%	5.3	5%	5.9	5%	57.5	50%
	Rural 2 Total		2.7	2%	13.2	12%	7.8	7%	4.4	4%	12.1	11%	4.1	4%	4.4	4%	5.4	5%	6.0	5%	60.2	53%
Rural 3	I	I	3.2	3%	13.7	12%	8.5	7%	4.7	4%	11.0	10%	5.9	5%	5.7	5%	4.7	4%	5.6	5%	63.0	55%
		NI	3.0	3%	11.1	10%	8.2	7%	4.7	4%	11.2	10%	6.2	5%	5.0	4%	4.5	4%	5.8	5%	59.7	52%
	Rural 3 Total		3.1	3%	12.3	11%	8.3	7%	4.7	4%	11.1	10%	6.1	5%	5.3	5%	4.6	4%	5.7	5%	61.3	54%
Rural 4	I	I	2.5	2%	11.4	10%	8.5	7%	4.6	4%	9.3	8%	6.8	6%	6.4	6%	4.7	4%	5.3	5%	59.5	52%
		NI	2.4	2%	9.6	8%	8.7	8%	5.0	4%	9.7	8%	6.3	6%	6.6	6%	5.0	4%	5.3	5%	58.5	51%
	Rural 4 Total		2.4	2%	10.4	9%	8.6	8%	4.8	4%	9.5	8%	6.5	6%	6.5	6%	4.9	4%	5.3	5%	59.0	52%
A Total			2.9	3%	13.5	12%	8.2	7%	4.7	4%	12.1	11%	5.0	4%	4.8	4%	5.4	5%	5.9	5%	62.4	55%
AG	I		5.1	4%	20.0	18%	7.4	6%	5.0	4%	12.9	11%	6.9	6%	4.4	4%	4.9	4%	5.3	5%	71.9	63%
AG Total			5.1	4%	20.0	18%	7.4	6%	5.0	4%	12.9	11%	6.9	6%	4.4	4%	4.9	4%	5.3	5%	71.9	63%
E	I	I	4.9	4%	20.2	18%	9.3	8%	5.2	5%	13.7	12%	7.2	6%	6.2	5%	6.7	6%	7.3	6%	80.8	71%
		NI	8.1	7%	21.0	18%	10.0	9%	5.1	5%	15.7	14%	3.7	3%	7.6	7%	7.9	7%	7.5	7%	86.7	76%
E Total			5.2	5%	20.3	18%	9.3	8%	5.2	5%	13.9	12%	6.9	6%	6.3	6%	6.8	6%	7.3	6%	81.3	71%
M	I	I	2.7	2%	16.1	14%	8.9	8%	4.6	4%	10.4	9%	3.5	3%	5.5	5%	3.2	3%	5.1	4%	59.8	52%
		NI	2.8	2%	14.2	12%	8.8	8%	4.9	4%	10.8	9%	4.2	4%	6.3	6%	3.9	3%	5.3	5%	61.2	54%
M Total			2.7	2%	15.1	13%	8.8	8%	4.8	4%	10.6	9%	3.9	3%	5.9	5%	3.6	3%	5.2	5%	60.6	53%
Grand Total	I		3.1	3%	15.8	14%	8.5	7%	4.9	4%	12.3	11%	5.3	5%	5.2	5%	5.6	5%	6.0	5%	66.8	59%
Grand Total	NI		2.9	3%	12.2	11%	8.0	7%	4.6	4%	12.0	11%	4.8	4%	4.4	4%	5.1	5%	5.8	5%	59.8	52%
Grand Total			3.0	3%	13.8	12%	8.2	7%	4.7	4%	12.1	11%	5.1	4%	4.8	4%	5.4	5%	5.9	5%	63.0	55%

5 Discharge policies, protocols, processes and infrastructure

5.1 Discharge policies, protocols and processes

To assess the policies, protocols and processes that the hospital has in place to guide discharge, the audit considered:

- (i) availability, level of endorsement and responsibility for development and review of policies, protocols and processes;
- (ii) procedures for measurement and benchmarking of performance;
- (iii) obstacles, strengths and deficiencies of the current discharge system.

The findings in these areas are considered in turn below.

5.1.1 Availability, level of endorsement and responsibility for development and review of policies, protocols and processes

All but one of the hospitals audited has a formal discharge policy, usually endorsed at the Board or CEO level and developed by a Discharge Planning or Quality Committee. The policy is usually reviewed on a yearly, or more frequent, basis.

A formal discharge protocol has been specified in most hospitals, usually endorsed at the Board or CEO level and developed by a Discharge Planning or Quality Committee. The protocol is usually reviewed on at least a yearly basis.

Specific clinical discharge protocols have been developed for almost all hospitals with a formal discharge protocol in place. These discharge protocols have been developed for the major clinical areas that may lead to post-discharge care needs, and include maternity and obstetrics, orthopaedics and joint replacements, cardiology and cardiothoracics and general surgery. Endorsement for these clinical protocols can be at Board and CEO level, but is more likely to be by a Discharge Planning or Quality Committee, with responsibility for development being at the ward or Director of Nursing level. The review of the clinical protocols is more frequent than the formal policy and protocol.

In general, hospitals' discharge processes are reviewed continuously, although more than one-third are reviewed annually or less. These reviews typically involve multiple disciplines across the hospital. More than two-thirds of the hospitals have Post Acute Care (PAC) Projects, evenly divided between those within the hospital or auspiced by an agency outside the hospital. Where PAC projects exist, hospitals reported a high level of general improvement in discharge planning processes.

5.1.2 Procedures for measurement and benchmarking of performance

Hospitals have been working towards the development of specific performance measures to measure discharge performance for their organisations as a whole. The most common measures used are comparisons with State average length of stay (ALOS), unplanned returns to hospital and patient satisfaction surveys. These measures are, however, not generally benchmarked, although they are very likely to be integrated with the hospital quality process.

5.1.3 Obstacles, strengths and deficiencies of the current discharge system

The major obstacles to discharging patients as planned are stated to be:

- lack of community health and welfare services to support discharge, especially in rural areas where the isolation of patients further reduces potential for early discharge (almost two-thirds of hospitals);
- lack of appropriate accommodation, particularly for elderly patients and in rural areas (almost one-third of hospitals);
- poor coordination and communication between medical staff, GPs and those parts of the hospital involved in discharge planning (almost one-third of hospitals);
- limited or inconsistent use of formal discharge planning protocols, partly due to lack of acceptance of need and/or limited dedicated resources (one-fifth of hospitals);
- increasing complexity of patients within the acute setting, particularly the aged (16% of hospitals); and
- under-developed discharge planning protocols and processes (7% of hospitals).

The implication is that hospitals are generally satisfied with their policies and protocols, but there needs to be more staff training, cooperation and communication and more community resources to support discharge.

When hospitals were asked to identify the strengths of their discharge systems, they noted:

- the high level of cooperation and coordination with community agencies (about half of the hospitals). Given that almost two-thirds of hospitals previously stated that these services were insufficient, this indicates good working relationships under difficult conditions;
- the formalisation of procedures and the development of appropriate discharge tools, such as risk assessment tools and discharge documentation (about half of the hospitals). This is in contrast to more than one-quarter of hospitals stating that undeveloped and poorly utilised discharge planning protocols and procedures were an obstacle to the current discharge system;
- the coordinated, multidisciplinary approach to discharge (over one-third of hospitals). However, poor coordination and communication within hospitals was regarded as an obstacle by another one-third of hospitals; and

- the high level of staff and patient/family enthusiasm and support (each about 14% of hospitals).

Not surprisingly, the strengths noted by some hospitals equate to the obstacles and deficiencies that other hospitals without these features are facing in their discharge process. The availability of a dedicated resource such as a discharge coordinator was mentioned as a strength by very few hospitals. This is likely to reflect that hospitals are at different stages of development regarding discharge planning and operate in environments with variable supporting community service infrastructure.

When asked to identify the deficiencies of the current system, the hospitals advised:

- poor discharge documentation and associated IT systems (43% of hospitals);
- poor communication, knowledge transfer and teamwork in the discharge process (38% of hospitals);
- lack of internal resources (24% of hospitals); and
- non-availability and/or poor timeliness in provision of community services (18% of hospitals).

Again, the translation of discharge policies and processes to hospital-wide action is limited by documentation, IT systems and poor knowledge and teamwork by staff.

Hospitals made a number of suggestions as to how their discharge processes could be improved. These included:

- improvement in documentation, including computerisation of information collection (about 35% of hospitals);
- introduction of, or enhancements to, formal discharge policies and protocols and provision of resources to enable emphasis on discharge planning, including pre-admission clinics, departure lounges, etc (about 35% of hospitals);
- improved education of staff to ensure consistent application of policies and protocols, especially for medical staff (about 25% of hospitals);
- introduction of formal mechanisms accountable for discharge planning, such as Discharge Planning Coordinator and discharge committees (20% of hospitals);
- improved coordination and consistent documentation within the hospital and with community providers (20% of hospitals);
- also mentioned were patient and carer education (12%) and the need for more resources to increase availability of community services and accommodation.

The audit findings corroborate some of these perceptions. For example, the audit found that hospitals generally need to improve documentation practices, and that the presence of good

policies and protocols did not necessarily result in evidence of effective discharge as measured by the audit tool. Specifically, there was an unclear relationship between the performance ranking of a hospital and the quality of the policies and protocols that relate to discharge and discharge planning.

Further, from the examples of hospital documentation received, good policy on discharge planning was not always transferred to the patient level documentation used by the hospital in the implementation of its discharge policies. This was the case even when the discharge policy was linked to discharge outcomes or standards (in a few hospitals only). However, many hospitals have developed policy and infrastructure that provides for clear and comprehensive assessment of post discharge needs and some, though not many, provide for clear tracking of action taken in relation to these assessments.

Policy statements rarely made reference to staff competence and training in relation to the use of the discharge planning instruments and processes. There is scope for increasing the training of staff, improving internal communications and making greater use of information technology to support discharge processes. While there are external barriers to the capacity of the hospital to discharge patients once they are ready for discharge (such as availability of community services), there are few external barriers to addressing many of the weaknesses identified in the audit findings and as perceived by hospitals.

5.2 Discharge infrastructure

The audit assessment of discharge infrastructure, which determines where and how discharge processes are undertaken in the hospital, considered:

- (i) organisational arrangements for discharge in the hospital;
- (ii) means of maintaining the relationship with the external service providers;
- (iii) facilitation of the process of discharge through information provision and training; and
- (iv) role of internal systems.

5.2.1 Organisational arrangements for discharge in the hospital

Discharge in hospitals follows one of two approaches: decentralised through individual wards or managed by a multidisciplinary team. The discharge process is facilitated by:

- use of care maps/plans and clinical pathways with the process of discharge within;
- use of specific discharge plans;
- less so, the use of risk screening tools; and
- regular case conferences/meetings.

However, as discussed in Section 5.3.1 above, even if hospital policies provide for the above, this often does not result in availability and appropriate use of these tools at the ward level.

Post discharge options recorded as available to hospitals are numerous:

- hospital or medical related services (outpatients, GPs, District Nursing, physiotherapy, occupational therapy, other allied health services) are generally regarded as available;
- almost two-thirds of hospitals regard PAC projects as post discharge options;
- domiciliary services for post natal, palliative and rehabilitation are less likely to be regarded as discharge options, reflecting the availability of these services;
- social work and psychiatric services and counselling are considered in fewer cases;
- accommodation, home help, personal care, meals on wheels and community transport services are considered as discharge options by almost all hospitals; and
- interpreters and ethno-specific support services are considered by about half the hospitals, reflecting the ethnic mix of their patients.

5.2.2 Means of maintaining the relationship with the external service providers

Most hospitals have mechanisms for ensuring they have information regarding appropriate external service providers to be used as referral options, including:

- a referral list (68% of hospitals);
- regular formal contact with service providers (60%);
- other, such as informal contact or use of broader regional resource manuals prepared by other agencies.

The information, which is maintained, includes contact details and service descriptions for three-quarters of hospitals. However, more specific information regarding eligibility criteria, assessment documentation and service availability data is less likely to be available. Reasonably complete information (including contact details, service description, assessment documentation and, less often, eligibility criteria and service availability data) is held by about half of the facilities, with extended care services generally holding the most complete information. This information is usually reviewed on an ongoing basis, and certainly within a year.

There is scope for substantial improvement in this area. In hospitals where the follow-up of service provision is provided for in discharge policies, there is generally no provision in the policies for the use of this information in a routine way to improve the arrangements with external service providers. Hospitals should formalise arrangements with a range of external service providers that are integral to effective discharge planning and, in doing so, develop an internal database of provider options that link patient needs with provider services.

5.2.3 Facilitation of the process of discharge through information provision and training

Hospitals have a number of mechanisms to ensure that discharge policies, protocols and processes are understood. Most used is informal on-the-job training, with formal training occurring in only about half of the hospitals. This formal training is most likely to be provided on induction or on an as needs basis. Protocol folders are kept on each ward at just over half of the hospitals. In general, hospitals believe that their discharge policies, protocols and processes are well understood in some areas, but less in others. Only 24 hospitals felt that their policies, protocols and processes were fully understood.

Even if there was a substantial amount of information available to staff to facilitate discharge planning, it was not necessarily fully utilised, especially if the hospital used a standard checklist tool. Improvements can be made in this area. Hospital administrators should consider the need for formal on-going training of staff in discharge planning requirements and their implementation.

5.2.4 Role of internal systems

Most hospitals felt that their internal systems (ie. information systems, documentation) at least partly supported effective discharge, although this was an area where some 43% of hospitals identified a deficiency in their current system. Major areas that might enhance these systems were felt by the hospitals to be:

- introduction of a risk screening tool;
- access to eligibility criteria and availability of service/waiting list information for external providers;
- on-line access for outpatients' appointments; and
- more comprehensive medical records forms and rapid handling of documentation by Medical Records, potentially through enhanced computerisation.

Given the low compliance with this audit and that hospitals openly acknowledge that there is room for development, it is timely that the Department undertakes a review of best practice policies, procedures and systems, including a review of the benefits of systems such as those discussed above, as part of the Effective Discharge Strategy.

6 Implementation of discharge policy, protocols and processes

Our findings from the review of 12,205 patient records across 139 sites is presented in this section. For each of the ten aspects of the discharge process, we discuss the responses for each question and consider the relative performance across hospital categories. The ten aspects of discharge are:

- estimation and review of the date and destination of discharge;
- timely and appropriate assessment and review of discharge needs;
- timely medical review prior to discharge;
- written authorisation in the record of the decision to discharge;
- initiation of timely and appropriate post discharge arrangements;
- involvement of the patient and carer in preparing for discharge;
- involvement of appropriate external service providers in consideration of options and decision making;
- provision of timely information to initiate post discharge care;
- follow up to ensure implementation, and evaluation to ensure effectiveness, of the discharge plan; and
- maintenance of accessible and comprehensive discharge information in the patient record.

Each of these aspects is considered in turn below and presented graphically in Appendix 4.

6.1 Estimation and review of the date and destination of discharge

Effective discharge is facilitated by the early identification of an estimated date and destination of discharge. The audit found less than one in five patients have an estimated discharge date or destination identified, although this was more likely for intensive needs patients and in aged and extended care services, and in rehabilitation centres. Reviews were less common: a quarter of patients with an estimated discharge date did not have that date reviewed and four in five with an estimated discharge destination did not have that destination reviewed.

This was an aspect of discharge where hospitals generally scored poorly against the audit tool, scoring on average just over 20% of the maximum possible score. The better scorers were aged and extended care services and rehabilitation centres.

6.1.1 Identification and review of estimated date of discharge

QB1: Was an estimated date of discharge identified?

The audit found 18% of records with the date of discharge estimated. There were a further 11% of patients where an estimated date of discharge was not possible, given the nature of the admission (for example, an unclear diagnosis).

There was slightly more evidence of an estimated date of discharge for non-intensive post discharge needs patients than for those with intensive needs. This reflects the higher proportion of planned admissions in the non-intensive needs group and the use of pre-admission clinics, particularly in acute hospitals.

Aged care, extended care and MPS services had a much higher percentage of records (around 30%) with a date of discharge estimated. Overall 17% of acute hospital records sampled had a discharge date identified, but this was higher for rehabilitation centres (50%) and the non-tertiary/specialist metropolitan hospitals.

QB2: When was this date of discharge identified?

The timing of identification of the estimated discharge date is usually during the care of the patient (59% of patient records with a discharge date identified), although there were a substantial proportion of patient records with a discharge date identified where this was determined at pre-admission (10%) or within 24 hours of admission (31%).

Early identification of estimated discharge date is most likely for non-intensive post discharge needs patients. Whilst this probably reflects the greater certainty with which such estimates can be made for these patients, it indicates that, paradoxically, timeliness is inversely related to intensity of discharge need. Early identification is most likely in acute and MPS facilities and, within the acute facilities, timeliness of estimation of discharge date is best for the larger metropolitan and rural hospitals.

QB3: Was the estimated date of discharge reviewed?

The review of the estimated date of discharge during the course of the patient's care is regarded by some as even more important for effective discharge than the initial estimation. Where a date of discharge had been estimated, it was reviewed in 58% of records audited. A further 18% of records were for patients where a review was inappropriate because of the short length of stay. This implies that reviews do not occur in about a quarter of relevant cases.

As expected, reviews for patients with non-intensive post discharge needs are less likely than for intensive needs patients. The proportion of cases reviewed is highest in aged and extended care services and rehabilitation centres and least in MPS and rural regional referral hospitals.

QB4: When did the review occur?

The timing of the review of the estimated discharge date is predominantly at critical points in treatment (74% of records reviewed). A further 16% of records indicated daily reviews, with daily reviews being more likely for patients with non-intensive post discharge needs, probably reflecting their shorter length of stay and the relative ease with which such reviews can be conducted. In aged care services, reviews were more likely to be weekly (62% of aged care records reviewed weekly and a further 33% at critical points). The large metropolitan and rural hospitals were more likely to review the discharge date as required at critical points.

QB5: Who was involved in this review?

The audit observed the personnel involved in the review of discharge date and assessed whether these appeared appropriate in terms of high, medium or low compliance. Compliance was generally highest amongst aged and extended care services and lowest amongst acute hospitals (especially rural regional referral hospitals) and MPS, indicating the absence of some important personnel in the review of discharge.

The personnel most likely to be noted as involved in estimating discharge date are medical staff. However, there were multidisciplinary teams involved in aged, extended care and MPS services and allied health was well represented for aged and extended care services.

6.1.2 Identification and review of expected discharge destination

QB6: Was an expected discharge destination identified?

The audit found 19% of records with an expected discharge destination identified, with the percentage for intensive compared to non-intensive needs patients being much higher. Aged and extended care services were more likely to have evidence of identification of the discharge destination. Amongst acute hospitals, rehabilitation centres and large rural hospitals were most likely to show evidence that the discharge destination had been identified.

QB7: What was the expected discharge destination?

The discharge destinations were predominantly to home, mostly without support but also with District Nursing, rehabilitation and other services. This pattern was similar for all facilities.

QB8: Was the expected discharge destination reviewed?

In around 14% of the records where a discharge destination was documented, the discharge destination had been reviewed, with a further 4% being assessed as not requiring review because of their short length of stay. The likelihood of review was higher for intensive post-discharge needs patients, as would be expected. It was also higher for extended care services and small metropolitan hospitals.

QB9: When did the review occur?

The timing of the review of the expected discharge destination is predominantly at critical points in the treatment (69% of records with a destination review), with a further 16% of records with a destination review occurring when the discharge destination appeared likely to

change. These percentages were similar for intensive and non-intensive needs patients. Across the hospital categories, extended care services had a higher proportion of reviews at critical points in the treatment, as did the large metropolitan and large country hospitals.

6.2 Timely and appropriate assessment and review of discharge needs

An area on which the audit gathered information, but which was not included as part of the assessment of relative performance of hospitals, was the use of risk screening. There is evidence to suggest that the application of an appropriate risk screening tool can increase the efficiency and effectiveness of discharge by identifying those patients who should receive specific attention. There was evidence of risk screening for two in five patients, and high compliance with the audit tool for the intensive needs patients and for aged and extended care services and the middle sized metropolitan and rural hospitals.

Effective discharge requires a timely and thorough identification of post discharge needs, and the timely reassessment of these discharge needs where appropriate. Around three-quarters of records showed at least one assessment of patient's post discharge needs, usually on admission (or in a pre-admission clinic). Around half of these patients had at least one reassessment, usually at critical points in the treatment. There was higher compliance with the audit tool for aged and extended care services, rehabilitation centres and larger rural hospitals.

This was an aspect of discharge where hospitals generally scored poorly against the audit tool, scoring just under 60% of the maximum possible score. The better scorers were aged and extended care services, rehabilitation centres and larger rural hospitals.

6.2.1 Use of risk screening

QB10: Was the patient screened for risk of failing to adequately recuperate after discharge?

The audit found around 41% of records with evidence of application of risk screening. Risk screening was more likely to occur for intensive post-discharge needs patients. The evidence was stronger for the records in extended care and aged care services and for some middle-sized metropolitan and rural hospitals.

QB11: Did the risk screening include appropriate risk factors?

The risk screening tools in use include the following risk factors (in order of greatest percentage of records observed):

- is patient likely to have problems in managing self care? (85%)*
- does the patient live alone? (80%)*
- is the medical condition of the patient disabling or deteriorating? (60%)

- is there any evidence of a mental and/or a behavioural problem? (58%)
- did the patient use community services prior to their admission? (56%)*
- did the patient have any problems in managing at home prior to the admission? (55%)
- does the patient have caring responsibilities for others at home? (42%)*
- does the patient hold a health care card or pension? (36%)
- does the patient have a history of recent multiple admissions? (33%)
- are there any unsafe aspects of the discharge destination for the patient? (29%)

It is interesting to note that the order of importance of the risk screening factors partly conforms with the research undertaken by Thomas and Associates ("Final Report of the development of a risk screening tool for service needs following discharge from acute care project", August 1998, for Department of Human Services), which recommended that a risk screening tool should, at minimum, include the factors marked with an asterisk above. This reflects a high level of consistency with the research findings.

The auditors assessed the evidence of application of risk factors and found lower compliance for non-intensive needs patients, as might be expected. About 17% of intensive needs patient records had low compliance with application of risk screening, whereas it was 32% for non-intensive needs patients. Across the hospital categories, the aged and extended care services and the middle sized metropolitan and rural hospitals were found to be more compliant.

6.2.2 Assessment of patient's discharge needs

QB12: Was an assessment of the patient's discharge needs made?

The audit found 74% of records with at least one assessment of patients' post-discharge needs made. As expected, there was a slightly higher likelihood of assessment for intensive needs patients. The percentage with at least one assessment was higher for aged care (88%), extended care (98%) and MPS (88%) services. Among acute facilities, rehabilitation centres and larger rural hospitals had higher levels of assessment.

QB13: When was the first assessment made?

The timing of the first assessment of patients' post-discharge needs was usually on admission, unless a pre-admission clinic was used. This timing is not greatly different between hospitals.

QB14: Did this first assessment include evidence of assessment of relevant factors?

The first assessments included evidence of assessment of the following factors (in order of greatest percentage of records observed):

- functional status;

- clinical status;
- social support network;
- home environment;
- carer capacity;
- cultural and linguistic needs.

The auditors assessed the evidence of application of these factors and found lower compliance for non-intensive needs patients, as might be expected. About 12% of intensive needs patient records assessed had low compliance with the application of discharge assessment, whereas it was 22% for non-intensive needs patients. Compliance was higher for aged and extended care services, and least for MPS and small rural hospitals.

QB15: Who was the first assessment undertaken by?

The audit observed the personnel involved in the first assessment of patient discharge needs and assessed whether these appeared appropriate in terms of high, medium or low compliance. Compliance was generally highest for intensive post discharge needs patients and within extended and aged care services and rehabilitation centres and least within MPS, indicating that the auditor observed an absence of evidence of involvement of key personnel in the assessment of discharge need.

The main personnel noted by the auditors for aged care, extended care and MPS services were multidisciplinary teams, primary care nurses or nurse managers, medical staff and allied health staff. Multidisciplinary teams were particularly important in extended care facilities. In acute facilities, multidisciplinary teams were rare and medical or nursing staff were most likely to undertake the first assessment.

QB16: Where was the evidence of the first assessment found?

The audit also observed where the evidence of the first assessment of patient discharge needs was found and assessed whether this appeared appropriate in terms of high, medium or low compliance. As for other aspects of discharge needs assessment, compliance was generally highest for intensive post-discharge needs patients and within extended and aged care services and least compliance within MPS and rural hospitals.

6.2.3 Review of patient's discharge needs

QB17: Were there subsequent reassessments?

The audit found that just over half of the patients who had received a first assessment of their post discharge needs received subsequent reassessments. Reassessments were more likely for aged care services (86%), rural regional referral hospitals (75%) and for patients with intensive post discharge needs (58% compared to 44% for other patients).

QB18: When did the reassessments occur?

The timing of the reassessments of patients' post discharge needs is most likely to be at critical points in the treatment. The auditors assessed that the timing of reassessments was generally high, with high compliance in aged and extended care services and lower compliance in metropolitan hospitals. There is also higher compliance for intensive post discharge needs patients.

QB19: When was the last reassessment made?

Where a reassessment was made, the last assessment was made usually on the day of discharge or on the day prior to discharge. This was similar across hospitals.

QB20: What factors did this last assessment include?

This last assessment included evidence of assessment of the following factors (in order of greatest percentage of records observed):

- functional status;
- clinical status;
- home environment;
- social support network;
- carer capacity;
- cultural and linguistic needs.

The auditors assessed the evidence of application of these factors and found very similar results to the first assessment of patients' post-discharge needs, including lower compliance for non-intensive patients and higher compliance of aged and extended care services and least for MPS.

QB21: Who undertook the last assessment?

The audit observed the personnel involved in the last assessment of post discharge needs and assessed whether these appeared appropriate in terms of high, medium or low compliance. Compliance was generally highest for intensive post discharge needs patients and within extended and aged care services, rehabilitation centres and larger rural hospitals and least within MPS and the smaller metropolitan hospitals, indicating that the auditor observed less complete involvement of key personnel in the reassessment of discharge needs. As for the first assessment, the main personnel noted by the auditors for aged care, extended care and MPS services were multidisciplinary teams (especially in extended care services and rehabilitation centres), primary care nurses or nurse managers, medical staff and allied health staff. Multidisciplinary teams were much less likely in acute facilities, with the majority of assessments undertaken by medical or nursing staff.

QB22: Where was the evidence of the last assessment found?

The audit also observed where the evidence of the last assessment of patient discharge needs was found and assessed whether this appeared appropriate in terms of high, medium or low compliance. As for the first discharge needs assessment, compliance was generally higher for intensive post discharge needs assessments and within extended and aged care services and rehabilitation centres and least within MPS. As for the first assessment, information relating to the assessment was predominantly located in the nursing progress notes and discharge summary and checklists. This was consistent across facilities, although discharge checklists were more extensively used in rural hospitals.

6.3 Timely medical review prior to discharge

A fundamental aspect of effective discharge is the timely review by a medical officer prior to discharge. Four in five patient records showed evidence of a medical review prior to discharge.

This was an aspect of discharge where hospitals generally scored highly against the audit tool, scoring on average over 80% of the maximum possible score. Aged care services scored least well.

QC1: Was the patient reviewed by a medical officer prior to discharge?

The audit found 81% of records with evidence of review by a medical officer prior to discharge. The percentage was higher for intensive post discharge needs patients and in extended care and MPS services. Among acute hospitals, the percentage of records was lower for metropolitan tertiary/specialist hospitals and rural base and sub-regional referral hospitals. Higher ranked hospitals were more likely to show evidence of a medical review.

QC2: When was the medical review conducted?

When a medical review occurred, it was most likely to occur within 24 hours of discharge. Only 1.5% of patients received a medical review more than one week prior to discharge. Reflecting the longer length of stay of patients, aged and extended care services and rehabilitation hospitals were more likely to have an earlier medical review.

QC3: Who conducted the medical review?

It was very difficult to determine from the record which medical officer had conducted the medical review. Where it could be identified, it was most commonly the resident or, especially in the rural hospitals, the VMO.

6.4 Authorisation in the record of decision to discharge

The audit sought evidence of who was involved in the decision to discharge and whether there was written authorisation in the record of the decision to discharge. The decision to discharge predominantly involves multidisciplinary teams in extended and aged care services, and clinical staff in acute hospitals and MPS. Nearly four in five patient records have evidence of written authorisation of discharge.

This was an aspect of discharge where all hospitals scored very well against the audit tool, scoring on average almost 80% of the maximum possible score.

QC4: Who from the hospital was involved in the decision to discharge?

The audit sought information on who was involved in the decision to discharge and assessed whether these appeared appropriate in terms of high, medium or low compliance. Compliance was higher for intensive post-discharge needs patients, as expected. Between hospital categories, compliance was generally high, particularly within extended care and aged care services and rehabilitation centres. It was least within MPS and small rural hospitals. The personnel most likely to be noted as involved in the decision to discharge were, for extended and aged care services, multidisciplinary teams, although clinical staff and allied health were also involved. For acute hospitals and MPS, the major involvement was from clinical staff.

QC5: Was there written authorisation in the record of the decision to discharge?

Seventy-seven per cent of records showed evidence of written authorisation, with a slightly higher percentage for patients with intensive post-discharge needs (79%) and for extended care services (86%), rehabilitation centres (89%) and large metropolitan community hospitals (88%). In general, higher ranked hospitals were more likely to show written authorisation on the record. Given that it was expected that all records would show evidence of written authorisation in the record of the decision to discharge, these data indicate some level of poor record keeping or neglect of a fundamental aspect of discharge practice.

6.5 Initiation of appropriate and timely post-discharge arrangements

Effective discharge requires the timely initiation of appropriate post-discharge arrangements, possibly facilitated by identification of responsibility for managing the discharge process. The identification of a person or team to manage the discharge process is not a common practice. However, nearly nine in ten patients have post discharge arrangements initiated, usually on the day of discharge.

This was an aspect of discharge where hospitals generally scored less well against the audit tool, scoring on average less than 70% of the maximum possible score. The better scorers were extended care services, rehabilitation centres and larger rural hospitals.

QC6: Was a person or team identified to manage the discharge process?

Overall, only 13% of the audited records showed evidence of a person or team being identified to manage the discharge process, with this being more likely for intensive post-discharge needs patients (16%) and least likely for patients in acute facilities (11%). Among acute facilities, smaller metropolitan and rural hospitals rarely identified a discharge manager. Higher ranking hospitals were slightly more likely to identify a person or team to manage the discharge process.

QC7: Which hospital staff were identified to manage the discharge process?

The auditors made an assessment of the appropriateness of the team or person identified to manage the discharge process which was quite low, with the exception of extended care services, rehabilitation centres and the larger rural regional referral hospitals. This is a reflection of the low likelihood of specific management responsibility being assigned.

For extended and aged care services, a multidisciplinary team or clinical staff were usually identified, while for MPS it was almost exclusively a clinical staff member. In acute facilities, clinical staff were most likely to be identified. Multidisciplinary teams were much less common, except in rehabilitation centres. Social workers were also identified but this was not very common.

QC8: Were post discharge arrangements initiated?

The audit assessed if post discharge arrangements had been initiated. In the sample, evidence was found in 86% of cases, with slightly higher percentages for aged care and extended care services. Among acute facilities, rehabilitation centres and metropolitan community hospitals had the most evidence of post discharge arrangements.

QC9: Which post discharge arrangements were initiated?

A wide variety of post discharge arrangements were initiated, but the majority were directly hospital related. Organisation of post discharge hospital services and notifying discharge to, and making appointments with, the patient's GP were the most observed post-discharge arrangements initiated. Psychiatric, accommodation and personal care services, and District Nursing were the most common external services initiated.

The auditors assessed the extent to which these post discharge arrangements represented high, medium or low compliance with appropriate discharge practice. The highest compliance was within extended care services and small metropolitan community hospitals and the lowest within MPS. Usually, patients with intensive post discharge needs had post-discharge arrangements initiated that were assessed as having high compliance.

QC10: When were these actions taken?

The audit sought to assess the timeliness of these post-discharge actions. Compliance was highest in the extended care services and rehabilitation centres and least in MPS. Compliance was not, however, always higher for intensive post discharge needs patients. For the majority of hospitals, most of the arrangements were initiated on the day of discharge, with external services such as accommodation, home help and meals on wheels being organised beforehand.

6.6 Involvement of the patient and carer in preparing for discharge

Increasingly, the literature around discharge has identified the benefits of patient and carer involvement in preparing for discharge. The audit found substantial room for improvement with half of the patients and less than a third of carers involved in preparing for discharge.

This was an aspect of discharge where hospitals scored poorly against the audit tool, scoring on average around half of the maximum possible score. The better scorers were aged and extended care services and small rural hospitals.

QC11: Was there involvement of the patient in preparing for discharge?

The audit found evidence of patient involvement in 51% of records, with a similar level for intensive needs patients (52%). The involvement of the patient was greatest for aged and extended care services and least for MPS. Among acute facilities, the highest level of involvement of patients was in small rural hospitals (63%) and the lowest was in rural base and sub-regional hospitals (35%). It is not necessarily the case that the most highly ranked hospitals have the highest patient involvement.

QC12: What did the patient involvement include?

This patient involvement included:

- consultation around needs and exploration of options; and
- decision making.

For extended care services, those patients involved in preparing for discharge were all involved in consultation and decision making. For other facilities, there was more likely to be consultation around needs and options than involvement in decision making. There is little difference between intensive post discharge needs patients and the rest.

QC13: Was there involvement of the carer in preparing for discharge?

The audit found evidence of carer involvement in preparing for discharge in 30% of records – 38% for intensive post discharge needs patients and 23% for the remainder. The involvement of carers was particularly in evidence in extended (63%) and aged (47%) care services, and in rehabilitation centres (50%). As with patients, it is not necessarily the case that the most highly ranked hospitals have the highest carer involvement.

QC14: What did the carer involvement include?

This carer involvement included:

- consultation around needs and exploration of options; and
- decision making.

As for patients, for extended care services, those patients involved in preparing for discharge were all involved in consultation and decision making. For other facilities, there was more likely to be consultation around needs and options than involvement in decision making. Again, there is little difference between intensive post discharge needs patients and the rest.

6.7 Involving appropriate external service providers in consideration of options and decision making

The involvement of appropriate external service providers in consideration of options and decision making can ensure that referrals are appropriate and discharge outcomes more effective. External service providers were involved in discharge decisions for four in ten patient records.

This was an aspect of discharge where hospitals generally scored very poorly against the audit tool, scoring on average around 40% of the maximum possible score. The better scorers were aged and extended care services and the largest and the smallest rural hospitals.

QD1: Were external service providers involved in consideration of options and decision making for discharge?

Involvement of external service providers in consideration of options and decision making occurred in 42% of records. This percentage is higher for intensive post discharge needs patients (47%) and for extended care services (62%). Amongst acute hospitals, the percentage was higher for the two rehabilitation centres (63%) and three large regional referral hospitals (64%). Involvement was lowest for metropolitan tertiary and specialist hospitals (33% of records).

QD2: Who were the external service providers involved?

The audit sought information on who were the external service providers involved in the consideration of options and decision making. The GP (either independently or as VMO) was recorded most often (45% of records), followed by the District Nursing service (10%) and accommodation providers (10%). The auditors assessed the compliance with this aspect of discharge and found higher compliance in aged and extended care services and smaller rural hospitals.

6.8 Timely provision of adequate information to initiate post discharge care

The audit assessed whether adequate, timely information and guidance had been provided to appropriate external service providers to initiate post discharge care. Information is mainly provided on the day of discharge to GPs and District Nursing, with four in ten records indicating adequate guidance.

This was an aspect of discharge where hospitals generally scored very poorly against the audit tool, scoring on average around 40% of the maximum possible score. The better scorers were extended care services and the largest rural hospitals.

QD3: To whom was information provided to initiate post-discharge care?

Information was provided predominantly to GPs (either independently or as VMO) (60%), District Nursing (8%) and accommodation providers (6%). This was similar across all hospital categories. The assessment of compliance indicated high compliance from extended care services and rural regional referral hospitals and low compliance from MPS.

QD4: Did the information provided give adequate guidance on post-discharge requirements?

The audit assessment of the adequacy of the guidance provided on post discharge requirements was for high compliance in extended care services and rehabilitation centres and low compliance in MPS, and generally higher compliance for intensive post discharge needs patients. In 58% of cases, the audit did not see evidence of adequate guidance.

QD5: When was information provided to external service providers?

The timeliness of provision of information to external service providers received an assessment of high compliance in around half the relevant records, with higher compliance for intensive post discharge needs patients. Mostly, the information was provided on the day of discharge, or before. Early advice to external service providers was most likely for accommodation and home help services. This pattern is similar across all hospital categories.

6.9 Follow up to ensure implementation, and evaluation to ensure effectiveness, of the discharge plan

The effectiveness of discharge and the potential to improve processes in future is enhanced by timely follow-up with service providers and with patients and carers, and evaluation of outcomes of the discharge process. For those records where information had been provided to initiate post discharge services, four in ten showed evidence of follow-up with service providers, but only one in twenty showed evidence of follow-up with the patient and/or carer/family. There was almost no evidence of evaluation of the discharge plan.

This was believed to be an area that receives little attention in current discharge practice, so it was excluded from the auditable questions and was collected for information only.

6.9.1 Timely follow-up with service providers and with the patient and/or carer/family to ensure implementation of the discharge plan

QD6: Was there follow-up with external service providers to ensure implementation of the discharge plan?

Where information had been provided to initiate post-discharge care, follow-up with the external service providers occurred in some 40% of records. The audit found generally low compliance, with limited follow-up, particularly in MPS (91% of records assessed as low compliance) and extended care services (81%). The smaller rural hospitals, however, had much more evidence of follow-up. Follow-up was most likely with GPs, and also post natal

domiciliary care and District Nursing. However, the numbers are quite small, indicating a low level of commitment to follow-up, which is consistent across all hospital categories.

QD7: When did follow-up with service providers occur to ensure implementation of the discharge plan?

The timeliness of any follow-up was also assessed to be very poor, especially for MPS and extended care services. The exception to this were the rehabilitation centres where timeliness of follow-up was assessed to be good. Unfortunately, timeliness was poorer for intensive post-discharge needs patients. It was often difficult to assess when follow-up action was taken, but it was usually about one week after discharge, with the exception of post natal domiciliary care and District Nursing where follow-up tended to be within one day. This was similar across all hospital categories.

QD8: Was there follow-up with patient and/or carer/family to ensure implementation of the discharge plan

The audit found only 5% of records with evidence of follow-up with the patient and/or carer/family. Follow-up was better for extended care (22%), MPS (18%) and large rural regional referral hospitals (20%) and was particularly poor for metropolitan acute hospitals.

QD9: When did follow-up with the patient and/or carer occur to ensure implementation of the discharge?

When this follow-up occurred, this was likely to be done on the day following discharge or in the week after.

6.9.2 Evaluation of the effectiveness of the discharge plan and its implementation

QD10: Was there evaluation of the effectiveness of the discharge plan and its implementation?

The audit found almost no evidence of evaluation of the discharge plan, with the exception of a few records in acute and extended care services.

QD11: From whom was feedback sought for this evaluation?

The auditors assessed the involvement of various groups/persons in the evaluation and assessed very poor compliance. Those from whom feedback was sought were mainly patients and carers and treating doctors. Feedback was sought from very few external service providers.

6.10 Maintaining accessible and comprehensive discharge information in the patient record

Whilst it is preferable for the purposes of the audit for discharge documentation to be accessible and comprehensive, it is also an important feature of ensuring appropriate patient management. The assessment of comprehensiveness is not meant to imply that the

documentation fully complied with all audit questions, but rather that the documentation was available on the patient record for review. Nine in ten records have accessible discharge documentation, three in ten are fully and five in ten partly comprehensive. Documentation is mainly in nursing notes or the discharge summary.

This was an aspect of discharge where hospitals generally scored well against the audit tool scoring on average 74% of the maximum possible score. The better scorers were extended care services and rehabilitation centres.

6.10.1 Accessibility and comprehensiveness of discharge documentation

Question E1: Was the documentation relating to discharge readily accessible?

The auditors found that discharge documentation was accessible in 89% of records, more so for intensive post discharge needs patients and for extended care facilities. Among acute hospitals, documentation accessibility was best in the two rehabilitation centres and in the larger metropolitan and rural hospitals. Overall, most hospitals scored well.

Question E2: Was the discharge documentation comprehensive?

The comprehensiveness of the documentation was assessed as being fully comprehensive in 30% of records audited and a further 53% were partly comprehensive. Comprehensiveness was more likely for intensive post-discharge needs patients, and for extended care services, and least likely for MPS. Among acute hospitals, the two rehabilitation centres had very comprehensive documentation, while the largest metropolitan and rural hospitals, along with the small rural hospitals, had a relatively low proportion of records that were fully comprehensive. Higher ranking hospitals did not necessarily always have the highest level of comprehensiveness in their documentation.

6.10.2 Location of discharge documents

QE3: Where was the discharge documentation contained?

The auditors recorded where they mostly found the discharge documentation on which they based their assessments. Most of the information was found in the progress notes/nursing management record and/or in the discharge summary. Discharge plans were used in some records, as were care plans, but they were a relatively minor source of information for discharge. Some facilities had evidence of discharge in other places; for example, MPS facilities were more likely than other facilities to use a discharge checklist, extended care services were more likely than other facilities to use allied health records and risk screening tools, and rural acute hospitals were more likely to use discharge plans and checklists.

The auditors also assessed the location of documentation relating to assessment (QB16) and review (QB22), as discussed above. For the first and last discharge needs assessment, the auditors generally found the required documentation where it was expected and compliance was generally highest for intensive post discharge needs assessments and within extended and aged care services and least within MPS.

7 Testing hypotheses regarding effective discharge

The preceding section provides detail on the performance of hospitals in each of the ten aspects of patient discharge. We have also explored some hypotheses relating to discharge to establish whether hospitals with given characteristics or practices were more likely to have high levels of documentation compliance. The hypotheses were those suggested by the Patient Record Audit Steering Committee and the Effective Discharge Strategy Expert Advisory Committee. It is recognised that there are many more which might be explored.

Hypothesis One: Aged care services and extended care centres have highest levels of documentation compliance.

This hypothesis has been confirmed in the table presented in Section 4, Table 4.1 above. Using One-way Analysis of Variance, significant differences were found between the four types of sites, with extended care having the highest reported level of compliance followed by aged care, acute and finally MPS.

Hypothesis Two: The discharge process associated with intensive post-discharge needs patients is better documented than for other patients.

This hypothesis has been confirmed in Section 4, Table 4.2 above but the differences are not substantial. Using correlation analysis, the association between sites' intensive and non-intensive performance ranking was explored. A significant positive correlation was found, with sites that reported higher levels of intensive documentation also reporting higher levels of non-intensive documentation.

Hypothesis Three: Rural hospitals have higher compliance than metropolitan hospitals.

This hypothesis is not confirmed. While some rural hospitals performed very well in the audit, others performed poorly. Rural hospitals have a higher proportion of high compliance sites, but they also have a higher proportion of low compliance sites. This indicates significant variability between hospitals. Using a t-test to assess the difference between rural and non-rural hospitals' compliance, compliance of non-rural hospitals was significantly better than rural hospitals' compliance.

Category	Total number of sites (not aggregated)	High compliance	Medium compliance	Low compliance
Metropolitan	39	4 (10%)	17 (44%)	18 (46%)
Rural	100	17 (17%)	23 (23%)	60 (60%)
Total	139	21 (15%)	40 (29%)	78 (56%)

Hypothesis Four: Hospitals with PAC projects have higher discharge process documentation compliance.

As the following table indicates, this hypothesis is not confirmed. It would appear that the presence of a PAC project did not influence the discharge processes across the hospital. A Chi-square analysis with PAC status and compliance documentation as the variables found a significant difference but this could be not be attributed to the presence of a PAC project. This requires further consideration as it may be that the compliance of hospitals with and without PAC projects is dependent on a number of factors relating to the characteristics of PAC and non-PAC sites.

Category	Total number of sites	High compliance	Medium compliance	Low compliance
With PAC project	71	6 (8%)	23 (32%)	42 (59%)
With new PAC project	18	6 (33%)	1 (6%)	11 (61%)
Without PAC project	50	9 (18%)	16 (32%)	25 (50%)

Hypothesis Five: Hospitals with aged care wards have higher discharge process documentation compliance

There was a prior belief (now confirmed by the audit) that aged care services provide more effective discharge planning. It was hypothesised that hospitals with aged care wards may disseminate their practice throughout the hospital and therefore such hospitals would have higher discharge process documentation compliance overall. No significant difference was found when a One-way Analysis of Variance was conducted with the presence of aged care wards as the independent variable and compliance as the dependent variable. This hypothesis has therefore not been confirmed.

Category	Total number of sites (aggregated)	High compliance	Medium compliance	Low compliance
Acute hospitals with aged care wards	16	1 (6%)	4 (25%)	11 (69%)
Aged care wards	12	4 (33%)	4 (33%)	4 (33%)
Other acute without aged care wards	92	11 (12%)	25 (27%)	56 (61%)
Total	120	16	33	71

Hypothesis Six: Hospital size is inversely proportional to documentation compliance.

To assess this hypothesis we have considered hospital size in terms of the number of separations of relevance for this audit (that is, excluding same day and one day plus overnight separations and several other specific patient types). As the following table indicates, this hypothesis is confirmed, with smaller hospitals having generally higher compliance. The Department has established for this audit 11 hospital categories based partly on number of separations, and these are analysed above in Hypothesis One. They confirm this hypothesis.

Category	Total number of sites	High compliance	Medium compliance	Low compliance
Large (3000 or more separations)	19	1 (5%)	5 (26%)	13 (69%)
Medium (1000 – 2999 separations)	23	3 (13%)	7 (30%)	13 (57%)
Small (less than 1000 separations)	97	17 (18%)	28 (29%)	52 (54%)

Hypothesis Seven: Hospitals with a dedicated discharge coordinator role have a better documented discharge planning process.

Using One-way Analysis of Variance and as the following table indicates, this hypothesis is not confirmed. This may reflect the very small sample of hospitals with a Discharge Planning Coordinator hospitals and indicates that this role has not resulted in evidence of superior discharge related documentation in patient records. It has been suggested that this result may indicate that this role is focussed on the development of broad processes and documentation, rather than individual patient discharge, or on the discharge of particularly difficult patients rather than all patients.

Category	Total number of sites	High compliance	Medium compliance	Low compliance
Centralised through a Discharge Planning Coordinator	16	3 (19%)	2 (12%)	11 (69%)
Decentralised through individual wards	45	7 (16%)	13 (29%)	25 (55%)
Managed by a multidisciplinary team	50	6 (12%)	18 (36%)	26 (52%)
Other	28	2 (7%)	8 (29%)	18 (64%)

Hypothesis Eight: Hospitals with a higher proportion of intensive post discharge needs patients have higher documentation compliance

As the following table indicates, this hypothesis is confirmed. Using a Kruskal-Wallis test, a significant difference was found between hospitals' compliance levels on the basis of the proportion of patients with intensive post-discharge needs. Hospitals with a high proportion of intensive needs patients have much higher compliance with the audit tool.

Category	Total sites	High compliance	Medium compliance	Low compliance
High proportion (50-100%) of intensive post discharge needs patients	38	10 (26%)	14 (37%)	14 (37%)
Medium proportion (25-49%) of intensive post discharge needs patients	59	5 (8%)	16 (27%)	38 (64%)
Low proportion (0-24%) of intensive post discharge needs patients	42	6 (14%)	10 (24%)	26 (62%)
Total	139	21 (15%)	40 (29%)	78 (56%)

Hypothesis Nine: The discharge process associated with patients treated as a result of a planned admission is better documented than for other patients.

This hypothesis is tested on the basis of the documentation compliance for those records relating to patients whose admission was either planned or unplanned, as specified on the VIMD (Admit Type). As the following table indicates, this hypothesis is confirmed, but only weakly. The differences in recorded evidence of discharge activities is not substantial for planned and unplanned patients.

Category	High compliance	Medium compliance	Low compliance	Hospitals with no patients in this category
Planned admission patients	26 (19%)	44 (32%)	66 (48%)	3 (2.2%)
Unplanned admission patients	20 (14%)	40 (29%)	69 (50%)	10 (7.2%)
Total	46 (17%)	84 (30%)	135 (49%)	

8 Implications for development and monitoring of performance indicators

The capacity of this project to inform the Department and hospitals of the effectiveness of patient discharge is limited by:

- the short time-frame in which the audit tool was developed. It has not been validated, although the criteria incorporated into the tool are consistent with the literature regarding 'best practice' discharge systems. The tool was also presented to hospitals and the Department for comment and amended accordingly. The audit tool will require further development following the experience of this audit;
- its analysis of patient records related to admissions before the Effective Discharge Strategy was initiated. This means that the audit results will not reflect any improvements flowing directly from the Effective Discharge Strategy, but will provide a baseline from which it could be expected that agencies will show substantial improvement in future; and
- the audit has relied upon evidence observed in the patient record. To ensure inter-rater reliability and consistency, auditors operated under the general rule that if it was not documented it was not done. However, it is acknowledged that patient records can only provide information on how the discharge process is documented and does not necessarily indicate that the process documented occurred or that it was 'effective' in achieving the desired patient outcomes. Nevertheless, it may be reasonable to assume that there is a relationship between the quality of documented evidence in the patient records and the quality of the process being documented. In the short term, therefore, documented evidence is considered sufficient for the purpose of providing base-line information on the discharge process. Future work by the Department is expected to include the development of performance indicators and methodologies that will yield the best possible information on patient discharge.

However, the audit has identified considerable scope for improvement in discharge practice. It is recommended that hospitals give consideration to the following actions, which may improve documented discharge performance:

- exploring the potential for using a risk screening tool to focus discharge planning activity;
- implementation of formal on-going training of both medical and clinical staff to ensure their understanding of discharge planning policies and requirements;
- enhanced accountability for and resourcing of discharge planning, including establishing formal mechanisms to monitor, plan and improve discharge processes (for example, Discharge coordinator and discharge committee);
- development of formal guidelines for staff to ensure follow-up of actions recommended in discharge assessments;
- formalisation of arrangements with a range of external service providers that are integral to effective discharge planning and, in doing so, develop an internal database of provider

options that link patient needs with provider services and contains information regarding eligibility criteria, assessment documentation and service availability data;

- provision of adequate systems to support staff in discharge processes, including for example on-line access for appointments with internal and external service providers and more comprehensive, and perhaps computerised, medical record forms; and
- on-going review by hospitals of their own performance against their own policies and protocols. This should include improved follow-up with external service providers and patients and carers to facilitate improved outcomes for individual patients and to inform discharge processes generally.

Given the low compliance with this audit and that hospitals openly acknowledge that there is room for development, the Department could undertake a review of best practice policies, procedures and systems, including a review of the benefits of systems such as those discussed above, as part of the Effective Discharge Strategy.

To measure performance into the future, performance indicators of effective discharge should be developed. The Department is initiating a project to establish performance indicators for discharge. The process will include broad consultation and field testing. Given that this project is unlikely to be finalised within a year, it may be necessary to repeat a process similar to the current audit to provide a basis for distribution of incentive funds for 1999/2000. In the longer term, the measurement of any performance indicators is likely to require some form of independent audit process. Given the experience with this audit, we recommend a rolling cycle of compliance audits to rank the discharge performance of hospitals. Specifically, those hospitals ranked as highly compliant might be re-audited every three years, those with a moderate ranking every two years and those with a low compliance - annually.

The audit tool developed for this assignment could be further refined in the light of this audit's results. A small expert group could test the validity of the aspects of discharge identified in the tool and the weightings and scores attached to rankings. The refined tool, containing only questions, which are auditable, could then be used to measure compliance with discharge standards as a proxy for discharge performance.

There are a number of other measures of effectiveness of discharge performance, which did not form part of this audit, but which could be analysed in conjunction with its findings. These include analyses comparing health outcomes for comparable hospitals and DRGs using indicators such as length of stay, rates of unplanned readmission and benchmarking of patient, carer and community based provider satisfaction.

Appendix 1: Audit tool and references

Table 1: Discharge policies, protocols and processes

The audit tool for gathering information on the discharge policies, protocols and processes for hospitals is set out below. This information is gathered from documentation provided by the hospital and through discussion at the site interview. This information does not form part of the auditable measures against which hospital performance is measured.

	<i>Audit item</i>	<i>Information only</i>			
P1	Does the hospital have a formal discharge policy? If no, go to P5	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
P2	If yes, what is the highest level at which the policy has been endorsed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Board of Management?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No CEO?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Discharge Planning Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Quality Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Medical Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Division/Business Unit?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Other? (specify).....
P3	If yes, who was responsible for the development of the policy?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Board of Management?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No CEO?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Discharge Planning Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Quality Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Medical Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Division/Business Unit?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Other? (specify).....
P4	If yes, when was the policy last reviewed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Within the last quarter?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Within the last 6 months?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Within the last year?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No New, so not relevant
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Unspecified/unknown
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No More than a year ago?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Never?
P5	Does the hospital have a formal discharge protocol? If no, go to P9	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
P6	If yes, at what level has the protocol been endorsed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Board of Management?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No CEO?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Discharge Planning Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Quality Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Medical Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Division/Business Unit?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Other? (specify).....

	<i>Audit item</i>	<i>Information only</i>				
P7	If yes, who was responsible for the development of the protocol?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Board of Management?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	CEO?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Discharge Planning Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Quality Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medical Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Division/Business Unit?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
P8	If yes, when was the protocol last reviewed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last quarter?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last 6 months?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last year?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	More than a year ago?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	New, so not relevant
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Unspecified/unknown
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Never?
P9	Has the hospital developed specific clinical discharge protocols? If no, go to P14	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
P10	If yes, for which clinical areas?	Specify:				
					
					
					
P11	If yes, at what level have these clinical protocols been endorsed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Board of Management?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	CEO?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Discharge Planning Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Quality Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medical Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Division/Business Unit?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
P12	If yes, who was responsible for the development of these clinical protocols?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Board of Management?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	CEO?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Discharge Planning Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Quality Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medical Committee?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Division/Business Unit?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
P13	If yes, when were the clinical protocols last reviewed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last quarter?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last 6 months?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last year?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	More than a year ago?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	New, so not relevant
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Unspecified/unknown
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Never?
P14	In general, how frequently are the hospital's discharge processes reviewed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Continuously?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Annually?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Less than once per year?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	As need arises?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Unspecified/unknown
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Not reviewed?

	<i>Audit item</i>	<i>Information only</i>			
P15	Who is consulted during these reviews?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple disciplines across hospital?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relevant disciplines only?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patients?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Carers/families?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	External service providers?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other? (specify).....	
P16	Is there a Post Acute Care project in which this hospital participates?	<input type="checkbox"/> Yes, within the hospital			
		<input type="checkbox"/> Yes, auspiced by an agency outside the hospital			
		<input type="checkbox"/> No			
P17	If yes, has the PAC project impacted on the hospital's discharge planning and processes?	<input type="checkbox"/> Yes, leading to improved practices generally			
		<input type="checkbox"/> Yes, leading to improved practices in limited areas			
		<input type="checkbox"/> No			
P18	Has the hospital developed specific performance measures to measure discharge performance for the organisation as a whole?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
P19	If yes, what are the performance measures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comparison with State ALOS?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unplanned returns to hospital?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient satisfaction?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	External service provider satisfaction?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other? (specify).....	
P20	Does the hospital undertake benchmarking of these performance measures with similar hospitals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
P21	Is the hospital's discharge process integrated into the hospital's quality process?	<input type="checkbox"/> Yes			
		<input type="checkbox"/> In part			
		<input type="checkbox"/> No			
P22	What are the major obstacles the hospital faces in discharging patients as planned?	Hospital to describe			
P23	What are the strengths of the current discharge system?	Hospital to describe			
P24	What are the deficiencies of the current discharge system?	Hospital to describe			
P25	What steps could be taken to improve the system?	Hospital to describe			

Table 2: Discharge infrastructure

The audit tool for gathering information on the discharge infrastructure in hospitals is set out below. This information is gathered from documentation provided by the hospital and through discussion at the site interview. This information does not form part of the auditable measures against which hospital performance is measured.

	<i>Audit item</i>	<i>Information only</i>				
I1	How is discharge organised in your hospital?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Centralised through a Discharge Planning Coordinator?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Managed by a multidisciplinary team?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Decentralised through the individual wards?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Assignment of a case manager?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other (specify)
I2	How does the hospital facilitate the process of discharge? (more than one can be ticked)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Risk screening
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Discharge plans?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Care maps/plans with process of discharge within them?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
I3	What are the post discharge options available to the hospital? (more than one can be ticked)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Outpatients?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	GP?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	District nursing services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Physiotherapy services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Occupational therapy?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other allied health services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Post natal domiciliary services
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Domiciliary palliative care?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Post Acute Care service?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Domiciliary rehabilitation service?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Social work services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Interpreter services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Psychiatric services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Accommodation provider?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Home help services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Personal care services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Meals on wheels?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Community transport?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ethno-specific support services?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Counselling?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
I4	Does the hospital have a mechanism for ensuring it has information regarding appropriate external service providers to be used as referral options? (more than one can be ticked)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	A referral list?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Regular formal contact with external service providers?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....

	<i>Audit item</i>	<i>Information only</i>				
I5	What information regarding external service providers is maintained?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Contact details?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Service description?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Eligibility criteria?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Assessment documentation?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Service availability data?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
I6	How frequently is this information reviewed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	On-going/as needed?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Weekly?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Monthly?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Quarterly?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last 6 months?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Within the last year?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	More than a year ago?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	New, so not relevant
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Unspecified/unknown
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Never?
I7	What mechanisms are in place to ensure that the hospital's discharge policies, protocols and processes are understood? (more than one can be ticked)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Formal training?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Informal on-the-job training?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Protocol folders on each ward?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Communications from Discharge Planning Coordinator?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
I8	How well understood are the discharge policies, protocols and processes?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fully understood?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Well understood in some areas, but less in others?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Poorly understood?
I9	How frequently is formal training provided?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	On induction?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Quarterly?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	6 monthly?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Annually?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Less often than annually?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	As needed?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Never?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
I10	Do the hospital's internal systems (ie., information systems, availability of documentation) support effective discharge?	<input type="checkbox"/>	Yes			
		<input type="checkbox"/>	In part			
		<input type="checkbox"/>	No			

	<i>Audit item</i>	<i>Information only</i>				
I11	How could these systems be enhanced to support effective discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	More rapid handling of discharge documentation by Medical Records?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	More comprehensive medical records forms?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Introduction of risk screening tool?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	On-line access for outpatients' appointments?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Access to eligibility criteria and availability of service/waiting list information for external providers?
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other? (specify).....
I12	Does the hospital's discharge documentation contain or make reference to the elements identified in the patient record audit tool?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hospital to advise whether the elements of the patient record audit tool are addressed in the hospital's discharge documentation. This is best undertaken by examining a real record against the tool.

Table 3: Discharge implementation

The audit tool to be used for the patient record review is set out below. Note that where the response to items is located in the "Auditable measure" column, it will form part of the audit measurement of the agency's performance. All other responses will provide important information to feed back to participating facilities and to inform the development of robust and realistic performance indicators. As specified, each item in the "Auditable measure" column has been assigned a weighting measure: high importance, medium importance or low importance.

Note: Items marked with * will be derived from the VIMD
 Unless otherwise specified, one category only should be completed; na means not applicable

<i>Patient data</i>		
A4	*UR number	**
A5	*Patient Gender	**
A6	*Patient Age	**
A8	*Date of admission	**
A9	* Planned/unplanned (Admission Type)	**
A10	* Intention to readmit	**
	*Diagnosis	**
A11	- principal diagnosis	**
A12	- secondary diagnoses	**
A13	*AN-DRG code	**
A14	*Intensive post discharge needs patient	** Yes/No
A15	*Date of discharge	**
A16	*Discharge destination (Separation Type)	**
A1	*Hospital	

<i>Patient data</i>		
A2	Discharging or Primary Unit	Specify <input type="checkbox"/> Obstetric ward/unit <input type="checkbox"/> Paediatric ward/unit <input type="checkbox"/> Neonatal ward/unit <input type="checkbox"/> Gynaecology medical ward/unit <input type="checkbox"/> Gynaecology surgical ward/unit <input type="checkbox"/> General Medicine ward/unit <input type="checkbox"/> General Surgery ward/unit <input type="checkbox"/> Screening/holding ward/unit <input type="checkbox"/> Day Surgery ward/unit <input type="checkbox"/> Aged Rehabilitation ward/unit <input type="checkbox"/> Cardiology ward/unit <input type="checkbox"/> Cardio/thoracic surgical ward/unit <input type="checkbox"/> Orthopaedics ward/unit <input type="checkbox"/> Oncology ward/unit <input type="checkbox"/> Opthamology ward/unit <input type="checkbox"/> Endocrinology ward/unit <input type="checkbox"/> Rheumatology ward/unit <input type="checkbox"/> Dermatology ward/unit <input type="checkbox"/> Neurology ward/unit <input type="checkbox"/> Neurosurgery ward/unit <input type="checkbox"/> Dentistry ward/unit <input type="checkbox"/> Other, <i>please specify</i> :
A3	Patient Admission Type	<input type="checkbox"/> General Medicine <input type="checkbox"/> Specialty Medicine, <i>please specify</i> <input type="checkbox"/> Acute Surgical <input type="checkbox"/> Elective Surgical <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Obstetrics and Gynaecology <input type="checkbox"/> Paediatrics <input type="checkbox"/> Aged care <input type="checkbox"/> Other, <i>please specify</i>
A7	First language spoken	

	Audit question	Auditable measure	Information only
B7	<p>If yes, was the expected discharge destination (using “Separation Type” classifications from the VIMD):</p> <ul style="list-style-type: none"> ■ Change to Nursing Home Type (NHT)/Non-Acute ■ Change to Designated Rehabilitation Program/.Unit – Level 1 ■ Change to Designated Rehabilitation Program/Unit – Level 2 ■ Change to Designated Rehabilitation Program/Unit – Level 3 ■ Change to Palliative Care Program ■ Change to Desig Psychiatric Unit or Psychogeriatric Prog ■ Change to Desig Geriatric Evaluation & Management Prog ■ Change to Family Choice, Awake Attendant Care ■ Change to Other Care Type (Acute) <p>To Transfer to other acute hospital / extended care / rehabilitation / geriatric centre</p> <p>N Transfer to nursing home</p> <p>A Transfer to non-acute psychiatric unit rehabilitation/continuing care/ other care) funded by Mental Health Services Output Group 115 in this hospital</p> <p>F Discharge to private accommodation/home with domiciliary postnatal care arranged before discharge</p> <p>P Discharge to private accommodation/home with provision of Post Acute Care program services arranged before Discharge</p> <p>M Discharge to private accommodation/home with referral to Community Rehabilitation Centre arranged before Discharge</p> <p>B Discharge to private accommodation/home with Palliative Care Service support arranged before discharge</p> <p>U Discharge to private accommodation/home with District Nursing support arranged before discharge</p> <p>R Discharge to private accommodation/home with other clinical care and support service</p> <p>H Discharge to private accommodation/home (without support arranged)</p> <p>K Other formal separation</p>		Yes for relevant destination
B8	If yes, was the expected discharge destination reviewed?		Yes/No/na for short LOS

	Audit question	Auditable measure	Information only
B13	<p>If yes, when was the first assessment made</p> <ul style="list-style-type: none"> ■ pre-admission? ■ at admission? ■ during in-patient stay and up to 3 days prior to discharge? ■ 2 days prior to discharge? ■ day prior to discharge? ■ on day of discharge? 	<p>(High importance)</p> <p>Yes/No/na because no pre-admission</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p>	
B14	<p>If yes, did this first assessment include evidence of assessment of (more than one can be ticked) ...</p> <ul style="list-style-type: none"> ■ clinical status? ■ functional status (eg. mobility, self care capacity, review of ADL)? ■ home environment? ■ social support network? ■ cultural and linguistic needs? ■ carer capacity? ■ other? (specify) <p>Provide overall assessment of response compliance</p>	<p>(High importance)</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>High/Medium/Low</p>	
B15	<p>If yes, was the first assessment undertaken by (more than one can be ticked) ...</p> <ul style="list-style-type: none"> ■ formal multidisciplinary team? ■ consultant? ■ VMO? ■ registrar? ■ resident? ■ unspecified medical officer? ■ primary care nurse? ■ Nurse Manager? ■ ward nurse? ■ Discharge Planning Coordinator? ■ social worker? ■ physiotherapist? ■ occupational therapist? ■ speech therapist? ■ audiologist? ■ orthotist and prothetist? ■ Geriatric Assessment Team ■ Post Acute Care (internal to hospital) ■ other? (specify) ■ unclear/unspecified? <p>Provide overall assessment of response compliance</p>		<p>Yes/No for each field</p> <p>High/Medium/Low</p>

	Audit question	Auditable measure	Information only
B16	<p>If yes, where was the evidence of the first assessment found (more than one can be ticked)...</p> <ul style="list-style-type: none"> ■ discharge summary? ■ discharge plan? ■ discharge checklist? ■ discharge assessment? ■ transfer form? ■ care plan? ■ progress notes? / nursing management record? ■ clinical pathway? ■ managed care pathway? ■ risk screening tool? ■ admission assessment? ■ allied health referrals? ■ Post Acute Care assessment form ■ documentation held outside the unit record? <ul style="list-style-type: none"> - Post Acute Care files? - Home Nursing files? - Allied health files? - other? (specify) ■ other? (specify) <p>Provide overall assessment of response compliance</p>		<p>Yes/No for each field</p> <p>High/Medium/Low</p>
B17	<p>Were there subsequent reassessments? If no, go to C1.</p>	<p>(Low importance) Yes/No</p>	
B18	<p>If yes, did the reassessments occur (more than one can be ticked)...</p> <ul style="list-style-type: none"> ■ at critical points in treatment? ■ daily? ■ weekly? ■ if the patient's clinical condition or functional status changed? ■ if the patient's family/social situation changed? <p>Provide overall assessment of response compliance</p>		<p>Yes/No Yes/No Yes/No Yes/No</p> <p>Yes/No High/Medium/Low</p>
B19	<p>If yes, when was the last assessment made ...</p> <ul style="list-style-type: none"> ■ at admission? ■ during in-patient stay and up to 3 days prior to discharge? ■ 2 days prior to discharge? ■ day prior to discharge? ■ on day of discharge? 	<p>(Low importance) Yes/No Yes/No Yes/No Yes/No Yes/No</p>	

	Audit question	Auditable measure	Information only
B20	<p>If yes, did this last assessment include evidence of assessment of (more than one can be ticked) ...</p> <ul style="list-style-type: none"> ■ clinical status? ■ functional status (eg. mobility, self care capacity, review of ADL)? ■ home environment? ■ social support network? ■ cultural and linguistic needs? ■ carer capacity? ■ other? (specify) <p>Provide overall assessment of response compliance</p>	<p>(Low importance)</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>High/Medium/Low</p>	
B21	<p>If yes, was the last assessment undertaken by (more than one can be ticked) ...</p> <ul style="list-style-type: none"> ■ formal multidisciplinary team? ■ consultant? ■ VMO? ■ registrar? ■ resident? ■ unspecified medical officer? ■ primary care nurse? ■ Nurse Manager? ■ ward nurse? ■ Discharge Planning Coordinator? ■ social worker? ■ physiotherapist? ■ occupational therapist? ■ speech therapist? ■ audiologist? ■ orthotist and prothetist? ■ Geriatric Assessment Team ■ Post Acute Care (internal to hospital) ■ other? (specify) ■ unclear/unspecified? <p>Provide overall assessment of response compliance</p>		<p>Yes/No for each field</p> <p>High/Medium/Low</p>

	Audit question	Auditable measure	Information only
C10	<p>If yes, when were the following actions taken (respond for those for which assessments were made) ...</p> <ul style="list-style-type: none"> ■ provision of immediate post-discharge medications? <ul style="list-style-type: none"> - for what period of time? ■ advice on on-going medication regimen to patient? ■ advice on on-going medication regimen to carer? ■ advice on on-going medication regimen to external service providers ■ provision of, or arrangements for, post-discharge resources (including wound dressings and mobility aids)? ■ provision of discharge information/training to patient? ■ provision of discharge information/training to carer? ■ advice on nutrition / dietetics regimen to patient? ■ advice on nutrition / dietetics regimen to carer? ■ advice on continence management/aids to patient? ■ advice on continence management/aids to carer? ■ advice on asthma management to patient? ■ advice on asthma management to carer? ■ advice on post natal issues to patient? ■ return of patient's own medications, valuables and clothing? ■ provision of medical certificate? ■ organisation of post-discharge hospital medical services, including outpatient/specialist/referral appointments? ■ notification of discharge to the patient's GP? ■ organisation of GP appointment for patient? ■ organisation of post hospital community services, including: <ul style="list-style-type: none"> - district nursing services? - physiotherapy services? - occupational therapy? - other allied health services? - post natal domiciliary services? - domiciliary palliative care? - domiciliary rehabilitation service? - Post Acute Care service? - social work services? - interpreter services? - psychiatric services? - accommodation provider? - home help services? - personal care services? - meals on wheels? - community transport? - ethno-specific support services? - counselling? - other? (specify) <p>Provide overall assessment of response compliance</p>	<p>(High importance)</p> <p>Before/day of/after discharge/unspecified (for each action where an assessment of need was made)</p> <p>High/Medium/Low</p>	

	Audit question	Auditable measure	Information only
C11	Was there involvement of the patient in preparing for discharge? If no or na, go to C13	(High importance) Yes/No/na (eg unconscious or mentally incapable)	
C12	If yes, did it include (more than one can be ticked) ... <ul style="list-style-type: none"> ■ consultation around needs and exploration of options? ■ decision making? 		Yes/No Yes/No
C13	Was there involvement of the carer/family in preparing for discharge? If no or na, go to D1	(Medium importance) Yes/No/na (eg no family/carer present or necessary)	
C14	If yes, did it include (more than one can be ticked) ... <ul style="list-style-type: none"> ■ consultation around needs and exploration of options? ■ decision making? 		Yes/No Yes/No

	Audit question	Auditable measure	Information only
D	<i>Communication with, and information to, post-discharge providers</i>		
D1	Were external service providers involved in consideration of options and decision making for discharge? If no or na, go to D3.	(High importance) Yes/No/na (eg. no specific needs and no GP)	
D2	<p>If yes, was there involvement in consideration of options and decision making of the (more than one can be ticked)</p> <ul style="list-style-type: none"> ■ GP? ■ district nursing services? ■ physiotherapy services? ■ occupational therapy services? ■ other allied health services (specify)? ■ post natal domiciliary services? ■ domiciliary palliative care? ■ domiciliary rehabilitation service? ■ Post Acute Care service? ■ social work services? ■ interpreter services? ■ psychiatric services ■ accommodation provider? ■ home help services? ■ personal care services? ■ meals on wheels? ■ community transport? ■ community case manager? ■ ethno-specific support services? ■ counselling? ■ other? (specify) <p>Provide overall assessment of response compliance</p>	<p>(High importance)</p> <p>Yes/No/No, but VMO is GP</p> <p>Yes/No/unclear for all following fields</p> <p>High/Medium/Low</p>	

	Audit question	Auditable measure	Information only
D3	<p>Was information provided to initiate post-discharge care to (respond for those for which referral occurred): If no, unclear or na, go to D6</p> <ul style="list-style-type: none"> ■ GP? ■ district nursing services? ■ physiotherapy services? ■ occupational therapy services? ■ other allied health services (specify)? ■ Post natal domiciliary service? ■ domiciliary palliative care? ■ domiciliary rehabilitation service? ■ Post Acute Care service? ■ social work services? ■ interpreter services? ■ psychiatric services ■ accommodation provider? ■ home help services? ■ personal care services? ■ meals on wheels? ■ community transport? ■ community case manager? ■ ethno-specific support services? ■ counselling? ■ other? (specify) <p>Provide overall assessment of response compliance</p>	<p>(High importance)</p> <p>Yes/No/No, but VMO is GP</p> <p>Yes/No/unclear for all providers to which a referral occurred</p> <p>High/Medium/Low</p>	

	Audit question	Auditable measure	Information only
D4	<p>If yes, did the information provided give adequate guidance on post-discharge requirements to (respond for those for which referral occurred):</p> <ul style="list-style-type: none"> ■ GP? ■ district nursing services? ■ physiotherapy services? ■ occupational therapy services? ■ other allied health services (specify)? ■ post natal domiciliary service? ■ domiciliary palliative care? ■ domiciliary rehabilitation service? ■ Post Acute Care service? ■ social work services? ■ interpreter services? ■ psychiatric services ■ accommodation provider? ■ home help services? ■ personal care services? ■ meals on wheels? ■ community transport? ■ community case manager? ■ ethno-specific support services? ■ counselling? ■ other? (specify) <p>Provide overall assessment of response compliance</p>		<p>Yes/No/No, but VMO is GP/ unclear Yes/No/ unclear for all providers to which a referral was made</p> <p>High/Medium/Low</p>
D5	<p>If yes, when was the information provided to (respond for those for which referral occurred):</p> <ul style="list-style-type: none"> ■ GP? ■ district nursing services? ■ physiotherapy services? ■ occupational therapy services? ■ other allied health services? ■ post natal domiciliary service? ■ domiciliary palliative care? ■ domiciliary rehabilitation service? ■ Post Acute Care service? ■ social work services? ■ interpreter services? ■ psychiatric services ■ accommodation provider? ■ home help services? ■ personal care services? ■ meals on wheels? ■ community transport? ■ community case manager? ■ ethno-specific support services? ■ counselling? ■ other? (specify) <p>Provide overall assessment of response compliance</p>	<p>(High importance)</p> <p>Before/day of/after discharge/unspecified / for each provider to whom a referral was made</p> <p>High/Medium/Low</p>	

	Audit question	Auditable measure	Information only
D6	<p>Was there follow-up to ensure implementation of the discharge plan with (respond for those for which referral occurred): If no, go to D8</p> <ul style="list-style-type: none"> ■ GP? ■ district nursing services? ■ physiotherapy services? ■ occupational therapy services? ■ other allied health services? ■ post natal domiciliary service? ■ domiciliary palliative care? ■ domiciliary rehabilitation service? ■ Post Acute Care service? ■ social work services? ■ interpreter services? ■ psychiatric services? ■ accommodation provider? ■ home help services? ■ personal care services? ■ meals on wheels? ■ community transport? ■ community case manager? ■ ethno-specific support services? ■ counselling? ■ other? (specify) <p>Provide overall assessment of response compliance</p>		<p>Yes/No/No, but GP is VMO Yes/No for each provider to whom a referral was made</p> <p>High/Medium/Low</p>

	Audit question	Auditable measure	Information only
D7	<p>If yes, when did follow-up to ensure implementation of the discharge plan occur for (respond for those for which referral occurred):</p> <ul style="list-style-type: none"> ■ GP? ■ district nursing services? ■ physiotherapy services? ■ occupational therapy services? ■ other allied health services? ■ post natal domiciliary service? ■ domiciliary palliative care? ■ domiciliary rehabilitation service? ■ Post Acute Care service? ■ social work services? ■ interpreter services? ■ psychiatric services ■ accommodation provider? ■ home help services? ■ personal care services? ■ meals on wheels? ■ community transport? ■ community case manager? ■ ethno-specific support services? ■ counselling? ■ other? (specify) <p>Provide overall assessment of response compliance</p>		<p>Within one day/ one week/one month /unspecified for each provider to whom a referral was made</p> <p>High/Medium/Low</p>
D8	Was there follow-up with the patient and/or carer/family to ensure implementation of the discharge plan? If no, go to D10		Yes/No
D9	<p>If yes, when did the follow-up with the patient and/or carer/family to ensure implementation of the discharge plan occur ...</p> <ul style="list-style-type: none"> ■ within one day? ■ within one week? ■ within one month? ■ not done? ■ not specified? ■ not applicable? 		<p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p>
D10	Was there evaluation of the effectiveness of the discharge plan and its implementation? If no, go to E1.		Yes/No
D11	<p>Did this evaluation include feedback from (more than one can be ticked):</p> <ul style="list-style-type: none"> ■ treating doctor? ■ GP? ■ patient? ■ carer? ■ external service providers ■ other? (Specify) <p>Provide overall assessment of response compliance</p>		<p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>Yes/No</p> <p>High/Medium/Low</p>

References accessed in developing the audit tool included the following:

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Discharge Direct: State operations manual – provider certification, United States Department of Health and Human Services, March 1997

Discharge Planners Resource Kit: Discharge Planning for Veterans and War Widow(er)s in South Australia, Commonwealth Department of Veteran Affairs, 1998

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Hospital Today, Community Tomorrow, South Australian Health Commission, June 1998

Patient Care Coordinators, S. McNamara, M. Sullivan, *Journal of Nursing Administration*, Vol 25, No.11, November 1995

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Appendix 2: Total separations and audit sample

Hospital name	Hospital code	Site type	Total separations	Total sample	Records audited	% records not available or not audited
Bethlehem Hospital Inc	A05	E	240	23	23	0.0
Caritas Christi Hospice	A08	E	181	23	20	13.0
Hampton Rehabilitation Centre	A14	A	267	26	19	26.9
Mercy Hospital for Women	A16	A	3864	181	179	1.1
Monash Medical Centre	A17	A	8854	288	248	13.9
Monash Medical Centre Clayton - Aged Care	A17A	AG	49	17	14	17.6
Royal Children's Hospital	A19	A	5757	253	173	31.6
Royal Talbot Rehabilitation Centre	A22	A	368	41	37	9.8
Royal Women's Hospital	A23	A	4724	203	191	5.9
Royal Victorian Eye & Ear Hospital The	A24	A	1118	204	199	2.5
Werribee Mercy Hospital	A32	A	2120	234	224	4.3
The Alfred	B01	A	6971	287	247	13.9
Austin & Repatriation Medical Centre - Heidelberg	B03-1	A	7024	290	245	15.5
Austin & Repatriation Medical Centre - West Heidelberg	B03-2	A	1991	263	219	16.7
Austin RMC - Aged Care (at W Heidelberg)	B03-2A	AG	103	21	19	9.5
Box Hill Hospital	B05	A	6108	288	242	16.0
Dandenong Hospital	B11	A	6318	282	266	5.7
Western Hospital	B18-1	A	6408	290	265	8.6
Maroondah Hospital	B21	A	2793	271	221	18.5
Monash - Moorabbin	B22	A	1834	222	210	5.4
The Northern Hospital	B28	A	5060	277	235	15.2
Royal Melbourne Hospital	B33-1	A	8399	291	234	19.6
Sandringham District Hospital	B36	A	1729	253	211	16.6
Caulfield General Medical Centre	B37	A	1618	257	109	57.6
Sunshine Hospital	B39	A	3021	230	219	4.8
Sunshine Hospital - Aged	B39A	AG	73	19	17	10.5
St Vincent's Hospital (Melbourne) Ltd	B45	A	5789	284	279	1.8
Williamstown Hospital	B46	A	1324	237	209	11.8
Ballarat HS - Ballarat Base Hospital	D01	A	4354	276	216	21.7
Bendigo Health Care Group	D02	A	3983	276	245	11.2
Barwon Health	D05	A	7347	289	278	3.8
Central Wellington Health Service	D06	A	1733	240	240	0.0
Western District Health Service	D07	A	1112	226	221	2.2
Mildura Base Hospital	D11	A	1895	240	169	29.6

Hospital name	Hospital code	Site type	Total separations	Total sample	Records audited	% records not available or not audited
Mildura Base Hospital - Aged Care	D11A	AG	89	20	16	20.0
Goulburn Valley Health - Shepparton	D12-1	A	3341	263	245	6.8
Goulburn Valley Health - Aged Care	D12-1A	AG	185	23	18	21.7
Goulburn Valley - Waranga	D12-2	A	118	86	84	2.3
Goulburn Valley - Tatura	D12-3	A	118	85	74	12.9
Wangaratta District Base Hospital	D15	A	2202	259	199	23.2
Wangaratta Base Hospital - Aged Care	D15A	AG	132	22	21	4.5
Warrnambool Base Hospital	D16	A	2575	257	234	8.9
Warrnambool Base Hospital - Aged Care	D16A	AG	173	22	22	0.0
Wimmera Health Care Group	D17	A	1287	231	221	4.3
East Grampians Health Service	E01	A	520	46	20	56.5
Djerriwarrh Health Services	E03	A	648	45	39	13.3
Bairnsdale RHS	E04	A	1868	250	213	14.8
Bairnsdale RHS - Aged Care	E04A	AG	82	20	17	15.0
Benalla	E05	A	843	48	47	2.1
Corangamite Regional Hospital Services	E08	A	434	45	45	0.0
Colac Community HS	E13	A	942	48	42	12.5
Hepburn Health Service - Daylesford	E16	A	249	42	39	7.1
Echuca Regional Health	E18	A	1076	223	196	12.1
Frankston Hospital	E22	A	5621	283	243	14.1
Kerang and District Hospital	E24	A	328	43	41	4.7
Gippsland Southern HS - Korumburra	E25	A	206	40	39	2.5
Kyabram & District Memorial Community Hospital	E26	A	694	47	43	8.5
Kyneton District Hospital	E27	A	454	45	44	2.2
Maryborough Hospital	E35	A	819	47	46	2.1
West Wimmera HS - Nhill	E37-1	A	327	44	42	4.5
West Wimmera HS - Kaniva	E37-2	A	84	32	31	3.1
West Wimmera HS - Jeparit	E37-3	A	62	29	29	0.0
West Wimmera HS - Rainbow	E37-4	A	86	33	21	36.4
Mallee Track Health and Community Services	E39	M	160	39	34	12.8
New Latrobe Regional Hospital	E44	A	1520	239	233	2.5
New Latrobe Regional Hospital - Aged Care	E44A	AG	33	15	15	0.0
Port Fairy Hospital	E45	A	171	40	24	40.0

Hospital name	Hospital code	Site type	Total separations	Total sample	Records audited	% records not available or not audited
Portland and District Hospital	E46	A	1009	48	47	2.1
East Wimmera Health Service	E48	A	182	40	39	2.5
Swan Hill District Hospital	E49	A	1257	231	204	11.7
Warracknabeal District Hospital	E57	A	246	43	38	11.6
West Gippsland Healthcare Group	E58	A	1592	239	214	10.5
Angliss Hospital	E59	A	3674	265	252	4.9
Angliss Hospital - Aged Care	E59A	AG	56	18	17	5.6
Wodonga Regional Health Service	E66	A	1837	223	219	1.8
Wodonga Hospital - Aged Care	E66A	AG	101	21	21	0.0
Wonthaggi District Hospital	E67	A	730	47	26	44.7
Gippsland Southern HS - Woorayl	E68	A	463	45	44	2.2
Yarram & District Hospital	E77	A	138	38	32	15.8
Yarrawonga District Hospital	E78	A	345	44	42	4.5
Alexandra District Hospital	F01	A	289	43	37	14.0
Otway Health and Community Services	F02	M	48	26	24	7.7
Boort District Hospital	F06	A	123	36	35	2.8
Casterton Memorial Hospital	F09	A	197	41	41	0.0
Cobram District Hospital	F12	A	443	46	46	0.0
Cohuna District Hospital	F13	A	320	43	43	0.0
Coleraine & District Hospital	F14	A	169	40	39	2.5
Upper Murray Health & Community Services	F15	M	100	33	32	3.0
Hepburn Health Service - Creswick	F16	A	111	35	34	2.9
Wimmera HCG - Dimboola	F18	A	118	36	36	0.0
East Wimmera Health Service - Donald	F19	A	99	34	33	2.9
Dunmunkle Health Services	F21	A	26	18	14	22.2
Edenhope and District Hospital	F24	A	178	40	36	10.0
Yarra Ranges Health Services	F33	A	287	42	41	2.4
Melvor Health and Community Services	F34	A	109	34	33	2.9
Heywood District & Memorial Hospital	F35	A	61	28	27	3.6
Inglewood Hospital The	F37	A	33	21	20	4.8
Kilmore & District Hospital	F46	A	475	45	45	0.0
Lorne Community Hospital	F55	A	95	34	29	14.7
Maffra District Hospital	F58	A	195	40	39	2.5
Maldon Hospital	F59	A	67	30	30	0.0
Managatang and District Hospital	F66	A	39	22	21	4.5
Mansfield District Hospital	F67	A	365	44	37	15.9
Alpine Health - Myrtleford	F88-1	M	238	42	41	2.4
Alpine Health - Bright	F88-2	M	106	33	21	36.4
Alpine Health - Tawonga	F88-3	M	135	37	36	2.7

Hospital name	Hospital code	Site type	Total separations	Total sample	Records audited	% records not available or not audited
Nathalia District Hospital	G01	A	110	35	34	2.9
Numurkah & District Health Service	G02	A	459	46	43	6.5
Omeo District Hospital	G04	A	27	19	15	21.1
Far East Gippsland Hlth & Support Service	G05	M	187	39	24	38.5
Western District Health Service - Peshurst	G08	A	35	21	21	0.0
Beaufort & Skipton Health Service - Ripon Peace	G12	A	161	39	39	0.0
Robinvale District Hospital & HS	G13	A	154	38	36	5.3
Rochester & Elmore DHS	G14	A	248	42	40	4.8
Seymour District Memorial Hospital	G19	A	448	45	35	22.2
Beaufort & Skipton Health Service -Skipton	G23	A	50	27	25	7.4
South Gippsland Hospital	G24	A	291	43	42	2.3
Rosebud Hospital	G25	A	1197	240	224	6.7
Stawell District Hospital	G26	A	589	46	37	19.6
Tallangatta Hospital	G29	A	89	33	29	12.1
Terang and Mortlake HS	G35	A	312	44	40	9.1
Timboon and District Healthcare Service	G36	M	201	39	38	2.6
Kooweerup Regional Health Service	G48	A	161	37	33	10.8
Hesse Rural Health Service	G50	A	98	34	32	5.9
Wycheproof District Hospital	G56	A	46	25	23	8.0
Yea & District Memorial Hospital	G59	A	116	36	31	13.9
Mt Alexander Hospital	H01	A	647	47	47	0.0
Mt Alexander Hospital - Aged Care	H01A	AG	164	22	20	9.1
Bendigo Health Care Group - Anne Caudle Centre	H02	E	542	24	20	16.7
Kingston Centre	H03	E	720	26	26	0.0
Barwon Health - Grace McKellar	H04	E	318	24	24	0.0
North West Hospital	H06	E	919	45	43	4.4
Ballarat HS - Queen Elizabeth Geriatric Centre	H07	E	492	24	23	4.2
Mount Eliza Aged Care and Rehabilitation Service	H08	E	559	24	22	8.3
Bundoora Extended Care Centre	H09	E	408	24	20	16.7
Peter James Centre The	H12	E	650	25	20	20.0
Beechworth - Ovens & Murray	H46	A	54	28	28	0.0
St George's Health Service	H70	E	475	24	24	0.0

Hospital name	Hospital code	Site type	Total separations	Total sample	Records audited	% records not available or not audited
Peter MacCallum Cancer Institute	Z55	A	1994	265	161	39.2
Total			170953	13868	12205	12.0

Appendix 3: Acute hospitals by category

Group	Hospital name
Metro 1	<p>Tertiary & specialist hospitals</p> <p>Monash Medical Centre - Clayton & Moorabbin Austin & Repatriation Medical Centre - Heidelberg & West Heidelberg Royal Melbourne Hospital The Alfred St Vincent's Hospital (Melbourne) Ltd Royal Women's Hospital Royal Children's Hospital Mercy Hospital for Women Peter MacCallum Cancer Institute Royal Victorian Eye & Ear Hospital The</p>
Metro 2	<p>Metropolitan community hospitals (>20,000 seps)</p> <p>Western Hospital Frankston Hospital Box Hill Hospital Dandenong Hospital The Northern Hospital</p>
Metro 3	<p>Small metropolitan community hospitals (<=20,000 seps)</p> <p>Angliss Hospital Maroondah Hospital Werribee Mercy Hospital Sandringham District Hospital Caulfield General Medical Centre Sunshine Hospital Williamstown Hospital Rosebud Hospital</p>
Rehab	<p>Rehabilitation</p> <p>Royal Talbot Rehabilitation Centre Hampton Rehabilitation Centre</p>
Rural 1	<p>Regional referral hospitals (>20,000 seps)</p> <p>Barwon Health Ballarat HS - Ballarat Base Hospital Bendigo Health Care Group</p>
Rural 2	<p>Base and sub-regional referral hospitals (4,000 - 20,000)</p>

Group	Hospital name
	<p>seps) Goulburn Valley - (Waranga, Tatura, Shepparton) Mildura Base Hospital Warrnambool Base Hospital Wodonga Regional Health Service Wangaratta District Base Hospital West Gippsland Healthcare Group Central Wellington Health Service Bairnsdale RHS Wimmera Health Care Group (& Dimboola) Swan Hill District Hospital Echuca Regional Health Western District Health Service - (& Penshurst) New Latrobe Regional Hospital Colac Community HS Portland and District Hospital Djerriwarrh Health Services Wonthaggi District Hospital</p>
Rural 3	<p>District hospitals (1,000 - 3,999 seps) Benalla Maryborough Hospital Kyabram & District Memorial Community Hospital Gippsland Southern HS - (Korumburra & Woorayl) Mt Alexander Hospital Seymour District Memorial Hospital Stawell District Hospital East Grampians Health Service Kyneton District Hospital Kooweerup Regional Health Service Yarrowonga District Hospital Kilmore & District Hospital West Wimmera HS - (Nhill, Rainbow, Jeparit, Kaniva) Corangamite Regional Hospital Services Cohuna District Hospital Kerang and District Hospital Mansfield District Hospital Yarra Ranges Health Services Numurkah & District Health Service</p>
	<p>Cobram District Hospital Alexandra District Hospital</p>

Group	Hospital name
	Terang and Mortlake HS Rochester & Elmore DHS South Gippsland Hospital Casterton Memorial Hospital
Rural 4	Small rural hospitals (<1000 seps) Robinvale District Hospital & HS Yarram & District Hospital Maffra District Hospital Edenhope and District Hospital East Wimmera Health Service (& Donald) Warracknabeal District Hospital Port Fairy Hospital Beaufort & Skipton Health Service - (Ripon Peace & Skipton) Boort District Hospital Coleraine & District Hospital Yea & District Memorial Hospital Lorne Community Hospital Hepburn Health Service - (Creswick & Daylesford) Mclvor Health and Community Services Hesse Rural Health Service Nathalia District Hospital Tallangatta Hospital Beechworth - Ovens & Murray Heywood District & Memorial Hospital Maldon Hospital Wycheproof District Hospital Manangatang and District Hospital Omeo District Hospital Dunmunkle Health Services Inglewood Hospital The

Appendix 4: Graphical analysis of audit findings

Implementation of discharge policy, protocols and processes

Our findings from the review of 12,205 patient records across 139 sites are presented graphically in this Appendix. The responses to the questions set out in the Audit Tool have been calculated and compared within eleven categories of hospitals as defined in Section 3.

Hospital categories

The categories and their short descriptions used in the graphs are as follows:

- A – acute hospitals;
 - Metro 1 – tertiary and specialist hospitals;
 - Metro 2 – metropolitan community hospitals (> 20,000 separations);
 - Metro 3 – small metropolitan community hospitals (</= 20,000 separations);
 - Rehab – rehabilitation hospitals;
 - Rural 1 – regional referral hospitals (>20,000 separations);
 - Rural 2 – base and sub-regional referral hospitals (4,000 – 20,000 separations);
 - Rural 3 – district hospitals (1,000 – 3,999 separations); and
 - Rural 4 – small rural hospitals (< 1,000 separations).
- AG – Aged care funded sub-acute units in public hospitals;
- E – extended care services;
- M – Multi-Purpose Services;
- Total – total of all A, AG, E, and M main categories; and
- Total A – total of all sub-categories of Acute.

Responses to questions in the Audit Tool

The responses are graphed in the order of the questions set out in the Audit Tool detailed in Appendix 1 and are marked with the relevant question number and a descriptive heading. The main groups are:

- B questions – B1 to B22;
- C questions – C1 to C14;
- D questions – D1 to D11; and
- E questions – E1 to E2.

Each question (denoted by the symbols above) usually has two graphs:

- the first provides the comparison of results for the main hospital categories;
 - A – acute;
 - AG – aged care;
 - E – extended care services;
 - M – Multi-Purpose services; and
 - Total – all of the main categories combined;
- the second provides the sub-categories for Acute hospitals; and
- where there are two parts to a question, the graphs are marked as follows, eg C14a and C14b.

Intensive and non-intensive post discharge needs

The responses to the review of records have also been compared separately for patients with:

- I – intensive post discharge needs;
- NI – non-intensive post discharge needs; and
- Total I and NI – total for intensive and non-intensive post discharge needs.

Level of compliance

For certain questions in the Audit Tool, an overall assessment of response compliance was provided. The compliance categories are as follows:

- H – high response compliance;
- M – medium response compliance; and
- L – low response compliance.