The key principles of effective discharge planning

Although the principles of discharging patients from hospital have not changed over many years (Department of Health, 2003), the process and pace of discharge planning has changed beyond all recognition. NHS resources provide for an increasingly ageing population, the needs of which are sometimes complex (Glaeconomics, 2008).

The NHS now encompasses a huge breadth of alternative services to hospital admission, including inreach and outreach services, and rapid-access clinics, which are aimed at increasing the pace of discharge or transfer. Furthermore, it is now recognised that each clinical area involved in the discharge of a patient, from the pharmacy to the transport services, must collaborate to reduce overlap, waste and frequent frustrations (Hindmarsh and Lees, 2012).

The 10 steps of discharge planning

Ready to Go – No Delays, one of the High Impact Actions (NHS Institute for Innovation and Improvement, 2009), offers a 10-step process for planning the discharge or transfer of patients.

For simple discharges carried out at ward level, the process should be standardised throughout an entire hospital. The key to making this or any process work consistently in an organisation is to adapt it to fit existing systems and processes; it is helpful to involve patients and their families in this process.

Although the 10 steps are not prescriptive, they should all be considered and should form the framework for audit and review of the discharge or transfer process.

Start planning before or on admission

In elective care, planning can commence before admission and may take the form of a screening tool, risk assessment or care pathway. The principle is to anticipate potential delays and manage those in a proactive manner. With the advent of the Liverpool Care Pathway and the renewed focus on end-of-life issues, care pathways exist to facilitate rapid discharge for patients at the end of life on admission to acute services.

In emergency, unscheduled care, advance planning is not possible, so robust systems to gather patient information must be in place – pivotal sources include the GP, primary care team and carers. Ward rounds, therefore, will be reviewed by the team the next day on the ward round. Ward rounds, therefore, become inextricably linked to management plans. Ultimately, a management plan should engage and focus the whole MDT with the patient to plan the aspects of care required leading to discharge.

Coordinate the discharge or transfer process

Although most clinical areas have developed systems in which coordinators are allocated to discharge planning, there is a lot of disparity between these roles. Some use clerical staff to coordinate simple tasks, while others employ nurses up to band 7; some rotate nurses into a daily shift coordinator role, while others hold the role of discharge coordinator full time. Communication, MDT working and assessment are three key roles for discharge coordinators.

Set an expected date of discharge within 48 hours of admission

This has proved incredibly tough to implement and embed within organisational philosophy. The patient’s discharge date should be estimated as early as possible to guide the discharge-planning process; the date can then be refined with reassessment of the patient’s progress against the clinical management plan (Webber-Maybank and Luton, 2009). The estimated discharge date has three purposes:

» Strategic: to predict overall hospital capacity;
» Operational: to assess progress and outcomes of clinical plans;
» Individual: for patients to understand expectations, limitations and what is
required from them in the discharge-planning process (Lees and Holmes, 2005).

**Review clinical management plan daily**
Provided the clinical management plan was commenced on admission, the review with the patient should be relatively straightforward. Review, action, progress (RAP) is the process suggested by the National Leadership and Innovation Agency for Healthcare (NLIAH, 2008). The important aspect is to update the plan with the MDT and the patient (Efraimsson et al, 2003).

**Involving patients and carers**
This is aimed at managing patient/carer expectations and understanding potential complexities or challenges; it mainly involves therapy and social care partners, who should be guided by the clinical referrals and actions in the clinical management plan. Patient choice with regard to utilising supporting services in intermediate care, care pathways and/or dementia care will need to be taken into careful consideration. Involvement is a core principle, not a one-off action. Involving patients takes experience and patience, and often necessitates a series of meetings with the patient, carers, MDT and social care.

**Plan discharges and transfer to take place over seven days**
This relies on engagement from services that support discharge, such as therapy, X-ray, transport, district nursing and intermediate care. Only with the support of seven-day working from hospital and community services will continuity over seven days of the week be possible.

**Use a discharge checklist 48 hours before transfer**
The checklist has proven difficult to sustain (Lees, 2006); what is new is the concept of having a single checklist across a trust/organisation and ensuring it is developed with primary and social care involvement. The point is not to replicate information but to ensure that amid the heightened activity in the planning stage and pre-discharge, vital aspects of the planning are not missed.

**Make decisions to discharge and transfer patients each day**
Nurse-led discharge will never replace the role of the MDT and senior clinical decision-makers such as consultants but well thought-out implementation will support MDTs to deliver services over seven days (Lees, 2007). It is crucial that nursing grasps the opportunity to develop this new way of working.

**Conclusion**
Discharge planning is a complex activity, particularly in the context of new services offered outside hospital, like intermediate care, and having a population with more older people, who often have extremely complex care needs. However, effective discharge planning is crucial to ensure timely discharge and continuity of care. It also helps healthcare providers use limited resources most effectively and unnecessary readmissions to be avoided.

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**References**

**TEST YOUR KNOWLEDGE**
Can you answer these questions? To check whether you are correct go to our learning unit at nursingtimes.net/discharge

1. **What key steps should be followed when planning a simple discharge?**
   - A. Order transport and tablets to take home, inform the patient and discharge the patient
   - B. Inform the patient, order tablets to take home and discharge the patient
   - C. Check the management plan, estimate length of stay, inform the patient, order tablets to take home, complete a discharge checklist and discharge the patient
   - D. Tell the patient when they can go, make sure they have transport and get the bed ready for the next patient

2. **How can you best prevent patients being readmitted to hospital?**
   - A. Ensure discharge checklists are completed on the day of discharge
   - B. Ensure patients understand their diagnosis, treatment and side-effects of medications
   - C. Ensure patients visit their GP after discharge from hospital
   - D. Ensure patients are happy to be discharged from hospital

3. **Which statement is true about patients who “self-discharge”?**
   - A. They do so without medical advice
   - B. They usually receive medical advice and sign a disclaimer form before leaving hospital
   - C. They usually receive medical advice and sign a disclaimer form before leaving hospital but are not entitled to return for treatment
   - D. They are in the same category as those who self-discharge

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**Learning objectives** so you know what you will learn

- Pre-study multiple choice questionnaire to find out what you already know
- Evidence-based review with live links to key reading, national policy and guidelines
- Case-based scenarios with questions and feedback, so you can apply your learning
- Live links to further reading
- Downloadable portfolio pages to undertake optional further study and store in your portfolio
- Post-study multiple choice questionnaire to see how your learning has grown
- Personalised certificates as a record of your learning

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