Better Training Better Care (BTBC)
Inspire Improvement Project Evaluation Report

This report is designed to capture your project in your own words. Each section should be completed in full, with appendices attached where necessary.

When completing the report, please adhere to the points below:

- Ensure that you complete each field provided.
- Ensure your answers are concise. Although there is no specific word count for each section, we are looking only for the relevant information to support wider adoption of your project. This report is intended to capture the fundamentals and the key outcomes of your project and should be succinct and easy to read, using plain English.
- Any toolkits, 'how to' guides or other resources that you feel are key to support the delivery of your project should be attached as appendices.

Title

Please insert the title of your pilot and if applicable, a strapline to sum up the project in one sentence e.g. Enhanced education in handover with supporting e-solution *Improving trainee skills and patient safety*

Barriers to Effective Discharge

A teaching programme aimed at junior doctors to improve the patient discharge process.

Introduction

The introduction should summarise the background to the project intervention, what it set out to achieve and why.

1. Background

1.1 Rationale and drivers

- What was the rationale for choosing the project?
- What was the situation before the project was initiated?
- What were the local drivers / contextual factors?
- What problems were you trying to solve by implementing the project?

Poor discharge planning accounts for a significant source of patient dissatisfaction, increased health spending and worsening clinical outcomes.

Clinical indicators, such as delays in discharge, have been increasing significantly over the last decade as the patient population has aged and become more complex.

There was no formal education in the patient discharge process in the medical curriculum. Research has shown that a lack of communication and low prioritisation of this topic was commonplace in the medical workforce.

The teaching programme was implemented to highlight the importance of patient discharge planning through clearly thought out objectives and good interdisciplinary communication. This would have a beneficial effect on the patient journey and teamwork in the workforce.

2. Approach and engagement

2.1 Project development

- How was the project developed?
- What was the approach taken for delivering the training intervention(s)?
- Who was involved in its development and implementation?
- What were the aims and objectives of the project?

The teaching programme was implemented in two sites: Whipps Cross Hospital in London and Royal Lancaster Infirmary in Lancaster.

The teaching was split into four separate one hour sessions to all foundation year one doctors. The teaching sessions were compulsory.

The teaching sessions were delivered in an informal case-based lecture. Participants were encouraged to think about their own experiences and critically analyse their own work place for potential pitfalls in patient care.

The teaching was delivered by a consultant and senior registrar from the department of care of the elderly.

The objectives of the teaching session were to highlight the importance of discharge planning and awareness of potential pitfalls which may occur when sending a patient home.

The objectives were measured through a survey and semi-structured interviews of the participants by assessing their views and beliefs before and after the teaching session. The survey questions were developed from psychological models e.g. theory of planned behavior. Potential questions were devised by a health psychologist. These were discussed and iterated by a multidisciplinary research team comprising clinicians and a health psychologist.

2.2 Engagement

- Who did you need to engage in the project – for example: trainees, trainers, consultants, patients, executive Board members?
- What was the level of lay and patient involvement?
- Did you get support from an academic partner to develop the evaluation and outcome measures?

The teaching sessions were designed by the consultant and senior registrars in the medical department. Some teaching sessions were also delivered by the discharge co-ordinators.

Senior faculty were overseeing the project to help overcome and possible barriers, such as reduced teaching time for participants due to clinical demands.

The survey and semi-structured interviews were designed and conducted by CPSSQ. The data was analysed by a PhD student at CPSSQ.

2.3 Project management and governance

- How was the project managed and implemented? i.e. what governance, project management structures and processes were put in place?

The project was managed by two junior doctor leads, one at each respective site.

Each project site had senior clinician leads overseeing the project

The foundation programme director and administrative staff ensured sessions took place within allocated teaching slots.

3. Resources

3.1 Funding

- What funding did you bid for as part of your application and how much were you awarded?
- What were the overall financial resources required to deliver your project? Please include the amount of trust funding required in addition to the BTBC funding if applicable
- What was the final budget amount at the end of your project? (Please include the detailed funding schedule as an appendix.)

3.2 Staffing

- What were the human resources required to deliver your project?

1. Consultant teaching
2. discharge co-ordinator teaching
3. junior doctor participation
4. secretarial work
5. senior staff to oversee the project and organise interview slots

3.3 Other key resources

- Did you require any IT equipment or other types of equipment / specialist input?
- Did you require any specialist medical devices or materials?

4. Achievements and outcomes

4.1 Overall achievements and critical success factors

- What have been your greatest achievements and why?
- What have been the critical success factors for enabling these achievements?

Overall, we have shown that training in the discharge-planning process is beneficial. Trainee participation in surveys and interviews have been pivotal in our analysis. This revealed components of an 'ideal' teaching programme and as well as current barriers to discharge planning.

Trainees identified that their 'ideal' teaching programme would be timely – at the beginning of the foundation years, consisting of short sessions involving case based learning and high interaction. Preference for the sessions to be run by doctors was made as well as a multidisciplinary element.

Evaluation of the teaching programme

Raising awareness

Consolidation and utilisation of knowledge

Complex nature of patient discharge Building on prior knowledge

Social needs of patients

Facilitating engagement with team members

Discharge summaries

Feedback on teaching

Timely

Case based learning

Ward based

Doctor led

Multidisciplinary training

Short sessions

Perceptions of the discharge process

Multidisciplinary approach

Decison making

Barriers to effective discharge

Communication

Management

Staff Workload

Medication

Social Needs

Role of the junior doctor

Fundamental team members

Clerical

Responsibility

1.2. Delivered outcomes

What outcomes has the project delivered for the following:

- For trainees
- For trainers
- For patients
- Across the wider multidisciplinary team
- That provide value for money

Please provide headline key findings.

For trainees For trainees, the programme raised an awareness of the complex nature of patient discharge. In addition, it highlighted the fundamental role that junior doctors play. It allowed junior doctors to consider patients' social needs, facilitated interaction with other team members and consolidated the importance of optimal communication between secondary care and primary care. Some doctors reported a changed attitude towards writing these summaries –in particular, with respect to their purpose, relevance and prioritisation of this task on a daily basis.
For trainers

For trainers, the project has highlighted optimal teaching format and content to target junior doctor's needs – short sessions, case based, interactive and physician led. Other key themes were the need for a multidisciplinary approach, communication and aiding trainees in decision making.

For patients

For patients, the teaching will potentially improve patient satisfaction via a raised awareness amongst junior doctors about the needs of patients – personal, medical and social. Overall, this will improve efficiency in transitioning patients from secondary care to primary care. Increased awareness of issues to be communicated and an over-riding responsibility for communication with primary care will potentially reduce patient safety incidents and optimise efficiency in care.

Across the wider MDT

We have identified that a multidisciplinary approach is vital to effective discharge planning. By introducing trainees to relevant multidisciplinary team members and increasing their understanding multidisciplinary roles, communication and future engagement between team members will be enhanced.

That provide value for money

Based on trainee responses and feedback, our analysis has shown the optimal teaching formats and content which can be implemented in the future. Once this teaching material has been designed and trainers have been trained, these sessions can be embedded in the existing teaching programme for junior doctors and rolled out annually.

5. Experienced challenges

List the challenges you experienced, why you experienced them and what steps you took to overcome them, or if not, why not? It is important to capture any challenges or issues that made an impact on progress - irrelevant of how small.

1. clinical pressure on staff and junior doctors meant it was difficult to organise a teaching session that everyone could attend
2. delays in the implementation of the project due to clinical pressure of organisers

These were both overcome by organising far ahead around the consultant availability and by making the sessions compulsory for all participants.

3. First year junior doctors would rather value teaching on a clinical topic. The subject was broached with as much clinical relevance as possible, showing that if successfully implemented these measures could have a large impact of patient care.

6. Lessons learnt and recommendations

6.1 Lessons learnt

- Other than the above challenges, what have you learnt through your experience of designing and implementing the project?
- Were there additional benefits realised that were not originally identified at the start of the project? E.g. knock-on impacts to other members of staff who were originally not targeted; greater collaboration across teams; and/or a financial gain which was not originally in the plan.
- If you were to undertake a similar project, what would you do differently?

Overall, we found that the problems surrounding patient discharge are multifactorial. The main issues concern communication, staff workload, organizational issues and social needs. To target this, a ‘holistic’ approach is required.

Future work would be aimed at a multidisciplinary audience, targeting specific barriers identified through our work: communication, management, staff workload, medication and social needs. Specific teaching for trainees would follow the optimal format identified –being timely, making use of case based learning and physician led teaching.

Not all change is improvement, but all improvement is change

6.2 Recommendations – project enablers

What recommendations can you provide to other NHS trusts who may want to adopt your project? Please think about the critical ‘enablers’ that need to be in place to ensure the success of the project.

This project requires a physician-led team to design and facilitate cases. Cases should be appropriate for the hospital's patient population and demographics, making them relevant to trainees.

It requires support of the foundation programme team –including director and administration staff.

Teaching should be timely, case based, interactive and multidisciplinary.

7. Sustainability and adoptability

You should be able to use the information provided in your project closure report as a basis for completing this section.

- What plans are in place to continue the project within your trust – please include details of wider trust roll-out and/or spread to other specialties?
- How is the project being managed and by who?
- What are the governance arrangements in place?

8. Feedback and testimonials

- Please use this section to capture the feedback and testimonials you have received throughout the project (where consent is given). This will be used for the final case study to support the engagement with and adoption by other trusts. You may include this as an appendix, weave the comments throughout the report or insert them in this section. Please state the title of the person concerned.

- Please aim to include a good selection of quotes from trainers, trainees, other members of the MDT, the Medical or Education Director and CEO if possible.

“I think the way you’ve organised it has been good … it’s been very interactive and I think it’s introduced us to all the essential like components in discharge planning.” (Junior doctor)

“I think running through the cases was quite useful, it was quite a good session in terms of being an interactive session, quite hands on which I think helps reinforce them.” (Junior doctor)

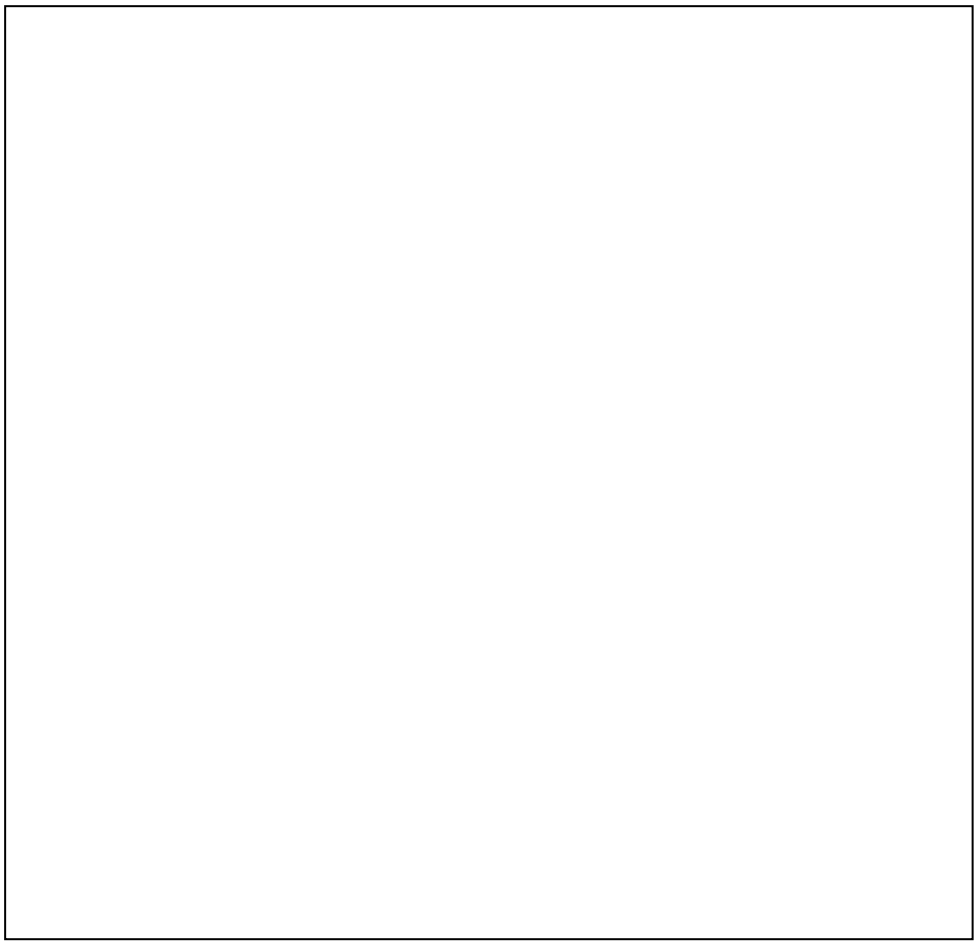
“It’s all been quite comprehensive actually and you’ve had a good mix of lecture based discussions and group discussions and you’ve had members of the whole MDT come in and talk to us... it’s good to hear from every angle of discharge planning as well and I think you’ve organised it well.” (Junior doctor)

Appendices

If you have developed any toolkits, ‘how to’ guides or other resources that you would like to share, please include these as an appendices to the report.

Barriers to Effective Discharge: Breaking the Bottleneck

2013-2014



Case Based Learning

Project Team:

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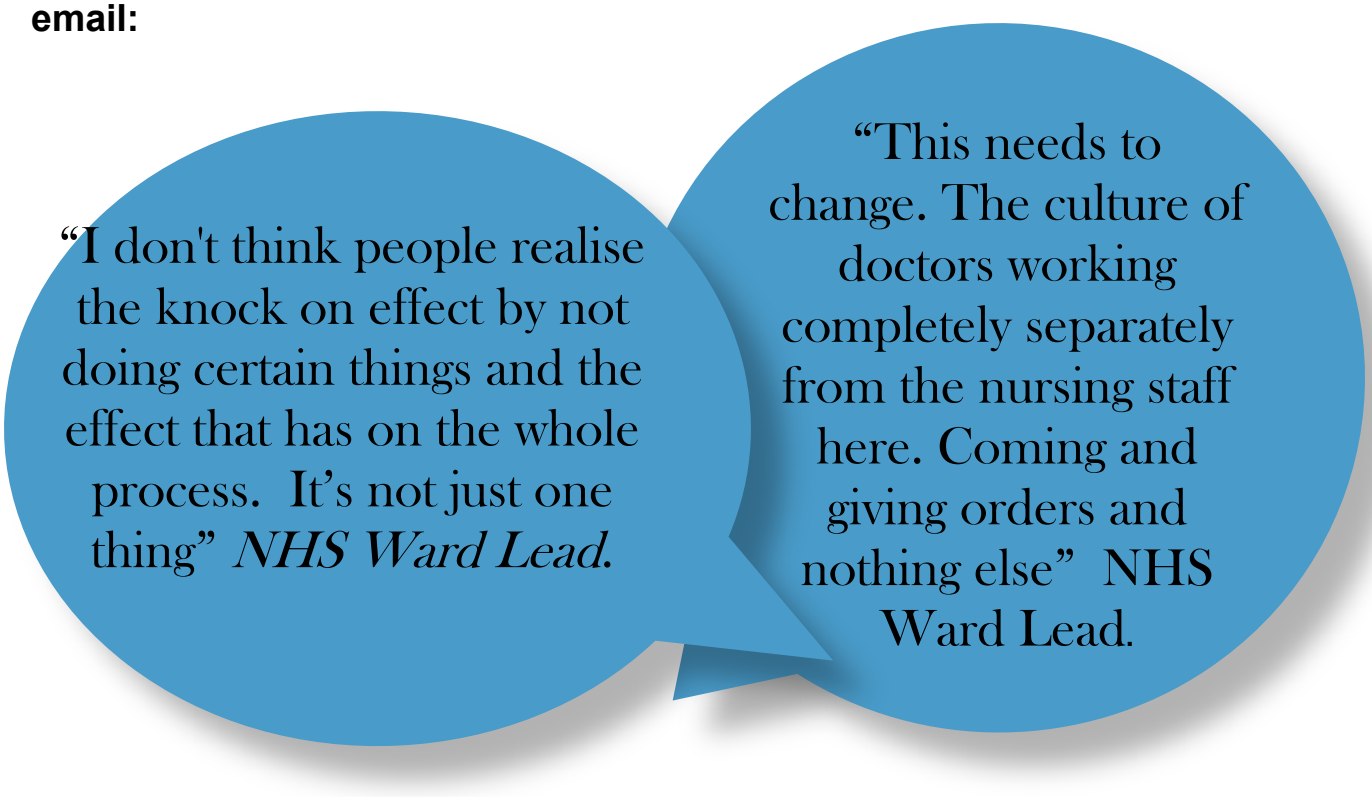
email:



"If the patient is going home they [doctors] are already switched off from that patient because they're well, they're fit to go home. They're concentrating on the next patient in the next bed who is not so

"On the day they are supposed to go home, nothing is really done, it's all at the last minute, that's why we can't shift them out

Barriers to Effective Discharge: Breaking the Bottleneck
Case Based Learning
Handbook 2013 - 14

CONTENTS

Page

NHS
Health Education England

Teaching Plan					
Session	**1**	**2**	**3**	**4**	**5**
Theme	**Patient Flow**	**Complex and Simple Discharge**	**Continuing Care**	**Multidisciplinary Team**	**Community Care Overview and Reflection**
Aims	By the end of this session, trainees will be better able to map out the patient flow pathway and have greater understanding of their role as a junior doctor	By the end of this session trainees will be better able to consider factors involved in discharge planning e.g. communication with nurses	By the end of this session trainees will be better able to consider factors involved in continuing care e.g. communication with discharge coordinators	By the end of this session trainees will be better equipped to participate in multidisciplinary discussions and understand the importance of non-technical skills	By the end of this session trainees will be better able to consider what community care needs a patient requires and its impact on inpatient care in hospital.

	Interactive Session Students to map out the patient flow pathway to gain an understanding of upstream and downstream effects Lecture on patient flow and the role of the junior doctor	Case Based Learning Discharge planning case study 10 students per group 1 case per hour 10 mins reflection	Case Based Learning Continuing care case study 10 students per group 1 case per hour 10 mins reflection	Enhancement of non-technical skills Encouragement of verbalisation of concerns Improved interdisciplinary interaction Students to watch a video (high risk patient) Volunteer to enter simulated multidisciplinary team scenario Case discussion	Interactive session: Involvement of community matron and GP Case Based Learning Community Care Case Study
Educational theory	Cognitive component	Practical knowledge and skills Cognitive component Constructivism approach	Practical knowledge and skills Cognitive component Constructivism approach	Social component Constructivism approach	Practical knowledge and skills Cognitive component Constructivism approach

Teaching Plan Continued	
Session	**5 Continued**
Theme	**Overview and Reflection**

Aims	By the end of this session trainees will be able to reflect on their previous learning and provide feedback to the committee Formative assessment Feedback Discuss election of committee members for next year Discuss participation in audits and evaluation Discuss participiation in semi-structured interviews
Educational Theory	Reflection

NHS
Health Education England

FEEDBACK – About the CBL process overall

The following pages provide you with templates on which you can record your thoughts as the course proceeds. At the end of the term you can enter your views onto SOLE. There will be an opportunity to comment on your PBL Tutor on the following page.

Please answer all questions by selecting the response which best reflects your view.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The content of this course is useful.	☐	☐	☐	☐	☐
The support materials available for this course (e.g. guide) is helpful.	☐	☐	☐	☐	☐
Overall, I am satisfied with this course.	☐	☐	☐	☐	☐

Please use this box for constructive feedback and suggestions for improvement.

NHS
Health Education England

Introduction to Barriers to Effective Discharge: Breaking the Bottleneck

Context:

Breaking the Bottleneck is a collaborative project between Barts Health Trust, University Hospitals of Morecambe Bay and the Centre for Patient Safety and Service Quality (CPSSQ), Imperial College London. It involves clinicians, educationalists and academics to develop, implement and evaluate training for Foundation Year 1 doctors in patient flow, discharge procedures and hospital efficiency at the start of their training.

Problem:

Delayed and unsafe discharges continues to be a serious issue in the NHS causing an unacceptable amount of failed discharges and bottlenecks to flow in certain trusts. The Collin's Report has identified serious shortcomings in junior doctor's training, particularly concerning patient discharge, inter-disciplinary team work and continuing care in the community. Despite this, junior doctors are often at the forefront of decision making.

Assessment of Problem and analysis of its causes:

Discharges are a complex process involving different health professionals and variables. Evidence shows that breakdown in communication is a major source of failed or delayed discharges. Although junior doctors are constantly working together with other health professionals, their role and responsibilities within the MDT is not clearly defined. They receive little training within the current curriculum to develop non-technical skills and practical knowledge in discharge procedures necessary to facilitate the patient journey seamlessly.

Intervention:

With support from the Trusts and Health Education England, this novel teaching will be embedded within the Foundation Program Curriculum at Whipp's Cross University Hospital and Royal Lancaster Infirmary. Case based teaching will be used to support the learning of practical knowledge relevant to trainees, covering different themes within patient flow theory. We aimed to address barriers to integration of new training programs by: (i) developing sustainable and self-evaluated teaching led by a junior doctor committee (ii) recruitment and training of senior doctors and other healthcare professionals to facilitate the session: in order to improve Junior doctors knowledge, attitudes and behaviours necessary for safe discharging and preventing delayed discharges.

Strategy for Change:

To facilitate this change, we require your help, to take ownership. The strategy is focused on engagement of core stakeholders.
2013: Recruitment and appointment of (i) Foundation trainee leads for local implementations (ii) Consultant, senior SpRs and other health professionals to act as facilitators
2013: Launch meeting to inform project initiation
2013: Lead and facilitator training
2013: Teaching sessions occurring over 5 months,part of the teaching curriculum
2013: Bi-monthly meetings which evaluate teaching and give support for facilitators
2014: Analysis of survey, interviews and audits to measure efficacy and impact of teaching
2014: Feedback conference to share results and inform development for 2014-2015
2014: Appointment of new trainee committee and Lead for 2014-2015
Ongoing: wider dissemination including national and international conferences and publications

Measurement of Improvement:

Evaluation:
Surveys and interviews to evaluate feedback from trainees
Development of practical skills, knowledge and non-technical skills (pre-post questionnaire)

Organisational impact:
Audits to measure a reduction in delayed and failed discharges. Open discussion regarding work place inefficiencies to promote innovation within junior doctors.

Sustainability and transferability:
Teaching sessions will be evaluated by trainees, allowing future iterations to be made, adapting teaching to junior doctor's needs.

Lessons Learnt:
We hope, by the end of this course, you will be aware of the problems faced by hospitals to streamline patient flow, you will have insight in how to help solve this and you will take ownership to help create change. We aim to promote junior doctor's having an active role within the discharge process. Patient discharge should start from the day a patient is admitted to hospital.

Vision

Education in the NHS must keep pace with the changes that take place, so that it can be pro-active rather than reactive:

Embed a cultural change within junior doctors, promote an active role in the discharge process and overall, streamline patient flow

Evaluation of Outcomes

1. Feedback questionnaires: Junior doctor satisfaction
2. Audits: failed discharges and delayed discharges
3. Semi-structured interviews
4. Formative Assessment: pre and post teaching

Systems Thinking

"We tend to focus on snapshots of isolated parts of the system, and wonder why our deepest problems never seem to get solved. Systems thinking is a conceptual framework, a body of knowledge and tools that has been developed over the past 50 years, to make the full patterns clearer, and to help us see how to change them effectively."

Senge, 1990, pp6.7

Patient Discharge

Communication has long been recognised as the key to effective discharge planning (Bull and Roberts 2001). Atwal 2002 revealed no evidence of health care professionals educating other health care professionals about the discharge process.

The literature highlights best practice as:

1. Improved communication between hospital and community health service providers
2. Specific education in aspects of planning for discharge
3. Development of structures and processes that address specific problems with effective discharge

Discharge planning is the process which hospital team organises the return of patients to their homes or transfers them to other places of care through liaison with relatives, carers, community services and general practitioners.

Discharging a patient form hospital requires each clinical area involved in the patient's discharge 0from pharmacy to transport services to collaborate with others in order to reduce overlap, waste and the frustrations caused by needless delays. To create effective and efficient discharge practice, clinical staff have to understand all the new terminology, technology, services and process steps in the context of a whole system approach (DH 2010b). this is a key theme of future workfoce planning and role design.

The different types of discharge

i. Simple
ii. Complex

Read 'Ready to go?' (DH2010a) in clinical practice (lees 2010).
www.institute.nhs.uk
In early January 2010, the Department of Health published a new policy: 'Ready to go? Planning the discharge and transfer of patients from Hospital and Intermediate Care' (DH 2010a). 'Discharge and transfer' are presented as synonymous, and there are planned sicharge pathways, with a series of coordinated steps in the process of planning a patient's discharge or transfer from 'Hospital and Intermediate Care'.

Discharge planning starts on admission, by collecting information from the patient and relatives and/or carers about social circumstances and function. Including risk assessment. A multidisciplinary process Involves good communication

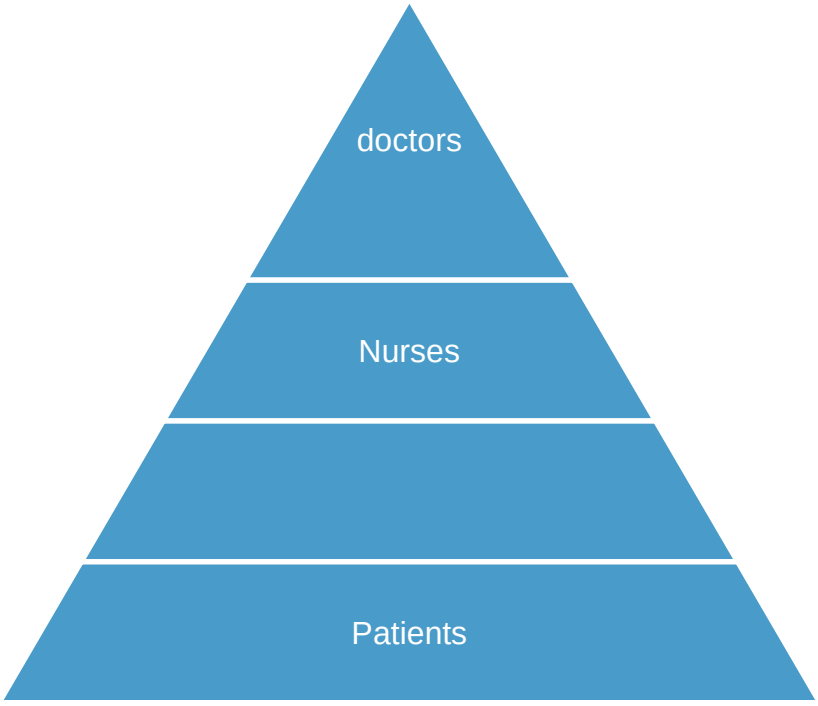
iii. With the patient, relatives, carers
iv. Within the ward based multidisciplinary team

Skeet 1970: there has been concern for some time about transfer of information to the community.

- **Communication gaps are a major impediment to effective discharge**

- ***1989 DOH reported it is a problem***

- ***1993 Audit commission reported lack of progress and shortcomings (communication, assessment + planning, notice to discharge)***



Need DPP:

1. **Increasingly elderly population**
2. **Pressure on beds**
3. **Recognised problems in patient discharge**

Problems associated with discharge planning

- 20% organising drugs
- 19% poor communication +/- coordination between staff
- 13% poor documentation
- 9% lack of formal discharge planning process

Problems with vacating beds:

The most common problem was lack of community support for newly discharged patients, waiting for equipment and lack of rehabilitation and nursing homes.

Difficult to discharge patients:

- 40% elderly
- 20% living alone
- 10% dementia/handicap

Structural constraints on quality of discharge planning.

- 36% timeliness of discharge
- 30% difficulty in predicting discharge decisions

Problems in coordinating with community care. Delays in providing appropriate documentation post discharge. Lack of coordination.

Success in discharge planning:

- 20% ward specific systems
- 15% MDT approach
- 15% discharge planning meetings

Successful discharge planning

1. Assessing the patient: to determine his or her medical, social, psychological and functional needs
2. Discussion with the family or care givers: their ability to care for the patient, whether they are under strain, whether care services will be needed, and the carers' educational needs are met
3. Sharing information with the patient, family and other team members
4. Implementation of the plan: arranging for the provision of services and equipment
5. Follow-up: the evaluation stage provides feedback that enables the effectiveness of the discharge process to be measured.

Comprehensive geriatric assessment

1. Patients identified as high risk should have a comprehensive geriatric assessment.
    a. Medical assessment and treatment
    b. Review of medicines and concordance
    c. Gathering information about social circumstances including details of cares, social services, benefits and whether there is carer strain
    d. Assessment of cognitive function, including the patient's ability to participate in discharge planning and if not identifying a representative
    e. Assessment of the functional ability (ability to perform activities of daily living and assessment of the patient's needs for rehabilitation)

   f. Asking about living arrangements e.g. are there stairs at home
   g. Formulating goals. These should be specific and agreed with the patient, relatives and carers.
   h. Eliciting patient preferences about discharge plans
2. After this, referrals to social services or mental health teams if necessary. May need physiotherapy and occupational therapy input.
3. Make an estimation of when patients will be medically fir for discharge. They may include when they will be ready to go to a rehabilitation facility if needed.

Types of suboptimal discharge

1. Too soon
2. Delayed
3. To unsafe environments
4. To inappriopriate environments e.g. premature discharge to long-term care
5. Poorly organised e.g. not meeting the patient's and relatives/carers' needs or expectations

The stages of discharge planning

1. Stage 1
   a. Getting to know the patient, identifying his or her needs, starting a comprehensive assessment. Gathering all the information takes time
2. Stage 2
   a. Making plans for a provisional discharge date, anticipating when the patient will be medically stable and investigations completed.
3. Stage 3
   a. Getting ready to go home. This includes communication with the community team and organising medication. In complex caes, a joint care manager may be involved, as well as district nurses, community matrons and home care services.
4. Stage 4
   a. Making the transition. Patients are transferred home, to residential or nursing homes, or to temporary care in the community bed for further rehabilitation.

Educational Theory

Case Based Learning is an educational fusion of Problem Based Learning. It stimulates cognitive processes and active learning through a constructivism approach (social interaction and teamwork). CBL allows trainees to develop a collaborative, team based approach to education; allowing hypothesis generation and the development of clinical reasoning.

The challenge: shape personal and professional development, apply taught theory and knowledge to the real-world, to support their role.

From the constructivism approach, conflict and problem solving are an important stimulus for learning. Knowledge evolves through social negotiation and evaluation of meaning.

Schmitt identified 3 principles of learning from a cognitive processing paradigm:

1. Activation of prior knowledge
2. Encoding specificity
3. Elaboration of knowledge

Some advantages of PBL have been described by Weller (2002)

1. Increased student motivation
2. Development of problem solving skills
3. Increased student responsibility
4. Flexibility
5. Exposure to different ideas and solutions
6. Contextualisation of information
7. Interactive and engaging
8. Deepening of the skills of reflection and analysis

A theoretical background.

Kolb and Fry (1975) viewed learning as a cycling process with four key stages:

1. Concrete experience
2. Observation and reflection
3. Generalisation and abstract conceptualisation
4. Active experimentation
    a. Action
    b. Reviewing

Malcolm Knowles proposed characteristics of adult learners that make them different from children. 4 significant differences:

1. Change in self-concept, since adults need to be more self-directive
2. Experience –mature individuals accumulate a reservoir of experience which becomes and exceedingly rich source of learning
3. Readiness to learn. Adults want to elan in problem areas.
4. Orientation towards learning. Adults have problem centered orientation.

Be a leader

There are 2 types of reaction to change:

1. Proactive

   a. It is this proactive reaction that we want to encourage. prevention. Action. Planning and predicting when things will go wrong or will change and ways to adapt or prevent this
2. Reactive
   a. You make changes once the change has occurred. It is a response to a situation.

Many people are reluctant to change. Change often requires people to think about things in a different way, and to do things in a different way. It requires a new learning process.

Leaders visualise how change can make an improvement, they create a climate in which plans for change are delivered and widely accepted. They stimulate action to achieve the change.

Case 1:

Complex Discharge Planning Case Study
Patient ID Number:

Presenting Problem

Diagnosis

Mental Status

Disabilities

Housing

Psychosocial support:

High Risk Screening Criteria:

Community agencies presently involved:

What discharge planning has occurred:

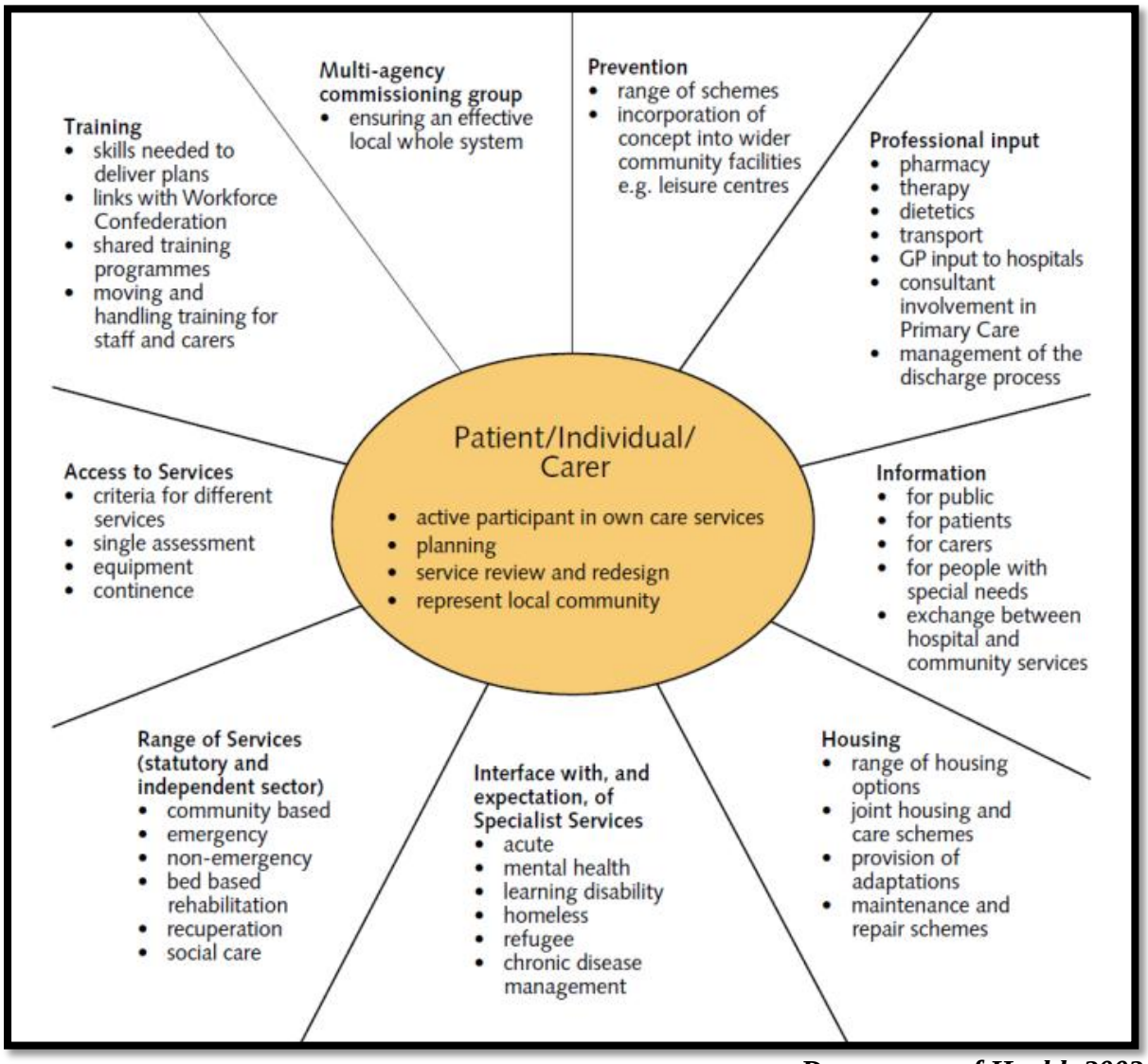
Barriers to transition:

Health Education England

Appendix A

Health, Housing and Social Care System for Adults

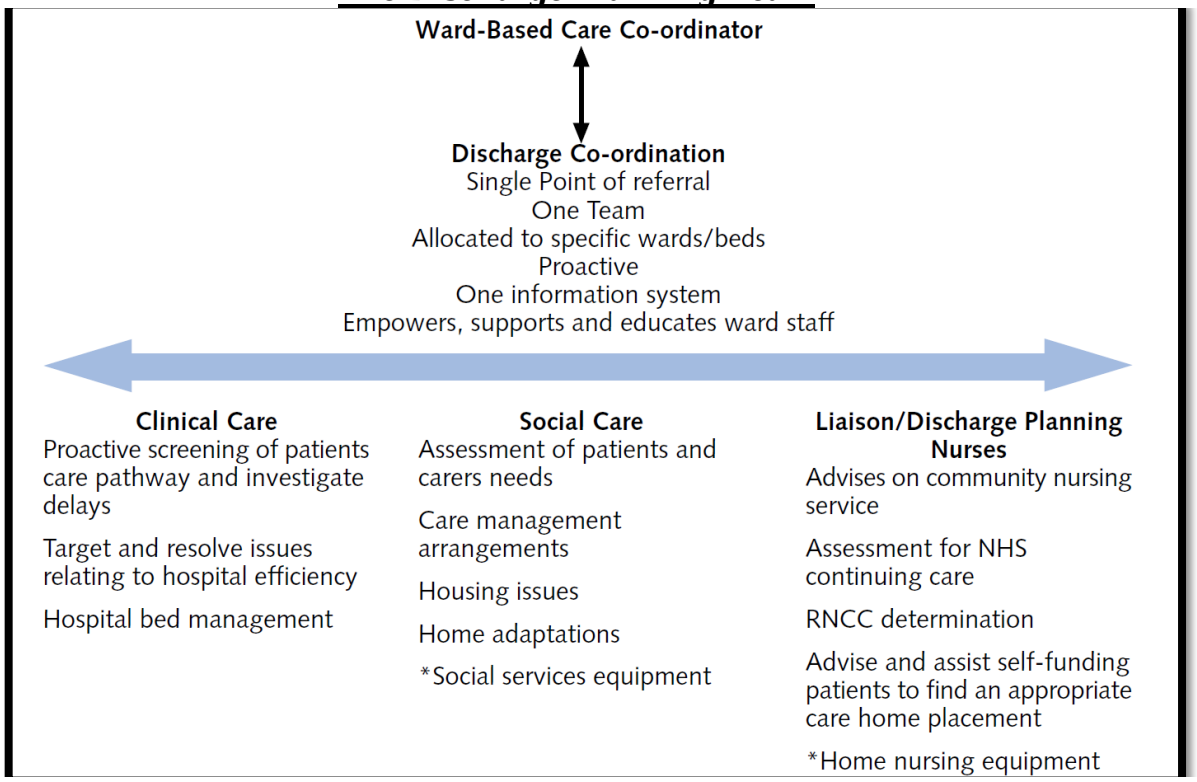
Discharge from hospital: pathway, process and practice



Department of Health 2003

Appendix B1

The Discharge Planning Team



Discharge from hospital: pathway, process and practice
Department of Health 2003

Appendix B2

The ten steps (adapted from 'ready to go' DH 2010)

		Tips	Problems
1	Start planning for discharge or transfer before or on admission	Create a user friendly screening tool or discharge risk assessment tool	Lack on continuity of documentation between wards and departments
2	Identify whether they patient has simple or complex discharge and transfer planning needs, involving the patient or carer in your decision	Develop a clear definition of 'simple' and 'complex' in your discharge policy	If this step is not integrated into a clinical management plan
3	Develop a clinical management plan for every patient within 24 hours of admission	Have a management plan proforma developed and available for download ono the intranet	The absence of stages in a plan, and failure to determine whether or not they have been completed
4	Coordinate the discharge or transfer or care process through effective leadership and handover of responsibilities at ward level	Prepare job descriptions aligned to knowledge and skills framework (KSF) to reinforce the role coordinate –also consider involvement of allied health professionals	Lack of leadership when staff shortages occur and coordinators are 'counted in the numbers', which means that they are not feed up to coordinate.
5	Set an expected date of discharge or transfer within 24-48 hours of admission and discuss with the patient or carer	Improve staff understanding in order to improve compliance with EDD –and conduct patient surveys to assess extent of patient involvement in the process	Estimating a date of discharge without clarification from the MDT of what is achievable

6	Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date	Incorporate EDD, simple or complex discharge and the anticipated destination (home, nursing home etc) in the plan	Management plans tend to exclude nursing actions and nursing plans
7	Involve patients and carers so that they can make informaed decisions and choices that deliver a personalised care pathway and maximise their independcene	With complex discharges, establish a key worker who coordinates the discharge plan	Lack of understanding of patient involvement strategies.
8	Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient	Analyse your high volume groups – what services are required by this group? Work to ensure that weekend provesion of those services becomes availbe, to enable seven day working and discahrges	Insistence on five day working from some essential services.
9	Use a discharge checklist 24-48 hours prior to discharge or transfer	Develop the checklist with input form social care series and PCT, keep it to one page, provide copies for patients	Each ward developing its own discharge checklist

10	Make decisions to discharge and transfer patients each day	Start work in an area with relatively simple discharges; identify high volume condition groups	There are pockets of excellent practice –but they are not shared

Tips for a successful discharge:

1. Make no assumptions e.g. that families can provide care, that family members agree with each other
2. Keep up to date with developments from other members of the MDT. New information can change the original discharge plan
3. Review the patient on the day of discharge, ensure there is no new medical problem.
4. Ensure patients are discharged only when necessary equipment and services are in place.
5. Ensure that the preliminary discharge summary (usually written by a junior doctor) is clear, comprehensive and correct.
6. Telephone the GP before discharge if the patient is terminally ill or requires medical monitoring in the early days after discharge.

Checklist for a discharge summary:

1. Hospital, ward, consultant, contact numbers
2. Patient's name and unique identifier (hospital number, date of birth, address)
3. Date of admission and date of discharge
4. Discharge destination (may not be home)
5. Problem list
6. Clinical story including significant investigation results
7. What information has been given to the patient and family
8. Functional and cognitive status on discharge
9. What follow-up is required or has been arranged
10. Medication list, with an explanation of changes.

If the patient has been discharged to a care home, or an intermediate care bed, a copy of the discharge summary should also be sent to the attending doctor there.

Discharge Checklist to be completed 48 hours before discharge

Task	*Completed by & Comments*	*Date & Signature*
Written and verbal advice given to patient		
Patient care discussed with family/carer		

Arrangement confirmed		
Family/carer advised of discharge date		
Arrangements confirmed		
Family/carer advised of discharge date		
Carer understands how to use any specialist equipment provided		
Transfer of care co-ordinator responsibilities confirmed & note of new coordinator made		
Discharge letter completed and signed		
GP letter written		
Letter faxed or emailed to primary care		
Transport arranged: own/hospital		
Arrangements for home equipment confirmed		
Training in use of equipment completed		
Relatives asked to bring outdoor clothes for patient to go home in		
House keys		
Heating on		
Food available		
Medication instructions discussed with patient/carer		
Prescription arranged		
Prescription dispensed		
Community therapies informed		
Community nursing informed		
Out-patient appointment given		
Transport confirmed		

Discharge from hospital: pathway, process and practice
Department of Health 2003

John Overtveit (cited in Maher et al 2007) stated: 'The challenge is not starting, but continuing after the initial enthusiasm is gone'.

Appendix C

Barriers to Effective Discharge: Breaking the Bottleneck Appendix			
HEALTH EDUCATION ENGLAND			
Case Based Learning			
CASE [ ]			
CASE EVALUATION			
(To be completed by trainees)			
Group..... Tutor's Name .....…….....			
Overall Evaluation of Case and Suitability for PBL			
4	**3**	**2**	**1**
Excellent	**Good**	**Satisfactory**	**Unsatisfactory**

Compare this list of objectives and mark degree of student achievement by ticking appropriate box.

	Case Objectives	**Identified by group**	**Partially identified**	**Not identified**
1				
2				
3				
4				
5				
6				

7				
8				
9				
10				
11				

Please list the additional objectives identified by your group and not the author. Please write out in full.

a	
b	
c	
d	
e	
f	
g	
h	
i	

Additional comments e.g. on this case, the PBL process or other issues. ***[Please use other side of sheet for further comments]***

Please return to:

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