Hospital discharge planning: evidence, implementation and patient-centered care

Discharge planning is an interdisciplinary process that assesses the patient’s need for follow-up care after leaving the hospital and makes arrangements for that care, whether self-care, care provided by family members, care from health professionals or a combination of these options. Comprehensive discharge planning can be considered as a series of interrelated processes. Preadmission assessment includes case-finding on admission, leading to inpatient assessment and preparation of a discharge plan based on individualized needs within an interdisciplinary team context. The second process is focused on patient preparation through discharge teaching – educational interventions that occur mainly during hospitalization to prepare the patient and family for the transition from hospital to home. The third process is discharge coordination, which involves implementing actions targeted to smoothing the transition from hospital, anticipating and reducing problems after discharge through arranging, linking and sequencing support services across providers and care delivery systems.

Although discharge planning is a routine feature of health systems, 40-50% of all hospital readmissions have been attributed to social problems and lack of access to community services, which adequate discharge planning is intended to circumvent. The impact of inadequate discharge planning includes prolonged hospital stays, hospital readmissions, breaks in continuity of care as well as increased costs.

In spite of the significance to the quality of care delivery, organizations and patients, there is a general lack of approach based on scientific evidence. When patients are discharged from the hospital to home, they may or may not receive a variety of information about how to care for themselves, which medications to take and when, adverse effects to monitor, and whom to call if they have questions. This array of discharge information may be delivered to the patient informally, without structural consideration of the patient’s knowledge needs. A lack of discharge education can leave patients with discontinuity of care and lead to risk taking in self-management, increasing the odds of adverse effects and readmission. Discharge planning is considered crucial to improving the patient’s experience of care, but many aspects of this important process are poorly implemented and the planning needs of diverse patient groups are not well understood or accommodated.

Discharge planning is a subject of continuing interest, particularly to nurses, as nurses have a significant role in facilitating hospital discharge. Outcomes such as improved patient satisfaction and reduced rebound admissions have been measured and can be attributed to discharge planning. However, it is important to note that these outcomes are dependent on having best practice standards in place to provide the structures, processes and resources needed by practicing health professionals.

In this editorial, we introduce new evidence for individual patient discharge planning, and consider a patient-centered approach highlighting recent implementation case studies that improved the quality of care.

Introducing the new evidence

Several articles in this issue of JBI Evidence Synthesis illustrate the complexity of the discharge planning process. The evidence consistently finds that organizations are motivated to improve discharge planning due to pressure on available beds and the intention to reduce length of stay; far less consistent is the availability of evidence to support these outcomes. The best practice implementation project to promote best discharge procedures in sedated patients following endoscopic procedures reveals the difficulty of implementing the best evidence in a context of reducing the number of available beds, consequently increasing the number of patients requiring care.

Perhaps in response to the lack of generalized evidence, systematic reviews are investigating the evidence of benefit at specialty level. For example, one of the systematic reviews in this issue investigates evidence for the effectiveness of discharge planning among patients with acute coronary syndrome. The results of this review illustrate the complexity of the discharge planning process and that the various components of this intervention are difficult to evaluate by only taking into account randomized controlled trials. This high-quality systematic review concluded that the available research
is inadequate to answer important questions regarding patients’ level of knowledge of their diagnosis, treatment, lifestyle choices, medication adherence and follow-up requirements, along with readmission and mortality.\textsuperscript{10}

Scoping reviews identify broad fields of knowledge, map existing research, categorize evidence, inform future research topics and facilitate more nuanced systematic review topics.\textsuperscript{11} This issue includes the methods and findings of a scoping review on admission and discharge criteria for adolescents who are inpatients or in residential mental healthcare facilities.\textsuperscript{12} Of 35 included publications, only two addressed discharge criteria, focusing on the need for integrated team-based planning and the need for coping strategy skills as part of patient education.\textsuperscript{12}

It is quite possible to conclude much quantitative research on discharge planning either has focused on the wrong outcomes, or is so lacking in quality that it fails to contribute to practice and has failed to fully investigate patient-relevant outcomes.

The convention that bed-days saved are the most appropriate or meaningful evidence of safe, effective discharge planning is open to question. A qualitative systematic review protocol using meta-aggregation seeks to investigate the lived experiences of patients and carers throughout hospital discharge planning to better understand the needs and perspectives of patients and their significant others.\textsuperscript{13} This centers the issue of discharge planning around the patient’s perspective, needs and priorities; it leads us to reconsider the significance of patient-centered approaches in the first phase of the discharge planning process. This qualitative systematic review protocol emphasizes the importance of evaluating the emotional dimension of patients and their families leaving the hospital. This protocol will also assess the readiness for hospital discharge, which is a predictive criterion for readmission to hospital at 30 days.\textsuperscript{14} Qualitative literature provides important insights into patient needs and expectations when the framework is a patient-centered approach, and program evaluations indicate that a patient-centered approach facilitates improved organizational processes in the lead-up to patient discharge.\textsuperscript{15,16}

Emphasizing implementation

Given challenges in the existing research base, the proposed studies in this issue present an exciting future, more contextually relevant research that may flow through to the organization and practice of care. As two projects in this issue demonstrate, implementation that is small-scale, local and contextualized can facilitate best practice and optimization of care delivery when i) clinicians are involved in the planning and implementation, and ii) the definition of evidence-based health care enables patient preferences and clinical expertise to be considered at the service unit or ward level, rather than solely based on a top-down metric such as bed-days saved.

The implementation study on transitional care for older people from hospital to home has global relevance, with important findings related to how clinician involvement reduces risks to patient well-being when based on patient-relevant outcomes.\textsuperscript{17} The audit criteria for these projects were informed by evidence from diverse sources that was carefully selected and screened for relevance, quality and reliability. A concern that informed the project was that patients or family caregivers were not routinely included during transitional care. Baseline data showed this concern was real, and the effect was to disconnect clinical staff and patients from the organization and planning of this important transition between hospital and home.

Discharge planning reduces patient harm, improves safety and facilitates improved patient outcomes.\textsuperscript{18} The literature also highlights that the system focus has traditionally been on technical aspects of discharge planning, such as arranging prescriptions and monitoring adherence, rather than on post-discharge coping mechanisms.\textsuperscript{18} What stands out to us is the need for more implementation studies that bring together the key stakeholders in an evidence-informed, patient-centered approach.

Localization to context and stakeholder groups cannot improve research quality, but does filter for important attributes, specifically relevance, feasibility, applicability and meaningfulness.\textsuperscript{19}
Evidence prioritization: have we got it wrong?

A focus on best practice standards in evidence review and research identifies important topics for systematic reviews; however, these often illustrate gaps rather than provide the best available evidence for policy or practice. The Joanna Briggs Institute (JBI) model and this issue of JBI Evidence Synthesis indicate that the quality and completeness of research are the researcher’s concern. The complexity of discharge planning suggests that approaches such as mixed methods systematic reviews and qualitative systematic reviews would be more appropriate for understanding the mechanisms of this intervention and identifying the most important components.

Clinicians manage gaps and uncertainties by localizing to context within a structured framework such as patient-centered care. The articles in this issue point to a patient-centered approach to discharge planning using an evidence-based framework that localizes evidence to context for implementation, supported by formalized context analysis, facilitation and impact measurement.

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References