

In this article...

- How pressures in healthcare are changing discharge processes
- Definitions of nurse-led and criteria-led patient discharge from hospital
- Debate and misconceptions around the two approaches to patient discharge

Dispelling myths around nurse-led and criteria-led discharge

Talking points

The terms 'nurse-led discharge' and 'criteria-led discharge' are often used synonymously

Criteria-led discharge can be undertaken by different health professionals using clinical criteria to inform their decisions

Nurses' role in patient discharge is pivotal, but not all discharges are nurse-led or recognised as such

Criteria-led and nurse-led discharge are both valid approaches if patient safety is at their core

Discharge could ultimately be patient-led and facilitated by all members of the multidisciplinary team

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Abstract In the current context of healthcare delivery, pressures on bed capacity and the development of services are driving changes to patient discharge from hospital. There has recently been an emphasis on criteria-led discharge, which seems to be often confused with nurse-led discharge, while nurse-led discharge is still considered by some as conflicting with doctor-led discharge. These misconceptions are explored by the authors of this article, who conclude that both nurse-led and criteria-led discharge are valid approaches to improving the discharge process as long as patient safety remains paramount.

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Criteria-led discharge is undergoing a resurgence in England, stimulated by NHS Improvement's (NHSI) criteria-led discharge collaborative (NHSI, 2017). Recent developments, as well as events organised by the collaborative, suggest that there are widespread myths or misconceptions concerning criteria-led and nurse-led discharge, which can be summed up as follows:

- Myth 1: nurse-led and criteria-led discharge are the same thing;
- Myth 2: it is what nurses already do;
- Myth 3: in nurse-led discharge, nurses assume the role usually undertaken by doctors;
- Myth 4: all clinical areas should adopt criteria-led discharge;
- Myth 5: criteria-led and nurse-led discharge are advanced practice roles;
- Myth 6: criteria-led and nurse-led discharge are only suitable for simple discharges.

With the benefit of knowledge from a recent systematic literature review (Lees-Deutsch and Robinson, 2018, review

pending) and the authors' combined expertise on the topic, this article explores these misconceptions (Lees, 2012; Lees and Field, 2011; Lees, 2007; Department of Health, 2004; Lees, 2004).

Definitions

Criteria-led (Marshall and Chung, 1999) and nurse-led discharge (Lees, 2004) are far from being new concepts, but the way these terms are currently used suggests that nurse-led discharge has undergone a metamorphosis and become criteria-led discharge – perhaps in response to bed pressures and workforce changes in the NHS. Despite small yet fundamental differences, the two terms are often used synonymously and, depending on the clinical context, sometimes referred to collectively (Webster et al, 2011). Definitions are provided in Box 1 and 2.

Myth 1: they are the same thing

Nurse-led and criteria-led discharge are not the same thing. In nurse-led discharge, nurses lead the whole discharge process,

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potentially using clinical criteria (Lees, 2004). In criteria-led discharge, a range of registered health professionals undertake discharge using clinical criteria to guide it (Agency for Clinical Innovation (ACI), 2016).

The use of clinical criteria can appropriately inform the patient's clinical optimisation in readiness for discharge – but this represents only one aspect of patient care. Discharge criteria are often developed from clinical guidelines for specific conditions or patient groups (Cundy et al, 2017; Bowen et al, 2014; Kasthuri et al, 2007). They may be sufficiently specific to indicate daily goals for the patient's recovery (Webster et al, 2011). By comparison, nurses are accountable for delivering holistic care that contributes to effective patient discharge, which extends well beyond the use of clinical criteria in isolation (Lees, 2012).

Clinical criteria are predominantly, but not exclusively, used for discharge from surgical settings (Bowen et al, 2014, Lawton, 2012), where patients are typically selected on admission according to their suitability for a treatment pathway. In criteria-led discharge, the patient's suitability for discharge is measured against clinical parameters to ensure safe discharge (Cundy et al, 2017; ACI, 2016; Webster et al, 2011). The important aspect here is that the health professional executing the patient's discharge has the competence to do so, regardless of who they are (Lees, 2007; 2012).

Criteria-led discharge therefore differs from nurse-led discharge because it is predominantly concerned with clinical stability and because a range of registered health professionals may undertake it.

Myth 2: it is what nurses already do

It was recently remarked, at a conference, that nurses already take responsibility for leading patient discharge from hospital and that nurse-led discharge was a misnomer. Is this really the case?

It is true that nurses' role in safely discharging patients is pivotal. Nurses have "the most consistent presence" in preparing patients for discharge (Nosbusch et al, 2010). From the moment of professional registration, they can facilitate the discharge of medically stable patients deemed 'fit for discharge'. They co-ordinate referrals to allied health professionals, discharge teams, intermediate care for example. They often trigger referrals for social care assessments from – or even before – the point of medical stability. They receive updates, oversee the patient's progress and adjust the discharge plan

Box 1 Definition of nurse-led discharge

Nurse-led discharge has been defined as including several or all of the following elements (Lees, 2004):

- Nurses providing ongoing patient assessment to inform timely and appropriate discharge
- Nurses chasing the results of clinical investigations that are needed to decide whether to proceed with discharge
- Nurses making the relevant discharge decisions in collaboration with the patient's family and multidisciplinary team
- Nurses initiating and leading the discharge process in collaboration with all other relevant professionals, with the aim of expediting discharges and helping manage bed capacity across the hospital
- Nurses leading the whole discharge process according to decisions they make using criteria, protocols or a given set of principles.

This definition places the emphasis on specific skills that nurses possess as part of their professional competences.

Box 2 Definition of criteria-led discharge

Criteria-led discharge can be described as "a process where the clinical parameters for a patient's discharge are clearly defined".

These parameters:

- Are determined in accordance with a care pathway, a condition-specific protocol or a bespoke clinical care plan
- Must be agreed between the consultant leading the care and the multidisciplinary team
- May be standardised for particular procedures or conditions, but must always be adapted to provide person-centred discharge
- Should allow patients to be actively involved in the process.

Once the criteria have been met, discharge can be facilitated by a competent member of staff (Lees-Deutsch and Robinson, 2017).

Criteria-led discharge is therefore an approach to patient discharge that can be used by a range of professionals.

Source: Lees-Deutsch and Robinson, 2017

according to changes occurring during the patient's stay in hospital. On the day, the discharging nurse ensures that all arrangements are in place and that all clinical/social parameters are adequately satisfied before the patient leaves the ward. Depending on the clinical environment, nurses also make significant clinical decisions about elements of acute care such as monitoring vital signs and titrating oxygen and intravenous fluids.

However, this is not, on its own, evidence that nurse-led discharge is routinely taking place. Indeed, this is where confusion and contention can set in. Ambiguity arises if the discharge process is already predominantly nurse-led, but not yet formalised as such through agreed protocols, procedures or policies. Some nurses explain that the level of trust placed in them varies according to how well they know the medical team on duty. Moreover, tacit knowledge on who to approach and how to get things done makes an essential difference to whether an action is nurse-led or not (Lees-Deutsch et al, 2016).

Consequently, nurse-led discharge may take place some of the time, albeit on an ad hoc rather than systematic basis, which leads to variation in practice. Nurse-led discharge is most recognisable as part of a discharge process that is clearly and consistently directed. This also supports safe practice (Bowen, 2014). Clearly, the context of care delivery determines the level of complexity of patient discharges, the process adopted for discharges, and to what extent they are nurse-led.

Myth 3: nurses assume the role of doctors

In nurse-led discharge, nurses do not assume the role of doctors. The adjective 'nurse-led' does not refer to some role substitution, but formalises the fact that decision-making is in the hands of nurses.

Nurse-led discharge does not operate in the absence of medical decision-making, as nurses predominantly work in an interdisciplinary team. Increasingly, discharge is multifaceted and sometimes multi-organisational and multiprofessional, especially with new models of care where therapists often lead discharge after medical stability has been determined. The traditional role of doctors is changing, as are other roles, including that of nurses, and the debate on 'nurse-led' versus 'doctor-led' should now be considered a thing of the past.

Nonetheless, the tradition of looking to a doctor for confirmation that a patient is

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'fit for discharge' implies a desire that doctors will continue to be involved in decision-making up until discharge. This is underpinned by the need of all to be reassured that discharge is timely and safe (Maher, 2014). Moreover, communications at the point of discharge may require specific medical advice to be conveyed to community teams, and that medical advice is best conveyed by a doctor.

Therefore, key aspects of a safe discharge may require a doctor's input, right up until the point of transfer of care. Doctors will focus on medical stability and accept that other areas such as wound management and home support are, as they have always been, the responsibility of nurses or other members of the multi-disciplinary team.

Essentially, clinical-decision making by more than one discipline in parallel is often required around the time of discharge. This is especially the case for patients admitted as an emergency whose stay in acute care may be very short (Gotz et al, 2014). Nurses will have their specific nursing responsibilities, but also a role in coordinating all decision-making and tasks agreed by the multidisciplinary team. This will ensure safe transfer of care and transparency of the discharge process.

Myth 4: all areas should adopt criteria-led discharge

It is not necessarily appropriate for all clinical areas to use criteria-led discharge. A thorough understanding of the issues that might arise in a particular setting is essential before introducing criteria-led discharge (Lees and Field, 2011) – improvements to the existing discharge process should be considered first. For example, one common reason discharge may be delayed is that the patient or relatives have to wait for medication to take home: to circumvent this, nurses may, where possible, introduce patient group directions (Ward et al, 2010). Implementing discharge criteria may require changes in practice, and new care pathways may need to be introduced to take account of these changes (Lawton, 2012).

Whether to introduce criteria-led discharge will depend on the complexity of patient cases and the type of service. In areas where patients often present as an emergency and have a relatively short length of stay, such as acute medicine or surgery, medical reviews may take place up to the point of discharge (see myth 3). In services where patients often transition to another care setting before full recovery, such as rehabilitation (Nosbusch et al, 2010), discharge will involve many health



Patient-centred care has the patient at the centre

professionals in addition to the team that determines the discharge criteria.

To introduce criteria-led discharge, a case-by-case approach, taking account of the context of each service may be more appropriate than a mandated or prescriptive top-down management approach. The most pragmatic approach is to map the existing discharge process with the team and determine the objectives of the service; an overall policy supporting governance and safe practice will always be needed (Lees-Deutsch and Robinson, 2018, review pending).

Myth 5: they are advanced practice roles

It was recently stated by a nurse in a conference workshop that nurse-led discharge must surely be an advanced practice role. If this was the case, the NHS would have introduced advanced practice roles dedicated to patient discharge, and it has not.

Nurse-led and criteria-led discharge are not routinely the preserve of advanced roles. However, some elements of the discharge process, such as the prescription of medication, are part of advanced practice.

The eclectic literature on nurse-led discharge, spanning some 15 years, does not mention advanced practice as a prerequisite for nurses to participate in nurse-led discharge. It indicates that some specialist areas, such as respiratory services, may employ specialist nurses with advanced skills whose role is to initiate care pathways, deliver care, discharge patients and follow them up (Cope et

Nurse-led and criteria-led discharge both have a place in modern healthcare

al, 2015; Mansbach et al, 2015). But these are nurse-led services encompassing clinical care reaching well beyond the parameters of criteria-led discharge.

Nurse-led or criteria-led discharge may provide a route into advanced practice for nurses or other health professionals (Lees-Deutsch et al, 2016). Making them an integral part of a nurse's role may even help recruit and retain nurses keen to embrace new responsibilities (Lees, 2012). Nevertheless, this is not described in the literature as advanced roles (Lees-Deutsch and Robinson, 2017).

How nurse-led or criteria-led discharge are introduced and whether they include elements of advanced practice entirely depends on the clinical context, the type of patients, the workforce and the service's objectives (Webster et al, 2011).

Myth 6: they are only suitable for simple discharges

The evidence suggests that it is possible to use nurse-led or criteria-led discharge both for simple and more complex discharges (Mansbach et al, 2015; Lees, 2012; Kasthuri et al, 2007; Lees, 2007). Simple discharges will only require relatively simple clinical criteria, especially if the patient is returning home and there are no changes in social circumstances. Simple

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discharges lend themselves well to a criteria-led approach because care follows recognised pathways that are usually non-divergent (Lees and Field, 2011). One area where simple discharges are the norm is day surgery (Lawton, 2012; Gibbens, 2010).

The number of discharge types is increasing in line with new pathways (National Institute for Health and Care Excellence [NICE], 2015). Discharge to intermediate care, for example, is provided for patients who need short-term rehabilitation. It is neither simple nor complex, and using criteria for the patient's clinical management plan in such situations could be entirely appropriate. In comparison, in complex discharges, there are many elements to consider beyond clinical ones, such as rehousing, care packages or continuing nursing care to support the patient at home (NICE, 2015). Nonetheless, despite the complexities, these patients may have elements of care that are simple to deliver.

NICE (2015) advocates that every patient with social care needs discharged from hospital has a named discharge coordinator (the person responsible for leading the patients discharge plan). Discharge may be led by different practitioners at different stages of the patient's clinical and rehabilitative recovery.

Complexity is brought about by the fact that patients may have a range of clinical, social and psychological needs, so their discharge requires continued assessment and professional judgement. This takes criteria-led or nurse-led discharge beyond a simple process to a stepped approach that addresses all the patient's needs, bridging the gap between simple and complex discharge.

Further considerations

It is not easy to perfectly delineate nurse-led and criteria-led discharge. They both have a place in modern healthcare, where new services, shorter lengths of hospital stay and pressures on bed capacity are driving changes to patient discharge as well as to the roles of nurses, doctors and the wider healthcare team.

The use of clinical criteria can appropriately inform the patient's clinical optimisation in readiness for discharge, and provide transparency on the goals, but criteria alone do not make discharge happen. Nurse-led discharge has a place, but the adjective 'nurse-led' narrows it to one professional group. Formalising discharge practices in which the wider team is involved, to include for example therapists, may better align with future service developments and the evolving future workforce.

Box 3. Implications for practice

Criteria-led and nurse-led discharge has the potential to address some time lags in the traditional discharge process and reducing length of stay for patients.

Evidence suggests that where implemented they can also improve the continuity of patient care – and improve patient satisfaction – with the discharge process.

Criteria for discharge can help make practice transparent between professionals caring for the patient.

The criteria (or protocol) provide a mechanism to document goals achieved (or not achieved) and improve the safety of patient discharge.

Advanced practitioners and advanced aspects of practice may have a role in patient discharge depending on a service's requirements. While some aspects of patient discharge, such as prescribing, are part of advanced practice, it is not in itself an advanced role. Formalising nurse-led and criteria-led discharge practices would advance nursing and empower nurses. It could also contribute to retaining nurses if discharge was to be recognised as part of nurses' personal or professional development.

Regardless of the approach used, nurse-led and criteria-led discharge are both ways of supporting the discharge process to improve practice, organisation, efficiency, patient safety and overall satisfaction of both patients and staff. The implication for practice is that health professionals should be empowered to know how and where to start developments leading to criteria-led discharge, with patient safety at the core of their endeavour. The issue of real concern is the clarity of the clinical parameters needed to undertake patient discharge safely and in a timely manner. Clear and consistent direction is needed on this.

The misconceptions examined in this article are part of ongoing debate, which could be hindering or conducive to positive developments in patient discharge depending on how you view the subject. Perhaps the elephant in the room is that discharge should ultimately be patient-led, and agreed with and facilitated by all members of the multidisciplinary team. Implications for practice are outlined in Box 3. **NT**

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