

Preventing Delay in the Patient Discharge Process: an Emphasis on the Nursing Role

by

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Abstract

Planning for a patient's post discharge care does not begin on the day when decision is made to release the patient from the hospital. It is generally accepted that discharge planning should start prior to admission (for planned admission) or at the time of admission (for unplanned admission). A combination of individual factors such as age and medical factors such as multiple health conditions, and organizational factors, such as a lack of alternative forms of care put patients at risk for delayed discharge or inadequate discharge planning. The lack of nursing participation also contributes to a delay in the discharge process. The role of nurses in discharge planning is the focus of this paper, which includes strategies to improve participation and the importance of involving patients and their home carers in decision making.

Keywords: Discharge planning, delayed hospital discharge, nursing role in discharge planning, Patient and Family involvement in discharge planning, nursing in Pakistan.

Introduction

The process of discharge planning often resembles the construction of a jigsaw puzzle: available pieces are placed carefully in relation to other pieces so that together they contribute to the whole picture. The challenge of discharge planning, like that of completing a puzzle, is to find missing pieces that are just the right size and shape and then place them securely in the right position. A clear idea of the finished picture or outcome improves the effectiveness of the discharge planning process.

Issue Identification:

There are various clinical issues which cause adverse effects for the patient either economically or psychologically. For instance; a delay in the discharge process, unnecessary laboratory investigations, and the need for complex procedures and assessments for procedures such as ascite tapping, lumbar puncture, maintaining intravenous canulation, and foley catheterization can all impact on the discharge planning process.

The issue highlighted in this paper is a very common problem and is worthy of immediate action. In Pakistan, patients who are physically and medically fit to go home are often kept waiting to begin the discharge process. In a few instances, the waiting time is so long that it extends into the late evening, which not only cause physical and psychological hardship for the patient but for their family as well. As Chatterjee (2004) stated “Patients do not want to hang around in hospital when they are well enough to leave.” Delays in discharge

planning not only adds additional risks for secondary health issues and increases health care costs. For instance, if the average length of stay for obstetrical gynecological patients is 3.5 days, then 2 patients should be admitted in a week. However due to a delay in the discharge process, the average length of stay may increase from 3.5 days to 4 days which results in 2 admissions in 8 days causing a revenue loss of 1 day per week. Data from the admission department of Aga Khan University Hospital (AKUH), Karachi, Pakistan, reveals that on average, 45% to 50% patients were admitted in a timely manner, however, the remaining 50% had to wait as long as 4~5 hours in the emergency department (for emergency admissions) or by the admission department (for elective patients).

The discharge data from the general Gastroenterology ward in 2005 reveals that on average only 25% patients were discharged before 1600 hrs (Table-1). This shows that there is a critical need to improve the discharge process to increase patient satisfaction and health outcomes.

Descriptions	Jul	Aug	Sep	Oct	Nov	Dec
Discharges before 1600 hrs	22%	15.40%	22%	31.10%	26.95%	25.67%

Table- 1 (Admission department of AKUH Karachi Discharge Data for 2005)

Discharge Planning

According to Erwin (2001), “Discharge planning - a centralized, coordinated, multidisciplinary process that ensures the client has a plan

for continuing care after leaving the hospital. It prepares the patient and family for transition from the health care setting to another which includes assessing patient needs at discharge, making arrangements and referrals for follow up care and coordinating the various professional and volunteer services. It needs to be initiated on admission to the hospital and then continues as an ongoing process throughout the hospital stay.” Good discharge planning involves the patient from the beginning, using his strengths, providing resources to meet his limitations, and is focused in improving outcomes on the patient’s life. Driscoll (2000) stated that discharge planning is a process where patients’ needs are identified and a plan formed for a smooth transfer from one environment to another.

Most modern definitions of discharge planning include the notion of helping patients through transitions from one level of care to another. It is not focused on moving the patients out of the hospital, rather on helping them progress through a number of levels of care. The discharge planning process facilitates successful transitions, such as: from intensive care to intermediate care; a surgical unit to a rehabilitation program, or from home care to a hospice unit. According to Rorden and Taft (1990), Discharge planning is NOT just:

- Limited to concern about the physical transfer of the patient.
- Focused only on the physical care needs of the patient.
- An activity that is done to or for the patient without his active involvement.
- The responsibility of a discharge planning specialist alone.

However, Discharge planning; IS a process that:

- Begins with early assessment of anticipated patient care needs.
- Includes concern for the patient's total well being.
- Involves patient, family and caregivers in dynamic, interactive communication as planning processes.
- Prioritizes collaboration and coordination among all involved health care professionals.
- Results in mutually agreed upon decisions about the most economic and appropriate options for continuing care.
- Is based on thorough, update knowledge of available continuing care resources.

Although the process is complex, the basic concept is straight forward:
discharge planning helps patients progress towards optimal health.

Another intriguing definition describes discharge planning as the “vehicle which moves the patient to the proper level of care” (Rorden & Taft, 1990).

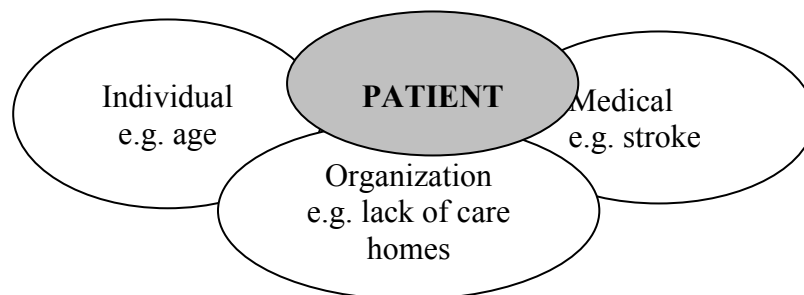
According to Procter et al; (2001), Unsuccessful discharge can be defined as unplanned readmission within six weeks of discharge. Forster et al; 2004 reported that a quarter of medical patients (19%-23%) experienced an adverse event within one month of their hospital discharge. Atwal (2002) found that 37% of patients who were discharged home from an acute setting had one or more unmet need one week after discharge.

Factors Associated with a Delayed Discharge

Recent researches have tended to highlight contributing factors towards delaying of discharge process. According to Black and Pearson (2002), the three important factors those are likely to cause delay in discharge process:

- (i) Individual factors
- (ii) Medical factors
- (iii) Organizational factors.

Figure-2 Black and Pearson (2002)



Individual factors

Individual factors associated with a delay in discharge process are diverse including; personal choice, age, emotional disposition and personal support from family and friends. Recent Australian research (Laughlin & Colwell, 2002) showed that the average length of stay was four times greater for people aged 65 years old and over with dementia compared to all other people. Black and Pearson (2002) conducted a study in Scotland that suggested that 1.3% of patients aged 65 to 69 experienced delays compared with 9.5% of those aged 90 years old and over.

Wells et al; (2002) stated that the data from Canadian Institution for Health information (CIHI) (2000) indicates that the average length of

hospital stay in Canada dropped by more than 5% between 1994-95 and 1997-98, from 7.4 days to 7 days. Elderly patients were the target of approaches aimed at earlier discharge, because they were the highest users of hospital services (34.7% of all hospitalizations in 1997-98) and because their length of stay were nearly double to those of patients in other age groups (10.5 days vs. 5.4 days)

Medical factors

Along with individual factors, medical factor also contribute toward delays in the discharge process. In Sweden (Black & Pearson, 2002) a study of people aged 64 years old and over suggested that this group of population was more likely to experience new medical problems requiring treatment after they had already been slated for discharge, thus further exacerbating and complicating their discharge from hospital. The rate of delayed discharge was strongly associated with diagnosis. In terms of broad groups of diagnosis, the rate was highest among those diagnosed with nervous system disorders and circulatory disorders and mental disorders. A Canadian prospective observational cohort study of 130 patients who had undergone an elective thoracic surgical procedure found that the three most frequent medical complications that prevented discharge were persistent air leaks, pulmonary infections and atrial fibrillation. (Anthony & Barr, 2004)

Organizational factors

Often the patient's clinical condition is not the cause of discharge delays: but rather, organizational management of health care services play a

greater role . The literature highlights a small number of studies that suggest, for example, that how a patient is registered influences discharge planning. Whether people are labeled as an emergency or elective admission or if they are a planned short stay admission or a long stay admission, may influence whether or not people are likely to have a delayed discharge. It has been found that people who were admitted to hospital as an emergency admission experienced greater delays than those with elective admissions.

Black and Pearson (2002), conducted a retrospective cohort study of 2232 people admitted for acute stroke in 13 hospitals in Canada and found that the majority of stroke patients remained in hospital after meeting criteria for medical discharge and that the main reason for this was lack of alternative care including nursing facilities and rehabilitation centres. Organizational factors associated with delay included a lack of home support and the unavailability of convalescent, nursing or rehabilitation facilities. Thus a combination of individual, medical and organizational factors interacts to put patients at risk of delayed discharge.

Lack of Nurse Participation

A lack of nurse participation in hospital discharge planning also contributes towards delaying of discharge process. There are a number of reasons why nurses in Pakistan and elsewhere, are reluctant to participate in discharge planning. The major factor is the perception that discharge planning involves a whole new set of activities that will necessarily require a time commitment. Nurses are realistically concerned about taking time away from

immediate nursing care needs. Discharge planning means becoming aware of long term needs, taking the opportunity to teach and to help family members understand what needs to be done after discharge, and communicating effectively with other caregivers. Certain aspects of coordination and implementing a discharge plan take considerable time. According to Rorden and Taft (1990), nurses are sometimes reluctant to get involved in the discharge planning process because it is wrongly perceived that they are responsible for all discharge planning activities. The person with this kind of attitude mentally concedes: "let the experts do it!" as a result of perceiving discharge planning as a process that is not a part of nursing care. According to Atwal, (2002) nurses were often reluctant to voice their opinions even if it was a "matter of life or death." Elizabeth and Annette (2001) stated that nurses often found it difficult to present relevant patient issues during medical rounds. Furthermore, nurses rarely introduced new problem in to the discussion.

Anthony and Hudson (1998) found that heavy work load, multiple demands, limited time to coordinate care, less teaching time, decreased patient involvement, and lower patient satisfaction were some factors that contributed to inadequate discharge planning. The descriptive cross-sectional study conducted by Lalani and Gulzar (2001) at the Aga Khan University hospital assessed nurses' knowledge, perceptions and actual practice related to patient discharge planning. Two questionnaires were used with a convenience sample of 15 nurses and 15 patients from four medical-surgical units. Fifteen patients' records were also studied. Analysis of the findings revealed that nurses

lacked knowledge regarding discharge planning which also had an impact on their current discharge planning practices.

Another qualitative exploratory study done by Watts and Gardner (2005), to explore nurses' perceptions of discharge planning. The findings revealed that some nurses do not understand the discharge planning process. One nurse believed that she had total control of the discharge planning while another believed it requires a team approach. Communication between nurses and other members of medical team were portrayed as impromptu and were not well documented. The majority of nurses did not embrace the concept of having a designated nurse fully responsible for discharge planning. In summary, some of the factors that discourage nurses to participate in discharge planning included increased work load, concerns about time, failure to recognize the discharge planning needs of patients, willingness to leave the responsibility to others and lack of nursing knowledge about discharge planning process.

Strategies to Overcome the Issue

Atwal (2002) stated that patient discharge is a key component of the nursing role. Rudd and Smith (2002) also asserted that nurses should take the lead in coordination of discharge planning. There are no legal or professional reasons hindering nurses from taking increased responsibility for the discharge process, including the decision about when to discharge a patient. Mckenna et al (2000) stated that the concept of a designated or primary nurse works well for the patient in the discharge planning process, and that the

practitioner can act as a focal point for providing information to the patient.

According to Rorden and Taft (1990), “When patient leave acute care, it is changes in nursing services that affect them the most. Acute care nurses constantly assess the impact their care has in the patients’ well being and can most easily anticipate what kind they will need in the future.” Carol and Dowling (2007) cited that discharge planning is a critical nursing intervention aimed at the prevention of post-discharge problems.

Nurses Participation

The roles assumed by nurses in meeting the changing needs of patients vary from basic communication to intense involvement in the coordination of services. Roles may blend and overlap according to patient needs and the nurses’ skills and resources. In noting daily responses to care and treatment, the nurse has a broad view about the continuity of patient care. If the patient has progressed slowly and not motivated to assume self care, the nurse can foresee that continued encouragement and care will be needed at home. If a patient has supportive family members who are willing and able to give continued care, the nurse will be able to anticipate that nursing home placement for dependent or elderly patients is not the only option. A nurse is able to do this kind of assessment of continuing care needs due to ongoing relationships with patients and their families, frequent communication with them and observation of their social support system. Rorden and Taft (1990) stated that nursing care plans should be initiated upon admission and include care for the entire hospital stay, including discharge planning. Attention to discharge planning is not

something that is separate from what the nurse usually does, rather it is an expansion of the nurse's view to include balanced and comprehensive care.

Teaching is an important nursing role that is just becoming considered important in Pakistan. If care is to be taken over by the patient or by a family member, teaching is an essential part of any successful discharge.

Established communication with the patient allows the nurse to teach effectively. It also allows nurse to know when the patient is ready to change levels of care. According to Erwin (2001), "Materials are sent home with the patient, but that doesn't mean they are read or understood." The patients and their families must be coached on how to do various procedures, how to organize and coordinate ongoing care and how to identify and respond to complications or set backs in recovery.

According to Rorden and Taft (1990), the aim of nursing intervention is to give patients and families the knowledge, attitudes and skills necessary for implementation of the discharge plan. Teaching related to continuing care is often left until shortly before a patient's discharge. Such teaching is uniformly ineffective for two basic reasons. One is that the patient's attention span and concentration ability will be limited because of natural anxiety about upcoming transition in care. Another reason is that teaching done under the pressure of a deadline is seldom well presented and may sound like a tape recording played on fast forward.

It is essential to understand how nurses actually implement their discharge planning responsibilities amid the competing priorities of clinical area. The qualitative study conducted by Foust (2007) to examine nurses' efforts in

hospitalization. This study was conducted in 32 bed surgical unit of a large academic medical center over an eleven month period. Eight nurses were observed and interviewed as they cared for selected patients. Major findings indicated that the nurses spent a significant amount of undocumented time assessing and preparing patients to go home. However, the nurses did not communicate the scope of their teaching and assessment to others on the team. The inclusion of discharge planning activities in daily care notes and shift reports would improve documentation and emphasize the importance of the nursing role in coordinating care, including ongoing discharge planning.

Mckenna et al; (2000) suggested that nurses have failed to improve communication and documentation in discharge planning despite the publication of research by Skeet (1975) identifying similar problems. Likewise, Payne et al (2000), found that nurses did not regard paper work as being as important as direct patient care. As Bull and Roberts (2001) argued, communication whether verbal or written, is viewed as one of the main components of a proper hospital discharge. They noticed that when nurses' completed the documentation on the discharge check list, they limited it to action items only such as 'home adaptation requested' and 'referral sent to district nurse'. Other information, such as the patient's functional status, environment status, social support and preferences were not documented in the discharge plan check list, even though the whole health care team considered this information vital to a proper discharge.

Social aspects of the discharge process are often ignored or neglected. A qualitative case study carried out by Atwal (2002), described 19 nurses who were interviewed using a critical incident approach. The interviews showed that a social history was not collected on admission. It was not regarded as an important factor that needed to be communicated at either the nursing handover or multidisciplinary team meeting. While being interviewed, one of the staff orthopedics nurses said, "I don't think that the full social history is given until the day before the patient is discharged." According to Atwal (2002), it is imperative throughout the discharge process that the social diagnosis is considered as important as the medical diagnosis. According to a suggestion made by Chatterjee (2004), all senior nurses should be put in charge of simple discharges where people are going home or have minimal care needs. Such cases make up to 80% of all discharges. Chatterjee (2004) cited Pat Johnson, matron of the Trauma and Orthopedic ward at East Kent hospital where 10 nurses, have been trained to autonomously discharge patients. Nurses at the hospital supervised five discharges before being declared competent enough to take over the discharge role. Over a six month period, out of 61 patients discharged by nurses, none were re-admitted. Nurse - facilitated discharge involves assessing the patient, liaising with the multidisciplinary team, planning timely discharge based in an agreed plan of care, writing discharge notes, teaching and advising patients and their carers.

Patient and Family involvement

Sensitive understanding of the patient as a person is an important quality for health care professionals in order to help patients and their families with continuing care decisions. Communication skills are at the centre of the nurses' contribution to discharge planning. The nurse gathers information about both facts and feelings, organizes them into an assessment of patient needs, and communicates these needs to professional colleagues. Improving communication skills will allow the nurse to teach, to guide patients towards decision making, and to coordinate patient care more effectively. According to Bull and Roberts (2001), three types of communication gaps have been identified:

- Between health care providers within the hospital and those involved in the hospital community interface.
- Between providers and patients
- Between providers and family caregivers for elders.

The communication gap among health care professionals revealed problems with timely receipt of information. Studies about the timing and receipt of information by community nursing staff showed deficiencies in information related to diagnosis, prognosis, self care ability and services initiated. Bull and Roberts (2001) also identified gaps in communication between health care providers and patients. For instance, elders who were hospitalized on acute care wards reported that they were not routinely asked about their home situation or how they would cope after they left the hospital. Breakdowns in communication often resulted in unmet needs of elders and their

family caregivers following hospitalization. Despite the diversity of methods, the consistent findings across studies indicated that elderly people were given little information about their medication and condition, they had difficulty managing special diets and they often were unclear about what activities they could engage in or activities that they should avoid post-discharge (Bull & Kane, 1996). According to Olsen and Wagner (2000), effective communication between patients and health care professionals is essential for successful discharge planning and is based on open dialogue where a common vision is shared.

Gaps in communication between providers and family caregivers for elders focused on a lack of family involvement, insufficient information provided to family members and limited preparation for home-based care giving. Across the studies analyzed, family carers consistently expressed a need for information about the elders' condition, medication, diet and any signs of potential complications. This lack of communication between providers and family care givers often results in subsequent hospital re-admissions.

The reason for this lack of communication may be the result of poor training of therapeutic communication skills in undergraduate health professional education. According to Atwal (2002), while in clinical education experiences, students should be enabled to put theory into practice and hence become competent discharge planners prior to starting practice. According to Leason (2003), delayed discharge is not only a problem of beds, budgets and statistics, but fundamentally involves people who become well enough to leave

the hospital but can not, and are relatively powerless to do much about it.

Busby and Gilchrist (1992) have reported that patients may have difficulties in understanding ward round discussions because of an inability to hear, or to actively take part, as the team talks around them.

Helping patients to learn about themselves, their care and what to expect post-discharge is part of nursing care, including the discharge planning process. Complexity becomes a factor when patient or family members need to learn special knowledge or skills that will allow them to take over responsibility for continuing care. According to Rorden and Taft (1990), including the patient and family as partners in gathering information and assessing needs is the first step toward making them full members of the continuing care team. Saunders (1995) confirms that patient participation is an active process, as he advocated that it involves patients performing clinical or daily living skills, or partaking in the decision making process from the time of admission till discharge. Hence, it is the patient's right and responsibility to make decisions about their continuing health care.

According to Bull and Roberts (2001), nurses need to discuss ongoing care and discharge planning with the patient early and all through the process. If the patient agrees, then you carry on. If the patient does not agree then you may need to give more explanation of why the patient might need physical therapy or other services. Nurses need to try to help patients to see why it is important and engage in open communication and discussion with the patient and family right from the beginning about options and preferences. It is

important to not tell the patient that this is what we have planned for you in a paternalistic fashion. The patient who has been kept well informed during acute care, whose stress response has been minimized by the care of concerned staff, and who is aware of his or her rights as a decision making adult is able to begin discharge planning earlier.

According to Rorden and Taft (1990), nurses are responsible for ensuring that patient understand what their options are before they can be expected to make decisions about their continued care. The quality of information given to patients and families within the discharge process affects the patient's and carer's stress and anxiety, satisfaction with care, ease of adaptation to the new environment on discharge and concordance with treatment. (Driscoll, 2000).

Efrimsson et al (2003) reported that successful discharge planning cannot be attained if patients are stripped of their power. The authors described a case of an older woman who suffered a stroke and had a severe heart condition that was displayed at a discharge planning conference. This case study interpreted the power and powerlessness a patient. Data for the study was obtained from the video recording of the discharge planning conference and two audio recorded interviews with the patient. The study concluded that professionals take most of the control of the content, structure and implementation of the discharge planning conference. Medical language was used by the professionals, which may not be understood by the patient. In addition, communication at the conference was mainly about the patient, instead

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of with the patient. The patient experienced a feeling of powerlessness and of
being treated as an object.

According to Macleod (2006), the traditional paternalistic model of health
care, where the health care professionals control information and makes
decisions which the patient is required to comply with, limits patient choice.
Conversely, the consumerist model of care, where the health care provider
provides information and the patient makes the decision facilitated patient choice
and participation. As more hospitals begin to use technology to record and plan
patient care, nurses will need to adapt and record all of their assessment to
prepare for discharge planning even more intensely.

Conclusion

For many patients, getting ready to leave the hospital is one of the most
critical aspects of their hospital stay. It is important that discharge
planning begins early in the patient's acute care so that future needs can be
anticipated as fully as possible before planning, teaching and the coordination of
resources begin. There is an old saying that "the proof of the pudding is in the
tasting" - so it is with discharge planning; the proof is in whether the plan, when
implemented, meets the patient's continuing care needs.

The patient and their families are the most important members of the
discharge planning team, since they hold the keys to the patient's real
needs and the motivation that will mean success or failure. Nurses are key
figures in the discharge planning and are best placed to deliver patient centered
care. The effectiveness of discharge planning process depends on the ability of

the nurse to use the skills of communication, coordination and teaching to meet the goals of continuing care and self responsibility. Although it is difficult for nurses to participate in discharge planning, if they take initiative, it will have a definite positive impact on the final patient outcomes.

It has been found that ineffective multidisciplinary communication and an absence of interprofessional discharge education and training is pervasive on a global scale. Therefore, it is recommended that the implementation of discharge planning education programs for nurses and other health care professionals are mandatory in all countries, not just Pakistan. As hospitals move to computerized documentation, discharge planning must be incorporated to ensure competent and patient-focused continuing care. Nurses are the key to ensuring that discharge planning is a key component of all patient care, regardless of geography or complexity.

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