



**CLINICAL PRACTICE GUIDELINE**

**Discharge of a Patient**

This document should be read in conjunction with the [Disclaimer](#)

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## Aim

To ensure a smooth patient journey culminating in timely discharge of all patients from King Edward Memorial Hospital and communication with ongoing healthcare providers.

## Key Points

1. Discharge planning is the responsibility of all medical, midwifery, nursing and allied health professionals involved in the care of the woman/neonate. It contributes to a continuum of care that starts prior to admission for elective and planned admissions and at the time of admission for emergency patients, ensuring that discharge occurs expediently and without unnecessary delays.
2. All admitted women (including emergency admissions) will have an Estimated Date of Discharge (EDD) communicated to them and / or their carer.
3. During periods of excess demand, an earlier discharge or transfer may be considered in consultation with the clinical team (both public and private).
4. Discharge planning shall take place as part of the written nursing / midwifery care plan / clinical pathway guidelines.
5. Ensure the woman has adequate information about:
  - Resuming normal living, including the expected time for and the stages of convalescence, return to paid employment and driving.
  - A clinic appointment / GP follow up.
  - Certificate of fitness for return to work.
  - Medications or prescriptions.
  - If necessary, arrange with the Visiting Midwifery Service to visit the woman. Ensure the woman understands this referral.
6. Arrange transport if necessary ([Discharge Policy](#)).
7. Record all discharge procedures in the medical record.

## Antenatal Patients

- Public antenatal women may be considered fit for discharge by an Obstetric Consultant or Registrar only.
- Ensure all documentation including the MR 207 (Discharge Summary and Morbidity Sheet) is completed at the time of discharge.
- For women discharged back into the Community Midwifery Program (CMP),
  - Call the CMP Midwifery Manager on mobile 0419162432 and provide discharge details if a verbal handover is required.
  - Complete MR 089 CMP Discharge Form and fax to the CMP office (94067721).

Ref [Clinical Guideline Assessment of the Woman on presentation to LBS: Presentation at KEMH of Women Booked on the Community Midwifery Program \(CMP\)](#)

## Postnatal Patients

- A midwife will determine those women fit of discharge following an uncomplicated vaginal birth from 4 hours if clinically appropriate and safe to do so.
- All women shall be informed of the Hospital's discharge policy and the advantages of discharge planning at their first antenatal visit and again at 32 weeks gestation.
- Labour and Birth Suite midwifery staff shall initiate the inpatient discharge plan by discussing with the women their expected date of discharge.
- Women require one postnatal check by a medical officer, to clear them prior to discharge (unless they meet the criteria for discharge by the midwife). If the woman's condition deteriorates, a further medical check shall be required. Document on the MR 251.
- A Registered Medical Officer (RMO) in consultation with the Registrar/Senior Registrar will determine those women fit for discharge following:
  - A caesarean section at 24-72 hours if clinically appropriate and safe to do so.
  - A complicated vaginal birth.
  - Admission to the Adult Special Care Unit (ASCU).
  - Management of a medical condition.

The RMO will complete the Postnatal Assessment for Discharge form (MR251).
- Those public patients who have had an uncomplicated antenatal course and a vaginal birth can have their discharge performed by a midwife. See KEMH Clinical Guideline [Transfer of a Postnatal Woman by a Midwife to Home / Visiting Midwifery Service / GP Care](#).
- On admission to the postnatal ward all women shall be informed of their expected day of discharge so that they may plan for their discharge e.g. arrange transport.
- Ward neonates must receive an examination / check by a Paediatric RMO prior to discharge. For neonate discharges under 72 hours, the 'Day 1 check' also covers the discharge examination, provided there is no change in the neonate's condition.
- If the neonates is < 37 weeks or under the care of the Neonatal team, the paediatric RMO will discharge the neonate in accordance with the [Neonatal Management on Postnatal Wards Guideline](#)
- Discharge duties require the completion of the necessary documentation including completion of the Stork Discharge Summary for postnatal women,

and the MR 207(Discharge Summary and Morbidity Sheet) for antenatal women.

- Stork Summaries must be completed and copies generated for the patient's:
  - Medical Record
  - General Practitioner
  - Child Health Nurse, and for
  - Referral to Visiting Midwifery Service as appropriate.
  - The patient may also have a copy if she requests one.

Additional copies may be required for referring services and other ongoing care providers e.g. Aboriginal Medical Services

- If a MR 251 (Medical Postnatal Discharge Form) has been required, this is to be forwarded to the clinician/s responsible for ongoing care.

### **For women discharged back into the Community Midwifery Program (CMP)**

- Complete the MR 089 CMP Discharge Form
- Fax a copy of the Stork discharge printout and completed CMP form to the CMP office (94067721).
- Provide a copy of the Stork printout to the woman to take home.
- The original handheld Pregnancy Health Record and copies of the Labour and Birth Summary (MR230.01) and Integrated Progress Notes (MR250) shall be forwarded to the Community Midwifery Programme department for filing.
- KEMH shall keep a copy of the Pregnancy Health Record in the patient's medical records.

### **Gynaecology Patients**

- A Consultant or Senior Registrar will determine those women fit for discharge. The RMO will complete the NaCS discharge summary.
- Ensure the woman has adequate information about:
  - Resuming normal living including an expected timeframe and the stages of convalescence, return to paid work and driving.
  - Clinic appointments or further planned treatments e.g. chemotherapy, radiotherapy etc.
  - Certificate of fitness to return to work / medical certificate.
  - If required, arrange referrals with the Visiting Midwifery Service and other agencies as appropriate e.g. SCNA, HCS. Ensure the woman understands these referrals.
  - Resumption of sexual intercourse, including a timeframe. Contraception if applicable. More detailed information regarding sexual activity may be required depending on the surgery performed. This should be assessed on an individual basis.
  - Discharge time for gynaecology women is 1000 hours.

- Prior to discharge, the nurse should check with the woman as to who will be providing her follow up i.e. which GP/service.
- A discharge summary shall be faxed / emailed to the woman's GP within 24 hours.
- The medical officer must contact the woman's GP by phone to give a verbal handover if the woman requires significant follow up or following significant events such as death or major complications.

### **Visiting Midwifery Service / Adolescent Service**

- All postnatal women may be seen up to the fifth day following birth or longer if required.
- All Adolescent Service women receive postnatal care up until their 6 week postnatal check.
- Further visits beyond this are based on clinical needs. Reasons may include lactation management, weight checks, jaundice, and wound care including removal of sutures / staples.
- Referrals and feedback to Breast Feeding Centre, Child Health Nurse or other agencies such as social work and psychological medicine should be initiated as soon as practical to facilitate discharge from VMS.
- Discharge advice should include
  - Visiting the GP at 6 weeks or prior if medically indicated.
  - Child health Nurse contact
- Patients will be discharged from VMS when they are obstetrically well, feeding is progressing normally and baby is gaining weight or they are transferred to another service e.g. BFC, CHN or another hospital's catchment. This may occur prior to the 5<sup>th</sup> day postnatally. Ensure the patient is aware of VMS discharge and expected follow up within the community.
- On discharge the clinical pathway should indicate the patient has been discharged. The pathways, variances and observation charts should be collected and returned to the VMS office for filing in medical records.
- A record of the VMS visits will be kept in the VMS midwives diary and this entry should clearly show the patient has been discharged from the service.
- These diaries are to be returned to the hospital for storage.
- TOPAS forms should indicate discharge and be returned to the VMS office for data entry by the clerks.

## Discharge from Labour and Birth Suite, Emergency Centre and MFAU

### Discharge of an Obstetric Patient from the LBS and MFAU

- The patients with the following obstetric conditions can be discharged by a level 1 Registrar or above:
  - Patients with symptoms of an uncomplicated UTI.
  - Patients who have been assessed in the Maternal fetal Assessment Unit (MFAU) and have been deemed suitable for discharge by a level 1 Registrar or above as per KEMH clinical guidelines.
- **Women with low risk pregnancies who present in spurious or very early labour may be sent home by the midwife.**
- Follow up for such patients, as delineated above, and all other presentations, should be in accordance with safe standards of clinical practice, and as per KEMH Clinical Guidelines.
- All patients who fall into the above categories where the Registrar or the midwife has concerns shall be discussed with the Senior Registrar or Consultant on call, prior to discharge.
- All patients not falling into the above categories shall be discussed with the on call Senior Registrar or Consultant before discharge. The time and content of the telephone conversation must be clearly documented in the patient's notes.

### Discharge of Gynaecology Patients from the EC

- Women with the following gynaecological conditions can be discharged by a Level 1 Registrar:
  - Hyperemesis.
  - Bleeding in early pregnancy when there is a definite intrauterine pregnancy, confirmed by a departmental ultrasound or by an ultrasound credentialed practitioner.
  - Follow up of conservative management of a failed pregnancy.
  - Quantitative BHCG follow up according to clinical guidelines.
  - Uncomplicated early pregnancy loss with a plan of management made for the next day.
  - Wound reviews unless complex or deteriorating.
  - Uncomplicated UTIs.
- Women with the following gynaecology conditions are to be discharged by a Level 3 or above Registrar:
  - Pelvic pain in a woman who is not pregnant.
  - Bartholin's abscess (to return for later management).

- Follow up for such patients as delineated above, and all other presentations, should be in accordance with safe standards of clinical practice and KEMH Clinical Guidelines.
- Any patient who falls into the above categories where the Registrar is concerned shall be discussed with the Senior Registrar or the gynaecology Consultant on call, or the EC Consultant prior to discharge.
- All patients not falling into the above categories shall be discussed with the on call Senior Registrar, the gynaecology consultant on call or the consultant in EC before discharge.
- The time and content of the telephone conversation must be clearly documented in the patient's notes.

## Discharge against Medical Advice

### Key Points

1. Attempts should be made to contact the Medical Officer to review the woman if the woman indicates she wants to discharge herself against medical advice<sup>1</sup>.
2. Patients wishing to leave the hospital against medical advice should be asked to sign a "Discharge against Medical Advice (MR340)" form.
3. The patient's signature should be witnessed whenever possible by the attending doctor. In the doctor's absence the nurse/midwife should witness the signature.
4. If the woman wishes to discharge herself and refuses to sign the MR340, document this in the woman's medical records.
5. If the woman refuses to sign, leaves before review by Medical Officer or is unable to sign, document this on the MR340.
6. Document in the woman's medical notes the circumstances surrounding the discharge and provide detailed documentation of the risks of discharge that were explained by the staff member to the woman.
7. Women who wish to leave the hospital may not be detained except under certain specific circumstances.<sup>1</sup> Consideration is to be given for requirements relating to the:
  8. Woman lacking sufficient decision making capacity.
  9. [Mental Health Act 2014](#)<sup>1</sup>.
  10. *Children and Community Services Act 2004*<sup>1</sup>.
  11. [Prisons Act 1981](#)<sup>1</sup>.
  12. [Court Security and Custodial Services Act 1999](#)<sup>1</sup>.
  13. [Guardianship and Administration Act 1990](#).
14. If assistance is required, contact Department of Psychological Medicine as per usual processes.



15. Where appropriate, provide medications, discharge letter and follow-up appointments<sup>1</sup>.
16. When explaining risks of discharge, consider cultural differences, communication barriers including language barriers or illiteracy, and be sensitive to the woman's behavioural cues<sup>2</sup>.
17. Impairments such as intoxication, head injury, delirium, intellectual disability, dementia or experiencing mental illness can interfere with the woman's capacity to comprehend<sup>2</sup>.
18. If a parent is wishing to discharge their baby against medical advice, consult Neonatologist and Neonatal Clinical Guideline NCCU: [Section 19](#) Transfer & Discharge: [Discharge against Medical Advice](#) for guidance.
19. For further assistance:
20. For guidelines specific to care provided in the Mother and Baby Unit, see [MBU Guidelines](#) e.g. "[Absent without Leave](#)".
21. Regarding the new *Mental Health Act 2014*, if assistance is required, contact the Department of Psychological Medicine.

## References and resources




1. Department of Health WA: OD 0540/14: [Admission Readmission Discharge and Transfer Policy for WA Health Services](#) (2014)

## Related policies

[WA Health State-wide Discharge Summary Policy \(0016/16\)](#)

## Related WNHS policies, procedures and guidelines

[WNHS: Discharge Policy \(2016\)](#); [Medical Records \(Documentation\) 2016](#)

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