Effective discharge planning for unplanned admissions to hospital

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Overview

- My Background
- Clinical Contextual
- Research synopsis
- Assessment on admission
- What do we really mean? What’s the risk?
- Patient and Carer emerging perspectives
- Interpretations: changes to practice
Background

• PhD Student, 3rd final year (Profs: Ann Caress & Janelle Yorke).
• 25 years post registered expertise
• Ardent interest in discharge practice
• Research is pre-clinical stage of ‘Complex Intervention’ (MRC, 2008)
• Case Study in Acute Medicine Unit (Yin, 1994).

• Primary research question: How do staff risk assess patients for discharge planning in acute care?

• Post Doctoral research: Development of risk assessment process/toolkit & testing in acute care.
Contextual issues

a. Patient assessment
b. Patient stabilization
c. Patient investigations
d. Diagnosis
e. In patient transfer
f. Discharge
g. Transfer to Intermediate Care or place of care.....
Initial Research Aims

1. To understand how we assess patients for patients
2. To robustly develop items required for a discharge assessment tool (risk assessment/screening).
3. Conduct small scale feasibility testing in acute practice areas.
4. Refine the tool in line with patient experience and the hospital discharge process
As a Scholar, in practice!

That discharge planning has become a managed activity which has far too much emphasis on ‘the organization’, ‘beds’ and ‘capacity’ .... And ‘push’ and ‘pull’ mentality. We must focus upon assessment skills to form a realistic discharge plan.
Research stages

- Risk Assessment Tools
- Literature Review
- Scoping Review
  - NHS & Social Care Policies
- Case Study
  - Research Questions & Knowledge Gap
## Case study – quick view

<table>
<thead>
<tr>
<th>Embedded units for Analysis</th>
<th>Data collection methods</th>
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</thead>
</table>
| **A:** Organizational associations: Policy, Guidelines, Discharge Teams, Capacity Team, Discharge Lounge | Stage 1: Concept Mapping of processes  
Stage 2: Documentary review  
Stage 3: Visits to key areas (field notes) |
| **B:** Initial patient assessment & Ward Round (reviews by medical team) | Stage 1: Non participant observations  
Stage 2: Review of medical records |
| **C:** Patients and their Carers | Joint Interviews with audio recording |
| **D:** Focus Groups: Acute Medicine and other staff associated with discharge practice | Audio recording |

Framework Analysis (Ritchie & Spencer, 2003)

Single Case
Design: Scoping Review

The five stages of the Arksey and O’Malley Scoping Review Process (2005)

1. Identify the review aims/questions
2. Identify relevant policies
3. Study selection
4. Chart the data
5. Collate & report the results
Stage 1: Review Questions

1. What if any, national discharge planning policy exists across the UK to guide the discharge of patients specifically from acute areas/acute medicine units?

2. What are the fundamental components of the discharge processes identified throughout the UK discharge policies and what are the similarities and differences across the UK policies?

3. What if any, are the key recommendations regarding the risk assessment of patients to be discharged from acute care?

4. What if any, commonalities from the scoping review could be integrated to revise the principles of discharge practice in acute care environments?
Stage 2a: Identification of Policy

“The administrative process of discharging the patient live or dead from hospitals”

- Patient Discharge
  - Acute Care
  - Emergency Care
    - Discharge Process
    - Adults
    - Dementia
    - Homeless
Policy Review: Results
Conclusions

- UK Discharge Policy provides ‘general guidance’

- Confusion created by overlaps in terminology, requires interpretation in practice

- Acute admitting areas create another aspect to the process of admission and discharge

- Policy is polarized into general & specialist – acute doesn’t feature

- Bespoke guidance for Acute areas is needed
Literature Review Questions

1. What national policy currently exists to guide discharge planning assessments?

2. What is the discharge process used in emergency care to assess a patient's needs prior to discharge?

3. What, if any, risk tools exist to identify assess discharge needs for patients being admitted to emergency care?

4. What is known about the issues related to the use of discharge planning tools?
Early research thoughts

The systematic use of a *standardised patient risk assessment tool* for discharge planning will improve;

‘the identification, assessment and reassessment of patients' discharge issues - prior to discharge; reduce failed discharges/readmissions and lengths of stay in hospital’
Risk tools*

- Tools in evolution since 1998 arising from USA
- PRA – Priority Risk Assessment
- UNAI – Uniform Needs Assessment Instrument (33 questions, 5 pages)
- Gradually been reduced to 4 core questions
- DRS – Discharge Risk Screening
- Implemented (badly) in Australia
- Sensitivity to respond to identified risk items

NB: *specifically in relation to risk tools & planning for discharge
What were the items on the tool?

**Issues with tools, in general:**

1. The transferability of the tool
2. The specificity and sensitivity of items
3. The lack of reassessment
4. Staff compliance
Pragmatic Interpretations

• Key names and contact numbers
• Key pad number
• Home environment
• Facilities at home
• Services they have
• Baseline function (Independence & goals)
• Equipment
• What they feel they need
Assessment on admission

“As soon as admitted start assessing and discharge planning, or refer to existing plan”

1.3.9

• Making start on assessment
• Asking the ‘right’ questions
• Deposit & transfer that information

Assessment

Structured approach is needed, there is no structured approach in terms of their social situation, home circumstances – everyone asks different questions... depends what WE think is important doesn’t it?

FG 1, Participant 4
Influences on assessment?

• “asking a patient where are they heading? Then you can see a gap between what they want to achieve and what they have (FG6:N)

• “The assessment and discharge plan will vary according to where you are working, I mean if you came in on night to ED, your plan is going to be discharge (FG6, NP)”
What’s the risk?

“Practitioners should explain to the person what type of care they might receive with reference to: managing risk”

1.2.3

- Risk and readmissions
- Risk and extended (perceived as prolonged) length of stay
- Risk and predictive use of resources post discharge
- Risk and adverse outcomes (excluding readmissions, e.g., functional decline).
- Risk and the early identification of discharge planning needs (x2 articles).

Holland et al 2006, 2012
Managing the risks?

• Patients don’t talk about risks
• Perception of risk, whose risk?
• The categorization & appropriate weighting/stratification of risks
• How an individual and their reaction to the issues that comprise them, is their experience of risk
• Risk changes according to setting
Whole concept of risk

Antecedents:
• Less than satisfactory prior living circumstances (socially isolated)
• A sudden event e.g., a fall
• Being new to a caring role/in poor health as a carer

Critical Attributes:
• Additional change in circumstances, e.g. mobility limitations
• Actual ability to of patient or carer to cope
• Number of occurrences of the problem

Consequences:
• Limits persons self care ability/lifestyle
• Needs new services at home
• Permanency of change (s)
Risk as a phenomena

• Span enormous breadth of interrelated topics

  “Risk is a characteristic or set of characteristics that are assessed as being risky if they are perceived as likely to impede discharge planning or result in an unwanted outcome post discharge”....
## Interviews & Interviewees

<table>
<thead>
<tr>
<th>Interview type</th>
<th>Number of interviews</th>
<th>Designations</th>
<th>Gender</th>
<th>Age range</th>
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</thead>
<tbody>
<tr>
<td>Sole</td>
<td>12</td>
<td>Patients</td>
<td>4 male</td>
<td>8 female</td>
</tr>
<tr>
<td>Joint</td>
<td>4</td>
<td>Patients &amp; informal carers (relatives)</td>
<td>7 female</td>
<td>25-101</td>
</tr>
<tr>
<td>Joint</td>
<td>5</td>
<td>Patients &amp; formal carers</td>
<td>4 male</td>
<td>101 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 female</td>
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### Methods:
- Maximum variation sampling strategy
- Framework Analysis (Ritchie & Spencer, 1981)
Emerging Thematic findings

- Discharge Process
- Communication
- Assessment
- Responsibility
- Interprofessional Tensions
- Assumptions
Discharge Process & Tensions

• Managerial contingencies in hospital capacity management – all about time
• Clinical staff contingencies in the discharge process – all about ‘right place right time’
• Patient & Carer engagement in the process
• Minor peripheral things that ‘get in the way’
• Service criteria that can delay patient discharge
Discharge Process & Tensions

The nurses said “leave her there until she’s had lunch & then you can take her down”. They were managers, I think bearing down on the nurses to move me, while I was eating. I sensed some real tension..... IW & JF 20

“I’ve been in prison a few times (laughs) and its like being released” PR-18
Communication

• Time to communicate
• Ability to take in information
• Confused communication
• Lack of communication
• Uncertainty about discharge (what & when)
Communication

“I was told it would be at least two days, then the Doctors came and just said “we are going to make your day, you can go home” MN-13

“Where I’m coming from is that its ‘all or nothing…….’ they don’t really tell you anything and then its ‘you can go’. PM-15

So, when you’re waiting to go, your ready, know what I mean? I waited but I wasn’t in control of when I was going…. PR-18
Assessment

• Lack of assessment
• Too many assessments ‘paperwork’
• The stability of situations – longevity of assessment
• Understanding that situations are dynamic
• Appreciating reality - the strain on carers
Assessment & Assumptions

• “I am not and have never been, his carer. And that is a big assumption they make. I am his wife. And I do totally resent being expected to pick up the pieces.....” FGP & AEP 27

• “They see everything through their eyes, not ours” CJ-11

• It doesn’t feel like an assessment, its just questions and what do they do with all the information? it doesn’t get acted on” ES-02
Responsibility

• It is about the development of a two way partnership, shared responsibility
• Seeing each others perspectives of planning
• Responsibility within a patients case & around the case (process)
Responsibility and sharing

• “I think the trick is to anticipate what you need in advance of going home.....I’ve always been a planner. I’ve always looked after myself” LH 25 Aged 99 years

• “You go to individuals and you ask them how Mom is and they say “sorry I’m not looking after your Mom” JM & C16

• “The thing I don’t get a sense of, that sort never said is, this is where we are at, this we are trying to achieve” SB-26
Cycle of acute discharge practice

- Process tensions
- Lack of readiness
- Uncertainty
- Lack of ownership
- Disempowerment

Patient and carers
Application to practice in AMU

• Written information about discharge on admission
• Using discharge principles
• Using a basic framework
• Sharing assessments with patients & carers
• Empowerment patients & carers through information
• Making time in the discharge process
• Emerging Typology ‘patient led discharge
• Customer service focus
Analytical thoughts

• Patient discharge assessment and risk assessment started to emerge as two different things: assessment of risk was about ‘patient safety’ and assessment for discharge is about ‘planning discharge’. They are referred to synonymously.
Summary

• Congratulations – first time where there is a strong presence of emergency care
• This is an optimum time for all partners involved in discharge to revisit the process
• Risk is contextual and dependant (contingent)
• Keep in mind ‘protocols’ must be patient centred
• They must not exclude
• Above all, training to assess and embrace complexity and to simplify
• There are many different models of discharge coordinator
• “Access, Choice and shared decision making”.
Just Published:

Work in press:

Questions

Thank you for listening

Life Time Fellow of Society for Acute Medicine – Awarded 2016