Discharge planning

With adequate plans, protocols, parameters and training in place, nurses or midwives can be empowered to make discharge decisions, which reduce the patients’ length of stay in hospital, freeing up beds and creating capacity for patients requiring urgent transfer from A&E. The system also has the potential to increase knowledge and improve nursing practice, with greater interaction with consultants and therapists around the discharge process. This could also benefit patients, who would have more interaction with the nurse or midwife responsible for their discharge.

Support

If nurse or midwife-led discharge is to succeed and be sustainable, it is crucial that the organisation is ready. In 2010, preparations were made at Heart of England Foundation Trust (HEFT) to introduce this system, yet interest was low and the project did not go ahead. We believe the potential benefits of nurse-led discharge in some areas were not well understood; such understanding is vital if change is to be implemented successfully (Walsh et al, 2004).

The second time around, support at board level from the chief nurse, deputy chief nurse, consultant nurse in acute medicine and medical director played a crucial role in getting it off the ground. This could also benefit patients, who would have more interaction with the nurse or midwife responsible for their discharge.

Several recent national policies have outlined the importance of improving the patient discharge process, part of which should include nurse-led discharge (DH, 2010a; 2010b; Lees, 2010; NHS Institute, 2009).

The High Impact Actions for Nursing and Midwifery are eight actions that, if adopted widely across the NHS, would reduce costs while improving care. One of these aims to increase the number of patients whose discharge from hospital could be led by a nurse or midwife (NHS Institute, 2009).

In best practice guidelines, the Department of Health outlines 10 key steps to improve discharge (DH, 2010b), one of which describes using nurse or midwife-led discharge (Box 1).

Definition

Nurse or midwife-led discharge is the delegation of responsibility for the discharge of a patient according to an agreed plan with specific criteria. The plan must be agreed by the consultant in charge of care, and the nurse or midwife must be willing to accept the delegated role and have the knowledge and expertise to execute the plan (Lees, 2007; DH, 2004).

Several approaches can be used, depending on the environment where it is being introduced (Box 2).

Benefits

Nurse or midwife-led discharge has many potential benefits. It enables more patients to be discharged after 5pm rather than discharge being concentrated between 9am and 5pm; this, in turn, improves the flow of patients admitted from accident and emergency.

From a patient perspective, a range of discharge times gives them greater flexibility to fit in with family arrangements and transport issues that often arise during working hours.

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Approach to implementation

HEFT comprises three acute hospitals. Head nurses and matrons at each were asked to nominate clinical champions to participate in a series of master classes. Nurses attending would be expected to lead implementation in their clinical area. Over four weeks, 20 nurses were
**5 key points**

1. **Nurse-led discharge should be integrated with and not separate from the usual discharge process**

2. **Bringing in nurse-led discharge requires a review of the whole discharge process**

3. **Outcome measures must be in place before a projects start so its effects can be evaluated**

4. **Implementation should help nurses to take charge of the revised discharge process through shared learning**

5. **Success will come to those who can show they can safely adapt elements of their existing discharge process for the new one**

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**BOX 1. READY TO GO?**

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

(Source: DH, 2010b)

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**BOX 2. APPROACHES FOR NURSE- AND MIDWIFE-LED DISCHARGE**

**Criteria-led**

Used for disease or condition groups where the parameters for discharge are similar; one example is the British Thoracic Society guidelines for pneumonia, which clearly state parameters for discharge of these patients

**Bespoke**

An individual, tailored plan that is documented and agreed by the multidisciplinary team and executed by the nurse or midwife. Can be used for patients admitted as an emergency where advance planning for discharge could not take place and parameters for discharge may vary

**Care pathway or protocol-led**

This tends to be used for patients admitted electively on a pathway for their condition. They could be screened for suitability for nurse-led discharge before admission. The pathway or protocol must indicate where the discharge process begins

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Ready to Go national policy guidance; this identified the stages of discharge process and highlighted those that worked efficiently and those that worked less well (DH, 2010b). This is important, as adopting the gold standard principles of discharge practice (Lees, 2010) is the foundation for introducing nurse or midwife-led discharge.

The second masterclass included discussion about the results of the baseline audits and issues encountered. Barriers to implementation were discussed, the most prominent being how to introduce estimated dates for patient discharges (Lees, 2008).

After this class, half of the nurses (7) felt they would be ready to implement projects in their clinical area. They were offered one-to-one support to work on the fine detail of implementation.

We invited a pharmacist to the final class to discuss medications for discharge. This was a great concern for nurses who were already dealing with daily concerns around the prescription, requesting and collection of patient medications.

Accountability issues and competency were also identified as areas for development.

After the workshops, a nurse-led discharge group was established to support the projects and aid their further development.

**Outcome measures**

One of the key challenges for nursing is to integrate the measurement of outcomes benchmarked against local (ward) standards when introducing strategies such as nurse-led discharge (West, 2010).

A telephone survey of Birmingham hospitals revealed nurse-led discharges were being undertaken in some clinical areas but outcome data was not often collected because this had not been considered before implementation. Such data would enable the impact of nurse or midwife-led discharge to be quantified and anticipated improvements to be measured.

We developed a pre-audit form to help nurses at the masterclasses to measure outcomes for nurse-led discharge and to introduce them to data collection before implementation. The form included a range of measurements such as use and accuracy of estimated date of discharges, last medical review and time of actual discharge. Participants were encouraged to adapt it to meet the needs of their individual clinical areas.

The information collected will eventually inform nurse or midwife-led discharge
outcome measures across the trust through a dashboard system – a tool recently introduced to monitor outcomes in areas of care such as patient experience and infection control (Fig 1). Using similar dashboards for nurse-led discharge should support implementation and sustainable changes.

**Complementary approaches**

Nurses involved in the masterclasses were given literature, documentation and presentations to share with their ward teams.

This shared learning allows staff to pass knowledge on to colleagues where large-scale engagement and change is required (Binnie and Titchen, 2003). A blog will be established on the trust intranet so questions can be posted and responses shared.

Facilitation and individual support were offered if there were areas of difficulty. For example, some nurses had made progress with implementation but were unable to engage all their team members.

Structured feedback in August 2011 indicated that all areas had improved their discharge process audited against the 10 steps (DH, 2010). However, while 14 nurses had been nominated to lead nurse-led discharge in their clinical areas, only five areas had actively started to carry out nurse-led discharge.

It seems that nurse-led discharge can only be implemented when the “usual discharge process” is working well with all 10 steps in place. Nurse-led discharge cannot have an effect until the discharge process is working satisfactorily.

**Learning from experience**

Over the past 10 years, nurse-led discharge has failed to make a major impact, with many projects being enthusiastically established but not sustained (Lees, 2007).

One approach used to implement nurse-led discharge involved employing a project nurse on a short-term contract to lead the changes. However, responsibility for implementation was not devolved to staff at ward level so the system did not continue when the project nurse or support was removed (Walsh, 2004).

In addition, evidence shows that nurse-led discharge projects have not always been fully evaluated (Office for Public Management, 2010).

In other cases, staff recruitment and retention was cited as a reason for the lack of sustainability – high staff turnover and vacancies meant it was not possible to retain the nurses experienced in the discharge process.

However, there are pockets of excellent practice in specialist areas, such as patients undergoing surgical procedures and paediatrics (Office for Public Management, 2010; NHS Institute, 2009).

It should be pointed out that nurses leading discharge should also be involved in the admission process, to enable them to have a thorough grasp of the whole patient’s journey.

Finally, discussions revealed that some nurses believed they already did nurse-led discharge. However, there was no framework of competency, training and governance to mitigate risks.

Early indications from our work at HEFT demonstrates that nurses leading changes in clinical roles will need time away from their usual duties to work on implementation. Moreover, formalisation of nurse discharge should prevent projects from being halted or not adopted in the longer term.

**Conclusion**

Nurse or midwife-led discharge should be introduced systematically in clinical areas that are prepared to embrace it.

In a hospital with many specialist clinical areas, one individual is unlikely to be able to implement the system alone. Skilled facilitation to guide nurses working within specialist areas is a sensible way forward.

It is crucial that everyone involved – consultants, nurses, therapists and patients – is clear what outcome measures are being used to look at the impact and effectiveness of the changes.

Assessing and adapting the existing discharge process in line with the 10 steps is vital to successful implementation.

It may not be possible to introduce nurse or midwife-led discharge in all clinical areas. For most areas the evidence indicates a blended approach is useful, supporting nurse or midwife-led discharge where it is clinically safe and appropriate alongside a traditional process for patients unsuitable for this, such as those whose care involves multiple organisations or specialists. The areas best suited to a nurse or midwife-led approach to discharge are those where ward teams can show they can safely adapt elements of their existing discharge process.

Patient discharge from hospital using this approach will require a transition period adapting the existing principles of discharge planning to one that creates a new identity for nurses and midwives. NT

### References


Department of Health (2010b) Ready to Go? Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care. London: DH. tinyurl.com/dischargeplanning


