Nursing Practice

Review

Discharge planning

Discharge assessment for frail older people in acute care is complex and slow. A discharge framework can help nurses integrate discharge guidance into daily practice.

A framework to discharge frail older people

In this article...

▷ Current problems associated with discharge assessment
▷ New guidance on discharge of frail older people
▷ A framework to help implement best practice

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Abstract Lees-Deutsch L (2016) A framework to discharge frail older people. Nursing Times; 112: 37/38, 11-13. This article focuses on discharge planning for frail older patients who have had an unplanned admission to hospital and are subsequently discharged (or transferred) to another setting. It discusses current issues in discharge practice, briefly reviews the background policy to guide the discharge assessment of older people and examines challenges in discharging them from the acute setting. Finally, it uses an assessment framework to integrate current principles from national discharge guidance into practice.

This year the Parliamentary and Health Service Ombudsman (2016) published a damning report on problems experienced by older patients discharged from hospital. The case studies contained in the report included patients aged 80-93 years and factors relating to discharge problems included:

» Pressure on bed capacity;
» Failure to respond to patient and carer concerns;
» Inadequate assessment prior to discharge.

The main themes identified in the report were clinical and operational issues (outlined in Box 1).

The National Audit Office (NAO) (2016) highlighted similar issues in its wide-ranging report on patient discharge, which looked at the entire health and social care system.

Most of the key points identified by the NAO (2016) link with the National Institute for Health and Care Excellence (2015) guidance on the transition of older people from hospitals to other settings. The guidance explores overarching principles of discharge practice for patients, carers and staff across the entire care pathway from pre-admission to post-discharge. The pathway is broken down into:

» Before – pre-admission strategies for prevention of admission to hospital;
» During – strategies for actively reducing the length of patients’ hospital stay;
» After – strategies to support care after discharge (NICE, 2015; National Audit of Intermediate Care, 2014).

The assessment for transition of older people from acute care using NICE (2015) principles is inextricably linked to the acute admission and discharge process, and executing this effectively can improve discharge planning (Lees, 2016).

Defining discharge planning

Discharge planning is categorised by the National Library of Medicine (2015) as “Patient discharge: The administrative process of discharging the patient, live or dead from hospitals or other health facilities.”

However, new terms are gradually being used in policy guidance and academic literature that reflect new services and the context in which they are delivered (NICE, 2015; NAIC, 2014). In particular, ‘transfer of care’ is being widely adopted across areas where older people are

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Challenges in Acute Admissions

There has been an 18% increase in emergency admissions of older people between 2010-11 and 2014-15 (NAO, 2016). However, despite continued emphasis on transforming NHS services to transfer more people into the community there is no sign of abatement of emergency admissions. A plethora of recommendations for discharge practice have been developed over recent years, which are often embedded in 'specialist older persons guidance', the relevance of which takes time to filter down into clinical practice (Department of Health [DH], 2013; 2011; 2007). Guidance can prove challenging to implement in acute settings where it has to compete with many other guidelines for the care of older people (Cook et al, 2012).

Acute admission and assessment units can be highly pressurised environments for staff to assess frail older patients (Hoyle and Grant, 2015). These challenges are further intensified with pressures to transfer or discharge patients from acute care whose needs can be met outside of a hospital setting, thereby relieving pressure on hospital bed capacity (Groene et al, 2012). The challenges for nurses are:

- Recognising the potential problems that can occur in the transfer and discharge process;
- Incorporating the latest national guidance into practice;

Achieving this in the time constraints of the acute admission setting.

Reviewing Discharge in Acute Care

Discharge processes

It is important to understand your current discharge process and the underlying principles (Lees, 2010). The set of questions in Box 2 will help you to focus on what you need to do to revise your discharge documentation as necessary, and make small changes in practice, briefings or audit mechanisms.

Incorporating national guidance

National discharge guidance needs to be adapted to local circumstances if implementation of changes from policy is to be successful. It is impossible to introduce all recommendations for the initial discharge assessment of older people on admission to hospital. An intercollegiate document developed by a range of professional associations and organisations representing older people (Cook et al, 2012) signposts specific considerations as principles for managing the older person’s discharge assessment in acute care. It argues that:

- Planning should begin as soon as possible;
- Comprehensive Geriatric Assessment should be triggered to ensure older people’s needs are considered holistically over time;
- The appropriate multidisciplinary team members who are best placed to assess individual patients should be involved;
- A validated assessment tool should be used;
- Types of services needed out of hours to support discharge should be considered;
- Care management after discharge should be assessed.

The starting point is to explore the appropriate timings of any required assessments for each patient to ensure standards and targets are met; this is crucial to ensure staff are not overburdened with unnecessary workload (Hoyle and Grant, 2015). Box 3 summarises the common features of recent guidance to help you integrate them into all areas where frail older people are assessed.

Addressing Time Constraints

Time constraints necessitate a pragmatic approach to gathering discharge information about older people in acute care. To address this, I developed a discharge framework, which was piloted, audited and introduced into practice to enable the
focused assessment of an older person’s needs using the acronym ‘DISCHARGE’ (Lees, 2005).

The original aim of the DISCHARGE framework was to ensure a consistent, systematic approach to information gathering, to guide the need for admission, transfer to another care setting or discharge of patients to their own homes. The framework proved to be a positive addition to existing documentation and an evaluation of it suggested that doctors’ clerking improved significantly as a result of the organisation and standardisation of assessment (Lees, 2005).

In light of new policy guidance, the framework has been modified and is illustrated in Table 1. The main intention is that the framework will enable and encourage early discussions about discharge plans and information-seeking/sharing beyond the initial acute assessment. It is not intended to replace comprehensive individual assessments, rather it is intended to promote best practice principles and identify older people’s needs triggering further assessment where appropriate.

**Conclusion**

The problems with discharge practice cannot be fixed overnight, but using NICE (2015) guidance to identify problems and make small achievable changes to address problems is a good starting point. As with any change it is important to view discharge policies in the context of organisational constraints (Lees, 2016). As their patients’ advocate, nurses have a pivotal role in assessing the needs of older people, and the modified DISCHARGE framework provides a focus based on NICE (2015) best-practice principles. As a minimum standard, discharge planning should incorporate the principles of information gathering, good communication and patient involvement in their discharge.

<table>
<thead>
<tr>
<th>The Framework: DISCHARGE</th>
<th>The prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestics</td>
<td>Who does the meals, laundry, shopping, housework? Are they currently coping?</td>
</tr>
<tr>
<td>Independence</td>
<td>Who do they live with? How are they coping? Are problems anticipated on discharge or transfer?</td>
</tr>
<tr>
<td>Services and support</td>
<td>Do they receive any services or informal support? How many visits – days and times of the week? Document current care, does it meet their needs? Are there any services to reinstate for after discharge?</td>
</tr>
<tr>
<td>Cognition</td>
<td>Are there any pre-existing issues regarding cognition? Ask age, date of birth, place and year (Abbreviated Mental Test). Are any issues identified?</td>
</tr>
<tr>
<td>Housing</td>
<td>Type of housing, access – any difficulties with heating or state of repair? Where do they sleep? Is the housing suitable for immediate return?</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>Eating and drinking (meal preparation, appetite). Washing and dressing – is assistance required? Mobility – how far can they walk aided or unaided? Are there problems with elimination? List the needs identified</td>
</tr>
<tr>
<td>Risk factors identified</td>
<td>For example, falls, live alone, change of medications, eyesight and hearing, cognition</td>
</tr>
<tr>
<td>Goals</td>
<td>Are they aiming to return home? From the patient’s perspective what do they prefer? Is this realistic?</td>
</tr>
<tr>
<td>End point anticipated</td>
<td>Is this the patient’s own home or do they need alternative accommodation? Why?</td>
</tr>
<tr>
<td>Social worker</td>
<td>Do they have a social worker? Provide contact details. Who is their KEY contact person coordinating the discharge?</td>
</tr>
<tr>
<td>Summary of information gathered</td>
<td>Who have you shared this information with?</td>
</tr>
<tr>
<td>Summary of information shared/handed over</td>
<td>Who have you shared this information with?</td>
</tr>
<tr>
<td>Actions or referrals triggered should be documented.</td>
<td></td>
</tr>
</tbody>
</table>

Source: adapted from Lees (2015)

**References**


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- Bit.ly/NTHCATransfer