Improving discharge: the role of the discharge co-ordinator

Discharge of patients from hospital has in the past been handled haphazardly by healthcare professionals. Co-ordination of this important part of a person’s experience of hospital would have psychological and emotional benefits for patients, staff and the NHS as a whole. In this article, the author describes the role of the discharge co-ordinator in planning strategically for patient discharge. In a second article, to follow shortly, the author discusses how multidisciplinary liaison can be improved.

As the population ages, more and more people, especially those aged 85 years and over, have continuing healthcare needs (Audit Commission 1996). Increasingly, these needs are being met by members of a multidisciplinary team. This team includes:

- Independent sector, community and hospital-based nurses
- Home care services
- Social services
- Housing departments
- Physiotherapists
- Speech and language, occupational and hearing therapists
- The person’s family.

Ensuring that the threads from different strands of care are woven to provide ‘seamless care’ requires careful planning and co-ordination.

Poorly co-ordinated discharge has enormous emotional and financial costs. The emotional costs are borne by older people, their families and professionals struggling to provide a service in the absence of strategic planning. The financial costs are borne by NHS hospitals as rising numbers of blocked beds and emergency admissions threaten to paralyse acute healthcare services. Discharge coordinators can enable hospitals to use a strategic approach to co-ordinate care, enhance its quality and reduce costs.

Box 1. The benefits of co-ordinating discharge

- Ongoing discharge planning will reduce ‘lost bed days’ and reduce costs
- Increasing efficiency and reducing numbers of people readmitted because of poorly co-ordinated discharge
- Reducing level of complaints by improving communication and involving patient, family and other professionals in ongoing discharge planning
- Improving staff morale and efficiency by offering well managed, co-ordinated discharge and ongoing care when required

Strategic planning Strategic planning takes into account the complexities and pace of change in current healthcare services and allows practitioners to examine action, interaction and the effect of internal and external factors on an organisation. Thompson and Strickland (1990) suggested that strategic management comprises five components, in that it will:

- Define overall business and develop a principal goal
- Break down the principal goal into specific long and short range performance objectives
- Craft a strategy to achieve organisational objectives
- Implement and execute the strategy
- Evaluate, review and adjust the implementation activities as required.

Box 2 contains an overview of these five components as applied to patient discharge.

The discharge co-ordinator’s work has two main components:

- To set up systems that enable health professionals to work together and allow effective discharge to take place
- To evaluate and review the effectiveness of each service’s interaction with the others.
Discharge planning should begin when the decision to admit has been taken. Hospitals have become increasingly busy and the average length of stay has fallen. Consequently, there is less time for staff to get to know the people they are caring for and plan for discharge, thereby meeting all their different needs.

**Interprofessional recordkeeping**
Interprofessional recordkeeping remains rare in UK hospitals. In normal circumstances, nurses, doctors, physiotherapists, occupational therapists, speech and language therapists and care managers keep their own records. This practice leads to poor communication and inhibits team working. The discharge co-ordinator must operate across professional boundaries and introduce interprofessional working and recordkeeping to allow effective discharge to take place.

Nursing records rarely contain details relating to a person's previous level of function or home circumstances (Wiffin 1995). However, without such information it is impossible to make informed decisions about discharge (King and McMillan 1995).

For example, nursing and medical staff may consider that Mrs Foster, admitted following a stroke, has made good progress as she is now able to walk short distances with the aid of a tripod. However, the fact that she lives in a first floor maisonette may only emerge when discharge is imminent. The lost bed days will mount as Mrs Foster awaits a home visit.

The average length of hospital stay following discharge delays will produce increased costs, increased bed occupancy, effect on the others and may lead to poor communication within the team. Without such information, the nurse is unable to plan for discharge. To improve the quality of patient care and reduce lost bed days, the discharge co-ordinator can demonstrate the need to introduce systems to prevent discharge delays.

**Box 2. Discharge planning – a strategic overview**

- To promote good health, thus reducing need for hospital treatment
- To provide efficient and effective health care when people become ill, thereby reducing the length of hospital stay
- To reduce morbidity, measure outcomes of healthcare interventions, reduce the rate of lost bed days and readmission
- To integrate health promotion, acute, rehabilitative and community care, and achieve measurable targets in improved health, reduced morbidity, lost bed days and readmission rates
- To implement and measure specific targets
- To evaluate and review implementation activities and assess the effects of each service's interaction on the others

**Box 3. Discharge planning in action**

Mrs McDonald was mobile and living at home. She was admitted to A&E following a fall. Although her fractured neck of femur was treated successfully, discharge was delayed because she developed a grade five pressure sore. Mrs McDonald waited for many hours on a trolley in the A&E department. The trolley was not fitted with a pressure relieving overlay and this, combined with the length of her stay in A&E, undoubtedly contributed to the development of a pressure sore. The discharge co-ordinator could use this incident to argue for the provision of pressure relieving equipment in the A&E department to improve the quality of patient care and reduce lost bed days.

Medical staff decided that Mrs Thatcher was ready for discharge. Multidisciplinary assessment revealed that Mrs Thatcher required continuing care. Her discharge to the nursing home of her family's choice was delayed by two weeks because her care manager was away. This delay resulted in 14 lost bed days and costs of £1,850. In this case, the discharge co-ordinator can demonstrate the need to introduce systems to prevent discharge delays.
**Fig. 1. Multidisciplinary discharge form in use**

<table>
<thead>
<tr>
<th>PROFESSIONAL</th>
<th>HISTORY</th>
<th>TREATMENT</th>
<th>OUTCOME: IE, RESOLVED OR RECOMMENDATIONS</th>
<th>FOLLOW UP?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td># Femur following fall</td>
<td>Stabilised with right dynamic hip screw. CVA post-operatively. Immobile</td>
<td>Femur successfully repaired. Hb 12.8</td>
<td>Co-proximal six hourly prn</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>Non-weight bearing Requires assistance to wash and dress Reluctant to eat Sacral pressure sore grade 3</td>
<td>Transfer using hoist Nursed on low airloss mattress Referred to continence adviser and dietician – awaiting visit</td>
<td>Remains immobile Wound clean, granulating now 3x7cm grade two</td>
<td></td>
</tr>
<tr>
<td><strong>Nurse specialist</strong></td>
<td>Atonic bladder post-CVA</td>
<td>Bladder USS = residual urine of 600ml. Urethral catheter 12Fg with 10ml balloon Catheter valve drainage</td>
<td>Will review in six weeks</td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Immobile, post-CVA and # femur</td>
<td>Foot drop, slight internal rotation, left foot and ankle</td>
<td>Refer to orthotist for specialist footwear to correct deformity Refer to community physiotherapy team Team leader – 0181 123 4567</td>
<td></td>
</tr>
<tr>
<td><strong>Speech and language therapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing therapy</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthotist</strong></td>
<td>Foot drop and internal rotation, left foot and ankle Measured for ankle boots to correct deformity</td>
<td>Boots to arrive 26/7/97</td>
<td>Will contact Hollyoaks nursing home to arrange fitting</td>
<td></td>
</tr>
</tbody>
</table>

Introducing discharge documentation that provides meaningful information about all aspects of care is vital to ensuring quality of discharge. Figure 1 shows how a multidisciplinary discharge form can be used to ensure effective communication and continuity of care.

**Evaluating service effectiveness** Monitoring and evaluating the discharge process enables the discharge co-ordinator to develop a strategic overview of healthcare in the hospital environment and to identify areas of practice that are preventing effective discharge. Box 3 contains two short case studies demonstrating how these factors might be applied in practice.

**CONCLUSION**
The discharge co-ordinator’s role should be wide ranging and encompass strategic and day-to-day discharge management. It is a role that requires an experienced senior nurse with excellent management, clinical and interpersonal skills. Support is essential if the discharge co-ordinator is to function strategically and work proactively to enable effective patient care and efficient use of available resources.

**REFERENCES**
NHS and Community Care Act (1990) London, HMSO.