Delayed discharge

Best practice guide

DELIVERING FOR QUEENSLAND

Queensland Government

Copyright statement

Delayed discharge: Best practice guide

Published by the State of Queensland (Queensland Health), July 2026

For more information contact:

Healthcare Improvement Unit, Clinical Excellence Queensland, Queensland Health, GPO Box 48, Brisbane QLD 4001, HIU@health.qld.gov.au.

An electronic version of this document is available at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-resources/patient-flow-resources-for-health-professionals#section__patient-flow-resources

Document last reviewed: July 2026

Printed copies are uncontrolled.

The Healthcare Improvement Unit gratefully acknowledge the Queensland Clinical Networks for their valuable guidance and expertise in the development of this resource.

Disclaimer

Purpose

This best practice guide aims to support Hospitals and Health Services (HHS) in their management of patients experiencing delayed discharge. It builds on the best practice principles for hospital discharge outlined in:

- Discharge from admitted care – best practice guide
- Discharge from admitted care – quick reference guide.

Additionally, this guide should be used in conjunction with Interim care – best practice guide in HHSs where patients experiencing delayed discharge are receiving care under an interim care arrangement.

This guide is designed to be adaptable to local context while promoting consistent, patient-centred practices across HHSs with different organisational structures, care delivery modes, and population needs.

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

Patients who are deemed clinically fit for discharge but continue to occupy hospital beds for non-clinical reasons, are experiencing a "delayed discharge".[1] The number of patients experiencing delayed discharge across Queensland Health inpatient facilities has increased in recent years, putting additional pressure on hospital capacity and workforce, negatively impacting patient health and wellbeing, and compromising access to acute health care for those who need it most.[1]

> Every additional day a patient remains in hospital beyond their clinical need increases the risk to their health, wellbeing, and quality of life.

Harmful effects of delayed discharge for patients can include:

- functional decline and loss of independence – for people aged 80 years and over, 10 days in a hospital bed can lead to muscle loss comparable to 10 years of ageing.[2]
- cognitive decline, including delirium
- social isolation and disruption to normal routines
- psychological and emotional impacts, including distress, depression, and despair
- increased risk of hospital-acquired conditions (e.g. infections)
- greater long-term morbidity and higher mortality risk.

> As well as causing harm at the individual patient level, strain on hospital capacity is linked to higher mortality rates and poorer health outcomes overall.[3]

Patient "long stays" in the emergency department are particularly detrimental; for every 82 patients whose transfer to an inpatient bed is delayed beyond 6 to 8 hours, there is one extra death.[4] Delays also affect transfers from intensive care units (ICUs) to wards, leading to ICU bed block and restricting access for critically unwell patients. Delayed discharge contributes to broader system pressures including ambulance ramping at emergency departments, which in turn affects ambulance responses in the community. Evidence from Queensland hospitals shows that reducing the number of patients remaining in hospital unnecessarily (patients with care type of maintenance) has a direct and measurable impact on improving patient flow, reducing bed block, and enhancing emergency department access.[5]

Queensland Health reports delayed discharge data to assist in efficient resource allocation and improved patient care. The Discharge Delay Census (formerly the Long-Stay Patient Census) is based on a manual, point-in-time patient data collection undertaken by the HHSs and reported to the Department of Health on a quarterly basis. Additional retrospective analysis of delayed discharge across the health system for the purposes of system and health service planning is undertaken by the Department of Health.

> Timely discharge from acute facilities is a shared responsibility. While system-wide factors contribute to delays (e.g. ageing population, limited residential aged care capacity, increasing patient complexity), Queensland Health plays a pivotal role in influencing outcomes.[1]

Strengthened governance and executive leadership are essential, including improved central visibility of patients experiencing delayed discharge. This enables better communication, greater transparency, and a stronger focus on action. Greater use of alternative care options outside the acute hospital setting, along with the adoption of "Home first" and "Discharge to Recover and Assess" (D2RA) approaches, is essential. Prioritising early identification and multidisciplinary coordination of discharge planning are critical to minimising delays. This needs to be supported by a culture that respects patients' dignity of risk and promotes shared decision-making.[1] This document summarises best practices for health services managing patients experiencing delayed 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 health care 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.

Best practices

1. Hospital and Health Service procedures champion person-centred, rights-based care.

- HHS procedures promote:
  - person-centred care and shared decision-making
  - dignity of risk
  - older persons' health, autonomy, dignity, and participation in care
  - culturally safe and responsive care, for example:
    - early and routine involvement of Aboriginal and Torres Strait Islander health workforce and Indigenous Hospital Liaison Officers (IHLOs) to inform assessment, communication and planning
  - alignment with the National Safety and Quality Health Service (NSQHS) Partnering with Consumers Standard
  - adherence to the Australian Charter of Healthcare Rights.

2. Systems and processes support multidisciplinary collaboration and discharge planning.

- All wards conduct action-focused regular multidisciplinary (MDT) meetings or huddles, with prompts to consider:
  - all possible public, private, and community transfer and discharge destinations
  - opportunities to access the Restorative Care Pathway via the Commonwealth Support at Home program, which includes a support plan and budget for a 16-week period of restorative care for people 65 years or older (or 50 years or older for Aboriginal and Torres Strait Islander people) who have an existing Support at Home package or are eligible for an aged care assessment.[6]
  - Eligibility for short-term funding via the HHS, or the Long-Stay Rapid Response (LSRR) program.
- MDT meetings should include a participant who can provide accurate advice on the availability and capacity of Hospital in the Home (HITH) and community services.

3. Models of care prioritise patient recovery and assessment in the community, or exceptional evidence-based care for high-risk cohorts who require ongoing admission.

- A "Home First" philosophy is embedded, including D2RA pathways.
- Evidence-based clinical management of complex care needs is implemented, including:
  - Practical Redesign Options for Violence in Dementia and Delirium (PROVIDE)[7]
  - Eat Walk Engage (EWE)[8]
  - Behaviour Response Teams.

4. The workforce supports specialist care and enables timely patient flow.

- Patients have access to specialist clinicians and services, including:
    - Queensland Ambulance Service Falls Co-Response Program
    - Geriatric Emergency Department Initiative (GEDI)
    - Residential Aged Care Facility acute support services (RaSS)
    - Specialist geriatrician and multidisciplinary community-based supports enabling proactive care planning for older people, including via networked models if necessary
    - Behaviour Response Teams
    - Behavioural and Psychological Symptoms of Dementia (BPSD) units
    - HHS-employed representative from the Office of the Public Guardian
    - HITH services – inclusive of all care types
    - Transition Care Program (TCP).
- Designated discharge planning or specialty roles are established (e.g. complex care coordinators, allied health clinical leads, nurse navigators) and have clearly defined roles and responsibilities including reporting responsibilities

5. Health services provide education, supervision, and system support to enable confident, timely, and person-centred discharge decisions.

- Clinical supervision is available to support management of complex patients.
- Education and training support clinicians' understanding of:
    - dignity of risk
    - Long-Stay Rapid Response (LSRR) program.
- Executive and senior leaders, and HHS policies/procedures, foster psychologically safe environments for clinicians to work within their scope of practice, including making appropriate discharge decisions where perceived risk exists (e.g. homelessness, falls risk, not returned to baseline).
- Inpatient teams have access to adequate referral criteria and referral process information (e.g. via QHEPS) for alternate care locations (e.g. HITH, community TCP, residential TCP).
- HITH and community services within the HHS actively partner with inpatient clinical teams to design referral processes and implement pull models, enabling timely identification and transition of suitable patients.
- Referral pathways to alternative care settings (e.g. HITH and residential aged care homes (RACHs)) are streamlined to support timely and efficient referrals.

6. Governance, accountability, and organisational structures enable consistent and accountable management of delayed discharge.

- HHSs should designate an accountable Executive Officer with overall responsibility for patients experiencing delayed discharge within the HHS, as well as the systems and processes for managing these patients. This role also provides support to clinicians in the escalation of patient-level issues (see example in Appendix 1).
- Delayed Discharge Meetings are held at least weekly and include:
    - Review of all delayed discharge patients
    - Senior clinician participation
    - Prompts for consideration of short-term funding via the HHS, or Long-Stay Rapid Response (LSRR) program.
    - Action-focused, decisions documented in medical record
    - Outcomes and systemic issues reported to Executive Officer
- A RACH Pathway Procedure is in place, including:
    - a requirement to apply to a minimum number of RACHs (e.g. 5). HHSs might also consider stipulating timeframes by which applications need to extend beyond preferred geographical boundaries.
    - defined escalation pathways, including processes to follow when a patient declines a RACH bed offer (see Appendix 1).
- HHSs should establish or maintain HHS-wide internal escalation pathways for patients experiencing delayed discharge, including defined steps for internal action and criteria for external escalation, with workforce education to support consistent use.
- HHSs should consider coordinated interagency responses for complex discharge management. For example, collaborating with non-government service providers, primary care, community, and the housing sector to develop creative solutions at the local level.
- HHSs should engage with the Delayed Discharge Policy and Program (DDPP) unit to escalate issues to state and Commonwealth agencies to facilitate solutions to patient discharge when local HHS options have been exhausted.
- HHSs should consider briefing the Office of the Director General (ODG) on high-risk situations that meet the criteria of the ODG Hot Issues Framework (i.e. as pertaining to patient or staff safety, the continuity or delivery of health services, or organisational resources or strategic operations).
- HHSs should develop or incorporate the management of patients experiencing delayed discharge into an HHS-wide procedure that includes:
    - roles and responsibilities of key staff and the governance structure
    - requirements for regular reporting to the accountable Executive Officer
    - escalation pathways for patient-level and systemic issues.

7. Delayed discharge is systematically monitored and reported to improve visibility, enable timely patient support, and identify and address system-level issues.

- HHSs should maintain a central record of all patients experiencing delayed discharge in the HHS and ensure this is visible to key staff and executives (e.g. Kyra Flow Delay-to-Discharge tab).
- HHSs should establish a process for regular reporting on patients experiencing delayed discharge to the accountable Executive Officer, steering committee, and/or Hospital Board. This reporting should support visibility, enable escalation, inform service planning, and assist in identifying and addressing recurring system-level barriers to discharge. It may also contribute to statewide analysis, policy development, and resource planning.
- HHSs should complete the quarterly Discharge Delay Census using the standard template issued by the Department of Health, and following local governance processes to ensure census data is reviewed and endorsed prior to submission by required timeframes.

8. HHSs proactively build and review partnerships with external providers to support timely and effective patient discharge and admission avoidance.

- HHSs proactively review current investments aimed at reducing delayed discharge using the Value Framework (for example, contracts with private interim care providers).
- HHSs review interim care arrangements to ensure alignment with the Interim care – best practice guide.
- HHSs ensure programs across the continuum of public and private services (including contracts with providers) include a requirement for multidisciplinary care supports and case management to reduce the risk of deconditioning.
- HHSs ensure programs across the continuum of public and private services (including contracts with providers) enable First Nations Elders and older persons to remain in their communities.
- HHSs proactively engage in relationship-building with local RACHs, aged care providers, Aboriginal and Torres Strait Islander Community-Controlled Health Organisations (A&TSICCHOs), Primary Health Networks, and other community providers, for the purposes of facilitating safe and timely patient discharge, as well as enabling the co-design of innovative, locally responsive solutions to ongoing systemic challenges.
- HHSs proactively engage in relationship-building with Queensland Ambulance Service to safely facilitate hospital avoidance and/or timely discharge home, as well as enabling the co-design of innovative, locally responsive solutions to ongoing systemic challenges.
- HHSs coordinate regular engagement with relevant external agencies including but not limited to, Department of Housing, Office of Public Guardian, QCAT, Department of Foreign Affairs, National Disability Insurance Agency and Hospital Liaison Officers (HLOs), and community service providers.

Appendix 1

Example escalation pathway for managing declined RACH bed offers

Situation

The social worker has received a RACH bed offer for a patient. The patient has declined the bed offer and wants to wait until a bed in their preferred RACH becomes available. The RACH has allowed a 48-hour window to respond (typical of RACHs in the HHS), or the bed offer will be rescinded.

Background

Patient is under maintenance care type and has had an extended length of stay. They have capacity to make decisions and through a process of shared decision-making, have consented to residential aged care placement. As per HHS procedure, the patient has been provided the opportunity to nominate preferences and has identified 5 RACHs for application.

The social worker has previously discussed this patient in regular clinical supervision with the senior social worker. The social worker has also supported multiple previous stakeholder engagement meetings between the patient, their family, and the treating medical and multidisciplinary teams.

Assessment

The patient's healthcare rights have been respected, and they have been actively engaged in shared decision-making throughout their admission and discharge planning, including providing consent for the RACH pathway. The patient has also been given the opportunity to identify and select up to 5 appropriate RACH options. Accordingly, the HHS has fulfilled its obligations to the patient.

Recommendations

Given the limited timeframe for accepting a bed offer within this HHS, and the high demand for hospital beds, escalation to an appropriately authorised decision-maker should occur promptly. The accountable Executive Officer should determine the most suitable role to undertake this responsibility. This role should have sufficient authority and oversight to balance patient flow across the HHS – for example, the accountable Executive Officer themselves, or a coordinated approach involving the Director of Medical Services and the Nursing Director – to engage with the patient regarding acceptance of the bed offer.

The escalation process itself should minimise burden on the treating clinical team. For example, escalation may occur via a same-day phone call from the Senior Medical Officer to the authorised decision-maker, supported by an ISOBAR handover. All actions and decisions should be documented in the patient's medical record.

Note

This example is intended to illustrate an escalation pathway. Each HHS should develop its escalation pathway in collaboration with accountable Executive Officers and key personnel involved in the process. The pathway should be formally documented within an HHS-wide procedure.

While this example presents a straightforward patient scenario, it is acknowledged that cases may be significantly more complex. Regardless of this variation in complexity, the escalation process itself should remain consistent.

References

1. Long Stay Policy and Program Unit, *Reducing delayed discharge: A system level response for older patients*. 2025, Queensland Health.
2. Kortebein, P., et al. *Functional Impact of 10 Days of Bed Rest in Healthy Older Adults*. The Journals of Gerontology: Series A, 2008. **63**, 1076-1081 DOI: 10.1093/gerona/63.10.1076.
3. Eriksson, C.O., et al. *The Association Between Hospital Capacity Strain and Inpatient Outcomes in Highly Developed Countries: A Systematic Review*. J Gen Intern Med, 2017. **32**, 686-696 DOI: 10.1007/s11606-016-3936-3.
4. Jones, S., et al. *Association between delays to patient admission from the emergency department and all-cause 30-day mortality*. Emerg Med J, 2022. **39**, 168-173 DOI: 10.1136/emermed-2021-211572.
5. Hassanzadeh, H., et al. *Strategies for Reducing Access Block and Waiting Time for Patients Seeking Emergency Hospital Care: Results of a Ward-Level Discrete Event Simulation at Queensland's Largest Public Hospitals*. Med J Aust, 2026. **224**, e70142 DOI: 10.5694/mja2.70142.
6. Australian Government. *Restorative Care Pathway*. n.d.; Available from: https://www.myagedcare.gov.au/aged-care-programs/restorative-care-pathway.
7. Queensland Health, *PROVIDE - Practical Redesign Options for Violence in Dementia and Delirium*. 2025, Queensland Government.
8. Queensland Health. *Eat Walk Engage*. 2025; Available from: https://www.clinicalexcellence.qld.gov.au/improvement-exchange/eat-walk-engage.