Audit in practice: planning for discharge from hospital

In this discussion of audit, the authors describe a pilot study on discharge planning. They review existing literature on discharge planning and outline how the results and lessons of the pilot study will help develop a full audit and quality cycle in the future.

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KEY WORDS

- MULTIDISCIPLINARY TEAMS
- DISCHARGE PLANNING
- NURSING AUDIT

Discharge planning has been widely researched over the past two decades. The literature covers a number of issues ranging from the assessment of patients, implementation of discharge planning to the outcomes of effective and ineffective discharge planning (Tierney et al 1994, Victor and Vetter 1988).

LITERATURE REVIEW

Most studies show that health professionals fail to assess patients' needs prior to discharge. However, Waters (1987) argued that 'discharge doesn't begin on the day the decision is made to send a patient home', suggesting that planning should commence on admission.

Social needs also appear to be ignored. Skeet's survey (1970) showed that few patients had been asked about their likely domestic arrangements on their return home, making accurate evaluation of need difficult. Bowling and Betts (1984) and McBride (1995) showed that the situation has not changed, highlighting similar concerns.
Assessing social circumstances may be of particular importance to the
discharge of elderly patients, as a number of reports suggest that they
are likely to need a greater level of care after discharge than they had
needed prior to admission (Bowling and Betts 1984, Victor and Vetter

Several studies have shown that the greater the level of patient and
family involvement in discharge planning, the more positive the patient's
perception of their readiness for discharge (Coulton et al 1982, Jacobs
et al 1985, Simmons 1986). Following such studies, the Guide to Good
Practice on Discharge from Hospital was published (SOHHD 1993),
emphasising involvement for patients, who had been previously
promised 'good information, good planning and constant attention to
detail' in the process of transfer from hospital to community care (DoH

Although many studies recommend assessing patients for discharge at
the time of admission, surveys relating to hospital discharge (Tierney et
al 1994) found that for both GPs and community nursing staff,
post-discharge assessment was a much more common activity. In
addition, it was considered essential to examine the impact of the
discharge planning process on the community.

**Communication** A number of studies suggest a complementary
relationship between quality of communication between hospital staff,
family and community personnel and patient outcomes (Agate 1985,
Waters 1987). However, few studies have investigated the effect of
hospital-community communication on the implementation of a plan or
on patient and family outcomes.

Poor communication between hospital and community staff is not new;
research carried out by Skeet (1970), Amos (1973) and Hurst (1975)
highlighted problems. Waters (1987) suggested that there was little
effective dialogue between hospital and community and not all the
relevant information was passed between care teams. Moreover, the
information exchanged was often insufficient or incorrect (Bowling and
information communicated from hospital to community staff. The
researchers went on to show that both GPs and the majority of district
nurses indicated a preference to receive information about a patient
before discharge, but almost 60 per cent had reported that they seldom
or never received written discharge information at their preferred time.

For effective and efficient discharge planning to be implemented, good
communication between all relevant health professionals, the patients
and their carers is required. However, it is difficult to assess inter-
professional interaction as most instruments already available tend to
focus on nurse-patient interaction.

**Multidisciplinary approaches** Although most studies recommend an
interdisciplinary approach to discharge planning, all literature reviewed
for this pilot study was found to be discipline specific. However, the
importance of interdisciplinary co-operation in discharge planning has
been a point of repeated emphasis in policy guidelines, research and
DoH recommendations. Tierney et al (1994) found that this approach
was limited beyond the confines of the acute sector; the researchers
stated that community-based professionals were reported by ward staff
to have little involvement with patients and the ward. The same situation
was found for patients, GPs and health visitors. Not surprisingly, district
nurse liaison staff were the most involved.
Outcomes of care

Previous studies of patient discharge planning have evaluated outcomes such as the type of aftercare arranged (Hurst 1975, Roberts 1975, Skeet 1970); how quickly aftercare is commenced (Amos 1973, Gay and Pitkeathley 1979, Vyclelingom 1989); how quickly community staff receive information from hospital (Bowling and Betts 1984, Hurst 1975, Skeet 1970); and readmission rates (McInnes et al 1988).

In their review of the literature, Thomas and Bond (1991) found that the most common measurable outcome used was that of patient satisfaction. However, although widely used, the concept of patient satisfaction is complex. Thomas and Bond (1991) also identified five other commonly used outcome measures in US literature, namely patients' knowledge of self-management, patient wellbeing, patient stress, length of stay and number of patient complications. However, these were not exclusively linked to discharge planning. It is difficult to establish whether discharge planning directly influences a patient's health status and indeed some studies have shown there to be no significant impact on patient outcomes (Naylor 1990). Therefore, while many of the studies reviewed have highlighted the outcomes of discharge, few have provided a detailed picture of the structures and processes associated with the outcomes.

Tierney et al (1994) drew attention to the perceived vulnerability of elderly patients among GPs and community nurses on discharge from hospital. However, most studies appear to concentrate upon discharge home when, in fact, residential care has now become a growing option for the elderly population. This growth is seen as a decline in local authority accommodation, offset by an expansion in private accommodation and, according to the DSS (1989), such a trend is likely to continue in the light of recent community care changes.

PERCEPTIONS OF CURRENT PROBLEMS

Staff perceptions of current discharge planning procedures are not well documented. However, in Tierney et al's study (1994) staff identified a number of factors which, in their experience, inhibit satisfactory discharge planning. The factors cited include ambulance/transport problems, discharge notice being too short, failure in provision of needed services, prescription problems, difficulties with relatives, delay in discharge letters, lack of multidisciplinary communication, difficulties with the social work department, inadequate occupational therapy input, and poor social circumstances.

Suggestions for improvement

Suggestions for improvement were few but did include the need for a better ambulance service, longer discharge notice, discharge planning standards, improved interdisciplinary communication, early planning for discharge, improved prescription provision, use of a discharge checklist and responsibility for the process resting with the named nurse.

In conclusion, Tierney et al (1994) reported that hospital staff generally felt positive towards current discharge practice but they recognised problems. Community nursing staff and GPs felt negative in relation to the effectiveness of discharge planning, particularly in the area of communication and their minimal involvement in pre-discharge planning. Although this study is valuable, it does not consider the perceptions of the other members of the interdisciplinary team and it could be argued that this reflects the focus of the rest of the literature.
Conclusions from the literature It is difficult to compare the literature on discharge planning due to variations in research design, validity, populations targeted and outcomes that are measurable (Hogan 1990). Most research has been quantitative with no qualitative studies of patients and families’ perceptions of their quality of life after discharge. When any attempt has been made to conduct a qualitative study, researchers have used phrases such as ‘probably has improved their quality of life’ (Jackson 1989, Naylor 1990).

More than a decade ago, Bowling and Betts (1984) identified that a multidisciplinary approach was needed and that nurses should fulfil the central co-ordinating role. Tierney et al (1994) supported this recommendation. The Audit Commission (1991) indicated that, in practice, much of the responsibility for discharge planning rests with nurses. Scottish Office guidance stipulates that the named nurse should co-ordinate discharge (SOHHD 1993), but it still appears that discharge planning is not as effective as it could be.

AUDITING DISCHARGE PRACTICE

In Wigan and Leigh NHS Trust, two part-time district nurses were appointed as community nurse auditors to develop the post and to identify areas of audit activity. The initial task was to carry out an audit of the interface between primary and secondary care, especially in the area of discharge planning. Discharge planning in this context was taken to refer to the ‘period of preparation’ (Armitage 1981) necessary for arrangements to be made and embraces ‘adequate notice of discharge, discussion of aftercare arrangements and liaison with community services’ (Victor and Vetter 1988), as well as the education of the patient and carers (Booth and Davies 1991).

A steering group was formed consisting of representatives of disciplines involved in the discharge process. The group comprised nurses from the medical ward and day surgery unit, district nurses, a school nurse, health visitor, practice nurse, specialist nurse, discharge co-ordinator, ambulance co-ordinator, research nurse, occupational therapist, home care organiser, liaison pharmacist, dietician, physiotherapist, carers’ representative and social workers. A named GP became a link person on the group. Other relevant professionals were to be co-opted as the project developed.

GP INVOLVEMENT

Participation from GPs was essential and their input was requested through the medical audit advisory group (MAAG). The project was presented at a MAAG meeting and received full support and co-operation from the GPs present.

The consensus was that the aims of this audit could be best achieved through developing a questionnaire in collaboration with the GPs. This was carried out at a subsequent meeting attended by the MAAG chair and two representative GPs, the MAAG facilitator and the auditors. Areas of concern to GPs surrounding discharge planning were highlighted and it was decided that two methods of data collection would be needed to cover the issues:

- A short but relevant questionnaire was sent to all GPs throughout the trust with a covering letter from MAAG
- A checklist to be completed by the receptionist in relation to the
discharge letter (after two weeks), and the typed discharge summary (at six weeks).

It was necessary to identify existing benchmarks. To achieve this, the trust's discharge policy and standard was compared with DoH recommendations (1991), UKCC recommendations (1997) and the Patient’s Charter (DoH 1991).

PROJECT DESIGN

Nurse managers in all directorates were informed of the appointment of the community nurse auditors and were invited to submit representatives from their area as contacts for the project. A critical pathway was created to ensure that the project managers were clearly focused on the task in the timescale allocated.

The project sought the views of patients, carers and health professionals, and data were collected using questionnaires for both hospital and community nursing staff, semi-structured interviews with patients, semi-structured interviews with carers, and a GP questionnaire. The project managers believed these two methods would provide reliable, timely information and would formulate the basis for a full study in the future.

As part of the project criteria certain categories of patients were excluded:

- Terminally ill patients – it was felt that these patients had very specific needs in relation to discharge planning and that this could not be demonstrated in a general audit
- Patients with mental illness – this patient group was also seen as having specific needs
- Patients with non-accidental injury – the sensitive nature of this issue made these patients unsuitable for general audit.

Pilot sample

Ten questionnaires were distributed to qualified nursing staff on medical and surgical wards in each of three hospital sites, a total of 30 questionnaires, with a 40 per cent (12) response rate. Fifteen questionnaires were distributed to qualified community nursing staff at a random selection of clinics. The major part of the community questionnaire was targeted solely at first level nurses holding a district nursing certificate. The response rate was 73 per cent (11). The low response rate, particularly from hospital staff, would need to be addressed in a full audit to allow valid recommendations to be made.

DISCUSSION

It would appear from this pilot study that there is an identifiable gap at the interface between primary and secondary care. There was dissonance between some of the staff responses; for example, 81 per cent of community nurses said they did not know the named nurse in the hospital when the patient is transferred, but 55 per cent said that they negotiated verbally with the hospital named nurse. This would indicate one of two scenarios:

- The concept of the named nurse is misunderstood
- The district nurses’ perception of the question asked about verbal communication differed to their perception of knowledge of the named nurse; this may be because the latter question was
The response to the question about hospital staff's estimation of the patient's/carer's ability to cope would point to a significant deficit in the hospital staff's perception of caring for the patient in the community. This would perhaps indicate a greater need for collaboration between hospital and community staff and it may be that a full study would highlight the need for a shared education programme.

All of the above would either be supported or rejected on the basis of the patient's/carer's responses to the interview questions proposed. On analysing the answers it has been found that several questions on both the hospital and community questionnaires are ambiguous and require amendment. This led to difficulty when inputting the data on some occasions. Some clinical staff had obviously used the opportunity of this pilot study to express both concern and dissatisfaction with the current system for discharge planning. In fact, on occasions, the replies appear to be giving vent to some frustration with the discharge process (Box 1).

One of the greatest benefits experienced to date from this project has been the development of the steering committee. The energy and enthusiasm brought to this project from the various group members has been invaluable. It has provided a resource for information gathering and sharing experiences. Additionally, it has increased all participants' awareness of the roles and responsibilities of the members of the healthcare team.

Staff in each specialty have now taken responsibility for co-ordinating questionnaires within their own area to provide feedback for the committee. This should provide information to ensure that the discharge planning audit process is truly interdisciplinary in nature.

Problems during the project Initially there was no office space identified for the managers. However, this was addressed within five weeks of the project starting. All the basic and technical equipment had to be purchased, thus causing some delay at the beginning.

Clerical support has proved problematic throughout. Although the project was allocated 20 hours per week clerical time, this was rarely a reality due to sickness and absence. In effect, both project managers have had to cover their own clerical work, causing a significant workload above that which was predicted at the start. Lack of clerical support was also the likely cause of the poor response from hospital staff.

RECOMMENDATIONS FOR THE FUTURE
Following the pilot study, the project managers believe that a full audit should be undertaken. This would involve:

- Questionnaires, modified for both community and hospital staff with focus groups being held to inform modified questionnaires
- Questioning 75 per cent of all qualified nurses on three hospital sites and 100 per cent of all district nursing sisters in all clinics within the trust. Such numbers would provide an adequate sample size to allow for non-returns, enabling valid recommendations to be made. The spread across three hospital sites and all clinics will enable comparisons to be made regarding both the process and the outcomes of discharge planning.
- Semi-structured interviews with both patients and carers. An opportunistic sample of 50 patients discharged over the three
hospital sites over a three-month period, within the definition of complex cases, would be required. Such cases are defined as those patients requiring care from district nurses and one other member of the interdisciplinary team.

- GP questionnaire to cover issues to be considered in the future, including the impact on community care of the day case surgery and minor injuries unit.

**CONCLUSION**

The aim for a full audit is to develop a transfer policy which creates an internal benchmark for future audit. This policy will embrace the concept that patient discharge will only occur when the episode of healthcare intervention is completed, regardless of setting.

On completion of the full audit, it is anticipated that the project managers will have developed the work of the steering group as an interdisciplinary link group. This would function as a quality circle in relation to discharge planning, interdisciplinary audit and outcome measurement.

Ultimately, an interdisciplinary system of audit and quality control and improvement within each clinical setting will be developed. In this way, staff from all disciplines involved in the process can provide data for quality improvement, for example, by demonstrating any changes in the caseload requirements of the community created by the impact of day case surgery and nurse-led minor injuries units.

**REFERENCES**


Amos G (1973) Care is Rare. Liverpool, Age Concern.


Hogan DB (1990) Impact of geriatric consultation services for elderly patients admitted to acute care hospitals. Canadian Journal of Aging. 9, 1, 35-44.


Roberts J (1975) Discharged from Hospital. London, RCN.


Simmons WJ (1986) Planning for discharge with the elderly. QRB. 12, 2, 68-71.


