Discharge Planning: Your Last Chance to Make A Good Impression

You begin your shift on a Monday morning at 7:00 a.m. One of your patients, Mrs. Smith, has had an uneventful weekend after surgery late last week. You walk into her room with her morning medications, and find the patient placing her belongings into her bag. “The doctor said I can go home today!” she says. “We have a long drive, so my husband is coming in 30 minutes to pick me up so we can get going.” You not only have to do your morning cares for your other patients, but also coordinate an unexpected discharge. You hope the patient was prepared over the weekend for her dismissal.

You quickly learn that the patient has not been taught how to care for herself after discharge, her prescriptions still need to be filled in the pharmacy, and the doctors have yet to complete her discharge paperwork. Things become more complex when you note Mrs. Smith still requires oxygen, and will need oxygen set up in her home and for transport. After a long morning of arranging for oxygen, calling her doctors to get her discharge paperwork finished, and educating the patient and her husband, you are able to discharge Mrs. Smith at noon. Unfortunately, she has expressed her dissatisfaction that it took so long for her to be discharged when, “The doctor told me at 7:00 a.m. that I could leave!”

Forming a Team

Too often, the quality care a patient receives while hospitalized can be overshadowed by a poorly orchestrated dismissal. Discharge planning is an essential element of providing quality nursing care. Effective discharge planning can decrease the incidence of hospital re-admissions, allow for the cost-effective use of inpatient beds, and increase patient satisfaction (Hansen, Bull, & Gross, 1998; Maramba, Richards, Myers, & Larrabee, 2004; Tilus, 2002). Nurses who are well-versed in discharge planning ensure a safe and effective discharge.

The American Nurses Association (ANA) defined discharge planning as “part of the continuity of care process which is designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care” (as cited in Watts & Gardner, 2005, p. 175-176). McGinley expanded upon this definition to include a more team-focused approach, stating, “[Discharge planning is] an ongoing process that facilitates the discharge of the patient to the appropriate level of care. It involves a multidisciplinary assessment of patient/family needs and coordination of care, services, and referrals” (as cited in Watts & Gardner, 2005, p. 176).

The nurse’s role in discharge planning is central to the process. The authors have identified four main components in effective discharge planning: assessment of the patient’s post-hospital needs; collaboration with the health care team to determine an appropriate discharge date and disposition; identification and coordination of necessary resources for ongoing care; and assurance that the necessary paperwork, prescriptions, and patient education were completed. The goal of this process is to ensure a safe and timely hospital dismissal.

Discharge planning has become a priority for the 33-bed thoracic surgical progressive care unit (PCU) in a 1,250-bed Midwestern teaching hospital. Because this is a transitional unit, where patients proceed from progressive care status to general care status while housed in the same room, discharge planning is intended to be an ongoing, seamless process. The average inpatient spends 6.3 days on the unit prior to being discharged. During that time, nurses often are required to coordinate arrangements for self-care, home oxygen therapy, home enteral nutrition, outpatient antibiotic

Katherine E. Rose, MS, RN, is a Progressive Care Nurse, Thoracic Surgery, Mayo Clinic, Rochester, MN.

Melissa B. Haugen, ADN, RN, is a Progressive Care Nurse, Thoracic Surgery, Mayo Clinic, Rochester, MN.
therapy, home health care, and transfers to skilled nursing facilities.

In 2000, unit leaders from the thoracic surgical PCU noted dissatisfaction among patients and staff members regarding the discharge planning process. To determine the root causes of the dissatisfaction, nurse leaders conducted patient and nursing staff surveys. The unit’s nurse administrator also did a “walk in the patient’s shoes,” shadowing a patient who was discharging from the hospital. This experience provided further insight into the complexities of the discharge planning process. These efforts demonstrated the primary issues delaying the discharge process were a lack of complete and accurate hospital dismissal summaries, incomplete prescriptions, inconsistent dismissal education, and lack of communication regarding the patient’s dismissal date, time, and disposition.

As a result, unit leaders formed a discharge planning team. This team was composed of a variety of disciplines that impact the discharge planning process. Team members included two registered nurses (RNs), a staff physician, physician assistant, nurse manager, outpatient pharmacist, social worker, discharge planner, unit secretary, and continuous improvement specialist. Team members designed surveys and audit tools to define the issues they were charged with improving. They met monthly to review the collected data and implement change processes.

**Dismissal Summaries**

Each patient discharged from the thoracic surgical PCU receives a dismissal summary in accordance with institutional and Joint Commission standards (Louden, 2009). This document includes six core elements: diagnosis, reason for hospitalization, significant findings, procedures/treatment, and instructions as appropriate. In 2005, the institution added medication reconciliation to this list based on Joint Commission recommendations (Joint Commission, 2006). In 2006, the discharge planning team also added the requirement of dismissal chest x-ray reports for lung surgery patients and dismissal diet specifications for esophageal surgery patients.

Though the dismissal summary is an essential piece of patient discharge, nurses indicated the documents were not being completed in an accurate and timely manner. Their completion required the nurse to follow up with the provider before the patient could be discharged, a time-consuming task for the nursing staff that led to delayed discharge. To define and address this problem, the discharge planning team audited a sample of summaries. Team members then regularly audited the dismissal summaries at the midpoint of each quarter. This timing allowed the resident physicians, who generally rotated every 3 months, to become acquainted with the thoracic surgical PCU practices and then receive feedback on their work before they completed their rotations.

The dismissal summary audit process entails selecting a random sample of summaries to assess completeness, accuracy, and timeliness. To evaluate the completeness of the summary, team members use an audit tool that lists the required elements. To evaluate the accuracy and timeliness, the team asks the discharging nurse to note any issues with the summary’s accuracy or timely signature by a provider. Results of the initial audit showed only 60% of the summaries were completed acceptably prior to nurse intervention.

Results prompted the discharge planning team to improve the hospital dismissal summaries. The improvement process involved educating the unit’s physicians and physician assistants regarding the importance of the dismissal summary and expectations for its appropriate completion. The team’s staff physician was instrumental in assuring compliance of the resident physicians with this practice. Audit results were communicated to all thoracic surgical PCU staff, emphasizing the areas in which improvement was needed. Results showed dismissal summary accuracy, completeness, and timeliness increased from the initial 60% to 91% in November 2007 (see Figure 1).

**Prescriptions**

Patients on the thoracic surgical PCU frequently require prescriptions at the time of discharge. They are given the option of taking prescriptions to their own pharmacies or obtaining them from the hospital outpatient pharmacy.

---

**Figure 1.**

**Dismissal Summary Audit Results**

Graph showing the percentage of dismissal summaries that were accurate and complete from August 2004 to November 2007. The graph highlights significant milestones, such as medication reconciliation required for all patients in November 2005 and x-ray reports/diet specifications required in May 2006.
Because 75% of patients choose to obtain their medications at the hospital pharmacy before leaving the hospital, mornings are a hectic time at the pharmacy. Patients may have to wait several hours for their prescriptions to be filled before they can leave the hospital.

The discharge planning team discussed ways to streamline the prescription process to limit patients’ wait time. The team’s pharmacist indicated a great deal of the delay on the day of discharge was created by insurance verification. This delay could be avoided by sending prescriptions to the pharmacy prior to the day of discharge. This small change in practice would allow the pharmacy additional time to process insurance information, and help assure prescriptions would be ready when patients were ready to discharge. In addition, if a prescription needed to be changed at the last minute (e.g., from pill form to elixir form), the change could be made quickly because insurance information had been verified already.

The team worked to educate prescribers about the benefit of writing prescriptions the night before the patient was to be discharged. To track the prescriber’s compliance with the new unit standard, the team began conducting audits that coincided with the quarterly dismissal summary audits. The unit secretary notified the pharmacy staff of patients who were discharged that day, and a pharmacist would determine if prescriptions had been received by the prior night. Because most postoperative patients are dismissed on predictable medications, prescribers on the thoracic surgical PCU have begun writing discharge prescriptions the day of surgery to allow ample time for completion. The percentage of prescriptions written the night before discharge increased from 45% in December 2002 to 88% in November 2007 (see Figure 2). Since then, the institution’s medication ordering and prescribing policy was revised to reflect the new practice. Prescribers are encouraged to write dismissal prescriptions the evening before the anticipated day of discharge.

**Dismissal Education**

Patients require extensive education prior to their hospital discharge. On the thoracic surgical PCU, physicians, physician assistants, dieticians, physical therapists, and nurses work together to assure patients are able to provide self care after dismissal. However, the team approach may lead to confusion about who is responsible for giving patients each component of their discharge information. The discharge planning team worked to clarify the discharge teaching process by delineating the dismissal roles. For example, physicians and physician assistants are responsible for reviewing patients’ surgical reports and pathology with them, while nurses are responsible for reviewing the post-discharge care requirements.

Another issue facing the thoracic surgical PCU staff members and patients was the timeliness of dismissal education. Components of patient education were frequently not addressed until the morning of dismissal, leaving nursing staff feeling rushed. This also left patients with less time to absorb the information they were provided and ask questions to ensure understanding. Team members encouraged nurses to initiate teaching prior to the day of discharge, and continue to reinforce the information until discharge. The practice is audited monthly by team members and feedback is reported to the staff.

**Communication**

Lack of adequate communication regarding a patient’s dismissal date and time was another issue identified by the discharge planning team. Though the physicians often knew the patient’s goal dismissal date, this information was not communicated consistently between disciplines. If nurses were unaware of projected dismissal dates, they were unable to effectively arrange the patient’s posthospital needs and complete timely discharge teaching.

The discharge planning team looked for ways to improve care providers’ communication regarding the discharge date and time. Dry erase boards already existed in patient rooms. The team determined the boards would be an effective tool for communicating dismissal information not only to the multidisciplinary team, but also to the patient and family. Having a designated place to note anticipated dismissal dates reminded the team to address this with the patient, family, and nursing staff members. Staff physicians quickly adopted this practice with their daily patient rounds on the
unit. Ultimately, this allowed more timely communication of anticipated dismissal dates and thereby more effective discharge arrangements.

**Patient and Staff Satisfaction**

The discharge planning team has intermittently assessed patient and staff satisfaction with the discharge process through the use of surveys. Staff satisfaction data are collected annually. Nurses rate their satisfaction level as “completely satisfied,” “satisfied,” “neither,” “dissatisfied,” or “completely dissatisfied.” The survey also captures written feedback from the nurses about improving the discharge process.

Upon dismissal from the unit, all thoracic surgical patients receive a survey about their hospital stay. This simple survey includes a question asking patients to provide their perceptions of the discharge process. They are asked to state if the discharge process was “very smooth and organized,” “smooth and organized,” “chaotic and disorganized,” or “very chaotic and disorganized.” They also are given the opportunity to write comments about their experiences.

The initial staff satisfaction survey collected in 2001 showed 37% of nursing staff reported being either “completely satisfied” or “satisfied” with the discharge planning process. The most recent data collected in 2007 revealed 91% of nursing staff reported they are either “completely satisfied” or “satisfied” with the process (see Figure 3). Patient satisfaction data collected in 2004 showed 93% of patients perceived their discharge process as either “very smooth and organized” or “smooth and organized.” Results of the most recent survey in 2007 showed 100% of patients perceived their discharge process to be either “very smooth and organized” or “smooth and organized” (see Figure 4).

**Recommendations**

The task of improving the discharge planning process on the thoracic surgical PCU has been challenging, but beneficial both for patients and staff. Of the many lessons learned, three have proven especially valuable:

- **Communication is key.** Communication was vital to the improvement process. It allowed open discussion between unit staff members and the discharge planning committee. This led to solutions that could be used by all disciplines.
- **Multidisciplinary contributions are essential.** The team benefitted greatly from the expertise and influence of individuals outside of nursing. For example, the outpatiant pharmacist provided critical education about pharmacy procedures. This led to practice changes that assured prescriptions were ready at the time of dismissal.
- **Improvement is an ongoing process.** Because health care is a dynamic, ever-changing field, providers must adapt continuously and respond appropriately to changes. For example, as new requirements became part of the hospital dismissal summary, the discharge planning team had to reassess how well providers were meeting the revised standards and provide appropriate education.

*continued on page 53*
Discharge Planning
continued from page 50

Effectively changing a process such as discharge planning can be a challenge. To be successful, the team must have a clear grasp of the problems and be committed to improvement. Change also takes time, as data collection and audits may require several cycles to produce meaningful results. Even with these challenges, witnessing the increase in patient satisfaction and staff morale that come with successful change can be very fulfilling.

References