



ICAHE: The principles of discharge planning

Best practice discharge planning principles have been suggested as an integral part of an episode of hospital care. These principles have been formulated from wide-ranging consultation with health care providers, patients and carers (Hedges et al 1999). The principles are that:

1. Appropriate and timely discharge planning should be an integral part of every patient's hospital admission;
2. Discharge planning is the responsibility of all health care providers involved with the patient, with a specific person designated as being responsible for ensuring that all aspects of discharge planning have been addressed by the time of discharge;
3. A multi-disciplinary approach is most appropriate to the development and implementation of discharge plans. To achieve best practice the multi-disciplinary teams should work collaboratively and in a planned, integrated manner;
4. A documented discharge plan should commence before, or on admission to hospital. The discharge plan should be subject to ongoing assessment throughout the hospital stay to take account of changes in patient and carer health and social status;
5. The patient and carer should be consulted and informed at all stages during the discharge process;
6. At all stages throughout the hospital stay, information and education should be provided to the patient and carer, on all aspects of care which will be required after leaving hospital;
7. Discharge from hospital should be timely and, where necessary, linked to appropriate and available local health and community-based services; and
8. Ongoing communication and coordination between hospitals and community-based services is essential, to ensure safe, effective and efficient discharge of the patient from hospital to the community.

Planning for discharge

Planning for discharge involves complex and often cyclical processes that:

- Take account of the patient's needs in the context of his/her community existence;
- Identify the key stakeholders in the patient's discharge and involve them in planning for discharge;
- Formulate appropriate plans to address patients needs;
- Match patient needs to available community services and supports;
- Develop and implement achievable discharge plans;
- Evaluate whether the plans have had the desired effect; and if not, revising and re-implementing these plans.

A number of models of planning for discharge are reported in the literature, with the collaborative multidisciplinary model seen to be most effective (Hedges et al 1999). This is where a number of different health professionals have input into the discharge planning process, and where the entire team takes responsibility for the processes of planning, organising and evaluating discharge.

Hedges et al (1999) described these processes of discharge planning in terms of the Total Quality Management Cycle (TQM) as proposed by Anderson and Noyce (1992). This cycle, as it is conceptualised with respect to discharge planning by Hedges et al (1999), is illustrated in Figure 1.

The term 'stakeholders' in Figure 1 refers to the key people who may provide input into discharge planning. This group should always include the patient and carer, and may also include health professionals in hospitals or day procedure centres, health professionals and service providers in the community, and where indicated, representatives of funding bodies.

To put this in context with respect to best practice discharge planning for patients, it is the responsibility of relevant hospital staff to identify the stakeholders whose

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input is required to appropriately deal with the discharge needs of any one veteran. Where the patient's health needs have changed significantly as a result

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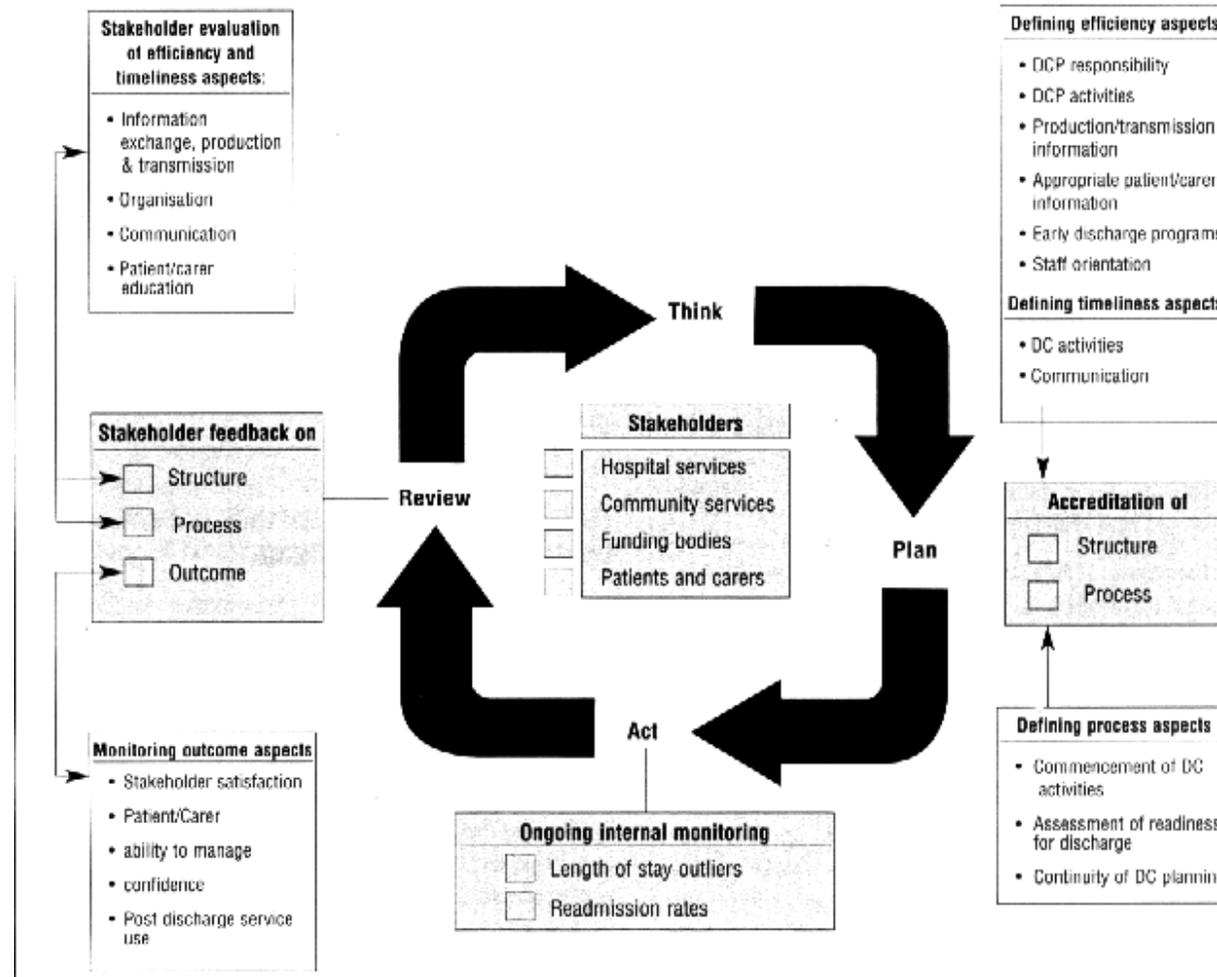


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of a hospital admission, it is also important to ensure proactive organisation of appropriate services.



NB. In this Figure DCP refers to Discharge Planning, and DC refers to Discharge.

Determining the quality of discharge planning

It is currently far easier to measure the processes of discharge planning than its outcome. That is because good discharge planning and good health status are not necessarily related (Grimmer and Moss 2001, Grimmer et al 2001). Patients may be very unwell following discharge from hospital and yet have received best practice discharge planning. Good discharge planning may not guarantee a quicker recovery, nor significantly improved health status in the short or long term. Furthermore, research has shown that successful transition from hospital to community is only partially dependent on discharge planning and community service provision. Personality, desire for independence, life experience and the support of carers are critical to the patient's successful transition from hospital to the community (Anderson and Steinberg 1985, Armitage and Kavanagh 1996a, Grimmer et al 2001).

Most research on the quality of discharge planning reports on perceptions of hospital staff. There is very little research from the perspective of consumers (i.e. patients and carers). Only one standardised instrument has been reported in the literature for obtaining feedback on the quality of discharge planning from the community perspective (Grimmer and Moss 2001) (PREPARED). This is a set of questionnaires for patient, carer, general medical practitioner and nursing home administrator to be completed within one week of discharge.

To assist with quality improvement activities, discharge planners are encouraged to consider obtaining feedback from the consumers of their discharge planning activities, in order to ensure that their discharge planning service is best practice, and that consumers' needs are being met.

Identifying patients who may present difficulties when planning for discharge

The literature suggests the need to 'flag' individuals who may prove difficult to discharge safely, efficiently and/or effectively. Early identification of such individuals will reduce last minute problems in organising and implementing appropriate discharge plans. The involvement of different health professionals in

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assessing patients' and carers' discharge needs should assist in early identification of problems. This is a distinct advantage of the multidisciplinary team model of discharge planning, compared with a single health professional who undertakes a multitude of tasks.

Recognised flags for potentially problematic discharge from hospital and day procedure centres include:

- living alone;
- being frail and/or aged;
- having multiple and/or poorly managed health problems;
- having multiple health problems and not having prior community health and support services in place;
- not having a regular LMO;
- when health care is shared by a number of medical practitioners;
- the presence of an ill, frail or incapable carer;
- when the patient cares for someone else;
- when patients are unwilling to participate in making discharge plans;
- being unrealistic about ability to manage in the community post-discharge;
- family conflict about the patient's ongoing independent community living arrangements;
- when patients are taking multiple medications; and
- when there are potential problems with compliance (including impaired cognition or dexterity difficulties).

The Discharge Planning Checklist provides examples of ways in which hospital staff can 'flag' patients who may be potentially problematic to discharge in a timely, effective and sustainable manner. Where such patients are identified early in the hospital stay, timely and appropriate plans can be made to smooth the transition from hospital to community, and to ensure sustainability of patient's independence in the community following discharge.

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Confirming arrangements

Towards the end of the hospital stay, all discharge plans should have been put in place. Services should be organised and implemented as appropriate, to ensure no delays on the day of discharge, or in service provision following discharge from hospital.

Research has shown that delays in leaving the hospital on the day of discharge have a detrimental effect on patient and carer confidence regarding successfully managing in the community (Hedges et al 1999, Grimmer et al 2001). The following issues should be considered.

- The person responsible for discharging the patient should be aware of discharge date and time to ensure no last minute delays to hospital discharge procedures.
- As soon as possible after discharge, the patient's LMO should be contacted by hospital staff regarding issues such as changes in health status, medication management, timing and reason for follow-up appointments. This communication is usually in the form of a written discharge summary. Staff should be aware of the National Privacy Principles Obligations for Health Service Providers regarding confidentiality of health information.
- Arrangements should be completed for community health and support services. If an assessment is needed for patient Home Care services, this should be organised as soon as possible after admission to ensure services are in place when the patient is discharged. The patient should know when to expect these services to visit. If the patient requires immediate assistance from community or support services following discharge, the services should be aware of, and responsive to, the time of veteran discharge.
- Patient and carer safety should be considered, from a range of aspects such as medication management, ambulation, hygiene, food preparation, eating, occupational health and safety issues, as well as domestic environmental safety and falls prevention.
- If the patient is not independently ambulating, special consideration should be given to suitability of transport home, and the level of assistance required from other people to assist the veteran to enter and maneuver around the home. Transport home should have been arranged, taking into account who will provide the transport, the distance that needs to be travelled and

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the availability of suitable transport for the patient's condition and health status.

- Equipment should be in place in the home, or supplied to the patient in hospital, before the day of discharge. The patient and carer should feel confident about using the equipment.
- Best practice discharge planning principles suggest that all test results should be known and there should be no last-minute changes to discharge plans based on test results.
- Supplies of all new medications should have been organised and sufficient education sessions held with the veteran and carer to ensure that they are confident in medication matters.
- Follow-up appointments should have been arranged, and the timing of follow-up appointments with multiple health providers considered in the light of veteran and carer health status and distance needed to be travelled for the appointments.

Follow-up appointments

The dates of initial follow-up health reviews and community service appointments should be organised before the day of discharge. The patient and carer should have written information about the time and date of appointments, the name and contact details of the consulting health professional, and the purpose of the appointments. Relevant clinical information should also be provided to any health professionals with whom appointments have been made, in time for the appointment.

Where possible, hospital staff should consider the nature of the follow-up appointment that will incur least physical and emotional stress to the patient and carer, for instance, a telephone call or home visit, or organising an appointment with a visiting specialist to a country area, rather than a face-to-face appointment at the hospital or specialist's rooms, where the patient needs to travel long distances.

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Potential issues immediately after discharge

The first 24-48 hour period after discharge has been identified in research as the critical time in testing patients' and carers' coping ability (Grimmer et al 2001). Problems that arise during this time can have a major impact on patient and carer confidence with respect to managing independently in the community.

Discharge planners and other health professionals need to consider the issues that may worry patients and carers immediately after discharge, and take steps to ensure that this period of transition runs as smoothly as possible. Issues that commonly cause concern include adequate short-term medication supplies, confidence in administering medications, adequate food supplies, organising and eating meals, negotiating the home environment safely, sleeping and sitting arrangements, care of pets, changing dressings or undertaking other wound care, and regular dressing and bathing.

Ideas for hospital staff to assist patients and carers in the immediate post-discharge period

The following section outlines ideas for discharge planners and other hospital staff that may assist patients and carers in the immediate post-discharge period.

1. Make regular follow up telephone calls to the patient and carer to discuss their progress and problems.
2. Suggest that a family member or friend stays with the patient for the immediate post-discharge period.
3. Encourage patients and carers to contact their LMO as soon as possible after discharge. Ensure that the patient knows the name and telephone number of the LMO and have access to a working telephone.
4. Provide the patient's LMO/GP with appropriate information about the patient's current health status and medication requirements on the day of discharge to encourage continuity of care.
5. Ensure that patients and carers know the emergency contact numbers for ambulance and hospital, and when to use them.