Making nurse-led discharge work to improve patient care

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This article discusses nurse-led discharge and provides guidance. Robust implementation of nurse-led discharge requires a thorough understanding of the ‘discharge planning’ process, and also requires educational support, training and achievement of discharge competencies. Without these, nurse-led discharges are at risk of becoming yet another quick-fix remedy for freeing up hospital beds.

The importance of nurse-led discharge has been highlighted in government plans to overhaul the NHS discharge process (Chatterjee, 2004). The new guidance recommends that in the case of simple discharges, which make up approximately 80 per cent of discharges, nurses are the appropriate health care professionals to undertake the process. It also recommends the involvement of nurses in discharging patients who have more complex needs.

A discharge toolkit

The Department of Health has launched a toolkit that will contribute to more effective discharge as part of a total approach to improving bed management. This ten-step guide can be used to ensure the essential steps are covered to improve hospital discharge processes (DoH, 2004). The steps are:

- The multidisciplinary team should take a proactive approach to discharge;
- Ensure executive-level support;
- Agree a range of patient groups with which to start;
- Clarify the roles and responsibilities of members of the multidisciplinary team;
- Review and revise the systems and processes you use to manage the discharge decisions;
- Identify the skills needed by team members;
- Gain acceptance and prove that the revised discharge process is effective;
- Develop a policy framework that encompasses the whole hospital trust;
- Refine policy and guidelines;
- Capture, monitor and audit the impact.

Nurse-led discharge is not a new concept – nurses have been involved in planning patient discharge for several years. The recommendations from the DoH are a further development and highlight the importance of well-planned discharge processes to ensure the smooth running of the modern NHS.

Defining nurse-led discharge

Evidence gathered around the country suggests that nurse-led discharge is commonly being interpreted as the transference of responsibility for the discharge decision from doctors to nurses. However, it could legitimately be argued that doctors have never discharged patients – they simply confirm their patients’ medical stability for discharge through the appropriate diagnoses and investigations.

Also, the term ‘nurse-led discharge’ may imply that discharging patients is a unidisciplinary activity. Therefore, it is important that the constructs of nurse-led discharge should be understood from professional and organisational perspectives.

Driving forces

The achievement of nurse-led admissions and discharges is one of ten key roles shaping the future of nursing, as set out by the chief nursing officer for England in The NHS Plan (DoH, 2000) and Making a Difference (DoH, 1999). Although there have been developments in nursing roles, discharge planning has rarely been seen as an area ripe for new roles. However, there are clear benefits for patients, nurses and trusts in developing nurse-led discharge (Box 1).

From a national perspective, until the DoH launched the discharge toolkit described above (DoH, 2004), little assistance had been offered to trusts grappling with the implementation of nurse-led discharge. Hopefully the toolkit will start to disseminate new developments demonstrating the measurable improvements that nurse-led discharge offers nurses and patients through improved care processes.

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**BOX 1. BENEFITS OF NURSE-LED DISCHARGE**

To raise the quality of discharge planning and in so doing improve care by involving patients in the process and perhaps help them to achieve a more timely discharge.

To improve the overall competence, confidence and responsibility of a ward team to discharge patients (viewed in its widest sense to include allied health professionals).

To reduce the volume of delayed patient discharges through the amalgamation of processes that drive the estimated date of discharge, and latterly the inextricable links to the recharging and reimbursement process.
For nurses working in a rehabilitation setting, on the particular clinical environment where they are based. For nurses working in a rehabilitation setting, discussing discharge plans at multidisciplinary meetings has always been part of their role. Conversely, nurses who work in day surgery will have little or no exposure to discharge planning. Yet both clinical areas may lay equal claim to conducting nurse-led discharges.

District nurses may be the leaders in this field. Unlike rehabilitation and surgery specialties, they often manage both the admission and discharge process for a caseload of patients. They are the gatekeepers of their service, unlike most hospital-based nurses.

Within hospital settings, surgery is currently developing nurse-led discharge as the norm rather than the exception. This is perhaps aided by surgery having its main focus in elective care, whereas medicine is predominantly concerned with emergency admissions and so has the disadvantage of not being able to plan ahead for the rising number of these emergency admissions. As a result, most elective surgery work can be planned for and accommodated from the preadmission stage.

There are several ways in which nurse-led discharge can be advanced:

- Bespoke discharge management plans (useful in emergency admissions);
- Discharge checklists with variance measured against the norm (day surgery);
- Protocol or criteria-driven discharges (useful for specific condition groups);
- Care pathways with integrated discharge points.

However, irrespective of the route of admission, it must be stressed that one approach to discharge does not fit all areas of practice or every single patient.

**Avoiding an event-driven process**

Practitioners working in environments with mainly older patients know that nurse-led discharge is not a totally new process – it is simply a new part of existing discharge processes.

More importantly, practitioners should remember that discharge is not a one-off event (Wade, 2004).

There is a danger that nurse-led discharge could be viewed by management as a single activity, conducted by nurses instead of doctors, exclusively on the day of discharge.

### BOX 2. WHAT IS NURSE-LED DISCHARGE?

The nurse providing ongoing patient assessments/evaluation to assist timely and appropriate discharges.

The nurse initiating and leading the discharge process with the involvement of all relevant professionals to expedite discharges and assist bed and capacity management across the whole hospital.

The nurse chasing the results of clinical investigations, which require her or his decision to expedite discharge.

The nurse promoting the relevant discharge decisions in collaboration with the patient’s family and the multidisciplinary team.

The nurse providing ongoing patient assessments/evaluation to assist timely and appropriate discharges.

### BOX 3. WHAT IS NOT NURSE-LED DISCHARGE?

Carrying out a series of instructions as indicated by the medical team. This is arguably what the nurse or multidisciplinary team would normally do.

Deciding a patient is fit for discharge without consultation with relevant professionals involved with the patient’s care.

Deferring discharge decisions to wait for the doctor to make a decision, for which the nurse has had the relevant training/knowledge.

Discharging a patient according to different rules depending who is on duty and bed capacity issues.

### References


This turns patient discharge into an ‘event-driven’ process that can be determined by capacity problems at peak periods, and that may not necessarily be in the best interests of the patient.

It is therefore important to be clear what is and what is not a nurse-led discharge. However, this will depend to a great extent on the clinical base. Some examples are shown in Boxes 2–3, p31.

Introducing nurse-led discharge

A consistent approach is required to support the implementation of nurse-led discharge across a trust (Box 4). Uniformity is required with regard to:

- Methods of training;
- Acceptable levels of competency;
- Policy development;
- Director-level support.

Flexibility will be required for directorates regarding the pace at which this is to be achieved and the development of protocols. Collaboration and cooperation is also essential among health care professions in the day-to-day management of adjusted/expanded practice.

Negotiations are needed within the multidisciplinary team regarding members’ parameters of practice and the relative ‘role adjustments’ that they are required to make. This negotiation will enhance crucial partnerships in care between professionals for the benefit of patients and assist in meeting organisational targets for discharge (Lees, 2004).

Conclusion

Some people believe that nurses are not taking on any new responsibilities when they undertake the process of nurse-led discharge. However, as a profession we must be clear that education, training and adjustment of practice should underpin any new, adjusted, advanced or extended nursing role, and nurse-led discharge is no exception.

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**BOX 4. KEY POINTS FOR SUCCESS**

- Good discharge-planning mechanisms must be in place before starting any new initiatives such as nurse-led discharge
- Patient safety is paramount
- The mechanisms should benefit the patient and the NHS
- Practice should support the role of doctors and the multidisciplinary team and not replace it
- Adequate educational preparation should be provided for all nurses who are undertaking discharge
- Nurse-led discharge should promote cooperation and coordination between everyone involved in the process
- Good communication is essential between everyone who is involved in the discharge process
- It should be a voluntary partnership
- Robust audit of new processes should be carried out to promote constant review and change as required

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