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Abstract

For the most part, discharge from hospital is routine and uneventful. However, for a percentage of persons, discharge from acute care requires careful planning to ensure continuity of care. This is particularly the case with elderly patients who have complex medical needs. This literature review reveals that the essential elements for discharge planning are communication, coordination, education, patient participation and collaboration between medical personnel. Outcomes measures of successful discharge planning include patient satisfaction and quality of life. Smooth and efficient coordination of this process reduces stress and anxiety for the patient, family, nurse, doctor, hospital organisation and community services.

Key words: Discharge planning, collaboration, co-ordination, patient participation.

Introduction

The need for successful discharge planning process (DPP), which contributes to improving practice, has never been so urgent. Institutional care has become more technologically sophisticated, and length of stay has reduced. Moreover, as the needs of patients have increased, transitions between hospital and home/rehabilitation have become more dramatic. Planning for these transitions can contribute significantly to a person's future quality of life. This impact is revealed in a meta-analysis reported by Phillips et al (2004) which concludes that comprehensive discharge planning plus postdischarge support for older persons with Congestive Heart Failure, significantly reduced readmission rates. Discharge planning therefore, has become an integral part of health care (Driscoll, 2000).

Discharge planning is an accepted nursing intervention aimed at the prevention of problems after discharge (Mistiaen et al 1999). While many discharge plans are routine, a subgroup of persons exists for whom non routine hospital discharge plans are required. These are mainly elderly patients with complex medical needs. It is critical for these persons to be identified early, either before, or on admission, in order to reduce or prevent post-discharge problems (Mistiaen et al 1999).

The aim of this review was to identify key elements of best practice in relation to discharge planning. The literature search for the review involved a search of the following databases: CINHALL (Cumulative Index to Nursing and Allied Health Literature), Medline, Science Direct, and Blackwell Synergy. Key words included, 'discharge planning', 'hospital', 'patient', 'nurse', 'case manager'. The search retrieved 222 relevant 'hits', and was then limited to primary research studies. The contemporary international interest in this

topic is evident in the diversity of studies reviewed, with research conducted in Taiwan (Huang and Liang, 2005; Lin et al 2005), Australia (Watts et al 2005, Watts et al 2007), Sweden (Efrainsson et al 2003, Efrainsson et al 2004, Efrainsson et al 2006), Denmark (Olsen and Wagner 2000), USA (Hansen et al 1998, Mistiaen et al 1999, Naylor et al 1999, Bull et al 2000, Bull and Roberts 2001), and the UK (McKenna et al 2000; Atwal, 2002).

The literature reviewed reveals that the essential elements for discharge planning are communication, coordination, education, patient participation and collaboration between medical personnel. Each of these key elements is now examined.

Communication

Effective communication between the patient and health care professional is essential for successful discharge planning, and is based on open dialogue where a common vision is shared (Olsen and Wagner, 2000). The importance of effective communication to successful discharge planning was highlighted as early as 1994. Bull (1994), in an early influential qualitative study employing semi-structured interviews, reported that both elderly patients (n=25) and professionals (n=38) identified the process of “asking questions, getting answers, and questioning inconsistencies- as key components of successful discharge” (p.55).

More recently, Olsen and Wagner (2000) report their work to develop a discharge plan that incorporates preventive health measures in a Danish hospital. Action research was chosen as the method to bring about this project. The researchers’ roles were to motivate staff, arrange meetings, and get everyone involved in the project. As a result of this project two

new tools were devised to enhance discharge, namely the 'Multidisciplinary Record' and 'My Admission and Discharge Journal'. Communication was seen as central to actualising the vision of this research. However, these tools were subjected to strong criticism by the staff using them and were continuously being changed as new ideas surfaced (Olsen and Wagner, 2000). This highlights a limitation of action research, which aims to solve a setting-specific or evaluate a setting-specific clinical practice (Norwood, 2000).

Bull and Roberts (2001) also argue that communication, whether verbal or written, is viewed as one of the main components of a proper hospital discharge. This study adopted a qualitative ethnographic design with the data collected in a 78-bed gerontology rehabilitation hospital. It consisted of 24 semi-structured interviews with hospital health care professionals (n=14), community team professionals (n=7), elderly patients (=2) and a family carer (n=1), and observation of all documentation relating to discharge planning. The findings of Bull and Roberts' (2001) study reveal that proper discharge planning takes place in stages, with communication central to all stages. Stage one of DPP actually begins on or before admission, and is characterised by getting to know the patient, and including the family members in communication with the medical staff. The staff perceived open communication and discussion from the start to be beneficial to all concerned in discharge plan. This finding is also reported in other studies (McKenna et al 2000; Atwal, 2002; Watts and Gardner, 2005). An interesting finding of Bull and Roberts' (2001) study is that when nurses completed the documentation on the discharge checklist, they limited it to action items only, such as, 'home adaptations requested' and 'referral sent to district nurse'. Information such as the patient's functional status, environment status, social support and preferences, was not documented on the discharge plan checklist, even though all the health care team considered this information vital to address a proper

discharge. Such revelations highlight the strength of ethnography, which provides a detailed description and analysis of explicit and tacit cultural knowledge used by a group or culture (Neuman, 2004).

Bull and Roberts (2001) describe the second stage of discharge involving setting a realistic date for leaving hospital, with the consensus of the members of the multi-disciplinary team (MDT) agreeing with the patient and family. Stage three is the preparation for home. The communication circle involved interaction with the community team, as in arranging outpatient appointments, informing the G.P., and connecting again with the district nurse. However, lack of communication sometimes resulted in problems with medication and the possibility of readmission. The final stage of the DPP is the actual transition from hospital to home, and the settling in period, which sees the patient's needs being met. It is at this stage that the greatest gaps in communication were revealed. One patient's wife stated she was not involved in her husband's discharge plan, and as a result, she had to take him to the Accident and Emergency Department three days post discharge for control of pain. It is important to highlight the difficulty in generalising the findings of this study from one hospital setting, to other geographical settings. Nevertheless, Bull and Roberts (2001) have made explicit the key issues relevant to the stages of the discharge planning process, which has a wider usefulness.

Communication is also reported as central to discharge planning by McKenna et al (2000). The objectives of this exploratory study were to examine the current discharge process of patients from acute care to community care and to review the communication between hospital nurses and community nurses. Moreover, the study aimed to ascertain the level of

satisfaction experienced by both sets of nurses regarding documentation, and to use these findings to develop a corporate discharge policy. McKenna et al (2000) sent questionnaires to 115 hospital-based nurses and 73 community based nurses in one Health Trust area (response rate 55.3%). This rate is acceptable according to Parahoo (2006), but moderately low, and McKenna et al (2000) provide no explanation as to why it was low. Tape-recorded semi-structured interviews were also conducted with six community nurses and five hospital nurses. Following data analysis, lack of communication between hospital and community emerged as a theme. Hospital based nurses stated that they were satisfied with the discharge documentation currently in use. 41.4% (n=24) found the documentation good. However, 56% (n=25) of community nurses were dissatisfied with the discharge documentation in use. This suggests a lack of synchrony between hospital and community nurses. The majority of community nurses 68 % (n=30) found the quality and quantity of communication between hospital and community sectors to be unsatisfactory. In comparison to this, only a small percentage (5.2%, n=3) of hospital nurses found communication unsatisfactory. 23 hospital nurses stated that the patient is always referred to the relevant agencies before discharge compared to only one district nurse sharing this sentiment. There were worryingly different opinions as to when information was sent and received by the different groups of nurses. This study reiterates that discharge planning remains problematic and concludes that where communication is poor, quality discharge is difficult (McKenna et al 2000).

Watts and Gardner (2005) report that communication can either enhance or impede the DPP following their study exploring nurses' perceptions of discharge planning using interviews in a qualitative exploratory approach. The findings revealed that not all nurses understand the discharge planning process the same way. One nurse believed she had total

control of the discharge planning while another believed it necessitates a team approach. Communication between the nurse and other members of the medical team was portrayed to be ad hoc and not well documented. The majority of nurses did not embrace the concept of having a designated nurse fully responsible for discharge planning. Moreover, each ward had its own form of communication regarding the DPP of the patient and there was no quality assurance on the effectiveness of the different methods used (Watts and Gardner 2005).

Co-ordination and Education

Other key aspects of successful discharge planning is the need for co-ordination and education, without which, the discharge planning process cannot be enacted effectively. A qualitative case study carried out by Atwal (2002), illuminates that the experience of the professionals carrying out a discharge plan influences positively on the process of co-ordination and education. Nineteen nurses were interviewed using the critical incident approach. This technique allows the researcher to collect data through direct observation as it depends on descriptions of actual events as they happen and not descriptions of events as they should happen (Cormack, 1996). For junior professionals, DPP was viewed as extremely challenging, and they sometimes did not question information they did not understand. They reported that discharge skills were learnt when qualified, and not as a student. Atwal's (2002) study also revealed no evidence of health care professionals educating other health professionals about their role and/or the discharge process. Moreover, interprofessional working was observed as being sometimes strained between nurses and doctors. On occasions, nurses failed to collect patients' social history, yet this was viewed as integral to the discharge process. In addition, co-ordination of patient care

was perpetuated through the nursing handover, a practice found to be lacking in focus in some wards.

The literature suggests some confusion as to who actually coordinates the DPP. An Australian exploratory descriptive quantitative study, reports on the current beliefs of nurses working in critical care regarding who does, and who should, carry out the discharge planning process (Watts et al 2007). The instrument used in this study (the 'Discharge planning questionnaire') was devised by the researchers themselves, as no other reliable and valid tool could be found. Face and content validity of this tool were checked with a pilot sample of eight critical care nurses. The study reports a significant association was found between who co-ordinates the discharge planning process, and the type of hospital one works in. For example, 50% of critical care nurses who worked in a hospital (and were not part of a health care network), responded that the bedside nurse or primary nurse is responsible for co-ordinating discharge planning. On the other hand, in a hospital associated with a health care network, only 29% of the bedside nurses were co-ordinating the discharge planning process. Watts et al's (2007) findings reflect that of Watts and Gardner (2005), discussed earlier, in that a designated discharge nurse is not highly favoured as the one who should co-ordinate the discharge process. Moreover, findings from this study suggest differing opinions regarding who does and who should co-ordinate the DPP.

Another study that portrays coordination, education and communication as pivotal to DPP is that reported by Lin et al (2005). The objectives of their research were to establish a discharge-planning program based on case management, and to raise patient satisfaction

with discharge services. The study participants were conveniently sampled from four orthopaedic wards of a 2800 bed medical centre, where 118 orthopaedic patients were screened by a newly devised high-risk screening tool and scored 7 and above. The maximum score was 14 denoting the highest possible risk patient. These were patients who may have difficulty with discharge due to medical health status, housing, financial situation, self-care ability and or age. The pilot programme developed by Lin et al (2005) utilised the following tools and documentation: high-risk screening tool, discharge nursing instruction checklist, homecare follow-up checklist and booklet, homecare booklet, and patient satisfaction questionnaire. Lin et al (2005) concluded that patient satisfaction with the new discharge-planning pilot model improved overall. Patient satisfaction was measured using a questionnaire developed by the researchers, which underwent content validity before its use. The mean score went from 3.6 before planning to 4.4 after planning (scale of 0-5: 5 was “very satisfied” and 1 was “very dissatisfied”). One important point was that patients were less satisfied with the provision of an instruction leaflet and the 3-day prior notice of discharge. This study was conducted in Taiwan, which limits its applicability to a European context. Nevertheless, the study does illustrate to nurses the significance of exerting effort into devising health care instruction leaflets.

The evidence clearly points to the role of good communication skills in facilitating a successful discharge (Bull and Roberts, 2001; Atwal, 2002). However, a holistic approach to DPP requires that patient outcomes must be evaluated, and addressed when discussing successful DPP (Pearson et al 2005). The main patient outcomes dominating the literature are patient satisfaction, length of hospital stay, and readmission to hospital. However, length of hospital stay and readmission are considered here to be intrinsically interwoven with patient satisfaction.

Patient satisfaction as an outcome measure of successful discharge

Patient satisfaction is linked closely to length of hospital stay and readmission. Pearson et al (2004) detailed patterns of discharge and readmission of medical patients, which helped identify patients at risk of 'unsuccessful discharge'. The unsuccessful discharge was defined as unplanned readmission within 6 weeks of discharge or delayed discharge. They also conducted interviews with 30 patients recruited from three different hospitals, using a topic guide developed from the earlier part of the study (Pearson et al 2004). Each patient's associated carer, as in, hospital staff member (doctors, nurses, physiotherapist, occupational therapist, dieticians), carer at home, general practitioner, and where available, the district nurse, were also involved in this research (resulting in a total of 121 interviews). Analysis of the qualitative data highlights the psycho-social consequences of living with chronic and degenerating illness, with the study themes emerging illustrating patients' response to illness, for example, panic, failure to cope, and a heavy reliance on family. Pearson et al (2004) conclude that a search for optimal quality of life must be seen as central to successful discharge planning. It is not enough for a discharge plan to concern itself only with reducing length of stay and readmission rates but it must embrace the patient's dignity and quality of life (Pearson et al 2004).

Kalisch (2006) reveals that when DPP is not adhered to, patient satisfaction is reduced. This qualitative study was undertaken to illustrate elements of nursing care that are regularly missed. Focus group interviews with staff from medical and surgical units in two hospitals (n=122 nurses, and n=51 nurses' assistants) provided the data for this study. The analysed text suggests that nurses regularly do not complete a discharge plan for their patients and they rarely know much about where the patient is going after hospitalization.

The 'it's not my job syndrome' theme prevailed in the focus group interviews, and some nurses said that the case manager was entirely responsible for the discharge plan. This, as outlined by Kalisch (2006), could be seen as missed quality nursing care resulting in reduced patient satisfaction

Quality of life as an outcome measure of successful discharge

Quality of life is also an important determinant of successful discharge. Discharge planning as revealed by Pearson et al (2004) should not only be directed towards physical problems, but also towards the patient's psychosocial well being. Atwal (2002) and Haung and Liang (2005) echo these findings. Haung and Liang (2005) conducted a qualitative study in a nurse managed acute setting and report that when a DPP with a holistic approach is in place, improved physical outcomes and quality of life for hip fracture patients ensues.

Following ethical approval, 126 hip fracture elderly hospitalised patients were randomly assigned to a control (n=63) or an experimental (n=63) group. The authors clarify this population was chosen because of their ongoing medical and long-term care needs. The hypothesis was that the intervention of a discharge plan, when applied to the experimental group, would show improvements in the following: length of hospitalized stay, rate of readmission to hospital, rate of repeat falls, survival rate, ability to perform activities of daily living (ADLs), and quality of life (QOL).

The results of this study clearly illustrate that when a discharge plan was introduced, a significant positive outcome in improvement in QOL, survival, ability to perform ADLs, readmission to hospital, and reduced length of stay, was evident. The main components of

the model used were written information for patient and health carer's use, communication between health care providing organisations, and involvement of the patient and family. The nurse coordinated the discharge planning process, with the intervention initiated within 48 hours of hospital admission, and extended to three months after discharge. Considered attention was given to the written information, in that the brochures were colourful, giving systematic detailed information with minimum word usage. The control group received routine hospital discharge planning, which did not have any written information available for the patients. The findings reiterate that coordination, communication and education are pivotal to successful DPP, and these elements must be approached holistically.

Patient participation in discharge planning process

The contribution of patients to their own discharge planning is also essential. Huber and McClelland (2003) discuss using the Patient Participation Preferences Assessment (PPPA), a 17-item self report measuring 3 areas of a patient's desire for participation in discharge planning. Another strategy to involve patients is a discharge planning conference, a form of institutional discourse that refers to face-to-face meetings, where representations of various levels of care, the patient, and in some cases, his/her relatives, participate in developing the plan of care on discharge. However, from Swedish studies reported, patient participation is not always fully actualized in these conferences.

Efrainsson et al (2003) report that successful DDP cannot be attained if patients are stripped of their power. This study interpreted the power and powerlessness a patient

displayed at a discharge planning conference (DPC), in a case study of just one elderly woman, who suffered a stroke and had a severe heart condition. Data for the study was obtained from the video recording of the DPC 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 DPC. Medical language was used by the professionals, which may exclude the patient. In addition, communication at the conference was mainly about the patient, instead of with the patient. The patient experienced a feeling of powerlessness and of being treated as an object.

Another study aimed to illuminate and describe communication and participation within a DPC is reported by Efraimsson et al (2004). Eight hospitalized women, aged 70 or older, who were ready for discharge, and were already the recipients of home care, were the chosen participants. Each of the eight conferences were attended by the patient, relatives and hospital staff, and were video recorded. The data were initially analysed to reveal the structure of the negotiation within the conference, and to what extent the women took part in the discussions. Subsequently, a more focused analysis of the data were carried out to validate the interpretations of the initial analysis. Efraimsson et al (2004) report five characteristics of the conferences, namely, 'there is no one to negotiate with', 'there are no options or the options are vaguely described', 'being subjected to pressure', 'actions are rarely taken', and 'the woman has given up or is unable to participate in the decision-making'. The findings illuminate that one's autonomy is limited in DPC. In addition, participants were deluding themselves into believing that their participation in the DPC influenced the discharge process when outcomes had already been decided (Efraimsson et al 2004).

A follow on study (Efrainsson et al 2006), reveals that patients often feel left out of decisions made about their discharge, with the findings portraying patients' perceiving themselves in vulnerable situations and feeling they were in 'the hands of others'. Patients felt uncomfortable due to their lack of knowledge about the other participants in the DPC. However, they felt safe and secure when their relatives were present (Efrainsson et al 2006).

Discussion

The literature reveals that an ad hoc approach to DPP exists internationally. Bull and Roberts (2001) argue that communication has long been recognised as the key to effective discharge planning, yet little attention has been allotted to the nature of communication within the DPP. The reason for lack of communication may be the result of the importance of communication not being addressed in the education of undergraduate medical personnel. According to Atwal (2002), students while on placement education, should be encouraged to put theory into practice and become competent discharge planners prior to starting practice. Bull & Roberts (2001) argue similarly. However, such a process involves time, and exposure to committed mentors within the health care system.

To bring the DDP to effective fruition through communication, a framework is required. However, some nurses are unclear about the extent of their role when it comes to discharge planning (Watts and Gardner, 2005, Watts et al 2007). Moreover, other studies such as Kalisch (2006), portray apathy towards who is responsible for DPP. This may be because the role of the staff nurse is not well defined and literature that delineates that role is

severely lacking. McKenna et al (2000) reveals that this is compounded by the fact that there is a lack of standardised policy regarding DPP.

It is apparent throughout the literature that no one person has the ultimate responsibility of co-ordinating the discharge plan of a patient. This further illustrates the importance of incorporating and displaying discharge plans within patients' plan of care, in order to promote communication among all members of the multidisciplinary team. Furthermore, the role of a designated discharge planner has not been investigated sufficiently to warrant this role or to bestow responsibility onto this person. Interestingly some study participants do not embrace the role of a designated discharge planner (Watts et al 2006). The exception to this was reported in Lin et al (2005). Moreover, the difficulty with a named nurse to manage the discharge planning process when a patient moves to different wards is highlighted by Macleod (2006). Nevertheless, the potential of the Clinical Nurse Specialist (CNS) to co-ordinate discharge planning, alongside the bedside nurse, is evident. For instance, a study reported by Naylor et al (1994), reveals that a CNS comprehensive discharge program utilised with an intervention group of elderly cardiac patients and their primary carers, resulted in fewer readmissions and fewer total days rehospitalised when compared with the control group. A similar approach to discharge is discussed in a recently published text. A nurse-facilitated discharge process is described as one with nurses taking responsibility for a proactive management of discharge with an explicit multidisciplinary team-working approach (Lees 2007).

It is important to note that directives from government to establish discharge policies and procedures, initiated several of the studies reviewed here (Olsen and Wagner, 2000;

Pearson et al 2004; Lin et al 2005). This initiation may not always have the sentiments of the patient as its focus, but instead, have economic issues and bed occupancy as its driving force.

The process of DPP will remain a theoretical myth, unless adoption of a proactive approach occurs. A possible way forward is through action research. This has the potential to generate genuine and sustained improvements in hospitals. It gives healthcare professionals new opportunities to reflect on and assess their practice, to explore and test new ideas, new methods, to assess how effective the new approaches are, to share feedback with fellow team members, and to make decisions about which new approaches to include in practice. It has the potential to bridge the gap between research and practice and allows open and honest communication between the researcher and the practitioner. Moreover, in true participatory fashion, action research would include the patient's perception of their discharge plan and what they want out of DPP.

Key points

- Open and honest communication between all members of the multi disciplinary team is required for successful discharge planning.
- Patient participant in all communication should be encouraged. Moreover, patients should be encouraged to appraise their DPP. This will help staff to amend practice where necessary.
- The bedside nurse (i.e. the staff nurse responsible for direct patient care) should be considered as coordinator of the DPP. The multi disciplinary team (MDT) should give full assistance to him/her, and if a designated discharge planner is employed by the organisation, s/he must liaise with, and support the bedside nurse.
- The discharge plan should be incorporated and displayed within the patient's plan of care. This allows all the members of the MDT and the patient to work towards the process of discharging the patient.

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