Discharge planning: the role of the discharge co-ordinator

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The barriers to implementing successful discharge are complex and linked to the individual, team and organisation (Cannaby et al 2003). A Cochrane Review by Shepperd et al (2004) suggests that evidence is unclear in relation to the effects of discharge planning on hospital stay, readmission rates and health outcomes.

International policy on older people is aimed at supporting and enabling people to remain in their own homes or community for as long as possible (DH 2001, DoHC 2001, Nies and Berman 2004, Government and the Government Offices of Sweden (GGOS) 2007). Various innovative types of supports and services...
have been developed to improve efficiency in the pre- and post-discharge period nationally and internationally. These include the introduction of discharge co-ordinators, case managers, nurse-led discharge, discharge teams, single assessment processes, reimbursement, rehabilitation teams, convalescent schemes and hospital-at-home schemes (Shepperd et al 1998, Dukkers van Emden et al 1999, Gibbon 1999, DH 2001, 2003, 2004b, DoHC 2001, Pethybridge 2004, Crocker and Keller 2005, Efraimsson et al 2006, Sargent et al 2007). Of these supports and services, the most frequently employed are nurse discharge co-ordinators. This may be because nurses occupy a central role in care, they identify needs and take patients’ histories as an inherent part of their work and interact with families and the multidisciplinary team on an ongoing basis (Houghton et al 1996, Peters et al 1997, Dukkers van Emden et al 1999).

A study from the United States by Naylor et al (1999) finds that individuals are less likely to be readmitted to hospital if discharge was arranged by an advanced practice discharge nurse and follow-up home intervention was given. Policy documents support the development of specialist and advanced roles to deliver more person-centred care (Government of Ireland 1998, DoHC 2001, Royal College of Nursing 2005) and discharge planning policy has emphasised nurse-led discharges (DH 2004a). A literature review by Coffey (2006) finds that there is a paucity of research into the role of discharge co-ordinators who were introduced to support discharge. This study explored the role of discharge co-ordinators and their perspectives on discharge planning in an Irish healthcare setting.

**Aim**
The aim of this study was to explore and describe how discharge co-ordinators perceived their roles.

**Method**
An exploratory, descriptive research design was used. After receiving ethical approval, permission to access the sample was provided by the directors of nursing and hospital managers. A convenience sample of discharge co-ordinators (n=6) was chosen from six acute hospital settings in one geographical area in the Republic of Ireland. Inclusion criteria were that discharge co-ordinators had to be a registered nurse with a minimum of two years’ experience as a discharge co-ordinator. Individual semi-structured interviews were conducted and assisted by an interview guide, as advised by Morse and Field (1996). A pilot study of the interview format was conducted and no changes were required. Participants were guaranteed anonymity, both verbally and in writing. All interviews were audio-taped with the permission of the participants and lasted on average 45-60 minutes.

Data analysis involved transcribing the interviews and examining the text for emerging themes. Bernard’s (1991) nine-stage process identified the patterns and unique themes, the commonalities and the differences in the participants’ responses. Themes were independently identified by three researchers.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories to emerge from interviews</th>
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| **Assessment**        | ■ Assessing patients’ needs  
■ Cognitive, activities of daily living, home environment and social support networks  
■ Identify future care needs  
■ Assessment for continuing care |
| **Communication**     | ■ Communicating, co-ordinating and planning  
■ Referrals: medical consultants, ward managers, nurses, public health nurses, patients and families  
■ Building relationships  
■ Sourcing supports and services  
■ Negotiation and interpersonal skills  
■ Methods: letter, fax, telephone, meetings, case conferences, hand-written records and computerised records |
| **Multidisciplinary working** | ■ Teams in hospital and community, voluntary agencies  
■ Variety of team members and services  
■ Development of teams at different stages |
| **Factors that affect role** | ■ Empowerment: length of services, supports in place pre- and post-discharge  
■ Disempowerment: duplication in assessment, services not in place, unplanned discharges  
■ Diversity in patient groups – worked with patients under and over 65 years  
■ Poor service development for people under 65 years  
■ Education – experience no formal education or training |
Assessment

Assessment of patient’s needs was considered vital for effective discharge planning by all participants. However, the way in which discharge assessment information was recorded and communicated varied in hospitals and between hospitals and primary care settings. The assessment in the discharge process was focused on identifying needs and was illustrated in the following comments:

“You are getting a grasp of what things are like at home, seeking information on what community services are in place, the home help, meals on wheels, regular visits from the community nurse, day care, personal alarm…home environment.” (Participant (P)5)

“The earlier they’re identified as patients who have complex issues around their discharge, the earlier we can intervene and speak to families and just get the feel of what the social situation is like, then the more successful the discharge is.” (P5)

All participants agreed that the assessment supported and enabled referral to the multidisciplinary team in the hospital and in community care. Although assessment was viewed as important by the majority of participants there were inconsistencies in the methods and rationale used. The majority did not use a comprehensive multidisciplinary assessment, discharge planning checklist or carer assessment. This means that coordinators did not use standardised assessment methodologies, as recommended by national or international guidelines (DH 2003, DoHC 2003, HSE 2008, GGOS 2007).

Communication

All participants played a role in co-ordination, liaison, planning, communication and execution of the discharge process. All participants stated that they worked mainly with ‘complex cases’ described by one participant as:

“Everybody who is living alone, recently bereaved, in rehabilitation previously, people who would have major complications in hospital and those who would be living with frail elderly carers and those who may or may not have community supports.” (P2)

Participants communicated with various people while co-ordinating and facilitating discharge, including carers, families and patients. The importance of good working relationships, with community nurses to identify home situations before admission, was highlighted in the following statement:

“The need to take on board the very valued opinion of the community nurses as regards knowing the detail of this person’s health, social situation and to marry that in with my perception of whether the patient would be physically able to achieve independence enough to go back to that situation.” (P4)

Participants commented on the pivotal role they had in discharge planning for the transition of patients across various settings, acute services to home, to convalescence or to continuing care. The role involved organising and sourcing various home supports according to need, for example respite care beds, convalescence care, home help, home care packages, meals on wheels, rehabilitation services equipment, transport, and applying for and negotiating finance for continuing care placement. Nearly all participants alluded to the hidden and multifaceted nature of their role. They provided examples outlining the use of interpersonal skills and knowledge required to manage team relationships, family carer’s issues, as well as sourcing a diverse range of agencies and services in easing discharge.

Methods of discharge communication practices varied from the use of occasional letters, phone calls and facsimiles, to occasional meetings, multidisciplinary team case conferences and home visits. All participants were involved in collecting statistical information but there was no evidence of audit in place. There were commonalities between participants in relation to the information collected, but diverse responsibilities were held in discharging this role function.

Multidisciplinary working

All participants stated that they worked with multidisciplinary professional teams in hospital and in the community and with a range of statutory and voluntary agencies. The multidisciplinary team approach was favoured, however, most participants expressed feelings of isolation, for example: ‘I’m a one-man band really, full time on my own.’ (P4)

The majority of participants met with the patient as soon as possible after admission, however, one participant commented that: “Consultants do not like me to get involved too quickly.” (P6), indicating some reservations concerning the role from one medical professional to another. Alternatively, nearly all participants took the lead for other team members in bringing concerns to consultants as they felt consultants knew them and listened to them.

Participants identified a range of people and
services with whom they interacted and engaged to smooth transition from hospital to interim care or to community care (see Table 2). One of the reasons given for the diverse engagement was ‘[We] try and prevent the revolving door and make things better for the client going home’ (P2). Engaging with social workers or community welfare officers during the discharge planning process was not the norm. This finding was surprising as these professionals are key personnel in supporting people in their communities.

Participants described involvement in a multidisciplinary team yet felt isolated in their role. This may be because multidisciplinary teams were at different stages of development and communication varied within teams.

Factors that affect the role of discharge co-ordinators

A number of factors were perceived to affect the role of discharge co-ordinators. These included working with a diverse population in terms of age; underdeveloped services in the community to meet the needs of those with chronic illnesses or disabilities; holding dual role responsibilities, for example, bed manager or complaints officer as well as co-ordinator; communication difficulties; and disempowerment.

Participants felt less confident when services or specialist assessment for patients were not readily available. In addition, all participants experienced disempowerment where medical consultants made the decision to discharge and unplanned discharges took place. Some of the difficulties experienced are captured in the following comment: ‘It is quite frustrating when you send patients home... you have communicated with the community nursing services in relation to giving home help and then three weeks later the patient is ringing up saying they had no assessment yet... or there is a lack of a resource or continuing care bed delaying discharge. Also seeking assessment from geriatrician and he comes when patient has gone home, this can be quite disheartening.’ (P1)

Empowering features of the role included: broad range of experiences and knowledge gained from length of service in post; good working relationships with other disciplines and the sense of satisfaction when co-ordination went well, as captured in the following comment.

<table>
<thead>
<tr>
<th>Table 2. Communication links identified by participants</th>
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<tr>
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<tr>
<td>Geriatrician/consultants</td>
</tr>
<tr>
<td>Clinical nurse managers/nurses</td>
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<tr>
<td>Physiotherapists</td>
</tr>
<tr>
<td>Occupational therapists</td>
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<tr>
<td>Speech and language therapists</td>
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<tr>
<td>Social workers</td>
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<td>Community welfare officers</td>
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<td>Public health nurses</td>
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<td>General practitioners</td>
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<tr>
<td>Voluntary and statutory groups</td>
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<tr>
<td>Community rehabilitation support team</td>
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<tr>
<td>Aged care team</td>
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<tr>
<td>Multidisciplinary team community</td>
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<tr>
<td>Continuing care placement co-ordinators</td>
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<td>Home care package teams</td>
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‘Getting a place for a patient on discharge is great as there are a lot of restraints in the system that you are up against.’ (P1)

None of the participants had an educational background in community nursing, and community staff were the main sources for information on community services and supports. Knowledge of services available in the community was gained ‘on the job’ and this led to difficulties at times. Factors that were empowering were good working relationships and a sense of satisfaction. Factors that were disempowering were poor communication, underdeveloped community services, duplication and lack of educational preparation for the role of discharge co-ordinator.

Discussion
The role of the discharge co-ordinator was described by participants as multifaceted. All participants in this study worked with complex cases and saw themselves as integral to the management of the patient’s transition from hospital to primary care. The methods of assessment for discharge varied and there were no standard practices in discharge assessment or documentation.

These results are at variance with best practice nationally and internationally (Peters et al 1997, DH 2003, DoHC 2003, Helleso 2006, HSE 2008) which find that the use of structured and standardised templates were effective in supporting discharge. It is apparent that nurses in Ireland need to develop best practice initiatives in assessment. Communication (verbal and through documentation) was identified as paramount to the role, however the methods and systems used were not consistent. These findings are consistent with previous research (Murphy 2002, Dunnion and Kelly 2005, 2007, 2008) that there are problems with communication across the interface between acute and community care. Good team working, communication and leadership are vital to the success of discharge planning (Dukkers van Emden et al 1999). Changes need to be made in communication patterns. Given the proliferation of information technologies now available, it is recommended that consideration to use such technology be given.

All participants in this study worked in conjunction with multidisciplinary teams in hospital and in community care. All participants had skills in communication, liaison and co-ordination of the discharge process, most of which was learnt on the job with no formal training. Evidence recommends that training and education on discharge planning is required to develop competencies and skills of nurses to lead multidisciplinary teams and support transition of clients from hospital to community (DoHC 2003, DH 2004a, Lees 2004). However, there was a perceived lack of autonomy in some situations regarding discharge management processes. A number of participants felt disempowered when assessment was duplicated by another professional or discharge took place in an unplanned manner. This may be attributed to dual role responsibilities which

References


participants held. Advanced nurse practitioners and nurse-led discharges have been shown in the literature to improve patient outcomes (Naylor et al 1999, Crocker and Keller 2005). These roles should be developed in the Irish healthcare system.

The present study had certain limitations. Participants were selected by convenience sampling and were not representative of the national situation and limit the generalisation of the findings. However, the research does provide a description of the role of discharge co-ordinators from the perspective of discharge co-ordinators, albeit in one geographical area. As the study was descriptive it did not explore the contribution of discharge co-ordinators in the individual multidisciplinary teams.

**Conclusions**

Good quality discharge planning process is essential for continuity of care across the interface of services. The main themes identified in this study capture many of the problems and difficulties on discharge planning. For nurses in Ireland it is recommended that policies and procedures for discharge planning, as well as discharge assessment and referral documentation, should be developed, agreed and standardised with key stakeholders. Audit needs to be put in place. The role of discharge co-ordinators should be clarified and maybe extended to include nurse-led discharges in Ireland. Training and education on best practice in discharge planning, teamwork, change management and leadership is required to challenge the current organisational systems and processes in place in the Republic of Ireland.

Discharge planning is a complex area of practice and discharge co-ordinators, in this study, need to be involved at an individual, team and organisation level to promote best practice in discharge planning practices. Future research in Ireland could look at communication practices, multidisciplinary team working, patient’s journey and process of discharge as well as outcomes.

**Implications for practice:**

- Standard policies and procedures for discharge planning need to be reviewed/developed and agreed by all stakeholders.
- An accredited standard assessment process should be devised and used across acute and community settings.
- Standard discharge referral documentation should be developed with all key stakeholders—patient, carers and multidisciplinary team members across health and social care in acute and community settings.
- Education and training in best practice in discharge planning should be provided for discharge co-ordinators and all staff involved in the discharge process.
- The role of the discharge co-ordinator should be clarified and could be enhanced to include nurse-led discharges. This could be implemented as a pilot project.

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