Implementation and Evaluation of a Unit-Based Discharge Coordinator to Improve the Patient Discharge Experience

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ABSTRACT

Hospitals are currently focusing on quality measure initiatives such as patient safety, satisfaction scores, and patient length of stay. Inefficient and ineffective discharge planning is often directly associated with long hospital stays and poor patient satisfaction with the overall discharge process. The purpose of this quality improvement initiative is to describe and address the implementation and evaluation of a unit-based discharge coordinator role on a general medicine pediatric unit at a tertiary care children's hospital. Improved outcomes, including an increase in patient satisfaction with the discharge process, decreased length of stay, and a decrease in patient safety net reports are demonstrated through implementation. A unit-based discharge coordinator can play an important part in enhancing the overall discharge experience for the patient and families by providing an effective and efficient approach to discharge, providing the patients and families with a feeling of preparedness. J Pediatr Health Care. (2015) *29*, 509-517.

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KEY WORDS

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The 2001 Institute of Medicine (IOM) report, Crossing the Quality Chasm, describes a decentralized and poorly organized and complicated U.S. health care system that patients and their families find confusing (Burton, 2012; IOM & Committee on Quality Health Care in America, 2001). Since this landmark report, the need to reduce health care spending continues to receive attention, and federal initiatives aimed at leveraging the cost of effective and efficient delivery of health care are necessary. Hospitals are being asked to evaluate contributing factors in order to reduce health care costs and eliminate wasteful spending without decreasing quality. Improving the patient's discharge experience to provide a smooth transition from hospital to home is one quality improvement focus of health care reform. Inadequate discharge planning is a major contributor to diminished quality of care and wasteful health care spending.

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Discharge planning involves a complex assessment of patient needs and the integration of hospital and community patient and support services. When

patients are discharged from the hospital to home, they receive a variety of information about how to care for themselves, what medications to take and when, adverse effects to watch for, and who to call if they have questions. This array of discharge information is also delivered to the patient in a variety of ways.

Current literature supports comprehensive discharge planning for many adult populations and suggests that different models are used to provide discharge planning. One model is to have point-of-care nurses provide discharge paperwork in addition to their other duties of processing admissions or transfers from another unit and managing an already busy patient assignment; another model is to have a social worker try to finish up loose ends on the day of discharge, even though he or she is unable to review medications to be taken at home with the patient/family because of the social worker's limited scope of practice. Providing the patient and family with the opportunity to participate in discharge planning enhances the discharge process, but there is a gap in the literature about the effectiveness of a unit-based, inpatient, pediatric discharge coordinator.

Quality improvement interventions for safe discharges are needed. Facilitating the discharge process can aid in the timeliness of discharges and ensure that appropriate care is available in the home to prevent readmissions, reduce costs, and lessen the burden of care on families. Discharge planning is described in the literature as both a *person* and an *overall process*. Within the hospital setting, discharge planning is defined as a process through which the nurse coordinates health care responsibilities with the patient (Clausen, 1984). Effective discharge planning is efficient, utilizes best practice standards, involves the patient and family from admission to time of discharge, and is inclusive and provides coordinated efforts of services from hospital to community (Domanski, Jackson, Miller, & Jeffrey, 2003). In addition to teaching patients necessary skills, the discharge process helps the patient and his or her family to feel prepared for discharge. The overall goal of discharge planning is to facilitate a transition back into the community in a manner that is as smooth, safe, and quick as possible for the patient and family (Hamilton & Vessey, 1992). The purpose of this article is to describe a quality improvement project regarding the implementation and evaluation of a unit-based discharge coordinator for pediatric patients on a general medicine inpatient unit. The goal of this organizationally based, coordinated discharge process is to ensure that pediatric patients leave the hospital in a favorable manner, are ready for discharge, and receive community-based services and follow-up as indicated.

LITERATURE SEARCH AND SYNTHESIS

Hospital discharge is an important part in the continuum of care and can affect patient outcomes. Foust (2007) found that 19% to 23% of medical patients experienced an adverse event within 1 month of their hospital discharge and that 6% to 12% of these adverse events were preventable. The day of discharge is often used as the last chance to identify unmet needs, with a focus on reconciling discrepancies pertaining to the discharge instructions and medications. In the medical literature, discharge strategies for adult populations (such as persons with congestive heart failure) are more commonly identified compared with discharge strategies for pediatric patient populations. Reports of the costs and benefits of providing a coordinated discharge plan for the pediatric population continue to be scarce within the medical literature.

A literature search and synthesis was conducted using a systematic process to include identification, screening, and review of eligibility of articles (Figure 1). Articles were identified using the subject terms *patient discharge* in combination with words for *coordinator* in the title or abstract, with the search limited to articles published in English and relating to pediatrics. PubMed and CINAHL database searches yielded 253 and 129 articles, respectively, for a total of 382 articles. Screening resulted in the removal of duplicates (n = 327) and a review of abstracts for similarity (n = 37). A total of 18 full text articles were reviewed for eligibility, and 10 were included in the final review. The synthesis of this literature is a representation of the overall discharge process and can be seen in Figure 1.

Discharge Coordinator Models

Children are highly vulnerable when discharges are not comprehensive and when safety is a concern (Capuano, 1995; Domanski et al., 2003). Because health care settings are different today than they were 10 years ago, children are being discharged more quickly and with more complex medical needs. It is essential that hospitals remain flexible, creative, and open to change so models of care and tools can be created to keep up with the challenges of our current health care environment. Discharge planning is an interdisciplinary responsibility that focuses on care across the continuum. Unit-based discharge coordinator roles and responsibilities for providing high-quality, cost-effective, family-centered discharge care may include (a) review of discharge medications and the discharge home care instructions using a teach-back method; (b) scheduling of multidisciplinary follow-up appointments prior to discharge; (c) providing linkage among internal and external providers; (d) collaborating with direct caregivers and community agencies as needed; and (e) ensuring optimal continuity of care for pediatric patients and their families with a consistent person throughout the hospital stay. It is often said that discharge planning needs to begin upon admission. With this focus of beginning the process of discharge