

EMERGENCY DEPARTMENT SAFE DISCHARGE PROTOCOL

Protocol 9: Clinical Readiness, Patient Understanding, Follow-up, Pending Results, and Safe Transition Home

DRAFT FOR CLINICAL, NURSING, PHARMACY, GOVERNANCE, AND PATIENT-SAFETY REVIEW

Important: Discharge is a clinical transition, not an administrative endpoint. A patient may leave the Emergency Department only after a documented final reassessment, a safe and understood plan, clear ownership of pending actions, and confirmation that the patient can reasonably carry out that plan.

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Supersedes	New protocol / [insert prior policy]
Related protocols	Protocols 1–8; Medication Safety; Results Tracking; Consultation and Escalation; condition-specific pathways; safeguarding; transport; self-discharge
Applies to	All ED medical, nursing, pharmacy, allied health, clerical, support, diagnostic, and follow-up staff involved in discharge

1. Purpose

To ensure that every patient discharged from the Emergency Department is clinically ready, has an understandable and achievable care plan, receives safe medicines and follow-up, knows when and how to seek further help, and is not exposed to avoidable harm from unresolved investigations, unclear responsibility, impaired capacity, unsafe transport, or social vulnerability.

2. Scope

This protocol applies to patients discharged from the Emergency Department to home, family or caregiver care, residential or custodial settings, primary care, outpatient clinics, community services, or other non-inpatient destinations. It begins when discharge becomes a possible disposition and ends when the patient has physically departed with the required information, medicines, equipment, referrals, result-follow-up plan, and documented safety checks. Admission and interfacility transfer are governed by separate protocols.

3. Core policy statements

- The decision to discharge shall be made by an authorized clinician who has reviewed the patient's current condition, investigation results, treatment response, diagnostic uncertainty, functional status, and follow-up needs.
- Discharge shall not be driven by crowding, bed pressure, transport convenience, time targets, inability to obtain a specialty opinion, or the assumption that another clinician will identify an unresolved risk later.
- A final clinical reassessment and a current set of appropriate observations shall be documented before departure. Abnormal findings must be explained, acted upon, or incorporated into an explicit follow-up and safety-net plan.
- The patient shall receive both verbal and written discharge information in a form they can understand and use. Interpreter and accessibility needs shall be addressed.
- Teach-back shall be used to confirm understanding of the diagnosis or working diagnosis, medicines, self-care, follow-up, pending results, warning symptoms, and return instructions.
- Medication reconciliation shall identify what to start, continue, change, withhold, or stop, why the change was made, and how the patient will obtain and use the medicine safely.
- Every pending result, referral, appointment, repeat test, or other post-discharge action shall have a named owner, expected timeframe, communication method, and backup escalation process.
- The patient shall not be made solely responsible for discovering or chasing clinically important test results.
- The discharge plan must be feasible. Staff shall consider transport, mobility, cognition, caregiving, housing, medication access, equipment, communication, and ability to return for care.
- High-risk discharges shall receive senior or designated second-clinician review according to locally approved criteria.
- Patients and caregivers shall be told that they may return for reassessment if symptoms worsen, new warning signs appear, the plan cannot be followed, or they remain concerned.
- All discharge decisions, instructions, follow-up arrangements, pending-result ownership, and communication shall be documented contemporaneously.

4. Definitions

Term	Operational definition
Safe discharge	A planned clinical transition in which the patient is medically suitable to leave the ED and has an understandable, achievable, documented plan for ongoing care and escalation.
Final reassessment	A focused review immediately before discharge that confirms current symptoms, examination, observations, treatment response, results, function, capacity, and disposition safety.
Working diagnosis	The most likely explanation for the presentation at discharge, which may remain provisional when serious alternatives have been reasonably addressed and safety-netting is explicit.
Diagnostic uncertainty	Residual uncertainty that remains after ED assessment. It must be communicated honestly and linked to follow-up and return precautions.
Safety-netting	Specific advice about the expected course, concerning changes, what action to take, where to seek help, and how urgently to act.

Term	Operational definition
Teach-back	A communication method in which the patient or caregiver explains the plan in their own words so staff can identify and correct gaps in explanation.
Pending result	Any ordered investigation whose final result is unavailable or not fully interpreted when the patient leaves.
Result owner	The named clinician, team, or approved service responsible for reviewing a pending result, acting on it, informing the patient, and documenting completion.
High-risk discharge	A discharge with increased potential for deterioration, diagnostic error, treatment failure, impaired adherence, safeguarding harm, or inability to access timely follow-up.
Self-discharge / declined recommended care	A patient's decision to leave or decline recommended assessment, treatment, observation, or admission after capacity and risk have been addressed. This is not equivalent to routine discharge.

5. Roles and accountability

Role	Minimum accountability
Hospital executive / Medical Director	Approves the discharge governance framework, staffing and service standards, escalation routes, information systems, follow-up capacity, and cross-organizational agreements.
ED medical lead	Owens the clinical discharge standard, high-risk review criteria, audit programme, clinician competency, and integration with specialty and outpatient pathways.
ED nursing lead	Ensures nursing reassessment, education, mobility and transport checks, caregiver communication, equipment readiness, and discharge documentation are completed.
Treating clinician	Makes or authorizes the discharge decision, documents reasoning and uncertainty, reviews results, reconciles medicines, arranges follow-up, assigns pending-result ownership, and confirms safety-netting.
Discharging nurse	Confirms identity, observations, treatment completion, medicine and equipment availability, written information, teach-back, transport, accompaniment, and actual departure condition.
Pharmacist / pharmacy service	Supports medication reconciliation, high-risk medicine review, supply, counselling, interaction checks, access planning, and resolution of discrepancies.
Diagnostic services	Issue verified results promptly, communicate critical/amended findings, and support reliable electronic result routing.
Outpatient / community / primary-care services	Acknowledge accepted referrals, provide appointment or review mechanisms, and clarify actions requested of the receiving service.

Role	Minimum accountability
Clerical / information staff	Generate accurate documents, transmit them securely, verify demographic and contact details, and escalate system or communication failures.
Patient / caregiver	Participates in planning, asks questions, states concerns and practical barriers, demonstrates understanding where able, and follows the agreed plan. This does not transfer professional responsibility for unsafe system gaps.

6. Safe discharge pathway

Stage	Required action
1. Consider discharge early	Identify probable destination, baseline function, caregiver and transport needs, medicine access, and likely follow-up requirements.
2. Complete assessment	Address immediate threats, obtain sufficient history/examination, consider dangerous alternatives, and review investigations and treatment response.
3. Confirm clinical readiness	Perform final reassessment, review observations and function, confirm stability or documented acceptable baseline, and identify residual uncertainty.
4. Apply high-risk review	Use local senior-review or second-clinician criteria; escalate unresolved concern or disagreement.
5. Reconcile medicines	Create one accurate discharge medicine plan; provide supply/prescription, counselling, and monitoring advice.
6. Close diagnostic loops	Review available results; assign named ownership and communication plan for every pending or amended result.
7. Arrange continuing care	Book or initiate referrals, repeat tests, equipment, home/community services, and a realistic route back to care.
8. Explain and confirm	Provide accessible verbal and written information; use teach-back; answer questions and address barriers.
9. Check practical safety	Confirm capacity, caregiver arrangements, transport, mobility, destination safety, infection precautions, and ability to obtain treatment.
10. Document and depart	Complete the discharge record and final checklist; record departure time, condition, destination, accompaniment, and outstanding responsibilities.

A discharge order or printed instruction sheet does not, by itself, establish safe discharge. The clinical, communication, follow-up, and practical requirements must all be satisfied.

7. Clinical readiness for discharge

The treating clinician shall determine whether the patient can safely leave the ED. Readiness is individualized and shall not be reduced to a single score or a requirement that every measurement be “normal.” The record must show why the patient is safe to leave now.

7.1 Minimum clinical requirements

- The primary complaint and immediate life-, limb-, organ-, pregnancy-, or function-threatening conditions have been assessed and treated or reasonably excluded to the level required for outpatient care.
- The patient has received the necessary emergency treatment and has demonstrated an acceptable response or a documented stable plan for continuing treatment.
- A final focused history and examination have addressed new symptoms, trajectory, and any change since the initial assessment.
- Appropriate observations have been repeated. Persistent abnormalities, changes from baseline, or concerning trends have been reviewed by the treating clinician and documented.
- Pain, nausea, dyspnoea, fever, agitation, mobility, hydration, oral intake, urine output, cognition, and other relevant functions are controlled or manageable outside hospital.
- Available investigation results have been reviewed and reconciled with the diagnosis and plan. Unexpected or discordant results have been resolved or escalated.
- The patient does not require a level of observation, treatment, nursing support, oxygen, equipment, procedure, or specialist review that cannot be reliably provided at the destination.
- The patient has decision-making capacity for the discharge plan or an appropriate substitute decision-maker / caregiver arrangement has been established according to law and policy.
- The destination, support, transport, medicines, equipment, follow-up, and ability to return are reasonably safe and feasible.

7.2 Abnormal vital signs or incomplete symptom resolution

An abnormal observation does not automatically require admission, but it must never be ignored. The clinician shall verify measurement accuracy, assess trend and baseline, identify the cause, evaluate risk, treat where indicated, and document why outpatient management remains safe. Discharge with unexplained new physiological abnormality, recurrent instability, worsening trend, or unresolved concern requires senior review and usually further observation, investigation, consultation, or admission.

7.3 Diagnostic uncertainty

- State the working diagnosis and the degree of certainty honestly.
- Record dangerous alternatives considered and why they are less likely or adequately addressed.
- Explain what has not been fully ruled out and what change would require reassessment.
- Do not use vague labels such as “viral illness,” “musculoskeletal pain,” or “anxiety” to close an unresolved high-risk presentation without adequate reasoning and safety-netting.
- Use observation, repeat examination, senior review, or consultation when time is required to clarify the trajectory.

8. High-risk discharge and senior review

The following features should trigger senior clinician review, a designated second-clinician review, or another locally approved safeguard before discharge. The list is not exhaustive; any staff concern is sufficient reason to escalate.

Risk domain	Examples requiring enhanced review
Physiological / clinical risk	Persistent or recurrent abnormal observations; syncope; hypoxia; hypotension; tachycardia; altered consciousness; severe pain; significant bleeding; treatment escalation; critical or unexpected result; diagnostic uncertainty; repeated presentation; or failure to improve as expected.

Risk domain	Examples requiring enhanced review
Time-dependent presentations	Chest pain or possible acute coronary syndrome, stroke/TIA symptoms, sepsis, major trauma/head injury, acute abdomen, ectopic pregnancy risk, acute limb/eye/testicular threat, significant poisoning, anaphylaxis, or other condition with a narrow treatment window.
Age / physiological vulnerability	Young infants, children with concerning features, pregnancy or postpartum state, frailty, advanced age, immunosuppression, anticoagulation, major comorbidity, renal/hepatic impairment, or complex polypharmacy.
Cognitive / behavioural risk	Delirium, dementia, learning disability, intoxication, sedation, acute behavioural disturbance, self-harm, suicidal thoughts, psychosis, impaired capacity, or inability to retain the plan.
Safeguarding / social risk	Suspected abuse, neglect, exploitation, domestic or sexual violence, unsafe caregiving, homelessness, custody, inability to obtain medicines, no transport, unsafe destination, or inability to return.
Process risk	Specialist review requested but unavailable, disagreement about disposition, significant pending results, electronic or diagnostic downtime, incomplete records, language barrier without adequate interpretation, or discharge after prolonged boarding / handover.

8.1 Proposed local senior-review criteria

Local category	Approved standard
Mandatory senior review	[Insert approved presentations, age groups, physiological thresholds, self-harm/mental-health criteria, repeat attendances, and junior clinician categories]
Second-clinician review permitted	[Insert circumstances and required grade/competence]
Consultant sign-off	[Insert high-risk conditions or times of day requiring consultant decision]
Exception process	If the required reviewer is unavailable, escalate through Protocol 8 and document the alternative senior decision-maker and rationale.

Local validation required: senior-review requirements must match staffing and competence, but resource limitations do not justify discharging a patient whom the treating team considers unsafe.

9. Final reassessment before discharge

The final reassessment shall occur after significant treatment and as close as reasonably possible to departure. It may be focused, but it must be clinically meaningful and documented.

- Current symptoms and overall trajectory: improved, unchanged, fluctuating, or worse.
- Relevant repeat examination and current observations, including age-specific parameters where applicable.
- Response to analgesia, bronchodilator, fluids, antiemetic, antimicrobial, glucose correction, immobilization, procedure, sedation, or other intervention.
- Review of all available investigations, consultations, amended reports, and incidental findings.

- Mobility, falls risk, oral intake, hydration, toileting, cognition, communication, and ability to perform necessary self-care.
- Capacity and freedom from clinically significant impairment due to sedation, intoxication, delirium, pain, or distress.
- Medication plan, allergy record, equipment, wound/device care, and required restrictions.
- Follow-up, pending results, destination, caregiver, transport, and ability to seek help.
- Patient or caregiver questions, unresolved concern, or disagreement with the plan.

10. Shared discharge decision and patient involvement

- Explain the clinical findings, working diagnosis, level of certainty, treatment received, and why discharge is considered appropriate.
- Invite the patient and caregiver to identify concerns, practical barriers, preferences, cultural needs, and previous difficulties with follow-up.
- Discuss reasonable alternatives when available, including observation, outpatient review, or return for reassessment.
- Do not represent discharge as proof that nothing serious is present; explain the expected course and the limits of emergency assessment.
- Where the patient lacks capacity, involve the legally appropriate decision-maker and act in the patient's best interests under local law and policy.
- Document significant disagreement and the steps taken to resolve it. Escalate when the clinician, nurse, patient, or caregiver believes the plan is unsafe.

11. Medication reconciliation and discharge medicines

- Compare the pre-arrival medication list, medicines administered in the ED, new prescriptions, and intended ongoing regimen.
- Create one clear list stating each medicine to start, continue, change, withhold temporarily, or stop, with indication and duration where relevant.
- Check allergies, interactions, duplication, contraindications, pregnancy/lactation, renal/hepatic function, age, weight, frailty, and ability to administer the medicine.
- Explain dose, route, frequency, duration, expected benefit, common or serious adverse effects, missed-dose advice, monitoring, and what to do if the medicine cannot be obtained.
- Ensure the patient can access the prescription or supply before the next dose is due, including nights, weekends, public holidays, cost, transport, and pharmacy availability.
- Provide appropriate devices and technique teaching, such as inhaler spacer, insulin equipment, epinephrine auto-injector, wound supplies, or measuring device.
- For high-alert medicines, antimicrobials, anticoagulants, insulin, opioids, steroids, antiepileptics, or medicines requiring laboratory monitoring, provide condition-specific written advice and follow-up.
- Communicate clinically important changes to the receiving primary-care, clinic, residential, or custodial service.

12. Investigation results and pending-result ownership

Discharge shall not occur until available results that are necessary for the decision have been reviewed by the responsible clinician. A test may remain pending only when discharge is clinically safe without the final result and a reliable closed-loop follow-up process exists.

- List every pending test, culture, pathology report, radiology over-read, specialist report, or send-away investigation.
- Name the individual clinician, team, or approved results service responsible for review and action.
- State the expected result timeframe and the action threshold or contingency.

- Confirm how and when the patient will be informed, including when a “no news” approach is not acceptable.
- Verify accurate telephone, electronic, postal, caregiver, and alternative contact details, respecting confidentiality and consent.
- Provide a backup process for failed contact, urgent recall, unreachable patients, and transfer of responsibility across shifts or organizations.
- Tell the patient what result is pending, what it may change, who is responsible, and whom to contact if the expected communication does not occur.
- Document review, communication attempts, advice, and completed action in the clinical record.

The patient may participate in checking a result, but the hospital retains responsibility for reviewing and acting on clinically important results assigned to its service.

13. Follow-up and continuity of care

- Identify the required service, purpose, urgency, and clinical question.
- Where possible, book the appointment or obtain acknowledged acceptance before discharge rather than advising the patient simply to “see a doctor.”
- State the timeframe in concrete terms, such as “within 24 hours,” “on Monday 29 June 2026,” or “within 7 days,” rather than “soon.”
- Clarify which investigations, repeat observations, wound checks, medication monitoring, imaging, or specialist decisions are required.
- Provide the receiving clinician with the ED assessment, results, treatment, medicine changes, pending results, red flags, and requested actions.
- Check transport, cost, communication, mobility, work/caregiving responsibilities, and other barriers that may prevent attendance.
- If the proposed follow-up cannot be secured and the risk is not acceptably mitigated, reconsider observation, admission, consultation, or another pathway.
- Document referrals sent, recipient, date/time, acknowledgement, appointment details, and contingency if the service does not respond.

14. Verbal and written discharge information

Information shall be concise, specific, consistent with the clinical record, and written in plain language. Standard leaflets may support but shall not replace individualized instructions.

Information domain	Minimum content
What happened	Reason for attendance; important findings; treatment and procedures performed.
Diagnosis and uncertainty	Confirmed or working diagnosis; important alternatives considered; what remains uncertain or pending.
Expected course	What improvement should occur, how long symptoms may last, and what self-care is appropriate.
Medicines	Complete reconciled list; starts/stops/changes; dose, duration, monitoring, adverse effects, and access.
Wound / device / activity care	Dressing, splint, catheter, cast, mobility, diet, hydration, exercise, bathing, work, school, sport, sex, driving, or travel restrictions as relevant.

Information domain	Minimum content
Warning signs	Specific symptoms or changes requiring urgent review, emergency services, or immediate return.
Follow-up	Named service, purpose, appointment or timeframe, location/contact, tests required, and what to do if access fails.
Pending results	Test, expected timeframe, named owner, communication method, and patient contact route.
How to seek help	ED return route, emergency number, after-hours service, primary-care/contact number, and language/accessibility support.

14.1 Teach-back

- Use a nonjudgmental introduction: “I want to make sure I explained this clearly. Please tell me how you will manage this when you get home.”
- Ask the patient or caregiver to explain the diagnosis/uncertainty, medicines, self-care, follow-up, pending results, warning signs, and return plan.
- Correct misunderstandings and repeat the process. Teach-back tests the explanation, not the patient.
- Use a qualified interpreter when needed; do not rely on a child or unapproved family interpreter for critical information except during a true emergency until proper support is available.
- Document the person taught, interpreter/accessibility method, understanding demonstrated, and unresolved limitations.

14.2 Accessible communication

- Provide information in the patient’s preferred language and accessible format where practicable.
- Use large print, pictograms, audio, easy-read, sign-language support, or caregiver duplication for visual, hearing, cognitive, or literacy needs.
- Provide a hard copy for patients returning to residential care, custody, supported housing, or other cared-for settings, unless a reliable equivalent electronic transfer is confirmed.
- Avoid unexplained abbreviations, technical jargon, conflicting instructions, and generic statements such as “return if worse” without defining concerning changes.

15. Minimum emergency-care discharge record

Record section	Required elements
Patient and encounter	Identifiers, contact details, arrival/discharge date and time, destination, responsible clinician, caregiver/escort.
Presentation and assessment	Chief complaint, relevant history/examination, observations and trends, risk factors, capacity, safeguarding and functional assessment.
Clinical reasoning	Diagnosis/working diagnosis, important alternatives, uncertainty, rationale for discharge, and senior review where required.
Investigations	Tests performed, key results, incidental findings, critical/amended results, and pending tests with named owner.

Record section	Required elements
Treatment	Medicines, procedures, devices, fluids, immobilization, response, complications, and post-procedure status.
Medication plan	Reconciled list, prescriptions/supply, changes and reasons, allergies, monitoring and counselling.
Follow-up	Service, purpose, urgency, appointment/referral status, repeat tests, equipment/community care, and contingency.
Patient information	Written and verbal advice, return precautions, interpreter/accessibility support, teach-back, questions and concerns.
Final safety check	Final reassessment, last relevant observations, mobility/function, destination, transport, accompaniment, and actual departure condition/time.

16. Transport, destination, and practical safety

- Confirm where the patient is going and that the destination can meet immediate care, mobility, supervision, infection-control, oxygen, equipment, and medication needs.
- Assess whether the patient can walk, transfer, use stairs, travel seated, manage toileting, and tolerate the planned journey.
- Arrange an appropriate escort for children, impaired adults, post-sedation/procedure patients, frail patients, behavioural risk, or anyone unable to travel safely alone.
- Do not permit driving when impaired by illness, injury, sedating medicine, intoxication, seizure/syncope risk, visual deficit, limb immobilization, or legal restriction. Provide explicit driving advice.
- Do not discharge a vulnerable patient into an unsafe environment, suspected abuse situation, extreme weather exposure, or setting without essential support. Activate safeguarding, social-work, shelter, police, or other approved pathways.
- If safe transport or destination cannot be arranged, escalate to the shift coordinator and senior clinician; reconsider observation or admission rather than allowing avoidable harm.
- Record departure mode, destination, escort/caregiver, equipment and medicines supplied, and the patient's condition at departure.

17. Special populations and circumstances

17.1 Children and young people

- Use age-specific observations and assessment; confirm feeding, hydration, urine output, behaviour, mobility, pain control, and caregiver competence.
- Provide weight-based medication instructions and appropriate measuring devices.
- Confirm a responsible adult can observe the child, recognize deterioration, administer treatment, access transport, and return promptly.
- Address safeguarding concerns, immunization/public-health advice, school/day-care restrictions, and follow-up.
- Use locally approved senior sign-off criteria for young infants, repeat attendances, abnormal observations, diagnostic uncertainty, or caregiver concern.

17.2 Pregnancy and postpartum

- Document gestational/postpartum status and assess obstetric and non-obstetric risks.

- Address bleeding, pain, hypertension, infection, thromboembolism, fetal concerns, ectopic pregnancy risk, and medication safety as relevant.
- Ensure obstetric/midwifery review or agreed follow-up when indicated, and provide pregnancy-specific warning signs and contact routes.
- Do not allow administrative separation between ED and maternity services to leave clinical responsibility unclear.

17.3 Older adults, frailty, and cognitive impairment

- Compare cognition, mobility, continence, nutrition, medication use, and function with baseline; actively assess delirium and falls risk.
- Review polypharmacy, high-risk medicines, caregiver availability, home environment, equipment, and ability to obtain food and treatment.
- Involve family/caregivers with consent or best-interest authority and provide a copy of instructions to the care setting.
- Consider observation, geriatric/community review, or admission when the apparent medical problem is treated but function or care capacity remains unsafe.

17.4 Mental health, self-harm, behavioural disturbance, or intoxication

- Complete and document appropriate physical, mental-state, suicide/self-harm, violence, safeguarding, capacity, and substance-use assessment.
- Do not discharge solely because a specialist bed or assessor is unavailable when the patient remains unsafe.
- Ensure clinically significant intoxication, sedation, delirium, agitation, or cognitive impairment has resolved sufficiently for capacity, mobility, and safe supervision.
- Provide a collaborative safety plan, crisis contacts, means-safety advice where appropriate, medication plan, responsible support person, and confirmed follow-up.
- Use the hospital's mental-health and self-harm pathway and local legal framework.

17.5 Safeguarding, violence, sexual assault, and social vulnerability

- Address immediate safety, mandatory reporting, forensic/evidence requirements, confidential communication, safe contact method, and referral to specialist support.
- Do not disclose the destination or contact details to a suspected perpetrator.
- For homelessness, insecure housing, food insecurity, or inability to pay for medicines/transport, activate available social and community support and document unmet need.
- For patients in custody or residential care, provide clear clinical information to the receiving responsible adult while preserving confidentiality and legal rights.

17.6 Procedures, sedation, anaesthesia, and immobilization

- Meet the approved recovery and discharge criteria for the procedure or sedation technique.
- Document airway, consciousness, observations, pain/nausea control, neurovascular status, ambulation, oral intake where relevant, and complications.
- Provide a responsible adult escort and supervision period when required; prohibit driving, machinery, alcohol, signing legal documents, or unsupervised care for the specified period.
- Give written wound, cast, splint, catheter, drain, dental, eye, or post-procedure instructions and emergency return signs.

17.7 Communicable infection and public-health needs

- Provide isolation, hygiene, mask, contact, treatment, prophylaxis, testing, and return-to-work/school advice consistent with current public-health guidance.

- Notify public-health or infection-control services when required and document the responsible service.
- Confirm the patient can safely isolate or follow precautions; escalate when housing or caregiving circumstances make this impossible.

18. Patients declining recommended care or leaving early

A patient who declines recommended observation, investigation, treatment, admission, or transfer is not a routine discharge. Staff shall use a respectful harm-reduction approach and the relevant self-discharge policy.

- Assess and document decision-making capacity for the specific decision, including impairment from illness, hypoxia, shock, pain, intoxication, sedation, delirium, mental disorder, or language barrier.
- Explain the recommended care, expected benefits, material risks of refusal, reasonable alternatives, and signs requiring immediate return.
- Address modifiable reasons for leaving, such as caregiving duties, cost, fear, pain, withdrawal, discrimination, transport, or communication failure.
- Offer the safest acceptable alternative: partial investigation/treatment, prescription, follow-up, transport, written information, or return at an agreed time.
- Involve a senior clinician, interpreter, caregiver, mental-health or safeguarding service as indicated.
- Do not use coercive, punitive, stigmatizing, or abandonment language. Tell the patient they may return at any time.
- Document the discussion, capacity, persons present, care accepted/refused, clinical condition, instructions, and attempts to reduce risk. A signature does not replace the clinical process.

19. Discharge delay, failure, or unsafe plan

- Any staff member shall stop the discharge and escalate if the patient deteriorates, new information emerges, understanding is inadequate, required medicines/equipment are unavailable, transport is unsafe, or the destination cannot provide necessary care.
- The patient shall be returned to an appropriate clinical area for reassessment; discharge paperwork shall be amended rather than allowing conflicting plans to remain active.
- Escalate unresolved barriers to the senior ED clinician and shift coordinator, then to bed management, pharmacy, social services, specialty team, administration, or executive on call as appropriate.
- Report system failures that create recurrent risk, including missing follow-up capacity, unavailable medicines, failed result routing, inaccessible patient information, transport gaps, or electronic downtime.
- Document the barrier, interim care, escalation, final resolution, and any residual risk.

20. Post-discharge contact and callbacks

The hospital should define which patients require proactive follow-up and who will perform it. Telephone or electronic follow-up does not replace safe initial discharge, but it may identify deterioration, medication problems, failed referrals, or misunderstanding.

- Locally approved groups may include high-risk older adults, children, significant diagnostic uncertainty, new high-risk medicines, pending cultures/results, post-sedation/procedure patients, frequent attenders, or patients with access barriers.
- The caller shall verify identity, review symptoms and warning signs, medicines and access, follow-up completion, pending results, and new concerns.
- Provide clear escalation: emergency services, immediate ED return, same-day review, or routine follow-up.
- Document successful and failed contact attempts, advice, referrals, and actions. Urgent failed contact shall follow the results/recall escalation process.

21. Documentation, confidentiality, and information transfer

- Complete the discharge record before or immediately at departure except during an overriding emergency; late entries must follow Protocol 4.
- Send the discharge summary securely to the appropriate primary-care, specialist, residential, custodial, or community service within the locally approved timeframe.
- Confirm patient identifiers and recipient before transmission; protect sensitive information and use safe contact methods in safeguarding situations.
- Record what information was given verbally, in writing, electronically, and to whom.
- Document interpreter identity/service, accessibility adjustments, teach-back, capacity, substitute decision-maker, and consent for caregiver involvement.
- When electronic systems fail, use the approved downtime form, retain a copy, arrange later upload/transmission, and track outstanding results and referrals manually.

22. Quality indicators

Indicator domain	Suggested measure
Clinical reassessment	Percentage of sampled discharges with documented final reassessment and current appropriate observations.
Discharge reasoning	Percentage with diagnosis/working diagnosis, uncertainty, and rationale for discharge documented.
Patient information	Percentage receiving documented verbal and written individualized advice; percentage with teach-back recorded in locally defined high-risk groups.
Medication safety	Percentage with reconciled discharge medicines, allergy review, and clear start/stop/change instructions.
Pending results	Percentage with every pending result named, owned, time-bounded, and communicated; proportion completed within target.
Follow-up	Percentage of required referrals/appointments initiated or booked with timeframe and contingency documented.
High-risk review	Compliance with locally approved senior/second-clinician sign-off criteria.
Equity and access	Discharge quality by age, language, disability, residence, socioeconomic vulnerability, and cared-for setting where data governance permits.
Outcomes	Unplanned ED return within locally chosen intervals; admission after return; serious adverse events, complaints, missed results, medication harm, safeguarding events, and deaths identified through review.
Balancing measures	Discharge processing time, avoidable delays, crowding impact, staff workload, and patient-reported understanding.

23. Incident reporting and review

- Report missed or delayed results, wrong-patient documents, incorrect medicines, failed follow-up, unsafe transport/destination, inadequate capacity assessment, absent safety-netting, or harm after discharge through the patient-safety system.
- Review serious and recurrent events across the full pathway, including staffing, workload, information design, pharmacy access, referral capacity, transport, equity, and communication—not only individual performance.
- Use patient and caregiver feedback, complaints, return visits, and near misses to identify confusing instructions and impractical plans.
- Feed learning back into standardized discharge materials, electronic prompts, training, and service agreements.

24. Training and competency

- Orientation for clinicians and nurses on the discharge pathway, high-risk review, medication reconciliation, pending-result ownership, capacity, safeguarding, and documentation.
- Training in plain-language communication, teach-back, interpreter use, disability access, shared decision-making, and trauma-informed care.
- Simulation or case review of abnormal observations, diagnostic uncertainty, self-discharge, failed follow-up, missed results, mental-health discharge, and unsafe transport/social circumstances.
- Competency assessment for staff authorized to discharge under standing pathways or advanced practice roles.
- Periodic multidisciplinary audit and learning with pharmacy, diagnostics, specialties, primary/community care, mental health, safeguarding, and patient representatives.

25. Implementation requirements

Implementation domain	Required local action
Governance	Approve responsible roles, high-risk sign-off criteria, result ownership, communication timeframes, referral agreements, and escalation authority.
Forms / electronic record	Build a mandatory discharge dataset, final reassessment, medicine reconciliation, pending-result tracker, follow-up fields, teach-back, and safety checklist.
Patient information	Develop accessible diagnosis- and procedure-specific leaflets in common languages and formats; maintain printed copies during downtime.
Pharmacy / medicines	Define supply hours, after-hours process, high-risk counselling, formulary access, and medicine affordability pathways.
Follow-up services	Create directories, booking routes, contact standards, referral acknowledgement, and escalation when appointments are unavailable.
Transport / social support	Map ambulance, taxi, family, community, shelter, safeguarding, and after-hours options.
Training / launch	Provide staff training, pilot the checklist, collect feedback, and begin targeted audit within three months.
Review	Review the protocol after early implementation and at least annually or following a serious incident, service change, or new national guidance.

Annex A. One-page safe discharge workflow

Step	Bedside action
1. Reassess	Repeat relevant observations and focused examination; confirm response, function, capacity, and trajectory.
2. Review	Review results, consultations, medicines, diagnostic uncertainty, and high-risk criteria.
3. Decide	Authorized clinician documents why discharge is safe; obtain senior/second review when required.
4. Reconcile	Produce one accurate medicine plan; ensure supply, access, technique, and monitoring.
5. Close loops	Assign owner and timeframe for every pending result, referral, repeat test, and follow-up action.
6. Explain	Give individualized written and verbal information; explain uncertainty, expected course, warning signs, and return route.
7. Confirm	Use teach-back; address language, disability, caregiver, transport, cost, and destination barriers.
8. Depart safely	Complete checklist and record; supply documents/equipment; record destination, escort, condition, and departure time.

Annex B. CARE safe-discharge checkpoint

CARE domain	Required confirmation
C — Clinical readiness	<ul style="list-style-type: none"> • Final reassessment completed • Current observations reviewed • Treatment response acceptable • Dangerous alternatives addressed • Function, capacity, and high-risk review complete
A — Actions closed	<ul style="list-style-type: none"> • Results reviewed • Pending results have named owner • Medicines reconciled and obtainable • Follow-up/referrals arranged • Equipment and wound/device needs met
R — Recipient understands	<ul style="list-style-type: none"> • Diagnosis and uncertainty explained • Written and verbal advice provided • Teach-back completed • Warning signs and return route understood • Caregiver/interpreter involved as needed

CARE domain	Required confirmation
E — Exit is feasible	<ul style="list-style-type: none"> • Safe destination and transport • Escort/supervision appropriate • Contact details verified • Documents transmitted • Departure condition/time recorded

Annex C. Minimum ED discharge dataset

Dataset section	Minimum fields
Patient / encounter	Name, unique identifier, DOB/age, contacts, address/destination, caregiver, arrival and discharge times.
Clinical status	Presenting complaint, diagnosis/working diagnosis, relevant examination, final observations, function, capacity, treatment response.
Risk / reasoning	Dangerous alternatives, residual uncertainty, abnormal findings, high-risk criteria, senior review, discharge rationale.
Tests	Key results, incidental findings, pending tests, owner, expected date, communication and failed-contact plan.
Treatment / procedures	Medicines, fluids, procedures, devices, complications, post-treatment reassessment.
Medicines	Allergies, reconciled list, start/stop/change, prescription/supply, duration, counselling, monitoring.
Continuing care	Follow-up service, appointment/status, repeat tests, referrals, home/community support, equipment.
Patient instructions	Expected course, self-care, restrictions, warning signs, return advice, contact numbers, written materials.
Communication	Interpreter/accessibility, teach-back, caregiver involvement, receiving-service transmission.
Departure	Mode, destination, escort, condition, date/time, staff completing discharge.

Annex D. Teach-back and patient-information checklist

- ☐ Patient/caregiver can state the diagnosis or working diagnosis and what remains uncertain.
- ☐ Patient/caregiver can describe the expected course and self-care plan.
- ☐ Patient/caregiver can name new, changed, withheld, and stopped medicines and how to use them.
- ☐ Patient/caregiver knows the important adverse effects or treatment complications to watch for.
- ☐ Patient/caregiver can identify specific warning signs and the required urgency of response.
- ☐ Patient/caregiver knows follow-up service, purpose, date/timeframe, location, and what to do if access fails.
- ☐ Patient/caregiver knows which results are pending, who owns them, and how communication will occur.
- ☐ Patient/caregiver knows whom to contact and that return to the ED is permitted if concerned.
- ☐ Language, literacy, hearing, vision, cognition, cultural, and accessibility needs addressed.
- ☐ Questions answered; remaining limitation or refusal documented.

Annex E. Discharge medication checklist

- ☐ Best available pre-arrival medication list reviewed.
- ☐ Allergies and adverse reactions verified.
- ☐ ED medicines reconciled with ongoing regimen.
- ☐ Each medicine clearly marked START / CONTINUE / CHANGE / HOLD / STOP.
- ☐ Indication, dose, route, frequency, duration, and monitoring clear.
- ☐ Renal/hepatic function, pregnancy, age, weight, frailty, interactions, duplication, and high-alert risk considered.
- ☐ Prescription or supply available before next dose; affordability and pharmacy access addressed.
- ☐ Device and technique teaching completed where relevant.
- ☐ High-risk medicine counselling and written information provided.
- ☐ Receiving clinician/care setting informed of important changes.

Annex F. Pending-result and follow-up ownership record

Field	Record
Patient / identifier	_____
Test / referral / action	_____
Reason / clinical question	_____
Expected date / timeframe	_____
Named owner and service	_____
Action threshold / contingency	_____
Patient contact method and consent	_____
Backup / failed-contact escalation	_____
Patient informed of plan	Yes / No Method: _____
Completion / result / action	_____
Date/time and staff signature	_____

Annex G. High-risk discharge review checklist

- ☐ Reason for enhanced review documented.
- ☐ Full trend of observations reviewed; abnormalities explained or acted upon.
- ☐ Dangerous alternative diagnoses considered and documented.
- ☐ Relevant ECG, imaging, laboratory, consultation, and amended results reviewed.
- ☐ Treatment response and need for further observation considered.
- ☐ Capacity, cognition, mental health, intoxication/sedation, and safeguarding assessed.
- ☐ Function, mobility, oral intake, caregiver support, destination, and transport assessed.
- ☐ Medicines, pending results, follow-up, and barriers addressed.
- ☐ Patient/caregiver concerns heard and teach-back completed.
- ☐ Reviewing clinician name, grade, decision, and date/time documented.

Annex H. Special-population discharge prompts

Population / circumstance	Prompt
Child	Age-specific observations; weight/dosing; feeding/hydration; responsible caregiver; safeguarding; return access.

Population / circumstance	Prompt
Pregnancy/postpartum	Gestation/status; obstetric red flags; medicine safety; obstetric contact/follow-up.
Frailty/older adult	Baseline function/cognition; delirium/falls; polypharmacy; home support/equipment; caregiver copy.
Mental health/self-harm	Physical and mental assessment; capacity; safety plan; crisis contact; means safety; follow-up.
Intoxication/sedation	Recovery, capacity, ambulation, escort/supervision, driving/activity restrictions.
Safeguarding/violence	Safe contact/destination; confidentiality; reporting/referral; perpetrator access risk.
Homeless/social vulnerability	Shelter, food, medicines, storage, transport, communication, community referral.
Custody/residential care	Receiving responsible adult, medication administration, observation needs, hard-copy information.
Communicable infection	Isolation/hygiene; treatment; public-health notification; work/school; safe housing.

Annex I. Transport and departure checklist

- ☐ Destination confirmed and able to meet immediate needs.
- ☐ Mobility, stairs, transfers, toileting, seating, oxygen/equipment, and journey duration assessed.
- ☐ Patient not driving when illness, medicine, injury, seizure/syncope, vision, cognition, intoxication, or legal restriction makes driving unsafe.
- ☐ Appropriate adult escort/supervision arranged where required.
- ☐ Medicines, prescriptions, equipment, written instructions, referrals, and contact details physically with patient/caregiver.
- ☐ Receiving residential/custodial/care service informed and accepts return.
- ☐ Safeguarding and confidential destination precautions followed.
- ☐ Patient reassessed after any delay or change before actual departure.
- ☐ Departure mode, escort, destination, condition, and time documented.

Annex J. Safe-discharge audit tool

Audit criterion	Finding
Final reassessment and current observations documented	Yes / No / N/A
Working diagnosis, uncertainty, and rationale for discharge documented	Yes / No / N/A
All available results reviewed and reconciled with plan	Yes / No / N/A
Pending result(s) named with owner, timeframe, communication, and backup	Yes / No / N/A
High-risk / senior review criterion applied correctly	Yes / No / N/A
Medication reconciliation and clear start/stop/change plan	Yes / No / N/A
Prescription/supply and medicine access addressed	Yes / No / N/A

Audit criterion	Finding
Follow-up/referral purpose, timeframe, and status documented	Yes / No / N/A
Written and verbal individualized instructions documented	Yes / No / N/A
Specific warning signs and return route documented	Yes / No / N/A
Teach-back / understanding documented where required	Yes / No / N/A
Interpreter/accessibility needs addressed	Yes / No / N/A
Capacity, safeguarding, destination, caregiver, and transport assessed	Yes / No / N/A
Discharge summary sent to appropriate receiving service	Yes / No / N/A
Departure condition, mode, destination, escort, and time documented	Yes / No / N/A

Annex K. Local configuration table

Local element	Approved specification
Authorized discharge roles / scope	_____
Mandatory senior-review criteria	_____
Age-specific paediatric sign-off rules	_____
Required final-observation intervals	_____
Approved teach-back documentation standard	_____
Discharge-summary transmission target	_____
Pending-result owner / results service	_____
Urgent recall and failed-contact pathway	_____
Primary/community follow-up directory	_____
Mental-health / self-harm discharge pathway	_____
Safeguarding and social-work contacts	_____
After-hours pharmacy / medicine supply	_____
Transport / shelter / community support	_____
Post-discharge callback criteria	_____
Audit frequency and accountable committee	_____

Annex L. References and source tools

World Health Organization. Emergency Care Toolkit and Emergency Care Checklists. <https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/emergency-and-critical-care/emergency-care-toolkit>

World Health Organization. Communication during patient handovers. <https://www.who.int/publications/m/item/communication-during-patient-handovers>

Agency for Healthcare Research and Quality. Improving the Emergency Department Discharge Process. <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/edenvironmentalscan/edenvironmentalscan.pdf>

Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html>

Agency for Healthcare Research and Quality. TeamSTEPPS Teach-Back tool. <https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/teachback.html>

Royal College of Emergency Medicine. Providing Patient Information in the Emergency Department: Best Practice Guideline, May 2025. <https://rcem.ac.uk/wp-content/uploads/2025/05/Providing-Patient-Information-in-the-Emergency-Department-RCEM-Best-Practice-Guideline-May-2025.pdf>

Royal College of Emergency Medicine. Guidelines for the Provision of Emergency Medical Services, January 2025. <https://rcem.ac.uk/wp-content/uploads/2025/01/GPEMS-Jan-2025.pdf>

Royal College of Emergency Medicine. Discharge to General Practice. https://rcem.ac.uk/wp-content/uploads/2022/10/Discharge_to_General_Practice_Updated_Oct22.pdf

Professional Record Standards Body. Emergency Care Discharge Standard. <https://theprsb.org/standards/emergencycaredischarge/>

Local law, medical-staff bylaws, formulary, primary/community referral arrangements, safeguarding policy, mental-health legislation, transport policy, public-health guidance, and patient-information standards. [Insert local sources]

Reference note: External sources support the principles of structured reassessment, medication reconciliation, accessible patient information, teach-back, closed-loop follow-up, pending-result ownership, and standardized discharge communication. Local law, resources, scope of practice, and service agreements remain controlling.

Local approval and sign-off

Approval role	Name / title and signature	Date
Prepared by	_____	_____
ED medical lead	_____	_____
ED nursing lead	_____	_____
Pharmacy / medicines safety	_____	_____
Clinical governance / quality	_____	_____
Medical Director	_____	_____