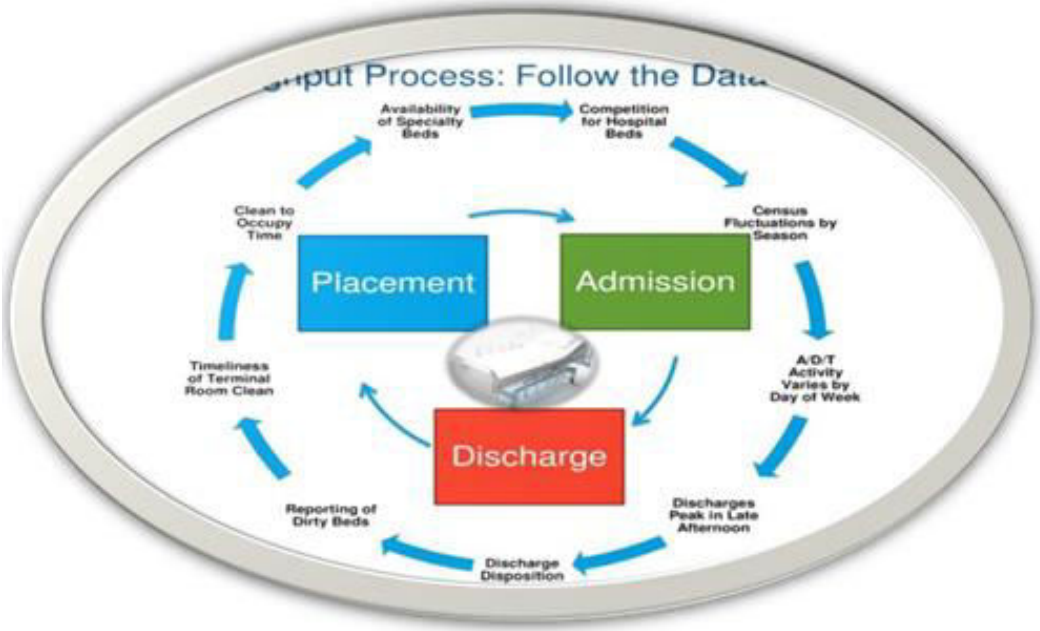
DEDER GENERAL HOSPITAL

DISCHARGE PLANNING PROTOCOL



PREPARED BY*: *HSQU

JULY 2016 E.C

DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVEAL SHEET

NAME OF PROTOCOL: DISCHARGE PLANNING PROTOCOL

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THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C

Table of Contents

PURPOSE:

The purpose of this Protocol is to establish structured discharge planning process to ensure safe, effective, and coordinated transitions for patients from **Deder General Hospital** to their care destination (home, rehabilitation, or long-term care). this process aims to reduce readmission rates, enhances patient and caregiver understanding of ongoing care, and promote patient satisfaction and safety.

SCOPE

This protocol applies to all healthcare providers at Deder General Hospital involved in the patient care and discharge planning, including:

- Physicians,
- Ward Nursing staff,
- Pharmacists,
- Laison officers, and
- **Social workers***

It encompasses all patient discharges, including medical, surgical, pediatric, maternity unit, and takes into account the special needs of high-risk populations.

Introduction

INTRODUCTION

Discharge planning is "a process used to decide what a patient needs for a smooth move from one level of care to another." The doctor is the one who will authorize a patients release from the hospital, but the actual process of discharge planning may be completed by a social worker, a discharge planning nurse, nurse, etc. Ideally, and especially for the most complicated medical conditions, discharge planning is done with a team approach.

Despite its benefits, which clearly increase the well-being of patients and caregivers, discharge/transition planning is often not given the attention it deserves, and indeed, ineffectual planning often serves to add to a patient and caregivers' stress.

GENERAL OBJECTIVES

The purpose of this protocols document is to provide health facilities with best practices, processes, and guidelines to deliver both effective and efficient discharge processes.

Specific Objectives

- ✓ To Share international Best Practice and adapt them to the Ethiopian context.
- ✓ To show standardized processes for admission and discharges that should be adhered to by all hospitals.
- ✓ To provide technical guidance that can be used for training and development of relevant staff particularly the liaison officers.
- ✓ To provide guidance for managers on the monitoring and evaluation of the admission and discharge process.
- ✓ To ensure elective admissions are prioritized and affected on the strict basis of clinical need.
- ✓ To support the improvement of bed management in hospitals

Roles and Responsibilities

For the purposes of these protocols all hospital staff are obliged to abide by these protocols.

Hospital SMTs

- ☞ Ensure that there is facility - wide communication and awareness of the discharge protocols.
- ☞ Using national protocols and principles, develop tailored protocols for the hospital
- ☞ Establish a team or broaden the scope and membership of an appropriate existing team to develop and drive the implementation of the protocols within the hospital.
- ☞ Ensure training is given to relevant staff.
- ☞ Avail necessary inputs for implementation.
- ☞ Carryout periodic monitoring and evaluation of the proper application of the discharge Protocols.
- ☞ Ensure that discharges are carried out seven days a week.
- ☞ Receive and review regular reports on bed occupancy and bed management improvement processes.

Medical Directors

- ☞ Champion the implementation of the discharge Protocols.

- ☞ Discuss discharge protocols with doctors in the “morning sessions”.
- ☞ Ensure that all those discharging patients are thoroughly familiar with the protocols.
- ☞ Review and discuss monitoring and evaluation reports with the Hospital liaison service and make recommendations for improvement

Liaison officers

- ☞ Maintain good communications with inpatient case teams and the wards.
- ☞ In collaboration with ward staff, play a leading role in the co-ordination of discharges.
- ☞ Ensure regular bed census is carried out, reported and used to update and manage the bed resources.
- ☞ Ensure that an estimated length of stay, where possible, is placed in the patients notes.
- ☞ Oversee the overall discharge process.
- ☞ Facilitate communication between medical, nursing, and allied health teams.
- ☞ Ensure the discharge plan is tailored to the patient’s specific needs and circumstances

Ward Nurses

- ☞ Assess the patient and prepare the nursing Care Plan, discharge planning and relevant others, and place in the patient medical record within 24 hours of admission.
- ☞ Follow the guidance set out for discharges.
- ☞ Maintain good communication with the Liaison Office particularly in relation to pending and actual discharges, and bed status reports.
- ☞ Conduct patient education on medications, wound care, diet, and activities.
- ☞ Prepare patients and families for post-discharge care.
- ☞ Communicate discharge instructions clearly and ensure patient understanding.
- ☞ Complete and document the discharge teaching process.

Discharging Physicians

- ☞ Adhere to the hospitals’ discharge protocols.
- ☞ Wherever possible do ward rounds early in the day and discharge early in the day.
- ☞ Approve the discharge, ensuring medical stability.
- ☞ Finalize and sign the discharge summary.
- ☞ Provide any necessary post-discharge follow-up recommendations

Clinical Pharmacists

- Perform medication reconciliation before discharge.
- Educate patients on new or modified medication regimens

Patients and Families:

- Actively participate in discharge planning.
- Ensure understanding of medications, treatments, and follow-up requirements.

Principles

The core principles for effective discharge planning provide that:

- A patient's use of a hospital bed and their discharge should be planned before their admission, where possible.
- The estimated date of discharge should be documented and communicated to the patient and relevant personnel within 24 hours of admission.
- Discharge should be "streamlined" e.g. prescriptions and letter should be completed in a timely manner; transport booked and test results made available promptly.
- Patients who were seriously ill should be regularly discussed by the MDT to facilitate timely discharge.

Process

- The decision for discharge should be made by a physician who should complete a discharge summary for the patient.
- A copy of the discharge summary containing medical history should be given to the patient and a second copy filed in the Medical Record.
- If a patient was referred from another facility the discharging physician should also complete the feedback section of the referral form.

The processes required for effective discharge planning provide that:

- There should be an organization led commitment to manage all hospital beds.
- Resources such as a discharge coordinator should be available to ensure delays are minimized and extensive patient and family involvement in decision making processes.
- Referrals to physiotherapy, occupational therapy, and psychosocial support should be identified as early as possible to access aids and appliances as appropriate.
- Discharge documentation should be audited to ensure compliance with hospital protocols.

- ☞ Analysis of trends and data should be undertaken by the discharge coordinator/Liaison Officer and communicated to hospital senior management.
- ☞ Multidisciplinary teamwork is the key to success with discharge planning.
- ☞ A patient's discharge plan should be coordinated by a nominated member of the multidisciplinary case team.
- ☞ Appropriate bodies within the attending case team should be involved in the discharge planning process.
- ☞ Patients and their caregivers should be partners in the discharge planning process.
- ☞ Discharge planning should be continually updated and improved.
- ☞ Discharge case team should be established to identify and resolve bed management problems with the support of the hospital Senior Management Team.
- ☞ There should be early involvement of Pharmacy to increase compliance with medication.
- ☞ Patients (or parents, caregivers, surrogate, or guardians) should co-sign the patient's discharge letter ensuring that the discharge instructions have been clearly explained to them.
- ☞ An expected date of discharge should be set within 24 hours of admission or in many cases before admission for elective patients and communicated to the patient and all staff in contact with the patient.
- ☞ The expected date of discharge should be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes communicated to the patient.
- ☞ Ward rounds should be scheduled in a way that it allows a review at least daily of all patients by a senior clinical staff member.

❖ Inpatient case teams can make significant improvements by:

- Identifying anticipated length of stay and expected date of discharge on admission;
- Using a Discharge Predictor as a core tool for effective bed management;
- Providing an updated list of expected discharges on a shift basis;
- Discharging patients in the morning on the day of discharge, and;
- Discharging patients over the weekend and holidays.

Key Steps in Timely Discharge

- Expected date of discharge is identified early as part of patient's assessment within 24 hours of admission (or in pre-assessment for elective patients). It is based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge.
- The patient and caregiver are involved and informed about the clinical management plan and the expected date for discharge.
- In parallel, all the necessary arrangements are put in place to optimize the (simple) discharge including Discharge Summary, outpatient appointment, hospital sick leave completed, any medicines to be taken away, and patient transport arrangements confirmed.
- Daily review of the patient's condition and response to treatment will determine if the expected date of discharge needs to be revised.
- Review of planned/actual discharge date. Did it go according to plan? Complete audit on a regular basis

The Purpose and Timing of Ward Round Reviews

- The ward round is seen as the time when the main decisions about the patient's care are made including the decision to discharge the patient.
- This will work if ward rounds happen on a regular basis and patients are assessed daily. However, in reality ward rounds in many specialties happen only once or twice a week.
- **The ways to avoid delays due to the timing of ward rounds could include:**
  - Early identification of patients that could be discharged (before ward rounds or reviews) so that these patients can be seen first.
  - Regular senior reviews outside the ward round including the prescription of treatment to take outs on the day prior to discharge.
  - Progress monitoring and interpretation of test results.
  - Expansion of the scope of practice of nurses and Non-Physician Clinicians (NPCs) with the appropriate knowledge, skills and competencies to review the patient and initiate discharge including to the GP. In the absence of the GP, nurses and NPCs can also

complete the hospital sick certificate. This may be supported by agreed protocols, guidelines, or criteria documented within the patient record.

- Expanding the scope of practice of clinical pharmacists to include the review of medications and transcribing of TTOs

Discharge Process & Information Needs

- Regardless of how patient discharge is organized within individual units, the actual discharge process should create a climate in which patients and their caregivers understand their roles and responsibilities in ongoing care.
- This should promote confidence in the discharge of the patient.
- In general, avoidance of early discharge usually ensures that any essential discharge criteria are met.
- Preparation of specific discharge information should be collected and readied for each patient so discharge is as smooth and unrushed as possible.
- The communication skills of nurses in coordinating this process are therefore of utmost importance.
- With the possible exception of a diagnosis, none of the information provided during the discharge process should be new.
- Wherever possible, the patient's identified caregiver should be involved in all pre-discharge assessments and information given.
- Nursing staff must ensure that they assess both patients and caregiver understanding of their ongoing care responsibilities through structured questioning.
- **As a general guide, procedure specific information should encompass:**
  - Medication - specific instructions regarding prescribed analgesia, antiemetic or antibiotics.
  - Wound care & when patient is able to bathe or shower.
  - Arrangements for dressing renewal and suture removal (if appropriate)
  - Resuming normal activities.
  - What 'normal' symptoms may be expected and their duration.
  - What would be abnormal symptoms and what to do if they occur.
  - Contact telephone numbers for information or in an emergency.

- Arrangements for follow-up (telephone and out-patients).

Medical Determination for Discharge

- Every patient should be seen following their operation by the anesthetist and surgeon involved in their care.
- Assessment of when the patient is clinically stable or ready for discharge can and should be performed by the treating physician with the involvement of the nursing staff.
- Each Case Team needs to identify clear discharge criteria as part of a written policy for staff to follow.
- These need to consider social factors as well as a medical assessment of sufficient recovery for discharge.
- All guidelines should address the following areas; however, the list is not intended to be all-inclusive:
  - Vital signs must be stable and consistent with age and the clinical baseline correct orientation as to time, place and person.
  - Adequate pain maintenance and has supply of oral analgesia.
  - Understands how to use oral supplied analgesia and has been given written information about these.
  - Ability to dress and walk where appropriate.
  - Minimal nausea, vomiting or dizziness.
  - Has at least taken oral fluids.
  - Minimal bleeding or wound drainage.
  - Has passed urine (if appropriate).
  - Has a responsible adult to take them home.
  - Written and verbal instructions given about postoperative care.
  - Knows when to come back for follow up (if appropriate).
  - Emergency contact number supplied.
- If one or more of these set discharge criteria is not met, then a discharge must not be made until that criterion is fulfilled, documented, and a discharge approved by an appropriate staff member.

Sample Discharge Decision Checklist

		Yes	No	N/A
1.	Has a date of discharge been estimated and documented?	☐	☐	☐
2.	Has the patient been involved or informed?	☐	☐	☐
3.	Is the patient clinically stable and fit for discharge?	☐	☐	☐
4.	Has medications been dispensed and purpose, regime explained to patient?	☐	☐	☐
5.	Is the discharge summary and any other relevant information included for the receiving facility?	☐	☐	☐
6.	Outpatient appointments made and given to patient?	☐	☐	☐
7.	Patient given information about self-care and who to contact if symptoms return?	☐	☐	☐
8.	Has the patient been given a hospital sick certificate if required?	☐	☐	☐
9.	Has the patient settled all financial issues?	☐	☐	☐

	Criteria of discharge		Yes	No	Remark
1	PATIENTS UNDERSTAND	What was done to him/her in hospital?			
		What s/he taking now and in the future?			
		Reviewed medication list with patient and family and used teach back?			
		Arranged any home care needed?			
		Explained medications to patient and family morning, noon, evening and bedtime?			
		Has a date of discharge been estimated and documented?			
2	FAMILY SUPPORTS	If s/he needs family support and the family understand their role			
3	HEALTH EDUCATION	Elicited patient and family goals for hospital stay?			
		Danger sign			
		Nutrition advises			
		Educated the patient and family about the patient's condition at every opportunity?			
4	APPOINTMENTS AND CONTACT INFORMATION	Wrote down and gave appointments to the patient and family?			
		Wrote down and gave contact information for follow-up person after discharge?			

Deder General Hospital liaison Office Phone Number_____

Name of Discharge Nurse_____ SIGNATURE_____

Name of client support_____ PHONE _____

DEDER GENERAL HOSPITAL

Discharge planning protocol implementation and adherence monitoring Mechanisms

Instruction: put "**Yes**" if completed, "**No**" if not implemented and put "**NA**" if not applicable to the patients

SN	Discharge planning protocol adherence monitoring checklist	Verification Criteria	MRN	MRN	MRN	MRN	MRN	MRN	MRN	MRN		
1	Patient Discharge planning format filled and attached in to patient chart	Chart reviewed										
2	Patient received all essential orientation about discharge he/she need during current hospital stay	Pt interview and document review										
3	Patient received all essential information on his/her clinical diagnosis and required care plan	Pt interview										
4	Patient clearly understand the name and essential features of his/her disease	Pt interview										
5	Patient clearly understand the treatment option and plan he/she will receive in current care process	Pt interview $										
6	Patient clearly understand life style modification needed in current or future management of his/her disease condition	Pt interview and document review										
7	Patient clearly understand the expected duration of stay and outcome of his/her current admission and treatment course	Pt interview $ document review										
8	Patient clearly understand the required follow up scheme and parameters after discharge	Pt interview $ document review										
9	Patient clearly understand the importance of adherence to medication and life style modification for effective management of his/her disease	document review										
10	Patient consistently Involved in care plan, intervention, expected discharge planning, estimated cost, and expected outcome	Pt interview										