



Original Article

A comparison study between two discharge planning tools

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ABSTRACT

Objective: The objective was to compare the effectiveness between a systematic assessment tool and a traditional assessment tool for discharge planning.

Methods: This research adopted a two-group comparison study design, and convenience sampling was adopted to recruit patients requiring discharge-planning services at eight wards in a regional teaching hospital in Southern Taiwan. The postdischarge care requirements of two groups of patients were evaluated using a traditional assessment tool and a systematic assessment tool in different implementation periods, respectively. Sixty-eight patients were matched with similar age and with similar activity in daily living index scores to compare the effectiveness of the tools.

Results: The systematic assessment tool exhibited higher assessment integrity and placement appropriateness, as well as lower rates of rehospitalization or mortality within discharge 14 days. The two groups exhibited no significant difference in inappropriate hospital days, primary decision-makers' satisfaction, and proportion of referral professionals who meet patient care requirements. However, the differences in three items of satisfaction exhibited moderate-to-large effect sizes, which may be of clinical importance.

Conclusions: To meet the needs of primary decision-makers in a family, enhance their satisfaction, and provide effective discharge-planning services, clinicians should adopt the systematic assessment tool to assess the postdischarge care requirements of a patient, and the hospital should provide relevant facilities to assist in implementing all plans.

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In January 2012, the registered number of Taiwanese people aged over 65 years accounted for 10.91% of the national population (Taiwan Ministry of the Interior, 2012) and the aging index had reached 72.6%. Long-term care involves providing medical, social, and everyday services to people who lack everyday functionality (Evashwick, 2005). Moreover, demand for long-term care is increasing because of population aging. In recent years, various long-term care models have been introduced to improve long-term care conditions. In 1994, the Ministry of Health and Welfare in Taiwan began promoting the policy of discharge-planning services. In the policy, discharge-planning services are aimed at coordinating emergency medical care and subsequent long-term care through patient care and follow-up program implemented by a medical team. However, American Hospital Association indicated that discharge planning is a centralized, coordinated, and multidisciplinary process aimed at providing appropriate care for inpatients throughout all stages of their hospitalization and ensuring that they have adequate resources before being discharged from hospital (Wen & Duh, 2016).

Combining with sound patient care and follow-up mechanisms, a discharge-planning service can be complete and effective for patient care. The following studies supported the view. Comprehensive discharge planning plus postdischarge support can reduce medical costs, reduce the rate of rehospitalization, and improve the quality of life, but not all-cause mortality or initial length of stay for older patients with congestive heart failure by meta-analyzing eighteen studies (Phillips et al., 2004). The discharge planning intervention in the patients with percutaneous transluminal coronary angioplasty can increase the patient satisfaction, and reduce the fourteen days post-discharge readmission, the fourteen days post-discharge with an emergency treatment, and the hospital length of stay (Tsai, Wang, Yin, & Liao, 2009). A systematic review showed that telephone-based post-discharge nursing care can decrease readmission rate in patients with heart failure (Lee & Park, 2010). The meta-analysis of nineteen randomized controlled trials (RCTs) also supported that heart failure management programs with nurse-driven pre-discharge interventions had the potential of reducing hospital readmissions (Lambrinou, Kalogirou, Lamninos, & Sourtzi, 2012). An RCT revealed that although a telephone-based Enhanced Discharge Planning Program makes the older adult patients more likely to have scheduled and completed physician visits by 30 days post discharge when compared with usual care

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patients, the two groups had no significant differences on patient or caregiver stress or hospital readmission; and implies that more intensive efforts may be indicated (Altfeld et al., 2013). By reviewing 30 trials (11,964 participants) a discharge plan was with moderate certainty evidence in reducing hospital length of stay and the risk of readmission, but not in mortality at three months follow-up for older people with a medical condition; and with low certainty evidence in increasing satisfaction for patients and healthcare professionals and in reducing care cost (Gonçalves-Bradley, Lannin, Clemson, Cameron, & Shepperd, 2016). To sum up, a complex discharge-planning can often reduce the rate of readmission, but not necessarily the mortality or initial length of stay, or health care cost.

Except for the objective indicators “post-discharge readmission, post-discharge with an emergency treatment, and the hospital length of stay”, the subjective indicator “the satisfaction of patient or caregiver” is also important in effectiveness assessments of discharge planning. For caregivers to home-care clients, items of dissatisfaction were financial aids (income tax reductions, living cost subsidies, medical expenses, fees for aides and medical devices), services (rehabilitation, nursing consultancy when needed, and transportation), and information and skills to support caring (Chiou, Hsu, & Wu, 2003). Higher levels of patient satisfaction are achieved by offering more nursing teaching, medical transfer and social services (Chang, 2008).

After controlling for other variables, the adoption of a care plan, and the discharge locations were factors associated with readmissions of stroke patients; therefore increasing home nursing resources to meet the demand for wound nursing care may reduce readmissions (Chuang, Wu, Ma, Chen, & Wu, 2005). Coleman, Parry, Chalmers, and Min (2006) also concluded that coaching chronically ill older patients and their caregivers to ensure that their needs are met during care transitions may reduce the rates of subsequent readmission. A Discharge Decision Support System was helpful to identify high-risk patients recommended for postacute referral and resulted in the reduction of readmissions (Bowles, Hanlon, Holland, Potashnik, & Topaz, 2014). Therefore, an assessment of patient needs is critical for providing effective discharge planning services (Yang & Huang, 2007). Accordingly at the beginning of hospitalization, the needs of patients and their family members should be identified to ensure the appropriate provision of adequate knowledge, skills, and resources. However, the qualitative interview using a hypothetical vignette indicated that older people and families hold different values and priorities in discharge-planning decisions about long-term care and few elders reported to adopt a consumer approach to long-term care (Denson, Winefield, & Beilby, 2013).

This study compared the differences of a systematic assessment tool (i.e., a rank-assessment scale for evaluating patient care requirements pertaining to discharge-planning services) and a traditional assessment tool (i.e., a discharge planning sheet) in terms of patient outcomes (including rehospitalization or mortality within 14 days, and inappropriate hospital days of the patients), satisfaction of primary decision-makers who are the primary decision-makers in a family, resource allocations (including appropriateness of postdischarge placement, and proportion of referral professionals who meet patient care requirements), and completeness of the assessment.

The framework is as in Fig. 1. This study adopted a systematic assessment scale for evaluating patients' requirements regarding discharge planning services, to identify patients' care requirements in various aspects. Providing timely services and adequate resources to patients with various care requirements ensures that they receive appropriate treatment. Moreover, the satisfaction of patients and primary decision-makers can be enhanced.

1. Methods

1.1. Design

This study adopted a two-group comparison study design.

1.2. Setting

Participants were recruited from eight wards at a regional teaching hospital in Southern Taiwan. The total number of hospital beds was 496. Four case managers were responsible for discharge planning, including two specialized case managers who are always responsible for discharge planning and two acting case managers who are temporarily responsible for discharge planning when the specialized case manager takes a vacation.

1.3. Subjects

This study adopted a convenience sampling method. From October to December 2012, one group of 34 patients requiring discharge-planning services was recruited and assessed by ward nurses using the traditional discharge-planning sheet. From January 2013, another group of patients requiring discharge-planning services was assessed using the scale for evaluating patient care requirements related to discharge-planning services until April 2013. 34 patients who used the systematic assessment tool and were matched with the group using the traditional assessment tool by age (± 5 years) and Barthel activity of daily living (ADL) index (± 1 grade) were recruited, and others were excluded.

1.4. The study procedure

First, nurses used an in-house information system to inform the case managers about patients requiring hospital discharge planning services. Subsequently, the case managers visited the patients, assessed their care requirements, and then allocated the necessary services and resources. Patients requiring discharge-planning services were identified within 24 hours of hospital admission. Subsequently, ward nurses used an in-house information system to inform case managers about these patients. The case managers used the traditional assessment tool and the systematic assessment tool in different implementation periods to assess the care requirements of these patients. The case managers were trained to use the systematic tool by the first author of the study. Demographic information was collected, the patients' care requirements were assessed, and adequate resources were allocated accordingly. Prior to discharge from hospital, a self-compiled scale was used to assess the primary decision-makers' satisfaction with the discharge-planning services, and the completeness of the assessment of care requirements was evaluated. Because most of patients in the study setting had ages greater than 60 years and were completely or severely dependent, they need others to take care of their daily activities. Therefore satisfaction of the decision-makers rather than the patients is measured in the study. The postdischarge placement of patients was

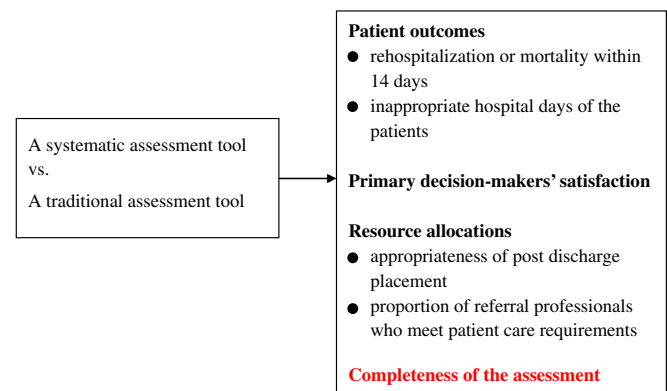


Fig. 1. The study framework of a comparison study between two discharge planning tools.

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