SA Health

Policy

Managing Transfer or Discharge of Patients

Version 3.0
Approval date: 28 July 2023
PDS Reference No: D0398

Government of South Australia
SA Health

1. Name of policy

Managing Transfer or Discharge of Patients

2. Policy statement

This policy provides the mandatory requirements for the timely transfer or discharge of patients from public hospitals, by ensuring early identification, intervention, and management of barriers.

3. Applicability

This policy applies to all employees and contracted staff of SA Health; that is all employees and contracted staff of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) including state-wide services aligned with those Networks and SA Ambulance Service (SAAS).

4. Policy principles

SA Health's approach to managing the transfer or discharge of patients is underpinned by the following principles:

- We will ensure the rights and interests of patients who cannot make decisions or advocate for themselves are protected and upheld.
- We will prioritise the clinical needs of the patient throughout the transfer or discharge process.
- We will seek to optimise patient flow through the public hospital system by minimising avoidable extended hospital stays through efficient discharge via the Criteria Led Discharge (CLD) pathway or following medical directed clearance.
- We will ensure patients/substitute decision makers are appropriately informed regarding transfer pathways, residential care options and community-based support services as early as possible.
- We will assist and support patients in their transition to alternative care options.

5. Policy requirements

- **All LHNs** must:
  - Proactively manage timely transfer or discharge of patients by:
    - Commencing discharge planning within 24-hours of hospital admission, or as soon as practicable, in accordance with the mandatory instruction at Appendix 1 noting discharge cannot occur until the acute or sub-acute care episode is complete.
    - Implementing and maximising utilisation of the CLD pathway to achieve timely discharge of suitable patients.
    - Having effective local procedures in place which incorporate the requirements of the Mandatory Instruction at Appendix 1, to ensure all staff are aware of, and compliant with, this policy.
    - Moving patients to appropriate interim options when hospital care is no longer required in accordance with Mandatory Instruction at Appendix 1.
    - Utilising transit/discharge lounges where available and when clinically appropriate.
  - Ensure there are effective escalation processes in place which:
    - Empower staff to progress towards transfer or discharge where there are significant delays or persistent declined offers in line with the Mandatory Instruction at Appendix 1.

- Clearly set out the roles and responsibilities of accountable officers at all escalation levels, ensuring accountable leadership.

6. Mandatory related documents

The following documents must be complied with under this Policy, to the extent that they are relevant:

- Aged Care Act 1997
- Application Process for South Australian Civil and Administrative Tribunal (SACAT) Guideline [IN DEVELOPMENT]
- Criteria Led Discharge Policy
- Fit to Sit Pathways Policy
- Hospital in the Home Guideline
- Mandatory Reporting Guide
- Mandatory Reporting of Suspicion That a Child or Young Person Is or May Be at Risk of Harm Policy
- Providing Medical Assessment and/or Treatment where Patient Consent cannot be Obtained Policy
- SA Health Fees and Charges Manual
- Statewide Demand and Escalation Policy

7. Supporting information

- Accessing Legal Services Across SA Health
- Information for Clinicians – Approaching Patients about a Transfer or Discharge
- Information for Clinicians – Care Awaiting Placement Program
- Letter – Discharge of a Patient (Adult)
- Letter – Discharge of a Patient (Child)
- Patient Information Sheet – Discharge Roadmap
- Patient Information Sheet – Information for Patients and Families on Admission
- Patient Information Sheet – Residential Aged Care Placement
- Patient Information Sheet – You are Leaving Hospital
- Request for General Legal Services Template
- Sunrise EMR & PAS Comprehensive Flow Plan
- Sunrise EMR & PAS Criteria Led Discharge Reference Guide
- Transition Care Programme information

8. Definitions

- **Appropriate transfer:** means transfer to an alternative care setting (eg RACF, National Disability Insurance Scheme (NDIS) accommodation setting, or appropriate community location) that best meets the patient's individual needs and circumstances.
- **Complex needs:** means a patient whose condition may involve multiple diagnoses, comorbidities, and psychosocial factors, including people who have functional impairments. This may also relate to a patient's social circumstances if there are multi-faceted factors preventing or contributing to a discharge decision being made by the patient/substitute decision maker.

- **Criteria Led Discharge (CLD):** means the use of discharge criteria, as determined by the multi-disciplinary care team, to assist clinical decisions within agreed parameters to support discharge facilitated by a CLD experienced clinician.
- **Management plan:** means the plan that is developed with a patient for their care in hospital and documented in the patient's medical record.
- **Estimated Discharge Date:** means the day in which discharge from hospital is predicted or expected based on experience and information available at the time. This estimation recognises that pertinent facts are unclear and unknown, and that the estimation will require updating regularly throughout the admission.
- **Maintenance care (or non-acute care):** means care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.
- **Medically fit:** means a patient is considered by hospital staff to have completed their inpatient episode of care, their clinical condition has stabilised, and they have been deemed clinically ready for discharge.
- **Other Relevant System:** means electronic medical record systems (eg Homer, Chiron) used in sites where Sunrise Electronic Medical Record (EMR) & Patient Administration System (PAS) is not available.
- **Residential Aged Care Facility (RACF):** means a facility providing personal and/or nursing care to a person in a residential facility in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, as well as furnishings and equipment for the provision of that care and accommodation. Admission is based on the assessment of the Aged Care Assessment Team (ACAT).
- **Senior Clinician:** means Senior Consultant, Medical Fellow or Visiting Medical Officer (VMO).
- **Statewide services**: means Statewide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks.
- **Substitute Decision Maker:** means someone who is authorised, by either formal or informal arrangement, to make decisions on behalf of a person with a disability or medical condition about that person's medical treatment where required. For the purposes of this Policy, this includes family members or legal guardians.
- **Transition Care Programme (TCP):** means time-limited, goal-oriented, and therapy-focused packages of services for older people after a hospital stay. Transition care can be delivered in either a facility based residential setting or in a community setting (eg the person's own home).

9. Compliance

This policy is binding on those to whom it applies or relates. Implementation at a local level may be subject to audit/assessment. The Domain Custodian must work towards the establishment of systems which demonstrate compliance with this policy, in accordance with the requirements of the Integrated Compliance Policy.

Any instance of non-compliance with this policy must be reported to the Domain Custodian for the Services, Planning and Programs Domain and the Domain Custodian for the Risk, Compliance and Audit Policy Domain.

10. Document ownership

Policy owner: Domain Custodian for the Services, Planning and Programs Policy Domain

Title: Managing Transfer or Discharge of Patients Policy

Objective reference number: A5098499

Review date: 28/07/2026

Contact for enquiries: Health.HSPUnplannedCare@sa.gov.au

11. Document history

Version	Date approved	Approved by	Amendment notes
3.0	28/07/2023	Chief Executive, DHW	Reviewed and updated in line with the SA Health Policy Framework. Previously named Management of Patients with Complex Needs Requiring Discharge or Transition Placement Policy Directive.
2.0	20/07/2020	Deputy Chief Executive, Commissioning and Performance	Reviewed and updated.
1.0	02/07/2015		Original version.

12. Appendices

1. Managing Transfer or Discharge of Patients Mandatory Instruction

Appendix 1: Managing Transfer or Discharge of Patients Mandatory Instruction

The following instruction must be complied with to meet the requirements of this Policy.

1. Clinical Assessment and Planning

1.1. A clinical management discussion must occur with the patient and/or substitute decision maker within 24-hours of hospital admission to address clinical requirements and patient goals, including a comprehensive assessment of the patient's medical and social needs, and likely discharge pathway (Table 1). This assessment must take place:

1.1.1. either in the pre-admission clinic or on admission for elective patients; or

1.1.2. as early as possible in the hospital stay for patients admitted via the emergency department or via interfacility transfer.

1.2. Where a clinician identifies concerns related to patient safety or decision-making capacity, they must comply with the following requirements and relevant policies:

1.2.1. Neglect of a patient under the age of 18 years, and/or serious doubt or dispute between the hospital team and parent/guardian/substitute decision maker regarding transfer or discharge and/or the ongoing health care arrangements, the hospital team, as mandated reporters under the *Children and Young People (Safety) Act 2017*, must file a report with the Child Abuse Report Line (via www.reportchildabuse.families.sa.gov.au or phone 13 14 78) in accordance with the Mandatory Reporting of Suspicion That a Child or Young Person Is or May Be at Risk of Harm Policy.

1.2.2. Abuse of vulnerable adults aged 65 years and over, 50 years and over for Aboriginal or Torres Strait Islander people, and adults living with a disability, the hospital team must report to the Adult Safeguarding Unit (via adultsafeguardingunit@sa.gov.au or phone 1800 372 310).

1.2.3. A patient aged over 18 years does not have sufficient capacity to make financial or health-related decisions, and does not have an appropriate substitute decision maker, an application must be made to the South Australian Civil and Administrative Tribunal (SACAT) via https://www.sacat.sa.gov.au/application-form in accordance with the Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy and with reference to the *Application Process for SACAT Guideline* [IN DEVELOPMENT].

1.3. Following the clinical management discussion, a senior clinician must determine an estimated discharge date (EDD), which must be:

1.3.1. Completed for all patients admitted to a public hospital within 24 hours of admission, or as soon as practicable in the event a patient is medically unstable.

1.3.2. Based on the knowledge and expertise of the senior clinician, or existing clinical protocols or care pathways for which an EDD is already documented.

1.3.3. Recorded in Sunrise EMR & PAS, or other relevant system.

1.3.4. Reviewed and updated daily, where appropriate.

1.4. The CLD pathway must be considered for all discharges to support efficient patient flow, in line with the Criteria Led Discharge Policy. This pathway can be revisited at any stage during the patient admission.

2. Communication and Information Sharing

2.1. Each LHN must develop and maintain local communication management processes and materials to assist in conversations between hospital staff and the patient/ substitute decision maker. As a minimum, the following information must be provided/communicated to the patient/substitute decision maker:

a) "Information for Patients and Families on Admission" flyer.

b) Patient/substitute decision maker rights and responsibilities.

c) Patient information (including care, guardianship, lifestyle and financial matters that may impact on care or placement).

d) Relevant clinical information (including psychosocial assessment of the patient where required).

e) Contact details for the hospital team and necessary ACAT, NDIS Hospital Liaison Officer and/or community support representatives, where available.

f) Services and strategies to support successful transition and prevent potential hospital re-admission (e.g., Rapid Access Service, Dementia Support Australia, or appropriate complex support plan for paediatrics).

g) Circumstances in which it is recommended that the patient visit the emergency department post-discharge, including re-admission strategies.

h) Potential fees arising from extended stays in hospital (35 days of continuous hospitalisation) as per the SA Health Fees and Charges Manual. This must be recorded as maintenance care in Sunrise EMR & PAS**,** or other relevant system.

i) The potential requirement to move to a suitable transitional accommodation option (refer to section 3.2).

2.2. The LHN must develop appropriate communication processes with General Practitioners (GP) and where possible, involve the patient's GP in discharge planning to maximise patient support in follow up care.

3. Transfer or Discharge Pathway

3.1. Following assessment and intervention, if the patient requires additional community support or cannot be discharged to their pre-hospital accommodation, a discussion must occur with the patient and/or substitute decision maker on a suitable transfer or discharge pathway listed in Table 1.

3.2. This discussion must include the senior treating clinician, and where required, the multi-disciplinary team. Where there is additional complexity, this discussion must occur via a case conference and may need to include relevant external stakeholders (e.g., DHW, NDIS, community services).

3.3. Where possible, every effort must be made to enable early identification of barriers or delays which may affect timely transfer or discharge (see section 5).

3.4. The relevant member of the multi-disciplinary team must then undertake the steps outlined in Table 1 to rapidly progress the patient to the agreed transfer or discharge pathway.

Table 1: Transfer and Discharge Pathways

Pathway	Minimum Requirements
Community	Depending on the care required, the hospital team must consider the most appropriate home support option for discharge. This could include Rehabilitation in the Home (RITH), Geriatrics in the Home (GITH), My Home Hospital (MyHH), Community TCP and Metropolitan Referral Unit (MRU). Referrals to these services may require assessment of: > Personal safety needs (emergency contact information and strategies). > In-home care (including paediatric nursing) and/or community supports. > Physical requirements (aid and equipment needs) and home modifications, including how these will be funded and the timeframe for completion. > Personal and domestic needs (i.e., washing, cleaning, shopping, laundry). > Meal preparation support (i.e., Meals on Wheels). > Community transport needs (i.e., local council, SA Transport Subsidy Scheme, Department of Human Services (DHS) Mobility Allowance).
NDIS (Including Paediatric)	> Provide the patient/substitute decision maker with access to information regarding the NDIS system (via www.ndis.gov.au or phone 1800 800 110) and the Commonwealth Carer Gateway (via www.carergateway.gov.au or phone 1800 422 737); including participant information booklets (available at the following link https://www.ndis.gov.au/participants). > Request the participant complete the NDIA Consent to Share Your Information form. > Work with local Disability Liaison teams within the LHNs. > For new referrals, support prospective NDIS participants in completing and submitting an Access Request Form.

Pathway	Minimum Requirements
	> For existing participants where increased supports are required, assist in completing a Change of Circumstances form, and where applicable a Request for Review. > Proactively arrange allied health assessments and discuss change in circumstances, support needs, and goals, in preparation for planning meetings (refer to "Health and NDIS Hospital Discharge Pathway" and NDIS Assessment templates). > Support the patient/substitute decision maker in accessing NDIS housing information if they are seeking an NDIS accommodation service (https://www.ndis.gov.au/participants/housing-and-ndis). > Actively involve the Support Coordinator and multi-disciplinary team in the implementation of the approved NDIS plan for discharge. > Support the participant to engage with their Support Coordinator/Hospital Liaison Officers to begin identifying their support needs and exploring suitable housing options and locations.
RACF	> For patients aged under 65-years who are at risk of entering residential aged care, please refer to https://www.health.gov.au/topics/aged-care/providing-aged-care-services/support-for-younger-people > For existing permanent residents returning to a RACF, ensure they are aware of their right of return in line with Security of Tenure Provisions of the *Aged Care Act 1997*. > For patients moving to residential aged care for the first time, check for current approvals before obtaining patient consent and progressing an ACAT assessment. > Provide the patient/substitute decision maker with access to information regarding the aged care system (via www.myagedcare.gov.au or phone 1800 200 422) and to the Australian Aged Care Quality Agency to review facilities they are considering (https://www.agedcarequality.gov.au/reports). > Inform the patient/substitute decision maker that they must: ○ list a minimum of six but preferably ten facilities (applicable to metropolitan region only). ○ move to the first available, clinically appropriate interim option listed in Table 2 at any time while on a RACF pathway, whilst waiting for placement in one of the preferred facilities identified. ○ accept the first preferred placement offered. ○ expand their initial RACF listing, if no preferred vacancy is identified within 72 hours of application submission, or there is a delay in accessing the preferred vacancy. > If the patient discharges to a transitional location due to delays in RACF placement, ensure that the patient/substitute decision maker liaises with their preferred RACFs to advise of their location and confirm their intent to move to their facility. > Ensure access to supports in RACF, including: ○ The Dementia Behaviour Management Advisory Service (DBMAS); and ○ SA Virtual Care Service.
Sub-acute service	Depending on the care required, the hospital team must consider the most appropriate sub-acute option, if required, for transfer: ○ Geriatric Evaluation Management [GEM] Unit ○ inpatient rehabilitation ○ mental health pathways > The criteria for each of these services may vary depending on the model of care.
Supported Accommodation (Paediatric)	> Discuss discharge arrangements with the patient/substitute decision maker, including transport requirements. > Liaise with the preferred accommodation provider regarding transfer and discharge arrangements.

4. Interim Options for Transfer or Discharge

4.1. During the discussion at section 3.1.1, the patient and/or substitute decision maker must be advised the current hospital care (this includes all episodes of care delivered in a hospital setting) is no longer required, and they will be transferred or discharged to a clinically appropriate interim option, as listed in Table 2.

4.2. Patients may access multiple interim options per episode of care, for any of the following reasons:

a) Patient is medically fit for discharge from current location.

b) Patient is awaiting placement in a RACF or NDIS accommodation.

c) Patient has accepted an offer of accommodation, but the location is not ready to accept the patient.

d) Accommodation in a preferred location cannot be secured.

e) Patient is declining suitable discharge offers.

f) Patient is awaiting supports to be in place which facilitate community discharge.

Table 2: Interim Transfer or Discharge Options

Option	Eligibility	Requirements
Care Awaiting Placement (CAP) Program	Patients over 65 years of age (or over 50 years of age for patients of Aboriginal or Torres Strait Islander descent) requiring permanent placement in a RACF or transition to an alternative care pathway. By exception, patients who are under 65 years of age (or under 50 years of age for patients of Aboriginal or Torres Strait Islander descent) may be considered for CAP if they have been assessed as eligible by an ACAT.	> No longer acutely unwell but unable to be discharged. > Have care needs that can be provided in a CAP facility. > ACAT approval in place, or referral made to ACAT for permanent RACF placement or TCP. > Inform the patient/substitute decision maker of RACF pathway expectations as per *Patient Information Sheet – Residential Aged Care Placement*. > Refer to *Information for Clinicians – Care Awaiting Placement Program.*
Community Supports *Examples: Home Care Packages, Hospital in the Home, Palliative Care in the Home GITH, RITH, MRU, Country Home Link.*	Patients able to access and utilise community supports.	For Commonwealth funded supports > Some supports require income and asset assessments, and ACAT or Regional Assessment Service assessments to be undertaken in the community. > Hospital staff must use the My Aged Care Make a Referral form (https://www.myagedcare.gov.au/make-a-referral) to refer patients to Commonwealth funded aged care services. For all other services please refer to LHN intranet for referral process information
My Home Hospital (MyHH)	Clinically appropriate patients who: > are aged over 13 years. > have a clinical condition requiring acute hospital level care. > can safely receive daily hospital level clinical care at home. > do not require 24-hour observation.	> Patients must: o provide consent o reside in the Adelaide metropolitan area, or the Gawler, Mount Barker regions, areas within Southern Fleurieu and their surrounds; o provide consent to receive services from MyHH; o have access to a mobile phone or landline and be able to make and receive phone calls; and o have a safe and suitable home environment to receive their care. o be assessed as clinically appropriate to receive care at home.

Option	Eligibility	Requirements
		> Referrals can be made 24/7 by completing a referral form. Unless urgent, a referral after 10:00pm will not be reviewed until 8:00am the following day. > Alternatively, between 8:00am and 10:00pm a phone referral can be made by called 1800 111 644.
NDIS interim accommodation *Examples: Transition to Home (T2H), Regency Green, NDIS Medium Term Accommodation (MTA)*	NDIS eligible patients over 18 years old with an approved NDIS plan who no longer need inpatient care and are awaiting their longer-term support arrangements.	For T2H and Regency Green: > Patient must be discharge ready with either SIL approval or NDIS plan and clinical assessment that describes their support requirements and discharge pathway. > T2H referrals must be sent to health.longstaydischargeproject@sa.gov.au > Regency Green referrals must be sent to: health.mhregencygreenreferrals@sa.gov.au
Respite	Patients able to safely receive short-term care in a residential or community setting (63 days per financial year with possibility for extension via ACAT).	> Residential respite is subject to ACAT approval. > CHSP Respite service applications must be referred via My Aged Care (https://www.myagedcare.gov.au/). > Patients must be advised they do not have security of tenure to the RACF in which they are receiving respite care.
Transfer to another Metropolitan or Peri-Urban Hospital	Patients able to safely receive care in another metropolitan or peri-urban hospital to ease pressure on tertiary metropolitan hospital bed availability.	> Inter-hospital patient transfers must follow LHN transfer and clinical handover procedures.

5. Discharge Barriers

5.1. Barriers or delays which may will timely transfer or discharge must be addressed promptly in line with the options outlined in Table 3. They must also be clearly documented in the patient's management plan.

5.2. The Office of the Public Advocate (OPA) are legally authorised and will provide a dispute resolution service to mediate disputes regarding advance care directives and health consent issues as an alternative to the more formal approach of applying for SACAT orders. Eligibility for this service includes:

a) A person who has made an Advance Care Directive.

b) A dispute about consent to medical or dental treatment.

c) A disagreement about decisions or decision makers.

Further information must be obtained via opa@agd.sa.gov.au or 8342 8200

Table 3: Barriers to Discharge and Options to Manage Delays

Barrier		Management Options
Accommodation	> Difficulty accessing equipment or arranging home modifications and community services in a timely manner. > Lack of suitable housing and/or support options due to high complex needs. > Limited housing availability for those with no fixed address who are ineligible for NDIA, RACF, or are complex patients awaiting SA Housing or Community Housing.	> Hospital team to work with relevant agencies and departments (e.g., SA Housing Authority, Community Housing Council of SA) to expedite processes and support timely discharge.
Guardianship/ Citizenship	> Delays related to guardianship. > Citizenship/residency issues.	> Hospital team to work with relevant agencies and departments (e.g., SACAT, Office of Public Advocate (OPA), Department of Foreign Affairs, DHW for non-citizens) to expedite processes and support timely discharge.
NDIS (including paediatric participants)	> Delays associated with NDIS not funding recommended and required supports to discharge. > Delays in NDIS access and eligibility process, including requests for further information. > Delays to NDIS plan approval, including reviews due to inadequate existing/active plans. > Difficulty obtaining NDIS approval assessments for Supported Independent Living (SIL) quotes, Specialist Disability Accommodation (SDA) eligibility, assistive technology and/or home modifications whilst an inpatient.	> Hospital team can assist patient in reapplying to NDIS or seek state funded services to facilitate discharge. > Hospital team to contact the NDIS Hospital Liaison Officers. > Hospital Teams to refer to NDIS Hospital Discharge Escalations Process. > Escalate to DHW Integrated Care Systems via health.longstaydischargeproject@sa.gov.au
Other Supports / Requirements	> Delays in coordinating community support services or acquiring necessary physical requirements including those listed under Home Care in Table 1.	> Hospital team to work with relevant agencies and departments (eg. MRU) to expedite processes and support timely discharge.

Barrier		Management Options
Patient/Substitute Decision Maker, Hospital Team or Other	> Family/substitute decision maker unresponsive to correspondence, attempts to establish contact, and not attending scheduled meetings. > Family/substitute decision maker unwilling to support/facilitate discharge and/or unwilling to take child home. > Patient medically fit for transfer or discharge and declining suitable offers (eg. RACF, NDIS SIL, MTA and/or SDA). > Lack of flexibility regarding transfer location. > Complex internal home environment. > Complex financial issues (e.g. hardship). > History of frequent admissions with the same or similar Diagnosis Related Group (DRG), and refusing alternative services offered. > Requirement for a culturally sensitive discharge plan or transfer. > Frequent changes to the patient's discharge plan. > No agreed discharge plan with the estimated discharge date approaching. > Unaccompanied or abandoned patient under the age of 18 years.	> Hospital team to work with relevant agencies and departments (e.g., SACAT, OPA, Department for Child Protection) to expedite processes and support timely discharge. > Refer to Attachment 1 - Escalating Continuing Discharge Delays.
Residential Care and Other Aged Care Services	> Delays in receiving a Home Care Package (HCP) allocation following ACAT approval. > Limitations accessing sufficient support under the Commonwealth Home Support Programme (CHSP), often while awaiting an HCP. > Patients with behaviours and psychological symptoms of dementia (BPSD) and the need for transitional supports on discharge. > Awaiting placement offer or no appropriate bed currently available. > Accepted placement offer but location is not ready for transfer. > Accepted placement offer and location is ready for transfer, but patient is awaiting ACAT assessment.	> Refer to interim transfer or discharge options in Table 2. > Liaise with Geriatric Outreach teams within LHN to access interim supports while awaiting Commonwealth funded services. > Hospital team must advocate for ACAT prioritisation.

6. Refusal to Discharge

6.1. If the patient/substitute decision maker refuses the first clinically appropriate transfer or discharge offer, the hospital team must arrange a case conference with the patient/substitute decision maker and prepare correspondence outlining the following as a minimum:

a) Written confirmation that the patient is medically fit for discharge.

b) A list of supports available to address the patient's individual post-discharge care requirements, as specified in Table 1.

c) Information regarding transitional short-term accommodation options, as specified in Table 2.

6.2. Where the patient/substitute decision maker continues to decline the offer and refuses arrangements to progress transfer or discharge, the hospital team must follow internal escalation processes via their Divisional Director in line with Attachment 1.

6.3. If a resolution is not forthcoming, the Division Director must liaise with Chief Operating Officer (COO) to escalate the case via a briefing to the LHN CEO. As a minimum, the briefing must include:

a) Patient history, including the complexities and barriers to discharge.

b) Relevant details regarding transfer or discharge (eg date, location).

c) Patient/substitute decision maker reasoning for declining transfer or discharge.

d) ACAT or NDIS eligibility.

e) Discharge preparations, including supports available to address the patient's individual post-discharge care requirements, and the agencies and staff involved.

f) Draft correspondence to the patient/substitute decision maker regarding discharge details.

g) An outline of the escalation strategies already implemented.

h) Proposed strategy if the patient/substitute decision maker refuses to discharge on the planned date, such as engaging hospital security, the Office of the Public Advocate (OPA), Department for Child Protection, or the South Australian Police.

6.4. In exceptional circumstances, such as risk to the patient or service, or the potential for adverse publicity, the LHN COO must:

a) Consider obtaining written legal advice from the Legal Governance Unit within the DHW.

- All requests for legal services must be referred via healthlegalrequests@sa.gov.au.
- Requests for legal services must be prepared using the 'Request for Legal Services' template and must:
  - Clearly identify the specific concerns which need to be addressed.
  - Include all relevant background material and context to the request.
  - Provide details of a contact person with sufficient knowledge and understanding of the matter at hand.
  - Be signed by a relevant executive (LHN Chief Executive Officer (CEO), COO, Executive Director, or delegate).

b) Prepare an internal memorandum for the Deputy Chief Executive, Clinical System Support & Improvement, DHW.

6.5. Physical eviction of a patient who refuses to leave hospital must only be considered as a last resort and is only possible if the patient is discharged into an alternative model of care or home with confirmed after-care provisions; this may include SA Community Care through MRU, aged care or NDIS supports as required. Patients must not be forced to sign residential agreements with a RACF.

6.6. Under the law of trespass, if someone remains on the hospital premises despite being asked to leave, they are trespassing and can be removed. Each incorporated hospital must refer to their by-laws in line with section 42 of the *Health Care Act 2008*, for certain purposes, including to prohibit persons from trespassing on the grounds of the hospital.

Attachment 1: Escalating Continuing Discharge Delays

If patient discharge continues to be delayed despite undertaking all management options specified within this Policy, the following escalation must be followed: