Introducing a discharge planning and resource folder on acute hospital wards: A simple intervention to improve communication and quality of care at discharge

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

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Introduction: Hospital discharge especially for those patients with complex needs requires good coordination between hospital and community services. Communication with patients, families and community healthcare teams is vital on discharge. Failure to enlist appropriate community services on discharge home may leave patients vulnerable to adverse outcomes and readmission.

Our hospital actively manages discharge procedures through our hospital planning committee. A survey of nurses in our hospital on discharge processes identified a lack of knowledge of relevant community services and also time wasted searching for contact details and other discharge information. A hospital project on readmissions highlighted inadequate discharge communication as an area for improvement.

Practice change: “Discharge Planning & Resource” folders were introduced to all wards. Existing hospital discharge procedures, referrals forms for community services and patient information leaflets were reviewed, updated and collated. The contact details of local health-centres, public health nurses and nursing homes were gathered. An electoral listing of streets in our catchment area matched to their community health-centre was assembled. All this information was arranged in standardised folders. The roll-out of the folders was accompanied by ward based education on the discharge process.

Aim: Achieving a safe, timely and person-centred discharge from hospital to home is our ultimate goal. The aim of this project was to introduce a standardised “go-to” discharge planning resource on each ward. The objective was to aid effective communication and onward referrals to relevant community services at discharge.

Targeted population: This project focused on the medical and surgical wards in the hospital. Nurses were seen as key staff in terms of communication with community supports at the time of discharge. Discharge coordinators and ward nurses worked together identifying the essential information for discharge planning. The multidisciplinary discharge planning committee could to sustain and update the information folders.
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**Highlights:** A standardised “Discharge Planning & Resource” folder for the hospital was developed and successfully introduced to all wards. This folder is colour coded in a standardised fashion aiding staff moving between wards. The procedures for discharge to home, nursing home, hospice care or rehabilitation beds are available in one “go-to” resource. Information on arranging oxygen, looking after nephrostomy tubes and other patient information are available to staff in the one place.

Criteria and referral forms for the different support services at discharge are now all available. There is a high level of staff satisfaction and increased knowledge about discharge processes. This simple initiative could easily be replicated elsewhere.

**Conclusions & Discussion:** Communication is fundamental to successful and safe discharge. A single “go-to” resource for discharge planning information can aid staff in organising timely discharges and communicating with community services. Education, training and availability of adequate information are essential for improving discharge processes from hospital.

**Lessons learned:**

Simple low-cost strategies can have significant positive effects

Hospital staff may not be aware of all community services

Lack of communication can be due to lack of contact details rather than lack of desire

Improving hospital discharge processes has potential to improve quality-of-lives for patients

**Keywords:** discharge planning; communication; patient information; transfer of care