Achieving timely 'simple' discharge from hospital

A toolkit for the multi-disciplinary team

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Acknowledgement

We are grateful to all the practitioners who have generously provided information about their experiences and their practice. Their willingness to share means that everyone can benefit and can work to improve hospital discharge. A special thanks to Liz Lees, Consultant Nurse, Birmingham Heartlands and Solihull NHS Teaching Trust for her contribution to the development of this work.

Achieving timely ‘simple’ discharge from hospital

A toolkit for the multi-disciplinary team

Contents

Foreword

What happens during the discharge process is a key part of patients' experiences of hospital care. Whether patients are admitted for elective care or as an emergency, they want to know how long they are likely to stay in hospital. Information about their treatment and when they can expect to be discharged helps them to feel involved in decisions and motivated in achieving goals towards recovery. It also helps them to make plans for their own discharge.

In the latest Healthcare Commission National Patient Survey (2004) patients identify delays in the day of discharge home from hospital as a key area where standards can be improved.

This toolkit, *Achieving timely 'simple' discharge from hospital,* focuses on the practical steps that health and social care professionals can take to improve discharge. It supports members of the multi-disciplinary team by providing practical advice, factsheets and case studies. The toolkit has been designed and tested with practitioners in the field and is grounded in the reality of day to day practice.

At least 80% of patients discharged from hospital can be classified as simple discharges: they are discharged to their own home and have simple ongoing health care needs which can be met without complex planning. Changing the way in which discharge occurs for this large group of patients will have a major impact on patient flow and effective use of the bed capacity. It can mean the difference between a system where patients experience long delays or one where delays are minimal, with patients fully informed about when they will be able to leave hospital.

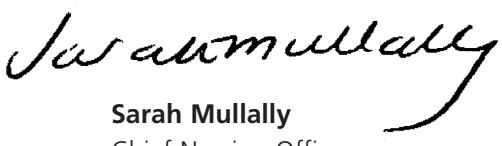
The Department of Health has also launched checklists that will contribute to more effective discharge as part of a total approach to improving bed management and flow of patients into and out of hospital.

You can use this toolkit in a number of different ways. The 10 Step Guide is central to improving hospital discharge processes and can be used to make sure that you cover the essential steps.

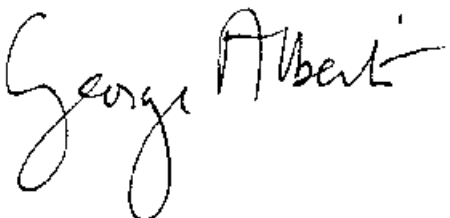
The case studies contain information about how others have made changes. They are pleased to share their experiences and their contact details are included.

The factsheets provide practical tools to check how you are doing and to identify what else needs to be done. They include examples of key aspects of improved discharge procedures that you can adapt to your local situation.

We are sure that you will find this toolkit useful. We welcome your feedback and comments about it so that we can continue to make sure that we are providing you with appropriate support. You can email the Emergency Care team at emergencycare@dh.gsi.gov.uk



Sarah Mullally
Chief Nursing Officer
August 2004



Professor Sir George Alberti
National Director Emergency Care

1. Tackling patient discharge: improving simple discharges

The purpose of this toolkit is to empower members of the multi-disciplinary team to achieve effective and timely discharge for patients classified as simple discharges. These patients make up at least 80% of the patient population, although there may be local variation depending on the type of hospital and case-mix.

Patients' perceptions of the NHS are influenced by experiences of their journey through the system. Improving and managing the patient journey is crucial to improving patient experience and making the best use of beds. *Freedom to Practise: dispelling the myths* (DH and RCN, 2003) identified patient discharge as one of the areas where multi-disciplinary teams can make a significant difference to the speed and quality of the patient journey.

Health care professionals, and nurses in particular, spend a disproportionate amount of time managing the mismatch between when a bed is needed (patient admitted) and when it is available (patient discharged). This detracts from time that could be spent on meeting the range of health and social care needs of all patients. This leads to frustration for the whole team and poor quality care for patients and carers.

The Department of Health and the Modernisation Agency have undertaken a range of work to help hospitals to improve patient flow by reducing delays in the patient journey from arrival to discharge. This work was drawn together in the two checklists on *Waits for a bed* and *Waits for a specialist,* launched in June 2004. www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare

The actions in the checklist which deal specifically with discharge, together with the new *Making Best Use of Beds* programme (more details at www.modern.nhs.uk/beds) launched in July 2004, represent the Department of Health and Modernisation Agency recommended approach to cutting delays in the patient journey through hospital. The principles and their application apply to all in-patient settings, in the community and acute sector.

The following sections highlight where timely discharge sits in the wider work to reduce delays in the patient journey by:

- demonstrating the impact of moving the peak of discharges from the afternoon to the morning on overall bed capacity; and
- giving the rationale for a focus on simple discharges.

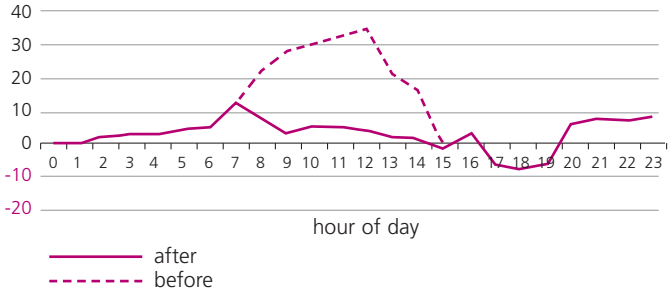
Mismatch between demand (admissions) and capacity (available beds)

It is important to note that mismatches between demand and capacity are normally temporary. At some point discharges at least briefly catch up with admissions (if not by the end of the day then usually by the beginning of each weekend). If they did not, patients queuing in A&E would never be admitted. However, while the mismatch lasts, beds are temporarily needed both for the new admissions *and* the patients not yet discharged.

As the graph opposite shows this puts unnecessary pressure on bed capacity which though temporary can be quite extreme. The dotted line shows the extra beds needed in this hospital during the few hours when admissions

outpaced discharges. The red line shows that moving even just 30% of discharges ahead of admissions would reduce the maximum bed requirement from 35 to a very short-term peak of just 10 over the average required.

Cumulative bed state across Monday
(from zero at midnight Sunday)



Moving discharges ahead of admissions

The key is to ensure that the beds needed are available before the demand for them builds up. This means discharging patients earlier in the day before the peak demand for admissions. Some hospitals have already moved to morning discharge as standard and two case studies, numbers 1 and 2 from Nottingham City Hospital and Royal Devon and Exeter found on pages 21 and 22 illustrate how this has been achieved and the impact on capacity.

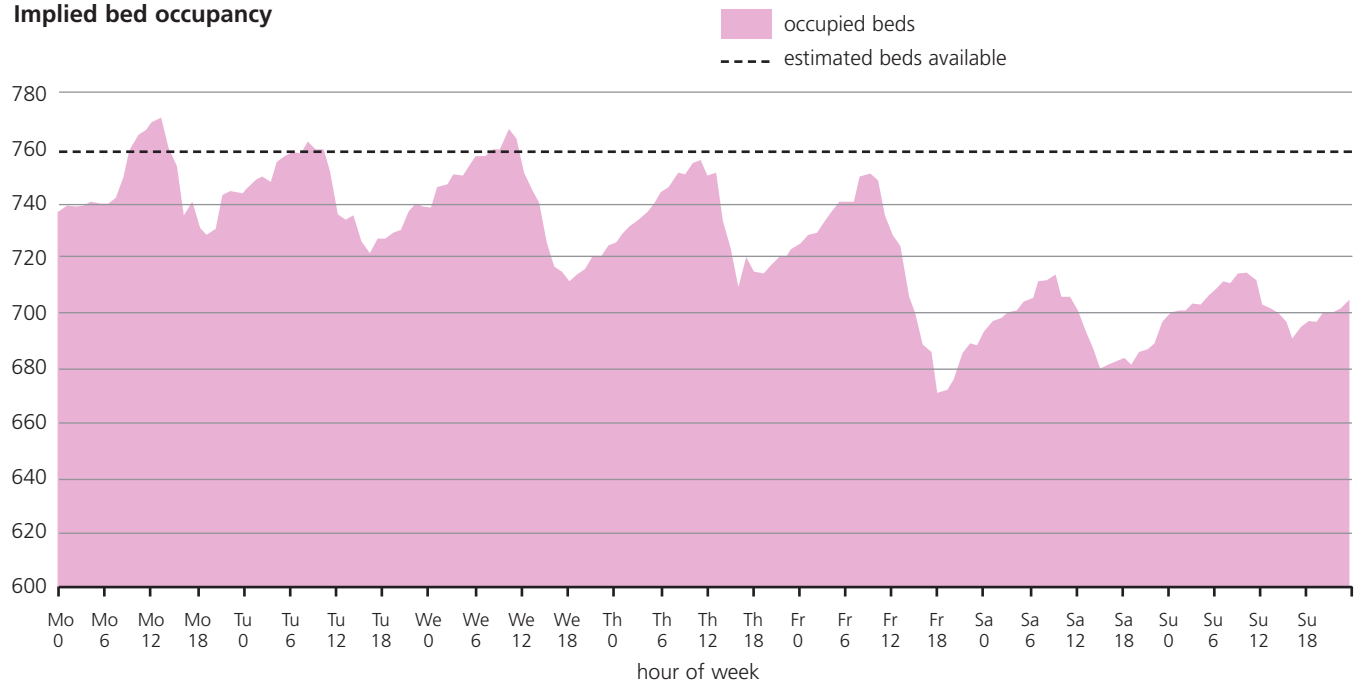
Seven day a week discharge

Ensuring discharge numbers match admission numbers on each day of the week is also very important if temporary, big swings in demands on beds are to be avoided. Many hospitals still try to manage weekend capacity by discharging large numbers of patients on a Friday. Discharges then slow to a trickle until Monday morning (or often Monday afternoon). This is not the most effective strategy. It often takes several days for the mismatch between admissions and discharges, built up over the weekend, to resolve, with predictable consequences in terms of pressure on beds. The example below shows this.

Establishing weekend discharge (often through systems such as proactive discharge) as standard is key to reducing these violent, though predictable, swings in numbers of beds required. Case study 4 from East Kent Hospitals Trust (page 24) shows how one trust has improved weekend and bank holiday discharge. Case study 3 from Birmingham Heartlands and Solihull (page 23) demonstrates weekend discharge.

All trusts are encouraged to carry out a simple hourly flow diagnostic to look at the pattern of their admissions and discharges as part of the core Department of Health/Modernisation Agency recommended approach to

Implied bed occupancy



understanding flows in and out of hospital. A standard central collection sheet is available. This can be analysed centrally on request (the graphs on the previous page are from this standard set). If you would like further information please contact emergencycare@dh.gsi.gov.uk

Focus on simple discharges

From the point of view of improving overall bed availability focusing on patients with simple discharge needs is likely to have the greatest immediate impact because, critically:

- the numbers of patients you can impact are very large (at least 80% of discharges are simple)
- the actions needed do not usually require any other agency's involvement to succeed.

The principles of cutting delay in the patient journey of course apply to all patients not just those with simple discharge needs. The DH workbook *Discharge from hospital: pathways, process and practice* by the Health and Social Care Joint Unit and Change Agent team (DH, 2003) addresses the particular additional issues involved in complex discharges. See www.dischargeplanning.dh.gov.uk

Learning materials to support the work book are available on the web at http://www.changeagentteam.org.uk/

Patients with simple discharge needs make up at least 80% of all discharges.
They are defined as patients who:

- will usually be discharged to their own home
- have simple ongoing care needs which do not require complex planning and delivery.

Many of these patients will be discharged from medical assessment units, short stay wards, or even A&E itself as well as medical and surgical wards. Time in hospital does not determine whether a patient has simple discharge needs. The key criterion is the level of ongoing care required – and therefore the complexity/ simplicity of the discharge arrangements.

Reducing delay through the whole patient journey

The fact that admissions often arrive before patients have been discharged from beds and discharge slows at weekends explains the extreme pinch points that trusts experience on a daily basis and particularly after weekends and bank holidays. However, improving timing of discharges is only part of wider action needed to reduce delay to the whole patient journey.

Action to improve patient flow includes:

- reducing delay at all stages of the patient journey
- predicting use of beds based on known demand and predicted/planned discharge dates.

Delays in setting treatment plans after admission, getting tests done in a timely way, infrequent ward rounds and a lack of proactive planning for discharge on or even before admission all add up to a longer length of stay.

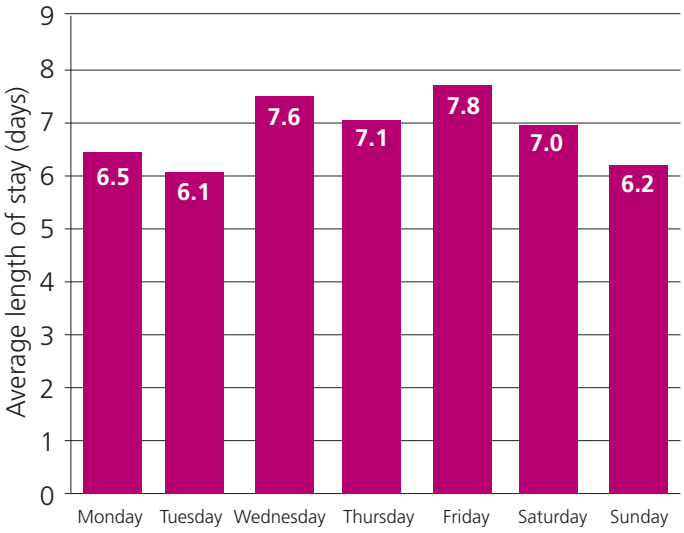
Key points for reducing delay include:

- All patients should have a treatment plan within 24 hours of arrival.
- An expected date of discharge should be set within 24 hours of arrival or in many case before admission for elective patients and communicated to the patient and all staff in contact with the patient.
- The expected date of discharge should be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes communicated to the patient.
- Ward rounds should be scheduled in a way that allows at least daily, a senior clinical review of all patients.

Variation in length of stay by day of admission

Some causes of delay stand out more clearly than others. One of these is delay predicted by day of arrival. Many hospitals find that currently length of stay (LOS) for patients with the same condition varies simply due to the day of the week of admission. Ensuring tests and treatment continue through 7 days (weekends and bank holidays) is a key part of reducing longer than clinically needed length of stay.

Typical Trust example
Average length of stay for medical patients by day of admission



Real time bed capacity/demand prediction

Linking demand predictors to real time bed management and information about planned and actual discharges, means that you can have an accurate picture of whether your hospital or trust will be able to accommodate all the expected patients by specialty that day (predicted demand). If not, it will enable you to see the level of mismatch between demand for beds and bed capacity, and enable you to take the relevant action. More information on demand prediction is available at http://www.modern.nhs.uk/scripts/default.asp?site_id=35&id=18111 including a simulation of a real time bed occupancy system and a tool to create a local demand predictor.

What are the outcomes of cutting delays?

The aim of improving use of beds is to move from a system which reactively responds to distress (discharges follow pressure from would be admissions), to one where the timing of admissions and discharges is planned and delay at all stages of the patient journey is minimised. As a result:

- patients know how long they should expect to be in hospital and the time of day they will be discharged in advance and can plan accordingly
- patients needing admission can have confidence they will not be cancelled or have a long wait in A&E
- the time professionals have to spend crisis managing the results of mismatches between demand and capacity will be freed for patient care.

How can the multi-disciplinary team make a difference?

The multi-disciplinary team can make significant improvements by:

- identifying anticipated length of stay and expected date of discharge on admission
- using a discharge predictor as a core tool for effective bed management
- providing an updated list of expected discharges on a shift basis
- discharging patients in the morning on the day of discharge
- discharging patients over the weekend and bank holidays.

This toolkit shows how the multi-disciplinary team can make practical changes to improve simple discharges. It describes a 10 step guide to achieving timely discharge, provides case studies of how changes are already being made and includes factsheets to use to make changes to your own practice.

2. The myths and obstacles holding back timely discharge

A number of myths, blocks and obstacles hold back improvements in the discharge process. Some of these include:

- effective discharge is seen as less important than the admission process – we concentrate on the front end of the system (admissions) and not on the back end (discharges)
- clinical management plan does not include expected date of discharge (EDD) based on an anticipated length of stay (LOS) resulting in:
  - discharges mainly happening in the afternoon
  - fewer discharges over the weekend and bank holidays
  - patients staying longer in hospital than clinically necessary
- no framework to plan the discharge
- lack of clearly defined roles and responsibilities amongst multi-disciplinary team around management of discharge
- multi-disciplinary team unclear about knowledge, skills and competencies needed to support discharge decisions
- feelings that nurse and AHP-initiated discharge is too 'risky' or concerns about patient safety
- patients/carers not involved in decisions and unable to plan for discharge.

The way that a multi-disciplinary team is organised and functions is fundamental to clinical effectiveness and timely decision-making. Senior level decision-making by doctors, nurses and AHPs assessing the patient prior to or early on in their hospital stay is more likely to lead to effective decisions about the clinical management plan. The plan should include the anticipated length of stay and expected date of discharge.

There are no legal or professional reasons why nurses or allied health professionals cannot take on more responsibility for the discharge process including the decision to discharge. They can assess the patient, liaise with the multi-disciplinary team, and plan timely discharge based on the agreed clinical management plan. They can also write discharge letters, make follow up calls, and give advice to patients/carers and other health and social care professionals involved in the person's care.

What have patients said about discharge?

'I was so ill, I thought I was going to die and that was why no-one had told me when I was going home'

'I can't hear what's said on those doctors rounds and I don't know what I have to do anyway'

'It all seems very laid back, once they have got you in, you have to fight to get out'

'No one seems to know, it's a mystery'

'When I was due for discharge the ambulance arrived but medicines were not ready. Then by the time the medicines were ready there were no ambulances'

The Healthcare Commission has just published its latest patient survey which features the theme of patients' dissatisfaction with discharge processes. More information is available on www.healthcare commission.org.uk/NationalFindings/fs/en

3. What the multi-disciplinary team can do to improve discharge

Patients and carers are at the centre of care and should be involved in discharge plans early in the patient's stay. It is important that they are confident they will be in hospital for an appropriate length of time. They also need information about how their treatment will be managed, when they should be discharged and what they can expect after they leave hospital.

What the multi-disciplinary team can do?

The multi-disciplinary team can speed up the discharge process and manage the care pathway to an expected or predicted date of discharge. They can make sure that:

- discharge decisions are made following senior assessment of the patient on admission and patients and carers are informed about the expected date of discharge early in their stay
- expected date of discharge (including weekends), based on the anticipated length of stay, is documented clearly in the patient record along with the clinical management plan
- diagnostic tests and other interventions are planned to avoid delays in treatment, and local standards are set for response times for referrals to radiology and pathology
- patient's response to treatment and condition is reviewed daily and the likely impact on the expected date of discharge documented
- nursing teams proactively manage the discharge process 7 days a week and take on more responsibility for initiating simple discharges
- nursing teams proactively co-ordinate the discharge process for patients with more complex needs with the involvement of the multi-disciplinary team. This includes issuing section 2 notices to social services for patients likely to need community care services on discharge.

  See Factsheet 8 for more information about the Community Care Act 2003.
- discharge (or transfer to discharge lounge) happens in the morning on the actual day of discharge (before the queues in A&E begin)
- bed bureau/bed management staff are informed immediately that the bed is empty
- the effectiveness of the discharge process is evaluated.

What is the estimated or predicted date of discharge?

The majority of patients in an acute hospital can be classified as requiring a period of time in hospital which can be estimated or predicted. These are generally patients for whom discharge planning will be straight-forward and simple, and where nurses and AHPs can take on more responsibility for initiating the discharge.

Estimated date of discharge relates to the anticipated length of stay in hospital needed to ensure that all the neccessary diagnostic tests are completed, and that the patient has responded to treatment sufficiently to be clinically stable and fit for discharge. The multi-disciplinary team must be confident that the length of stay in hospital is determined by clinical need and that the patient is in the right place to meet their level of need.

Simple discharge and complex discharge

Simple discharges relate to at least 80% of patients who:

- will usually be discharged to their own home

or place of residence

- have simple ongoing care needs that do not require complex planning and delivery

In addition they:

- are identified on assessment with LOS predicted
- no longer require acute care
- can be discharged directly from A&E, ward areas or assessment units.

However, the remaining patients in hospital who have more complex needs require referral for assessment by other members of the multi-disciplinary team.

Complex discharges relate to patients:

- who will be discharged home or to a carer's home, or to intermediate care, or to a nursing or residential care home, and
- who have complex ongoing health and social care needs which require detailed assessment, planning, and delivery by the multi-professional team and multi-agency working, and
- whose length of stay in hospital is more difficult to predict.

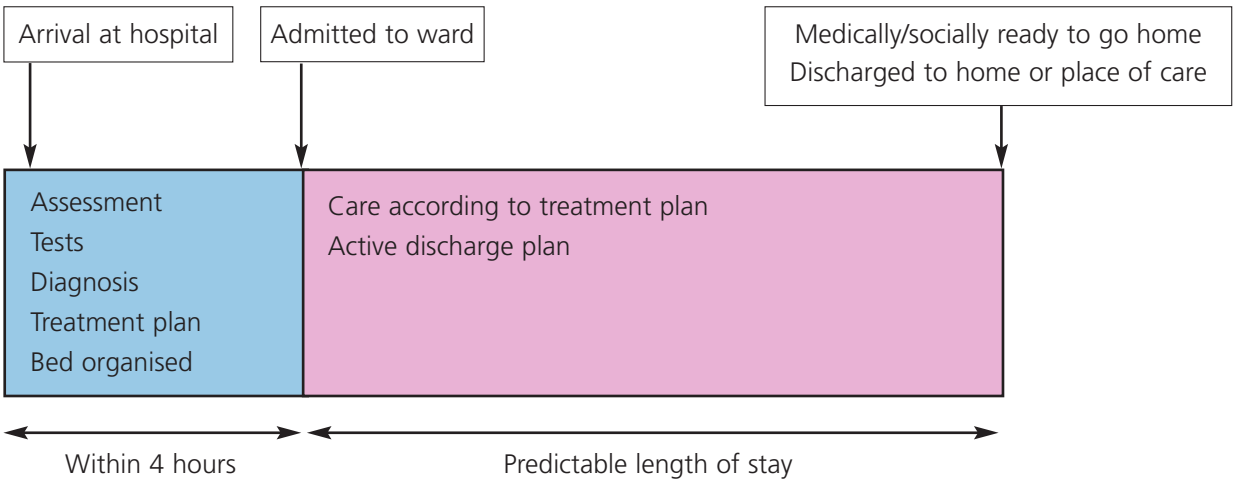
The Department of Health workbook *Discharge planning: pathway, process and practice* was revised and reissued last year (DoH, 2003). It is aimed particularly at those people whose needs are more complex and where ward based staff will need extra help in planning their discharges.

Learning materials to support the workbook are available on the web at www.dischargeplanning.dh.gov.uk and on CD Rom.

What is timely discharge?

Timely discharge is when the patient is discharged home or transferred to an appropriate level of care as soon as they are clinically stable and fit for discharge.

Ideal patient journey



Key steps in timely discharge

- Expected date of discharge is identified early as part of patient's assessment and within 24 hours of admission (or in pre-assessment for elective patients). It is based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge
- the patient and carer are involved and informed about the clinical management plan and the expected date for discharge
- in parallel, all the necessary arrangements are put in place to optimise the (simple) discharge including GP letter, outpatient appointment, hospital sick certification completed, any medicine to take out (TTOs), and patient transport arrangements confirmed
- daily review of the patient's condition and response to treatment will determine if the expected date of discharge needs to be revised
- review of planned/actual discharge date. Did it go according to plan? Complete audit on a regular basis.

How is clinical stability defined?

The terms clinical stability and medical stability mean the same thing. The patient can be defined as clinically or medically stable when tests such as bloods and investigations are considered to be within the normal range for the patient. 'Fit for discharge' however has a different meaning.

Is the patient 'fit for discharge'?

The patient is 'fit for discharge' when physiological, social, functional, and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate. It is safe for the patient to be discharged or safe to transfer from hospital to home or another setting. The patient who is 'fit for discharge' no longer requires the services of acute or specialist staff within a secondary care setting, and where:

- review of the patient's condition can be shared with the GP including adjustments to medication
- ongoing general, nursing, and rehabilitation needs can be met in another setting at home or through primary/community/intermediate/social care services
- additional tests and interventions can be carried out in an outpatient or ambulatory care setting.

Further information on the definitions of 'medical stability' and 'safe to transfer' can be found on the Change Agent Team's website at www.changeagentteam.org.uk

Review the purpose and timing of ward rounds

The ward round is seen as the time when the main decisions about the patient's care are made including the decision to discharge the patient. This will work if ward rounds happen on a regular basis and patients are reviewed daily. However, in reality ward rounds in many specialities happen only once or twice a week.

The ways to avoid delays due to the timing of ward rounds could include:

- early identification of patients that could be discharged (before ward rounds or reviews) so that these patients can be seen first
- regular senior reviews outside the ward round including the prescription of treatment to

takeouts (TOT) on the day prior to discharge

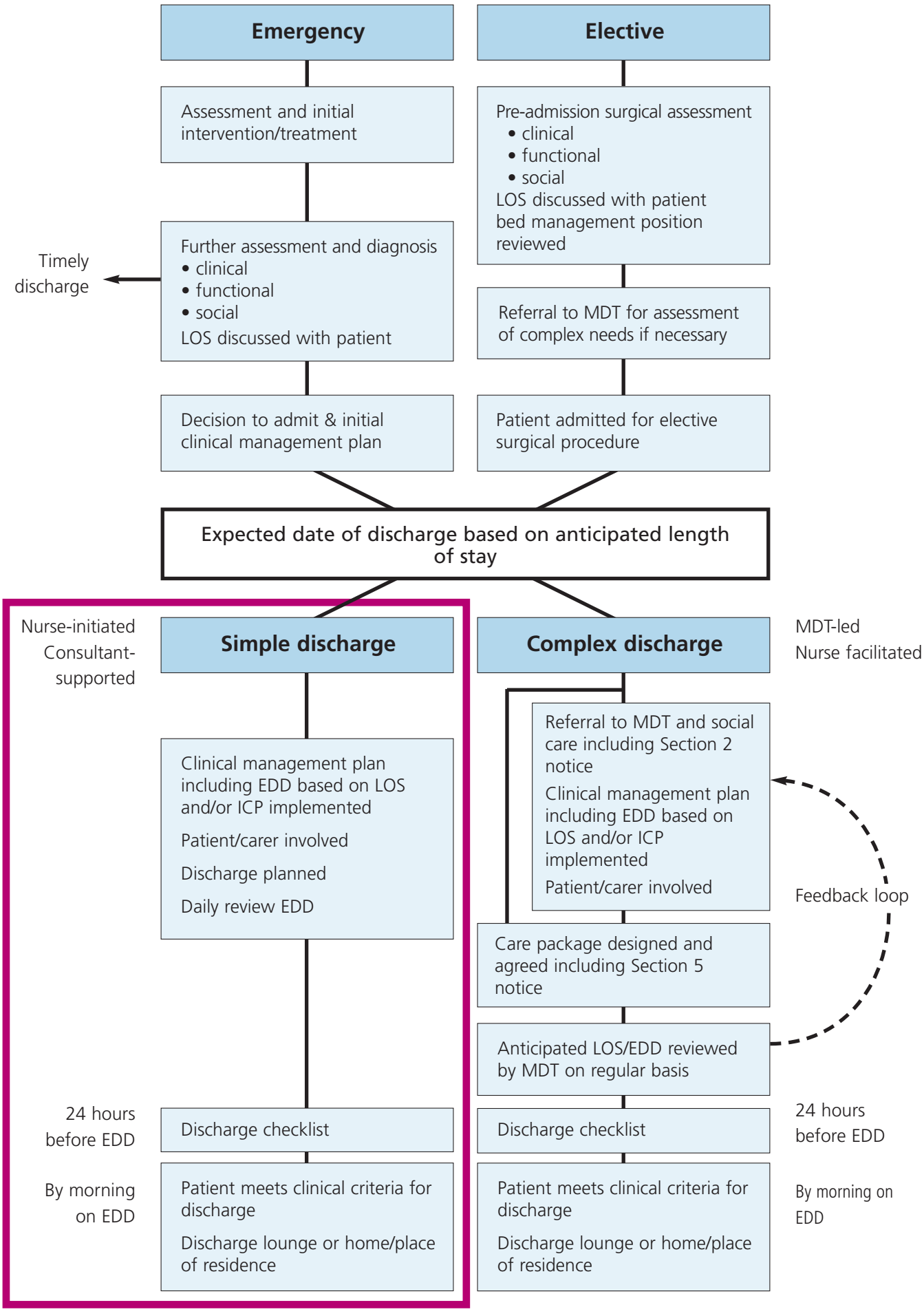
- progress chasing and interpretation of test results
- expanding the scope of practice of nurses and AHPs with the appropriate knowledge, skills and competencies to review the patient and initiate discharge including the discharge letter to the GP. Nurses and AHPs can also complete the hospital sick certificate. This may be supported by agreed protocols, guidelines, or criteria documented within the patient record
- expanding the scope of practice of clinical pharmacists to include the review of medications and transcribing of TTOs.

The diagram opposite analyses the key steps in the patient's journey and identifies how and where important decisions about discharge are made. The diagram shows both emergency and elective routes into hospital and both simple discharge and more complex multi-disciplinary team led discharge routes.

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare

The simple discharge decision – questions to ask

1. Has a date of discharge been estimated and documented?
2. Has the patient been involved or informed?
3. Is the patient clinically stable and fit for discharge?
4. Have transport arrangements been made?
5. Clothes for discharge and keys on ward area?
6. Tablets to take out dispensed and purpose, regime explained to patient?
7. GP, district nurses, carers involved/informed?
8. Outpatient appointments made and given to patient?
9. Transfer time to discharge lounge agreed?
10. Patient given information about self-care and who to contact if symptoms return?
11. Has the patient been given a hospital sick certificate if required?


Emergency
Elective
Assessment and initial intervention/treatment
Pre-admission surgical assessment
• clinical
• functional
• social
LOS discussed with patient bed management position reviewed
Timely discharge
Further assessment and diagnosis
• clinical
• functional
• social
LOS discussed with patient
Referral to MDT for assessment of complex needs if necessary
Decision to admit & initial clinical management plan
Patient admitted for elective surgical procedure
Expected date of discharge based on anticipated length of stay
Nurse-initiated Consultant-supported
Simple discharge
Complex discharge
MDT-led Nurse facilitated
Clinical management plan including EDD based on LOS and/or ICP implemented
Patient/carer involved
Discharge planned
Daily review EDD
Referral to MDT and social care including Section 2 notice
Clinical management plan including EDD based on LOS and/or ICP implemented
Patient/carer involved
Feedback loop
Care package designed and agreed including Section 5 notice
Anticipated LOS/EDD reviewed by MDT on regular basis
24 hours before EDD
Discharge checklist
Discharge checklist
24 hours before EDD
By morning on EDD
Patient meets clinical criteria for discharge
Discharge lounge or home/place of residence
Patient meets clinical criteria for discharge
Discharge lounge or home/place of residence
By morning on EDD

4. A step guide to making it work

Multi-disciplinary teams have made many changes to their practices in recent years and have challenged old ways of working. However, myths about practice are not easy to break through. Changing practice needs a combination of a clear vision of what is required, self confidence and a willingness to take informed risks. We have to engage with those who are most sceptical, while fostering allies for change, and being prepared to explain many times what it is we are trying to achieve. Often, resistance to change comes from lack of understanding rather than an inherent unwillingness to change the *status quo*.

To understand an organisation and the cultural change needed, we have to probe below what is visible such as policies and procedures and look at the less visible world of people's beliefs, perceptions, attitudes and behaviours. Only then can we understand the culture and how to plan our approach to change. Achieving change depends on winning hearts and minds as much as convincing with rational arguments!

For further information, see the Leader Guide on Human Dimensions of Change at www.modern.nhs.uk/improvementguides/human

The key to success is to tackle both cultural change and changes to processes and organisational systems. Services will be more effective if everyone has a better understanding of the whole health and social care system and of how actions and changes in one area can influence the whole system.

Successful team working depends on a number of elements including:

- strong executive leadership supporting the discharge process
- respecting each other's roles in the discharge planning process
- taking responsibility
- working in partnership with the patient, family and multi-disciplinary team.

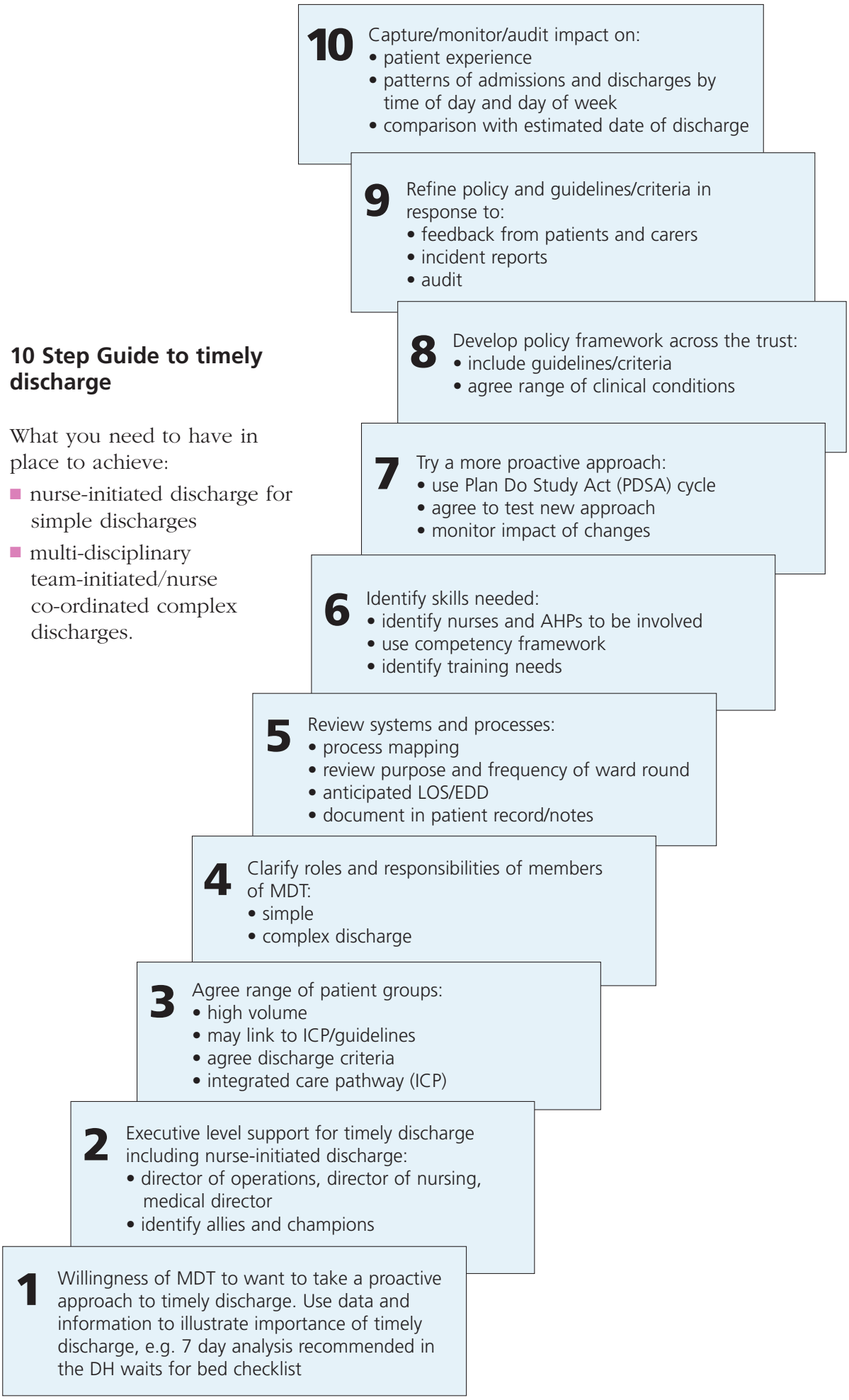
10 steps to effective and timely discharge

To move forward, the multi-disciplinary team needs to start talking about how they want to work differently and planning how to take this forward. The 10 Step Guide outlines how you can successfully break through the barriers.

10 Step Guide to timely discharge

What you need to have in place to achieve:

- nurse-initiated discharge for simple discharges
- multi-disciplinary team-initiated/nurse co-ordinated complex discharges.



The steps you need to take

Step 1

Multi-disciplinary team take a proactive approach

The multi-disciplinary team including the clinical director for the service must be committed to a change in process. Timely and effective discharge will only happen if the team are willing to take a more proactive approach. You may find that data and information can support you in the decisions you make. For example, regular information about the profile of admissions and discharges by time of day and day of week may help to illustrate the root causes of queues in A&E or cancelled operations.

See Factsheet 3 on Benefits of improving discharge process

Step 2

Executive level support

All trusts now have an executive lead who will support the work around timely discharge. There may be inter-professional and/or inter-departmental barriers to achieving effective change and it is a good idea to have others on board to support the change. You need to identify your allies and champions who will help you to make it a success, and equally you need to identify the obstacles that are likely to get in the way or the people who may try to resist a more proactive approach.

Step 3

Agree range of patient groups

Agree which patient groups you are going to start with. It is a good idea to try to identify high volume patient groups so that you can demonstrate the impact and benefit from the bed capacity it releases. Many trusts have started with elective patients. More trusts are now also successfully implementing this approach for patients admitted as an emergency. You may also want to start with patients where you have clearly defined ICPs or guidelines, or where you can agree discharge criteria. You can expand the range of patient groups as the multi-disciplinary team becomes more confident in the system and process.

Step 4

Clarify roles and responsibilities of the multi-disciplinary team

Clarify the responsibilities of the multi-disciplinary team in taking a more proactive approach to simple discharges. You will need to agree responsibilities around who, how, and when the EDD based on anticipated length of stay is assessed and documented, communicated to the patient and carer, and reviewed on a daily basis. Clarify and agree any protocols or criteria that nurses who are competent to make discharge decisions can use to support decisions about clinical stability and fitness for discharge. The knowledge, skills and competency framework identified in step 6 may help to guide you. You will need to decide:

- who can identify and document EDD
- who can review the patient
- how multi-disciplinary decisions are made about when the patient is clinically stable and fit for discharge or safe to transfer.

Step 5

Review systems and processes

You need to review and revise the systems and processes you use to manage the decisions around discharge. This is likely to include a review and clarification of the purpose and frequency of ward rounds, the documentation used by the multi-disciplinary team, and how decisions about EDD are made and documented. Ensure that diagnostic tests can be planned and organised to support timely decisions and discharge. Mapping the assessment to discharge will identify elements of the patient pathway that create delays or include extra steps that do not add any value to patient care or experience.

Step 6

Identify the skills needed by team members

Identify nurses and AHPs who can take on more responsibility for initiating timely discharge including at weekends and bank holidays. Use the competency framework to confirm competence and if needed to identify training needs for the team involved. Agree

supervision arrangements and use the competency framework across the whole multi-disciplinary team to ensure that people are working to consistent standards.

See Factsheet 6 Matrix of training competencies

Step 7

Try a more proactive approach

Agree to pilot or run Plan, Do, Study, Act (PDSA) on nurse-initiated discharge and monitor the impact of any changes made. Initiate buy-in and prove that the revised discharge process will work. Gain acceptance ahead of new ways of working.

Step 8

Develop a policy framework

Develop a policy framework for the whole trust including elective and emergency pathways with emphasis on timely simple discharge. Agree more specific guidance and criteria for different patient groups.

Step 9

Refine policy and guidelines

Refine policy and guidelines/criteria in response to audit and/or incident reporting. As the multi-disciplinary team become more competent and confident in achieving timely discharge, then the policy and guidelines can be refined and simplified.

Step 10

Capture, monitor and audit the impact

Audit and evaluation are important steps. Routine collection of data and information that includes discharges by time of day and day of week and LOS for elective and emergency patients will confirm that timely discharge is working more effectively. You will be able to demonstrate the benefits for patients, staff, and the hospital bed management system. Other longer term quality indicators could include re-admission rates and impact on primary and community services. Comparison with planned and actual discharge date. Identify common causes for non-compliance. This should provide evidence for continuous improvement.

These steps are a guide and although they are represented as sequential steps some of the elements can be worked through in parallel. You may need to adapt the wording to suit your local team and hospital.

While the emphasis is on the acute hospital sector, the principles can be applied to primary care, community hospitals and working as a whole system as services become more integrated, for example:

- primary care taking more responsibility for pre-assessment of elective patients
- primary care led managed care approaches for frail older patients and patients with chronic conditions to reduce repeated hospital admissions.

Clinical governance and risk

The framework of clinical governance ensures that clinical professionals can demonstrate professional accountability within their practice when addressing the issue of timely hospital discharge. It acts to underpin minimising the risks associated within clinical practice and supports the development of policy/guidelines.

The following key areas need to be considered to ensure that all staff are competent in recognising the abnormal rather than the normal.

- Patient and carer involvement within the process
- clinical as well as environmental risk is identified and addressed
- auditing of the process and ensuring that the findings are embedded into clinical practice
- use of patient/carer information to expedite/amend the process
- ensuring that education and training are part of the individual's personal development programmes to ensure staff have the right competencies.

It helps to ensure that the right systems and processes are in place for monitoring and improving the delivery of quality patient care.

For further information refer to the Clinical Governance Support Unit pages at www.cgsupport.org

Professional and legal implications of nurses and AHPs taking on more responsibility for initiating discharge

Overall legal responsibility for a patient's care remains with the named consultant during admission, stay and discharge. However, the consultant can delegate responsibility to an appropriately qualified health professional. When a task is delegated the consultant/lead clinician assumes responsibility for delegating appropriately. The person to whom the responsibility is delegated takes on committment and responsibility for carrying out the task in a responsible, accountable, reasonable and logical manner in keeping with their own professional code of conduct.

The consultant/lead clinician should always make sure that the person taking on the responsibility has the appropriate knowledge and skills. Where nurses and allied health professionals are taking on responsibility, clear competencies and training should be developed for staff.

See Factsheet 6 for a Matrix on training competencies.

The person to whom responsibility is delegated should be aware that they are accountable for all their actions. There should be clear lines of communication between the consultant/lead clinician and the health professional discharging the patient so that they are accessible for advice when necessary.

It is recommended that the parameters of clinical/medical stability for each individual patient are agreed with the consultant or lead clinician and recorded on a locally developed form or documented in the patient's healthcare record. This form should be completed on admission (or as soon as is reasonably practical, although written reasons should be given for any delay) and be subject to ongoing review. Each review should also be documented on the form within the patient's notes. The patient should be told about the content of this form and kept up-to-date in line with the principles of informed consent.

Only when the person responsible for discharge is confident that the patients' condition falls within these agreed parameters should the nurse or AHP initiated discharge begin. There should be provision on the form for confirmation that parameters have been met.

It is vital that each step of the process is documented fully and precisely. Every decision must be capable of scrutiny. Everyone involved in the discharge process must be prepared to explain not just what they did, but why they did it. In this regard the law which governs discharge is extremely helpful. It provides a framework within which health care professionals can be confident that they are

making and documenting appropriate decisions. Accordingly competencies should include (but not be limited to) knowledge of:

- the principles of informed consent
- the human rights act
- the data protection act
- the community care act
- professional codes of conduct.

Audit of the new regime should include critique of the quality of record keeping. Accurate and full health records are vital, not just to defend against legal action, but to ensure continuity of care and to assist in audit and so improve the service afforded to patients.

Accountability for timely discharge and nurses and AHPs taking on more responsibility for initiating discharge

The new Changing Workforce document *The Question of Accountability – a guide to answer your questions* will be published in Autumn 2004. This sets out to consider the issues around:

- personal accountability
- supervisor accountability and delegation
- employer accountability and vicarious liability
- accountability to the regulator
- transparency
- record keeping.

It aims to assist all health care staff in identifying issues around accountability, but in particular focuses on those who through new ways of working have extended their practice or moved into new roles which are outside of their original remit.

The document will be available through www.modern.nhs.uk/cwp

The RCN have recently published a helpful guide on interpreting accountability to support new ways of working. It is available at http://rcn.org.uk/publications.pdf/interpreting-accountability.pdf

What knowledge, skills and competencies are needed to support discharge decisions?

Clarity of roles and responsibilities for timely discharge can be more easily discussed when the multi-disciplinary team is informed about the knowledge, skills and competencies needed to support effective discharge decisions and to co-ordinate and manage timely discharge.

The competency framework has been designed so that any member of the multi-disciplinary team can assess their own knowledge and skills. These can be discussed with the team leader, and training needs can be identified for both individuals and the team as a whole.

See Factsheet 6 for the Matrix of training competencies.

5. Case studies

These case studies are from practitioners throughout the country who have been working to change and improve discharge practice. Their work demonstrates the variety of ways in which health and social care professionals are improving the patient experience and achieving better outcomes for patients, staff and the service.

The examples are intended to help others to challenge aspects of practice and to make changes. Contact details are provided so readers can contact colleagues to find out more about their work. We hope that practitioners will be able to build up networks to share expertise and experience and to support each other as they improve the discharge process.

Case study 1

Discharge earlier in the day

Nottingham City Hospital NHS Trust recently worked to ensure patients were discharged earlier in the day resulting in fewer cancellations of elective procedures because more beds were available for elective patients to come in for their procedures. The Trust also attached a consultant acute physician to serve the emergency care units and introduced GP streaming for emergency patients to help avoid inappropriate admission to an acute hospital bed.

Making it Happen

Prior to the change, discharges peaked at the end of the day, rather than being spread evenly throughout the day (see Figure 1)

Avg. admissions/discharges by time of day

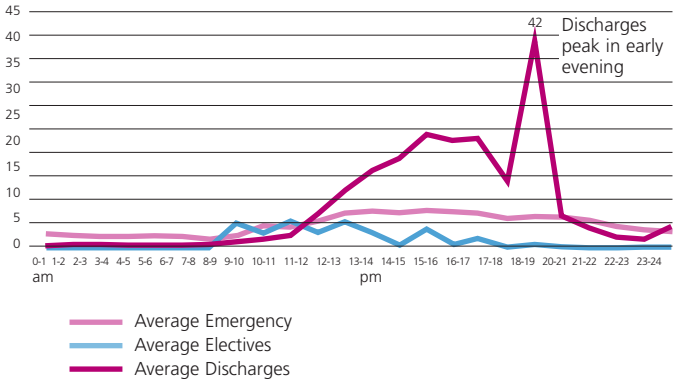
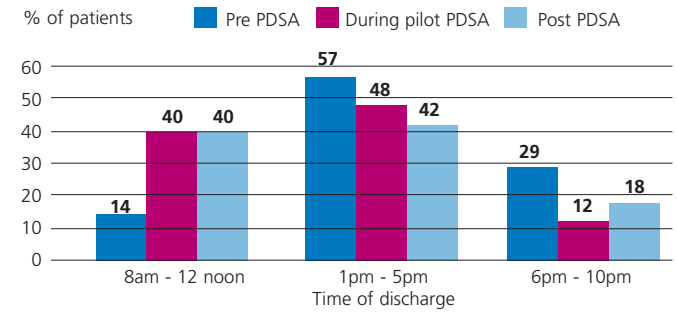


Figure 1
Before improvements, a large number of patients were being discharged between 6pm and 9pm.

The trust ran a small Plan-Do-Study-Act cycle, during which four wards were encouraged to discharge medically fit patients by midday. As a result, about 40% of patients were discharged before 1pm (up from 14% prior to the PDSA) and the number of discharges became more evenly distributed throughout the day (see Figure 2).

Figure 2
After a PDSA cycle, improvements to the discharge process, in four base medical wards in Nottingham City Hospital, levelled out the discharge rate throughout the day.



Emergency care redesign has improved the patient experience and increased the number of discharges without admission to an acute hospital bed. To support this:

- the Medical Assessment Unit was expanded to form an emergency admissions unit and an emergency short-stay unit
- the two admissions wards have been re-designated as specialist medical wards
- both emergency care areas have access to a consultant acute physician Monday to Friday, from 9am to 6pm
- GPs stream over 60% of patients before admission to ensure patients are admitted to the right unit.

Implementation advice

Attaching a consultant acute physician to serve the emergency care units, at the same time as introducing GP streaming for emergency patients made the difference to patient care. Rather than patients waiting until the early evening when the consultant would visit the medical assessment unit on a post take ward round, care can now be completed by acute physicians during the day and the patient discharged.

Impact

The benefits from redesign have been enjoyed across the trust:

- 36% patients are discharged from the emergency care areas following assessment and treatment – an improvement of 19%
- the numbers of medical outliers and cancelled operations have been reduced
- patients who are assessed by their GPs before entering the hospital are now directed towards the correct unit for their needs: short stay or longer admissions.

Contact:

Anna Burns, Redesign Manager, Emergency Pathway
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Email: aburns@ncht.trent.nhs.uk

Case study 2

Focusing on discharge

The gastroenterology ward at Royal Devon & Exeter NHS Foundation Trust has recently shifted the bulk of its discharges to midday. Staff are now working to discharge most patients even earlier in the day. At present, the ward staff have a goal of starting patients on their way home by 10 am.

Making it happen

The changes that Okement Ward made were quite simple, and had the powerful effect of organising everyone's efforts toward making the discharge process a transparent and visible process.

The ward developed boards to be posted above each patient's bed, predicting the discharge date and setting a deadline, so that everyone involved in that patient's care could be aware of the anticipated timing. Each patient's discharge board had a discharge checklist, and everyone could see whether that patient was likely to be ready for discharge on the planned date. If a scope was needed and had not been done then a nurse or consultant could follow it up and begin the process.

Where appropriate Senior House Officers began dictating take-home drugs (TTOs) on ward rounds in advance of the day of discharge.

Implementation advice

It was important to have the support of the Matrons and multi-disciplinary team for the discharge board system to be effective.

Information on the process was widely available. Staff put up posters around the ward informing patients and their relatives of the time when patients would need to vacate beds, which meant that relatives/carers could make arrangements for transport home

Impact

The culture of the ward changed completely from reactionary to forward-planning and proactive culture.

Staff have felt a marked benefit from the change, said Jo Churchill, Ward Manager:

'In particular, consultants engaged with the change almost immediately because they now knew what was expected of them – they could aim for the discharge deadline. They were tired of being nagged without knowing when the patient needed to be discharged. Throughout the ward, the KanBan [discharge] boards united and organised staff efforts.'

Next steps

The use of discharge boards has provided a valuable basis for further work in improving patient discharges. The trust is currently working on a number of other schemes.

Contact:

Jo Churchill, Ward Manager
Okement Ward
Royal Devon & Exeter NHS Foundation Trust
Telephone: 01392 402800

Case study 3

Nurse-facilitated weekend discharge

Birmingham Heartlands and Solihull NHS Trust has worked to ensure weekend discharge for clinically fit patients. This has allowed patients to be discharged home or to an appropriate facility rather than unnecessarily staying in hospital over the weekend. This has also reduced length of stay and created capacity for the organisation.

Starting point

Traditionally the Trust has experienced a significant reduction in discharges over the weekend period, which subsequently caused problems with bed availability by late Sunday and Monday morning. Therefore discharges that were happening on Mondays needed to be brought forward to Saturdays and Sundays using nursing skills.

Making it happen

Two discharge co-ordinators were identified for each hospital site. Their role was to visit participating wards on a Friday and collate the names and identification numbers of patients who nursing staff felt could potentially leave on Saturday or Sunday, particularly if medical protocols had been identified in patients' records (e.g. if blood pressure below 110/70, if no further vomiting).

On the Saturday and Sunday mornings the discharge co-ordinator then visited the wards to ensure that if the protocols had been met that discharge did take place. During the initial project sixteen general medical and surgical wards participated and this was then rolled out into other in patient areas.

Implementation advice

The critical success factors to the project are the following:

- A Matron was responsible for the overall implementation of the project and this gave clarity and focus
- leadership qualities and expertise of the discharge co-ordinators. The discharge co-ordinator needed to feel comfortable with using facilitative techniques with ward staff and challenging why patients could not go home over the weekend. The discharge co-ordinator role was shared between a small group of F Grade nurses from different specialties who had volunteered for this project
- support of the Medical Director was imperative to ensure buy-in from consultant colleagues. The Medical Director offered support to the project through the engagement of the on-call consultant. However, in reality the use of this consultant was minimal and within the first few weeks the on-call consultant was not used at all in the project.

Impact of this change

During the initial project 372 patients were discharged by this process over three months. However, what became evident was instead of discharging on the Saturday and Sunday in fact these discharges were being brought forward to the Friday. Compared to baseline discharge activity this project doubled discharge figures over weekends. Current performance has increased and shows an average of 350-400 weekend discharges per month.

The visit to the ward by the discharge co-ordinator enabled some development of staff skills to take place as the co-ordinator coached on the type of patients suitable for weekend discharge.

Next steps

Following the initial period and a report to the Executive Directors it was agreed to continue the project permanently. This was on the basis that the impetus the project provided meant that this work would no longer need to be supported by a co-ordinator and each ward and directorate would take responsibility for nurse facilitated discharge activity. Matrons for each individual ward area have agreed to take the responsibility for ensuring nurse-facilitated discharge continued.

Discharge data was reviewed and weekend discharge targets were set for the organisation. The total nurse-facilitated discharge target for the organisation is 100 nurse-facilitated discharges per weekend. Although performance fluctuates this target is achieved 80% of the time.

Contact

Cheryl Etches
Deputy Director of Nursing
Birmingham Heartlands and Solihull NHS Trust
Email: Cheryl.etches@heartsol.wmids.nhs.uk

Case study 4

Nurse discharge using discharge criteria

In the Trauma and Orthopaedics Directorate at East Kent Hospitals Trust a nurse can discharge patients when they have met the criteria set by the consultant. This has reduced delays to patient's discharge and saved bed days. Over a period of six months, none of the 61 patients discharged by nurses were re-admitted.

Making it happen

A working group from all three DGH sites within the trust was formed. A literature search was undertaken and the trust was benchmarked against other trusts. Separate criteria for elective and emergency patients were drafted (this has since been combined into one set of criteria). A training package was developed and cascaded to consultants for approval and practice development and then an implementation plan was written. Finally once the changes were in place an audit was undertaken.

It was decided that in order for nurses to discharge patients they had to be an E grade or above, identified by the ward manager as suitable and to have undertaken five supervised discharges and been declared competent.

The criteria

- The consultant management plan was recorded in the notes. This would include any range of movements to be achieved
- if a patient is considered not suitable for nurse-led discharge, this must be recorded in the management plan
- check x-ray seen and documented satisfactorily, including post-op x-ray
- all patients to be apyrexial on the day of discharge and previous days temperature assessed.
- wound and drain site is dry or District Nurse wound care agreed and organised
- physiotherapy to have recorded that the patient is safe for discharge
- occupational therapist to have recorded no further input and that the patient is safe for discharge
- care management input completed and informed of expected date of discharge
- any input from other disciplines completed:
  - documented in-patient notes by nurse possessing appropriate training that the patient is suitable for nurse discharge
  - Make out-patient appointment if necessary and clinic plan is clearly documented (e.g. plaster removal / x-ray on arrival).
- patient comfortable and pain controlled.

Implementation advice

The trust have found that:

- nurses have to understand the need to formalise a process that they perceived to be in place already
- consultants need to agree to one set of criteria
- time must be made available to train nurses in a very busy operational environment.

Impact

The benefits identified include a more appropriate timely planned discharge for the patient, improved bed management which allows the directorate to meet targets set for A&E and waiting lists, patient, nurse and multi-disciplinary team satisfaction as well as recognising the competence and knowledge of nurses.

In the first six months, 61 patients were discharged by nurses using this criteria. Previously these patients would have waited for the next consultant ward round to be discharged. An audit was done of 15 of these patients who were under one of two consultants – one who does a weekly ward round and one who does a twice weekly ward round. It was estimated that for the 15 patients under these consultants 41 bed days were saved.

Next steps

As a result of the success of the scheme nurse-led discharge will be shared and rolled out to all directorates across the trust. The process will continue to be developed to include the transcription of the discharge summary by the nurse.

Contact:

Pat Johnson, Matron
East Kent Hospitals NHS Trust
Email: Pat.Johnson@ekht.nhs.uk

Case study 5

Redesigning EAU (combined assessment and discharge unit)

The EAU at West Suffolk Hospital has been redesigned leading to a reduction in bed numbers and the creation of an assessment bay and discharge unit in their place.

Making it happen

The EAU was reconfigured to create an "assessment bay" and discharge unit in areas previously occupied by beds (33 in total). GP referred medical patients are now assessed and treated in the assessment bay which consists of a combination of chairs and two assessment beds. The area is staffed by a senior, skilled nurse who starts treatment immediately and "sieves" out potential discharges.

The discharge unit helps maintain patient flow from EAU and across the Trust by helping to create beds earlier in the day and is essential in making the whole unit work effectively.

The remainder of EAU now has 17 beds but due to the increased staff/skill mix has increased activity and productivity.

Implementation advice

A significant cultural change was required as well as the need to win senior management and executive support to test the proposal that reducing bed numbers would improve patient flow. The change was initially tested with a small scale (2 day - 1 of which was deliberately chosen as a busy Monday) PDSA of the assessment bay concept.

The main problem was "protecting" the sustained change - ensuring that the assessment bay and discharge lounge were used for the purpose they were intended for and not converted back to beds at times of increased pressure.

These changes were achieved as part of redesign work that also included the development of the patient flow team and full shift medical specialist registrar cover. These have also had a significant impact on patient flow and emergency care performance.

Impact

- Improved patient care (secondary to a better patient: staff ratio)
- earlier discharges (from assessment bay)
- earlier commencement of diagnostics/treatment
- reduced waiting in A&E for emergency medical GP admissions
- improvement in performance against the 4-hour emergency care target
- reduction in median EAU journey time from 20 hours 15 minutes (Sept 2003) to 8 hours 45 minutes (April 2004) (see run chart below).

Next steps

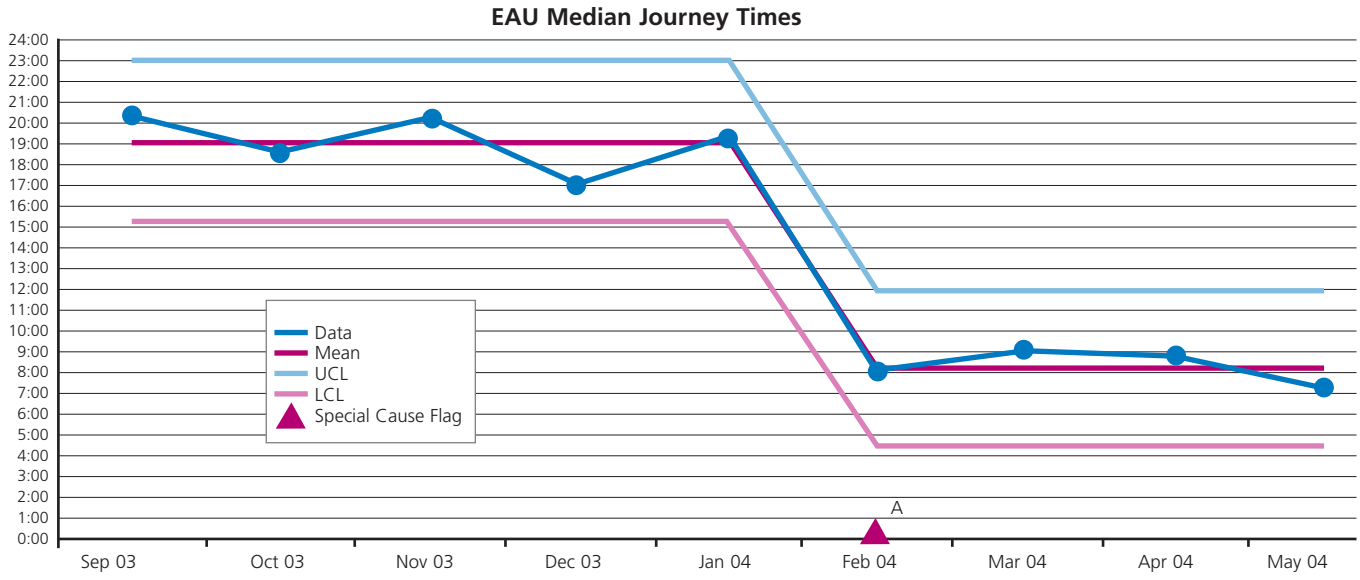
The concept is sustainable, subject to recruitment and retention of nursing staff on the unit. The model will be further improved by the development of senior medical staff based in the unit, criteria based discharge and protocol based care.

Contact:

Chris Doyle, Clinical Service Manager, Acute Medicine
Tel: 01284 713605

Andre Davies and **Sue Jones:** EAU Ward Mangers
Tel: 01284 713972

Gary Morgan: Service Improvement Manager
Emaill: gary.morgan@wsh.nhs.uk



Case study 6

Early senior review boosts speedier discharge and bed availability

At Airedale General Hospital's Clinical Decision Unit (CDU) discharge now begins on admission with liaison between the consultant and patient.

Making it happen

Clerical support was provided for rapid discharge communication with GPs and discharge liaison nurses in the CDU review team were included in planning for discharge. A consultant physician is released from elective commitments for periods of one week each and based on the CDU from 10am to 6pm to review all patients for admission on arrival. The case mix is predominantly medicine, older people and surgery and all patients for initial assessment except paediatrics and mental health. The rota for consultant of the week was drawn from volunteers from both medicine and specialty medicine, e.g. for the elderly and gastroenterology. It included volunteers who did not initially support the scheme but having completed a week became converts!

Implementation advice

- This has been sustainable on a rotational basis for two months – with the impact on outpatient waiting lists of small medical specialities becoming evident quickly. However, a reorganisation of consultants has resulted in the establishment of an emergency physician post that has made the change sustainable without additional funding
- early concerns regarding the loss of learning opportunity for junior medical staff have been resolved by altering methods of working to incorporate their needs
- monitoring of bed availability for acute admissions has demonstrated that this is the most valuable outcome and meant that a way had to be found to sustain the change.

Impact

Measurable results show a decreased length of stay, reduced number of patients placed on inappropriate wards and significantly increased bed availability. Staff morale was greatly improved for both nursing and medical staff – the consultants report enjoying their week of clinical work.

Next steps

Expressions of interest in the vacant consultant post have already been made and it looks likely that final sustainability will be achieved in late 2004. The existing physicians have agreed to provide annual leave and study leave cover.

Contact

Mr Melvin Birks
Divisional Manager – Acute Services
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Email: melvin.birks@anhst.nhs.uk

Operational changes evaluation

Details	Jan 03	Jan 04	Change
Patients admitted	813	850	+37
Number of patients sent home from CDU	168	242	+74
Percentage of patients sent home from CDU	21%	28%	+7
Self discharges from CDU	10	6	-4
Outliers	59	29	-30

Case study 7

Nurse-led discharge improves patient experience

Nurse-led discharge has led to a reduction in the time patients wait to go home once they are fit for discharge.

Making it happen

A nurse-led discharge pro-forma was developed in consultation with consultants and other staff. This was distributed along with a letter of guidance and the pro-forma was then tested and changes were made as needed. An information letter was made available to relatives and staff.

Nurses began to liaise with relatives and book transport earlier in the patients stay as well as liaising with other departments, for example pharmacy to transcribe drugs.

Some patients that were seen in the morning by the medical team were set criteria for going home later in the day so that the consultant did not need to come back and review the patient before discharge.

Implementation advice

Inter-departmental co-ordination was the most difficult challenge and this has only been achieved by the nursing staff being very proactive and reminding staff of the new process. In order to remind medical staff of the new process case notes were stamped with the reminder to Proceed to Nurse Led Discharge.

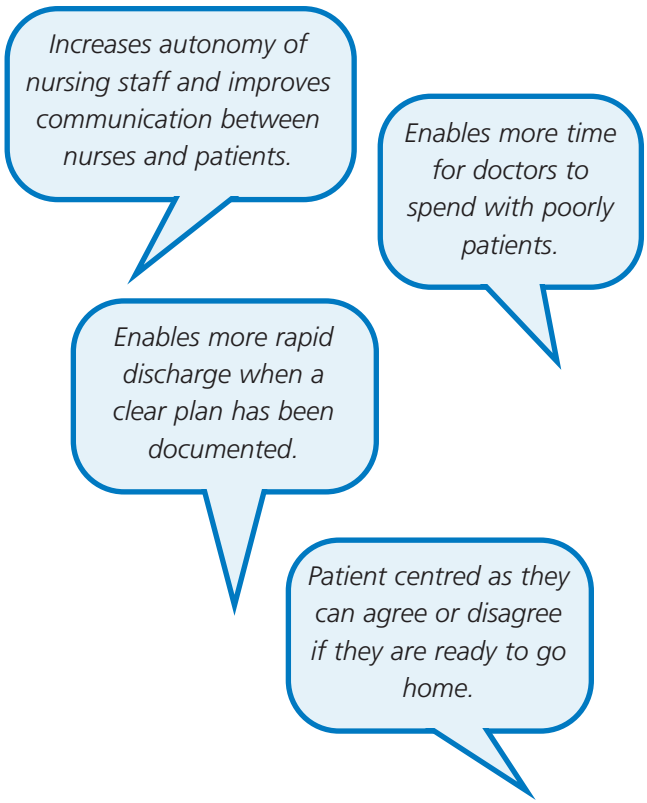
Nurses have encouraged the medics to sign the consent form that leads to the patient being put on the nurse led discharge plan.

Senior management support was important and they supported this initiative from the beginning.

Impact

Patient feedback:

Nurse feedback:



Next steps

Patients who are social delays are now included onto the plan once they have been assessed as medically stable.

The process will be continued and will slowly include other surgical procedures onto the plan with the medical staff's support e.g. stoma formation, orthopaedic surgery and other areas that may benefit from this process are being investigated.

The discharge form is being revised to include the patient's signature.

Contact:

Dawn Brannan, Matron, Calderdale Royal Hospital
Calderdale and Huddersfield NHS Trust
Email: dawn.brannan@cht.nhs.uk

Professional/patient led discharge proforma for all surgical services

Demographic details (attach ID label)	Ward Hospital	Specialty Consultant

Circle correct answer and insert details where indicated	
TPR and B/P within patient's normal limits	Yes/No
Urine output satisfactory(within patient's normal limits)	Define
Bowels opened	Yes/No Date
Surgical wound clean and healing	Yes/No (if no state Community Nurse requirements)
Drainage amount from surgical wound	mls. colour Type of drain
Care of surgical drainage accepted by Community Nurse	Yes/No Name of Community Nurse
P.V. loss	Yes/No or N/A
Pain Score	0/1/2/3 CRH or 1 to 10 HRI state or pt states 'painfree'
Analgesia prescribed for score of 1/2/3 or 1 to 10	Yes/No
Eating and drinking	Yes/No
Free of atypical chest or calf pain	Yes/No
Anti-embolic stockings required	Yes/No or N/A
Anti-embolic stockings supplied with advice	Yes or N/A
Verbal information given re surgical procedure and post op advice	Yes/No
Patient's standard of independence with steps attained	Yes/No or No steps
Patient's standard of independence with mobility attained	Yes/No or normally dependant
Patients standard of activities of daily living attained	Yes/No or normally dependant
Blood results within acceptable limits (as per specialty care pathway)	Yes/No
Multi-disciplinary team aware of discharge and in agreement	Yes/No or N/A
Discharge medication reviewed by Doctor	Yes/No
Discharge medication reviewed by Pharmacist	Yes/No or Checked by 2 Nurses
Discharge checklist completed	Yes/No

Please note that nurse-led discharge cannot be progressed outside the specialty; this process will then revert back to a medical-led discharge. If any of the above answers state 'No' then nurse-led discharge must revert back to a medical-led discharge.

Completing nurse must have at least 6 months experience within the specialty. Please note that the following must be stated/stamped in the patient's notes/record by the Consultant responsible or their deputy – 'proceed to nurse led discharge' and it is dated and signed

Signature……..…… Printed name……..……..……. Grade…… Date ……

Time saved by professional/patient led discharge = ……. Mins/Hrs/Days

Nurse led working group/L S Thornton/ 14th May 2004. – Calderdale & Huddersfield NHS Trust

Discharge plan and checklist – to be commenced on the day of admission

On admission – State date ..... Circle multiple choice answer

Patient Name Hospital number Address (addressograph label)	Provisional discharge date	Name of Carer/relative	Relative/carer phone no 'Dosette Box' used Yes/No

Home Care

Does patient have existing services Yes/No	Which services? Frequency?	Have they been cancelled Yes/No or N/A Date	Section 2 form done Yes or N/A Date sent

Other Community Services

District Nurse Yes/No	Reason? Frequency?		District Nurse cancelled? Yes/No Date
Aids/Adaptations to be put in place for discharge Yes/No or N/A	Which aids - include oxygen + nebuliser	Date requested + contact name	Date planned for aids to be in place
Other relevant information			

Home circumstances

Type of accommodation? Bungalow/ Flat/House/Care Home	Lives alone/carer (if with carer – relationship and name)	Digital Door Code Yes/No Number	Name of Nursing Home/Residential Care or N/A	House key kept with Or N/A

Access to home

Steps - Yes/No How many?	Distance to door Approx	Type of route to door Path/Field/Unadopted road/Other – please state

Multi-disciplinary referrals

Date referred	By who	Date seen	Seen by who	Outcome
Physio				
Occupational Therapy				
Medical Social Worker				
Specialist Nurse				
Other please state				

Prior to discharge

Plans discussed and agreed with patient/carer Yes/No	Comments	Plans discussed and agreed with MDT team members Yes/No	Comments	Equipment/Aids delivered to patient's home inc. oxygen/ nebuliser Yes/No	'Dosette box' required for discharge Yes/No If yes, pharmacy aware Yes/No
District Nurse informed Yes/No Date ……	Comments	Outpatient appointment booked Yes/No or own GP	Outpatient transport arranged Yes/No or N/A	Location of key/ digilock code/ clothes	Section 5 form sent Yes or N/A Date sent
Essential food, heating, water in situ in own home Yes/No or N/A	If No what arrangements have been made?		Referred to other professional or services Yes/No State service + reason		
Transport Arranged Yes/No	Relative/carer collecting Yes/No Who	WYMAS - Car 1/ Car 2 / stretcher/ tailift or N/A	Discharging address - as addressograph or state alternative address		

On day of discharge

Medically fit for discharge Yes/No	Discharge information confirmed with patient/carer Yes/No	Sutures remove Yes/No or N/A	Dressings removed/changed Yes/No or N/A	Venfon/lines removed Yes/No or N/A	House key/ valuables returned to pt/carer Yes/No or N/A
Medications given + explained to patient/carer Yes/No medication or N/A – as in Care Home	Discharge education/ Advice/ post-op information given to patient/carer Yes/No	Nurse transfer letter + property list done Yes/No or N/A	Social services support confirmed start date Yes/No Date	GP letter sent Yes/No	District nurse start Date Or N/A
Hospital Medical certificate Yes/No or N/A	Dressings/aids supplied for District Nurses Yes/No State type + amount of supply			Other community support arranged - state	

Date …….…… Signature of person completing…..…… Printed Name…..…… Grade……

Lesley S Thornton/Nurse led discharge working group/23.1.04 – Calderdale & Huddersfield NHS Trust

Case study 8

Patient involvement to improve the discharge process

Staff at Chesterfield and North Derbyshire Royal Hospital, accelerated discharge by making sure patients received their take-home medicines earlier in the day. The Trust actively involved patients in making these changes and took all comments on board and tried to alter working practices to improve the quality of the patient journey. This has helped improve the patient experience and sped up discharge.

Getting patients involved

From October 2003 alongside discovery interviews, patients were invited to be part of a focus group. From their experience of delays in the discharge process changes were made. Following on from the success of this a patient representative from the patient forum now participates in the project team meeting. The representative feeds back to the patient forum on a regular basis and is currently undertaking more discovery interviews to get additional feedback on the discharge lounge from patients who have used it as part of their discharge process.

Making it happen

The ward round was changed so that patients intended for discharge were seen first. Prescriptions for take-home medicines (TTOs) for soon-to-be-discharged patients were written during the ward rounds.

A discharge lounge was opened and patients were then collected from the ward by staff from the discharge lounge. TTOs were checked and dispensed in the discharge lounge by a pharmacy technician.

Patients are counselled and given all the necessary discharge information and wait in the discharge lounge for transport home.

Implementation advice

The trust actively involved patients in these changes. Diagnostic work and discovery interviews were undertaken to determine how patients believed care could and should be improved. The interviews were either done at the hospital or in the patients' homes. From these interviews, both negative and positive issues were raised.

Impact

A number of benefits have resulted from these changes, including pulling patients through the system more quickly, which frees up acute medical beds earlier in the day. Patients felt more informed and educated about their condition, especially as the system provided two checkpoints for ensuring that the patients had all they needed for discharge.

Next steps

We aim to continue to involve, and act on all comments made from the patients and carers who utilise our services, through the patient and liaison service at the trust.

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Case study 9

Improving discharge by improving transport co-ordination

The Royal West Sussex Hospital addressed problems with transport for in-patients and outpatients by introducing the role of a transport co-ordinator. The aim was to promote education, communication and improve flow of patients into and out of hospital.

Starting point

The processes in place for ordering transport for in-patient discharges, outpatients and other hospital attendances meant that it was booked by staff from across all hospital departments in a random manner. There were no strategies in place that either prioritised transport requests based on need, or took account of any balance of emergency and elective flows. Pathways to alternatives for NHS ambulance trusts were not clear and were hard to access. There was difficulty for the ambulance service in managing its capacity to meet demand as requests were uncoordinated. Transport problems impacted across all patient streams and resulted in cancelled discharges, cancelled operations and DNAs at outpatients.

Making it happen

An education programme to inform all staff (AHPs nurses, clinicians, administration and clinical support) of impact of current practice regarding transport was launched. The processes and systems for arranging transport were subsequently changed so that:

- Requests involving stretchers for patients are monitored for appropriateness.This has reduced requests for transport on stretchers by 75%.
- Where needed, case management of discharges on day of discharge to bring all elements of discharge together.
- Close links with alternatives to ambulance service such as community transport, private ambulance services, contracts with taxi companies, voluntary organisations.
- Peaks in demand managed through close liaison with bed management team and use of alternatives to NHS ambulance service when needed.
- Across both primary and secondary care an awareness of opportunities, alternative and impact of transport on whole service delivery.
- Linking of transport arrangement of patients attending the hospital for OPA and discharge of patients from hospital.
- Improved communication and working with ambulance service.

Implementation advice

- Turnover of staff from all professions in primary and secondary care requires a rolling education programme
- encourage ownership at ward level of the opportunity to make a positive impact by changing practice
- make most of diverse opportunities available in community as alternatives to ambulance service
- work with staff across primary and secondary care to develop a comprehensive transport strategy.

Impact of this change

- Earlier discharge from the ward freeing up beds earlier in the day
- flow of elective and non-elective patients improved.
- fewer cancelled discharges due to lack of transport or last minute cancellations
- decrease in outpatient delays and DNA rate in outpatients
- demonstrable financial savings as a result of robust contract management with service providers
- key contact for patients with transport queries resulting in improved patient experience.

Next steps

- Further work to smooth discharge across time of day and day of week
- direct access to ambulance computer information to further minimise telephone communications
- the post was funded 9-5 Monday to Friday, outside of these hours the role is carried out by the bed managers, further work is needed to investigate the impact that this service would have if its hours were extended.

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Case study 10

Improving discharge: intensive care at home

An Intensive Care at Home (ICaH) scheme was developed by Western Sussex PCT to assist in the local health economy's response to increased demand on services. This whole systems approach has helped facilitate earlier discharges, reduced the number of repeat admissions, shortened the length of stay as well as providing an alternative to admission. The scheme receives some funding from West Sussex County Council social and caring services and complements and works alongside the social and caring services' hospital discharge service.

Starting point

Following an increase in emergency admissions and delayed transfers of care, there was a need to develop health provision in the community to enable early discharge and enhance capacity management for the local acute unit.

Implementation advice

The major redesign in service provision means all partners need to support the service development from the beginning. They need to accept different ways of working and have realistic expectations of what the project will achieve. The development of good interpersonal relationships with secondary and primary care organisations is key and when initially presenting the project/concept doing it face to face is preferable to gain confidence. Recruitment to the new service with extended hours needs to be carefully considered.

It is important to ensure that referrals to the service are appropriate and that all patients referred will benefit from the intensive care within their home environment. Improved cohesive discharge using close links with community nursing, primary care and other community based specialist services was needed.

Referrals were received direct from OTs in A&E department, deferring admission to acute unit.

Time needs to be allowed to pilot the service, and fully evaluate the pilot period. Successes should be shared as and when they become apparent.

Impact information

- Shorter length of stay in acute hospital, especially for elective surgery and intravenous therapy e.g. cellulitis treated with IV therapy once a day reduces stay from 10 days to 24 hours.
- there has been a high level of satisfaction with the service from patients - who have more choice in their care journey and are able to remain at home or get home sooner - and referral sources - who have more options available for discharge planning
- the provision of palliative care for some conditions makes it possible for people to choose whether to die at home
- the scheme enables some acute episodes of chronic disease management to be catered for at home, either without admission or preventing a long stay admission
- nursing skills within the community have improved to match demand such as IV therapy, parental feeding, mid and PICC lines etc
- the impact of the scheme meant it was rolled out across the PCT after 6 months rather than a year as previously planned.

Next steps

- There are plans to extend the service provision to include blood transfusions in the community and palliative care for other end stage diseases e.g. heart failure
- links will be developed with evolving community based specialist services e.g. COPD to enhance its contribution to chronic disease management
- further work to be done with referral agencies to ensure appropriate referrals are made to the service
- work with discharge facilitators to ensure all potential ICaH patients are identified
- integrate ICaH service with West Sussex County Council social and caring services hospital discharge teams
- look at extending qualified nursing cover to 24 hours in line with PCT's out of hours developments.

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6. Practical tools to improve discharge

The series of factsheets in this section are intended to support the stages of the discharge process. They can be used and adapted to your practice to continue to improve the discharge process. The factsheets include:

Factsheet 1
Organisational barometer
Use this to identify where you are in relation to the key steps to implement timely patient discharge.

Factsheet 2
Development 'health check' progress tool
Use this checklist to establish how close are you to implementing timely patient discharge and to identify the steps you still need to take.

Factsheet 3
Benefits of improving discharge processes
Use these points to support the rationale for working to achieve effective and timely discharge for simple discharges.

Factsheet 4
Developing a nurse/allied health professional-initiated discharge policy
Includes the elements that a policy should address. Use this to develop your policy.

Factsheet 5
Example of discharge checklist
An example developed for an emergency assessment which demonstrates patient involvement. Use this to develop your local checklist.

Factsheet 6
Matrix of training competencies for timely discharge
Use this matrix to identify training needs among members of the multi-disciplinary team.

Factsheet 7
Key steps towards auditing discharge processes
Use this list of points to develop your audit of the discharge system.

Factsheet 8
The Community Care Act (Delayed Discharges etc) Act 2003
Summarises the main points that members of the multi-disciplinary team should consider.

Factsheet 9
Medicines management and role of the clinical pharmacist
Summarises the Hospital Medicines Management Collaborative work to optimise medicines management systems.

Factsheet 1

Organisational barometer

Use this barometer to identify where you are in relation to the key steps to implement timely patient discharge. When you have read the toolkit, reflect on your current practice in the clinical team and see where you are.

Where is your organisation positioned on the line?

Unpredictable, discharge not managed to EDD, discharge may not be timely

Predictable, discharge managed to EDD, leading to effective, timely discharge

What have you achieved so far?

What will you need to do to make it happen in your organisation?

What do you think is stopping you?

Who are your allies and champions who will support you in making this happen?

Who are the stakeholders/people you need to influence/persuade that this is a positive direction to take?

What are your next steps?

Factsheet 2

Developmental 'health check' progress tool

Use this check list to establish how close you are to implementing timely patient discharge and to identify the steps you still need to take.

1. Willingness to try

• Have you started to review the discharge process through process mapping?	Yes	No
• Have you started to discuss timely discharge within the multi-disciplinary team?	Yes	No
• Have you approached the information manager to look at current pattern of discharges?	Yes	No

2. Support

• Do you have support from the lead consultant, clinical director, and senior manager?	Yes	No
• Have you started to discuss timely discharge with the director of operations executive lead?	Yes	No
• Have you gained support and agreement with the director of nursing and medical director to begin nurse-initiated discharges earlier in day and at weekends?	Yes	No
• Have you identified your allies and champions who will support you?	Yes	No
• Have you reffered to the DH workbook 'Discharge Planning - pathway process and practice'?	Yes	No

3. Discharge pathway

Have you agreed the elective or emergency pathway and patient group?	Yes	No
Referral routes established (access to pathway)	Yes	No
Scope of pathway decided:	Yes	No
– Pre-operative or pre admission	Yes	No
– From point of admission	Yes	No
– At point of medical stability (clinical stability)	Yes	No
– On day of discharge	Yes	No
– Post discharge	Yes	No
– Exit route(s) established	Yes	No

Checklists

Discharge checklist developed?	Yes	No
Nurse or AHP led discharge checklist?	Yes	No
Decision when checklist is to be used (48hr/24hr/ON DAY)	Yes	No
Patient focus (involvement) considered?	Yes	No

4. Clarify roles and responsibilities

• Have you identified the members of the team who are involved in the discharge process?	Yes	No
• Have you mapped the discharge process with the roles and responsibilities of members of the clinical team?	Yes	No
• Could you clarify the roles and responsibilities?	Yes	No
• Could you change the roles and responsibilities so that it improves the discharge process?	Yes	No

5. Estimated date of discharge (acute)

Estimated date of discharge (EDD) process in place?	Yes	No
Endorsed by consultant teams and junior doctors?	Yes	No
Agreements with labs and X-ray for turn around times of tests etc?	Yes	No
Implemented consistently at post take ward rounds or MDT meetings?	Yes	No

Estimated date of discharge (rehab)

Supported by regular multi-disciplinary team input	Yes	No
Links from EDD and nurse initiated discharge established?	Yes	No
Wider consideration of 'number of contacts' required by AHP	Yes	No

Estimated date of discharge (primary/intermediate)

Considers primary care perspectives (e.g. district nursing input)	Yes	No
Considers intermediate care service input/assessment/availability	Yes	No

6. Training(knowledge, skills and competencies

Skills/competencies required, are clearly identified (matrix)?	Yes	No
Supporting nurse initiated assessments are developed?	Yes	No
Training and work-based learning needs identified	Yes	No
Supervision and assessment in carrying out nurse-initiated discharge in place	Yes	No

7. Agree to pilot or run a PDSA

Have you run a PDSA around timely discharge for a specific group of patients?	Yes	No
Have you identified the criteria you will use to monitor the impact of change on the patient pathway and timely discharge?	Yes	No

8. Policy

Have you reviewed your hospital discharge policy?	Yes	No
Nurse initiated discharge as part of policy?	Yes	No
Nurse initiated discharge policy links with Trust discharge policy?	Yes	No
Written in collaboration with multi-disciplinary team including social services?	Yes	No
Written in collaboration with primary and intermediate care services	Yes	No
Signed off by legal team / clinical governance approval?	Yes	No

Policy indicates scope of nurse initiated discharge from secondary care, primary care, intermediate care and nursing / residential settings

9. Protocols/guidelines

Individual condition based protocols developed with lead consultants?	Yes	No
Exclusion/inclusion criteria decided (to assess suitability for NID)?	Yes	No
Screening tools written in conjunction with physician or surgeons?	Yes	No

Protocol clear about when transfer of care from medical profession to nurse or AHP protocols is to happen?

- Protocols signed off by relevant professionals with implementation and review date
- Clinical governance aspects of protocols are agreed by trust clinical risk departments, legal advisers

10. Outcome measures

Agreed measures before and after new process in place?	Yes	No
Audit mechanism in place?	Yes	No
Established as a pilot project?	Yes	No
Agreement about how to disseminate best practice or lessons learned?	Yes	No

Factsheet 3

Benefits of improving discharge processes

Improving discharge processes has distinct benefits for patients, the service and for health professionals. Use these points to make the case to stakeholders about the benefits to be gained from improving the discharge process.

Benefits for patients

- Identifying expected date of discharge can help patients to plan for when they go home
- Patients' own responsibility for elements such as transport and arrangements at home can be clarified, discussed, and agreed in advance
- Patients' experiences can be improved when they have more information about their care and they feel included in the decisions
- Patients have more realistic expectations of the care they will receive
- Patients only stay in hospital for the optimum amount of time for their recovery and are less likely to pick up hospital acquired infection

Benefits for the service

- Health and social care can work as a whole system, supported by a managed care approach, resulting in improved quality, better match between demand and capacity, and better use of resources such as staffed hospital beds
- Improved discharge processes contribute to improving patient flow and the effectiveness and efficiency of the system: right patient, right place, right time
- Increased bed days will be available for the organisation, reducing queues and cancellations
- More effective communication between hospital and community will mean more streamlined services for all
- Consistency in approach to single assessment and services based on need – joint assessment processes mean an integrated approach and less time wasted on duplicating the assessment process by different teams

Benefits for health professionals

- Improved discharge processes make professionals' working lives easier and clearer
- seeing their role as part of the whole system with each part impacting on the effectiveness of every other part
- The development of proactive processes and taking a more managed care approach to their work, leading to greater job satisfaction
- Professionals have an increased sense of responsibility, recognition and support for the work they contribute
- Clinical team members will be directly contributing to improving the patient's experience of healthcare

Factsheet 4

Developing a nurse/allied health professional-initiated discharge policy

The following elements can be included in a nurse/allied health professional-initiated discharge policy. Examples are included under each heading.

Statement of philosophy

- Patients and carers are involved in making decisions and kept informed of their discharge plans
- Plans allow for flexibility, accessibility and individual choice
- Early planning for discharge through multi-disciplinary working
- Non-discriminatory practice
- Includes directives for the safe and effective provision of nurse/allied health professional discharge

Strategic intention or aim

Organisational

The aim will determine the key drivers underpinning the policy, such as:

- Percentage of discharges aimed for
- explicit links to reducing the length of in-patient stay
- links to preoperative assessment and suitable patient groups

Professional

- To extend or formalise current practice
- To assist in delivering the working hours directive
- To promote confidence in the discharge process
- To assist with the development of new roles

Objectives

- To ensure more timely discharges occurs and reduces the discharge delays
- To promote independence for the professional carrying the discharge
- To ensure practice is safe and does not put the patient at risk
- To provide continuity of care, through effective communication across all professionals and teams irrespective of setting

Definition of a nurse/allied health professional-initiated discharge

- Interfaces with other professional roles to support discharge planning
- Part of a process, to secure safe timely discharge
- Can be supported by condition specific protocols

Scope of the policy

- Medicine
- Surgery
- Where does it start? Where does it finish? Pre-admission to post discharge
- Agreements with intermediate care and outreach teams
- Primary care provision to support the policy?
- Integration with PCT commissioning processes?

Areas of special concern

Highlight the categories of patient who need particular attention and who should not be excluded on an age or condition related basis, provided they are medically stable:

- People who live alone
- People who are elderly
- People who are frail irrespective of age

- Terminally ill patients
- People with chronic conditions who may return to Hospital for further treatment.
- People living in sheltered accommodation

Authorised responsibilities

- Level of health professional
- Core team to support health professional
- Length of time need to be qualified.
- Role of MDT and support provided by named team members

Education and training

- Core discharge skills analysis to determine areas of training required
- Competency assessment
- Competency based training and declaration of competence

Legal liability

- Undergone preparation and training for the role
- Deemed competent to undertake the role
- Authorised framework has been developed
- Supporting protocols, criteria where appropriate

Professional accountability process

- Suitability of patient selection
- Links with appraisal process
- Recorded onto a local database for named nurses competent to initiate discharge
- Job descriptions need to reflect the additional role dimension

Patient responsibility in the process

- Giving consent
- Learning self-care (if required to facilitate discharge planning)
- Involving their family/carers

Policy links

- NMC Code of Professional Conduct
- The Scope of Professional Practice
- Equivalent codes for AHPs
- Royal College policy statements
- Any other Trust specific documents

Audit and evaluation framework

- What framework will be employed? What are the key measures?
- How will you measure patient's satisfaction?
- Who is signing this document off?
- Has it been presented at a clinical risk or governance group?

Legitimising the policy

- Trust policy reference number
- Date
- Review date
- Key signatures: e.g. executive nurse, medical director and head of allied health professionals

Factsheet 5

Example of discharge checklist

This example of a discharge checklist is used in partnership by the patient, who fills in the first section, the nurse and the ward clerk. It is an example of patient involvement in the discharge process in action.

Patient section
Please complete these questions and the nurse will collect the form from you.

Your Name:			
Date:			
Is this the first time you have attended the Department?	☐ Yes	☐ No	
Do you understand your diagnosis?	☐ Yes	☐ No	
Has a clinic appointment been made for you?	☐ Yes	☐ No	☐ Not sure
Have further investigations been arranged for you?	☐ Yes	☐ No	☐ Not sure
Do you understand your medications?	☐ Yes	☐ No	☐ Not sure
Have you been prescribed any medications?	☐ Yes	☐ No	

Thank you for completing this, please hand to the nurse looking after you.

Nurses to complete

Medically fit for discharge (in notes)	☐
Venflon removed	☐
Discharge discussed with patient	☐
GP discharge letter given to patient	☐
Drugs to take home supplied and explained	☐
Any patient's own drugs returned	☐
Dressings and equipment supplied	☐
District Nurses contacted	☐

Follow up call indicated	☐ Yes ☐ No
Notified patient about follow up call	☐ (time) ……

Clerical staff

Transport arranged	☐ (time) …… (how) ……
Appointments and relevant documentation	☐ (with)……
Other follow up arranged	☐ ……

Discharging signature ……..…… (time) ……..……

Factsheet 6

Matrix of training competencies for timely discharge

The competency framework has been designed so that any member of the multi-disciplinary team can assess their own knowledge and skills, these can be discussed with the team leader, and training needs can be identified for individual staff and for the team as a whole.

You and your team will need to agree the level of practice, supervision and assessment needed by each member of the team. You will also need to agree roles, responsibilities, and contributions individual team members will make to discharge decisions and the co-ordination of the discharge process. This may help you to identify training needs and support you in designing local education and training. For example, the team may include:

- ward clerks and administrative assistants
- health care assistants
- newly qualified professional staff
- more experienced staff including staff nurses, allied health professionals, junior doctors and social workers
- expert practitioners including consultants practitioners including doctors, nurses and allied health professionals, specialist registrars, ward sisters, matrons, nurses, social services managers and allied health professionals with specialist interest.

It will also help you to plan the rotas to ensure that staff with the appropriate knowledge, skills and competencies are available to follow through clinical management plans and discharge criteria so that patients continue to be discharged over the weekend.

We suggest that individuals must achieve an expert level of competence before taking full accountability for initiating discharge.

The competency framework will allow self-assessment and peer review of the range of knowledge and skills required. It is suggested that you identify your level of competence for each section or elements within each section. You may be fully competent in some areas, but only partially competent and need further training and supervision in other areas.

The competency framework is a suggested guide and can be adapted to ensure it is consistent with your usual approach to education, training and assessment of competence.

Use the boxes to assess your competence:

C = Competent **P** = Partially competent **N** = Not yet had experience

	Multi-disciplinary team working	Estimating expected date of discharge	Development, implementation and review of clinical management plan
Advanced Practitioners (Expert) **Able to make decisions independently**	Able to: • Lead a team effectively • Demonstrate collaborative working and has trust of senior colleagues • Communicate effectively with team/other HCP/patients and carers • Develop/implement clinical management plan • Identify and achieve shared goals	Able to: • Undertake full assessment of the patient including physical, physiological, social and functional • Demonstrate excellent knowledge of the clinical condition and the investigations/ interventions required • Estimate the length of stay needed to complete treatment to a level where the patient is clinically fit for discharge • Review and revise EDD based on further assessment/data	Able to: • Develop clinical management plan based on full assessment • Implement and review CMP developed by another member of MDT • Review patient progress and adjust the plan in response to assessment and test results • Identify EDD within the plan • Demonstrate ability to make effective discharge decisions
Practitioners (Experienced) (Completed foundation years) **Able to present all information needed for decision making but requires support in making decision**	Able to: • Demonstrate good understanding of individual roles within MDT and their contribution to discharge • Communicate effectively with members of MDT/patients/carers • Anticipate information needed by MDT in order to make decisions • Demonstrate high level of knowledge of discharge process	Able to: • Undertake partial assessment of the patient including physical, physiological, social and functional • Use protocols/guidelines/ ICPs to support planning and implementation of care • Prompt MDT to estimate EDD and document in patient record • Prompt review of EDD based on assessment of patient	Able to: • Implement aspects of the CMP and co-ordinate care around the patient • Assess the patient (clinical condition specific) for discharge using criteria or protocols developed by MDT • Identify when patient's condition has deteriorated and are no longer suitable for discharge
Newly qualified Practitioners (Novice) (During foundation years) **Able to demonstrate an understanding of discharge process**	Able to: • Demonstrate an awareness of individual roles within MDT • Understand the importance of effective and timely communication	Able to: • Carry out basic components of assessment • Follow instructions and report any variances to team leaders • Demonstrate awareness of importance in discharge model	Able to: • Demonstrate understanding of elements of CMP • Implement aspects of the plan under supervision • Demonstrate understanding of importance of effective documentation and communication

	Making referrals	Interpretation of test results and investigations	Patient decides to self discharge against healthcare professional advice
	Able to: • Demonstrate excellent ability to identify when a referral is needed • Initiate referral to other members of MDT • Follow up actions and results from referrals • Co-ordinate and run MDT review of patient • Use outcome of MDT review to adopt CMP and EDD	Able to: • Refer and interpret test results • Adjust CMP in response to the results of tests and investigations • Identify when future discussion and review by medical colleagues and other members of MDT • Take responsibility for discharge decision based on clinical assessment and best results	Able to: • Attempt to persuade patient to remain in hospital if this is in the clinical interest of the patient • Explain the risks and potential consequences of self discharge to the patient and carers • Rapidly co-ordinate care package if accepted by the patient • Document events accurately within patient record • Communicate with GP including discharge letter
	Able to: • Recognise when referral to MDT may be needed • Make referrals based on guidance from others • Co-ordinate actions and results from referrals • Demonstrate understanding of MDT review and implications for CMP and EDD	Able to: • Proactively chase test results • Understand the significance of test results • Communicate abnormal test results effectively and in timely manner to appropriate member of MDT	Able to: • Explore reasons for self discharge • Inform patient's consultant or senior medical team of patient's intention • Ensure all relevant documentation is completed
	Able to: • Follow instructions and plans developed by other members of MDT • Document when referrals have been made in patient record	Able to: • Accurately record and document test results • Demonstrate an awareness of normal and abnormal test results	Able to: • Demonstrate awareness of the risks and potential consequences of self discharge for patient • Demonstrate awareness of the policy and procedures/documentation required

Factsheet 7

Key steps towards auditing discharge processes

A number of key questions have been included for consideration. These questions are not designed to be comprehensive and may need to be adapted. However, audit of the efficiency and effectiveness of the discharge process should be considered as part of the audit programme for the hospital or specialty.

1. Use standard statistical data sets to include

- Patient identification number
- Age or age range/date of birth
- Sex
- Address
- Condition group (clinical codes)
- Discharge destination
- Date of discharge
- Time of discharge

2. Address focused questions, such as:

- **Are patients being discharged earlier in the day?**

  To answer this you will need to establish data demonstrating the time patients were/are normally discharged before the implementation of the changed discharge process and compare with the times recorded on the audit sheets.

- **Are patients being discharged over the weekend (and bank holidays)**

  Retrospective audit of the number of discharges by day of the week will reveal the trend and pattern of discharges occurring across the 7 day period. Implementation of nurse-initiated discharge at weekends should demonstrate that there is an increase in the number of patients discharged on a Saturday and Sunday.

- **What proportion of patients have an expected date of discharge written in the notes as part of the initial assessment?**

  Retrospective audit of patient records will identify the proportion of patients who have an expected date of discharge recorded as part of the management plan. You may want to focus on medical or surgical patients or other defined groups of patients. The audit can also identify when the EDD was recorded during the patient's stay in hospital.

- **What proportion of patients are discharged on the expected date of discharge?**

  Retrospective audit of patient records will identify what proportion of patients have an expected date of discharge (EDD) and what proportion of these that are actually discharged on the EDD. In addition, the audit could include the proportion of patients discharged before or after the EDD and the reasons given for this variance.

3. Involve clinical governance, service development or audit support staff

They will help you to design the audit form so that it is easy to complete, does not ask ambiguous questions, and uses objective measures. They will also ensure that data is easy to interpret and analyse the results.

4. Other specific areas for audit consideration

- Types of staff (by professional group) who initiate discharge
- volume of patients being discharged in EDD (of total ward or specific patient group) before and after implementation
- baseline audit data, comparison of duration of length of stay (LOS) episodes of relevant groups and difference in LOS after the nurse initiated discharge implemented
- number of bed days saved for each specialty with the introduction of identification of EDD and/or nurse-initiated discharge for simple discharge categories
- compliance with discharge criteria documented in the patient record for example vital signs, eating and drinking normally, blood results; and specialist condition factors, e.g. peak flow measurement , blood glucose levels
- re-admission rates within 48 hours (or specified period of time): and reasons for re-admission
- compliance with standards of documentation within the healthcare record demonstrating an audit trail for the key stages of the discharge process
- patient/doctor/nurses/APH/other professionals satisfaction surveys.

Factsheet 8

The Community Care (Delayed Discharges etc) Act 2003

- The Community Care (Delayed Discharges etc) Act 2003 introduces a system of reimbursement for acute beds occupied by people who no longer need to be there, where social services is solely responsible for the delay. It places duties upon the NHS and local authorities in England relating to communication between health and social care systems concerning the discharge of patients and communication with patients and carers.
- The NHS is required to notify the local authority of any patients likely to need community care services on discharge (a Section 2 notice), and of their proposed discharge date (a Section 5 notice).
- Reimbursement for delayed transfers of care relates initially to adult patients receiving acute care. Delays in mental health, learning disability and intermediate care services and other non acute services such as community hospitals are currently excluded from the arrangements, although the scheme may be extended to these areas in the future. If a patient remains in hospital because the local authority is solely responsible for the delay (be it assessment or provision of a social care package), then the Local Authority must pay the NHS organisation £100 per day of delay (£120 in London and certain other parts of the country). This came into force on 5 January 2004 following a shadow period from the previous October.
- The Act is therefore intended to promote the independence of older people. Additional funding was provided to local authorities to enable them to invest in services for older people in partnership with their health colleagues to reduce the likelihood of delays. The aim is to improve services, and hence ensure that more people will be cared for in the most appropriate setting for their needs, thus avoiding the need to pay reimbursement charges.
- As the commissioners for health, PCTs are key to working with NHS bodies and local authorities in order to identify the main causes of delays and focus investments into those areas to reduce the delays, and the need for reimbursement. Many localities have entered into joint agreements on how any reimbursement monies paid will be reinvested into services for older people.
- The regulations require that patients be screened for possible continuing health care at the beginning of the process.
- Strategic Health Authorities (SHAs) have a specific duty under the Act to establish Dispute Resolution Panels, and appoint members to them.
- A training package on reimbursement is available at www.dischargetraining.doh.gov.uk

Responsibilities of the nursing team

The nursing team co-ordinates the discharge process for patients with more complex needs and ensures referrals to the multi-disciplinary team are made and co-ordinated. This includes issuing section 2 notices to social services for patients likely to need community care services on discharge. The nursing team is responsible for initiating timely complex discharges once the care package has been agreed and put in place. They should ensure a section 5 notice is issued to social services giving the proposed date of discharge, with 24 hours notice, for those patients already notified under section 2. People whose transfers of care are delayed should be jointly discussed with social services and their status jointly agreed, including who is responsible for the delay, before they are included in the weekly Sitrep. They are subject to the reimbursement charges if social services are solely responsible for the delay. It is worth remembering that nationally about 67% of delays are for NHS reasons, not social services.

Based on work within the South Devon health community

Factsheet 9

Medicines management and the role of the clinical pharmacist

Managing medicines effectively is central to the quality of health care. The Hospital Medicines Management Collaborative (HMMC) has established a programme which aims to optimise medicines management systems in the hospital service.

The HMMC programme has highlighted a number of key factors that can improve medicines management systems.

- Appropriate use of technology so pharmacy services can be concentrated on patient-centred clinical activities.
- increased review processes for managing the use of non-formulary items, unlicensed medicines and 'off-label' usage.
- develop partnerships between primary and secondary care that support improved medicines management services, including development of initiatives such as joint formularies; admission and discharge planning; improved information flow; and sharing information where medicines are involved.
- develop the skills of the whole pharmacy team, so the potential for the clinical skills of pharmacists can be realised – involve medical, ward and department staff in the development of, and increasing strategic involvement with, the improvement of medicines management services.
- optimise the impact of drug and therapeutic committee decision, within and beyond the hospital system while promoting safe medication practices.

The HMMC will work with project teams in hospital trusts. Participating trusts will have help in creating learning culture within their organisation, better links between medicines management and other local health priorities and sustainable improvement to the range of medicines management services they provide.

Participating trusts will develop their own local objectives and tools for measuring and assessing progress. This information will give rapid feedback on improvement activities and will help to spot ideas that work.

Further information about the development of the programme can be found at www.npc.co.uk/mms

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Health and Social Care Joint Unit and Change Agent Team (2003) *Discharge from hospital pathways, process and practice,* Department of Health: London. www.dischargeplanning.doh.gov.uk

Healthcare Commission (2004) *Patient Survey Report*, Healthcare Commission: London.

Web addresses and useful information

Care pathways: Link to the National Electronic Library for Health
http://libraries.nelh.nhs.uk/pathways/

Change Agent Team website provides further information and learning materials to support proactive and timely discharge
http://www.changeagentteam.org.uk/

The Changing Workforce Programme
www.modern.nhs.uk/cwp

Department of Health, Modernisation Agency and National Primary and Care Trust Development Programme (2002) Liberating the Talents: helping primary care trusts and nurses to deliver the NHS Plan,. Department of Health: London.
http://www.dh.gov.uk/publicationsandstatistics/publications/publicationslibrary

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www.modern.nhs.uk/scripts/default.asp?site_id=35

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http://www.dh.gov.uk/publicationsandstatistics/publications/publicationslibrary

National Clinical Governance Support Team
www.doh.gov.uk/policyandguidance/healthandsocialcaretopics/clinicalgovernance

Nurse Prescribing
www.dh.gov.uk/policyandguidance/medicinespharmacyandindustry/prescriptions/nursingprescribing

Modernisation Agency
www.modern.nhs.uk

PDSA Plan, Do, Study, Act - Model for improvement
www.modern.nhs.uk/improvementguides

Abbreviations

CDU	Clinical Decision Unit
CMP	Clinical management plan
DNA	Did not attend
EAU	Emergency Assessment Unit
EDD	Expected date of discharge
ICaH	Intensive Care at Home
ICP	Integrated care pathway
IPH	Improving Partnerships with Hospitals
LOS	Length of Stay
MAU	Medical Assessment Unit
MDT	Multi-disciplinary team
NID	Nurse-initiated discharge
OPA	Out patient appointment
PDSA	Plan, Do, Study, Act
SAP	Single assessment process
TTO	Treatments to take out

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