Exploring the principles of best practice discharge to ensure patient involvement

Improving discharge planning and involving more nurses is one of the eight high impact actions. New guidance outlines a systematic approach to patient discharge.

INTRODUCTION
A new policy to guide the discharge or transfer of patients from hospital and intermediate care was published earlier this year (Department of Health, 2010). Its title – Ready to Go? Planning the Discharge and Transfer of Patients from Hospital and Intermediate Care – should leave nurses in no doubt that the scope of discharge practice has evolved significantly.

“Discharge” and “transfer” are presented as synonymous, and “hospital and intermediate care” are presented as a part of planned discharge pathways, functioning through a series of 10 coordinated steps in the process of planning patients’ discharge or transfer.

As with any health policy, Ready to Go? (DH, 2010) must be considered together with previous policies (Health Service Executive, 2008; National Leadership Innovation Agency for Healthcare, 2008; DH, 2004; 2003).

The high impact actions for nursing and midwifery (NHS Institute for Innovation and Improvement, 2008) are also crucial, incorporating a standard that focuses on discharge, entitled “ready to go – no delays”.

This is where nurse led discharge should come to the fore to support an array of existing measures aimed at reducing overall length of stay and promoting seven day working patterns (Webber-Maybank and Luton, 2009; Lees, 2007). Although the simplicity and clarity of the new DH policy is refreshing, it is important that nurses are not lulled into a false sense of security about its implementation.

The 10 steps require tenacity and sustained commitment if an appropriate fit is to be achieved and maintained throughout healthcare services.

Contextual issues
Although the principles of discharging patients from hospital have not changed over many years, the process and pace of discharge planning have changed beyond all recognition.

This has evolved as a result of cultural, political and financial pressures on the health service. The discharge process in the NHS now encompasses a huge breadth of viable alternatives to hospital, ultimately aimed at speeding up patients’ discharge and frequently entailing new – and sometimes innovative – steps for assessment and referral. A plethora of outreach services (such as intravenous therapy at home) and rapid access clinics that work with acute medicine and surgical admission units also increase the pace of discharge or transfer.

Furthermore, a whole new vocabulary on patient discharge and transfer has developed, such as “capacity”, “flow”, “predictability” and “breaches”.

To ensure effective and efficient discharge practice, clinical staff and managers have to understand the interactive dynamics of new terminology, new services and new process steps not only in the context of their clinical area but also across the hospital and community.

Considerations for older people
New health and social care policies during 2009 were prolific, perhaps demonstrating the complexity and challenges faced by the health service and social care in developing services fit for patients with dementia while accommodating safe discharge and transfer (DH, 2009a; 2009b).

These documents are extremely relevant to the new policy on discharge. For example, discharge and transfer for patients with dementia may require a new type of healthcare worker and new support services that encompass the whole care pathway for a society growing older and living longer with increasing frailty (DH, 2009a).

Moreover, general awareness must be increased and dementia care must become mainstream in acute and intermediate care settings, not perhaps viewed forever as the domain of “specialists” (DH, 2009b). Few services offer adequate provision for people with dementia.

In addition, facilities in discharge lounges...
that are inadequate for people with dementia and a lack of appropriate medication or equipment often mean that problems are considered to be a result of patients’ dementia rather than of poor infrastructure. Considered to be a result of patients’ that are inadequate for people with dementia and a lack of appropriate medication or equipment often mean that problems are considered to be a result of patients’ dementia rather than of poor infrastructure supporting discharge plans for this group.

**TRANSLATING THE 10 STEPS INTO PRACTICE**

Having considered discharge and transfer in the context of current issues in the health service, the 10 steps can be more easily considered in practice (Box 1).

Steps 6 and 7 suggest patient involvement at two levels, with patients being adequately informed to enable choice; and, where required, to assess their progress according to the choices made. Members of the multidisciplinary team need to act as advocates to enable patient/krnoset to make choices, and must have the skills and knowledge to navigate through available and appropriate services with patients (Birmingham, 2009). Steps 6 and 7 depend on step 5 being in place.

Steps 8 and 10 are inextricably linked but looking at them separately means we can consider different perspectives – organisational processes required to instigate appropriate availability of seven day services and the clinical infrastructure needed to include senior clinical decision makers across a spectrum of care (Royal College of Physicians, 2007).

Although the 10 steps are not prescriptive, they should all be considered to prevent a collapse of the entire system. They form the framework for audit and review of discharge processes and also inform quality improvement in the future.

Clinicians who are involved in discharge planning should explore the following issues in the redesign of processes to speed up patient discharge and transfer:

- Which of the 10 steps may be missing in their discharge process?
- Where implementation might fail through lack of support or where it has already failed?
- Where there may be resistance to any of the 10 steps.

Table 1 gives practical tips on implementing each step.

**Step 1: Planning**

If we consider elective care first, this step can be started before admission in the preoperative admission phase and may take the form of a screening tool, risk assessment or care pathway. The principle is to anticipate potential delays and respond by managing those proactively.

With the advent of the Liverpool Care Pathway and the renewed focus on end of life issues, care pathways aim to facilitate rapid discharge for patients who are dying following admission to acute services (NHS National End of Life Care Programme, 2009). Conversely, in emergency care, advance planning is not possible.

Robust systems to gather patient information have to be in place – this information must then be shared with the multidisciplinary team to ensure early engagement in the discharge process. Rich sources of information streams are often missed in the activity around assessment and transfer (Hellaso, 2006); key sources include GPs, primary care teams and carers, who may provide the mainstay of support yet receive little attention or mention.

Furthermore, the numerous types of documentation used to catalogue discharge communications in hospitals and intermediate care settings make planning a more complex process. If each ward uses a different set of documentation, this will undoubtedly slow the process of retrieval and discharge from hospital.

**Step 2: Simple or complex discharge?**

The aim of this step is to identify the likely patient pathway from or before admission. The advantage of this differentiation is that it should enable discharge planners to recognise when simple becomes complex.

Simple discharge can be executed at ward level with the multidisciplinary team. Funding issues, change of residence or increased care needs that need to be negotiated between health and social care make discharge complex.

Predicting whether a discharge will be simple or complex is far preferable to an insidious deterioration of the patient's condition, with risk issues perhaps not recognised before the discharge date is set (HSE, 2008). It may also prevent some failed discharges and help patients and healthcare professionals understand/set expectations.

**Step 3: Clinical management plan**

Most patients admitted by junior medical staff will have an outline (initial) management plan. Multidisciplinary team involvement may have been minimal, depending on the time of day of the patient's admission. For example, admissions after 5pm will be reviewed by the whole team the next day on ward rounds; these therefore become inextricably linked to management plans (Lees et al, 2006).

Ultimately a management plan should engage and focus the whole team with patients to plan the aspects of care that are needed leading up to the point of discharge. Clinical management plans do not have to be prescriptive – they should serve as a guide and be revisited if/when patients move through the continuum of care (Lees and Delpino, 2007). They act as an integral part of the handover between clinical settings extending to nursing homes, intermediate care and GPs, and should prevent delays or lack of clarity about what has or has not been completed.

**Step 4: Coordinating discharge or transfer of care**

The pace of discharge and transfer is such that most clinical areas have developed systems where they have a dedicated

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**Table 1. THE 10 STEPS**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>1</td>
<td>Start planning for discharge or transfer before or on admission.</td>
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<td>2</td>
<td>Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient or carer in your decision.</td>
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<td>3</td>
<td>Develop a clinical management plan for every patient within 24 hours of admission.</td>
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<td>4</td>
<td>Coordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.</td>
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<td>5</td>
<td>Set an expected date of discharge or transfer within 24-48 hours of admission and discuss with the patient or carer.</td>
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<tr>
<td>6</td>
<td>Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.</td>
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<tr>
<td>7</td>
<td>Involve patients and carers so they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.</td>
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<tr>
<td>8</td>
<td>Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.</td>
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<td>9</td>
<td>Use a discharge checklist 24-48 hours before transfer.</td>
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<td>10</td>
<td>Make decisions to discharge and transfer patients each day.</td>
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Source: Department of Health (2010)
TABLE 1. TIPS FOR EACH STEP

<table>
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<tr>
<th>Step</th>
<th>No-nos</th>
<th>Nice ifs</th>
<th>Niggles</th>
<th>Nuggets</th>
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<tbody>
<tr>
<td>1</td>
<td>Not acting on information gathered in a timely manner</td>
<td>Information could be shared at a central point such as an electronic handover system</td>
<td>Lack of continuity of documentation between wards and departments</td>
<td>Create a user friendly screening tool or discharge risk assessment tool</td>
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<td>2</td>
<td>Lack of decision regarding simple or complex discharge at the outset</td>
<td>Simple or complex is included on ward patient journey boards</td>
<td>If this decision is not integrated into a clinical management plan</td>
<td>Develop a clear definition of both simple and complex within your discharge policy</td>
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<tr>
<td>3</td>
<td>Following basic clerking instructions and daily changes of care in the absence of an overall plan</td>
<td>A management plan is created by the multidisciplinary team and shared at team meetings</td>
<td>The absence of actions in a plan and determining whether they have been completed or not</td>
<td>Have a management plan proforma developed and available for download on the intranet</td>
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<tr>
<td>4</td>
<td>Tackling discharges day to day without a strategic approach on the wards</td>
<td>Assessment of need and process mapping to be carried out – accounting for the needs of the ward to involve the multidisciplinary team</td>
<td>Lack of leadership when staff shortages occur and coordinators are “counted in the numbers” and not freed up to coordinate discharge</td>
<td>Prepare job descriptions aligned to the Knowledge and Skills Framework to reinforce the coordinator role – also consider allied health professional involvement</td>
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<td>5</td>
<td>Not estimating a date of discharge</td>
<td>Patient is involved from the outset in planning of discharge date</td>
<td>Estimating a date without clarification from the multidisciplinary team of what is achievable</td>
<td>Improve staff understanding to improve compliance with estimated date of discharge. Conduct patient surveys to assess extent of involvement in the process</td>
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<td>6</td>
<td>More than one management plan</td>
<td>Plan is used in multidisciplinary team meetings or SMART (specific, measurable, achievable, realistic and time based) ward rounds</td>
<td>Management plans tend to exclude nursing actions and nursing plans</td>
<td>Incorporate estimated date of discharge, simple or complex discharge and the anticipated destination (home, nursing home) in the plan</td>
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<tr>
<td>7</td>
<td>Excluding the patient and making decisions in isolation of the multidisciplinary team</td>
<td>Integrated care pathways were to be established</td>
<td>Lack of understanding of patient involvement strategies</td>
<td>With complex discharges establish a key worker who coordinates the discharge plan</td>
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<td>8</td>
<td>Planning to accommodate organisational capability rather than patient needs</td>
<td>Nursing and support workers (healthcare assistants) were to be able to continue the therapy plan over weekends</td>
<td>Five day working from some essential services</td>
<td>Analyse high volume groups – what services do they need? Work to ensure weekend provision of those services becomes available to enable seven day working and discharges</td>
</tr>
<tr>
<td>9</td>
<td>Not using any form of pre-discharge checking process, which is recorded and shared with the team</td>
<td>Carry out audit concentrating on completion to embed process. Do they reduce complaints? Do they improve the quality of the discharge process?</td>
<td>Every ward developing their own discharge checklist</td>
<td>Develop with social care and primary care trust. Keep to one page. Give a carbon copy to patients</td>
</tr>
<tr>
<td>10</td>
<td>To hope to introduce nurse led discharge without supporting education and time to embed</td>
<td>Medical champions to assist the process and work towards delegated decision making with nurses and multidisciplinary team</td>
<td>Pockets of excellent practice – but not shared</td>
<td>Start work in an area with relatively simple discharges. Identify high volume condition groups</td>
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Communication, ensuring multidisciplinary teamworking and assessment are three key roles for discharge coordinators (Rose et al, 2009), as well as the transfer of information that may otherwise be missed (Hellesø, 2006). Paradoxically, the very roles set up to manage complexity in discharge planning, promoting flow and increased capacity, may cause a loss of the skills and experience to carry out discharge planning across a team. This concern needs to be balanced with effective timely discharges where communication and coordination are the essence of good practice (Macleod, 2006).

Step 5: Setting an expected date of discharge
This area of practice has proved extremely difficult to implement and embed within NHS organisational philosophy. Essentially, the expected date of discharge is estimated and is intended as a guide for the discharge coordinator. However, there is much disparity between the responsibilities within this role in different settings, with some systems of coordination using clerical staff and others employing nurses up to band 6. Some staff rotate into a daily shift coordinator role while others hold the dedicated role of discharge coordinator. Certainly, a “one size fits all” approach cannot accommodate all simple and complex discharges.
planning process. It is not intended to be exact and is refined with reassessment of patients’ progress set against the clinical management plan (Webber-Maybank and Luton, 2009).

There is also a play on words evident in practice areas: predicted date of discharge and length of stay, estimated length of stay and estimated date of discharge (Lees, 2008). Regardless of what we choose to call it, if the estimated date of discharge is to have any meaningful application in practice, its underpinning principles must be understood at three levels:
- Strategically – to predict overall hospital capacity;
- Operationally – to assess progress and outcomes of clinical plans;
- Individually – for patients to understand the expectations, limitations and engagement required from them in the process of planning discharge (Lees and Holmes, 2005; DH, 2004).

Patient engagement is often absent from the process or conducted on a very superficial level (Sargent et al, 2007). This is where the greatest improvement could be made in the whole process of setting an estimated date of discharge.

Estimating dates for discharge requires a change of mindset among health and social care workers towards a way of organising discharge where “time” is of the essence and lost “time” (or waiting) during the process of discharge planning should be minimised or – and this is preferable – eliminated.

Time can be translated into money and, by estimating length of stay, the aim is to focus on carefully planning time and accounting for possible variance (except for an unexpected deterioration in patient condition).

Step 6: Reviewing clinical management plans with patients
Provided that the clinical management plan was started on admission of the patient, reviews with them should be a relatively straightforward process.

Review, action, progress (RAP) is the process that has been suggested for this (NLIAH, 2008). The important aspect is to update the plan with the multidisciplinary team and patients (Efraimsson et al, 2003; clinicalmanagementplansreflectprogresssto medical and therapy milestones.

In some cases, it is likely that the plan will form part of a multidisciplinary team meeting or will be used in one, depending on their frequency. Ideally, only one plan should be central to the discharge process; this will avoid confusion and duplication of documentation, and should ensure transparency. Sometimes separate, conflicting plans may be developed, for example, if a patient is transferred to a series of wards after admission.

Step 7: Involving patients and carers
This step is aimed at managing patient expectations and understanding potential complexities or issues. Predominantly, but not exclusively, these are likely to involve therapy and social care partners which should be guided by the clinical referrals and actions in the clinical management plan (Sargent et al, 2007).

Patient choices in terms of using supporting services in intermediate care, care pathways and/or dementia care need to be considered, as involvement is a core principle rather than a one off action.

Patient involvement is about genuine and meaningful engagement with patients throughout the entire discharge planning process. It requires that nurses not only deliver care with the team but also act as patient advocates and understand their own barriers to enabling truly shared decision making (Milton-Wildy and O’Brien, 2010).

Step 8: Planning discharges to take place over seven days
This step relies on engagement from therapy services, X-ray services, transport, district nursing and intermediate care services; only with the support of seven day working from hospital and community services will continuity over this period be possible (DH, 2004).

For example, in general therapists only work Monday to Friday, which means that the therapy plans in place must continue on a weekend with nursing staff support. In some areas with early supported discharge schemes, Saturday working is becoming more commonplace.

Multidisciplinary teamworking over seven days in hospital settings also requires service provision in primary and social care at the same time to speed up patient discharges. Without doubt, “out of hours” services and “winter pressures” are vastly outdated concepts in discharge planning and accommodating capacity over seven days.

Step 9: Using a discharge checklist
Discharge checklists have proven to be a difficult area of practice to sustain. Although the principle of a checklist is not new (Lees, 2006), the concept of using the same one across a trust/organisation and making sure it is developed in collaboration with the primary care trust and social care is new.

Discharge checklists are seen more commonly in integrated care pathways, often for surgical conditions. The aim is not to replicate information but to ensure that vital aspects of planning are not missed amid the increased activity before discharge. If used appropriately, they can help to prevent complaints about the discharge process and aid compliance with the standard for discharges within the clinical negligence scheme for trusts. There is potential for the checklist to be merged with the discharge letter and for carbon copies to be given to patients on discharge from hospital.

Step 10: Making decisions to discharge and transfer patients each day
The key difference between this step and step 8 is decision making. Many pieces of work on safety and service development suggest consultants’ decisions are critical to this (RCP, 2007). This raises a whole new debate in the area of discharge planning, which is concerned with the reduction of junior doctors’ working hours – and changing roles and responsibilities across a team to support that change (RCP, 2007).

Each clinical area needs to decide a structure for the future that takes into account decision makers, regardless of profession. The high impact actions have made nurse led discharge a key deliverable (NHS Institute for Innovation and Improvement, 2009). Although it will never replace the role of the multidisciplinary team and senior clinical decision makers, such as consultants, well thought out implementation of nurse led discharge will support the multidisciplinary team to deliver services over seven days (Lees, 2007; 2004; Macleod, 2006).

The evidence base is gradually increasing – and it is crucial that nursing grasps the opportunity to develop this new way of working as part of the discharge process.

CONCLUSION
It is often a challenge to know where to start implementing a new policy. The clarity of the 10 steps enables specific areas of the discharge process to be audited in order to create a focus for where work needs to be undertaken on specific points in the pathway. Equally, it is important not to overlook the elements of the existing process, as it is vital to understand the obstacles that staff might face on a daily basis; this is the key to the new process being
sustainable. For example, if there is no clinical management plan, this alone may cause staff to dismiss the process and “do it their own way”.

The process used on each ward must be the same, underpinned by specialist aspects of discharge planning relating to the individual area. For example, adding to the process may be acceptable but missing elements from it will delay discharges.

The discharge process must work efficiently out of hours and must not add to delays caused by lack of transport, medications and so on.

REFERENCES


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