

# **Discharge from Hospital**

Literature Review

Prepared for the:  
Discharge Planning and ALC Policy Task Team  
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## **Overview**

- The topic of hospital discharge planning policy is embedded in the broader literature on discharge planning
- The studies selected represent a cross-section of the literature
  - There are two major reviews included (Shepperd; Glasby)
  - There are several hospital-based studies, including reports on discharge planning improvement efforts
  - There are some reflecting the professional perspective, some the patient and family perspective
  - There are reports and position papers from national bodies and healthcare associations
  - There are some studies that focus on specific patient populations, predictors of discharge delay and screening tools
- This review is organized by theme:
  - The discharge planning process/process improvement
  - System view/patient flow
  - Discharge planning policies
  - Patient outcomes
  - Patient participation
- The importance of a clear policy on discharge to chronic care is mentioned as a necessary improvement measure in more than one of the studies reviewed; delays in discharge from acute to long-term care are a common problem in health systems around the globe; national policy measures have been implemented in the U.S. and the U.K. to address this problem at the systemic level; some interventions are possible at the hospital level
- There are many other causes of discharge delay; some are under the control of hospitals and are targeted for process improvement efforts

## ***The Discharge Planning Process / Process Improvement***

- Discharge planning is critical to ensuring rapid, safe and smooth transition from hospital to another care environment; it involves the social work functions of high risk screening, social work assessment, counselling, locating and arranging resources, consultation/collaboration, patient and family education, patient advocacy and chart documentation; it is a complex activity requiring a wide range of clinical and organizational skills to address needs of patient, family and health care system and to promote the optimum functioning of patients, families and support systems. Delay factors may be internal (waiting for discharge summaries; waiting for declaration of chronicity; transfer between nursing units; lack of documentation of discharge plan); external (lack/delay of access to rehabilitation, convalescence, palliative care, home care resources, long-term care facility); and psychosocial (waiting for family adjustment to illness, waiting for patient function to improve, unrealistic expectations of patient/family, social isolation of patient, inadequate support at home, lack of concrete medical aids, transportation for treatments, financial, family burden prevents discharge home). Respondents to a survey of interdisciplinary staff at Montreal General Hospital identified the following discharge planning issues (Tennier 1997):
  - Hospital system issues
    - Discharge date not known in advance and planning for discharge at the last minute
    - Lack of communication and coordination between disciplines and various departments
    - Lack of clear documentation of the discharge plans in the patient's medical chart
    - Lack of clear hospital policy on chronic status and placement options
  - Community resources
    - Inaccessibility of community resources at the appropriate time
    - Lack of appropriate structured and supervised resources for psychiatric patients
    - Home care expensive and often inaccessible to families
    - Lack of palliative and long-term care resources
  - Patient/family issues:
    - Patient and family not adequately informed about the discharge date
    - Patient and family not adequately informed about chronic care fees
    - Failure to include the patient and family in the discharge planning process

- Families lack support and interaction with community resources
- The respondents recommended:
  - Hospital system issues:
    - Physicians identify discharge date upon admission and in all orders
    - Daily, weekly or bi-weekly interdisciplinary rounds on all services/wards
    - Summary sheet in the patient's medical chart to document discharge planning events
    - Inform staff, patient and family of clear chronic care policies and placement options
  - Community resources:
    - Liaise / develop close contacts and alliances with key community resources
    - New resource development for the very ill psychiatric patient population
    - Use of alternative resources in the private sector
    - Improved knowledge of community resources for all disciplines
  - Patient/family issues:
    - Improve communication with patient and family concerning discharge date and planning
    - Provide patient and family with accurate information on chronic care status and fees
    - Hold family meetings of high-risk patients within 24-48 hours of admission
    - Provide patient and family with information concerning community resources and encourage contact
- At Hôtel-Dieu Grace Hospital in Windsor, staff struggled with how best to accommodate dying patients in light of pressures on acute-care beds. Resource utilization nurses were added to the discharge planning team to follow the progress of patients through the acute care stay, and ensure the patient would be cared for in an appropriate setting, if discharged. Discharge planners were spending a great deal of time with the families of dying patients; the process was lengthy and, as patients sometimes died just before or shortly after transfer, this time allocation wasn't always warranted. There was a need to identify which patients should be transferred to long-term care facilities. Only 20 per cent of predictions of how long a terminally ill patient will survive are accurate; among incorrect predictions, 63% are optimistic (the clinician predicts the patient will survive for longer than the patient actually survives). The hospital discharge planning and resource utilization team used the Palliative Prognostic Indicator (PPI) to predict length of survival. Patients with a life

expectancy of 18 days remain in acute care. Additional criteria were developed for transfer to long-term care or chronic care. In a trial of the tool for 40 assessments, which included one-third of patients with diagnoses other than cancer, 91 per cent of patients expected to live no longer than 18 days died within the predicted timeframe. The tool was adopted throughout the institution. An assessment form was developed incorporating both the PPI and the Palliative Performance Scale (PPS). Neither the form nor the score are added to the patient's chart, as a consequence of an event in which the prognosis was inappropriately communicated to a patient. The fact that the assessment was done and the resulting recommendations for care are indicated in the progress notes. The process enables the hospital to provide compassionate care while using health care resources more effectively (Oldfield 2006).

- On average, 74% of the chronically critically ill are transferred from the ICU to a medical / surgical nursing unit prior to discharge. Extensive preparation is necessary prior to discharge. The hospital mortality rate of the CCI is 35 to 55%, overall one-year mortality rate 55 to 65%, and readmission rate to acute care within six months 38%. Patients may leave hospital without adequate preparation when staff nurses are unaware of the discharge date. The CCI have complicated care needs at the time of discharge; nurses and family members/caregivers need to be notified of and prepare for discharge well in advance. The authors were unable to locate data on awareness of discharge date after a comprehensive literature search. In their small pilot study of 16 chronically ill patients in Ohio, almost one-third of study participants were on partial or full mechanical ventilation, 60% required tracheostomy care and 75% required oxygen post-discharge. Five were readmitted to acute care within two months. On average, family caregivers knew of the discharge date 1.4 days and nurses 0.6 days prior to discharge. The authors conclude that discharge planning may be overlooked or not well communicated in the fast-paced environment of the acute care hospital (Lipson et al 2006).
- A study of 80 social workers employed in 36 not-for-profit acute care hospitals in Cook County, Illinois provides an overview of the tasks of discharge planning within the categories of assessment, coordination, documentation, counselling and linkage. The respondents rate the importance of each of 73 tasks. Ten core tasks of discharge planning are identified. The authors conclude discharge planning consists primarily of concrete resource provision with a counselling component based upon decision-making. They cite a study that found that in discharge planning, psychosocial problems and relationship issues are addressed to the extent that they interfere with timely discharge (Kadusin & Kulys 1993).
- Two approaches to discharge planning became prevalent in the U.S. following introduction of a new payment system based upon diagnosis-

related groups. The nursing approach, or medical model, involves specialized knowledge of illness, understanding of medical terminology, ability to instruct patients and families on the use of technical equipment, ability to provide instructions on general home health care procedures and a close working relationship with physicians. The social work approach focuses on non-medical aspects of hospital care; it includes the use of clinical skills, assessment techniques, advocacy, problem-solving abilities and community resource identification. The organizational environment of the hospital greatly affects the discharge planning process. Organizational policies and legislative policies are determining how discharge planning is carried out. A 1988 survey of discharge planners in 229 California hospitals found 52.4% of hospitals located discharge planning services within the social work department, 31.4% in an administrative department and 16.1% in a nursing department. The most frequently mentioned criteria for selecting patients to receive discharge-planning services were social situation, medical condition, age, mental condition and referral from another professional. Progress notes were the most frequently used assessment tool, followed by the nursing care plan and activities of daily living scales. More than half (58%) had a procedure for evaluating the quality of services to which a person is discharged; follow-up telephone calls were mentioned most frequently, while audit at readmission and questionnaires ranked second and third, respectively. Home-visits were the least-used evaluation method. The author suggests that hospitals' structure, goals, technology, ideology and adherence to the medical model may be more powerful than the professional perspective in defining discharge-planning services. All discharge-planning models include: screening, assessment and diagnosis, planning, implementation, and evaluation and follow-up. The author cites studies suggesting the then-prevalent screening procedures may not have been sufficiently accurate to target patients' post-discharge needs. The author also cites research suggesting indicators need to target a broad range of post-hospital needs rather than those primarily related to delayed discharge. The author expresses the view that the use of progress notes and nursing care plans for assessment and screening does not reflect adherence to a comprehensive model of discharge planning, and notes the importance of evaluation in a comprehensive model (Inglehart 1990).

- Research among adult patients in two Midwest U.S. hospitals found that, of 24 variables examined, only age, disability, living alone and self-rated walking limitation were jointly predictive of using specialized discharge planning services. A screening tool using a limited number of characteristics was found to be highly predictive of using specialized discharge planning services. Early identification allows for the timely coordination of services required for complex discharges. The variables are identifiable early in the hospital stay and easy to measure. Co-morbidities and severity of illness were not predictive of specialized

hospital discharge planning services. The authors of this study suggest these variables may be more related to the outcomes of the discharge plan, e.g., institutionalization (Holland et al 2006).

- An interpretive study contrasted the discharge experience in a rural and an urban Ontario setting (McWilliam & Sangster 1994). The authors found that in the rural setting, the efficiency of bed utilization was compromised by democracy and professional autonomy, resulting in the overuse of hospitalization and learned helplessness among patients. Family involvement was limited in the urban setting; communication between the hospital and home care agencies was kept to the minimum, focusing on efficiency. The process differed in the rural and the urban setting, while the patient experience of the process was similar. In both settings, patients deferred to the professional management of discharge care. Rural professionals took a collegial approach, whereas those in the urban setting focused on their own area of specialization to avoid stepping on each other's toes. The urban approach resulted in fragmentation, adversely affecting patient-centredness, continuity and effectiveness. Home-care professionals noted the challenges created by the hospital's focus on efficient bed utilization. They were also uncertain of which physician to contact for which concern. Variations in physician practice style were identified as a complicating factor in the urban setting. Challenges common to both settings included communication and coordination, and lack of information. In the urban setting, family physicians and home-care professionals often faced delays of several weeks post-discharge in receiving details of care requirements. Potential solutions are identified, including systematic approaches to written correspondence, face to face communication, interdisciplinary planning meetings that include patients and families as well as hospital and community-based professionals; continuous family physician involvement; improvements in discharge teaching; better understanding of the roles of all health professionals; and interdisciplinary clinical education. The authors conclude that approaches to discharge care should be evaluated for their impact on accessibility, coordination, continuity, comprehensiveness, patient-centredness, and the effectiveness of overall patient care, and they note the importance of teamwork.
- The professional practice component of discharge planning goes beyond the mere application of the organization's procedures. It involves attention to the particulars of each case in light of the organization's principles. It also requires the ability to understand operations and how to intervene effectively within the organization (Marcus 1987). "The optimally successful discharge is one that meets the goals, needs, and objectives of as many of the parties concerned as possible, to the greatest extent possible." (41) To understand the process, identify the various interests, understand their objectives and determine their measures of success. The

discharge planner mediates between the individual's needs and the system's policies. An understanding of the roles and responsibilities of the parties involved in discharge planning helps the social worker to contribute to planning based on common service values. The concerns of the parties must be balanced to reach a suitable discharge plan. The discharge planner should know and understand the health care system, appreciate its impact on the patient and family, and negotiate plans that work optimally for all. Clinical and organizational issues are inseparable.

## ***System View / Patient Flow***

- Under legislation introduced in England in 2003, social services departments are charged for hospital beds unnecessarily occupied by people awaiting social service provision. The system is referred to as reimbursement. Numerous other initiatives have been implemented or are underway to address the problem of discharge delay. Nonetheless, hospital discharge remains a difficult area of practice characterized by negative patient experiences, inadequate communications, cost shunting and insufficient interagency collaboration (Glasby et al 2006). In this review of the U.K. evidence on delayed hospital discharge, commissioned by the English Department of Health, the authors find that reported rates of discharge delay vary widely owing to the lack of a common definition; the causes of delayed discharge are very broad and involve different agencies and services; and that multiple contributing factors are at work in each individual site. The reviewers note that the causes of delayed discharge are complex and multifaceted. Accounts of actions taken in specific locations include nurse-led discharge planning, the introduction of discharge lounges, the development of joint health and social care databases, changes to assessment, and the expansion of intermediate care. The studies are found to have limitations constraining their utility. One of the main limitations noted is the failure to consider the patient and carer perspective. The studies also fail to identify potential solutions. The local setting is found to be important; each area has its own demographic characteristics and level of service provision by various agencies. This makes it difficult to apply the experience in one locale to another. (Different hospitals within Edinburgh were also affected in different ways). The reviewers comment that, "This suggests that responses to delayed hospital discharges need to be equally localized, based on a detailed understanding of local services, the local context and the history of local agencies." (p. 56) They identify the need for a joint, systems approach that is wide-ranging ("'joined-up' action from all relevant partners").
- In England, the implementation of a system to reduce the incidence of delayed discharge among the elderly may have contributed to a rise in emergency admissions in some local areas. Where there is a focus on

speeding up hospital discharges, it appears appropriate to extend community-based rapid response services and round-the-clock crisis support to achieve an ideal, whole systems approach (Henwood 2006). Investment in the expansion of community-based services is helpful in the implementation of an initiative to reduce discharge delays. Adequate lead-in time is required to avoid short-term inappropriate quick fixes. The service gaps for older patients with mental health difficulties must be considered prior to implementation. All vital outcomes should be considered in initiatives to reduce delayed discharges. Hospital discharge delays are an indicator of whole health system performance.

- In the U.K., 82% of acute trusts have a discharge coordinator and two-thirds have a discharge team. One quarter have a [paper] system of joint records with social services and of these most have seen a positive impact on discharge rates. On any given day, 4,100 older patients in NHS acute care beds are the equivalent of ALC. Factors contributing to discharge delays for older patients on elective admissions include: the absence of alternatives to acute care; poorly coordinated or tardy discharge planning; delays in starting or completing needs assessments; bottlenecks in post-acute hospital care; delays in preparing packages of care due to funding or workforce constraints; poorly coordinated or tardy preparation for day of discharge; and lack of capacity in post-acute care in all health, social services and independent sectors. In September 2002, 26% of patients experiencing delays in discharge were awaiting placement in a residential or nursing home and a further 10% were awaiting placement in a home of their choice. Lack of capacity in alternate care facilities is the leading cause of delayed discharge in England. Recommendations are made for NHS Trusts, including wider circulation of their discharge policies (outside the Trust); early commencement of discharge planning and assessment; mapping older people's pathways through hospital care to identify bottlenecks; involving patients and their caregivers in the discharge process; monitoring the rate and cause of emergency re-admissions; and enhancing the organization of equipment services (National Audit Office 2003).
- A study within a large integrated NHS in Northern Ireland associated poor communication among health and social care professionals with quality problems in discharge planning (McKenna et al 2000).
- Discharge planning is important to overall recovery from illness/injury; has an impact on readmissions; reduces lengths of stay; is particularly important to elderly persons. It is crucial that it be efficient and rapid in an era of financial constraint. Montreal General Hospital staff identified patient populations as in need of new or alternative resources: the very disorganized psychiatric patient who does not integrate well with traditional psychiatric resources in the community (i.e., needs a structured

and supervised group home setting); palliative patients; and patients awaiting transfer to long-term care. Staff recommended the development of interim resources in light of lengthy waiting periods at LTC facilities (Tennier 1997).

- In a Cochrane Database Systematic Review of discharge planning from hospital to home, Shepperd et al (2003) report that nearly 30 per cent of all hospital discharges are delayed for non-medical reasons. The causes of such delay, reported by the U.S. Department of Health in 2003, include inadequate assessment resulting in, e.g., poor knowledge of the patient's social circumstances; poor organization, e.g., late booking of transport; and poor communication between the hospital and providers of services in the community. Readmissions account for one-quarter of Medicare inpatient expenditure in the U.S. The review failed to detect a significant impact on length of stay or readmission rates for elderly patients with a medical condition for discharge planning compared to usual care. Some trials found higher patient satisfaction to be associated with discharge planning. The impact of discharge planning on health outcomes is uncertain. One study found hospital total costs were significantly lower with discharge planning for patients with a medical condition (e.g., readmission at two weeks), but no different for surgical patients. Another found lower costs for laboratory services for patients receiving discharge planning. In one study of discharge planning for stroke patients, a quicker improvement in quality of life and activities of daily living was found for the control group; this surprise finding might indicate there are benefits arising from a less structured, more flexible approach to continuing patient assessment. The reviewers note in their conclusions that a high level of communication between the discharge planner and the providers of services outside hospital is important. They also note in the review that even a small reduction in length of stay or readmission rates could free up capacity where there is a shortage of acute hospital beds.
- The average delay for 3,111 patients awaiting discharge from acute to sub-acute care in 80 North Carolina acute care general hospitals during May 1999 was 16.7 days. A comparable Michigan study identified a rate of 6.5 days. Delayed discharges are believed to compromise the quality of patient care, reflect a lack of efficiency and effectiveness within the continuum of care as well as a lack of service coordination. One study associated discharge anomalies with hospitals being disadvantaged, i.e., larger, urban, not-for-profit facilities located in southern or mid Atlantic states and affiliated with the Council of Teaching Hospitals. The authors of the study note heavy-care patients no longer requiring acute care but with needs exceeding the capacity of nursing homes are occupying hospital beds for long periods of time relative to traditional acute stays (Falcone et al 1991).

- A study conducted in a Barcelona hospital (Moya-Ruiz et al 2002) attempted to determine whether feedback to physicians could lower rates of inappropriate hospitalization. In Spain, more than 75% of inappropriate stays are attributed to medical decisions. The results achieved were not statistically significant for the control or the intervention groups, although feedback to medical staff did produce an absolute reduction of 8.5% of inappropriate stays attributable to physicians. The study authors note that a reduction of as little as 5% can have important economic benefits for hospitals. Approximately one-third of inappropriate stays were attributed to the physician or the organization policy; only two to three per cent was attributed to the patient or family. Length of stay decreased from eight days pre-intervention to seven days during the intervention and six days post-intervention within the intervention group. "Analysis of the reasons behind inappropriate stays reveals that, in line with other studies, the low number of inappropriate days imputable to the patient or the family contradicts the extended belief that these factors are responsible for a significant proportion of inappropriate hospital occupation. Even when taking into account the percentage of inappropriate stays that are deemed to be due to deficiencies in the health care network in general (such as lack of alternative health care facilities), >90% of the inappropriate stays exposed in our study were due either to the physician or to the hospital." (p. 310) The authors conclude that providing feedback to physicians is effective in reducing inappropriate stays attributable to medical staff.
- A study of the appropriateness of stay in five internal and surgical departments providing adult acute care at the University Hospital of Maastricht, the Netherlands, found that 20% was inappropriate (Lambert et al 2002). External factors beyond the hospital's control accounted for 51.5% of inappropriate stay. The lack of availability of ALC facilities accounted for 73.4% of inappropriate stay caused by external factors. Internal hospital procedures accounted for 45.1% of the inappropriate stay. Of this, delay in discharge procedures accounted for 38.1% and delay in diagnostic procedures 34.4%. A low incidence of inappropriate stay in neurology was associated with the practice of using care supervisors, who control discharge procedures. A follow-up study (Lambert et al 2003) of inappropriate stay, which included general surgery, obstetric, gynecologic and ophthalmologic wards, found the rate of inappropriate stay higher in elderly patients, in vascular and general surgery and in cases of lack of available home care. Delay in discharge accounted for 27.5% of inappropriate stay (21.3% attributable to the lack of alternate care facilities), while delay in therapeutic or diagnostic procedures accounted for 38.8%. The study found patients waiting for discharge had a mean age of 45 years and were predominantly female. The average delay caused by lack of available alternate care facilities was 21.8 days, compared to 2.2 and 2.7 for delays caused by diagnosis and

treatment and discharge procedures, respectively. The factors associated with delays in discharge procedures included: patient (18.2%), personnel (13.6%), and planning procedures (68.2%). The proportion of inappropriate stay in the obstetrics ward fell from 13.3% in 2000 to 7.2% in 2002 (Lambert et al 2004) after a change in discharge procedure. Mothers previously remaining in hospital only because the newborn required hospitalization were instead discharged to a nearby Ronald McDonald House, but continued to receive maternity care at the hospital. Admissions increased by eight per cent, reflecting a growing focus on high-risk and/or difficult deliveries, and earlier admission for these patients. Lengths of stay increased but throughput improved, allowing more patients to be admitted. The authors note that the majority of births in the Netherlands take place at home or in an outpatient setting, while hospitalization is indicated for deliveries involving increased risk for the mother and/or child.

- Patient flow problems arising from delayed discharge tend to occur in four stages: (1) delayed discharges on medical/surgical floors increase bed occupancy to full capacity on these floors; (2) ICU units become backed up as new patients are admitted and beds are not available for step-down on the medical/surgical floors; (3) the ED, trauma centre and PACU become full as new patients arrive and existing patients cannot be transferred to the ICU or medical/surgical floors; (4) the ED and trauma centre are forced to go on divert, direct physician admissions and interfacility/intrafacility transfers are denied; surgeries are cancelled. A process improvement initiative at the University of Utah Hospitals and Clinics began with an analysis of the causes of discharge delay (Clark 2005). Thirty non-medical barriers to timely discharge were identified. Patient delay accounted for 8% of occurrences and was the third largest barrier after transportation (27.9% of occurrences) and late discharge order (13.4%), while family delay accounted for 1.5%. Several root causes were identified: lack of awareness of 11 am discharge time among staff and physicians; lack of notification of pending discharge given to discharge planning staff, nurses and patients by physicians; discharge tasks and responsibilities not well defined and delineated among case managers, floor nurses, discharge planners and social workers; discharging patients not a priority for attending physicians, house staff, floor nurses, PICC-line nurses, physician consults, and staff in radiology, lab, physical therapy, inpatient rehabilitation and messenger service areas; transportation delays; manual and cumbersome processes such as writing discharge orders, preparing discharge paperwork and filling discharge pharmacy scripts; and medical patients being much more difficult to prepare for discharge than surgical patients. Benchmarking against 21 best-practice hospitals was used to determine how to facilitate timely discharges. Recommendations for improvement were, in order by greatest potential:
  - Discharge policy (official 11 am discharge policy)

- Discharge orders (official discharge order policy was created requiring physicians to write orders for discharge and discharge-dependent lab work, tests and X-rays preferably the night before the day of discharge and no later than 8 am on the day of discharge)
- Discharge facilitator (a nursing discharge facilitator was hired to expedite orders, assist with patient teaching and discharge paperwork and coordinate among physicians, radiology, lab, pharmacy, case managers, discharge coordinators, and floor nurses, and to work with bed placement nurses and the house supervisor)
- Physician communications (physicians were required to communicate expected discharge dates and times as soon as possible; the standard was on the days of admission for routine patients and no later than 24 hours in advance for more acute patients)
- Other communication (communication to patients regarding discharge time that included request to arrange transportation by 10:30 am); census alerts (an official critical census plan and policy)
- Physician rounds (rounding times were changed to accommodate early discharges and physicians' patients were grouped on the same unit to enhance efficiency)
- Discharge waiting area (used for stable patients awaiting transportation during days of critical census; the authors note that the benchmarking process revealed several hospitals had abandoned the concept of discharge lounges)
- Order alerts (orders for lab work, tests and X-rays were marked 'discharge-dependent' to ensure priority; patient binders were visually flagged to notify unit secretaries that discharge orders had been written; pharmacy process for filling discharge prescriptions was streamlined)
- Order entry (use of CPOE)
- Discharge monitoring (intranet website monitoring discharge times [by physician, unit, service and the overall hospital], census and occupancy rates); goal was to discharge 30% of discharging patients by 11 am and attain an average discharge time of 1 pm
- Staff notification (new bed board showing pending discharge dates and times / entry on EPR)
- Paperwork consolidation (one form used for admission, discharge and transfer; goes directly to patient with discharge orders)
- Discharge coordination (social work used on referral basis for psychosocial issues; case management roles expanded to include discharge planning and coordination oversight; discharge coordinators assigned by floor rather than service to provide single point of contact for physicians and staff)

- Staff notification of completed discharges (entered into admission, discharge and transfer system within 30 minutes of discharge)

The results following implementation included a change in average discharge time from 5:24 pm to 1:16 pm, an increase in annual admissions of 6.5 per cent in year one and 6.1 per cent in year two (following a decline of 3.9% pre-implementation); an increase in the average daily census of nine patients with a constant acuity mix; drop in LOS from 6.3 to 6.0 days; decrease in trauma-divert times; \$5 million increase in net revenue within the first month (Clark 2005).

- In a May 2006 collaborative position paper, OACCAC, OANHSS, OHA, OLTCA recommend the establishment of standard requirements for hospital discharge to LTC homes. For consideration, the associations suggest applicants be required to select two LTC homes with relatively short waitlists on their selection of three alternatives, that applicants' choices be matched with their care requirements and the geographic location of the LTC home relative to their home and/or family, that applicants maintain their ranking on the waitlist of their preferred home upon placement in the second or third-choice home, revoking of the option to turn down bed offers after applications are submitted unless the patients needs have changed substantively or the patient is returning home or to an alternate discharge destination and the setting of a provincially determined per diem rate that ALC patients must pay when waiting for LTC if they do not comply with the requirements of the policy. The associations also recommend the development of common tools for patient assessment and placement. Numerous other recommendations are aimed at resolving system-level challenges.

### ***Discharge Planning Policies***

- A performance framework to monitor discharge delays provides the means to review practice and revise joint hospital/agency policy in a dynamic way. The policy should be readily available to patients, caregivers, families and advocacy services in various formats and languages. The policy should aim to: ensure the patient is treated as an individual and provided with continuity of care; ensure acute hospital facilities are used appropriately; and identify priorities for change. Key outcomes of an effective policy are described (Health & Social Care Joint Unit and Change Agents Team 2003).
- In Australia, NSW Health released a 2001 policy that recommends two strategies for effective discharge: the use of a discharge risk screening tool to identify those at risk of discharge delay and a discharge plan containing an estimated date of discharge. The patient is to be told of the

expected length of stay in advance for booked surgery. An audit of the discharge experiences of patients who had elective carotid endarterectomies failed to link patients' perception of readiness for discharge with preparation through preadmission clinic consultations. Post-discharge communication with GPs was found to be poor; fewer than half of the patients' GPs reported receiving discharge summaries within two weeks of patients' discharge. Personal letters from surgeons were rated as more useful by GPs than the discharge summaries. An electronic discharge referral system is expected to replace written discharge summaries. A subsequent draft policy of NSW Health requires 32 critical 'must-do's as the minimum discharge planning requirements for every patient (Middleton et al 2004).

- A definition of discharge planning by Blumenfield & Rosenberg, cited in Tennier 1997: an "interdisciplinary hospital-wide process that should be available to assist patients and families in developing a feasible post-hospital plan of care."

## ***Patient Outcomes***

- In a retrospective medical audit of the causes of death or hospitalization of adult home care patients from a three-hospital system in Ohio, Taft et al (2005) identified wound deterioration and falls as the principal causes of re-hospitalization. Increasing age and number of medications were correlated with falls resulting in hospitalization. Patients had an average of 9.5 prescribed and OTC medications. The authors cite a study that predicted the risk of adverse drug events approaches 100% when the average number of medications reaches 10. Only 1.9% of the patients in the study were hospitalized, but of these, for 95% the hospitalization was unexpected. Patients with peripheral vascular disease and surgical incisions had the highest incidence of hospitalizations; 37.5% suffered from a decline in wound status. A high rate of diagnoses of diabetes within the sample may explain this finding. Another 31.3% of patients hospitalized had suffered a fall. Obesity, mobility problems and polypharmacy were found to be the likely contributing causes. Other causes of hospitalization were unstable diabetes, respiratory problems, terminal diseases and cardiovascular symptoms. The average number of medications for patients who had falls was 11.08, compared to 8.94 for those who did not fall. Patients who fell were relatively older than those who did not (79.96 years compared to 74.73 years). Being female and living alone were other factors associated with falls. The audit found that 17% of patients who died or were hospitalized had a poor home environment that negatively influenced patient status. An analysis of deaths and hospitalizations suggested 20.8% of cases, mostly hospitalizations, were potentially preventable. Some of the 16 factors

associated with preventable hospitalization were caregiver inadequacy (17.8%), poor home environment (17%), inadequate discharge planning, including referral information (13.9%), insufficient physical assessment or monitoring by care provider (13.9%), poor patient compliance (9.9%), failure of doctor to treat signs and symptoms, to intervene or to monitor (8.9%), failure of home care provider to report findings to doctor (7.9%). This article includes a comprehensive review of related research, and, from this, a list of tactics for reducing the incidence of hospitalization among home-care patients.

- An Israeli study, based on data from a national coronary artery bypass grafting (CABG) study, examined the relationship among hospital ownership (government, insurer, private, public not-for-profit), discharge policy and patient outcomes. The aim was to explore to what extent patient discharge from hospital is a balanced decision between clinical considerations and management policy. The modal day of discharge (day with the highest frequency of discharges) was used in the study as a better reflection of hospital policy. The modal day of discharge was four days for private, five for government, six for public and seven for the nation's largest insurer. Ownership was found to prevail over risk in the study. Two socio-demographic factors were associated with delayed discharge: living alone and country of birth. The authors conclude the results suggest the discharge decision is largely determined by owner-specific policy when the patient does not experience major postoperative complications. Government and not-for-profit hospitals received the same fees for the surgery regardless of length of stay. The insurer was reimbursed by means of a global budget with no incentive related to length of stay. Patients in private hospitals paid a surgeon's fee and daily per diem for hospitalization. The results suggest discharge policy is mainly dependent upon hospital owners' considerations of cost effectiveness. This study found that early discharge after CABG did not have adverse effects on mortality at six months or the re-hospitalization rate at three months providing patients did not have major clinical complications (Galai et al 2003).
- The authors of a UK study of medical patients at risk of difficult or problematic discharge noted a shift in research toward including patient-oriented outcome indicators in addition to organizational outcome indicators for measuring successful discharge. The study tracked decisions about discharge in relation to patient outcomes for patients and their carers. Four sets of participants are identified in the process: hospital-based professionals; community-based professionals, and patients and their carers. Patients and carers were found to negotiate their social roles. The negotiation process can be destabilized by factors such as exacerbation of chronic illness, withdrawal of a resource, or additional stressors (not necessarily health-related), at which point either or both

seek a way out (patient may seek relief of symptoms, family may seek respite care). The result is admission to hospital. Hospital consultants and GPs noted the difficulties they faced in identifying who was responsible for taking action in relation to any particular discharged patient and the resulting postponement in decision-making. District nurses felt hospital staff failed to perceive the breadth of their role. The search for quality of life among patients and families was superseded by the professionals' goal of achieving a minimum functional threshold for health once in hospital. The authors propose an alternate model of discharge planning: a worker who is aware of the patient and carer in their environment and focused on quality of life reviews social roles and sets new goals related to capacities, resources and quality of life to avoid the repeating cycle of admission and discharge. The model promotes health for all parties rather than a functional focus on symptom management (Pearson et al 2004).

### ***Patient Participation***

- In a 1999 study of patients discharged from the medical service of a New York City teaching hospital, Makaryus and Friedman found fewer than half were able to list their diagnoses (41.9%), or the names of their medications (27.9%), their purpose (37.2%), and common side effects (14%). The authors note that discharge from hospital is a critical time for effective physician-patient communication. Upon discharge, patients assume the responsibilities previously held by the health care team and must become familiar with their illness, medications, dosing schedule and the side effects of their medications. Proper instruction is necessary to assure compliance with the treatment initiated in hospital. It is also a right under New York State's Patients' Bill of Rights. Recall tended to be better for those younger than 50 years of age. The authors of this study recommend that a structured and extended physician-patient discussion should occur to improve patients' understanding of their post-discharge instructions. The physician should determine whether the patient understands the plan. Discharge summaries should be well-written and organized and they should provide an easily understandable overview of the patient's condition, symptoms to expect, medications with instructions on how to take them, and expected side effects. Written information has been found to enhance patient recall, e.g., of a physician's name. Counselling by a pharmacist and comprehensive discharge planning and instruction by nurses might also help. Home care providers and family members should reinforce the patient's recall of the discharge planning information. Poor communication is likely the major cause of non-compliance with the discharge treatment plan. The choice of appropriate language, allocation of sufficient time and practicality of the discharge treatment plan should be considered by the health care team.

- In a Swedish study (Efrainsson et al) of the discharge planning conference (DPC), transcripts were analyzed to examine how patients, relatives and healthcare professionals dealt with problems and responsibilities within the institutional context. Patients' rights to autonomy, integrity and normality are emphasized in the governing national DPC procedure. The authors describe the DPC as an institutional conversation with a special form, content, purpose and closure consisting of a formal decision. Professionals have an agenda consisting of questions to elicit information for decision-making. Unaware of this agenda, the patient replies to individual questions without an understanding of the context. The participants are not on equal ground with respect to knowledge, aims and resources, and the communication is asymmetric. The analysis found that patients and relatives had only limited opportunity to influence decision-making in the DPC. The conferences were used to convey information about rules and routines to patients and families. The healthcare professionals did not have the ability to exercise discretion. Participants attempted to find room within the institutional frame of the conversation or to challenge it. The authors conclude that the DPC does not actually achieve its ideological intention. They call into question the need for, validity and efficiency of DPCs in their present form.

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