

# Staff perceptions of discharge planning: A challenge for quality improvement

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## Abstract

*One hundred staff in three acute care public hospitals were asked about their perceptions of successes and failures of their discharge planning activities. The intention was to highlight ways in which the quality of discharge planning could be improved within the acute hospital setting. Generally staff described failures more commonly than successes, with a number of key failures being identified, including problems associated with vacating beds, lack of appropriate staff, patients and carer education about discharge activities, general process issues, problems associated with community service provision and patients who are difficult to discharge. Staff identified the lack of feedback on the outcome of their efforts as a source of frustration and a barrier to improving discharge planning activities. The challenges for improving the quality of discharge planning in the acute hospital setting would appear to be in establishing appropriate structures and processes that promote interaction between staff, patients and community providers, and provide incentives for behavioural change.*

## Introduction

Planning for discharge appears to have the aim of facilitating seamless transition from hospital to community following a hospital stay (Farren 1991; Feather 1993). Quality discharge planning is believed to involve specific and dynamic liaison within and between hospital staff and the communities served by the hospital (Blumenfield & Rosenberg 1988; Armitage & Kavanagh 1996b).

Stakeholders in discharge planning comprise patients and carers, hospital managers, funding bodies and hospital and community-based health care providers (Hamilton & Vessey 1992; Armitage & Kavanagh 1995). The largest available body of discharge planning literature is written from the perspective of hospital staff (Edwards 1991;

Farren 1991; Rhoads et al. 1992; Gruber Wood, Olsen Bailey & Tilkemeier 1992; Jewell 1993; Jackson 1994). This largely describes specific hospital-based activities for specific client groups, and highlights the agency role of health providers in determining, interpreting and addressing perceived patient needs (Fuchs 1974). It would appear that variability in funding arrangements for post-acute care initiatives, and in staffing levels and expertise in planning effective discharge from hospital makes discharge planning a complex area in which 'best practice' does not always occur (Hamilton & Vessey 1992; Faruggio 1993; Commonwealth Department of Health and Family Services 1996).

The literature highlights aspects of perceived best practice, including improved communication between and within health disciplines, and between hospital and community health service providers, specific education on aspects of planning for discharge, development of structures and processes that address specific problems with effective discharge and improving the transparency of the hospital–community interface (Edwards 1991; Rhoads et al. 1992; Faruggio 1993; Jewell 1993; Armitage & Kavanagh 1995, 1996a; Commonwealth Department of Health and Family Services 1996). However, the literature lacks concerted examination of organisations and behaviours that underpin consistent delivery of quality discharge planning activities. This article (which reports on Stage One of a three-stage project examining discharge planning) attempts to address this lack by reporting on the perceptions of staff in three acute public hospitals regarding failures and successes in discharge planning. The key areas of concern identified in this study highlight opportunities for the development of a model of quality practice which addresses practical behavioural and organisational aspects of quality service provision.

## Method

Approval to conduct the study was obtained from the relevant Human Research and Ethics Committees in each of the participating hospitals, and from the two universities with which the authors are affiliated (Universities of South Australia and Adelaide).

## Subjects

All hospital-based personnel who were involved in discharge planning activities in three large acute care teaching hospitals in one Australian capital city were invited to participate in this study. These included all medical, registered nursing and allied health staff assigned to specific hospital wards, and all discharge planners/case managers/liaison nurses.

## Data collection

Semi-focused interviews or focus groups were undertaken with participants to determine common perceptions of discharge planning success and failure. This approach used an accepted qualitative methodology for eliciting detailed perceptions relating to complex

topics (Patton 1990; Krueger 1994; Armitage & Kavanagh 1996a). The one researcher conducted all focus groups and interviews. Each focus group involved up to four individuals, and homogeneity of group composition was sought by combining individuals by discipline, level of training and experience. Predetermined questions (listed in the appendix) standardised enquiry, although the questions and questioning approach were sufficiently flexible to allow new subject matter to be introduced by the interviewee.

### **Data management and analysis**

All focus groups and interviews were audio-taped and transcribed. Forty hours of tape-recordings were made, providing 350 pages of transcripts. These were summarised by hand to identify key words and phrases, and each key theme was then dissected into component items. Responses to each component item were expressed as the percentage of the total responses to the related key theme. Discipline-specific differences in responses were investigated. Phrases from the transcripts are included in this article to illustrate each key theme.

## **Results**

### **Participation**

A total of 100 individuals participated in the study: 58 from Hospital A, 16 from Hospital B and 26 from Hospital C. A high level of compliance with the study was found across nursing, allied health and specialist discharge planning staff, with senior nurse and allied health participation rates per hospital ranging from 60% to 100%. In each hospital, all discharge liaison personnel participated. Eighty per cent of the medical consultants and unit directors participated, but there was considerably less compliance with the study by other medical personnel, evidenced by less than 10% participation rates by registrars, residents and interns.

### **Perceived problems with discharge planning**

The study elicited a total of 485 responses regarding perceived problems with discharge planning, and six key themes were identified. Each theme occurred in similar proportions in the transcripts from interviews in each hospital, despite site-specific implementation of different discharge planning activities and processes. In descending ranked order of percentage of total responses, the themes represented:

- lack of appropriate staff and patient education about discharge activities (29%)
- process issues (27%)
- problems associated with vacating beds (22%)
- difficult patients to discharge (10%)

- structural constraints on quality discharge (8.5%)
- problems with community service provision (3.5%)

### *1. Lack of appropriate staff and patient education about discharge activities*

This theme contained approximately one-third of the total number of responses overall, and highlighted recurring concerns regarding the need to educate medical and nursing staff, patients and family regarding appropriate planning for discharge. Education of medical staff was the most frequently mentioned issue (ranging from 47% to 64% of responses to this theme across sites), followed by education of patients and family (ranging from 28% to 40% of responses to this theme across sites). The remainder of responses addressed education of nursing staff.

#### **Examples from transcripts: Staff and patient education**

‘Often everything is organised and then a doctor will come in and say it’s OK for them to stay one more day. That’s very frustrating for us having put a lot of work into the discharge. They [doctors] seem to have a different understanding of what discharge planning is.’

‘Patients need clearer documented information and education about what is happening to them in hospital, how long they’ll stay and what is expected of them.’

‘You need to make sure you provide adequate education to relatives.’

### *2. Process issues*

Commonly expressed concerns regarding general failures included poor communication and/or coordination between staff, poor documentation of patient information in the notes, delays in ordering discharge drugs, a lack of formal discharge planning processes, and duplication of patient assessment. The overall percentage of responses attributed to general process failures is listed in Table 1.

#### **Examples from transcripts: General process failure**

‘Duplication in effort occurs and discharge plans become confused.’

‘The main problem for us is being called in too late and being given too little time to organise things.’

‘I think the coordination of discharge planning could be better.’

‘Discharge planning often fails because some piece of information is not passed on by a staff member, or someone forgets to document an important point.’

‘The multidisciplinary team often is more reactive than proactive and a lot of the patients’ needs are identified perhaps a little too late.’

**Table 1: Concerns regarding processes of discharge planning**

Items	Percentage total responses on this theme
1. Problems with organising drugs for discharge	20
2. Poor communication and/or coordination between staff	19
3. Poor documentation	13
4. Poor medical decisions regarding discharge	12
5. Lack of formal discharge planning process	9
6. Duplication of patient assessment	8
7. Problems with outlying patients	5
8. No communication from pre-admission clinic	4
9. Not enough allied health staff (for example, social workers)	3
10. Short length of stay (in and out before discharge planning meeting)	3
11. Lack of early identification of domiciliary care needs	2
12. Discharge occurs reactively, not proactively	1
13. Difficult to record discharge planning activities on Excelcare (nursing care database)	1
14. Too much information provided for patients to absorb while in hospital	1
15. Need more hospital transport	1
16. Discharging processes suit the institution, not the patient	1

### *3. Problems associated with vacating beds*

A range of common problems in bed management were identified, the most common being the lack of community supports for newly discharged patients, waiting for equipment and the lack of rehabilitation and nursing home beds. Overall concerns with vacating beds are reported in Table 2.

#### **Examples from transcripts: Vacating beds**

‘I think, on our ward, waiting for nursing home beds and hostel beds is the biggest downfall.’

‘There are no slow stream rehabilitation beds.’

‘There are hardly any convalescent beds and the wait for the few that are around is long.’

‘Just the way they [assessment team] work, in essence that they only come certain days, and if the patient’s not there then you’ve missed them for another week.’

‘The amount of community resources is being limited all the time. There are less choices and less placement beds.’

**Table 2: Problems in vacating beds**

Items	Percentage total responses on this theme
1. Lack of community services	20
2. Lack of nursing home beds	14
3. Lack of rehabilitation beds	11
4. Lack of home support	8
5. Transferring between hospitals	8
6. Waiting for equipment	7
7. Waiting for assessments	6
8. Lack of convalescent beds	6
9. Lack of remote area services	5
10. Lack of hostel beds	4
11. Lack of palliative care beds	4
12. Waiting for test results	3
13. Young people needing community services	2

#### *4. Difficult patients to discharge*

In all sites, elderly patients and patients living alone were reported to be the most difficult to discharge. Differences in other responses appeared to reflect site-specific practices that had been implemented to deal with recognised problematic patient groups, namely, the employment of case managers and liaison personnel, increased community involvement in planning discharge and step-down or slow-stream wards. Overall responses regarding difficult-to-discharge patients are listed in Table 3.

#### **Examples of focus group responses: Difficult patients**

‘They are staying here longer than they need to, just while those things like legal and financial implications and aftercare services are being arranged.’

‘Elderly people who usually live alone and are normally independent are often in longer than they need to be while social and support systems are being sorted out.’

‘With medical patients the time frames are a lot harder to predict so it’s harder to plan their discharge.’

‘The elderly hostel patients who are borderline are the most difficult group.’

**Table 3: Difficult-to-discharge patients**

Items	Percentage total responses on this theme
1. Elderly patients	39
2. Patients living alone	20
3. Patients with dementia/mental handicaps	9
4. Patients with poor mobility	7
5. Patients with social problems	7
6. Hostel patients	4
7. Medical patients	4
8. Long-term patients	2
9. Elective patients	2
10. Patients in transitional accommodation	2
11. Patients with HIV	2
12. Patients with sick partner	2

### *5. Structural constraints on quality discharge*

There were common findings across sites on the structural constraints on quality discharge planning. The most frequently mentioned concerns included the timeliness of the discharge decision, difficulties in predicting the decision to discharge a patient, the lack of time available for discharge planning and the lack of money to support appropriate discharge planning activities. The frequency with which structural constraints on quality discharge were reported is listed in Table 4.

**Table 4: Structural constraints on quality discharge**

Items	Percentage total responses on this theme
1. Timeliness of discharge	36
2. Difficulty in predicting discharge decisions	30
3. Time for quality discharge activities	24
4. Available finances of health service	9

**Examples from transcripts: Structural constraints**

‘Actually I find the biggest barrier to discharge planning is pinning the medical staff down on a date or time frame. They are not good with time frames.’

‘We are often the meat in the sandwich arguing that you can’t possibly send this person home tomorrow. I have to tell them I can’t possibly ring all the community agencies and organise the necessary supports and tell the wife in half an hour. I need more time.’

‘Discharge planning often isn’t begun as early as it could be.’

*6. Problems with community service provision*

There were common problems across sites in coordinating care between hospital, general medical practitioners and other community services. Predominant concerns related to delays in providing appropriate documentation post-discharge and lack of coordination between hospital and community service providers.

**Examples from transcripts: Coordination of effort**

‘GPs have a lot of concerns, and poor content and quality of discharge summaries are the main ones.’

‘GPs want more information on the patient.’

‘A GP has rung and said “I have this person in front of me without a letter, what have you done with them?”’

*Discipline-specific differences in responses*

Each discipline – nursing (including specialist discharge planning), allied health, medicine – mentioned each of the key themes with similar frequency, and provided rich discipline-specific insights into component items within the themes. The major differences in responses within each key theme were complaints about behaviour and performance of other health disciplines within the hospital, and many suggestions were provided to improve performance of other health professionals.

*Successes with discharge planning*

Overall, participants provided 197 responses regarding successful aspects of discharge planning, usually illustrating hospital-specific initiatives oriented to specific patient groups. Ward-specific organisational systems rated highly in perceptions of success: examples were the use of whiteboards to record activities, the implementation of clinical paths, and the use of structured discharge planning meetings. Providing specific education for patients and family also rated highly, as did multidisciplinary approaches



(including discharge planning meetings), the employment of liaison officers and implementation of pre-admission clinics. The findings are summarised in Table 5.

**Table 5. Perceived successes in discharge planning**

Items	Percentage total responses on this theme
1. Ward-specific systems	17
2. Multidisciplinary approach	14
3. Discharge planning meetings	14
4. Pre-admission clinics	11
5. Liaison officers	11
6. Family and patient joint education sessions	9
7. Patient education (handouts)	7
8. Good staff communication	7
9. Specific community initiatives	3
10. Early discharge if all systems are in place	2
11. Referral systems in place	2
12. Follow-up telephone calls to patients	2
13. The use of Excelcare (nursing database)	1
14. Good nursing assessment	1
15. Home programs	1
16. Summary of discharge planning in case notes	1

#### **Examples of focus group responses: Successes**

‘Families and the patient find family conferences invaluable and I think they save a lot of problems with an inpatient and they establish a rapport so the patient feels comfortable ringing up once discharged.’

‘The patients who have come through pre-admission clinic are much better prepared for all aspects of admission and discharge when compared with the patients who come through the normal elective list.’

‘It works well when the patient’s been in for a while and we’ve had the time to get to know them and have a family conference.’

*Discipline-specific differences in responses*

As found with responses regarding failures of discharge planning, each discipline-specific group similarly identified successes. In contrast to the information provided on failures in discharge planning, successes that involved education of, and collaboration between, disciplines were commonly cited.

**Discussion**

This study elicited rich personal experience from a range of hospital-based health professionals involved in discharge planning. Key theme analysis of the data provided a way of overviewing perceptions regarding failures and successes in discharge planning activities, while examination of component items within each theme explored subtleties of response. The potential for loss of sensitivity during analysis was reduced by reporting phrases taken directly from the transcripts.

In work such as this, there is always a possibility of response bias, providing the opportunity for both inflation and attenuation of major issues. Additionally, the use of a small sample of hospitals from the one city constrains the generalisability of the findings. However, the study found consistency in reporting across sites and between disciplines. This, coupled with concurrence of findings with the literature, suggests that response and selection biases may not be prominent factors in this study. Moreover, the key elements of perceived success and failure of discharge planning appear to be robust across health disciplines. The hospitals participating in this project were known to have implemented different strategies for planning patient discharge, and thus interview/focus group responses were expected to differ from hospital to hospital. The overall agreement in the findings between disciplines within hospitals, and between hospitals overall, indicated that common problems continued to occur, despite a variety of approaches to planning and effecting discharge. Thus issues underpinning failures and successes of discharge planning may well be independent of location, patient type or health discipline.

Complaints from each discipline regarding performance and behaviour of other health disciplines within the hospital highlighted the practical need for behavioural and organisational change (Phillips et al. 1998), with such activities as definition of roles and responsibilities, improved education on best practice in discharge planning, and enhanced communication between staff groups. These features of quality discharge planning are commonly proposed in the literature within the context of best practice (Faruggio 1993; Feather 1993). Armitage and Kavanagh (1996a) have also highlighted intrinsic differences in perceptions of quality discharge planning between hospital and community health providers. These differences may contribute significantly to failure in the discharge planning process across the hospital–community interface. Thus there is a need to repeat this study with community health service providers so that models

of best practice can be developed that address concerns not only within the hospital setting, but also between hospital and community.

The discharge planning successes reported in this study largely involve activities developed to address site-specific problems. Some of these activities have been reported in the literature as best practice in addressing discharge planning problems (Rhoads et al. 1992; Feather 1993; Jewell 1993; Armitage & Kavanagh 1995, 1996b). The activities perceived to be most successful in this study involved improved stakeholder education, and communication and coordination of effort between hospital staff, and between staff and patients. However, it was of note that within each site there had been little evaluation of these perceived successes, from the perspective of any stakeholder (hospital or community service providers, or patient and carer). In particular, there was a lack of community feedback to hospital staff regarding the outcome of their discharge planning efforts. Thus staff perceptions that time constraints failed to produce quality discharge, or that multidisciplinary teams improved the quality of discharge, could not be verified because there was no formal evaluation mechanism. The study found that, despite a desire to improve patient discharge, the lack of feedback commonly led to staff frustration and was a disincentive to concerted attempts to improve practice.

It would thus seem that monitoring performance in specific discharge planning activities, as highlighted by this study, could provide practical and widely valued opportunities for continual review and improvement. A number of monitoring opportunities were highlighted by the transcripts, as follows.

- Bed management could be monitored by auditing the prevalence of common causes of delay, such as waiting time for prescriptions, blood test results or equipment.
- Planned and regular education or problem-solving sessions for medical staff could address concerns that medical staff lack understanding of issues that constrain quality discharge planning. Feedback on the success of such activities could be in the form of improvements in nature and frequency of communication. Communication channels within the hospital, and between the hospital and community, could be formalised and their use audited to benchmark and improve performance.
- Ward-specific or condition-specific education packages could be developed in consultation with patients and carers to give patients greater control over their circumstances.
- The lack of feedback from community service providers and patients and carers could be addressed by the development and routine use of a monitoring instrument that seeks information on key processes and outcomes of discharge planning. Provision of this information to ward staff on a regular basis would provide them with information that is currently unavailable (that is, on how their patients fared following discharge) and could form the basis for ongoing evaluation of the quality of hospital-based discharge planning activities.

However, it remains to be seen whether education or feedback alone will lead to the changes seemingly desired by the staff who responded to our study . Underlying staff perceptions of the quality of their efforts in planning discharge appeared to be concerns regarding the degree of importance attached to planning patient discharge within the organisational culture, and by each group of key stakeholders. Moreover, staff highlighted the removal of organisational barriers and the recognition and fostering of partnerships between staff within the hospital, and between staff in hospital and community settings, as imperative to ensuring quality discharge for patients.

## Summary

This study highlighted widespread hospital staff interest in improving the quality of discharge planning. It also highlighted the complexities of planning quality patient transition from acute hospital care to the community, and the numerous ways in which planning for discharge requires thoughtful, structured and timely effort. Common concerns in discharge planning were found across health disciplines, and across the participating hospitals. The study highlighted the need for better understanding of behaviours associated with successes and failures of discharge planning. Improved understanding of roles and partnerships could result in the implementation of behavioural and organisational models that support quality care provision. Moreover, to ensure and improve the quality of planning and facilitation of discharge, formal monitoring and feedback mechanisms are required to keep hospital staff regularly informed of the outcome of their efforts.

## Acknowledgements

This study was funded by the South Australian Health Commission through a Primary Health Care Initiatives Grant 1997–9.

## Appendix

### Broad interview/focus group questions

NB. Questions are indicative only – each of these was explored more fully, depending on the answers obtained, and the clarity that was required from the initial responses.

Can you tell me about:

- the type of patients you generally deal with?
- their general admission model? (emergency or elective admissions?)
- the sort of admission procedures there are for your patients?

Can you tell me about:

- the type of discharge activities you are involved in? (depending on the person, this may reflect a ward, functional unit etc)
- the frequency and nature of ward discharge activities (i.e. meeting)

Can you tell me about:

- the documentation that you use in your area (work) regarding discharge?
- how often this is completed?
- where the documentation is held in the ward, and where it is lodged after discharge?
- who completes the information?
- what input staff have to improving this documentation?

Can you tell me about:

- the sort of problems you encounter when discharging patients? *(this question generally led to a number of related ones, depending on the answers, and depending on the need for clarification of answers, such as):*
  - how difficulties discharging patients relate to ward turnover and bed availability?
  - whether beds are blocked regularly because people are waiting to go elsewhere?
  - knowledge of other wards that have similar problems to the ones described?
  - communication between wards and functional units about discharge planning activities?

Can you tell me about:

- your knowledge about community resources for your patients?
- how readily can you find out information?
- useful contacts in the community who keep the hospital wards up to date with community information?

Can you tell me about:

- the timeliness of the discharge activities that you are involved in?
- opportunities to improve the timeliness of these activities?
- whether the nature of the admission has any bearing on the success of discharge?

Can you tell me:

- what constitutes a successful discharge?
- what benefit you get personally when discharge has been successful?
- about problems you might personally have when the discharge hasn't happened as well as it could?

Can you tell me about:

- your relationships with community health care providers, for instance, the patient's GP?
- the type of communication that you regularly have with community health care providers?

Can you tell me about:

- your feelings regarding patient responsibility for their discharge?
- the hospital's responsibility for arranging discharge for patients?

Can you tell me about the resources used in planning discharge?

- what formal and informal discharge planning do you undertake?
- what time (approximately) do you spend per patient on planning discharge?
- do you record this anywhere?
- is discharge planning time costed on your ward?
- is there a procedure for discharging patients to which costs can be assigned?
- what other resources do you use for discharge planning (for example, fax, printed forms etc)

Can you tell me anything else about discharge activities that you think is relevant?

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