Discharge from admitted care: Quick reference guide

For more information, see Discharge from admitted care: best practice guide.

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.

- Discharge planning should begin at admission for unplanned patients and pre-admission for planned surgical patients.
- The MDT plays a key role in identifying and proactively addressing discharge barriers. Regular MDT discussions (e.g. huddles, case conferences, ward rounds) help teams stay connected, deliver better care, and keep discharge on track.
- Patients (and families/carers or substitute decision-makers) should be actively involved in discharge planning from the outset, including discussions about estimated date of discharge (EDD).

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

- Partner with patients in shared decision-making, integrating clinical expertise with their preferences, values, and goals, to reach decisions that are right for them.
- Respect patient autonomy by supporting informed choices, including those that involve some level of risk, and enable dignity of risk by helping patients manage those risks as safely as possible.

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

- Focus on patients' abilities, goals, and supports rather than deficits.
- Limit hospital functional assessments to what's necessary for safe community transfer.
- Discharge patients as soon as clinically ready, with recovery and care needs assessed in the community.

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.

- Ask: "Where is the right place this this patient to receive the right care at the right time?" Early discharge can improve health and reduce harm, with short-term support arranged if needed to help people stay independent.
- Adopt a "home first" philosophy. Home is best for most people leaving hospital – including older people – for recovery and assessment of any additional needs.

5. Escalate to avoid delay

- A delayed discharge is a patient safety and system risk.
- Information on managing delayed discharge can be found in the Delayed discharge – best practice guide.

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

- Use CLD for simple discharges to improve coordination, reduce stays, and free up hospital beds. Criteria-led discharge should begin pre-admission for planned care, and on admission for unplanned care.

7. Plan transport options early

- Prioritise family, carers, or community transport; use hospital transport only as a last resort.
- Patients awaiting transport should wait in a transit lounge (where available).

8. Support safe and timely medication management

- ED discharge: Provide prescribed medications and/or required prescriptions and clear follow-up instructions (e.g. GP contact or outpatient review).
- Ward discharge: Ensure take-home medications are ordered early and delivered to the ward the day before discharge.
- Patients awaiting medication dispensing should wait in a transit lounge, where available.

9. Provide safety netting and follow-up support

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

10. Ensure timely and effective clinical handover and information sharing

- Share discharge summaries with GPs 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.

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