Emergency Care Improvement Programme
Safer, faster, better care for patients

NHS Improvement

Rapid Improvement Guide to:

Expected Date of Discharge and Clinical Criteria for Discharge

Introduction

Expected Date of Discharge (EDD) and Clinical Criteria for Discharge (CCD) are essential care coordination tools mandated by:

- The Royal College of Physicians
- The Royal College of Surgeons
- The Enhanced Recovery Programme
- The Keogh Review
- The Seven Day Programme

EDD and CCDs must be clearly defined and used consistently if they are to work effectively. They should be set using simple rules as part of clearly constructed clinical case management plans.

The aim is to get the whole multi-disciplinary team (MDT) aligned to specific objectives for every in-patient stay. EDDs and CCDs flush out the constraints or waits (both internal and external). It is the rigour with which the constraints or waits are identified and proactively managed that reduces length of stay.

The guidance in this short paper is based on experience across a large number of organisations and the principles of the 'Theory of Constraints'.

The Process

Clinical Criteria for Discharge

1. This is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge. It should be agreed with the patient and carers where necessary.

2. The CCD should not be stated as 'back to baseline'. For example, the BTS/SIGN (British Thoracic Society) guidance 2014 states that there is no one physiological parameter that defines absolutely the timing of discharge. A patient admitted with acute severe asthma who normally runs a PEFR (peak expiratory flow rate) of 90-95% may not need to achieve this level at the point of discharge, but does need to achieve a PEFR >75% with less than 25% variability due to the higher risk of relapse.

3. For patients with frailty or impairments in activities of daily living, the clinical criteria should include functional factors. For example, a patient with dementia and reduced mobility who has a normal exercise tolerance of 25 yards but whose toilet is only five yards from their bedroom, may well be fit for discharge if mobile with a frame and has the supervision of one person for five yards. It is important to anticipate that patients will continue to recover at home with or without support.

4. For a proportion of patients, the CCD can be used to trigger discharge if agreed with the patient and well communicated across the team. For other patients, the CCD are a guide, and sign off for discharge by a senior clinician may still be required.

5. The CCD can be a short list of objectives and the aim is to keep them simple to act as an aid to maintain team focus.

Expected Date of Discharge

1. EDDs should be set at the first consultant review and no later than the first consultant post-take ward round the next morning. If a patient is to be transferred to a ward based specialty team, then the EDD and CCD should be set by the team who will be responsible for their discharge. Crucially, the sooner the patient is identified as in need of sub-specialty care and that sub-specialty team reviews and sets the EDD and CCD, the sooner that patient's care will be progressed.
2. For patients with an expected length of stay of two days or less, it is also appropriate to set an expected time of discharge.
3. It is important that EDDs are set assuming an ideal recovery pathway unencumbered by either internal or external waits. If the EDD is set embedding anticipated waits and delays in the system (for example waits for clinical decisions, diagnostics, inter-specialty referrals, social care decisions etc.), then these waits become hidden and thus not amenable to resolution.
4. The EDD and CCD are clinical, not managerial, tools. Together with a comprehensive clinical care and discharge management plan, they describe the objective for the admission. They can be used to co-ordinate care and minimise unnecessary waits in the patient's journey. The system's managerial capacity should focus on tackling unnecessary waits in support of the clinical team. In most circumstances, it will be the internal waits within the acute hospital that predominate.
5. If a patient's stay goes beyond the EDD, best practice is to highlight this as EDD +1, +2 etc. and clearly identify the constraint(s) that caused this (for example, delays in critical inter-specialty referral responses).
6. The use of **Red Green Bed Days** at Board Rounds and the implementation of the **SAFER patient flow bundle** help teams identify and manage constraints to delivering the EDD.

Management plan for a patient with an acute exacerbation of COPD