Discharge from admitted care

Best practice guide

DELIVERING FOR QUEENSLAND

Queensland Government

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Discharge from admitted care: Best practice guide

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Disclaimer

Purpose

This guide establishes the best practice principles for discharging patients from admitted care (including Hospital in the Home) and provides direction to Queensland Health staff and Hospital and Health Services (HHS) to ensure patients are discharged safely, effectively, and at the point when they are clinically ready.

A quick reference guide for this document exists as well as additional information for health services on managing patients experiencing delayed discharge.

Each HHS has a unique configuration of organisations, care delivery models and populations and as such, this guide should be adapted as required.

Scope

This best practice guide is relevant to all Queensland Health staff, as well as organisations and individuals acting as agents on behalf of Queensland Health, who are involved in the care of admitted patients and in the transition of their care from admitted care. This best practice guide does not apply to the discharge of patients from ambulatory care services.

Background

Discharge is the coordinated process by which a patient's health care transitions from a health service to another care provider, care setting, or their home. This may involve transition of care from hospital or Hospital in the Home (HITH) to a general practitioner (GP), community health provider, disability or aged care service, Aboriginal and Torres Strait Islander Community Controlled Health Organisation, or to support from family and/or carers. Discharge planning includes developing a personalised plan for a patient leaving admitted care that identifies the services, equipment, information, and follow-up required to support a safe and effective transition of care. Responsibility for some or all aspects of the patient's health care may be transferred, either temporarily or permanently.

Effective discharge processes support safe, timely, and integrated transitions of care across all relevant health and social care providers. For unplanned admissions, planning for discharge should commence early in a patient's admission to reduce unnecessary delays and length of stay in hospital. For planned surgical patients, discharge planning commences prior to admission, supporting early preparation, optimisation, and alignment of care pathways across the patient journey. Early planning also enables proactive identification of support needs and establishes clear expectations for recovery and discharge.

Policy and strategic alignment

- Reducing delayed discharge: A system-level response for older patients policy paper
- Department of Health Strategic Plan 2025-2029:
    - **Access:** A consumer-centric healthcare system that recognises the impact of increasing demand and complexities of services.
    - **Sustainability:** Driving a sustainable model of health care to ensure an efficient, equitable, safe and quality service for patients.

Supporting documents

- Patient Access to Care Health Service Directive QH-HSD-025:2015
- Protocol for managing capacity of Queensland public hospitals QH-HSDPTL-025-3
- National Safety and Quality Health Service (NSQHS) Standards
    - Clinical Governance Standard
    - Partnering with Consumers Standard
    - Medication Safety Standard
    - Comprehensive Care Standard
    - Communicating for Safety Standard
- SAFEST Patient Journey Home
    - Adapted from NHS models in the United Kingdom, this framework outlines 6 evidence-based principles designed to improve access to care, reduce delays and length of stay, and most importantly, achieve better patient outcomes.
- Surgiflow
    - Six interlinked elements designed to work together as a surgical journey bundle including: Enhanced recover after surgery and prehabilitation (ERAS+), Surgical Rapid Assessment Units (SRAUs), Unplanned Surgery Coordinators (USCs), day surgery by default (DSbD), criteria-led discharge (CLD), and Post-Operative Discharge Support Service (PODSS).

Best practices

1. Engage the multidisciplinary team (MDT) to support early discharge planning, ensuring patients (or their families/carers/substitute decision-makers) are kept informed and involved throughout the process.

Key points

- For unplanned admissions, discharge planning should commence from admission. For planned surgical patients, discharge planning commences prior to admission.
- The MDT are key to identifying discharge barriers and can work with patients to manage these as early as possible. For planned surgical patients, this includes during the pre-admission phase, where the MDT can support optimisation and preparation for discharge.
- Actively involve the patient (and their families, carers, or substitute decision-makers where appropriate) in discharge planning from the outset of the healthcare episode, including in discussions about estimated date of discharge (EDD).
- Regular MDT discussions (e.g. daily huddle, case conference, ward-rounding) help teams stay connected, deliver better care, and keep discharge on track.

Supporting information

Preparation for discharge begins at the point of admission (or earlier for planned admissions) to ensure that any complex or ongoing needs are identified promptly. All patients (and their families, carers, or substitute decision-makers where appropriate) should be informed early about the purpose of admission and actively involved in discharge planning from the outset of the healthcare episode, including discussions about the estimated date of discharge (EDD).

Engagement of the multidisciplinary team (MDT) is essential to support effective discharge planning, enabling early identification and proactive management of potential barriers. With MDT input, the EDD should be determined on the day of admission, clearly documented (e.g. in Kyra Flow/Patient Flow Manager), visible to all team members, and reviewed daily. The use of EDDs is a core practice of the SAFEST Patient Journey Home Framework.[1]

Clear communication and effective teamwork are essential for patient safety, enhancing patient flow and achieving better health outcomes.[2, 3] Brief MDT huddles are associated with improved outcomes, including reduced length of stay (LOS), earlier in the day discharges, and lower re-admission rates.[4-7] Conversely, when MDT huddles are ineffective, they can lead to

miscommunication, adverse events, patient dissatisfaction, and delays in clinical care delivery and patient discharge.[9]

Planned admissions

Early initiation of discharge planning in the pre-admission phase is particularly important for planned surgical patients, as it enables proactive optimisation of modifiable risk factors, alignment of perioperative care pathways, and clear expectation-setting regarding recovery and discharge. Evidence from Enhanced Recovery After Surgery (ERAS) programs demonstrates that structured preoperative preparation – including prehabilitation, patient education, and coordinated multidisciplinary planning – improves functional recovery, reduces post-operative complications, and supports earlier readiness for discharge.[10] Establishing a shared, pre-defined recovery and discharge plan prior to admission also promotes patient engagement and consistency of care across the multidisciplinary team, which are critical to achieving timely discharge and avoiding unnecessary variation in length of stay.[8]

Patients for residential aged care placement

For patients progressing to residential aged care home (RACH) placement, ensure they and their support network are provided with clear information about the application process, and the implications of accepting or declining placement offers, including potential consequences and available escalation pathways for issue resolution. If applicable, ensure patients, families, carers, and substitute decision-makers are informed of fees related to the cost of accommodation for non-acute care longer than 35 days. Fees and charges are calculated in accordance with Fees and charges for healthcare services Health Service Directive.[11]

2. Engage patients in shared decision-making and respect and support their dignity of risk.

Key points

- Engage patients in shared decision-making by working in partnership to reach decisions that are right for the individual.
- Acknowledge and support dignity of risk. Patients may choose options that involve some level of risk. The clinician's role is to ensure patients are fully informed through shared decision-making, respecting their choices, and supporting them to manage risks as safely as possible.

Supporting information

When a person is admitted to hospital, they should be asked: *"What matters to you?"* and *"How can we reflect this in your care?".* This information is critical for care planning and should be documented. Where a patient is unable to respond, carers, family, or friends should be consulted (with consent where practicable).

Patients may also have:

- a Julian's Key Health Passport, outlining communication preferences and care needs[12]
- an advance health directive, specifying their wishes[13]

All patients have a right to healthcare services and treatment that meets their needs, and to be involved, along with their carers' and/or families, in planning and decision-making about their care and treatment.[14, 15] Patients have the right to be treated with dignity, respect and compassion, and to make decisions about their own health care and treatment and have those decisions respected.[16] This includes the right to accept or decline the offer of certain health care, and to change that decision. In order for a patient to exercise this right to decide, they require the information that is relevant to them.[17]

Healthcare providers should support patients to make informed healthcare decisions through a process of 'shared decision-making'. Shared decision-making is a collaborative process that combines clinical expertise (treatment options, risks, and benefits) with the patient's values, goals, and preferences to enable patients' informed decision-making.[18] Shared decision-making is an integral component of person-centred care and partnering with consumers.[19, 20]

At times, patients may consider healthcare choices that involve some level of risk to them. Through the process of shared decision-making, healthcare providers must ensure patients understand the risk to them (and others), work with patients to manage these risks, and respect their choices.[21] Supporting patient autonomy in this way enables a patient's "dignity of risk".

In practice, risk is often viewed primarily as something to avoid, with a strong focus on safety and harm prevention. This can result in risk reduction being prioritised over supporting patient choice and independence. Applying dignity of risk requires clinicians to consider which risks are reasonable, meaningful to the patient, and able to be supported. Duty of care extends beyond preventing harm and includes supporting informed risk-taking where it contributes to the patient's dignity, wellbeing and quality of life. Supporting dignity of risk means balancing duty of care with respect for autonomy and self-determination, ensuring patients are not denied their choices or preferences solely because of clinicians' risk assessments or perceived risk. This is an important component of person-centred care.

Clinicians should feel supported by their HHS to uphold a patient's right to make informed choices, even where these involve some level of risk. This support can be strengthened through clear HHS procedures, as well as ongoing staff education and training.

For more information on informed decision-making, see the guide to informed decision-making in health care.

Capacity assessment

If there are concerns about a patient's decision-making capacity, a formal assessment should be undertaken in accordance with the Queensland Capacity Assessment Guidelines.[22] Where a patient is assessed as lacking the mental capacity to make a specific decision, clinicians should follow the flowchart for health care decision-making in adults without capacity to identify the appropriate decision-maker.[23] If an enduring power of attorney has not been appointed, or an appropriate statutory health attorney (such as a spouse, relative or friend) identified, the person

may be referred to the Queensland Civil and Administrative Tribunal (QCAT) to be appointed a public guardian for further decision-making. To minimise any delay to discharge, this should be commenced as early as possible. If acute care is no longer required, transition to an appropriate non-acute setting during the management of this process should be considered.

3. In-hospital assessments should be strengths-based and limited to what is needed to transfer someone into the community.

Key points

- Assessments should be strengths-based, focusing on individuals' abilities, needs and goals, as well as their existing social supports and environmental facilitators, rather than emphasising problems, deficits, risks, or a return to "baseline" (which may be unrealistic with ageing or disease progressions).
- Functional assessments in hospital should be limited to what is needed to safely transfer someone to the community. Ongoing care needs are best assessed at home by community or hospital in the home support services if required including via Discharge to Recover and Assess (D2RA) pathways.

Supporting information

Information about home circumstances, supports, and equipment should be gathered from the first point of contact or admission. For patients arriving by ambulance, information collected by the Queensland Ambulance Service (QAS) – including details of home environment, carers, family support, property access, and equipment – should be captured on admission. For planned admissions, this information should be obtained prior to admission. Early access to this information supports safe and effective transfer of care planning.

A strengths-based assessment should be proportionate to the individual's stage of recovery and undertaken with their involvement, and others as appropriate. Assessments should occur at the right time and in the right place to ensure an accurate understanding of the patient's longer-term support needs.

In-hospital functional assessments should be limited to what is necessary to enable safe transfer to the community and conducted early enough to support same-day discharge. More comprehensive assessment of longer-term care needs is best undertaken in the home environment by community, primary care, or hospital in the home services, including through Discharge to Recover and Assess (D2RA) pathways (see Practice 4 below).

For older or frail patients

For patients who may be frail, frailty should be assessed using a validated tool such as the Rockwood Clinical Frailty Scale.[24, 25] Specialist services, such as the Geriatric Emergency Department Initiative (GEDI), should assess pre-admission function and commence early discharge planning, including linkage to community and out-of-hospital services.

Comprehensive geriatric assessment is a multidisciplinary, multidimensional diagnostic process that evaluates the medical, psychological, and functional capacity of frail older patients to inform a coordinated and integrated treatment and long-term follow-up plan, including medication optimisation, patient and carer education, falls prevention, and provision of assistive devices to support function and safety. Comprehensive geriatric assessment during inpatient care is associated with improved outcomes for older patients, with significantly more patients surviving hospital admission and returning home, fewer deaths or functional decline, and more people demonstrating improved cognitive function.[26]

4. Adopt a "Home First" approach to discharge planning, supported by Discharge to Recover and Assess (D2RA) to enable recovery and ongoing assessment in the community.

Key points

- Consider: Where is the right place for this patient to receive the right care at the right time? All staff should be supported to raise this question with treating medical teams.
- Adopt a "Home First" approach. Home is best for most people leaving hospital, including older people[27] – for recovery and assessment of any additional needs. Ongoing care needs are best addressed at home by community or hospital in the home support services if required, including via D2RA pathways.

Supporting information

Patients should remain in an acute hospital only whilst receiving treatment that cannot be delivered in any other setting. Staying longer may be detrimental to the patient and deny access to care for others. Evidence suggests that 10 days of bed rest leads to the equivalent of 10 years ageing in the muscles of people over 80.[30] Timely discharge from acute settings improves patient outcomes and reduces the risk of medical complications such as loss of independence, hospital-acquired infections and deep-vein thrombosis.[27-29]

Alternative care pathways

HHSs should establish a 7-day multidisciplinary team within the emergency department (ED). This would normally include nursing and nurse navigators, and allied health such physiotherapy, occupational therapy, social work, and pharmacy staff.[31] These clinicians can rapidly assess patient needs to inform discharge planning, including the appropriateness of referral to alternative care pathways, such as:

- Rapid Access Clinics (RAC). These exist statewide and provide an alternative pathway for emergent new or returning patients, bypassing or diverting from ED to enable targeted

management of unplanned presentations, reduce congestion and admissions, and improve patient experience with timely, appropriate care.[32]

- Urgent community response services provide care for people who do not require hospital admission and are more appropriately supported in the community (i.e. Post Acute Care Services (PACS), Multidisciplinary Avoidance and Post-Acute Service (MAPS), voluntary/community based support services).
- Hospital in the Home (HITH) provides hospital-level care in a patient's residence and/or safe location as a substitute for inpatient care. Eligible patients should not be excluded if they can be treated safely outside the traditional inpatient hospital environment. Specialised models exist for the following care types (HHS dependent): acute, geriatric evaluation and management, rehabilitation, palliative care, maternity, mental health, and maintenance.[33]

Home First, and Discharge to Recover and Assess (D2RA)

The default pathway for all patients, including those who are frail, should be discharge home with appropriate recovery support. A "Home First" philosophy means prioritising discharge to the patient's usual residence wherever safe and appropriate. Evidence shows that patients prefer to recover at home in the familiarity and comfort of their home environment, and achieve better outcomes, greater independence, and have fewer complications.[28, 34-36] Discharge to Recover and Assess (D2RA) supports this approach by enabling early discharge once clinically appropriate, with recovery and ongoing needs assessed in the community. When supported with high-quality home-based care, patients have a shorter hospital length of stay and reduced unnecessary re-admissions, and this free up critical bed capacity for incoming acute patients.[27-29, 37] Where required, short-term, personalised recovery support should be provided in the community to facilitate this transition, with many patients benefiting from a brief, intensive period of post-discharge support aimed at maximising independence, promoting self-management, and reducing or preventing longer-term care needs.

Decisions about long-term care and support should not be made while a patient is in crisis or in an acute hospital bed unless absolutely necessary, as this may not reflect their true functional capacity and may lead to over-prescription of services. For some individuals with severe frailty, a short period of step-down care may be appropriate to support rehabilitation and further assessment, with the goal of maximising independence and delaying progression to long-term residential care. Social prescribing and community-based supports can further assist recovery and prevent unnecessary admissions by addressing broader needs such as social isolation, mental health, and long-term conditions, and connecting patients with community resources.

For patients who are homeless or at risk of homelessness

For patients who are homeless or at risk of homelessness, needs are often complex, which can delay discharge and make arranging appropriate support challenging. Homelessness is associated with early ageing, frailty, and issues such as self-neglect, requiring coordinated health, housing, and social care through a D2RA approach to improve outcomes. People who are homeless or at risk may be eligible for aged care services from 50 years of age.[38] Additional information and key contacts for homelessness support can be found online.

5. Escalate to avoid delay.

Key points

- A delayed discharge is a patient safety and system risk.
- Information on managing delayed discharge, including advice to HHSs on escalation pathways for patients experiencing delayed discharge, can be found in the Delayed discharge – best practice guide.

Supporting information

Patients who are clinically ready to leave hospital though remain admitted for non-clinical reasons are experiencing a "delayed discharge". The number of patients experiencing delayed discharge across Queensland Health inpatient facilities has increased in recent years.[39]

Every day that a patient stays in hospital longer than they need poses a risk to their health and wellbeing, including increasing their risk of hospital-acquired complications and reducing their quality of life. The impact is especially severe for people aged 80 years and over.[40] Delayed discharge places additional strain on hospital capacity and the health workforce, which is associated with increased patient mortality, poorer health outcomes, and reduced access to acute care for those most in need.[41, 42] This pressure contributes to ED stays exceeding 24 hours and increased ambulance ramping.

Ensuring the timely discharge of patients from acute facilities is a shared responsibility. Queensland Health plays a pivotal role in influencing outcomes. Information on managing delayed discharge can be found in the Delayed discharge – practical guide.

6. Use criteria-led discharge (CLD) to support timely transitions.

Key points

- Every patient should have a clinical plan, with an expected date of discharge (EDD) and clear criteria that need to be met for discharge to happen.
- For "simple discharges", use CLD.
- CLD should begin pre-admission for planned care, and on admission for unplanned care.

Supporting information

CLD is a structured process that enables appropriately trained and competent members of the MDT – including nursing, allied health, and junior medical staff – to discharge patients once they meet clearly defined, pre-agreed clinical criteria. These criteria are developed collaboratively by

the MDT, documented in the patient's care plan alongside an expected date of discharge, and approved by the Authorised Admitting Practitioner or nominated delegate who retains overall clinical responsibility.

CLD removes the need for patients to wait for medical officer review (e.g. consultant or registrar) when discharge criteria have already been met. CLD does not replace appropriate clinical review or oversight by the treating team, nor does it limit the patient's opportunity to discuss their care, treatment, or discharge with clinicians as required. If there is any uncertainty, including when criteria are slightly outside the defined range, clarification can be sought directly from the Authorised Admitting Practitioner or nominated delegate.

Examples of CLD in practice:

- A nurse or allied health professional can discharge without a further review if documented criteria are met.
- A junior doctor can discharge without a further review if documented criteria is met.

CLD has been shown to improve coordination of discharges, reduce length of stay, increase patient and staff satisfaction, free up hospital beds, and enable better use of medical specialist time. By setting clear expectations early in the patient journey, CLD supports timely, safe, and coordinated discharge planning. It enhances patient flow while ensuring care remains patient-centred and evidence-based. Importantly, it also empowers patients, families, and support persons to be actively involved in discharge planning, promoting shared understanding, preparedness, and continuity of care.[43]

7. Plan transport options early.

Key points

- Transport home should first be arranged through family, carers, neighbours or friends, with volunteer or non-government services, taxis and public transport considered where appropriate.
- Hospital transport should be used only as a last resort when all other options have been exhausted. This should be planned and booked in advance and in readiness for discharge.
- Patients awaiting transport should wait in the transit lounge (where available).

Supporting information

Many discharges are unnecessarily delayed due to a lack of early transport planning. Any opportunity to expedite discharge should be pursued. Saving even a small amount of time by arranging transport in advance will avoid unnecessary delays for the patient and make a big

difference for someone requiring access to an acute bed. Consider utilising transit lounge for discharge, if available.

8. Support safe and timely medication management.

Key points

- A patient discharged from ED should be provided any medication prescribed within the ED and/or a prescription for the required medication, and information about required follow-up actions (e.g. contact GP, return for outpatient appointment, etc.).
- A patient discharged from the ward should have their "take home" medication ordered in good time and delivered to the ward the day before discharge.
- Patients awaiting medication dispensing should wait in the transit lounge, where available.

Supporting information

Medication management should include timely medicines reconciliation, identification of medication changes, and clear communication of these changes to patients and onward care providers. Patients should be provided with clear instructions on how to take their medications following discharge, including any changes made during admission. This should include advice on dosage instructions, administration considerations (e.g. with food), potential adverse effects, interaction risks, and when to seek medical review. Patients at higher risk (e.g. polypharmacy, complex and/or high-risk medicines, or adherence concerns) should receive appropriate counselling and support prior to discharge, which may involve pharmacy where available.

Medication-related issues are a common reason for avoidable ED presentations. Any opportunity to prepare for and expedite discharge should be pursued. Saving even a small amount of time by arranging discharge medications and scripts ahead will avoid unnecessary delays for the patient and make a big difference for someone needing access to an acute bed.

9. Provide safety-netting and follow-up support.

Key points

- Provide the patient with follow-up instructions for once they leave hospital.
- For complex discharges or where a patient is at risk of representation, HHSs should consider additional post-discharge supports.

Supporting information

A complete hospital discharge process includes a follow-up and monitoring component, often referred to as "safety netting". It is the process through which patients are given advice on discharge, ensuring they are monitored and followed up once they leave hospital. The key principles of safety netting are good communication, maintaining continuity of care and minimising handover. Providing patients with the relevant advice and contact details in a timely manner will enable them to seek the right support after discharge.

A hospital discharge safety netting matrix is provided in Appendix 2. This is to help clinicians and members of the discharge team make balanced decisions to support safe discharge. The preferred method is patient-initiated follow-up where a patient is given the contact details of their discharge team at the point of discharge and advised to make contact if they are concerned. Low-risk patients should not be asked to go to the ED following discharge and they should not be followed up by a new team unless this is an agreed process with a good handover. For complex discharges or where a patient is at risk of representation or re-admission, HHSs should consider additional post-discharge supports, such as nurse navigation.

Existing models of follow-up care include:

- Post-Operative Discharge Support Service (PODSS): A telehealth service led by Clinical Nurse Consultants (CNCs) designed to reduce unnecessary ED presentations by providing targeted support to post-operative patients within 30 days of discharge. Contact details for PODSS should also be listed on HHS-specific health.qld.gov.au web pages for patients to access.
- Medical Discharge Support Service (MeDSS): A nursing and allied health-led post-discharge support service (via phone call, telehealth or face to face review) for known medical patients who have been discharged from hospital within 30 days. Contact details for MeDDS should also be listed on HHS-specific health.qld.gov.au web pages for patients to access.
- Rapid Access Clinics (RAC)
- Minor Injury and Illness Clinics at Satellite health centre (formerly satellite hospitals)
- Nurse-walk-in clinics
- Medicare Urgent Care Clinics
- Residential Aged Care Facility Support Service (RaSS)
- Nurse navigators

Virtual wards and HITH should not be used to support safety netting – appropriate use of the discharge pathways should be considered. Virtual wards and HITH should only be used if patients meet criteria.

10. Ensure timely and effective clinical handover and information sharing

Key points

- Sufficient and accurate information is to be provided to onward care providers to meet the needs of the patient, including details about their condition, medications, equipment needs, safety netting arrangements, whether existing services are to be reinstated, and contact details in case there is an issue or concern following discharge.
- A discharge summary should be sent by the hospital to the patient's GP on discharge, within 24 hours. It is also best practice to share the discharge summary with the patient on discharge. Patients being discharged to a residential aged care home or other facility should have a discharge summary provided at the time of discharge.

Supporting information

Timely, high-quality discharge summaries are essential to support continuity of care and follow-up, including in primary care. The hospital should therefore provide accurate and comprehensive information about the patient to ensure that providers of onward care can safely and effectively meet their needs. This includes details about the patient's condition, their medications (especially if changes have been made), equipment needs, safety netting arrangements, whether any existing services are to be reinstated, with whom and where follow-up appointments have been arranged, and contact details in case there is an issue or concern following discharge. This should also include information about their communication needs and care preferences (i.e. dementia, learning disability) and their family's or carer's details.

All patients discharged to a RACH should have complete clinical handover documentation, including individualised care plans, medication information, behaviour support plans, advance care planning and cultural considerations.[44]

Appendix 1

Example: Shared decision-making and supporting dignity of risk

Situation

A patient in interim care who had previously consented to residential aged care placement has now reconsidered and expressed a preference to return home.

Background

The patient had been living alone and had experienced several recent falls prior to admission. They were brought to hospital by their family with delirium and were diagnosed with a urinary tract infection. Family members also raised concerns about the patient's ability to safely return home, noting that the patient has previously declined services. The family are unable to provide the level of support the patient requires.

During their admission, the patient experienced further deconditioning, associated with reduced mobility due to falls risk and poor oral intake. Following resolution of the delirium, a stakeholder meeting was held with the patient, their family, and the treating medical and multidisciplinary team. At this time, the patient consented to residential aged care placement.

While in interim care, the patient's overall condition has shown slight improvement; however, they have experienced 2 further falls. The patient has since expressed a desire to return home, stating that they miss their home environment and pets. They have capacity to make their own decisions.

Assessment

The patient has expressed a desire to return home. In accordance with the HHS procedure supporting shared decision-making and the principle of dignity of risk, this should be explored in greater detail through discussion between the patient and the treating medical and multidisciplinary team.

Recommendations

The patient should be informed of their risk of falls and the potential consequences. They should be offered further multidisciplinary assessment, conducted using a strengths-based approach, and, as appropriate, provided with options for risk management including ongoing rehabilitation, in-home supports, community services and Assistive Technology and Home Modifications to assist them on their return home.

If the patient declines these options, this decision should be respected, despite the associated level of risk and any family opposition. If the patient has decision-making capacity and has made an informed choice, supporting this decision is consistent with upholding their dignity of risk.

Appendix 2

Table 1: Safety Netting Matrix [45]

Situation	Consider	Reconsider
Patient is low risk	• Providing patients with the discharge team's contact details and advice to make contact if they have any concerns (i.e. patient-initiated follow-up). • Encouraging the patient to reintegrate with primary care and their GP as standard.	• Advising patient to go to the ED following discharge. • Arranging routine outpatient appointments.
Patient lacks confidence about how they will cope post-discharge	• Scheduling a telephone call with the patient a day or so after discharge to check all is well and provide reassurance. • Encouraging the patient to reintegrate with primary care and their GP as standard.	• Extending a patient's acute hospital admission. • Advising patient to go to the ED following discharge. • Arranging routine outpatient appointments.
Patient is awaiting results of investigations	• Providing patients awaiting investigation results with clear instructions on how and when they will receive their results, including a specified timeframe for communication, and ensuring this plan is documented in the medical discharge summary. • Providing the patient with their results as soon as they are available and discussing any required changes to management. This contact may be made by the discharge team or, where care has been formally handed over, by an appropriate community or voluntary team, if care has been transferred to them.	• Requesting the patient's GP or relevant care team to follow up and action results, unless a clear and timely handover has already occurred.

Patient needs a review at a certain time, (e.g. for a wound check, removal of drain, trial without a catheter).	• Booking the patient into an outpatient clinic or Rapid Access Clinic.	• Advising patient to go to ED.

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