

Policy

Clinically Ready for Discharge (CRFD)

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1.0 Introduction

- 1.1 The purpose of this policy is to ensure that people are discharged from inpatient care in a timely manner. Evidence shows that unnecessarily extended inpatient care can be harmful. As such this policy seeks to support services across ELFT to identify barriers to discharge and work proactively to remove them, ensuring people receive the right care in the best place for them.
- 1.2 The focus of this policy is to support services to identify service users who no longer need to receive care and treatment in the hospital, but who, for whatever reason remain there as they are not able to be discharged to the appropriate place for them.
- 1.3 To ensure that we are making the right decisions at the right time, information about people who are determined to be 'Clinically Ready for Discharge' will be collected in both acute and non-acute settings acute and non-acute, including mental health and community service users. The submission and reporting of CRFD will be in accordance with the national reporting (MHSDS).
- 1.4 The local implementation of this policy will require systems to work proactively to identify potential barriers to discharge at the point of admission and work to address them during the admission rather than at the point of the person being clinically ready for discharge.

2.0 Scope

- 2.1 The policy scope of the Clinically ready for Discharge (CRFD) will cover all bed types, including acute mental health, learning disability, autism, and specialist beds. The policy will apply to all-age groups, including children and young people services, as well as adults and older adult's beds. The FutureNHS collaboration platform provides access to the national policy and definition for Clinically Ready for Discharge.

3.0 Underlying Principles

- 3.1 Staying longer in the hospital than needed can cause avoidable harm to the individual, through long-term disruption to usual routines, reduced independence and reduced access to support networks.
- 3.2 The new definition for delayed discharges is rooted in the need for purposeful admissions and robust discharge planning from early on in admission

- 3.3 Planning a service user's discharge needs to start at the point of admission. At the point of admission, the local authority responsible for Care Act and/or S117 aftercare provision should be identified, and an assessment of their Care Act and/or Aftercare needs has taken place. Where there are partnership agreements in place between the Trust and the responsible local authority for adult and older adult mental health services, the duty to undertake these assessments will likely have been delegated to integrated teams within the Trust. The timescales within which each local authority assesses social care needs and determines an outcome will vary depending on local assessment arrangements and resources available. Therefore, the Trust will agree to reasonable assessment timescales with each of its local authority partners that ensure effective and timely discharges. This includes neighbouring local authorities whose residents may be admitted to ELFT inpatient services.
- 3.4 Discharge plans should be agreed upon by the multidisciplinary team, and should consider the full range of a service user's needs, i.e. both health and social. Care plans should also take into account the needs of the Carers and dependents (i.e. children and others) of the service user. Carers, including young carers, must be identified at the point of admission and be involved in decision-making throughout the admission. This is particularly important when the person resides with family members and their ability and willingness to provide ongoing support is a key factor in discharge arrangements.
- 3.5 Decision-making about discharge should be with the service user and their carer, although there may be very rare occasions where this has not been possible, where this is the case, reasons for the inability to involve in decision-making should be recorded. Where the service user lacks the capacity to make specific decisions regarding their discharge, assessment of capacity should be evidenced, including how the principles of the MCA have been followed and Best interests processes followed and recorded. To support service users and their carers in making decisions, the following will be made available: support for people to understand their options, and rights and where they can find additional support and accessible information including that of local community resources including advocacy and universal services.
- 3.6 Where a service user has been assessed as lacking the capacity to make decisions regarding their discharge consideration should be given to referral to an Independent Mental Capacity Advocate (IMCA). Clarification should also be sought as to the existence of a Power of Attorney, should a Lasting Power of Attorney be in place, the identified 'attorney' should be involved in planning of care from the earliest possible stage.

3.7 The national CRFD guidance makes it clear that the criteria of Clinically Ready for Discharge applies equally both to people who are informal and detained under Mental Health Act (MHA).

3.8 Section 17 leave is an essential part of assessing whether or not a person is clinically ready for discharge. If used as part of this assessment then by definition the person is not CRFD as it is still assessing this. It is for the team to decide whether the section 17 leave is part of an essential ongoing assessment or therapy plan to get the person clinically ready for discharge in which case it should not be labelled CRFD.

If the discharge location is not available for the person to be discharged to or if a period of Section 17 leave is needed to 'test' whether the discharge location is suitable, then on both of these occasions the person would be reportable as clinically ready for discharge.

3.9 A report on CRFD is available for local monitoring and operational purposes, providing local oversight and meeting national reporting expectations in **Appendix 1**.

3.10 The submission and reporting of CRFD will be in accordance with the national reporting requirements

4.0 Clinically Ready for Discharge (CRFD) Definition

4.1 Some is determined to be 'Clinically Ready for Discharge' when the multidisciplinary team (MDT) supporting them conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.

There are three key criteria¹ which need to be met before the MDT can make this decision:

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing the discharge plan.

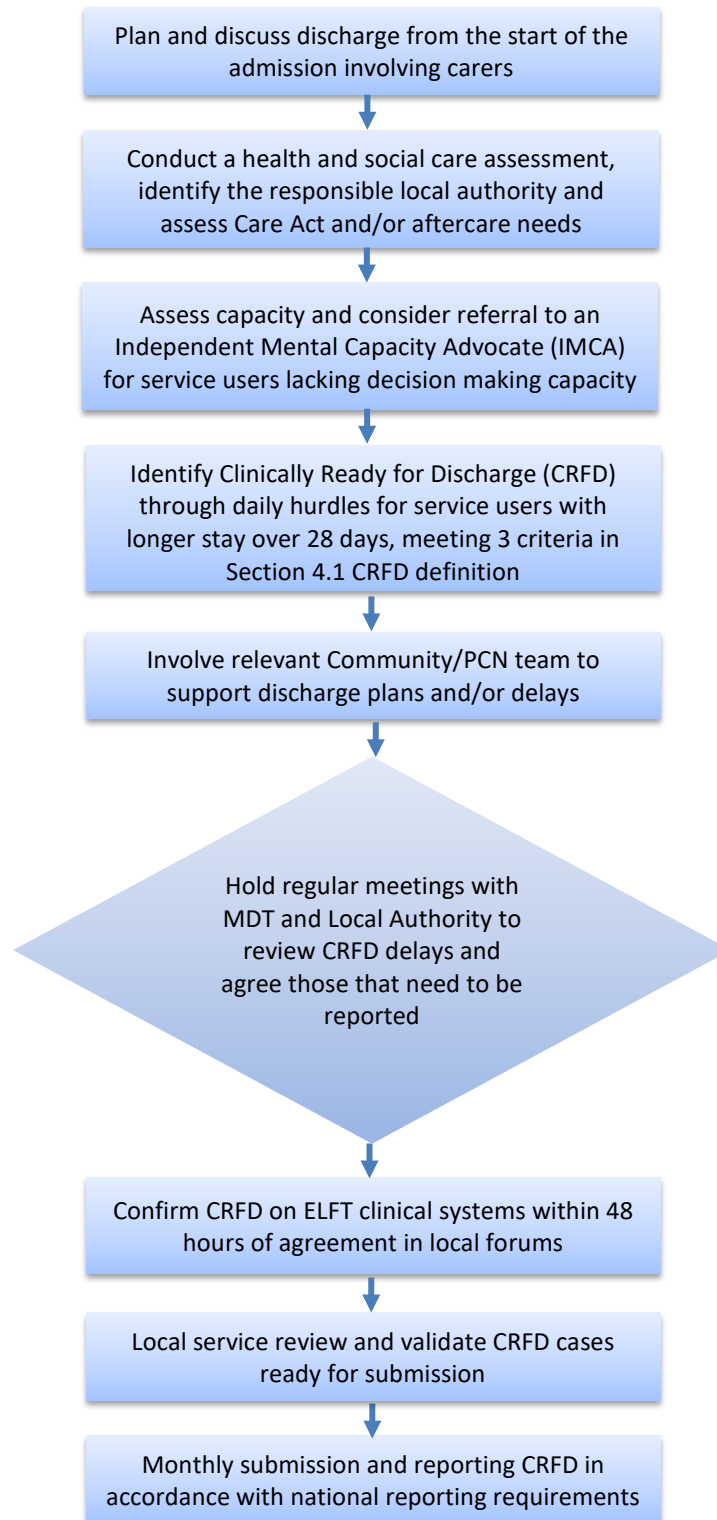
¹ National guidance has been issued to support implementing Clinically Ready for Discharge - [Implementing The New Clinically Ready For Discharge Definition](#)

- The MDT must also have involved any services external to the provider in their decision-making where these services will play a key role in the person's ongoing care e.g. social care teams.
- 4.2 The definition covers all bed types (acute mental health, learning disability, autism, and specialist) and is all-age (children and young people services, adults and older adults beds)
- 4.3 Once the criteria above is met, the person is clinically ready for discharge. This doesn't necessarily mean the person can be discharged e.g. their required package of community care might not be in place and therefore this would count as a delayed discharge.
- 4.4 An MDT in this context should be made up of practitioners from different professions, and organisations, including social workers/other stakeholders where appropriate, with the skills and expertise to address the service user's ongoing health and social care need post-discharge.
- 4.5 Where delays occur for people of no fixed abode, the crucial issue is to identify the local authority responsible for providing them with social care and support services. If they are admitted to the hospital from a public place then the postcode of that place should be used to identify the responsible local authority. The rules relating to ordinary residence will always apply.
- 4.6 For asylum seekers or other service users from overseas, should be listed under the local authority in which they currently reside. It is the responsibility of the local authority to decide whether they are eligible for social care services. The basic principle is that, where local authorities are responsible for providing care and support services for an individual under the Care Act 2014², the NHS body may seek reimbursement for any delays attributable to social care should they wish to do so.
- 5.0 Recording of Clinically Ready for Discharge**
- 5.1 The following should be in place to support rapid decision-making;
- A 7 days a week, daily clinical decision-making system with senior clinical peer review of longer stays over 28 days.
 - Daily huddle or board round identifying areas of need, potential and actual delays and mitigations.

² Care Act, HM Gov 2014 - <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

- Outcome of review and huddle linked to escalation.
 - Weekly bed management meeting with decision makers led by senior staff (clinical lead, inpatient Consultant, Ward Manager, Social Worker and OT) to discuss and assign responsibility for addressing barriers to discharge for “medically optimised” people.
 - Effective information sharing and reporting arrangements that are kept up to date by the Trust and its local authority partners as above this is mostly us, with reports shared in a timely manner to enable effective decision-making at bed management meetings
- 5.2 A service user is ready for transfer when;
- a) Service user on the ward with longer stay over 28 days
 - b) A MDT decision has been made that the service user is ready for transfer based on the three key criteria mentioned for MDT in **section 4.1**
 - c) Supporting services are aware of what ongoing support is needed.
- 5.3 There must be an explicit agreement in the MDT that a service user’s care has been delayed. Where agreement cannot be reached, the disputes and escalation process should be followed.
- 5.4 A Clinically Ready for Discharge must be recorded in RiO and also shared with the local authority and should also include details of the following;
- Start date of CRFD:
 - Agreed attribution of the delayed reason
 - End date
- 5.5 It is the responsibility of the inpatient lead (or designated person) following bed meetings to;
- Ensure CRFD bed management monitoring sheet is reviewed and
 - Identified/agreed CRFD cases and provide details to local performance managers each Monday for submission
- 5.6 To determine the discharge pathway for each service user and handle any disputes, we will follow the process outlined in **Figure 1**. The Trust will agree on the terms of reference, operating arrangements and membership of each body and group referred to in this pathway with each of its local authority partners. Each borough will have its own local protocols, which will outline the specific processes and procedures agreed upon with partners.

Figure 1: High Level Process Flow to agree CRFD



Please note:

Each borough will have its own local protocols, which will outline the specific processes and procedures agreed

6.0 Discharge Plan

- 6.1 Discharge planning should start on admission with the collection of information that will be required for effective discharge planning. For example, current living arrangements, family and social networks, employment & financial issues.
- 6.2 Appropriate help and support will be given to the service users to facilitate safe and effective discharge from an inpatient setting.
- 6.3 To enhance their discharge and transfer processes and practices, health and social care practitioners working in acute and community hospitals and intermediate care services are encouraged to refer to the Discharge Planning guide 10 steps (**Appendix 2**) provided. This guide contains essential information for health and social care organizations, highlighting key messages to equip practitioners with the necessary tools to achieve good practice.

7.0 Attributing Reasons for Delays

- 7.1 Both the number of service users whose transfer of care is delayed and the number of days delayed within the month are subdivided by the reasons for the delay. A service user should only be counted in one category of delay. This category should be the one most appropriately describing their reason for the delay as summarised below.

Table 1: Reasons for delay and attribution

Category Description	Attributable to:			
	NHS, excluding housing	Social Care, excluding housing	Both (NHS & Social Care), excluding housing	Housing (inc. supported/specialist housing)
A2: Awaiting Care coordinator allocation	✓	✗	✗	✗
B1: Awaiting public funding	✓	✓	✓	✗
C1: Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc.)	✓	✗	✗	✗
D1: Awaiting Care Home Without Nursing placement or availability	✗	✓	✗	✗
D2: Awaiting Care Home with Nursing placement or availability	✓	✓	✓	✗
E1: Awaiting care package in own home	✓	✓	✓	✗
F2: Awaiting community equipment, telecare and/or adaptations	✓	✓	✓	✗
G2: Service user or Family choice (Reason not stated by family)	✓	✓	✗	✗

Category Description	Attributable to:			
	NHS, excluding housing	Social Care, excluding housing	Both (NHS & Social Care), excluding housing	Housing (inc. supported/specialist housing)
G3: Service user or Family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	✗	✗	✗
G4: Service user or Family choice - Care Home Without Nursing placement	✗	✓	✗	✗
G5: Service user or Family choice - Care Home with Nursing placement	✓	✓	✓	✗
G6: Service user or Family choice - Care package in own home	✓	✓	✓	✗
G7: Service user or Family choice - Community equipment, telecare and/or adaptations	✓	✓	✓	✗
G8: Service user or Family Choice - general needs housing/private landlord acceptance as service user NOT covered by Housing Act/Care Act	✓	✓	✗	✓
G9: Service user or Family choice - Supported accommodation	✓	✓	✗	✓
G10: Service user or Family choice - Emergency accommodation from the Local Authority under the Housing Act	✓	✓	✗	✓
G11: Service user or Family choice - Child or young person awaiting social care or family placement	✓	✓	✗	✗
G12: Service user or Family choice - Ministry of Justice agreement/permission of proposed placement	✓	✗	✗	✗
H1: Disputes	✓	✓	✗	✓
I2: Housing-Awaiting availability of general needs housing/private landlord accommodation acceptance as service user NOT covered by Housing Act and/or Care Act	✓	✓	✗	✓
I3: Housing – single homeless service users or asylum seekers NOT service user not covered by Care Act	✓	✗	✗	✓
J2: Housing- Awaiting supported accommodation	✓	✓	✗	✓
K2: Housing- Awaiting emergency accommodation from the Local Authority under the Housing Act	✓	✓	✗	✓
L1: Child or young person awaiting social care or family placement	✓	✓	✗	✗
M1: Awaiting Ministry of Justice agreement/ permission of proposed placement	✓	✗	✗	✗
N1: Awaiting outcome of legal requirements (mental capacity/mental health legislation)	✓	✓	✗	✓ in sheltered or supported housing

Category Description	Attributable to:			
	NHS, excluding housing	Social Care, excluding housing	Both (NHS & Social Care), excluding housing	Housing (inc. supported/specialist housing)
P1: Awaiting residential special school or college placement or availability	x	✓	x	✓
Q1: Lack of local education support	x	✓	x	x
R1: Public safety concern unrelated to clinical treatment need (care team)	✓	✓	✓	x
R2: Public safety concern unrelated to clinical treatment need (Ministry of Justice)	✓	✓	✓	x
S1: No lawful community care package available	x	✓	x	x
T1: Lack of health care service provision	✓	x	x	x
T2: Lack of social care support	x	✓	x	x
98: No reason given	✓	✓	✓	✓

- 7.2 A service user should only be counted in **ONE** category of delay; this category should be the one most appropriately describing their reason for the delay, and the total numbers allocated to reasons for the delay should be equal to the number of service users delayed.
- 7.3 For service users of No Fixed Abode (NFA), the responsible local authority is the one in whose area they normally reside, irrespective of whether they live on the street or in a hostel. Ordinary residence rules apply³.

A) Delay awaiting assessment

All service users whose transfer is delayed as a result of delays with the completion of an assessment of care needs and an identification of an appropriate care setting is considered as delayed awaiting assessment. This can include any assessment by health and/or social care professionals of a service user's future care needs. Therefore, delays can be due to either: NHS, Social Services or a combination of both. Trusts will want to identify with their Social Services partners where in the process and why delays are occurring. Any existing local agreements about built-in time to undertake assessments before delay is counted no longer apply.

Trusts need to monitor locally the amount of time taken to arrange assessment. Good practice would suggest that this process should be in place prior to the decision to discharge being made.

³ HM Gov, updated June 2017 - <https://www.gov.uk/government/publications/identifying-the-ordinary-residence-of-people-in-need-of-community-care-services>

B) Delay awaiting public funding

All service user whose assessment is complete but transfer have been delayed due to awaiting Social Services funding (e.g. for residential or home care), or NHS funding (e.g. for nursing care or continuing healthcare). This should also include cases where Social Services and NHS have failed to agree funding for a joint package or an individual is disputing a decision over fully funded NHS continuing care in the independent sector. It does not include delays due to arranging other NHS services (residential or community) – see below.

C) Delay awaiting further NHS care, including intermediate care

All service users whose assessment is complete but transfer have been delayed due to awaiting further NHS care, i.e. any non-acute (including Integrated Care Board (ICB) and mental health) care, and intermediate care. Also continuing health care fully funded by the NHS in the independent sector. It also includes where a decision has been made to defer a decision on continuing health care eligibility, and to provide NHS-funded care (in a care home, the service user's own home or other settings) until an eligibility decision is made but the transfer into this care is delayed.

Acute delayed transfers of care:

Include all delays of service users leaving acute care. This includes service users waiting to move to non-acute care within the same trust. Do not include delays of service users continuing to receive acute care moving from one bed to another, even if these beds are in different trusts.

Non-acute (including Integrated Care Board (ICB) and mental health) delayed transfers of care:

Include all delays of service users leaving non-acute (including Integrated Care Board (ICB) and mental health) care. This includes service users waiting to move to other types of non-acute (including Integrated Care Board (ICB) and mental health) care within the same trust. Do not include delays of service users continuing to receive the same type of non-acute (including Integrated Care Board (ICB) or mental health) care moving from one bed to another, even if these beds are in different trusts.

These should not include delays in providing NHS-funded care provided in the service user's own home, such as that provided by a District Nurse (rather than a conscious decision to defer consideration of eligibility for continuing health care). These delays should be recorded under 'E' – delay due to awaiting care package in own home. See below for details.

D) Delay awaiting Residential/Nursing Home Placement/Availability

All service users whose assessment is complete but transfer have been delayed due to awaiting Nursing/Residential home placement, because of lack of availability of a suitable place to meet their assessed care needs.

This does not include service users where Social Services funding has been agreed, but they or their family are exercising their right to choose a home under the Direction on Choice. These service users should be counted under category G.

E) Delay due to awaiting care package in own home

All service users whose assessment is complete but transfer have been delayed due to awaiting a care package in their own home.

The delay should be logged as the responsibility of the agency responsible for providing the service that is delayed. This should be possible to ascertain even where agencies operate in partnership, as statutory responsibilities for care do not change under partnership arrangements. NHS input to a home care package might include the services of a District Nurse or CPN, an Occupational Therapist or Physiotherapist.

The 'further non-acute (including Integrated Care Board (ICB) and mental health) NHS care' box should be used to record NHS services where these are not provided in the service user's home, examples of which might include intermediate care, rehabilitative care, care provided in a community hospital, or fully-funded NHS continuing care.

The delay should only be logged as the responsibility of both agencies where both NHS and local authority services are delayed.

F) Delays due to awaiting community equipment and adaptations

All service users whose assessments is complete but transfer have been delayed due to awaiting the supply of items of community equipment (Note that the Community Care (Delayed Discharges etc.) Act (Qualifying Services England) Regulations 2003 stipulate that all items of community equipment and minor adaptations must be provided free of charge.

Where equipment is provided via a service delivered in partnership between the NHS and the local authority, it should nonetheless be possible to identify the cause of any delay, and the parties responsible. Where delays are solely the responsibility of the council, such delays should be included in the attributable to Social Care columns.

G) Delay due to service user or family exercising choice

All service users whose assessment is complete and have been made a reasonable offer of services, but has refused that offer. It would also include delays incurred by

service users who will be funding their own care e.g. through insisting on placement in a home with no foreseeable vacancies.

Note that the Direction on Choice should not be used as a reason to delay a service user's discharge. The provisions of the Direction on Choice continue to apply to service users leaving hospital for a place in a care home. Health and social care systems should put in place locally agreed protocols on service user information incorporating how the issue of service user choice will be dealt with. These should make it clear that an acute setting is not an appropriate place to wait and alternatives will be offered.

Where Social Services are responsible for providing services and a service user's preferred home of choice is not immediately available, they should offer an interim package of care. All interim arrangements should be based solely on the service users assessed needs to sustain or improve their level of independence. If no alternative is provided which can meet the service user's needs, Social Services are liable for reimbursement.

Where service users have been offered appropriate services, either on an interim or permanent basis, by the local authority but are creating an unreasonable delay as above, such delays are not considered to be the responsibility of the local authority and thus do not incur reimbursement charges. The responsibility for discharging the service user reverts to the NHS body. Such delays should be recorded in the column 'Attributable to the NHS'.

H) Disputes

This should be used only to record disputes between statutory agencies, either concerning responsibility for the service user's onward care, or concerning an aspect of the discharge decision, e.g. readiness for discharge or appropriateness of the care package.

Disputes may not be recorded as the responsibility of both agencies. NHS bodies and Councils are expected to operate within a culture of problem solving and partnership, where formal dispute is a last resort. The service user should not be involved in the dispute, and should always be cared for in an appropriate environment throughout the process.

Accordingly, frontline staff should allocate responsibility for the service user's care to one organisation, who may then take the dispute to formal resolution without involving the service user or affecting his/her care pathway. The delay should be recorded as the responsibility of the agency that is taking interim responsibility for the service user's care.

Where a delay is caused because of a service user's disagreement with an aspect of the care package or decision to discharge, this should not be listed under disputes but

recorded under service user choice. For example, a disagreement with the decision to discharge would be listed for an assessment and or responsibility of the NHS. If a service user had been offered a care package in their own home and they felt they should be offered a residential care placement, it would be listed under Social Services responsibility or residential care.

I) Housing – service users not covered by NHS and Community Care Act

The guidance accompanying the Community Care (Delayed Discharges) Act 2003 requires Social Services departments to make appropriate interim arrangements for service users delayed waiting for housing, rather than allow them to remain in hospital when they are fit to move on. If there are delays in arranging the interim placement, the reason for delay should be recorded under that of the delayed interim package (e.g. residential care, care package in own home).

However, some service users delayed for housing reasons may not be eligible for community care services and therefore are not the responsibility of Social Services. Examples could be asylum seekers or single homeless people.

We have therefore introduced a new box to cover housing delays where these relate to people who are not eligible for community care services. All other service users with long-term housing delays should be found an interim placement, and any delays in arranging this logged under the care package they are waiting for as discussed above.

The focus of the form is on delays to service users leaving the medical environment. Where service users are eligible for community care services, and major home adaptations or alternative housing arrangements are needed for safe discharge, Social Services staff should inform and work with housing counterparts to arrange the necessary services. Remaining in a medical setting whilst long-term adaptations are made, however, is not an appropriate care option. In these circumstances, Social Services will need to make appropriate interim provisions to enable the service user to move on from the medical environment. Social Services are deemed liable for reimbursement for delays in the arrangements of interim social care provision in these circumstances.

The revised form reflects these arrangements. If there is likely to be a housing-related delay, Social Services should focus on finding an interim placement. Any delays in providing interim care should be recorded under the appropriate box on the new form, for instance, under domiciliary care or residential care, as appropriate.

Interim arrangements are of course intended to be provided on a temporary basis. If long-term arrangements of housing support are a significant problem in making discharge arrangements for service users, Councils should ensure they have their own monitoring arrangements to inform progress.

Service users delayed waiting for housing support is not eligible for community care services. This means their discharge is not the responsibility of Social Services and such delays are not eligible for reimbursement. In response to feedback from Councils, we have introduced a new category 'I' on the form to cover this group of service users, who might include asylum seekers or single homeless people. Please see the section I in this guidance document for further detail.

J) Delay due to awaiting supported accommodation

This would typically include delays when people are waiting for sheltered housing, long and short term supported housing, extra care housing, adult placement schemes, crisis houses, refuges, therapeutic communities, short stay hostels and other specialist step up/step down accommodation.

K) Delay due to awaiting emergency accommodation from the Local Authority under the Housing Act

This category should be used when a person cannot be discharged from care because they are awaiting accommodation under the Housing Act, for example, for people who are legally homeless, or have a priority need.

L) Delay due to awaiting emergency accommodation from the Local Authority under the Housing Act

This category should be used for children and young people whose discharge is delayed because they are awaiting placements in children's homes, foster care placements or kinship care

M) Delay due to awaiting Ministry of Justice agreement/ permission of proposed placement

N) Delay due to awaiting outcome of legal requirements (mental capacity/mental health legislation)

This could typically include delays relating to decisions from Independent Mental Capacity Advocates (IMCA) and/or for a deprivation of liberty safeguard (DOLs)

8 Placement without Prejudice

8.1 Decisions to fund placements or packages are not causes for extended hospital stays and should not be a cause of delayed transfer of care. The following needs to be in place to support the service user and teams working with service users so as to expedite discharge when appropriate;

- Clear funding systems and processes with good guidance are available and known by all.
- Accessible information is made available to people and their support network, upon decision to admit for private funders.
- Interagency agreements are in place for individuals with complex needs.
- Strong assurance process is in place for checking the quality of assessments.
- Clear S117 process and responsible ICB/ LA funding officer identified and known to staff.
- All staff understand how to identify individuals with S117 aftercare needs.
- Daily decision making around funding done outside of panel, with no delays caused. Single decision maker in place.
- Streamlined collaborative panel process.
- No one waits more than 48 hours for a funding decision

9 Disputes and escalations

9.1 **Disputes** – where disputes arise, these should be resolved in the first instance through the MDT process with escalation to operational line managers for discussion, agreement and resolution.

9.2 **Escalation** - where the dispute cannot be resolved at operational level this should be escalated to health and social care commissioners for discussion, agreement and resolution.

9.3 A person's care must not be delayed whilst disputes are resolved.

9.4 Where the CRFD is identified the data is reported to MHLDA COVID-19 SiteRep from 1st April 2023. In addition, when version 6 of MHSDS goes live in April 2024 changes will be made to the delayed discharge reason codes to support the new definition.

Appendix 2 – Key Practices and Principles 10 steps

The 10 steps

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.

For further detailed information on each step, please click on the [Department of Health Policy guide on 10 Steps](#) to achieving safe and timely discharge