Why do patients with complex palliative care needs experience delayed hospital discharge?

A team carried out an audit to discover why complex palliative care discharges are often delayed. Their findings and recommendations are revealed.

INTRODUCTION
Over the past year, the palliative care team at North Middlesex Hospital has become increasingly aware that patients with complex needs were experiencing delays in discharge. There are no standardised timescales within the trust that can be used to determine a discharge date. Work is under way to implement a discharge policy.

By their very nature, this group of patients is likely to present challenges:
- They may be medically unstable;
- Equipment may need to be ordered, which requires at least seven days’ notice;
- Care packages rely on gaining access to funds from primary care trusts and social services.

We decided to carry out a clinical audit to establish the reasons for delayed discharges.

The National Institute for Health and Clinical Excellence et al (2002) defined clinical audit as “a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change”.

We aimed to make recommendations to improve the discharge process.

COMPLEX DISCHARGES
Day et al (2009) argued that “securing a timely discharge is a key feature of policy documents”.

Early identification and coordination of individual patients’ needs are important and effective communication is paramount (McCoy et al, 2007; Lees and Wade (2004) and rely on a multidisciplinary approach (Macleod, 2006).

The trust’s discharge pathway, updated earlier this year, also emphasises the importance of cohesive working between nursing staff, medical staff, pharmacists and allied healthcare professionals.

The issues identified in delayed discharges include poor communication (Vetter, 2003) and documentation of discharge plans (Day et al, 2009). Vetter (2003) argued that tools for measuring inappropriately delayed discharges have poor validity and reliability.

Kydd (2008) said that delayed discharge is a “human issue”, where patients feel they had no control. In addition, delayed discharge leaves patients powerless, increases their risk of developing infections and reduces comfort and quality of life (Macleod, 2006).

Apart from having psychological effects on patients and families, delayed discharges result in bed blocking, which has cost implications. Palliative care patients often have a range of physical, psychological, social, spiritual and financial needs which are not adequately met and the care they receive is often poor (National Institute for Health and Clinical Excellence, 2004).

Pearce et al (2001) pointed out that survivorship is increasingly recognised in national policy. However, there is an underlying question of whether the NHS is appropriately equipped and recognises the growing demands of an increasingly ageing population with complex health needs when it comes to discharge planning.

THE AUDIT
The case notes of 40 patients admitted between September 2008 and March 2009 (20 with cancer and 20 with other conditions), who were identified as having complex needs and were preparing to be discharged, were reviewed during the audit period to determine reasons for delays. The palliative care team agreed that 40 sets of case notes would be feasible and manageable as this work was incorporated within the team’s clinical role.

The selected patients’ notes were obtained from the discharge planning department, which holds a weekly register of patients whose discharge is delayed irrespective of age, gender or clinical area.

The 20 non-cancer patients identified had a range of medical conditions. Data was collected using a pro forma designed by the team, who wanted to establish the factors that affected discharge. This included:
- Proposed date versus actual date of discharge;
- The borough of patients’ residence;
- Category of assessment made to ascertain type of funding required;
- The date this assessment was started and completed;
- Continuing care assessment panel date;

PRACTICE POINTS
- There are many reasons for delays in discharging patients with complex needs. The audit found that the most common was securing care packages, followed by obtaining equipment.
- Discharge can be delayed because of poor communication between hospitals and primary and social care, and because paperwork is not coordinated.
- Changes to workforce planning and training can help speed up discharge and prevent discharge failures.
Audit results
The audit revealed a variety of reasons for delayed discharges such as changes in patients’ medical condition; delays in organising care packages as a result of poorly coordinated paperwork; and poor communication between disciplines involved within both internal and external organisations and departments.

Ward location: cases came from across the trust. Nearly half of those reviewed were from the care of older people wards (45%). The oncology ward was responsible for 33%, while medical wards and surgical wards had 10% each of the cases reviewed.

The audit may not be representative of the total number of delayed patients because of the methodology. First, we were actively seeking to follow oncology patients and, second, while note tracking, we took the first 20 notes that could be found for each diagnostic group (cancer/non-cancer).

Primary care trusts: two main boroughs were identified and were close to the hospital. Nearly half (48%) of patients were from borough E and 28% from borough H. Only one patient was from another area, while six patients’ data on this was missing.

Length of stay: nearly half (43%) of people were inpatients for more than 30 days but less than 60 days; 18% spent more than 60 days (two months) in hospital. Nine stayed for less than 30 days, while seven patients’ data on this was missing.

Length of planning process: where documented, the discharge planning process took more than 30 days for 51% of patients and more than 60 days for 21%. Seven case notes had missing data.

Outcome of requests for continuing care: more than half (55%) of patients had funding for care packages agreed at the first attempt, while 5% of funding decisions (affecting two patients) were deferred (the continuing care panel had requested further information on the patient), resulting in an additional delay of between 16 and 30 days for both patients.

More than one quarter (28%) of patients were refused continuing care funding on the first attempt, resulting in additional documented delays of under seven days for three patients, 31-60 days for two and more than 60 days for one.

Other delays could not be deduced from the remaining five case notes.

Proposed date of discharge to actual date of discharge: although these patients were flagged up by either the oncology multidisciplinary team or the trust discharge system as delayed, the proposed date of discharge was poorly recorded in patients’ notes, making it difficult to determine the difference between proposed date of discharge and actual date.

There is full documentation for 17 patients, of whom eight were discharged more than two weeks after the initial proposed date. Of these eight, three were discharged more than one month later. Our review also revealed seven out of 40 patients died while waiting for their preferred place of discharge to be offered and become available.

Total number of days from proposed date of discharge to panel date: the audit also looked at delays between the proposed date of discharge and the date on which the panel reviewed the patient information. Again, nearly half the data could not be found; there were significant delays of 16-30 days for 8% of patients and over a month for a further 8%.

Reasons for delay: individual patients had multiple reasons for delay. Of note, 28% experienced changes in their medical condition that affected planning. The most common reason for delay, however, was “waiting for care packages” to be set up. Some 40% of patients were waiting for continuing care packages and 25% for social care packages (Fig 1). Delays in getting equipment accounted for delays in 25% of cases.

Overview
The audit provided evidence that there are multiple reasons for delays in discharging patients with complex needs.

This group often have changes in their medical condition (28% of cases reviewed). It has not been possible to determine whether delays were detrimental to any patient’s physical condition, although it is likely that prolonged admission puts this group at increased risk of hospital acquired infections. The most common reasons for delayed discharge are securing care packages (65%) and obtaining equipment (25%).
We have provided evidence of:

- Poor documentation of discharge planning in patients’ notes;
- Delays in completing health needs assessment paperwork and getting applications to the panel;
- Only 55% of applications to continuing care panels were successful at the first attempt. We could not deduce whether the other applications were inappropriate or poorly prepared as no copies had been filed in the case notes. Some resubmissions were successful, presumably because either the patient's condition had changed or a more comprehensive report had helped to gain funding approval.

**ACTIONS AND RECOMMENDATIONS**

The palliative care team aims to carry out another audit a year from the initial audit; this is due to take place in September 2010.

The team has designed two discharge planning flow charts and disseminated these to all ward areas to guide staff involved in the safe and timely discharge of patients with complex needs and imminently dying patients. The trust is also developing a “discharge standard”, which will support the discharge pathway documentation launched in September 2009.

There is a need to improve understanding of the continuing care process, as the data analysis showed a lack of understanding of the continuing care criteria. Macleod (2006) stressed the importance of interprofessional discharge education and training.

McKenna et al (2000) identified the importance of a “named nurse” to aid an effective discharge planning process.

A designated named ward nurse should take an active role and ownership for their patients’ discharge, as supported by Atwal (2002), cited in Macleod (2006). This role is also ranked in the top 10 high impact areas to guide staff involved in the safe and timely discharge of patients with complex needs and imminently dying patients. The trust is also developing a “discharge standard”, which will support the discharge pathway documentation launched in September 2009.

All members of the multidisciplinary team need to understand the significance of the discharge coordinator’s role for patients with complex needs. Trusts need to clarify the purpose of this role for staff, as problems still need to be shared with the professionals involved in patients’ discharge (Lees and Holmes, 2005).

An estimated discharge date is essential to allow for advanced planning and coordinating of services between agencies (Baumann et al, 2007). Setting a proposed date will enable this standard to be audited as a service and quality improvement target.

Patients with potentially complex needs on discharge should be identified from as early as their first assessment on admission.

In the literature, there is much debate about the shortcomings of acute care in meeting the needs of those whose disease is progressing or who are dying (Willard and Luker, 2006). In addition, Baumann et al (2007) recognised that organisations rather than people were responsible for delays.

**Communication**

More effective communication between hospitals and community services is needed to ensure seamless discharge. Further evidence for better liaison between primary care and hospitals might lead to a reduction in the number of inappropriately delayed discharges (Vetter, 2003).

**REFERENCES**


Our findings suggest the discharge process could be improved by undertaking a more thorough multiagency assessment on admission, thereby initiating earlier discharge planning and referrals to the appropriate agencies/professionals.

The essential elements of discharge planning include effective communication, a multidisciplinary team approach and early coordination of patients’ assessment needs and home circumstances (Day et al, 2009).

 Undertaking this audit has resulted in cohesive working between the palliative care and primary care teams. Authorisation to order equipment for patients with complex discharge needs and packages of care has been speeded up.

**CONCLUSION**

The planning of complex discharges was often found to be uncoordinated and the evidence demonstrated a lack of cohesiveness between the services relevant for a safe and timely discharge.

As a result of this audit, there have been developments in training and workforce planning to introduce a discharge pathway to ensure a seamless discharge process. The trust has invested in the recruitment of discharge nurse specialists, including a designated nurse for complex discharges who coordinates the preferred place of care for patients at the end of life.

Work is ongoing in relation to the discharge pathway including the proposed discharge date. However, tracking applications made for funding continues to be difficult, as there is no designated part of patients’ notes where this can be found easily.