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Feature Article

Nursing discharge planning for older medical inpatients in Switzerland: A cross-sectional study

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ABSTRACT

Nursing discharge planning for elderly medical inpatients is an essential element of care to ensure optimal transition to home and to reduce post-discharge adverse events. The objectives of this cross-sectional study were to investigate the association between nursing discharge planning components in older medical inpatients, patients' readiness for hospital discharge and unplanned health care utilization during the following 30 days. Results indicated that no patients benefited from comprehensive discharge planning but most benefited from less than half of the discharge planning components. The most frequent intervention recorded was coordination, and the least common was patients' participation in decisions regarding discharge. Patients who received more nursing discharge components felt significantly less ready to go home and had significantly more readmissions during the 30-day follow-up period. This study highlights large gaps in the nursing discharge planning process in older medical inpatients and identifies specific areas where improvements are most needed.

Introduction

In 2011, people aged 65 years or older represented 17.2% of the Swiss population, but accounted for 43.1% of hospital discharges.[1] Similar observations have been reported in other countries.[2,3] In this older population, the simultaneous presence of several diseases and their related functional impairment, together with psychosocial problems, increases the complexity of care.[4]

Chronically ill older patients commonly experience health transitions that require the attention of a wide range of health professionals from various settings.[5] Increased financial pressure and a shorter length of hospital stay add to the transition challenges and require improved care coordination during hospitalization and after discharge. However, the rising fragmentation of health care services results in increased difficulties in coordinating health care providers' interventions and matching them to patients' needs.[6] Furthermore, the time available for discharge preparation has been significantly reduced.[7] Indeed, most hospitalized older people are discharged home "quicker and sicker"[8] and are less prepared for the transition.

To address these challenges, enhanced approaches to the discharge planning process and a focus on transitional care have become a priority to ensure optimal transition across care settings. The discharge planning process is deemed essential to improve the continuity of care and to avoid or reduce the occurrence of adverse events after hospital discharge.[9] Accordingly, the use of a standardized discharge planning process is now being considered as a quality indicator in many health systems.[10–14]

Despite this observation, the discharge planning process still lacks a systematic and structured approach in most inpatient settings to address the complexity of health and transitional care in older people.[15] Among the numerous studies published, only a few have included patients' and caregivers' perspectives,[16,17] even though most researchers recognize the importance of these perspectives for a successful hospital discharge.[18,19]

Comprehensive discharge planning has been defined as a broad range of time-limited services designed to ensure health care

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continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another and/or from one type of setting to another.[20] Its purpose is to smooth the transition from hospital to home, or to prevent or diminish adverse events after hospital discharge.[21] Key components of this planning have been identified in several literature reviews.[21–23] There are a number of identified discharge planning elements that are necessary for a successful discharge, including: (1) communication, (2) coordination, (3) education, (4) patient participation, and (5) collaboration among health care personnel.[24] When considering the process itself, a complete and safe hospital discharge planning includes: (1) assessment of the patient, (2) development of an initial discharge plan, (3) implementation of the plan, and (4) assessment of the transition back to the community and follow-up after discharge.[25]

The Transitional Care Model (TCM) is focused on patient needs and includes seven patient-centered key components of discharge planning (Table 1).[26] Three randomized controlled trials tested this model and demonstrated its benefits in reducing hospital readmissions and health care costs in cognitively intact, older adults at high risk of readmission.[27–29] The last trial also showed improvement in patients' quality of life and satisfaction.

One cannot examine nursing discharge components without taking into account the readiness of patients for discharge.[30] The concept of readiness for discharge was first defined as the feeling of being prepared to face the transition from hospital to home and to adapt to changes in health status.[31] Later on, it was characterized as "a complex multidimensional, multiphase phenomenon that provides an estimate of a person's ability to leave the hospital."[32] The concept is described in five areas: (1) physiologic stability, (2) patient competency, (3) patient-perceived self-efficacy to handle self-management regimens, (4) availability of social support, and (5) access to community resources.[33] Information deemed necessary by this patient for a safe discharge provided by health care professionals is a strong determinant of a patient's readiness for hospital discharge.[18] Assessing readiness to return home provides some insight into a patient's perspective and state of mind just before discharge, and can potentially allow further adjustments in care to better address this patient's needs.[34]

To date, only four studies have investigated the concept of readiness to return home and its relationship to nursing discharge planning and health care utilization. Results indicated that higher perception of readiness for discharge was associated with reduced difficulties in coping within 3 weeks of hospital discharge,[34] fewer readmissions at 3 weeks post-discharge,[17,35] and increased use of informal and formal support.[36]

These observations all suggest the potential significance of readiness for discharge as an indicator of the quality of hospital discharge preparation. Most of these studies were performed in a US health care environment, and so whether similar results will be observed in a different health care context remains unclear. In addition, no study specifically investigated the relationship between the comprehensiveness of nursing discharge components and patients' readiness for hospital discharge. Finally, data are conflicting about the relationship between readiness to return home and subsequent health care use in older medical inpatients.

The present study had several objectives. The first was to describe the usual discharge planning process used in older medical inpatients. A second objective was to investigate the relationship between the comprehensiveness of the nursing discharge planning process and a) the patients' readiness for hospital discharge; b) unplanned health care utilization after discharge.

The hypotheses were that more comprehensive discharge planning would be associated with higher readiness for discharge and lower use of unplanned health care services (readmission, emergency visits, and community care) after discharge.

Table 1
Transitional care model.

Key components
1. The presence of transitional care nurses/advanced practice nurses who lead the discharge planning process.
2. Early comprehensive assessment of the patient's goals, preferences, and needs. Upon the patient's hospital admission, the nurse needs to conduct an assessment of the patient's needs for the post-hospital period and to establish an initial and provisional discharge plan.
3. Patient and caregiver information and counseling about new treatments, symptom management, and functional impairments. Consulting interventions include information, actions to encourage and empower self-care and coping, and assisting the patient to make decisions and solve problems.
4. Patient participation, including enhanced communication between the patient and the nursing staff and direct patient involvement in the discharge planning process.
5. Continuity of care and communication between health care providers within and across health care settings. Coordination of care between the hospital and home must be prearranged between the primary care providers and the primary physician.
6. Pre-discharge assessment, or evaluation of whether or not the patient is ready for the return home.

Methods

Design

A cross-sectional design was used. Data were collected between November 2011 and October 2012.

Settings

The study was conducted on medical units in four French-speaking Swiss hospitals. Three hospitals were classified as "regional hospitals" (number of beds ranging from 130 to 197), and one was a 914-bed academic hospital. These four hospitals have similar discharge procedures that are based on collaboration between physicians, nurses, physical therapists, and other health care professionals, as well as the involvement of a liaison nurse. This nurse is in charge of assessing patient's and caregiver's needs. She determines whether home care services are required and, in this case, coordinates care between hospital and home. Interdisciplinary discharge meetings differed in frequency and team composition across the four hospitals. Three hospitals had two weekly meetings, while the last hospital had three weekly meetings. One hospital team included bedside nurses and liaison nurse, two teams included nurse manager, and the last team also included a physician assistant.

Sample size

Sample size was calculated based on prior research[35] using the Readiness for Hospital Discharge Scale (RHDS) in people aged 75 years and older whose average score was 8.1 (SD = 1.4). In addition, sample size was estimated using a two-level regression randomized effect.[37] The following assumptions were made: the average RDHS score ranged one-half a standard deviation ($\Delta = 0.35$) around an average of 8.1; patients who received little discharge preparation had an average score of 7.75 and those who received much discharge preparation had an average score of 8.45; variance was the same between the two groups (SD = 1.4) and inter-service correlation was the same among the four medical wards ($r = 0.05$). Sample size was calculated for a one-sided test of average differences in the groups with little and much discharge