Principles of safe and timely hospital discharge

Introduction

Achieving a safe and timely hospital discharge can be a formidable challenge. For most patients discharge planning is straightforward, but around 20% of patients have more complex needs. They need multidisciplinary assessment before discharge, and may require a period of rehabilitation, a programme of health care or social support at home, or placement in a residential or nursing home.

A timely discharge ensures patients spend as little time as possible in a hospital environment. Maximizing efficiency of bed use is a strategic priority for the NHS. Both the *Framework for Action* (Darzi, 2007) and the NHS white paper (Department of Health, 2010b) advocate that chronic disease should be increasingly managed in the community. Despite this, acute hospital admissions are rising (Blunt et al, 2010) while acute bed numbers are falling (Harker, 2009).

Our ageing population places increasing demands on health and social care. Individuals over 85 years of age are around 10 times as likely to have an acute hospital admission as someone in their 20s, 30s or 40s (Blunt et al, 2010). Delayed discharges can impact adversely on bed management, for instance blocking discharge of patients from intensive care, preventing elective surgical admissions by shunting new acute admissions into surgical beds, or in extreme cases contributing to a hospital bed crisis requiring cancellation of surgery or diversion of emergencies to a neighbouring hospital.

Physicians have a key responsibility towards safe and timely discharge of patients, and are pivotal members of the multidisciplinary discharge team. This team includes the discharge lead or ward-based care coordinator, physiotherapists, occupational therapists and social workers. The physician should understand each team member's role, and effectively communicate any information about a patient's medical condition pertinent to discharge, both in a ward setting and at discharge-focused multidisciplinary meetings.

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General considerations

In accident and emergency or the acute medical unit, consideration should first be given as to whether the patient's condition actually warrants admission. Many patients with a low mortality risk can be managed in the outpatient setting, e.g. troponin-negative low risk chest pain, or community-acquired pneumonia with a CURB65 severity score of 0 or 1 (Lim et al, 2009). Patients without acute medical problems but with social needs should not be admitted unless they are at immediate personal risk. Assessment of any escalating social support needs should ideally happen urgently in the community, coordinated by a community matron, district nurse or GP.

The interaction between medical and social problems can be complex and underappreciated. For example, a patient with a simple shoulder injury may only require conservative management and analgesia, but because of functional impairment may also require inpatient rehabilitation, or a temporary social care package to facilitate activities of daily living at home. In some trusts, admission avoidance teams can arrange admission to a community hospital rather than an acute bed.

Local ambulatory care pathways facilitate safe early discharge. In chronic obstructive pulmonary disease these effectively reduce length of stay without adverse effects on re-admission or mortality rates (Cotton et al, 2000). Similar schemes appear feasible in low risk pulmonary embolism (Agterof et al, 2010), heart failure and cellulitis (Leff et al, 2006). Referrals to specialist teams and investigation requests should occur as early in the admission and in the day as possible, so that patients are not kept in hospital waiting for these. Consideration must be given as to whether such referrals and investigations could take place in the outpatient setting.

A thorough accurate discharge summary informs the GP about new diagnoses, treatments and any medication changes. It also enables hospital coders to determine what tariff GPs should be charged for each aspect of a patient's investigation and treatment. A formal discharge letter should be electronically sent to the GP within 24 hours of discharge. This is now a government target following a report by the Care Quality Commission (2010), which found that almost 50% of GPs received summaries too late for them to be useful. Patients with deteriorating or complex health or social status are also best discussed with the GP or district nurse before discharge. Once a patient is ready for discharge, he/she can be transferred to a discharge lounge to await take-home medication.

Practical considerations before discharge include ensuring necessary equipment or oxygen has been installed. Oxygen can be provided urgently within 4 hours, albeit associated with an increased tariff, so should not delay discharge. Hospital transport requires booking 24 hours before the discharge date and is for patients who, for medical reasons, are unable to use private or public transport. Relatives who may collect the patient also need adequate notice of the planned discharge date.

Discharge planning should start at hospital admission (or before for planned elective admissions). Consideration should be given to the patient's preferred discharge destination, and whether discharge is likely to be complex. If so this should be highlighted immediately to the ward-based care coordinator – usually a senior nurse who should have overall responsibility for the discharge process and for actioning appropriate referrals and assessments.

An expected date of discharge should be set within 24–48 hours of admission, and should be discussed with the patient and carer. Pro-active discharge decisions should be made daily and not be dependent on twice-weekly consultant rounds. Discharges should occur 7 days a week. Any change in the expected date of discharge, should be documented in the medical and nursing notes.

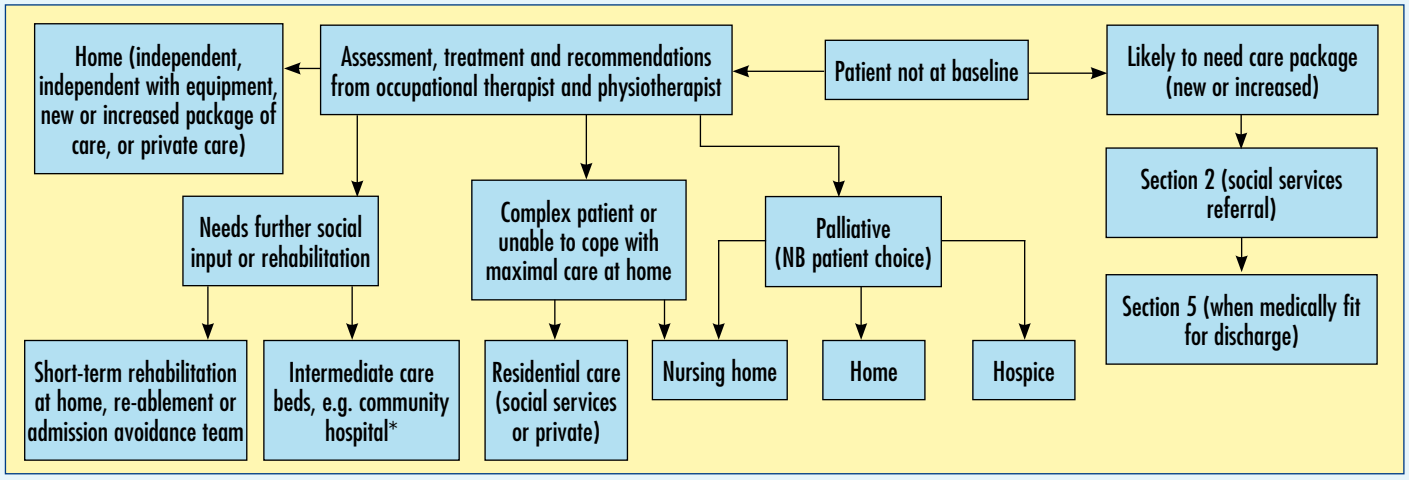


Figure 1. Complex discharge planning flowchart. *There is limited availability for this – there needs to be clear evidence of rehabilitation potential and the patient must be medically fit.

Occasionally unexpected obstacles to planned discharge occur. Patients with diarrhoea should not be discharged to a care home (or to their own home if they have a care package), since personal care may be difficult, and they may pose an infection risk to other patients, staff or carers.

Complex discharge is illustrated in *Figure 1*. For a simple discharge, the patient is rapidly back to his/her baseline level of function following brief medical treatment. He/she can be discharged with either no input, or with re-instatement of a pre-existing social care package, which is usually possible within 24 hours.

For a complex discharge (*Figure 1*), once a patient's acute medical condition is treated, his/her ability to undertake activities of daily living, mobility, confidence and/or independence will be worse than the pre-admission baseline best. Physiotherapy and occupational therapy referrals should be made by ward nursing staff. All assessments require patient consent.

At discharge-focused board rounds or multidisciplinary meetings, physicians should explain key medical issues, while avoiding complex medical discussions. They should outline the basis for outstanding investigations, referrals or treatments, and likely timeframes for their completion. They should propose a realistic timeframe for expected clinical improvement to the point where the patient no longer requires management in an acute bed and is 'medically fit'. Medically fit patients require brief medical review while discharge arrangements proceed, but should not have excessive blood tests or other investigations.

Physiotherapy and occupational therapy

Physiotherapists and occupational therapists review the patient's current level of function in relation to the baseline best. The physiotherapist will attempt to promote safe assisted or independent transfers (bed-to-chair or sit-to-standing), improved mobility, including managing stairs where necessary, and bolster confidence.

The occupational therapist will assess whether there is any need for personal aids, equipment, home modifications or the likelihood of needing additional social care. He/she needs comprehensive information from the patient, relatives and carers about the home to establish whether new equipment will fit inside the home. The occupational therapist may also need to inspect the property with this in mind (access visit) or review whether a patient functions safely there (home visit). *Table 1* shows the authors' local referral criteria for occupational therapy.

Social services

The likelihood of needing a new or increasing social care package is often best gauged after occupational therapy or physiotherapy review, although nursing staff are also pivotal in realizing this. A section 2 referral is a notification of initial need for assessment by social services and should be made at least 72 hours before the expected date of discharge.

A social worker will assess the need for social input, with the benefit of physiotherapy and occupational therapy recommendations and reports. For consenting patients, he/she will then source carers from agencies to build the appropriate care package. Eligibility criteria and the level of care available currently vary between local authorities, although the Department of Health (2010c) has published recommendations on this. Typically the maximum level of input is four times daily carer(s), with a patient being able to transfer (bed-

Table 1. Suggested referral criteria for occupational therapy

Refer	Mismatch between baseline and current function
	Previous care not working
	Struggling before admission
	Change in circumstances, e.g. new gastrostomy, new wheelchair user
	Equipment needs
	Family or carer concerns
	Perceived need for new or increased care package
	Palliative patient wishing to go home
	Concerns about cognitive function or confusion
Do not refer	Independent on ward
	At baseline, had no previous problems
	Normally dependent, e.g. residential home or full care package
	Existing care package adequate, and no change in function
	No potential to change anything, e.g. not cooperating with physiotherapy, refusing care
	Not consenting to intervention

to-chair) with the assistance of two or less staff. Some patients may not need carers per se, but may benefit from low-level supervision in warden-controlled sheltered housing. Patients who are homeless need to be referred to local homeless services providers, and should ideally not be discharged until such an agency has ensured availability of accommodation, e.g. in a hostel.

At a later stage, once a patient is medically fit and needs no further acute hospital physiotherapy or occupational therapy input, a section 5 referral should be made. This indicates the patient is ready to be discharged with a social care package, but needs to be made at least 24 hours before the expected date of discharge. Any unreasonable delay can result in the local authority being fined for a delayed discharge. Social care is jointly funded by the local authority and the patient. The patient's contribution is derived by means testing of his/her savings and assets.

It remains an option for patients to source care privately according to their wishes rather than the result of social services assessments of their needs. A brochure should be available locally from social services detailing what is available and at what cost. For patients from a neighbouring local authority the social worker will need to liaise with social services in that authority to plan social input post discharge. It may be an option to transfer or repatriate such patients to their local acute hospital, from which to plan community support post discharge.

Intermediate care and homecare re-ablement

Intermediate care encompasses an integrated range of acute and rehabilitative health care and social services designed to bridge the gap between acute hospital and primary and community care. It is for a finite duration of usually 1–2 weeks but up to 6 weeks. It can comprise short-term care and support at home, sheltered housing or residential home, but for patients discharged following an acute hospital admission is more typically in a community hospital setting. Patients must be medically fit, and have been deemed to have suitable rehabilitative potential by occupational therapists and physiotherapists.

Homecare re-ablement is a temporary package of predominantly social support that can be provided after discharge to help a patient adapt to managing his/her illness, his/her level of independence, or learning or relearning skills necessary for daily living (Department of Health, 2010a). Intermediate care and re-ablement services are jointly funded by the NHS and the local authority. Patients are not liable for any charge provided services do not continue beyond 6 weeks.

Residential and nursing homes

Residential placement may be appropriate for patients whose level of dependence necessitates more than the maximal available carers, but do not need nursing care. Sometimes this can be an interim rather than permanent placement, with a view to reassessment of needs after a few weeks. The patient's wishes are paramount – if he/she has mental capacity and declines best advice for residential placement, the patient should be allowed to go back home, even though this might result in a failed discharge.

If a patient has both social and nursing needs, a nursing needs assessment is required (Royal College of Nursing, 2004). This considers and scores nursing needs within three domains: maximizing life potential, prevention and relief of stress, and promotion and maintenance of health. It also looks at stability and predictability of these needs. From this the total registered nursing input requirement can be calculated. Any nursing needs are NHS funded, and can be provided in the patient's own home, residential or nursing home. Accommodation costs for both residential and nursing homes are funded jointly by the local authority and patient, following means testing.

NHS continuing health care

This constitutes a package of continuing health- and often social care which is arranged and funded solely by the NHS (Department of Health, 2009d). Eligibility depends on a patient's primary need for continuing care being a health need. The totality of the relevant needs are considered in determining this, together with their nature, intensity, complexity and unpredictability. *A Continuing Care Checklist* (Department of Health, 2009c) is useful in identifying individuals likely to be eligible for NHS continuing care and evaluates needs in the following domains: behaviour, cognition, psychological/emotional, communication, mobility, nutrition, continence, skin integrity, breathing, medication, therapies and symptom control, and altered states of consciousness.

For individuals with overall significant needs identified in the checklist, the decision support tool is used to further assess eligibility (Department of Health, 2009a). This is undertaken by the multidisciplinary discharge team, led by the ward-based care coordinator, together with the patient, family member or carer. Needs, as described in the checklist, are scored as priority, severe, high, medium, low or none. Eligibility is dependent on the demonstration of priority, severe, or sometimes multiple lesser needs. The discharge multidisciplinary team will recommend patients they deem eligible to an independent panel, for approval, whose funding decision must occur within 28 days of completion of the checklist (Department of Health, 2009d).

NHS continuing care can be provided as a package in a patient's own home, residential or nursing home. For 24-hour care at home, the property must have adequate space for carer's accommodation. For those patients not deemed eligible for NHS continuing care, eligibility should be reviewed after 3 months, or earlier if their condition is deteriorating.

Discharge of the patient with cognitive impairment

Some patients will have an established diagnosis of dementia. Those with no such diagnosis and no apparent organic basis for their confusion should be assessed, usually in conjunction with an elderly medicine physician (*Figure 2*). This should include a collateral history from close family about the temporal basis for cognitive impairment, a 30-point mini mental state exam, a computed tomography brain scan, and a blood screen to exclude reversible causes of confusion: vitamin B_{12}, folate levels and thyroid function. If dementia is diagnosed, it is important to consider whether a patient has mental capacity. If he/she does, discharge planning should proceed as for any other patient. Discharge planning for patients lacking mental capacity should proceed in their best interests, taking into consideration views of close family members and an independent mental capacity advocate where no close family members exist. This is particularly important in decisions about long-term care provision and change of residence.

Palliative care

Patients with a precipitous terminal decline may be suitable for hospice admission, although beds at hospices are often scarce, and other discharge options must be considered. Patients who are rapidly deteriorating and likely to fulfil eligibility criteria for NHS continuing care can be funded for this following completion of an NHS continuing healthcare fast track tool (Department of Health, 2009b). A community-based multidisciplinary team may formally review eligibility with a decision support tool after discharge. Patients who are not likely to fulfil criteria should be urgently assessed, including by physiotherapy and occupational therapy with regards to social, equipment and nursing needs, and discharged with a care package. District nurses and palliative care may be able to provide nursing interventions and urgent community support.

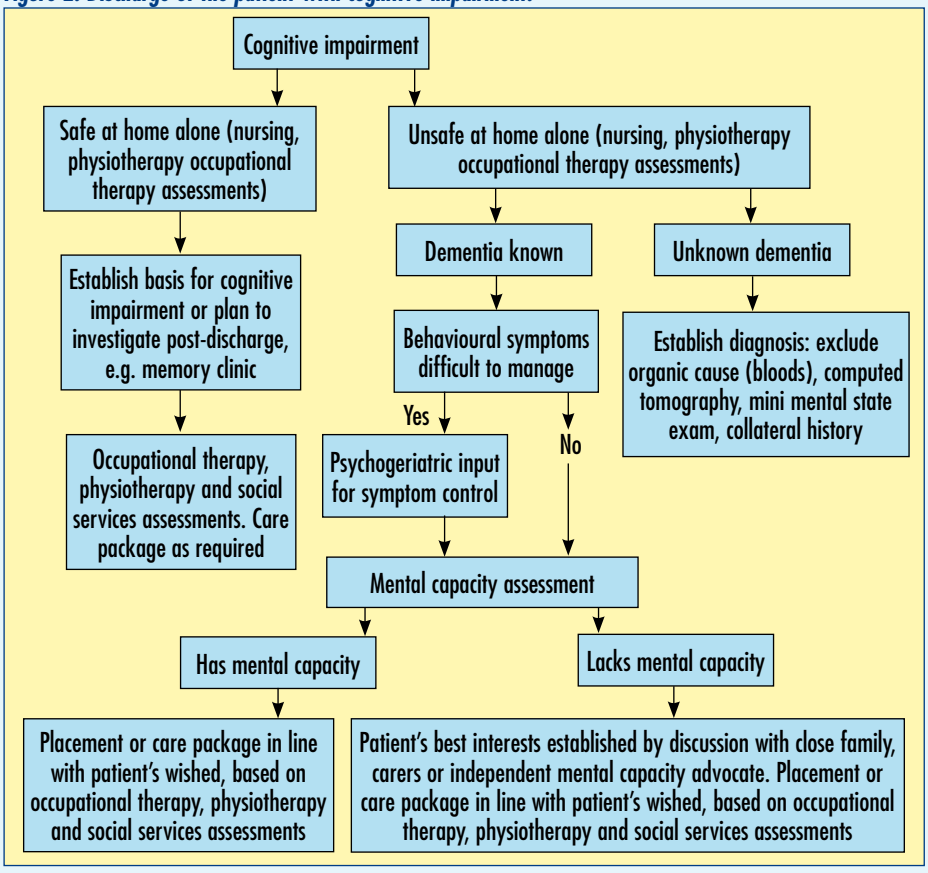
Conflict

Good communication in many cases prevents conflict. Any source of dispute should be managed in conjunction with any hospital discharge lead, where they exist. Common sources of conflict relate to waits for a preferred nursing home and being deemed not being eligible for NHS continuing care. Government guidance (Department of Health, 2003) states that a patient should be discharged to a suitable interim placement while waiting for a bed at his/her preferred home. For disputes over eligibility for continuing NHS health care, a local dispute resolution procedure should first be followed. Failing resolution, the dispute may need to be escalated to the local primary care trust level, a strategic health authority's independent review panel, or occasionally referred to the Health Service Commissioner (Department of Health, 2009d).

Conclusions

Safe and timely hospital discharge is a priority for patients and for the NHS. Understanding the importance of timely discharge summaries, good communication, thorough documentation, the roles of the discharge team members, and the wider discharge process should empower physicians to function as key and valued members of the multidisciplinary discharge team. **BJHM**

Figure 2. Discharge of the patient with cognitive impairment.



Conflict of interest: none.

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KEY POINTS

- To achieve safe and timely hospital discharges, physicians need to work as part of a multidisciplinary discharge team.
- This team is led by a ward-based care coordinator, but also includes nurses, physiotherapists, occupational therapists, and social workers.