practice high impact actions

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The high impact actions for nursing and midwifery 8: ready to go – no delays

Patients who are waiting to go home can become frustrated by delays. Nurses should develop systems to ensure patients receive a smooth and timely discharge.

INTRODUCTION

There is a common misconception in the health service that delays in discharging patients from hospital are unavoidable as certain processes cannot be sped up. There are also times when effective discharge is regarded as being less important than speedy admission. Nurse led discharge may be perceived as risky, or discharge may be regarded as wholly the responsibility of one group of healthcare professionals. Additionally, in many cases, hospitals believe that clinical management makes estimating discharge dates impossible.

It is not just the frustration and inconvenience to patients that makes timely discharge a pressing issue. The average patient stay on a surgical ward costs up to £400 per day (Webber-Maybank and Luton, 2009), so there are financial benefits too. A reduction in the length of stay of by 2-6 days per patient could save NHS trusts an estimated £15.5-46.5m a year (National Audit Office, 2000). For the NHS as a whole, the House of Commons’ Select Committee on Health (2002) calculated that beds being occupied by patients who could be discharged represented an annual cost of £720m.

WHAT CAN NURSES DO?

Nurses can take a lead by developing clear systems and processes to ensure that patients receive a smooth and timely discharge. Nurse led discharge enables hospitals to offer patients a discharge that is better planned and has fewer delays. This leads to a more positive patient experience as well as a lower risk of patients contracting healthcare associated infections.

While implementing nurse led discharge does not necessarily require additional roles and investment, it should be recognised as an extended role. It should be voluntary and come with training, and be backed by clear guidance and policy.

To make nurse led discharge work, the whole discharge process needs to be evaluated. The best place to start is by reflecting on your organisation’s effectiveness. The Department of Health’s (2010) Ready to Go? Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care will enable you to evaluate your practices and identify those areas in which changes are needed. Discharge planning should begin at the admission stage.

The Essential Collection (NHS Institute for Innovation and Improvement, 2010) includes four case studies, taken from different settings. In each case the healthcare organisation has found a way to successfully address the issue of patient discharge.

CASE STUDY 1: DISCHARGE AND EXTENDED NEONATAL OUTREACH

Cambridge University Hospitals Foundation Trust’s neonatal unit developed discharge and extended outreach services in order to get babies home safely and in a timely manner. The unit takes babies who are aged from 23 weeks old and is equipped with 33 cots, including 17 equipped for those needing intensive care. It cares for a total of 950 babies each year.

With more preterm babies now surviving and one in eight babies needing some form of neonatal input, there is increasing demand on services. Staff here were facing bottlenecks and length of stay was...
an education programme was developed for parents. This was established, giving all medical staff the opportunity to provide nurse-led discharge. A project was carried out in 2007, which showed that 39% of parents wanted to leave without seeing their child, 21% by more than six hours and 11% by more than eight hours.

Impact of the initiative
Babies were now being discharged earlier. This was because of better planning and preparation as everyone was aware of the discharge date. Documentation was being revised so that parents could take better control.

The team now identifies teenage mothers for extra support and works with the local hospice to improve end of life care.

Staff are working towards greater standardisation by aligning the criteria for outreach tertiary referrals. It is estimated that this allows for 1.4 cots per day in the unit, at a cost of £450 per day. The team is generating money by delivering a national training course and the outreach team is helping to prevent readmissions by reinserting nasogastric tubes in the home.

CASE STUDY 2: PEDIATRIC NURSES DISCHARGING PATIENTS
At the same hospital, children were facing long waits for consultant discharge, which usually happened at the end of the day. Some parents wanted to leave without seeing the doctor, resulting in a note of “left without medical advice” in children’s notes. A retrospective audit of 646 patients, which was carried out in 2007, found that 39% of discharges were delayed by more than four hours, 21% by more than six hours and 11% by more than eight hours.

The trust introduced a pilot scheme to provide nurse-led discharge. A project group was established, giving all medical colleagues the opportunity to comment, and an education programme was developed to provide training and supportive documentation. In May 2008, the nurse facilitated discharge policy and procedures were ratified.

Impact of the initiative
Of the 588 discharges that took place on the children’s wards between April and September 2009, 410 were nurse led. The experience for children and parents has improved as the nurses who looked after them during their stay are responsible for discharging them. Nurse facilitated discharge is now being introduced on a number of adult wards.

A pro forma has been developed to allow nurse led wound review post surgery to take place on the ward. The team has also developed a patient group directive to allow nurses to administer an oral sedative to children who are undergoing scans on the ward.

CASE STUDY 3: NEW DISCHARGE FACILITATOR ROLES
NHS North Staffordshire Community Healthcare has 180 beds across three community hospitals. It handles GP admissions and provides rehabilitation and end of life care.

Many patients were being admitted for continuing care and had an average length of stay of six weeks. The trust identified delayed discharge as a problem; one hospital site was using being used as a nursing home, with some patients staying for up to five years. There were waiting lists in acute trusts for transitional care and the number of acute beds was to be cut by 300 across the local health economy.

The trust developed services to provide subacute and acute rehabilitation. It appointed a discharge planning lead and, under the new system, an estimated discharge date is established within 48 hours of a patient’s admission to hospital. Documentation has been revised and all ward managers now receive training in discharge planning. Patients undergo an assessment by occupational therapists within 24 hours of admission.

Impact of the initiative
Sixty per cent of patients now leave hospital on their estimated date of discharge. The trust has reduced length of stay from six weeks to four weeks and achieved 98% bed occupancy. Individual hospitals manage their own waiting lists. Readmissions for patients with chronic obstructive pulmonary disease have been cut from eight or nine a year to just two or three.

CASE STUDY 4: AN URGENT HELP SERVICE FOR ADOLESCENTS
Sussex Partnership Foundation Trust set up a community outreach team eight years ago. In 2009, it opened a new purpose built adolescent unit catering for 12-18-year-olds, which takes around 60 admissions a year, half of whom have eating disorders. The average length of stay was 2-3 months. Consultant led admissions meant that patients required assessment in clinic, which resulted in waiting lists.

The trust redesigned its outreach team in conjunction with key stakeholders. It developed an urgent care service, led by mental health practitioners, to provide intensive support to patients. The service supports weekend leave for patients needing to be discharged. Speeding up discharge has been part of an overall approach to reducing hospital admissions.

Impact of the initiative
Urgent care teams respond to all urgent referrals within four hours. The teams are exceeding their targets of 15 contacts per clinician per week. The trust now has a more streamlined referral service, supporting 80 families. Length of hospital stay has reduced from 2-3 months to 6-8 weeks.

REFERENCES