Title: Effective Discharge Planning in Acute Care

How effective is discharge planning when the multi-disciplinary teams are preparing a patient for discharge?

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# 1.0 Introduction

A patient during the course of treatment encounters with several clinical and non-clinical services. These services have potential impact on the care of the patient. The services through which the patient passes are having multiple steps and handovers. Handovers communicated from one service to another need to be well planned so that the patient gets appreciable amount care at proper timing. Such a planning is essential as if it is not followed it will result in delay in treatment of the patient. It also affects subsequent delay in treatment of the next patients who has to use the same facility or service (Kripalani, 2007). In case the final step of a treatment that is discharge from hospital is delayed it will have an impact on the bed management in hospital. It is hence there should be a discharge planning for the patients, who are availing treatment in the hospital.

Discharge planning is a practice carried out in order to plan, when the patient or resident can leave a care facility. The process of planning involves health care professionals and the care providers of the patient. It begins before or soon after the admission to the hospital. Discharge planning for patients availing acute care is a vital practice, which ensures smooth transfer of an acute care patient from hospital to community (Kripalani, 2007). The process of planning discharge is becoming more important as the, number of acute care patient increasing whereas the numbers of beds in hospital wards are not available proportionately in almost all health organization. In order to maintain the balance between the patients under acute care, number of available beds and new patients requiring acute medical care, it become necessary to plan the timely discharge of the patients undergoing treatment under acute care.

Acute care can be defined as a branch of secondary health care. A patient under acute care receives short term active treatment, which may be from a severe traumatic injury, sever illness, or, cases of medical urgency. The present report is focused to discuss the discharge planning process of patients availing acute care facility from hospital or related health care organization (Naylor, 1999). The report will discuss how to propose an effective discharge planning process. It should be noted that the purpose of the work is to discuss the process of smooth in flow of patients and timely discharge of patients under treatment in acute care.

The study thereby addresses the required communication between the triangle of relevant hospital personnel, the primary care physician and the patient or care provider of the patient. In the later part, the proper implementation criteria will be visited. It also provides the check list for the patient’s requirements (Naylor, 1994). Along with above discussions, the study will highlight the role of support organizations in health care, and issues related to follow up check-up of the patient.

# 2.0 Research Questions

* How effective is discharge planning when the multi-disciplinary team are preparing a patient for discharge?
* What are the steps for successful discharge of patients from a hospital, and how can hospitals provide the best care to the patient?

# 3.0 Objectives

The main objective is to provide reviews of literature regarding the on-going patient discharge process and to examine their knowledge as to possible methods to improve this process releasing patients. A breakdown of the process is as follows:

* Study the examination of the patient by the doctor before discharge.
* Study the discussion between doctor and care provider.
* Learn to implement proper planning when moving to a home or rehabilitation centre.
* Create a checklist to see whether on-going care is needed.
* Identify the role of support organizations in health care.
* Identify the arrangements for follow up appointments.

# 4.0 Rationale

According to recent analysis, it was determined that the growing population of elderly citizens is causing various health issues. Elderly people require immediate hospital care in the case of any health problem; in this situation, it is necessary for hospitals to manage their patients effectively and improve the discharge process for outbound patients. A stable patient must be discharged from the hospital on time (Bradley et al, 2013). Effective discharge planning also dictates that specific methods must be applied in order to reduce the problem of readmission for elderly patients. The impact of the discharge planning process occurs when a patient in the hospital is uncertain about the readmission rates and the length of hospital stay. For this type of health planning process, it is simple to achieve small reductions in the length of stay and number of readmissions to hospitals (Yam et al, 2012).

# 5.0 Methodology

The databases Scopus, PubMed and were searched on September 2014 with limitation of publication date after 2009. The search was conducted using the following criteria.

* **Keywords for search:** “Discharge” AND “Hospital” AND “Plan” AND “Acute”
* **Limiters:** English Language (at available databases), peer reviewed scholarly journals, published after 2009.
* **Exclusion Criteria:** Articles with full text availability were considered and the rest were excluded from study if it does not discuss the discharge planning in acute hospitals.

**Table 1:**

**Search Strategy: Stepwise record of literature search**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Search Key** | **Limited by** | **Database** | **Date** | **Results (raw)** | **Results (filtered)** |
| “Discharge” “Hospital” “Plan” “Acute” | Language-English, Peer reviewed Scholarly journals, Published after 2009 | Scopus | 12th Sep 2014 | 1246 | 738 |
| PubMed | 13th Sep 2014 | 257 | 108 |
| **Totals** | **1493** | **864** |

The selection process for inclusion of the article in the current study was performed as per PRISMA process (Moher, 2010), depicted in Figure 1. After retrieving the results from the mentioned databases, the article title and abstracts were reviewed by order of relevance. The articles which were not discussing acute care in relation to discharge planning or were reported in any language other than the English were not considered. After that, relevant articles matching the research criteria were checked for duplicity, which were retrieved from different databases.

There after the filtered articles were accessed by reviewing its abstract and were further inspected on the basis of the enlisted eligibility criteria outlined in Figure 1. Then the full text articles were examined against the eligibility criteria and chosen for the study purpose.

846 Numbers of retrieved articles from databases using key terms and filtration criteria

102 Numbers of articles after duplicate removed

744 Numbers of retrieved articles screened

321 Numbers of retrieved articles with full text accessed for eligibility

423 Numbers of articles excluded

309 Numbers of full text articles excluded, as they were found irrelevant for the study

12 Numbers of articles included in qualitative analysis

4 Numbers of articles included in meta-analysis

**Figure 1:** Flow chart represents the steps of information flow in systematic review of Discharge planning in acute care hospitals.

# 6.0 Timeline

This study proposes a comprehensive review of the discharge process in order to decrease the rates of readmission in hospitals. The target schedule for the completion of the final report is from September 2014 to November 2014; a schedule of events is presented in Table 1 below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Task** | **SEP 2014** | **OCT 2014** | **NOV 2014** |
| **1 2 3 4** | **1 2 3 4** | **1 2**  |
| Research Proposal |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Literature review |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Literature search |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Collate literature |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Draft report |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Complete Final Report |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Submission |  |  |  |  |  |  |  |  |  |  |

Retrieved from : (Maylor, 2001)

# 7.0 Literature Review

In health care services, the acute care hospitals are intended to deliver acute in-patient care to the patient (Bowlers, 2000). Usually the average length of stay in hospital for patients requiring acute care is very short, i.e. between two to three days. In-patient rehabilitation facilities and long term care hospitals provide acute care to the patients (Parkes&Sheeperd, 2000). The average length of stay in long term care hospitals is around 25 days and for inpatient rehabilitation facilities it is around 13 days (Shepperd, 2013).

## 7.1 Discharge Planning Process

For an acute care hospital the plan of care for a patient includes the information regarding discharge planning and the evaluation of discharge planning. The process of discharge planning involves the following notable features:

* Accessing the suitable post discharge destination for the patient.
* Identification of services required by the patient in order to smooth transition from the acute care hospital to the discharge destination.
* Initiating the identified services required by the patient after discharge (Philips, 2004).

Health care personnel in acute care hospital have to identify the patient who needs to or demanded for a discharge plan at the beginning of their hospitalization. The discharge planning protocol in a hospital should be neat, thorough, comprehensive and unambiguous to all the clinical or non-clinical personnel of the hospital (Haggerty, 2003).

It should be noted that in case the interdisciplinary clinical team decides for a patient, that the discharge plan is not required, still the primary care physician demands a discharge plan then the team should prepare a discharge plan for the same patient (Kripalani, 2007). As the primary care physician has the authority to take the final decision, whether if the patient requires a discharge plan. The discharge process includes multiple disciplines with specific expertise, having appropriate qualification such as registered staff nurses, clinical personnel, social workers and other relevant qualified personnel. The health care professionals thus work in collaboration and jointly prepare the discharge plan depending on the patient’s requirements (Jack, 2009). It is hence the health care professionals are supposed to have the following skills:

* Relevant experience in planning a discharge.
* Sufficient knowledge of social and physical factors, which can potentially affect the discharge process and have the ability so as to plan accordingly.
* Sufficient knowledge of available community services and scopes which can aid patient after discharge from hospital (Greenwald, 2007).
* Proper facilities are those which are able to fetch the patient’s accessed necessities on the basis of after discharge from the hospital. And those facilities should meet the standards of the government recommended safety standards (Evans & Hendricks, 1993). The discharge planning process employees the following steps:
* Asserting a comprehensive, timely and precise discharge plan evaluation method, that includes assessment of high risk factors.
* Maintenance of a comprehensive and precise file of proper community based care facilities and services such as; nursing facilities, skilled nursing facilities care, home health care, hospice, long term acute care, post discharge rehabilitation service etc. where the patient can be referred or transferred.
* Coordinating the discharge planning evaluation among various specialized disciplines involved in patient care in the hospital (Hedges, 1998).

## 7.2 Discharge Planning Evaluation

Until and unless a discharge planning evaluation has been conducted for a patient, the hospital authority should notify the information to care providers regarding the patient and to the primary care physician, who are supposed to request for an evaluation. The hospital should acknowledge them further in the documentation that upon their request the discharge planning can be prepared (Weinberger, 1996).

The process of discharge planning evaluation assists in determination of the patient’s requirements. The process depicts whether a particular service should continue or not after the discharge from the acute care hospital. The discharge planning evaluation must be completed and thoroughly revised by properly qualified personnel (Holland & Harris, 2007). The evaluation process should be carried out if:

* The identified potential risk factors for a particular patient, which may bring adverse health hazards without a discharge plan.
* In case the patient, the care giver to the patient or the primary care physician request for such an evaluation.

Based on the clinical condition of the patient and the period of stay in the hospital, competent authority should complete the discharge planning evaluation after admission of the patient to the hospital and sometimes the revaluation may be required during the stay of the patient (Hansen, 2011). The discharge planning evaluation must be included in the patient’s clinical record file. The evaluation of discharge plan recognizes the required services for the patient after discharge from acute care hospital (Pethybridge, 2004). These facility care services required after discharge often includes:

* Biophysical requirements of the patient.
* Re-admission to the acute care facility hospital.

## 7.3 Benefits of Discharge Planning

The transition of patient from hospital to community is a complex process. The process involves several assessments and fore vision (McKenna, 2000). If the planned discharge process is properly executed, and health of patient is without any unavoidable complications, then the patient keeps succeeding towards the goal of the discharge care plan. The process is helpful in many a ways, which are as follows.

* Measure of quality that links hospitals, community based services, private organizations and carer of the patient.
* Assists the patient to return to the community in appropriate time and provides essential support to the patient.
* The aids patient to avail most appropriate care facility available in the community.
* Avoids readmission to hospital.
* Aids the family or carer and the patient in the discharge process (Jha, 2009).

## 7.4 Implementation of Discharge Plan

The discharge planning strategy should be designed in such a way such that it can be adaptable at different hospital environment and in different community. It would be better to start the implementation experimentation from a pilot scale, which is to learn from single unit pilot implementation of the discharge plan (Atwal, 2002). Later the approach can be refined and then can be scaled up. In this way a hospital can standardize the process of implementation of discharge plan (Maramba. 2004).

###  7.4.1 Identification of improvement areas

* Engagement of patient and care givers and acute care hospital staff in the process of preparing the discharge plan as a multidisciplinary team.
* Assessment of family visit policy.
* Assessment of views of the patient and care givers on discharge process.
* Identification of altering acute care staff behaviour.
* Set goal to achieve improvement in discharge planning (Moss, 2002).

###  7.4.2 Implementing the modified discharge planning

* Decide the procedure to adapt the modified discharge planning.
* Decide the way to adapt checklist and booklet for the family of patient.
* Proper training of clinicians, to prepare and implement the discharge planning (Gross, 2001).

###  7.4.3 Evaluation of newly implemented discharge plan

* + Issue circular, to acknowledge all the hospital staff regarding the change
	+ Training staff to adapt to the newly implemented discharge plan.
	+ Distribution of tools to adapt to the key principles in to practice.
	+ Assessment of implementation periodically.
	+ Feedback collection from hospital staff.
	+ Further refinement of the process (Balaban, 2008).

## 7.5 Check list for care services after discharge

To determine whether the patient requires the current care services or not, a thorough revision of the health condition of the patient should be done. Again the availability and knowledge of the care giver should be considered, in determining continuing or dropping a particular service after discharging the patient.

|  |  |  |
| --- | --- | --- |
| Check items (to be asked to the patient) | Yes | No |
| Can take medication by own? |  |  |
| Have option for Home Health Care? |  |  |
| Do you need any support equipment? |  |  |
| Can do your day to day activities by your own? |  |  |
| Do you have family or care giver? |  |  |
| Can you manage to come to hospital on your appointment dates? |  |  |

It will be better to decide continuing or dropping a service after collecting the duly filled up checklist from the patient. The above checklist will be helpful for the clinical staff to judge the mental willingness of the patient (Zhang, 2002). Accordingly the services required can be continued and rest should be dropped, in order to reduce the expanses of the patient (Halasyamani, 2006).

## 7.6 Role of the Support Organization in Healthcare

Healthcare support organizations help in the promotion of the patient care by sharing experimental results of their scientific research. The information shared by the healthcare support organizations is open for both healthcare professionals and the patient (Dennis, 2003). The following major duties performed by the Support organizations are enlisted below:

* **Health Protection**: It is the primary function of all types of healthcare system. Here the organization provides the research data for food and water, which helps the society to choose healthy food and water. Acknowledges about infectious diseases and alarms the society against potential environmental threats (Bauer, 2009).
* **Health Surveillance**: Recognizes early stages of outbreaks, disease trends etc. such early information helps the society to take sufficient precautionary measures.
* **Disease and Trauma Prevention**: Educates the society how a disease progress can be delayed or prevented. Again teaches how to stay safe, by using protective devices, which reduces the intensity of trauma.
* **Health Assessment of the population**: Health organizations perform statistical analysis of the population. These services are useful to modulate the optimal care process (Thornicroft, 2004).
* **Promotion of Health:** The organization work along with individuals, communities or other groups in order to improve health policies.

## 7.7 Arrangements of follow up appointments:

The patient should be accessed prior to discharge and be well informed to follow the discharge plan, which is following dietary restrictions, taking medication on proper time and other similar terms (Backer, 2007). After that they should be acknowledged on their checklist, about the follow up appointment dates and should be asked to follow the same in order to prevent near future readmission into the hospital (Anthony, 1998).

**Words account (2848)**

# 8.0 References:

Anthony, M. K., & Hudson-Barr, D. C. (1998). Successful patient discharge: A comprehensive model of facilitators and barriers. *Journal of Nursing Administration*, *28*(3), 48-55.

Atwal, A. (2002). Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *Journal of Advanced Nursing*, *39*(5), 450-458.

Backer, T. E., Howard, E. A., & Moran, G. E. (2007).The role of effective discharge planning in preventing homelessness.*The journal of primary prevention*, *28*(3-4), 229-243.

Balaban, R. B., Weissman, J. S., Samuel, P. A., &Woolhandler, S. (2008). Redefining and redesigning hospital discharge to enhance patient care: a randomized controlled study. *Journal of general internal medicine*, *23*(8), 1228-1233.

Bauer, M., Fitzgerald, L., Haesler, E., &Manfrin, M. (2009).Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence.*Journal of clinical nursing*, *18*(18), 2539-2546.

Bowles, K. H. (2000). Patient problems and nurse interventions during acute care and discharge planning.*Journal of Cardiovascular Nursing*, *14*(3), 29-41.

Bradley, Elizabeth H., Curry, Leslie, Horwitz, Leora I., Sipsma, Heather, Wang, Yongfei, Walsh, Mary Norine, . . .Krumholz, Harlan M. (2013). Hospital strategies associated with 30-day readmission rates for patients with heart failure. *Circulation: Cardiovascular Quality and Outcomes, 6*(4), 444-450. doi: 10.1161/circoutcomes.111.000101.

Dennis, C. L. (2003). Peer support within a health care context: a concept analysis. *International journal of nursing studies*, *40*(3), 321-332.

Evans, R. L., & Hendricks, R. D. (1993).Evaluating hospital discharge planning: a randomized clinical trial.*Medical care*, *31*(4), 358-370.

Greenwald, J. L., Denham, C. R., & Jack, B. W. (2007). The hospital discharge: a review of a high risk care transition with highlights of a reengineered discharge process. *Journal of Patient Safety*, *3*(2), 97-106.

Gross, P. A., Greenfield, S., Cretin, S., Ferguson, J., Grimshaw, J., Grol, R., ...& Shaw, C. (2001). Optimal methods for guideline implementation: conclusions from Leeds Castle meeting. *Medical care*, *39*(8), II-85.

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., &McKendry, R. (2003). Continuity of care: a multidisciplinary review. *Bmj*, *327*(7425), 1219-1221.

Halasyamani, L., Kripalani, S., Coleman, E., Schnipper, J., Van Walraven, C., Nagamine, J., ...& Manning, D. (2006). Transition of care for hospitalized elderly patients—development of a discharge checklist for hospitalists.*Journal of Hospital Medicine*, *1*(6), 354-360.

Hansen, L. O., Young, R. S., Hinami, K., Leung, A., & Williams, M. V. (2011). Interventions to reduce 30-day rehospitalization: a systematic review. *Annals of internal medicine*, *155*(8), 520-528.

Hedges, G., Grimmer, K., Moss, J., & Falco, J. (1998). Performance indicators for discharge planning: a focused review of the literature. *The Australian journal of advanced nursing: a quarterly publication of the Royal Australian Nursing Federation*, *16*(4), 20-28.

Holland, D. E., & Harris, M. R. (2007). Discharge planning, transitional care, coordination of care, and continuity of care: Clarifying concepts and terms from the hospital perspective. *Home health care services quarterly*, *26*(4), 3-19.

Jack, B. W., Chetty, V. K., Anthony, D., Greenwald, J. L., Sanchez, G. M., Johnson, A. E., ... & Culpepper, L. (2009). A Reengineered Hospital Discharge Program to Decrease RehospitalizationA Randomized Trial. *Annals of internal medicine*, *150*(3), 178-187.

Jha, A. K., Orav, E. J., & Epstein, A. M. (2009).Public reporting of discharge planning and rates of readmissions.*New England Journal of Medicine*, *361*(27), 2637-2645.

Kripalani, S., Jackson, A. T., Schnipper, J. L., & Coleman, E. A. (2007). Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. *Journal of Hospital Medicine*, *2*(5), 314-323.

Kripalani, S., LeFevre, F., Phillips, C. O., Williams, M. V., Basaviah, P., & Baker, D. W. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *Jama*, *297*(8), 831-841.

Kripalani, S., LeFevre, F., Phillips, C. O., Williams, M. V., Basaviah, P., & Baker, D. W. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *Jama*, *297*(8), 831-841.

Maramba, P. J., Richards, S., Myers, A. L., &Larrabee, J. H. (2004). Discharge planning process: applying a model for evidence-based practice. *Journal of nursing care quality*, *19*(2), 123-129.

Maylor, H. (2001). Beyond the Gantt chart: Project management moving on.*European Management Journal*, *19*(1), 92-100.

McKenna, H., Keeney, S., Glenn, A., & Gordon, P. (2000). Discharge planning: an exploratory study. *Journal of clinical nursing*, *9*(4), 594-601.

Moher, D., Liberati, A., Tetzlaff, J., and Altman, D.The PRISMA Group. 2010. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *International Journal of Surgery*. 8. 336-341.

Moss, J. E., Flower, C. L., Houghton, L. M., Moss, D. L., Nielsen, D. A., & Taylor, D. M. (2002). A multidisciplinary Care Coordination Team improves emergency department discharge planning practice. *The Medical Journal of Australia*, *177*(8), 435-439.

Naylor, M. D., Brooten, D., Campbell, R., Jacobsen, B. S., Mezey, M. D., Pauly, M. V., & Schwartz, J. S. (1999). Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *Jama*, *281*(7), 613-620.

Naylor, M., Brooten, D., Jones, R., Lavizzo-Mourey, R., Mezey, M., &Pauly, M. (1994). Comprehensive discharge planning for the hospitalized elderlyA randomized clinical trial. *Annals of internal Medicine*, *120*(12), 999-1006.

Parkes, J., &Shepperd, S. (2000). Discharge planning from hospital to home. *The Cochrane Library*.

Pethybridge, J. (2004). How team working influences discharge planning from hospital: a study of four multi-disciplinary teams in an acute hospital in England. *Journal of interprofessional care*, *18*(1), 29-41.

Phillips, C. O., Wright, S. M., Kern, D. E., Singa, R. M., Shepperd, S., & Rubin, H. R. (2004). Comprehensive discharge planning with postdischarge support for older patients with congestive heart failure: a meta-analysis. *Jama*, *291*(11), 1358-1367.

Shepperd, S., Lannin, N. A., Clemson, L. M., McCluskey, A., Cameron, I. D., &Barras, S. L. (2013). Discharge planning from hospital to home. *Cochrane Database Syst Rev*, *1*.

Thornicroft, G., &Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care Overview of systematic evidence. *The British Journal of Psychiatry*, *185*(4), 283-290.

Weinberger, M., Oddone, E. Z., & Henderson, W. G. (1996). Does increased access to primary care reduce hospital readmissions?.*New England Journal of Medicine*, *334*(22), 1441-1447.

Yam, Carrie, Wong, Eliza, Cheung, Annie, Chan, Frank, Wong, Fiona, &Yeoh, Eng-kiong. (2012). Framework and components for effective discharge planning system: A delphi methodology. *BMC Health Services Research, 12*(1), 396.

Zhang, L., Ahn, G. J., & Chu, B. T. (2002, June).A role-based delegation framework for healthcare information systems. In *Proceedings of the seventh ACM symposium on Access control models and technologies* (pp. 125-134). ACM.