Recommendations for Discharge Planning in Community Health

By

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Abstract

 Background: Patients with similar demographics and diagnoses spend varying amounts of time on community health nursing (CHN) caseloads at the discretion of individual nurses. CHNs operate with a high level of autonomy, however there are no existing guidelines related to discharging patients from community-based nursing care. The purpose of this practicum was to explore discharge planning (DP) in community health and make recommendations.

Methods: An integrative literature review, key informant consultations, and chart reviews of surgical patients were conducted.

Results: There was clear research evidence that DP supported by guidelines and tools can positively affect patient outcomes in a hospital setting. However, no similar studies evaluated DP in a community health context. Chart reviews revealed most surgical patients (23 – 64% depending on surgery type) were discharged after staple removal; this was considered a routine discharge. There was an average of 5-14 extra service days if the patient had a medical complication, while 24-54% of patients with no medical complications received an extra 1 - 4.3 service days with no documented explanation. Key informants stated that DP tools would be beneficial in standardizing discharge, reducing discharge variability, and supporting nurses' assessment skills.

Implications: A report of my findings and a list of discharge planning recommendations will be presented to the Community Health Nursing Program along with a sample DP checklist for frontline CHNs and a chart audit tool for community health managers.

Key words: community health nursing, discharge planning, community health decision-making, discharge planning tools, discharge guidelines.

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Community health nursing is a rapidly expanding field of the primary healthcare

sector. In recent years, nursing services have been diverted to the community as a result

of an ageing population, development of portable nursing technologies, and the budgetary

constraints of frequent hospitalization (Grypma, Wolfs, & Reimer-Kirkham, 2012). The

increased flow of older, high acuity patients has resulted in larger, more complex nursing

caseloads in the community, ranging from post-operative care to chronic disease

management and palliation (Eastern Health, 2014). However, there is one process

frequently conducted in hospital settings that has yet to take root in community health

nursing: the practice of discharge planning. In hospitals, patient care and discharge from

services is guided by evidence-based care plans and standard discharge planning tools

(Pellett, 2016). In community settings, no such guidelines or tools exist and the discharge

process is at the discretion of individual community health nurses (CHNs). Thus, this

practicum project was dedicated to exploring discharge planning in a community health

context with the overall goal of producing a report of key findings and recommendations

for Eastern Health's Home and Community Care Program.

This practicum report begins with an overview of the goals and objectives of the

project and an overview of the methods undertaken, followed by a discussion of the key

findings from the literature review, consultations, and patient chart reviews. It concludes

with a discussion of the findings and discharge recommendations presented in a report to

the Home and Community Care Program.

Background and Rationale

Unlike nurses working in structured institutional environments such as hospitals,

CHNs work autonomously in the field, have little physician contact, and are the primary

decision-makers in care delivery (Ellenbecker, Samia, Cushman, & Alster, 2008). Their responsibilities include post-operative assessments, nursing interventions such as wound care, teaching and support, and determining when patients are ready to be discharged from services (Eastern Health, 2014). Given that there is little direct oversight of their clinical practice, CHNs are especially reliant on available evidence-based policy and practice guidelines to support competent and safe nursing care.

Within the Home and Community Care program in Eastern Health, there is a substantial lack of policies and clinical practice guidelines for discharging patients from service. While standardized policy and treatment guidelines inform other facets of community health nursing, discharge practices remain at the complete discretion of individual nurses. Recently, managers and frontline staff have observed considerable variation in the length of time patients spend on nursing caseloads. Patients with similar diagnoses may be followed anywhere from days to months at the discretion of an individual nurse. Since nursing practice in community health is primarily autonomous without direct supervision, the service discrepancy between CHNs remains unexplained and unexplored. Such variation poses important questions regarding the basis for care decisions made in Home and Community Care including whether some nurses are discharging patients prematurely, whether they are waiting beyond what is reasonably necessary to discharge, and whether different criteria are being used to determine readiness for discharge. Without guidelines, the root cause of inconsistent discharge practices is unclear as well as the potential impacts on nurses and patients in community.

Goals and Objectives

The purpose of this practicum project was to develop a report of recommendations related to discharge from nursing services for Eastern Health's Home and Community Care Program. The specific objectives of the practicum were to:

1. Learn more about length of stay/discharge guidelines;

2. Describe decision making factors surrounding discharge from community health nursing services from the perspective of frontline nurses, team leaders, and program managers;

3. Describe current discharging practices of community health nurses (CHNs);

4. Demonstrate the competencies of advanced nursing practice as outlined by the Canadian Nurses Association (2008); and

5. Develop a report of findings for the Home and Community Care Program.

Methods

Three primary methods were used throughout the practicum project: a literature review, consultations with key informants, and surgical patient chart reviews. The literature review and literature summary tables are included in Appendix I, the consultation report is included in Appendix II, and the chart review report is included in Appendix III. A detailed summary of each method is presented below.

Literature Summary

Methods

A comprehensive literature search was completed using CINAHL, PubMed, and Google Scholar. The search was conducted in two parts: identifying literature first on discharge planning from community health settings, then from hospital settings. Searches were limited to include reports published in English within the last 10 years (2008-2018).

Beginning with CINAHL then searching PubMed and Google Scholar respectively, the descriptors "community health nursing", "district nursing" and "home care" were used in combination with the following key search terms: "discharge", "discharge planning", "service duration", "care maps", "decision making", "autonomy", and "discharge-readiness". Abstracts incorporating these terms were retrieved and reviewed for inclusion or exclusion, and if included, the entire article was reviewed. For the second part of the search, the process was repeated using the descriptors "hospital" and "acute care" in combination with the same search terms. Relevant literature was then critically appraised using the Public Health Agency of Canada (PHAC) critical appraisal tool kit for quantitative research studies (2014) and the Joanna Briggs Institute checklist for qualitative research (2017). In all, two qualitative studies were identified on discharge planning in community health and nine studies (a systematic review, a meta-analysis, a randomized controlled trial, a literature review, and five qualitative studies) on different aspects of the discharge planning process in a hospital setting. The literature review was structured to present a comparison of hospital and community based discharge planning in the following six themes. The full literature review report can be found in Appendix I.

Definition and Goals of Discharge Planning

The purpose and goal of discharge planning in a hospital setting is generally acknowledged as supporting a smooth transition for the patient from hospital to home thereby preventing readmission to hospital post-discharge (Gonclaves-Bradley, Lannin, Clemson, Cameron, & Shepperd, 2016). Discharge planning aims to utilize comprehensive clinical assessment and support tools to mitigate patient vulnerability to adverse outcomes during the transition to home from a clinical setting (Ho, Kuluski, & Gill, 2014; Waring, Bishop, & Marshall, 2016). While no studies were identified that defined discharge planning in a community setting, information obtained from the website of the Home and Community Care program outlines goals similar to those identified in hospital settings. The website states CHNs in community aim to provide patients with sufficient skill and knowledge to become independent with their own care after discharge, preventing readmission to hospital or to community health services (Eastern Health, 2014).

The Discharge Planning Process

The discharge planning process is often unique to each hospital or regional health authority, but includes comprehensive assessment and planning throughout patient admission. Standardized discharge tools and the work of discharge coordinators substantially facilitate this process. While healthcare providers may adapt discharge planning to suit individual patient needs, hospitals have policies, guidelines, and plans in place to streamline the process and prevent adverse events.

Planning for discharge from community was found to be an unstructured process. Although many components of discharge planning such as assessment, education, goal-

setting, and communication with patients and families overlap between the two settings, the informal nature of the process in community allows CHNs to tailor their approach based on clinical preferences and desired approach to patient care. While in hospitals there are standardized and validated clinical tools to guide the discharge process and reduce variability between nurses, no such documents were identified in the literature for CHNs. Rather, CHNs within the Home and Community Care program rely on personal experience and peer guidance when determining patient discharge readiness.

Discharge Planning Tools

In contrast to the hundreds of available hospital based discharge planning tools, no discharge planning tools pertaining to community health services were identified in the literature. While discharge tools are typically unique to individual hospitals or health authorities, they all primarily include common elements of discharge planning (e.g., assessment, goal setting, planning, coordination, and evaluation), and encompass evidence-based initiatives. The most common examples include discharge checklists, patient care plans, and flow diagrams. Each type of tool has strengths and limitations in the clinical setting, but when used in combination with each other as part of a comprehensive discharge process, they can streamline decision making, ensure comprehensive patient assessments were conducted prior to discharge, and help identify potential gaps in care before these gaps lead to adverse patient outcomes at home (Basoor, Doshi, Cotant, Saleh, Todorov, Choksi, & Halabi, 2013; Lees, 2013; Rinke & Driscoll, 2013).

Discharge Related Decision Making

In hospital settings, decision making related to discharge is substantially guided by clinical tools as previously described. However, in community settings, no such clinical tools exist; discharge related decisions are made by individual nurses based on personal experience and values. This decision making process was the subject of the two community health based qualitative studies (O'Connor, Moriarty, Madden-Baer, & Bowles, 2016; Stajduhar**,** Funk, Roberts, McLeod, Cloutier-Fisher, Wilkinson, & Purkis, 2010). Both O'Connor et al. and Stajduhar et al. found health care providers in community have their own methods of assessing readiness for discharge, and that nurses base decisions on many contextual factors such as patient capacity and nurse-patient relationships. Specific assessment areas CHNs considered important for discharge were: patient safety, having long term plans in place, reaching maximum self-care potential, the presence of a willing and able caregiver, specific patient attributes, patient needs and capacity, CHN relationship with patient and family, CHN workload and availability of resources, and finally CHN expertise and approach to care.

Effectiveness and Evaluation of Discharge Planning Practices

In a systematic review of the effectiveness of discharge planning in hospitals, Gonclaves-Bradley et al. (2016) found that a discharge plan individually tailored to patients probably reduces hospital length of stay and readmissions to hospital for elderly patients based on moderate quality evidence. Specifically, those participants who received discharge planning stayed in hospital an average of 0.73 days less than the control group, with the intervention group experiencing fewer unscheduled readmissions (221 per 1000 people) than the control (254 per 1000 people) at three months post-discharge. A

randomized controlled trial which evaluated the effectiveness of a specific, standardized discharge intervention led by nurses, indicated the presence of a structured discharge planning intervention is potentially effective at reducing hospital readmissions and increasing patient satisfaction. In this study, only 34% of the intervention group were readmitted post discharge compared to 65% of the control group; a statistically significant finding (Cajanding, 2017). As well, three qualitative studies on the importance of discharge planning reported that interviewees believed poor discharge planning can negatively impact patient health, satisfaction, and family life, even potentially result in patients returning to hospital (Ho et al., 2014; King, Gilmore-Bykovskyi, Roiland, Polnaszek, Bowers, & Kind, 2013; Vat, Common, Laizner, Borduas, & Maheu, 2015). Therefore, not only does the literature indicate discharge planning can be effective at reducing readmissions and increasing patient satisfaction, but poorly-conducted discharge planning may have adverse effects on patients and the healthcare system. As discharge planning in community health is not a formalized practice, no data are available on whether current practices are effective in producing positive patient outcomes.

Interventions to Enhance Discharge Planning

Although discharge practices in hospitals are guided by policy and decision making support tools, the complex nature of discharge planning can lead to missed steps, poor coordination, adverse events or inappropriate discharge (King et al., 2013). Several interventions have been suggested by researchers to improve the discharge planning process and promote positive patient outcomes. As previously described, having tools such as checklists, care plans, and flow diagrams in place can streamline discharge, provide guidance for those unfamiliar with discharge practices, and ensure information is

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not missed by healthcare providers (Ho et al., 2014; King et al., 2013; Vat et al., 2015). Waring et al. (2016) recommended increased collaboration and involvement by all invested stakeholders, including patients and family, in the discharge process, while Bauer, Fitzgerald, Haesler, and Manfrin (2009) reported that interviewees believed the discharge process can be improved by increasing communication between healthcare professionals and family members or caregivers specifically.

In a community health context, the primary recommendation to enhance discharge was the development of standardized discharge planning tools. While no specific recommendations were made regarding the design or content of such tools, O'Connor et al. and Stajduhar et al. emphasized the importance of allowing for flexibility within each tool as there is significant situational variability in community health nursing typically not experienced in acute care.

Summary of Findings from the Literature

For many decades, researchers and health professionals in North America have promoted discharge planning as the primary method of ensuring the patient's safe transition from hospital to home (Chin-Jung, Shih-Jung, Shou-Chuan, Cheng-Hsin, & Jin-Jin, 2012). Studies conducted in acute care settings indicate individualized discharge planning can have a positive effect on patient outcomes (e.g., reduced rehospitalisation, decreased length of stay in hospital, and increases in patient satisfaction), while reducing adverse events post-discharge such as medication errors, injuries, and worsening illness (Branowicki, Vessey, Graham, McCabe, Clapp, Blaine, & Jay, 2017; Cajanding, 2017; Gonclaves-Bradley et al., 2016). As the goals and process of CHN discharge are comparable to those of discharge planning in acute care, the benefits of having standard

discharge plans may apply to community health nursing programs as well. The natural direction in which to progress toward discharge planning in community health is the development of specialized tools and guidelines for CHNs (O'Connor et al., 2016). There is a substantial need for community-based discharge planning research, but until such research is conducted there are a number of resources available in hospital setting which can be built upon and adapted for community health purposes.

Consultations Summary

Methods

To further inform the development of discharge planning recommendations for CHNs in Eastern Health, a series of key informant interviews were conducted. The full consultation report is attached in Appendix II. Initially, emails were sent to potential participants from each of the six community health nursing zones in Eastern Health describing the project and the purpose of the interviews. Responses were received from, and interviews scheduled with, five frontline CHNs with experience in community health ranging from three to thirteen years (i.e., two junior nurses with three to four years of experience, and three senior nurses with 10-13 years of experience), one team leader with 20 years of experience, and one program manager with three years of experience in her current position. An attempt was made to arrange an interview with a hospital based discharge liaison nurse, however scheduling complications prevented the meeting.

Each interview took place in a one-on-one session in a quiet, private setting. At the request of participants, all but one of the interviews took place in person in the office of the participant, with the final interview conducted via telephone. Interviews were conducted over approximately thirty minutes using a semi-structured interview guide.

Broad interview questions were developed to guide the interviews along with additional probes based on participant responses. During the interviews, data were recorded by hand on a copy of the interview guide, with more detailed notes written directly after each interview. The notes were then typed, saved on a personal computer, and password protected to ensure participant confidentiality. There was no audio or video recording during interviews and no identifying information was recorded during note taking.

After all of the interviews were completed, the transcripts were analyzed question by question to identify common themes related to discharge from community health nursing services. The transcripts and analysis were shared with my practicum supervisor to verify emerging themes. Findings are presented in the following eight categories.

Defining Discharge Planning

Each of the five nurses interviewed identified discharge planning as a hospital based process that is not formally conducted in a community setting. Although planning and assessment are conducted by both hospital based nurses and community based nurses, no interviewee identified their actions as "discharge planning". The program manager and team leader also identified discharge planning as a hospital based initiative; however they further described the process as "planning for the termination of healthcare services and support". None of the interviewed CHNs could remember receiving education or orientation specifically related to discharge planning in the community setting.

The Discharge Planning Process

There was consensus that planning for discharge begins early and involves making a mental assessment of the patients' condition and capacity to determine what duration of services they will likely need. Two nurses stated that rather than a formal

assessment they "just know based on gut feeling" approximately how long clients will be on their caseload.

Key Assessments and Criteria for Discharge

When asked what factors would lead CHNs to determine whether a patient was ready for discharge, CHNs responded with five broad assessment areas: physical healing, patient safety, environmental safety, independence with care, and psychosocial needs. Probing questions were asked for each category in order to glean specific details surrounding the assessment process. For example, when asked broadly about assessment factors for discharge, interviewees were primarily concerned with the physical health of the patient, specifically, assessing whether wounds were healed and surgical hardware was removed. CHNs were asked to elaborate on what key questions would be posed to patients to determine discharge readiness, as these questions were used to inform the development of the discharge planning checklist included in the final report to Eastern Health.

Overall, participants described the importance of "reaching an optimum level of functioning" as an ultimate criterion they considered important for discharge. That is, patients have reached, or are on track to reach, the same level of functioning they had prior to hospital admission based on positive outcomes from the five assessment areas described above.

Patient and Nurse Attributes Affecting Decision-Making

Every interviewee also addressed the role of specific patient attributes in determining discharge readiness. CHNs described some patients as naturally highly capable people, requiring little support or teaching, while other patients are utterly

dependent on CHN services. Based on natural disposition, education level, societal

factors etcetera, some patients exhibit greater coping abilities, or have a better

understanding of medicine, all of which impact the level of CHN services required.

CHNs also discussed the effect of different types of nursing attributes in community.

Distinctions were made between "task oriented nurses" who are heavily focused on

physical health and healing and "holistic nurses" who spend more time completing

assessments outside of physical wellbeing.

Although interviewees were divided on the extent to which patient attributes and

nurse attributes affect discharge practices, there was a consensus between all participants

that these attributes are a highly influential factor in discharge decision making.

Nurse and Patient Relationships

All interviewees discussed the immense effect of nurse-patient relationships on

patient length of stay in community. The program manager stated she considers this factor

one of the strongest determinants of service duration in community health. Primarily,

interviewees spoke of the importance of establishing strong, trusting bonds with their

patients, emphasizing the importance of being seen as an accessible healthcare resource

and member of the community. However CHNs also described forging strong

relationships as "a careful balance", where strong bonds can foster the patients'

confidence in their own abilities leading to more rapid discharge, but they can also lead to

dependency in patients and unwillingness to let go on the part of nurses.

Workload and Resources

Many CHNs indicated workload would not affect their discharge planning as

"they always put patients' well-being over operational concerns like workload".

However, they noted high workloads would cause them to work faster and push themselves further indicating high workloads may have greater impact on nurse well-being than patient well-being. Two CHNs suggested high workloads do provide incentive to discharge patients as soon as possible.

Variations in Discharge Practices

Variation in nursing practice was observed by all participants to varying degrees with some disagreement on the extent to which variation affects patient care and interactions between nurses. Two interviewees indicated that variations are relatively subtle and not an issue among the nurses who work together within zones, while the other interviewees stated they observe huge discrepancies between CHNs that have the potential to negatively affect the patients and the program. Negative implications and problematic practices included confusion and conflicting expectations for patients, CHNs keeping patients on their caseload longer than necessary to inflate workloads, and the undermining of patients' confidence in nursing assessments.

Every interviewee agreed that there are benefits to reducing variation between nurses and that the community health nursing program is currently lacking, and would benefit from, concrete guidelines surrounding discharge practice.

Recommendations for Discharge Planning Tools

The creation of guidelines or policies surrounding discharge were supported by all nurses who stated they would "feel much more comfortable having something concrete to refer to" when conducting patient assessments. Two nurses stated guidelines would be useful in a litigious context as they would confirm the CHN conducted all proper

assessments before considering discharge. Two nurses also stated guidelines would be useful to present to managers during caseload reviews and chart audits.

Four interviewees recommended a general discharge planning checklist or flow sheet encompassing broad assessment areas. The other interviewees indicated tools would be more useful if broken down by patient diagnoses, or some other distinguishing factor. The program manager recommended the creation of multiple tools to ensure all CHNs are held accountable and critiqued using the same standards. She recommended a tool for nurses, a tool for workload reviews, and a tool for managers conducting chart audits. All interviewees agreed that a guideline would be most beneficial for casual nurses, novice nurses, and those orienting to community health.

Summary of Findings from the Consultations

Results of these consultations mirror the findings from the literature review in that all participants indicated discharge planning is not a formal practice in community health nursing, but rather a process highly dependent on patient assessments and the attributes of individual nurses. The CHNs, team leader, and program manager all linked the subjective discharge process with variability in discharge practices between nurses. There was consensus that variability in practice has the potential to negatively affect patients, workloads, and relationships between CHNs. Similar to findings from the literature review, discharge guidelines and workload reviews were suggested by interviewees as potential interventions for reducing variability in practice. Specifically, suggestions included the creation of discharge guidelines which are flexible and focused primarily on identifying patient assessments to be completed prior to discharge.

Chart Review Summary

Methods

In anticipation of conducting chart reviews, a referral identification tool was developed and emailed to support staff in each community health zone requesting they record the name, date, identification number, and diagnosis of incoming referrals from March 12th to April 13th, 2018. The purpose of the tool was to generate a list of pertinent referrals which would be used as a master list during the data collection period. The tool initially included four diagnoses (i.e., hip replacements, knee replacements, mastectomies, and bowel resections) however support staff reported only two referrals were received for bowel resections over the course of the referral collection period. As such, bowel resections were eliminated from the chart review process leaving three primary surgery types. A copy of the letter to support staff and the referral identification tool are included in Appendix III-A. This tool was reviewed and approved by my practicum supervisor Dr. Moralejo and the manager of each community health nursing zone prior to being sent to support staff. After April 13th, referral identification tools were collected from each community health zone and a master list of charts was developed.

Each referral on the master list was assigned an identification code to maintain patient confidentiality during data analysis. Codes indicated the zone in which the referral was received, but contained no confidential patient information. Each referral was reviewed in CRMS (Eastern Health's electronic charting system) to determine the patient's admission date, discharge date, diagnosis, and any complications outside of routine care (e.g., post-operative infections, need for home support etc.). Data were recorded on a copy of the chart review tool included in Appendix III-B, then were

transferred to an Excel spreadsheet for analysis. A trial review of seven charts, encompassing a variety of surgical types and service durations, was completed to determine whether or not the data collection tools required any changes prior to the principal chart review. During the trial, the data were well-captured by the tool and no changes were required to the methods of the chart review. Chart reviews were conducted in my office at the Portugal Cove CHN site.

Results from each of the three diagnoses (i.e., hip replacements, knee replacements, and mastectomies) were analyzed using simple descriptive statistics. I calculated the mean length of stay, the frequency of each complication, as well as a comparison of lengths of stay by patient characteristics and the occurrence of complications. A routine discharge was defined as a patient who underwent post-operative care at home and was discharged with no complications, while a non-routine discharge was defined as any patient who experienced post-operative complications (e.g., infection, delayed healing, poor pain management etc.) prior to discharge from community health. A list of potential complications is located in the chart review tool included in Appendix III-B. Further, patients without complications were considered eligible for discharge once sutures or staples were removed as this is the earliest possible discharge point.

Managerial approval for the chart review was granted by the Home and Continuing Care program. A completed Health Research Ethics Authority Screening Template, included in Appendix III-C, indicates this project did not require approval from the Health Research Ethics Board as it was a quality improvement project rather than research. While the aim of this phase of the practicum project was to gather data from

patient charts surrounding discharge, the nature of Eastern Health's electronic documentation guidelines in community health meant little descriptive information was available on each patient's circumstances and resources. Discharge notes were found to be brief, describing specific nursing care provided, but scarce details on the assessment and decision to discharge patients. Thus, the data analyses in this review focused on an examination of length of stay in relation to factors such as age, gender, surgery, and complications, all of which were explicitly charted. The results of the chart review are presented in the following three sections.

Knee Replacements

A total of 25 referrals were received for patients who underwent a total knee replacement. The average age for this group was 66 years (range: 45-87) and the average days spent on CHN caseloads was 12.8 (range: 6-32). Eleven of the patients were male (42%) and 14 were female (58%). The 25 charts were further categorized into three different types of discharge: group 1 patients received routine discharge with no follow up, group 2 patients received routine discharge with follow up, and group 3 patients had a complicated discharge (e.g., poor healing, post-operative infection etc.).

Patients in group 1 received an average of 11.3 days of service (range: 8-14), group 2 received 12.2 days (range: 6-15), and group 3 received 22.6 days (range: 17-32). While the increase in service days for group 3 is explained by the presence of complications, it was unclear why the patients in group two received extra follow up services compared to group 1. Groups 1 and 2 underwent similar routine discharges with no explicitly charted complications. As such it is unclear why follow up visits and phone calls were provided based on the information charted by CHNs.

Further data analysis revealed there was no age difference observed between groups 1 and 2 (66.3 years), although group 3 patients were an average of 4 years younger than those who experienced routine discharge (average 62.3 years). Given that the differences in age or gender between groups were minimal, it is unlikely there is an association between these factors and increased or decreased service duration. I was also unable to find any associations between length of stay and the frequency of patient teaching as very few charts (12% - 33%) made reference to whether patient teaching occurred. However it does appear that patient teaching was more likely to be documented in groups 2 (33%) and 3 (33%) versus group 1 (12%).

Hip Replacements

A total of 35 referrals were received for patients who underwent a total hip replacement. The average age for this group was 65 years (range: 47-80) and the average days spent on CHN caseloads was 9 (range: 2-22). Sixteen of the patients were male (46%) and 19 were female (54%). As with the patients who underwent knee replacements, the 35 charts were categorized into three different types of discharge: routine with no follow up, routine with follow up, and complicated.

Patients in group 1 received an average of 7.3 days of service (range: 2-11), group 2 received 11.6 days (range: 4-22), and group 3 received 12.5 days (range: 11-14). Again, while the increase in service days for group 3 is explained by the presence of complications, it was unclear why the patients in group two received extra follow up services compared to group 1, in this case an average of 4 extra service days. The information included in electronic patient notes was unable to explain the discrepancy.

Once again, there was minimal variation in age and gender between the three groups. There was also little evidence of patient teaching captured in the electronic notes; in fact, no patient teaching was charted for all four patients who had medical complications in group 3.

Mastectomies

A total of 13 referrals were received for patients who underwent a mastectomy in the data collection period. All (100%) patients were female, while the average age was 62 (range: 35-73), and the average service duration was 16.4 days (range: 3-32). As with knee and hip replacement patients, the 13 mastectomy patients were further categorized into three groups: routine discharge with no follow up, routine discharge with follow up, and complicated discharge.

Group 1 patients received an average of 16 days of service (range: 10 – 22), while group 2 patients received an average of 13 days (range: 3 – 20) and group 3 patients received an average of 24.3 days (range: 15 – 32). Interestingly, group 2 patients, who received follow up visits after their drains were removed, had a lower service duration average than group 1 patients who received no follow up after drain removal. While this is an unexpected finding, the variable nature of Jackson Pratt drain removal may explain the discrepancy. Unlike staple removal, which is ordered for a specific post-operative date, drain removal is contingent on a patient's drainage levels and is highly variable. It is likely the small sample of patients included in group 1 had drains left in longer due to increased drainage compared to the sample from group 2.

While a gender comparison is not warranted in this group, the average age of patients who had routine discharge (group 1: 58.3 years) was over 10 years younger than

those who experienced a complication (group 3: 68.7 years). This could indicate older

women are more likely to need increased community nursing services after a mastectomy.

Again, there was little record of patient teaching in the electronic notes with no patient

teaching reported for all three patients with medical complications.

Summary of Findings from the Patient Chart Reviews

While there were no major discrepancies identified throughout the chart review,

there were two key findings that impact the development of recommendations to Eastern

Health: the unexplained extension of services for patients with routine discharges, and the

lack of information charted in electronic nursing notes. First, although patients in group 2

underwent a similar routine discharge compared to patients in group 1 for knee and hip

replacements, they received a number of extra service days (range: 1 – 4 days) with no

explicitly charted reason. While it is unlikely managers or CHNs would consider this an

excessive use of services, it remains important to explore why these patients were kept on

CHN caseloads for follow up beyond the point of discharge eligibility. Second, a key

limitation of this chart review was the lack of information available in electronic patient

charts. Ideally, information about patients' living situations, capacity, medical history, or

any other non-medical contributing factors would be captured in the electronic charting

system. However, guidelines surrounding documentation in community health indicate

nurses can include or exclude any non-medical patient information at their discretion. It is

possible that changes to charting guidelines, or the addition of a standard discharge

charting tool, would better capture the patient's condition and help explain CHN

decisions regarding follow up care.

Report to the Home and Community Care Program

A report entitled "Recommendations for Discharge Planning in Community Health" (Appendix IV of this practicum report) was developed to be presented to the managers and CHNs of the Home and Community Care program. The report provides a short summary of each phase of the project including the methods and key findings of each stage, a list of recommendations for managers and CHNs related to discharge planning in community, a copy of a proposed discharge planning checklist for frontline nurses, and a revised chart audit tool for managers.

Recommendations

Based on the findings from the literature review, consultations, and patient chart reviews, the recommendations are divided into those for managers and those for nurses. For management:

1. Form a community discharge planning committee to review current policy and practices, determine the discharge related needs of nurses and clients through extended consultations and workshops, and spearhead program changes.

2. Introduce a general discharge planning tool for CHNs in the form of a checklist, guideline, or policy. A proposed discharge checklist is included in Appendix IV-A, and is discussed further on page 24.

3. Develop the CHNs' knowledge and skills related to discharge planning:

   3.1. Incorporate education on discharge planning and assessment into orientation sessions for nurses who are new to community health.

   3.2. Incorporate an assessment of discharge practices in annual workload reviews.

4. Assess discharge practices:

   4.1. Adapt the current managerial chart audit tool. A copy of the tool with
        proposed changes is included in Appendix IV-B and is discussed further on page
        25.

   4.2. Conduct a review of CRMS charting policies, with emphasis on the content of
        nursing notes, to avoid significant charting variations between nurses.

   4.3. Conduct further patient chart reviews over a period of approximately 6 months to
        inform the development of surgery-specific service guidelines which include
        average service duration, typical recovery milestones, most common
        complications experienced by clients, and surgery-specific discharge
        considerations.

For nurses:

1. Increase documentation surrounding the decision to discharge patients including any
   discharge-related assessments or concerns.

2. Incorporate a discharge planning tool into frontline nursing practice to promote
   positive patient outcomes.

3. Review discharge practices regularly and consult with colleagues when faced with a
   complicated client.

4. Discuss discharge planning expectations with colleagues and team leaders to ensure a
   similar standard of care is being provided.

Discharge Checklist

Using the findings from the literature review and the assessment categories outlines by CHNs throughout the consultations, a discharge checklist was developed. The checklist was designed to ask yes or no questions in five key areas of assessment: physical healing, patient safety, environmental safety, patient independence, and psychosocial needs. Answering yes to a question indicates discharge readiness, while answering no indicates follow up may be required prior to discharge. For example, a question in the psychosocial needs category asks whether the patient is coping well with their diagnosis and treatment. Answering no would indicate the patient may need a referral to counselling services or increased patient education, while answering yes indicates discharge readiness for this category. A copy of the checklist is included in Appendix IV-A.

The purpose of the checklist is to provide the community health team with a working example of a discharge planning tool and there are a number of options for its implementation. The tool can function as a discharge guide for complicated patient cases, as a discharge assessment guide for novice nurses, or as part of routine patient charting. The tool could also serve as a guide for the development of further discharge tools and educational modules on discharge planning. It will be important for the home and community care program to determine the most appropriate role for this discharge planning checklist and evaluate the tool's effectiveness in that role through frequent feedback and chart audits. Managers should assess whether the tool is being used in appropriate situations (e.g., for complex patients with multiple co-morbidities) and

whether CHNs are documenting the use and outcomes of the tool in the electronic

charting system (CRMS).

Chart Audit Tool

Along with the discharge checklist, the chart audit tool currently used by

managers of the Home and Community Care program was adapted to reflect the

recommendations in this project. A new section was added to the tool that includes

information on average service durations for the three diagnoses examined during the

patient chart reviews (knee replacements, hip replacements and mastectomies). The

purpose of including this information in the chart audit tool is to allow managers to

determine whether patients were discharged after an appropriate length of time, and

explore cases where patients received extended services. In the added section, managers

are also asked to assess whether electronic nursing notes adequately describe the rationale

behind extending patient services beyond expected discharge readiness. The overall

purpose of adapting the chart audit tool is to encourage managers to assess the discharge

practices of frontline nurses and familiarize themselves with appropriate discharge

practices. A copy of the tool with proposed changes is included in Appendix IV-B.

Dissemination

In addition to the report developed for the Home and Community Care program, a

presentation will be given to managers and frontline nurses in each community health

zone throughout Eastern Health. The purpose of the presentation is to provide an

overview of the project and key recommendations while encouraging discussion and

planning for the implementation of discharge planning initiatives.

As well, throughout the project I was unable to identify any community-based discharge planning resources across Canada. Therefore it is my intention to bring this project to the national Community Health Nurses of Canada conference and to submit an article to a key Canadian community health nursing journals, to initiate a discussion around the implications of discharge planning in community.

Advanced Nursing Practice Competencies

A primary objective of this practicum project was to meet the competencies of advanced nursing practice as outlined by the Canadian Nurses Association (CNA) (2008). The competencies are divided into four categories: clinical, research, leadership, and consultation and collaboration. This project focused primarily on the research and leadership competencies. It did not emphasize the consultation and collaboration or clinical categories.

Throughout this project, competency in research was demonstrated through the use of research methods and through the utilization of research findings in each stage. Although a research project was not completed, the consultations and chart reviews allowed me to use a number of research methods including designing data collection tools, collecting data in a variety of settings, analysing and interpreting data in the context of exploring an identified gap in practice, and contributing informative patient care statistics to the Home and Community Care program. The data from the early stages of the project were utilized to inform each subsequent step, i.e., the findings from the literature review were developed into questions for key informants and a data collection tool for patient chart reviews, while findings from the consultations and chart reviews were developed into a discharge checklist and chart audit tool. Overall, research from

each phase of the project was utilized in the development of a report of findings and recommendations for the Home and Community Care program. These research findings and avenues for further inquiry will be disseminated at the local, provincial, and potentially national level with the completion of the project.

The competency of leadership involves nurses in ANP positions acting as advocates and agents of change in their workplace (CNA, 2008). The topic of discharge planning in community health was chosen based on personal practice observations and the identification of a lack of discharge resources for CHNs, but has since developed into a discussion of the importance of evidence-based care and the culture of nursing care in community. The topic of discharge planning in community is a significantly understudied area of research and has required comprehensive assessment of the needs of frontline CHNs and the current organizational practices surrounding discharge decision-making. My work has highlighted several strengths, weaknesses, and key areas for change within the Home and Community Care program. The experience and skills I've gained throughout this project have contributed to my ability to lead the implementation of discharge planning initiatives in our local organization.

Conclusion

This project has explored key aspects of discharge planning in a community health context, an area of research that has received little attention to date from nursing researchers. In hospitals, discharge planning is a formalized concept supported by standardized guidelines and tools which promote evidence-based care and comprehensive patient discharge. In community, discharge planning is a non-existent concept. Although patients admitted to community health nursing programs undergo a similar process of

assessment, goal-setting, planning, coordinating and eventual discharge, there are no existing policies, tools, or guidelines to support CHN decision making practices surrounding discharge from services. My investigation into discharge planning revealed a number of qualitative studies that suggest the lack of a formalized discharge process could result in adverse effects for nurses and patients. Although more research is needed, the literature review emphasized the potential positive effects of discharge planning, which could be transferrable to a community setting.

In consultations with CHNs, there was a consensus that patients and nurses would benefit from further exploration into community-based discharge planning, and the development of discharge resources. This project utilized information from the literature, consultations, and patient charts to create examples of such resources with the intention of initiating a discussion about conscious, safe, discharge decision-making in community health. Using the information presented in this report, and beginning with the formation of a discharge planning committee, Home and Community Care program leaders can use the information and recommendations I have outlined to improve the discharge planning process and promote consistent, quality nursing care at home. I encourage CHNs, team leaders, and managers to collaborate, discuss the role of discharge planning in their workplace, and be active participants in the change process.

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Appendix I

Integrative Literature Review

A Literature Review of Discharge Planning in

Community Health Nursing Services

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Table of Contents

Community health nursing is a rapidly expanding field of the primary healthcare sector. In recent years, nursing services have been diverted to the community as a result of an ageing population, development of portable nursing technologies, and the budgetary constraints of frequent hospitalization (Grypma, Wolfs, & Reimer-Kirkham, 2012). The increased flow of older, high acuity patients has resulted in larger, more complex nursing caseloads in the community, ranging from post-operative care to chronic disease management and palliation (Eastern Health, 2014).

Unlike nurses working in structured institutional environments such as hospitals, community health nurses (CHNs) work autonomously in the field, have little physician contact, and are the primary decision-makers in care delivery (Ellenbecker, Samia, Cushman, & Alster, 2008). Their responsibilities include post-operative assessments, nursing interventions such as wound care, teaching and support, and determining when patients are ready to be discharged from services (Eastern Health, 2014). Given that there is little direct oversight of their clinical practice, CHNs are especially reliant on available evidence-based policy and practice guidelines to support competent and safe nursing care.

Within the Home and Community Care program in Eastern Health, there is a significant gap in policy and clinical practice guidelines for discharging patients from service. While standardized policy and treatment guidelines inform other facets of community health nursing, discharge practices remain at the complete discretion of individual nurses. Recently, managers and frontline staff have observed considerable variation in the length of time patients spend on nursing caseloads. Patients with similar diagnoses may be followed anywhere from days to months at the discretion of an individual nurse. Since nursing practice in community health is largely unsupervised and

autonomous, CHNs and managers have difficulty reconciling this discrepancy. Such variation poses important questions regarding the basis for care decisions made in Home and Community Care including whether some nurses are discharging patients prematurely, waiting beyond what is reasonably necessary to discharge, and whether different criteria are being used to determine readiness for discharge. Without guidelines, it is unclear whether the lack of consistency in discharge practices unduly impacts nurses and patients.

However, while researchers have significantly understudied discharge planning from the community, discharge planning in hospital settings is essentially a universally accepted concept. Researchers have extensively studied the effectiveness of discharge planning in hospital settings including guideline development, use, and their impact on patients, nurses, and the overall healthcare system. Thus, this literature review encompasses research from both hospital and community health settings to determine whether guidelines for discharge planning, or elements of the discharge planning process, may be beneficial in a community health context.

Search Methods and Findings

A comprehensive literature search was completed using CINAHL, PubMed, and Google Scholar. The search was conducted in two parts, identifying literature first on discharge planning from community health settings, then from hospital settings. Searches were limited to include publications made in English within the last 10 years (2008-2018).

Beginning with CINAHL then searching PubMed and Google Scholar respectively, the descriptors "community health nursing", "district nursing" and "home

care" were used in combination with the following key search terms: "discharge",

"discharge planning", "service duration", "care maps", "decision making", "autonomy",

and "discharge-readiness". Abstracts incorporating these terms were retrieved and

reviewed for inclusion or exclusion, and if included, the entire article was reviewed. For

the second part of the search, the process was repeated using the descriptors "hospital"

and "acute care" in combination with the same search terms. Relevant literature was then

critically appraised using the Public Health Agency of Canada (PHAC) critical appraisal

tool kit for quantitative research studies (2014) and the Joanna Briggs Institute checklist

for qualitative research (2017); literature summary tables included in Appendix A are

presented in bolded text once per section throughout the review.

The community health-based search yielded 300 results between all databases

with limits applied. However, when articles were retrieved and reviewed for relevancy,

the majority of articles discussed the process of discharge planning from hospitals in

relation to community health referrals rather than discharge from actual community

health services. Only two studies were identified relating to discharge from a community

services setting both of which are qualitative in design, using focus groups and interviews

for data collection (**O'Connor**, Moriarty, Madden-Baer, & Bowles, 2016; **Stajduhar** et

al., 2010). These studies were determined to be suitable for inclusion based on criteria

from the Joanna Briggs Institute checklist for qualitative research (2017). O'Connor et al.

(2016) identified factors home health clinicians consider when determining whether a

patient is ready to be discharged, while Stajduhar et al. (2010) explored the decision

making process surrounding allocation of CHN services (i.e., how many home visits a

patient will receive during what length of time).

The search conducted on discharge planning from hospital settings returned 5000 articles from CINAHL and PubMed and over 20,000 articles from Google Scholar after limits were applied. An additional search conducted in the Cochrane Library produced a systematic review of the effectiveness of discharge planning from hospital settings (**Gonclaves-Bradley**, Lannin, Clemson, Cameron, & Shepperd, 2016). This review summarized thirty randomized controlled trials on discharge planning effectiveness conducted prior to 2016. When appraised using the PHAC critical appraisal tool kit (2014), it was determined to be methodologically sound. Results from each database were screened for inclusion in light of adding to the review by Gonclaves-Bradley et al. (2016). Eight additional studies were included: a randomized controlled trial examining the effect of discharge planning on patient outcomes (**Cajanding**, 2017), a literature review focused on beneficial discharge practices for the elderly (**Bauer**, Fitzgerald, Haesler, & Manfrin, 2009), a meta-analysis detailing the effectiveness of post-discharge interventions on readmission rates (**Branowicki** et al., 2017) and five qualitative studies which examined specific elements of the discharge planning process. These descriptive studies focused on the process of discharge planning (**Pellett**, 2016), patient and liaison nurse perspectives of the discharge process (**Waring**, Bishop, & Marshall, 2016; **Vat**, Common, Laizner, Borduas, & Maheu, 2015), and barriers to effective discharge (**King** et al., 2013; **Ho**, Kuluski, & Gill, 2014). They were each critiqued using the Joanna Briggs Institute checklist for qualitative research (2017) and found to be suitable for inclusion. A detailed description of studies from both community and hospital settings is included throughout the body of this review.

Overall, there is a substantial body of high quality research dedicated to discharge planning from hospital settings. In comparison, discharge from community health nursing services has received little attention from researchers, providing only descriptive studies with no tested interventions. Therefore, the analysis of literature in this review is divided into the two categories of hospital based discharge and community based discharge, with comparison of the findings and themes present in each.

Definition and Goals of Discharge Planning

Hospital Setting

Numerous researchers have studied discharge planning in hospital settings over the past decade, and while authors may emphasize different facets of the process, discharge planning retains a relatively standard definition across studies. **Gonclaves-Bradley** et al. (2016) combined common elements from the studies included in their systematic review, stating that discharge planning involves creating "...an individualized plan for a patient prior to them leaving the hospital for home" (p. 6). Other common definitions emphasize the different steps of the discharge process including assessment, goal setting, planning, coordination, and evaluation of patient outcomes (**Vat** et al., 2015; **Waring** et al., 2016). Although subject to variation between authors, the purpose and goal of discharge planning is generally acknowledged as supporting a smooth transition for the patient from hospital to home thereby preventing readmission to hospital post-discharge (Gonclaves-Bradley et al., 2016). Discharge planning aims to utilize comprehensive clinical assessment and support tools to mitigate patient vulnerability to adverse outcomes during the transition to home from a clinical setting (**Ho** et al., 2014; Waring et al., 2016).

Community Setting

While discharge planning in hospital settings is a well-defined, well-researched concept, only two articles were found discussing discharge from community services. Both studies are qualitative and descriptive in design focusing on CHN decision making factors surrounding discharge (**O'Connor** et al., 2016), and factors influencing CHN's decision making around the need for service (**Stajduhar** et al., 2010). While both studies concluded that discharge from community health services is significantly under-researched and in need of further exploration, neither study included any specific goals or definitions for discharge planning in a community setting.

Similarly, the Home and Community Care program of Eastern Health does not define discharge planning nor does it list any specific purpose or goals for the discharge process. However, information obtained from the Eastern Health website (Eastern Health, 2014) and learned through personal experience as a nurse in Home and Community Care suggests that the overall program goal is to provide high quality care and promote patient independence through assessment, teaching, planning, and the setting of mutual-goals. Overall, much like the goals of hospital-based discharge planning, CHNs in community settings aim to provide patients with sufficient skill and knowledge to become independent with their own care after discharge, preventing readmission to hospital or to community health services.

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The Discharge Planning Process

</div>

Hospital Setting

The discharge planning process begins upon admission and continues throughout the duration of a hospital stay. It involves assessment of patient status and needs,

developing a plan for expected length of stay, providing support and education for patients and family, and arranging community services post-discharge (Chin-Jung et al., 2012). Multidisciplinary healthcare providers, including physicians, nurses, social workers, pharmacists, and occupational or physiotherapists, complete these steps at certain checkpoints throughout the patient's journey. The need for coordination across disciplines can make the discharge planning process quite complex. Several tools, guidelines, and programs have been published by regional health authorities to facilitate the process and support coordination. At the nursing level, these tools include discharge checklists, care maps or care plans, and flow diagrams which ensure evidence-based decision making and support outcomes suitable to individual patients (Chin-Jung et al.). Such tools are explored in greater depth in the next section of this review.

Organizing discharge services is typically within the scope of a nursing discharge coordinator or discharge liaison nurse, whose role is to assess patient needs from multiple perspectives and to coordinate post-discharge community resources accordingly (Santé Montréal, 2015). In Canada, liaison nurses are also responsible for gathering demographic information and completing assessment tools such as the Bounceback Probability Legend and the LACE Index Scoring, which predict the likelihood of patients being readmitted to hospital after discharge (**Vat** et al., 2015). Liaison nurses use these tools to gather information on patient health status, family support, co-morbidities etc. to determine whether the patient is at high risk for readmission, in which case they can be provided with increased home support services upon discharge. Essentially, liaison nurses act as the link between hospital and community services, ensuring that patients receive appropriate teaching and have adequate supports at home, supporting the overall goal of

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reducing readmission and promoting patient independence (Day, McCarthy, & Coffey, 2009).

The discharge planning process is often unique to each hospital or regional health authority, but includes comprehensive patient assessment and planning throughout patient admission. Available standardized discharge tools and the work of discharge coordinators substantially facilitate this process. While healthcare providers may adapt discharge planning to suit individual patient needs, hospitals have policies, guidelines, and plans in place to streamline the process and prevent adverse events.

Community Setting

Within the Eastern Health Home and Community Care program, CHNs throughout metro St. John's are assigned responsibility for a geographic district. All patients living in the district are screened for admission, assessed, cared for, and eventually discharged by a single CHN. Although CHNs within Home and Community Care frequently collaborate with each other for advice, the decision making power ultimately resides with the individual nurse. Unlike discharge planning in hospital settings, planning for discharge from community is an unstructured process. Although many components of discharge planning such as assessment, education, goal-setting, and communication with patients and families overlap between the two settings, the informal nature of the process in community allows CHNs to tailor their approach based on clinical preferences and desired approach to patient care.

While in hospitals there are standardized and validated clinical tools to guide the discharge process and reduce variability between nurses, no such documents were identified in the literature for CHNs. Rather, CHNs within the Home and Community

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Care program rely on personal experience and peer guidance when determining patient discharge readiness. This was described in the study by **Stajduhar** et al. (2010) where personal experience and the ideals of individual nurses were found to be important contributing factors in decision making. Nurses interviewed for this research spoke of assessing patients' physical functioning, emotional and cognitive needs, caregiver needs, and patient capacity while deciding how to allocate services. The authors noted that each nurse described slightly different assessment criteria, ranging from available family support to financial capacity, and made clinical decisions based on their interpretation of the assessment. Thus, a successful informal discharge planning process hinges on the experience and decision making of individual nurses. The details of this process, and implications for CHNs were examined by **O'Connor** et al. (2016) and are explored in the discharge related decision making section of this review.

Although hospitals and the Home and Community Care program share similar goals related to discharge and patient care, the process by which patients are discharged is vastly different between the two settings. Hospitals rely on standardized discharge planning tools, discharge coordinators, and follow up services from community to ensure patient health and safety. In the community, this process is reliant on CHN decision making without any routine patient follow up after discharge. The following two sections of this literature review explore the discharge process in more detail by outlining existing discharge planning tools in hospitals and describing the factors contributing to CHN decision making processes.

Discharge Planning Tools

In contrast to the hundreds of available hospital based discharge planning tools, no discharge planning tools pertaining to community health services were identified in the literature. While discharge tools are typically unique to individual hospitals or health authorities, they all primarily include common elements of discharge planning (e.g., assessment, goal setting, planning, coordination, and evaluation), and encompass evidence-based initiatives. Although formats vary between locations, the most common examples include discharge checklists, patient care plans, and flow diagrams.

Checklists are frequently used during the discharge process as they are succinct, user-friendly, and easy to implement into patient care routines (Soong et al., 2013). Studies have shown they can positively impact the discharge planning process by improving quality of care and potentially reducing patient-readmissions (Basoor et al., 2013). Discharge checklists occur in two categories: those completed by healthcare providers and those completed by patients. Appendix B contains an example of a discharge checklist created for hip or knee replacement patients which is completed by nursing staff just prior to discharge. The purpose of this particular checklist is to ensure a successful transition from hospital to home by gathering information related to patient condition, required support, and scheduled follow up services. Specifically, this checklist includes information on the logistics of discharge (e.g., transportation, appropriate clothing for travelling home, family available to assist with transfer), management of the patient's medical condition (e.g., plan for dressing changes, prescriptions signed, discharge education completed), and follow-up paperwork required for hospital staff (e.g., referrals to community health, physiotherapy, information letter sent to family physician).

While discharge checklists may vary between institutions, this list is representative of the typical assessment areas. Amid the heightened activity of discharge planning and coordination, checklists for healthcare providers, such as the example in Appendix B, ensure vital aspects of discharge planning are not missed (Lees, 2013).

Alternatively, discharge checklists can be completed by patients, an example of which is included in Appendix C. This checklist is dedicated to gathering information patients will require after discharge (e.g., medications, recovery plan, support services) and, through reviewing the checklist with nursing staff, ensures patients have a comprehensive understanding of their post-operative treatment plan. Specifically, the checklist in Appendix C includes questions about the logistics of transferring home (e.g., will you have medical equipment at home?, will you have a family caregiver available?, will you require education from a social worker about coping with illness?), and knowledge required to manage their medical condition (e.g., what post-operative signs or symptoms should you look for at home?, what medications are you taking and what is their purpose?). This method of discharge planning is particularly effective at engaging patients in their own care and identifying potential self-care deficits prior to discharge. Once a deficit is identified by the patient (e.g., a patient is unsure of the purpose of a newly prescribed medication), they can review the checklist with their nurse and develop a plan to address the issue prior to discharge. However, while checklists are useful for ensuring key discharge information is not missed, the generic nature of the tool means further surgery-specific information may need to be assessed prior to discharge, which can be accomplished by referring to patient care plans.

Care plans, also referred to as patient care maps, are key discharge planning tools because they provide information specific to a patient's diagnosis and include information about typical recovery milestones. They are widely implemented in hospital settings and are effective in coordinating appropriate patient care (Lees, 2013). Using care plans, nurses can initiate different steps of the discharge planning process throughout the post-operative period. For example, the care plan for a total hip replacement included in Appendix D outlines what information should be gathered each day post-operative: on day one, nurses will discuss discharge needs with patients (e.g., equipment and services); day two is dedicated to arranging a discharge plan with outpatient services including occupational and physiotherapy, the services for which should be confirmed on days three to four. Finally, the patient is given the discharge instructions, post-operative exercise routines, and follow-up appointments on the day of discharge. Such care plans are user-friendly and allow nurses to assess whether patients are meeting typical recovery landmarks, thus determining whether increased support will be needed after discharge (d'Entrement, 2009).

Another widely used clinical tool is the flow diagram, which presents the typical path of care required to reach a designated outcome, in this case, patient discharge. These diagrams include each step in the discharge process, presenting important assessment questions and guiding healthcare professionals in decision making. They are favoured by healthcare professionals for their usability and utility (Jun, 2009) and are effective in streamlining patient care processes (Rinke & Driscoll, 2013). An example of a discharge planning flow diagram is presented in Appendix E. In this diagram, the discharge process begins by questioning whether the patients' needs can be met in a setting other than a

hospital. By answering yes or no to each subsequent option the healthcare provider is

guided to the appropriate discharge process for their patient (e.g., return home, return

home with enhanced support, or apply to a care facility). As a clinical tool, the flow

diagram is particularly useful for novice nurses or those undergoing orientation in new

environments as it allows practitioners to become familiar with evidence-based practices

in their work place without solely relying on personal experience or trial and error

(Dowding & Thompson, 2004).

While there are hundreds of different hospital-based discharge tools in use around

the world, the most common formats for such tools are checklists, care plans, and flow

diagrams. Typically, these tools are not part of a patient's permanent record, but rather act

as a guide for patients and practitioners throughout the discharge process, after which

they are discarded. Each type of tool has strengths and limitations in the clinical setting,

but when used in combination with each other as part of a comprehensive discharge

process, they can streamline decision making, ensure comprehensive patient assessments

were conducted prior to discharge, and help identify potential gaps in care before these

gaps lead to adverse patient outcomes at home.

Discharge Related Decision Making

In hospital settings, decision making related to discharge is substantially guided

by clinical tools as previously described. However, in community settings, no such

clinical tools exist; discharge related decisions are made by individual nurses based on

personal experience and values. This decision making process was the subject of the two

community health based qualitative studies included in this review (**O'Connor** et al.,

2016; **Stajduhar** et al., 2010).

In their study of decision making surrounding discharge, O'Connor et al. (2016) conducted a series of focus groups and semi-structured interviews with 32 home health professionals (e.g., nurses, nurse managers, physicians) in order to determine which factors they consider important to determine discharge readiness. Transcripts were analyzed using content analysis, manifest coding, and thematic analysis, and five key assessment areas emerged from the data.

The first assessment area, patient safety, was considered the paramount assessment before discharge can be considered. Clinicians spoke of assessing patients to ensure they had the capacity to get help during emergencies, that environmental hazards had been identified and removed, and that patients had caregivers or family to check on them periodically. The second area related to assessing whether patients had a long term plan in place, including connections to community health services such as meals-on-wheels, medical transportation, and social engagements. This was considered an important factor in preventing health decline and rehospitalisation. In the third area, clinicians noted they assess whether patients have reached their maximum self-care potential prior to discharge; that is, patients must be able to complete activities of daily living and successfully manage their chronic diseases without CHN intervention. This theme also included assessing whether the patient has reached the same level of function they exhibited prior to admission. The fourth assessment area prior to discharge is the presence of a willing and able caregiver. Study participants noted that in many circumstances patients may appear to have a family member available as a caregiver, but upon further inquiry the family member is unwilling or unable to commit the time and energy required. The final assessment area, patient attributes, was considered a significant

factor in determining when a patient should be discharged. Some patients heal quickly and demonstrate greater capacity to self-manage their care. These patients will not require as much support as others and may be considered for early discharge. Overall, these five assessment areas represent the key criteria community health professionals consider important prior to discharge from services.

In the second community based study, Stajduhar et al. (2010) examined decision making surrounding need for services in community health (e.g., how many visits or phone calls will patients require from CHNs). The authors first recorded narrative descriptions of decisions made during home visits from a group of 29 home care nurses. Findings from these descriptions informed subsequent semi-structured interviews with 27 home care nurses focusing on access to care and interactions with clients and families. Of the total sample, two nurses participated in both stages of data collection. Through thematic analysis and coding, Stajduhar et al. identified four broad factors which influence CHN decision making when determining the amount of services patients will receive. These factors were the assessment of client and family needs and capacity, CHN relationship with patient and family, CHN workload and availability of resources, and finally CHN expertise, practice ideals, and approach to care.

The first category, described as the key influence on decision making, was the assessment of client and family needs and capacity. These assessments are conducted through questioning, observation, and reading patient charts over multiple, repeated interactions with patients and family. Study participants described how they assessed physical, functional, emotional, and cognitive needs of patients, taking into account individual personalities, values, beliefs and wishes when making care decisions.

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However, the authors noted that while CHNs were able to explain these assessment strategies in detail, none of the participants could link the assessment outcomes with specific patient cares decisions. Each CHN interpreted patient need and capacity differently and as such, they each assigned different levels of care based on the outcomes of their assessment. There was no standardized approach to patient assessment and decision making among participants.

The second category, CHN relationship with patient and family, emphasizes the importance of building trust in the nurse-patient relationship. Participants described how, in instances where trustworthiness was established, patients were more likely to follow advice and contact the CHN with issues, thereby reducing the need for services. However, participants also discussed the negative impact of relationships on decision making, wherein nurses provide more services to patients they are close to and decrease services to those with whom they do not form a bond. Whether positive or negative, participants described the responsibility of CHNs to reflect on their connection to patients and make patient care decisions irrespective of the nature of the relationship. Building a trusting relationship with patients is vital to the decision making process, however, participants stated setting and maintaining professional boundaries within this relationship is key to successful patient care.

The third category was CHN workload and available nursing resources. Participants spoke of resource restraints within the healthcare system such as large workloads, lack of staffing, and excessive paperwork. Increased work and stress on CHNs influenced the type and duration of care provided. For example, nurses prioritized some patients over others based on characteristics such as severity of condition, determining

some patient care could be delayed by a day or two when workloads were high. That being said, participants noted that patient care was always a priority over office work and organizational duties.

The final category influencing decision making was CHN expertise, practice ideals, and approach to care. The authors described how each nurse participating in the study had unique practice experience and had different priorities when assigning patient care. These differences were highlighted in each judgement made by CHNs throughout the decision making process and there were substantial variations in how need, capacity, relationships, and resource considerations were balanced by each nurse. Some participants prioritized patient relationships, devoting more time and resources to home visits, while other CHNs focused on reducing family dependence, limiting visits to necessary nursing tasks. Again, it is unclear how expertise and judgement directly influence patient care decisions as each nurse will come to their own unique conclusion about patient need and capacity. In addition, organizational culture and assumptions also influenced decision making. For example, one participant described her subconscious assumption that a male patient's care needs would not be fully met by his son, but would be better met had he a daughter to assume the role, meaning more resources would be allocated to patients with sons rather than daughters. This example highlights the connection between patient care decisions and societal contexts. In order to mitigate the assumptions potentially influencing decision making, CHNs need to reflect on their values and practice, and ensure they are assessing patients' actual capacity and need for service.

In all, Stajduhar et al. elucidated key elements of the CHN decision making process through these four broad factors; however their findings were significantly contingent on the perceptions and experiences of the individual nurses. They highlighted the high degree of variability surrounding CHN decision making and suggested further research into the usefulness of decision making tools to guide appropriate access and patient care.

Both O'Connor et al. (2016) and Stajduhar et al. (2010) found health care providers in community have their own methods of assessing readiness for discharge, and that nurses base decisions on many contextual factors such as patient capacity and nurse-patient relationships. The information gathered by O'Connor et al. and Stajduhar et al. is useful foundational research as it provides insight into the practices and decision making skills of CHNs; a significantly understudied area of nursing research. A summary of the findings of O'Connor et al. and Stajduhar et al., including the implications for discharge planning tools and practices in community health, is included in Appendix F.

Effectiveness and Evaluation of Discharge Planning Practices

Hospital Setting

For many decades, researchers and health professionals in North America have promoted discharge planning as the primary method of ensuring the patient's safe transition from hospital to home (Chin-Jung et al., 2012). As such, a substantial amount of research has been dedicated to the impact and effectiveness of discharge planning in producing positive patient outcomes. However, because researchers often use differing outcome measures to evaluate the effectiveness of discharge planning, and because their studies have small effect sizes, comparing individual studies often produces contradicting

conclusions surrounding discharge planning. Thus, systematic reviews and meta-analyses are important in determining the effectiveness of discharge planning as they summarize studies using similar outcome measures and similar discharge practices.

Gonclaves-Bradley et al. (2016) recently conducted a Cochrane review of discharge planning effectiveness in which they summarized the findings of 30 randomized controlled trials. Using the criteria of the PHAC critical appraisal tool kit (2014), this review was determined to be methodologically sound and well-conducted. A strength of the review was the meticulous screening of literature; Gonclaves-Bradley et al. included only studies which focused on similar outcome measures (i.e., rates of hospital readmission and patient satisfaction) while ensuring each individual study tested a discharge planning intervention against standard discharge practices. They found that a discharge plan individually tailored to patients probably reduces hospital length of stay and readmissions to hospital for elderly patients based on moderate quality evidence. Specifically, those participants who received discharge planning stayed in hospital an average of 0.73 days less than the control group, with the intervention group experiencing fewer unscheduled readmissions (221 per 1000 people) than the control (254 per 1000 people) at three months post-discharge. As well, although the authors stated discharge planning potentially increases patient satisfaction, evidence to support this outcome was of low quality as individual studies measured patient satisfaction in different ways. Overall the findings of Gonclaves-Bradley et al. are indicative of discharge planning producing some positive outcomes for patients and the healthcare system.

Since this review was published, two additional studies have reported similar findings, a meta-analysis by **Branowicki** et al. (2017) and a randomized controlled trial

conducted by **Cajanding** (2017). Both articles were critiqued using the PHAC critical appraisal tool and were determined to be of strong methodology and design. Branowicki et al. evaluated the effectiveness of hospital-initiated post-discharge interventions (HiPDI) on reducing hospital readmissions. While Gonclaves-Bradley et al. (2016) focused on discharge planning as a total intervention, HiPDI is one aspect of discharge planning that encompasses the coordination of home visits and phone calls after discharge. Branowicki et al. analyzed 20 articles on HiPDI which followed a collective 7,952 hospitalized patients post-discharge over an average period of three months after discharge. In a pooled meta-analysis of all studies, exposure to HiPDI was associated with reductions in hospital readmission with an odds ratio of 0.8 (95% confidence interval, 0.7-0.9), a significant finding. To distinguish which discharge interventions were associated with the lowest likelihood of readmission, authors also calculated odds ratios individually for home visits, phone calls, discharge education, and combinations of interventions. Findings indicate that having two or more home visits (odds ratio [OR] 0.6; 95% confidence interval [CI]: 0.4–0.7), two or more phone calls (OR 0.7; 95% CI: 0.6–0.8), and exposure to discharge education (OR 0.7; 95% CI: 0.6–0.8) were all associated with reduced likelihood of readmission. However, exposure to multiple interventions was associated with the lowest likelihood of readmission with an odds ratio of 0.5 (95% CI: 0.4-0.7). The findings of Branowicki et al. are consistent with the work of Gonclaves-Bradley but provide more detail on which elements of discharge planning can be the most effective.

Similarly, the randomized controlled trial conducted by Cajanding evaluated the effectiveness of a specific, standardized discharge intervention led by nurses. Of the 143

study participants, 75 participants were randomly assigned to an intervention group in which they underwent a 3-day discharge planning program led by a nurse-practitioner. The program encompassed mini-lectures and discussions, problem-solving, goal setting, and action planning. The control group of 68 participants received routine discharge care. Outcome measures included patient satisfaction at baseline and discharge, and readmission rates one month post-discharge compared to the control group. Findings indicated a statistically significant improvement in patient satisfaction scores (control = 49.7, intervention = 48.7 on the short form patient satisfaction questionnaire), and significant reductions in readmission rates for the intervention group (34% of intervention group readmitted, 65% of control group readmitted within 30 days post-discharge). Congruent with the findings of Gonclaves-Bradley et al. and Branowicki et al., these results indicate the presence of a structured discharge planning intervention is potentially effective at reducing hospital readmissions and increasing patient satisfaction.

As these studies indicate, discharge planning is a beneficial process in that there is the potential for reduced readmissions, shortened hospital stays, and increased patient satisfaction. However, discharge planning interventions are often conducted improperly or not at all, leading to negative implications for patients and hospital staff. The implications of poor discharge planning were the subject of three qualitative descriptive studies conducted by **Ho** et al. (2014), **King** et al. (2013), and **Vat** et al. (2015).

Ho et al. (2014) analyzed surveys from 166 patients who had recently undergone discharge from hospital to determine what concerns patients with chronic illness have when being discharged. Findings indicated that patients had three overarching concerns with the discharge process: uncertainty in their care plan, friction between patient and

healthcare provider (e.g., physicians and nurses), and premature discharge. Participants reported that the consequences of improper discharge included loss of confidence in hospitals, adverse events at home such as falls, and increased burden on family members.

King et al. (2013) conducted semi-structured focus groups and individual interviews with 27 nurses in the community who regularly transition patients from hospital to home. The authors' intention was to determine how community-based nurses cope with the patient care transition from hospital, the barriers they face, and the outcomes of improper transition. After conducting three levels of coding on interview transcripts, authors concluded that poor communication between hospitals and community-based nurses was the primary barrier in providing a smooth transition for patients. Poor communication, particularly improperly completed referrals, was found to result in unnecessary delays in patient care (e.g., CHNs unable to give prescribed medication due to improperly signed physician orders), increased stress for staff and patients (e.g., CHNs being unaware of patients' medical history as proper report not provided by hospital), and increased risk of patient rehospitalisation. Study participants felt poor communication between hospital discharge staff and CHNs undermined their ability to provide safe, effective transitions of care to community.

Finally, Vat et al. (2015) interviewed eight patients who had been discharged from hospital only to report back to the emergency department within 14 days. As readmission rates are frequently used by researchers as an outcome measure of discharge planning effectiveness, the purpose of this study was to determine the patient's perspective on what went wrong during the discharge process that led them back to the emergency department. Findings indicated that the patients felt they were discharged too soon, they

felt weak at discharge, they did not have enough support at home, and that they received insufficient discharge instructions. Based on these findings, patients who do not receive proper consultation and support from their healthcare providers at discharge will potentially return to the emergency department or be readmitted to hospital.

All three of these studies indicate that poor discharge planning can negatively impact patient health, satisfaction, and family life, even potentially result in patients returning to hospital. Therefore, not only does the literature indicate discharge planning can be effective at reducing readmissions and increasing patient satisfaction, but poorly-conducted discharge planning may have adverse effects on patients and the healthcare system.

Community Setting

As discharge planning in community health is not a formalized practice, no data are available on whether current practices are effective in producing positive patient outcomes. However, some preliminary research supports the conclusion that a lack of readiness for discharge from community-based health services may result in adverse patient outcomes such as those experienced by patients improperly discharged from hospital settings. A retrospective observational study conducted by O'Connor et al. (2015) examined the association between length of stay in home health services, number of skilled nursing visits, and hospital readmission rates within 90 days of discharge from hospital. The authors gathered data from financial assessments and claims from patients hospitalized in 2009 and cross-referenced the data with home health claims. They conducted two separate analyses, the first on the correlation between length of stay in

home health services and subsequent hospital readmission rates, and the second on the correlation between the number of nursing visits received and hospital readmission rates. Length of stay in home health was divided into three categories: low receiving 0-21 days, medium receiving 22-41 days, and high receiving greater than 42 days of service. Results of data analysis indicated patients who had a medium length of stay were 11% less likely to be rehospitalised ($p<0.01$), and the group with a high length of stay 13% less likely to be rehospitalised ($p<0.01$) compared to those who had a low length of stay (i.e., less than 21 days of service). Similar analysis of the correlation between number of skilled home visits and rehospitalisation indicated that patients who received 4-6 visits were 61% less likely to be rehospitalised, and patients who received greater than 7 visits were 62% less likely to be rehospitalised, when compared to those patients who received 3 visits or less. While the exact number of days and visits should be further examined based on individual diagnoses, these findings indicate that receiving less than 21 days of home health services and less than three home visits by community health nurses could result in adverse outcomes leading to rehospitalisation. Although no other studies were identified which explored service duration in community health, it is possible that patients discharged prematurely from community health may be vulnerable to adverse health outcomes other than rehospitalisation, such as those experienced by patients discharged improperly from hospital settings.

This lack of information on discharge from community health services also highlights the issue of evaluation and oversight within community health programs. In hospital settings, annual statistics of readmission rates and surveys of patient satisfaction etc. determine whether there are gaps in discharge planning which leave patients

vulnerable post-discharge. Neither of the qualitative studies on discharge planning from community health indicated whether a current evaluation process exists for determining if successful discharge was achieved (**O'Connor** et al., 2016; **Stajduhar** et al., 2010). When patients are discharged from community health nursing, they are considered independent with their care and there is no subsequent communication to evaluate their status post-discharge. Within Eastern Health, community health nursing programs are not electronically linked to hospital systems, meaning it is not possible to gather post-discharge data such as emergency department visits or physician follow-ups. As such, there are currently no avenues for CHNs in Home and Continuing Care to evaluate their own practice, and adapt their care as they gain experience discharging patients. If improper discharge from community health has the potential to negatively impact patients by increasing the likelihood of readmission to hospital, CHNs need to be able to evaluate the care they provide and learn from decisions they made during the discharge process.

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Interventions to Enhance Discharge Planning

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Hospital Setting

Although discharge practices in hospitals are guided by policy and decision making support tools, the complex nature of discharge planning can lead to missed steps, poor coordination, adverse events or inappropriate discharge (**King** et al., 2013). Several interventions have been suggested by researchers to improve the discharge planning process and promote positive patient outcomes. In a descriptive study of barriers to effective discharge, **Pellett** (2016) conducted six focus groups with a total of 120 participants from community health nursing services in order to make recommendations for improving the discharge process. After thematic analysis of data, a key

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recommendation was the use of standardized discharge planning tools across disciplines to decrease variation in discharge practices and to enhance collaboration between healthcare providers. As previously described, having tools such as checklists, care plans, and flow diagrams in place can streamline discharge, provide guidance for those unfamiliar with discharge practices, and ensure information is not missed by healthcare providers. **Vat** et al. (2015), **Ho** et al., (2014), and King et al. (2013) also recommended implementing standard discharge planning tools, citing the importance of comprehensive assessment and consistent care.

Another recommendation for improving the discharge process is increased collaboration and involvement by all invested stakeholders, including patients and family. In a qualitative, descriptive study of healthcare professionals' and patients' perceived threats to safe discharge from hospital, **Waring** et al. (2016) conducted 213 semi-structured interviews with healthcare professionals involved in discharge planning and transitional care. They analyzed interview transcripts using a systems thinking approach to identify active and latent factors that threaten safe hospital discharge and the relationships between these factors. The authors identified three categories of commonly and consistently identified threats which were: direct patient harms (e.g., falls, infection, sores, medication-issues, and relapse), proximal contributing factors (e.g., completion of tests, patient assessments, care plans, follow-up care, and patient education), and finally distal or latent factors (e.g., discharge planning process, discharge timing, referral process, resource constraints, and organizational demands). In analyzing the relationship between each factor, they found that most of the perceived threats to discharge related to, or were the result of, poor communication and collaboration across disciplines. Based on

their findings, Waring et al. advocated for frequent and diverse discharge planning meetings with all invested stakeholders (e.g. physicians, nurses, physiotherapists, pharmacists etc.), and involving the patients and their families in decision making and planning to the greatest extent possible. Such meetings have already been integrated into the discharge process of some regional health authorities. For example, the National Health Service in Cornwall, UK abides by a best practice guideline for discharge planning meetings which encompasses instructions on how to arrange meetings, core criteria to be covered, and procedures for documentation and follow-up (Amukusana, 2015). The purpose of these meetings is to improve communication between all members of the patient's healthcare team and develop a plan agreed upon by all disciplines in collaboration with the patient and his or her family. Waring et al. recommended that regional health authorities adopt this type of discharge planning activity to promote communication, collaboration, and reduce threats to safe discharge.

Finally, a literature review focused on discharge planning practices for the elderly found that the discharge process can be improved by increasing communication between healthcare professionals and family members or caregivers specifically (**Bauer** et al., 2009). In this review, the authors identified 28 studies published in English since 1995 which focused on patient and caregiver experiences during discharge. The aim of the review was to determine which discharge practices were most beneficial for elderly patients. Findings indicated that comprehensive discharge planning can bridge the gap between hospital and community care for seniors and that the most effective forms of discharge planning address family inclusion and education. Since family members are likely to provide a significant portion of post-operative care at home, interventions which

include early and active involvement of family, as well as assessments of caregiver needs,

led to a better experience and greater coping skills in caregivers in the studies analyzed by

Bauer et al. They recommended discharge planning interventions make significant efforts

to improve communication between all members of the healthcare team, patients,

families, and community caregivers in order to produce the best patient outcomes for

seniors.

Each of these suggested interventions, standardized tools, discharge meetings, and

increased communication, are already well-established discharge planning practices.

However, not all institutions effectively implement the best options for discharge

planning. In order to ensure the most effective practices are in place, hospitals should

undergo regular reviews of their discharge planning process and determine whether the

tools in use enable the best patient outcomes (Holland & Hemann, 2011).

Community Setting

The majority of recommendations made for improving discharge planning

practices in acute care have not been discussed in the context of discharge from

community health nursing. No research is available on the potential benefits of discharge

planning meetings, increased collaboration with patients and families, and better

communication in the context of CHN discharge practices. However, the development of

standardized discharge planning tools, which were recommended for acute care settings

by **Pellett** (2016), **Vat** et al. (2015), **Ho** et al. (2014), and **King** et al. (2013), was also

recommended by both **O'Connor** et al. (2016) and **Stajduhar** et al. (2010) as a method

of improving discharge planning practices in the community. While no specific

recommendations were made regarding the design or content of such tools, O'Connor et

al. and Stajduhar et al. emphasized the importance of allowing for flexibility within each tool as there is significant situational variability in community health nursing typically not experienced in acute care. No such discharge planning tools have yet been developed, however O'Connor at al. stated they intend to expand on their research to develop clinical support guidelines for interdisciplinary members of community health teams. They plan on conducting a nationwide study to determine the factors that prevent and contribute to adverse events after discharge from community health services. Both O'Connor et al. and Stajduhar et al. recommended any future research on discharge from community health be inclusive of patient and caregiver perspectives along with clinical, functional, and socio-demographic factors involved in making patient care decisions.

Summary of Findings and Nursing Implications

The quantity and type of research identified in this review is extremely disparate between the two practice settings. Research on discharge planning from hospitals is generally quantitative in design, with a significant number of randomized controlled trials, systematic reviews and meta analyses conducted in the past 10 years. By comparison, discharge from community health has remained practically unstudied with only two qualitative descriptive studies available. Because of this, it is not possible to determine whether variation in discharge practices and a lack of discharge planning has an impact on patient outcomes based solely on research conducted in community health. However, studies conducted in acute care settings indicate individualized discharge planning can have a positive effect on patient outcomes (e.g., reduced rehospitalisation, decreased length of stay in hospital, and increases in patient satisfaction), while reducing adverse events post-discharge such as medication errors, injuries, and worsening illness

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(**Branowicki** et al., 2017; **Cajanding**, 2017; **Gonclaves-Bradley** et al., 2016). As the

goals and process of CHN discharge are comparable to those of discharge planning in

acute care, the benefits of having standard discharge plans may apply to community

health nursing programs as well.

The logical direction in which to progress toward discharge planning in

community health is the development of specialized tools and guidelines for CHNs

(**O'Connor** et al., 2016). In hospital settings, nurses have access to clinical decision

making tools and standardized programs when making discharge-related decisions. No

such tools exist in community health, and in this review, CHNs were found to rely

heavily on personal experience when making decisions (O'Connor et al.; **Stajduhar** et

al., 2010). As each CHN will possess different education and practice backgrounds,

relying on personal experience may lead to the type of service variation currently

experienced in the Home and Community Care program. This reliance on personal

experience is also concerning in the context of newly hired CHNs who lack such

experience in discharge related decision making. It is unclear how these novice nurses

ensure appropriate discharge has taken place as they have no standardized tools or

guidelines to refer to. Both O'Connor et al. (2016) and Stajduhar et al. (2010) make

recommendations for the development of such guidelines stating CHN decision making

processes should be conceptualized as a nursing skill requiring structural and educational

support. A summary of their findings, recommendations, and implications for nursing

practice surrounding discharge is included in appendix F.

However, before such guidelines and tools can be developed, there needs to be

substantial growth in the field of community health discharge planning research.

Inferences made in this review are based on data collected in acute care and applied to a community health setting. While O'Connor et al. (2016) and Stajduhar et al. (2010) provide excellent groundwork on which future research can build, it will be imperative that researchers create guidelines using accurate data from many different community health nursing programs. Researchers should begin by evaluating current discharge practices and determining whether gaps exist in discharge-related patient care. Following this, CHNs should be consulted on which tool format they would find most beneficial to their practice, whether it be checklists, specialized care maps, or decision-support tools like flow diagrams, as are the formats currently utilized in hospitals. Finally, tools will need to be evaluated for effectiveness in CHN practice settings. This review highlights the need for community-based discharge planning research, and indicates there are substantial resources available in hospital setting which can be built upon and adapted for community health purposes.

Conclusion

Discharge planning in hospital settings is an interdisciplinary process which involves the creation of an individualized plan for discharge from services. Encompassing assessment, goal setting, planning, coordinating and evaluation, reviews of the effectiveness of discharge planning indicate positive outcomes for both hospitals and patients, including reduced rehospitalisation and length of stay, and increased patient satisfaction. The process has been formalized by the creation of standardized tools, checklists, and guidelines which enforce evidence-based care and contribute to comprehensive patient discharge. However, in community health settings, discharge planning is a non-existent concept. Although patients admitted to community health

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nursing programs undergo a similar process of assessment, goal-setting, planning, coordinating and eventual discharge, there are no existing policies, tools, or guidelines to support CHN decision making practices surrounding discharge from services. In hospital settings, research indicates that in the absence of discharge planning, patients are vulnerable to adverse events such as medication errors, injuries, or worsening medical conditions leading to rehospitalisation. Although community based research in this area is lacking, patients who are discharged improperly from community health nursing may suffer similar adverse effects.

In Eastern Health's Home and Community Care program, significant variation has been observed in the discharge practices of individual CHNs. Research included in this review suggests standardized discharge guidelines may have a positive impact on reducing this variability by ensuring individual CHN practice is founded on similar principles of care. Further research into discharge practices in community health, and consultations with frontline CHNs in a variety of community health settings will be fundamental to the development of such guidelines. Although more research is needed, this review emphasized the potential positive effects of discharge planning in a community setting. Recommendations based on this literature review, and on future consultations with CHNs, will be presented to nursing leaders within the Home and Continuing Care program with the goal of initiating a dialogue about changes that can be made to enhance evidence-based decision making surrounding discharge from community health.

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Appendix A

Literature Summary Tables

Study	Methodology	Key Results	Conclusion and Rating
Author: Bauer et al. (2009) **Design:** Literature Review **Objective:** To examine the available evidence concerning hospital discharge practices for frail older people and their family caregivers and determine which practices are most beneficial for this group	A narrative literature review including 28 studies published in English between 1995 -2007. Included both qualitative and quantitative research studies. Studies reviewed for evidence of effectiveness of various discharge planning interventions.	Factors found to increase the effectiveness of discharge planning include: • Assessment of the family caregiver's involvement after care, what they need to carry out the role. • Active and early involvement of family caregivers in the process of discharge planning • Provision of adequate information during the discharge process • Effective communication between family carers and staff members • Effective interdisciplinary communication by health professionals as a basis for success • Access to ongoing support for both the patient and caregiver such as community health services, support groups and counseling.	**Rating** Quality: Medium **Limitations:** • Little description of data collection methods within article. • Unclear if further inclusion/exclusion limits placed on studies other than English and published within date range. • No clear critical analysis of included studies

Study	Methodology	Key Results	Conclusion and Rating
Author: Branowicki et al. (2017) **Design**: Meta-Analysis **Objective:** To assess the effectiveness of hospital-initiated post-discharge interventions (HiPDI) on reducing hospital readmissions	Systematic review of clinical trials published in English between 1990 and 2014. Twenty studies analysed. A total of 7952 participants were followed for a median of three months (range 1-24) after discharge for readmission. HiPDI defined as any intervention that was initiated before and continued after hospital discharge for the purpose of helping patients to mitigate disease burden and prevent hospital readmission. Interventions included follow-up phone calls and home visits. 85% of studies included multiple HiPDI.	Exposure to HiPDI was associated with a lower likelihood of readmission OR 0.8 (95% CI, 0.7-0.9). Patients receiving greater than 2 post-discharge home visits or greater than 2 follow up phone calls had the lowest likelihood of readmission OR 0.5 (95% CI 0.4-0.8). Combining multiple discharge interventions may be the most effective HiPDI to reduce hospital readmission.	**Rating** Strength: Strong Quality: High **Limitations:** • Patient diagnosis was accounted for as a variable between studies; however other factors may contribute to causes of readmission. • HiPDI Interventions differ between studies, meaning conclusions cannot be drawn about the most effective type of intervention for reducing readmission.

Study	Methodology	Key Results	Conclusion and Rating
Author: Cajanding (2017) **Design:** Randomized Controlled Trial **Objective:** To determine the effectiveness of a nurse-led structured discharge planning program on perceived functional status (PFS), cardiac self-efficacy (CSE), patient satisfaction (PS), and unexpected hospital revisits (UHR) among Filipino patients with AMI.	**Setting:** Cardiovascular unit at a tertiary care hospital in the Philippines. Control: n= 68 Intervention: n= 75 **Control** = standard care **Intervention =** 3 day structured discharge planning program implemented by a cardiovascular nurse practitioner, which was comprised of individual lecture discussion, provision of feedback, integrative problem solving, goal setting, and action planning. **Data Measurement Tools:** • Minnesota Living with Heart Failure Questionnaire (Likert Scale) • Cardiac Self-Efficacy Questionnaire (Likert Scale) • Short-Form Patient Satisfaction Questionnaire (Likert Scale) Data collected before and after intervention and at 1-month follow-up.	At baseline there were no statistically significant differences in: • Perceived functional status (PFS) (p= .15) • Cardiac self-efficacy (CSE) (p = .77) • Patient satisfaction scores (PSS) (p = .84). Mean difference between control and intervention groups: • PFS: 8.59 ± 2.29 (95% CI, 4.02–13.16; $P < .01$) • CSE: -5.61 ± 1.13 (95% CI, -7.87 to -3.36; $P < .01$), • PSS: -17.33 ± 2.73 (95% CI, -22.78 to 11.89; $P < .01$). Authors found a statistically significant difference in the frequency of UHR between the control and the intervention groups ($P <= .01$; 95% CI: odds ratio, 1.475–6.233; risk ratio, 1.229–2.367).	**Rating** Strength: Strong Quality: High **Strengths:** • Blinding observed throughout data collection. • Interventionists not included in data collection. **Limitations:** • Only short-term outcomes measured.

Study	Methodology	Key Results	Conclusion and Rating
Author: Goncalves-Bradley et al. (2016) **Design:** Systematic Review **Objective:** To assess the effectiveness of planning the discharge of individual patients moving from hospital.	This is the third update of the original review. Review comprised of 30 randomized control trials. Included studies must have a control group receiving standard care with no individualized discharge plan. Discharge interventions were defined as the development of an individualized discharge plan for a patient prior to them leaving hospital. Primary outcome measures: • Length of stay in hospital. • Readmission rate to hospital. Secondary outcomes included: • Complications related to initial admission • Place of discharge • Mortality rate • Patient satisfaction • Patient health status • Caregiver satisfaction • Healthcare costs Data collection completed using protocol from previous version of review. Risk bias of each article assessed using Cochrane risk of bias criteria and the Cochrane handbook.	Findings: • A small reduction in hospital length of stay for those allocated to discharge planning (Mean Difference [MD] 0.73, 95% CI 1.33-0.12, moderate certainty evidence) • Lower readmission rates in discharge planning groups at three months of discharge (RR 0.87, 95% CI 0.79-0.97, moderate certainty evidence) • Discharge planning may lead to increased satisfaction for patients and healthcare professionals (low certainty evidence). • All other outcomes were deemed "uncertain" based on evidence.	**Rating** Quality: High **Limitations:** • Few included studies addressed all outcomes. For example patient satisfaction was addressed in only 6/30 studies, where readmission was assessed in 12/30.

Study	Methodology	Key Results	Conclusion and Rating
Author: Ho et al. (2014) **Design:** Qualitative Study **Objective:** To identify the concerns of patients with chronic disease as they are discharged from hospital.	**Setting:** Bridgepoint Hospital in Toronto, Ontario. Total of 116 participants, 42% male, mean age 63 years, 89% Caucasian, average of 5 health conditions, average length of stay in hospital was 162 days. Data collection method was a researcher designed surveys with closed and open ended questions. Research question: "What are the issues and concerns complex chronic disease patients have about hospital discharge?" Data analysis completed in three steps (open coding, axial coding, and Final theme generation). Conducted by three reviewers independently.	Results broken down into three themes: Process: • Uncertainty in the care plan • Friction in the provider-patient relationship • Premature discharge Consequences: • Loss of comforts and security in the hospital • Care burden on family • Adverse events at home • Uprooting life Needs: • Home care supports • Accessible home • Management of daily activities. No demographic differences between age, sex, marital status, health conditions, and length of stay for all themes. A small number of patients reported no concerns; however these participants tended to be younger, had fewer health conditions, shorter stays in hospital and were more likely to have a partner.	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. Authors determined patients with complex disease processes have multiple concerns related to discharge practices. They recommend introduction of patient-centered care plans, increasing home and community supports, and introducing new models of care including system navigators and integrated care models. **Limitations:** • Secondary analysis of data.

Study	Methodology	Key Results	Conclusion and Rating
Author: King et al. (2013) **Design:** Qualitative **Objective:** To examine how skilled nursing facility nurses transition the care of individuals admitted from hospitals, the barriers they experience, and the outcomes associated with variation in the quality of transitions.	**Setting:** Conducted in five Wisconsin skilled nursing facilities. A qualitative study using grounded dimensional analysis, focus groups, and in-depth interviews. In-depth interviews conducted in focus groups or individually with a total of 27 RNs. These were audio taped and recorded verbatim. Constant comparison analysis throughout study. Analysis completed by multiple researchers in three phases: 1) open coding 2) axial coding and 3) selective coding.	Nurses were found to rely heavily on written hospital discharge information, which often includes issues with medication orders (including lack of opioid prescriptions for pain), little psychological or functional history, and inaccurate information regarding current health status. These inadequacies necessitated follow-up phone calls, clarified orders, care delays (including delays in pain control), increased staff stress, frustrated patients and family members, and increased risk of rehospitalisation. Authors conclude that poor-quality discharge communication is a major barrier to safe and effective transitions post-discharge. They recommend implementation of evidence-based interventions that support discharge and transitions of care.	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. **Limitations:** • Demographic data gathered on facilities, but not on participants. • No direct participant observation, retrospective data collected. • No data gathered from for profit facilities, only non-profit (which generally have higher nurse-to-patient ratios).

Study	Methodology	Key Results	Conclusion and Rating
Author: O'Connor et al. (2016) **Design:** Qualitative **Objective:** To explore what home health clinicians consider critical factors when determining discharge readiness among patient populations.	**Setting:** Home health care agency in the northeastern United States. **Participants:** 34 clinicians from multiple disciplines within the home health program: Registered nurses, Physiotherapists, occupational therapists, and Physicians. All participants had at least one year experience working in community health. Participants were divided into four focus groups, and two individual interviews. Focus groups were guided by researchers who asked the open ended-question "What are the clinical or non clinical factors you consider or believe to be important when you think about discharging an older adult from home health" (p. 271). Data analysis from transcripts and notes was completed using a naturalistic approach, first for manifest coding, then thematic analysis of all data.	Five themes were identified as influencing factors when discharging from home health: • Patient safety • Long-term planning • Reached maximum self-care potential • Presence of a willing and able caregiver • Patient attributes The authors intend to develop these five themes into clinical decision-support tools to provide a standardized approach in determining readiness for discharge.	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. **Strengths:** • Audit trails used during analysis process as well as research team debriefings. • Significant emphasis on, and description of, methods for ensuring rigour and trustworthiness of results. **Limitations:** • No explicitly followed research method. A combination of methods used, however authors attempted to compensate with detailed audit trails.

Study	Methodology	Key Results	Conclusion and Rating
Author: Pellett (2016) **Design:** Qualitative **Objective:** To identify barriers and challenges preventing effective discharge from hospital to home.	**Setting:** Queens Nursing Institute on behalf of the Department of Health in the UK. **Participants:** 200 participants in focus groups. 794 survey responses from community and hospital based nurses involved in discharge planning. Mixed-methods study, primarily presents qualitative research findings. A total of 10 focus groups were conducted with 20 participants each. Groups were multidisciplinary and included community nurses, managers, educators, discharge nurses, all with experience in managing hospital discharge. Two surveys were also conducted involving hospital and community nurses. Thematic analysis of focus group data and survey data conducted.	Barriers to discharge planning: • Lack of time to ensure discharge plan is appropriate and workable • Differing technology systems in hospitals and community providers • Poor communication between hospitals and community based-services • Hurried, ineffective discharges due to pressure to turn over beds in hospital • A lack of knowledge regarding medication management services in community, and no rehabilitation in hospital to ensure patients are independent with medications and self-care. • Seniors identified as most likely to suffer ill-effects of poor-discharge practices Enhancers of discharge planning: • Effective communication • Appropriate care packages • Multi-disciplinary team work.	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. Authors make the following recommendations: • Improved communication (including clear, precise discharge summaries) • Improved co-ordination of services (such as beginning discharge planning upon admission and ensuring appropriate services are in place prior to discharge). • Improved collaboration (Inviting patients and families to become involved in the discharge process). **Limitations:** • No physicians participated in focus groups. • No specific data presented on participant demographics. • Limited information on specific methods of data analysis.

Study	Methodology	Key Results	Conclusion and Rating
Author: Stajduhar et al. (2010) **Design:** Qualitative **Objective:** To explore and identify factors influencing home care nurses' decisions regarding services required at end of life.	**Setting**: Western Canadian Regional Health Authority. **Participants**: 56 total participants. 29 participants completed phase one and 27 participants completed phase two. All were registered nurses who have worked in home care for greater than one year. Qualitative study with ethnographic methodology Data collected in two phases. First phase included "Think Alouds" which were nurses giving narrative descriptions of visits made to palliative patients. Phase two included full semi-structured interviews with CHNs. Interviews were summarized individually, then underwent coding and thematic analysis which was compared to thematic findings of the "think alouds". Data analysis adhered to ethnographic procedures.	Factors found to affect decision making included: • nursing expertise • various approaches to care • individual nursing values • consideration for use of healthcare resources • assessments of patient and family capacity. A positive therapeutic relationship was deemed essential to facilitate trust building and determine client capacity. However, positive relationships may lead to an overstepping of professional boundaries, while negative relationships may influence the duration of services received when nurses perceive their services are not wanted.	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. Authors recommend access decisions should be conceptualized as part of clinical decision making, and skills involved in these decisions as a home care nurse competency requiring structural and educational support. **Strengths:** Clear efforts to increase rigour of research through use of validated tools and systematic data analysis.

Study	Methodology	Key Results	Conclusion and Rating
Author: Vat et al., (2015) **Design:** Qualitative **Objective:** To understand the patient's reasons for returning to the emergency department soon after their discharge from an internal medicine unit	**Setting:** Montreal, QC, Canada. **Participants**: Eight participants. Primarily women (6/8), aged 64-91, and living with chronic illnesses. **Inclusion criteria**: Participants had been discharged home from hospital and had returned to the emergency department within 14 days of discharge. Qualitative, descriptive study using semi-structured interviews lasting 25-60 minutes. Following each interview, researchers retrieved the participants risk assessment of returning to the ER which had been completed by a discharge liaison nurse prior to initial discharge. Interviews were transcribed and subjected to inductive thematic analysis. Interview data was compared to the information obtained from discharge liaison nurses throughout analysis.	Participants attributed their return to the emergency department to four reasons: • Being discharged too soon • Being too weak to go home at discharge • Having limited resources for help at home • Insufficient discharge instructions. Comparisons between liaison assessment of potential reasons for returning to the ER, and actual reasons identified by patients indicated many participants returned with exacerbated symptoms of their previous medical condition which was not predicted by discharge liaison. Based on results authors suggest 1) Assess patient readiness for going home prior to discharge 2) Evaluating potential risk of returning to the ER by asking patients about their needs and concerns 3) Addressing these in discharge planning practices for a safe return home.	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. These results indicate a need for greater patient involvement in the discharge process. The authors recommend standardized assessments which encompass patients' health status, autonomy, remission of symptoms, and the ability to manage their care. **Limitations:** • Small sample size. • 6/8 participants were women and primarily elderly. • Retrospective data.

Study	Methodology	Key Results	Conclusion and Rating
Authors: Waring, et al. (2016) **Design:** Qualitative **Objective:** To investigate the views of healthcare professionals and patients and their caregivers about threats to safe hospital discharge.	**Setting:** Study was conducted in the UK in two distinct health English healthcare systems. **Participants:** 213 participants comprised of 18 different roles within the medical system including physicians, nurses, patients, OT, PT, pharmacists, social workers etc. Data collected through semi-structured interviews with each participant. Interviews followed a narrative approach using a topic guide and patient safety scenarios. Analysis was aimed at elaborating on three categories 1) safety incidents 2) immediate proximal factors and 3) latent distal factors. These were then re-analysed for relationships between them. Specific analysis methods included close reading of data, coding, constant comparison, elaboration of emerging themes, and re-engaging with wider literature.	Safety issues included: • Falls • Medication-related incidents • Infection, sores/ulcers, and relapse of conditions. Proximal factors influencing these safety issues included: • Patient assessment • Completion of tests • Ordering and use of medications • Ordering and use of equipment, follow-ups and monitoring • Patient education. Distal factors included: • Discharge planning, • Referral processes • Discharge timing • Resource constraints • Organizational demands. The authors identified several assumed causal relationships and recommended these for further research and intervention (i.e. causal relationships between discharge safety and patient assessment/follow-up and monitoring).	Johanna Briggs Checklist (2017): Rated acceptable for inclusion. The authors recommend increasing involvement of all stakeholders throughout the discharge process, streamlining forms of communication between stakeholders, and that stakeholders share the responsibility of discharge rather than disperse elements of discharge among different settings. **Limitations:** - The authors mention the use of focus groups under the heading "data collection" but never refer to focus groups under data analysis or results. Unclear if focus groups were conducted.

Appendix B

Discharge Checklist for Hospital Staff

Pre Discharge & Discharge Checklist (Transfer of Care) NHS   HEART of ENGLAND NHS Foundation Trust

Please affix patient's label or fill in here	Social Worker's Name (If applicable):...........................
Name:	Tel. No of discharge destination: ....
PID:	Discharge Address:..........................
	Destination: Own home ○ Nursing home ○ Residential home ○ Intermediate Care ○ Other ○

Please commence completion 48 hours prior to discharge

Estimated date of discharge: ..../............./...................

Pre Discharge	Yes	No	N/A	Comments
• Medically fit for discharge (documented in the medical notes)	○	○	○	....
• Is intermediate Care arranged?	○	○	○	....
• MDT agreed and aware of discharge/transfer	○	○	○	....
• Equipment ordered	○	○	○	....
• Next of Kin/Carer informed of discharge	○	○	○	....
• Check access to: keys clothing and provisions	○	○	○	....
• Discharge discussed with Patient/Carer	○	○	○	....
• Referral to other agencies eg: District Nurse, Macmillian	○	○	○	....
• Home oxygen arranged?	○	○	○	....
• Blister pack medications arranged?	○	○	○	....

Appointments

Outpatient's appointments: Consultant follow-up ○ GP follow-up ○ No follow up ○

Other: ○ (Please comment e.g. Physio, Specialist Nurse, C.P.N.)_____

Sutures to be removed on: _____ (if applicable)

Transport Arrangments

• Type of transport arranged? Ambulance ○ 2 man lift required ○ Taxi ○ Relative/Friends ○

Other Please Specify: ....

	Yes	No	N/A
Does patient require an escort?* (If travelling alone and unsure of suitability please refer to Adult Safeguarding Policy)	○	○	○

At the point of discharge:	Yes	No	N/A	Comments
Venflon removed	○	○	○	....
TTO/Discharge Letter - printed at the point of discharge (3 copies for the patient, G.P. and notes)	○	○	○	....
TTO's Supplied, checked against the current inpatient prescription	○	○	○	Signature: ....
Discrepancies on TTO's are escalated to Dr. /Pharmacist	○	○	○	....
TTO's are discussed with the patient/carer explaining what medication are for, including any changes/side effects	○	○	○	....
Valuables/property returned	○	○	○	....
Dressings & equipment supplied (comments)....................	○	○	○	....
Care package arranged	○	○	○	....

Date of discharge: ....   Time of discharge: ....

Signature: ....   PRINT NAME: ....

Figure 1. Pre Discharge Check List, Public Domain. Reproduced from Heart of England, NHS foundation Trust, 2017. Retrieved from https://www.whatdotheyknow.com/request/283673/response/696221/attach/2/Discharge%20Practices%20Policy%20and%20Procedure%20v6.0.pdf

Appendix C

Discharge Checklist for Patients

Your Discharge Planning Checklist:

For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting

Name: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (a family member or friend who may be helping you) are important members of the planning team. You and your caregiver can use this checklist to prepare for your discharge.

Instructions:

- Use this checklist early and often during your stay.
- Talk to your doctor and the staff (like a discharge planner, social worker, or nurse) about the items on this checklist.
- Check the box next to each item when you and your caregiver complete it.
- Use the notes column to write down important information (like names and phone numbers).
- Skip any items that don't apply to you.

Action items	Notes
What's ahead?	
☐ Ask where you'll get care after you leave (after you're discharged). Do you have options (like home health care)? Be sure you tell the staff what you prefer.	
☐ If a caregiver will be helping you after discharge, write down their name and phone number.	
Your health	
☐ Ask the staff about your health condition and what you can do to help yourself get better.	
☐ Ask about problems to watch for and what to do about them. Write down a name and phone number of a person to call if you have problems.	

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Action items	Notes

☐ Use "My drug list" on page 5 to write down your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.

  ☐ Review the list with the staff.

  ☐ Tell the staff what drugs, vitamins, or supplements you took before you were admitted. Ask if you should still take these after you leave.

  ☐ Write down a name and phone number of a person to call if you have questions.

Recovery & support

☐ Ask if you'll need medical equipment (like a walker). Who will arrange for this? Write down a name and phone number of a person you can call if you have questions about equipment.

☐ Ask if you're ready to do the activities below. Circle the ones you need help with, and tell the staff:

- Bathing, dressing, using the bathroom, climbing stairs
- Cooking, food shopping, house cleaning, paying bills
- Getting to doctors' appointments, picking up prescription drugs

☐ Make sure you have support (like a caregiver) in place that can help you. See "Resources" on page 6 for more information.

☐ Ask the staff to show you and your caregiver any other tasks that require special skills (like changing a bandage or giving a shot). Then, show them you can do these tasks. Write down a name and phone number of a person you can call if you need help.

☐ Ask to speak to a social worker if you're concerned about how you and your family are coping with your illness. Write down information about support groups and other resources.

☐ Talk to a social worker or your health plan if you have questions about what your insurance will cover and how much you'll have to pay. Ask about possible ways to get help with your costs.

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Action items	Notes
☐ Ask for written discharge instructions (that you can read and understand) and a summary of your current health status. Bring this information and your completed "My drug list" to your follow-up appointments.	
☐ Use "My appointments" on page 5 to write down any appointments and tests you'll need in the next several weeks.	

For the caregiver

☐ Do you have any questions about the items on this checklist or on the discharge instructions? Write them down, and discuss them with the staff.	
☐ Can you give the patient the help he or she needs?	
☐ What tasks do you need help with?	
☐ Do you need any education or training?	
☐ Talk to the staff about getting the help you need before discharge.	
☐ Write down a name and phone number of a person you can call if you have questions.	
☐ Get prescriptions and any special diet instructions early, so you won't have to make extra trips after discharge.	

More information for people with Medicare

If you need help choosing a home health agency or nursing home:

- Talk to the staff.
- Visit **Medicare.gov** to compare the quality of home health agencies, nursing homes, dialysis facilities, and hospitals in your area.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users can call 1-877-486-2048.

If you think you're being asked to leave a hospital or other health care setting (discharged) too soon:
You may have the right to ask for a review of the discharge decision by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) before you leave. A BFCC-QIO is a type of quality improvement organization (a group of doctors and other health care experts under contract with Medicare) that reviews complaints and quality of care for people with Medicare. To get the phone number for your BFCC-QIO, visit **Medicare.gov/contacts**, or call **1-800-MEDICARE**. You can also ask the staff for this information. If you're in a hospital, the staff should give you a notice called "Important Message from Medicare," which contains information on your BFCC-QIO. If you don't get this notice, ask for it.

For more information on your right to appeal, visit **Medicare.gov/appeals**.

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My drug list

Filled out on: _____

Fill out this list with all prescription drugs, over-the-counter drugs, vitamins, and herbal supplements you take. Review this list with the staff.

If you have Medicare and limited income and resources, you may qualify for Extra Help to pay for your Medicare prescription drug coverage. For more information about Extra Help, visit **Medicare.gov**.

Drug name	What it does	Dose	How to take it	When to take it	Notes

My appointments

Appointments and tests	Date	Phone number

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Resources

The agencies listed here have information on community services, (like home-delivered meals and rides to appointments). You can also get help making long-term care decisions. Ask the staff in your health care setting for more information.

Area Agencies on Aging (AAAs) and Aging and Disability Resource Centers (ADRCs): Helps older adults, people with disabilities, and their caregivers. To find the AAA or ADRC in your area, visit the Eldercare Locator at **eldercare.gov**, or call 1-800-677-1116.

Medicare: Provides information and support to caregivers of people with Medicare. Visit **Medicare.gov**.

Long-Term Care (LTC) Ombudsman Program: Advocates for and promotes the rights of residents in LTC facilities. Visit **ltcombudsman.org**.

Senior Medicare Patrol (SMP) Programs: Works with seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error, and abuse. To find a local SMP program, visit **smpresource.org**.

Centers for Independent Living (CILs): Helps people with disabilities live independently. For a state-by-state directory of CILs, visit **ilru.org/html/publications/directory/index.html**.

State Technology Assistance Project: Has information on medical equipment and other assistive technology. Visit **resna.org**, or call 1-703-524-6686 to get the contact information in your state.

National Long-Term Care Clearinghouse: Provides information and resources to plan for your long-term care needs. Visit **longtermcare.gov**.

National Council on Aging: Provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Visit **benefitscheckup.org**.

State Health Insurance Assistance Programs (SHIPs): Offers counseling on health insurance and programs for people with limited income. Also helps with claims, billing, and appeals. Visit **shiptacenter.org**, or call 1-800-MEDICARE (1-800-633-4227) to get your SHIP's phone number. TTY users can call 1-877-486-2048.

Medicaid: Helps with medical costs for some people with limited income and resources. To find your local office, visit **Medicare.gov/contacts**, or call 1-800-MEDICARE.

CMS Product No. 11376
Revised February 2017

The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit **Medicare.gov**, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

"Your Discharge Planning Checklist" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit **CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html**, or call 1-800-MEDICARE for more information.

Figure 2. My Discharge Planning Checklist, Public Domain. Office of Disease Prevention and Health Promotion, 2017. Retrieved from https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf

HIP REPLACEMENT PATIENT CARE PLAN

	Day of Surgery	Day 1 Post-Op	Day 2 Post-Op	Days 3-4 Post-Op	Discharge Goals
Nutrition	⇒ Intravenous (IV) started for fluids & medications ⇒ Catheter may be inserted in bladder. Urine output monitored for 24 hrs ⇒ Diet as tolerated	⇒ Fluids taken as tolerated ⇒ Sit up for meals if able ⇒ IV as needed ⇒ Catheter removed ⇒ Start bowel routine ⇒ Go to bathroom by commode chair/walker with help	⇒ Sit up in chair for all meals ⇒ Discontinue IV if no nausea and no IV medications needed	⇒ Sit up in chair for all meals ⇒ Enema or suppository given if no bowel movement	⇒ Eating and bowel movements returning to normal
Hygiene	⇒ Assisted mouth & skin care as needed	⇒ Wash at sink or basin		⇒ Shower if able	⇒ Patient can manage personal hygiene without help
Wound	⇒ Dressing checked & changed or reinforced as needed	⇒ Wound checked daily ⇒ Dressing removed & wound redressed if draining	⇒ Dressing removed & wound redressed if draining	⇒ Incision exposed when wound is dry	⇒ Surgical wound is clean & dry, or wound care management arranged for home ⇒ Removal of staples or stitches arranged
Pain	⇒ IV or oral medications for pain control once spinal wears off ⇒ May have epidural (local anaesthetic)	⇒ IV or oral pain medication continued ⇒ Patient asks for pain medication when needed	⇒ Pain medication taken as needed & coordinated with activity or rehabilitation schedule	⇒ Pain control medication taken prior to exercise ⇒ Patient reviews home instructions for giving self anti-coagulant to help prevent blood clotting	⇒ Pain management discussed with & understood by patient ⇒ Required prescriptions provided to patient
Mobilization	⇒ Every hour when awake patient does: • Deep breathing & coughing • Foot & ankle exercises • Place pillow between legs to keep knees apart ⇒ Sit up on side of bed & stand with help ⇒ Walk if able & as requested by doctor	⇒ Deep breathing & coughing ⇒ Transfer to/from bed & chair with help ⇒ Sit up in chair for short periods ⇒ Walk using walker or crutches with help (not exceeding doctor-ordered weight limit on operated leg) ⇒ Begin daily rehab to increase range of motion in operated hip & exercises to strengthen operated leg & hip	⇒ Deep breathing & coughing ⇒ Increase frequency of transfers to/from bed & chair, & increase independence of transfers ⇒ Increase distance & frequency of walks & progress to crutches as able ⇒ Continue exercises (with therapist & independently) ⇒ Occupational therapy initiated as needed	⇒ Deep breathing & coughing ⇒ Progress to crutches as appropriate ⇒ Review procedure for going up & down stairs ⇒ Review home exercises ⇒ Continue to increase independent transfers to/from bed & chair, & walking to bathroom & in hallway as able ⇒ Attend physiotherapy session ⇒ Attend occupational therapy session to review tub transfers & dressing if needed	⇒ Patient is able to: • Transfer to/from bed & chair, & stand independently & safely • Walk 30 metres using walking aid without exceeding doctor-ordered weight limit on operated leg • Go up/down stairs safely • Perform home exercises & daily living activities safely (or has support in place at home for required activities) ⇒ Patient will be transferred to sub-acute facility if more rehab needed
Discharge Planning	⇒ Expected length of stay is 3-4 days ⇒ Planned day of discharge is written on bedside communication board	⇒ Patient discusses discharge needs (i.e. equipment, services) with care providers	⇒ Nurse, physio & occupational therapists confirm discharge plan & equipment in place ⇒ Resources contacted (i.e. sub-acute facility, Home Care, mobile lab)	⇒ Out-patient physiotherapy arranged if requested by surgeon (when new hip does not have enough flexion and/or thigh muscles significantly weak)	⇒ Patient is given & understands: • Discharge instructions • Required exercise routine • Follow-up appointment dates

Patient Pathway

	Day of Surgery	Day 1 Post-Op	Day 2 Post-Op	Day 3 Post-Op	Day of Discharge
Diet	Begin food & drink as tolerated	Sit up for meals if able			
Activity					
Treatment	As ordered by physician	Increase flexion in leg	Increase flexion	Increase flexion	Increase flexion
Medication	IV or pills for pain	IV or pills	Pills for pain as needed		
Discharge Planning		Discharge needs discussed			

Adapted from *Patient Care Guide for Total Hip Replacement.*

Figure 3. Hip Replacement Patient Care Plan, 2013. This image is public domain, reproduced from https://albertaboneandjoint.com/wp-content/uploads/2013/008/alberta_bone_and_joint_hip_replacement_care_plan.pdf
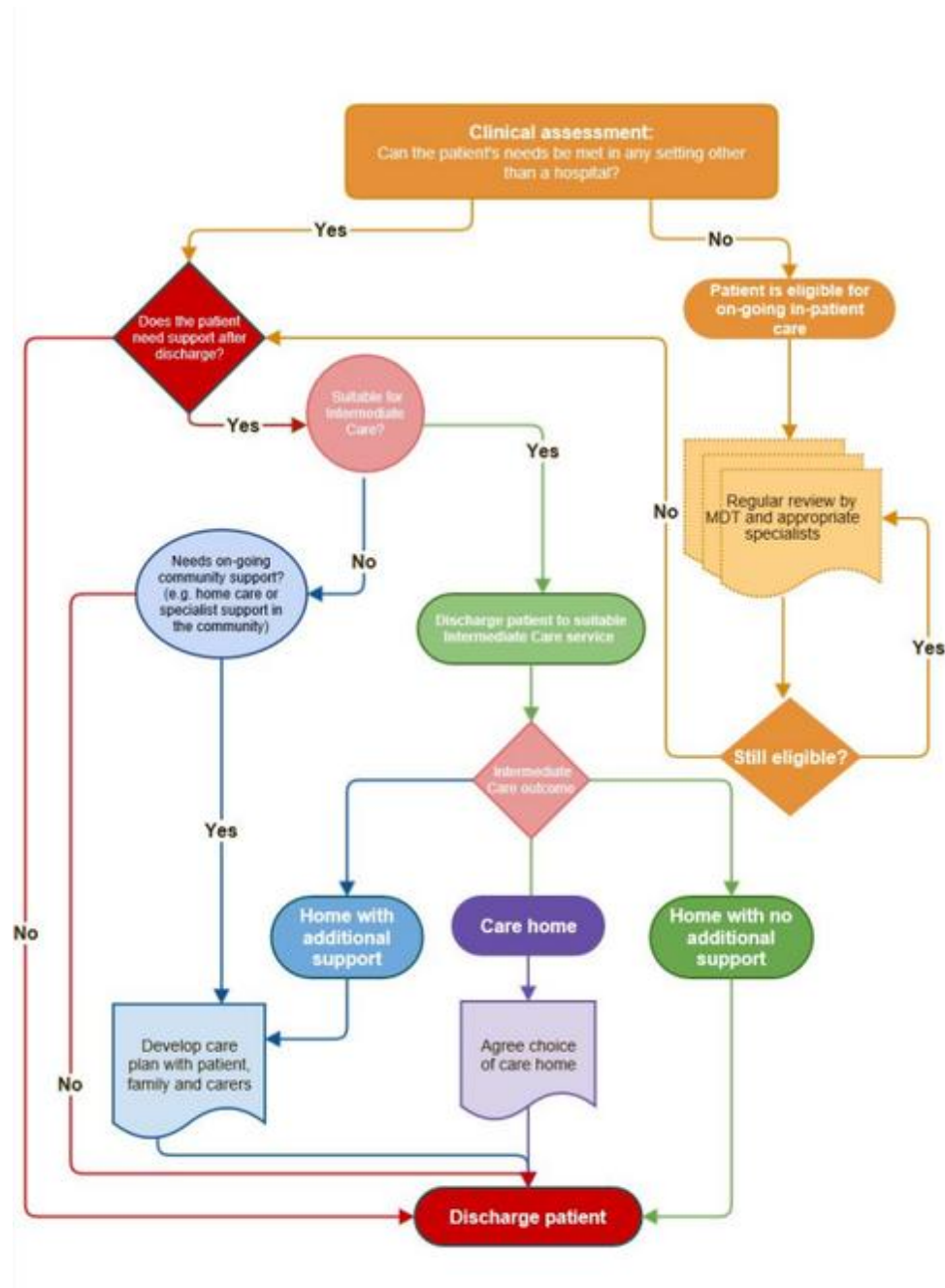
Appendix E

Discharge Flow Diagram

Figure 4. Discharge Planning Flowchart. This image is public domain, reproduced from the Scottish Government, 2015. Retrieved from http://www.gov.scot/Resource/0047/00479150.pdf.

Appendix F

Summary of Findings from O'Connor et al. (2016) and Stajduhar et al. (2010):
Factors Influencing Discharge from Community Health Nursing

Finding	Details	Implications
Patient safety	• Primary safety assessments included the patient's ability to leave the house in an emergency and whether they live alone (O'Connor et al., 2016). • A safety assessment should also include the physical environment. This could include checking for clutter, missing railings, loose steps or carpet, and making sure appropriate assistive equipment is in place (e.g., commode, grab bars, shower chair) (O'Connor et al., 2016; Sajduhar et al., 2010).	• Assess these criteria prior to patient discharge. • Incorporate into a discharge checklist for nurses. • If patients live alone or are unable to vacate the home in an emergency, they may require a referral to home support services. • If environmental hazards exist, send referral to occupational therapy prior to discharge. • Consider personal care home placement if uncertain about patient safety at home.
Having a long term plan for meeting patient needs	• Ensure patients have transportation to future medical appointments and have someone to check in on them periodically (O'Connor et al.). • Ensure patients have ability to meet needs on a daily basis (e.g., go grocery shopping, pick up prescriptions, and maintain personal hygiene) (O'Connor et al.). • Assess patient capacity and develop long term plan throughout duration of service (Sajduhar et al.).	• Assess these criteria prior to patient discharge. • Incorporate into discharge checklist for nurses. • Collaborate with patient and family to develop long term plan. • Refer patients to community support services like accessible transportation and grocery delivery services if necessary.
Patient has reached self-care potential	• When patients are able to take care of themselves, or if patients are no longer making progress and achieving goals they can be considered for discharge (O'Connor et al.). • Patients have reached their self care potential when they have achieved their pre-operative level of function, or when they have reached the highest level of functioning possible for their condition (O'Connor et al.).	• Assess these criteria prior to patient discharge. • Incorporate into a discharge checklist for nurses. • Confer with patients and family to compare level of function pre and post admission to hospital. • Refer patient to home support services if necessary. • Refer to specialist teaching services if necessary (e.g., ostomy care specialist).

Finding	Details	Implications
Presence of a willing and able caregiver	• Caregivers must have the willingness, capacity, and knowledge to manage patient care (O'Connor et al.; Stajduhar et al.). • Caregivers may include family members, friends, neighbors etc. (O'Connor et al.; Stajduhar et al.). • Demonstrations of capacity in caregivers include following a care plan, administering medications appropriately, giving input throughout the care process, and attending to their own daily needs (Stajduhar et al.).	• Assess these criteria prior to patient discharge. • Incorporate into a discharge checklist for nurses. • Arrange a meeting between nurse and caregiver to assess willingness, capacity and knowledge, rather than relying solely on patient testimony. • Refer patient to home support services if necessary.
Patient Attributes	• Patient attributes comprise elements of health and wellness which are specific to the individual. This may include stability of condition, compliance with treatment regimes, understanding of medications, and ability to meet goals (O'Connor et al.). • Patient and family capacity are key indicators of discharge readiness. This involves assessing physical, functional, emotional, and cognitive needs. (Stajduhar et al.) • Nurses may also consider patient personality, values and beliefs, wishes and receptivity to care, preparedness, and expectations (Stajduhar et al.)	• Assess these criteria throughout patient stay in community health. • Develop discharge goals related to patient specific attributes such as capacity and willingness. • Collaborate closely with patient and family to ensure there are similar expectations for care. • Incorporate discharge planning meetings with patient and family to set mutual goals.
Relationship between nurse and patient	• Nurses should develop a trusting, therapeutic relationship with patients and families to facilitate accurate assessments of needs and capacity. Patients who trust their nurse will likely adhere to care plans and advice and will feel comfortable seeking assistance (Stajduhar et al.). • Nurses need to set appropriate boundaries for nurse-patient relationships, ensuring the nature of the relationship does not unduly impact patient care (Stajduhar et al.).	• Educate nurses on the positive and negative impacts of relationships on decision-making and discharge. • Promote self-awareness and reflection on personal practice. • Encourage collaboration with peers when a nurse-patient relationship may affect discharge decision making.
Workload and available resources	• Community health workloads are typically high with financial restrictions placed on resources such as dressing supplies, home support, and number of home visits. Nurses indicated these factors influence the amount of care patients will receive (Stajduhar et al.) • Nurses with high workloads may prioritize patients with greater needs, defer care by a few days for those with fewer needs, or transfer patients to other community nurses.	• Address this factor at a health care system level by ensuring there are appropriate staffing and resource levels. • Routinely assess nursing workloads and encourage nurses to collaborate when prioritizing patient care based on available resources.

Finding	Details	Implications
	There is incentive to discharge patients when workloads are high and resources are scarce (Stajduhar et al.).	
Nurses' experience and approach to care	• Each community health nurse has unique practice experience, values, and approaches to nursing care. Every patient assessment and subsequent care decision is influenced by the judgement of individual nurses. This can lead to substantial variability in decisions made surrounding discharge from services (O'Connor et al.; Stajduhar et al.) • Organizational culture also affects decision making surrounding discharge. For example, one nurse's poor experience with a patient may negatively influence subsequent nurses visiting the same home (Stajduhar et al.).	• Address this factor at a health care system level by promoting self-awareness and reflection among nurses. • Provide education on recognizing and reducing preconceived stereotypes or judgements, particularly those which are culturally prevalent.

Appendix II

Consultation Report

Recommendations for Discharge Planning in Community Health Nursing:

Consultation Report

H. Taylor Kerr

Project Introduction and Background

This practicum project was conceptualized in response to a noted variation in discharge practices among community health nurses (CHNs) in Eastern Health. Patients with similar demographics and diagnoses spend varying amounts of time on nursing caseloads at the discretion of individual CHNs. As CHNs operate with a high level of autonomy and make decisions that directly affect patient health outcomes (Community Health Nurses of Canada, 2011), the lack of policy and guidance documents warrants further investigation.

Through the completion of a literature review on discharge planning in both hospital and community settings, it was evident that the presence of a discharge planning process in hospitals can positively affect patient outcomes upon discharge. This discharge planning process includes assessment, goal-setting, planning, coordination, and evaluation of outcomes, all of which are guided by standardized decision-support tools, patient care plans, and hospital policy (Vat, Common, Laizner, Borduas, & Maheu, 2015; Waring, Bishop, & Marshall, 2016).While no such discharge planning processes currently exist in community health settings, it is probable patients being discharged from community health services would benefit from a similar form of discharge planning. Although the literature review supports the development of standardized care guidelines and decision-support tools, it is also important to understand the specific needs and perspectives of CHNs working in Eastern Health as they are the focus of this practicum project.

To inform the development of discharge planning recommendations for CHNs in Eastern Health, a series of key informant interviews were conducted over the course of

three weeks. Frontline CHNs in the Home and Community Care program, along with team leaders, program managers, and discharge liaison nurses from acute care were approached to determine their interest in participating in semi-structured interviews. The purpose of these interviews was to obtain the perspectives, needs, and recommendations of key stakeholders in community health to tailor the development of discharge planning recommendations to the needs of local nurses and patients. Incorporating consultation findings in the recommendations made to Eastern Health will ensure the development of discharge guidelines which are compatible with the current system of nursing care.

Consultation Objectives

1. To determine the current discharge practices of frontline CHNs in Eastern Health.

2. To determine the factors that influence discharge decision-making from the perspective of frontline CHNs.

3. To identify what educational materials, discharge tools, or processes would be most beneficial in a community health context from the perspective of CHNs, team leaders, and managers.

Methods

Emails were sent to potential participants from each of the six community health nursing zones in Eastern Health describing the project and the purpose of the interviews. A copy of this email is included in Appendix A. It was made clear that participation was not mandatory and there would be no repercussions for declining to participate. Participants included five frontline CHNs with experience in community health ranging from three to thirteen years (i.e., two junior nurses with three and four years of experience, and three senior nurses with ten, twelve, and thirteen years of experience),

one team leader with twenty years of experience, and one program manager with three years of experience in her current position. An attempt was made to arrange an interview with a hospital based discharge liaison nurse, however scheduling complications prevented the meeting.

Each interview took place in a one-on-one session in a quiet, private setting. At the request of participants, all but one of the interviews took place in person in the office of the participant, with the final interview conducted via telephone. Interviews were conducted over approximately thirty minutes using a semi-structured interview guide. Broad interview questions were developed to guide the interviews along with additional probes based on participant responses. Copies of the interview guides used for CHNs, Team leaders, and managers are included in Appendix B. During the interviews, data were recorded by hand on a copy of the interview guide, with more detailed notes written directly after each interview. The notes were then typed, saved on a personal computer, and password protected to ensure participant confidentiality. There was no audio or video recording during interviews and no identifying information was recorded during note taking.

After all of the interviews were completed, the transcripts were analyzed question by question to identify common themes related to discharge from community health nursing services. The transcripts and analysis were shared with my practicum supervisor to verify emerging themes. The results of this analysis are presented in the following section titled results.

Ethical Considerations

A meeting was scheduled with my program manager to discuss the interview

format, duration, and locations, while confirming interviews could be conducted during work hours. Approval was granted to move ahead and approach participants by email. A completed Authority Screening Template, included in Appendix C, indicates this project does not require approval from the Health Research Ethics Board as it is a quality improvement project as opposed to research.

As previously mentioned participants were informed of the nature and purpose of the interview and were reminded the interview was entirely voluntary and they could withdraw at any point. Verbal agreement was obtained from each participant before beginning the interview. All informant responses were kept confidential and in a locked office at the Portugal Cove CHN site only accessible by me.

Results

The aim of this phase of the project was to take the information gathered during semi-structured interviews and develop common themes relevant to the development of community health based discharge guidelines. The interviews began with five CHNs whose perspectives were amalgamated to generate major themes. The data from two subsequent interviews with a team leader and program manager were incorporated into the analysis of major themes, introducing new perspectives unique to their leadership role.

Defining Discharge Planning

Each of the five nurses interviewed identified discharge planning as a hospital based process that is not formally conducted in a community setting. Although planning and assessment are conducted by both hospital based nurses and community based nurses, no interviewee identified their actions as "discharge planning". The program manager and

team leader also identified discharge planning as a hospital based initiative; however they further described the process as "planning for the termination of healthcare services and support".

None of the interviewed CHNs could remember receiving education or orientation specifically related to discharge planning in the community setting. The team leader stated there used to be an educational booklet for CHNs which included service expectations for the common medical diagnoses; however this booklet was discontinued approximately 10 years ago. The program manager was also unaware of any discharge specific education or training for CHNs.

The Discharge Planning Process

CHNs were asked to describe the typical patient journey through community health. All five nurses described receiving a referral for care from the hospital, contacting the client to arrange services, making an initial home visit and completing a comprehensive initial assessment, deciding what level of support the patient will require (e.g., how many home visits or phone calls will be necessary), then continuing nursing care until the patient is ready to be discharged.

When asked when they would initiate discharge planning during this patient journey, four nurses and the team leader stated it should begin during the first home visit while making an initial assessment. The fifth nurse stated she begins planning for discharge "as soon as she gets a referral". There was consensus that planning for discharge begins early and involves making a mental assessment of the patient's condition and capacity to determine what duration of services they will likely need. Two nurses stated they "just know based on gut feeling" how long clients will be on their

caseload. When asked to elaborate on this decision making, they stated their

determinations were likely the result of many subconscious assessments and experience

seeing other patients with similar diagnoses.

Key Assessments and Criteria for Discharge

When asked what factors would lead CHNs to determine whether a patient was

ready for discharge, CHNs responded with five broad assessment areas: physical healing,

patient safety, environmental safety, independence with care, and psychosocial needs.

Probing questions were asked for each category in order to glean specific details

surrounding the assessment process.

For example, when asked broadly about assessment factors for discharge, interviewees

were primarily concerned with the physical health of the patient, specifically, assessing

whether wounds were healed and surgical hardware was removed. If patients had moved

into the "monitoring stage" of wound healing (i.e., wounds/incisions have mostly healed

and the area is being monitored for infection or deterioration), participants stated the

patient would likely be ready for discharge. As another example, when probing questions

were asked about patient and environmental safety, two nurses indicated they always

assess the patient's ability to access "vital" areas of the home (e.g., kitchen, bathroom,

bedroom.) and another two nurses listed specific criteria they assess to determine whether

the patient is at risk for falling (e.g., presence of stairs, loose carpets, clutter etc.). Patient

independence included specifically assessing whether patients can cope with the everyday

management of their illness. CHNs described the importance of patients vocalizing their

comfort with being discharged and the nurses feeling comfortable leaving the patient

independent with care. One CHN stated she will consider discharge only if the patient has

received enough teaching and she can trust they will reach out to her with any complications. This was reiterated by the program manager who stated discharge should be a mutual process carried out by the CHN, patient, and patient's family. Finally, determining the patient's psychosocial needs includes an assessment of the patient's role within the family and community, and their ability to cope with managing their illness autonomously. For each assessment criterion, participants listed specific observations and questions they ask prior to discharging a patient. The details for all five assessment categories are summarized in a table of key assessments included in Appendix D.

Overall, participants described the importance of "reaching an optimum level of functioning" as an ultimate criterion they considered important for discharge. That is, patients have reached, or are on track to reach, the same level of functioning they had prior to hospital admission based on positive outcomes from the five assessment areas described above. One nurse described this as "a sure indication the patient is ready to be discharged".

Patient and Nurse Attributes Affecting Decision Making

Every interviewee also addressed the role of specific patient attributes in determining discharge readiness. CHNs described some patients as naturally highly capable people, requiring little support or teaching, while other patients are utterly dependent on CHN services. Based on natural disposition, education level, societal factors etcetera, some patients exhibit greater coping abilities, or have a better understanding of medicine, all of which impact the level of CHN services required. Three CHNs described their specific assessments of patient ability with one nurse stating "you really need patients to reach a level of comfort prior to discharge, so their comfort level at

the initial visit plays a large role in how long we will wait before discharging them". Another nurse stated "it's all about patient capacity; how much of their own care can they handle? Whatever remains, whatever they can't handle is the responsibility of the CHN". Two interviewees stated since nurses can't predict or influence specific patient attributes, their discharge practices are extremely variable from case to case and based primarily on "getting lucky with a good patient". However, one of the junior nurses countered this perspective, stating "there is somewhat of a divide between CHNs. Some are heavily focused on educating and promoting patient independence, while others embrace the task-oriented nursing model, completing all required care until the patient is healed. It is less related to patient attitude and more to CHN attitude".

This finding, that CHN attitude and approach to care significantly influences decision making, was reiterated by all interviewees. The team leader stated "[CHN experience and attitude] play a huge role in discharge. So much of decision making in community is a direct result of the values and personality of the nurse and we frequently see this manifest in either over-servicing or under-servicing". Four CHNs discussed the effect of different types of nurses in community. Distinctions were made between "task oriented nurses" who are heavily focused on physical health and healing and "holistic nurses" who spend more time completing assessments outside of physical wellbeing. The program manager stated she regularly observes this distinction in CHNs. She noted that one type is not more beneficial than the other, that "each type comes with its challenges; successful CHNs require skills from both a task-oriented and holistic perspective if proper discharge is to be achieved".

Although interviewees were divided on the extent to which patient attributes and nurse attributes affect discharge practices, there was a consensus between all participants that these attributes are a highly influential factor in discharge decision making.

Nurse-Patient Relationships

When asked to describe factors which influence decision-making and discharge, all interviewees discussed the immense effect of nurse-patient relationships on patient length of stay in community. The program manager stated she considers this factor one of the strongest determinants of service duration in community health. Primarily, interviewees spoke of the importance of establishing strong, trusting bonds with their patients, emphasizing the importance of being seen as an accessible healthcare resource and member of the community. One nurse described forging strong relationships as "a careful balance", where strong bonds can foster the patient's confidence in their own abilities leading to more rapid discharge, but they can also lead to dependency in patients and unwillingness to let go on the part of nurses. Other interviewees responded similarly stating relationships should be trusting and therapeutic while not pushing the boundaries of professionalism. Alternatively, nurses who do not bond with patients have "less incentive to go above and beyond and complete holistic assessments" according to two interviewees, and thus may discharge patients sooner.

Workload and Resources

As workload and resource concerns were prevalent themes in the literature on discharge planning, CHNs were asked whether high workloads would ever impact their discharge decision-making. Three CHNs indicated workload would not affect their discharge planning as "they always put patients' well-being over operational concerns

like workload". However, they noted high workloads would cause them to work faster and push themselves further indicating high workloads may have greater impact on nurse well-being than patient well-being. The other two CHNs suggested although they do not intentionally let it affect their patient care, high workloads do provide incentive to discharge patients as soon as possible.

Variation in Discharge Practices

As observed variation in discharge practices was the impetus of this practicum project, interviewees were asked whether they also noted variation in the practices of CHNs. While every interviewee stated they frequently observe variation, opinions varied as to the extent of the variation. One nurse and the team leader stated that variations in practice exist, but they are relatively subtle and not an issue among the nurses who work together within one of Eastern Health's six urban nursing zones. She indicated there are larger variations between zones as they do not collaborate on a day-to-day basis. While the team leader stated that subtle variations do not affect her team's functioning, she felt they negatively impact casual nurses who are not used to the team dynamic and may over service patients rather than upset the routines of district nurses by discharging.

The other four nurses and the program manager stated they observe "huge discrepancies in nursing practice between individuals, teams, and zones". Nurses stated they observe many problematic practices, including CHNs keeping patients on their caseload longer than necessary to inflate workloads. Because high workloads often result in the delegation of increased support and resources (e.g., assigning a casual nurse to assist with extra work, or having new referrals screened and seen by other nurses with lower workloads), there can be incentive to inflate caseload numbers. The program

manager stated while this does happen, chart audits and workload reviews are conducted to discourage this practice.

Other implications of variation in practice included confusion and conflicting expectations for patients. One nurse stated she frequently observes patients being given two very different time frames for care when they are seen by more than one nurse. For instance, if one nurse indicates a patient will receive a week of service but a subsequent nurse advises several weeks of service, patients may be unsure which assessment was the "correct" assessment and may lose trust in the nursing program. The participant indicated this can "undermine the patient's confidence in our nursing assessments".

Every interviewee agreed that there are benefits to reducing variation between nurses, however two nurses indicated this is likely an "impossible task" as nursing practice is unique and based on different, individual values. The other interviewed nurses stated increased awareness of the factors influencing over servicing would be beneficial, as well as the development of patient care guidelines. Nurses indicated that when they are unsure of whether to discharge, they have no policy or guidelines to fall back on, thus forcing them to rely on experience or the opinions of colleagues.

Overall, variation in nursing practice was observed by all participants to varying degrees with some disagreement on the extent to which variation affects patient care and interactions between nurses. However, every participant agreed the community health nursing program is currently lacking, and would benefit from, concrete guidelines surrounding discharge practice.

Recommendations for Discharge Support Tools

       The creation of guidelines or policy surrounding discharge were supported by all nurses who stated they would "feel much more comfortable having something concrete to refer to" when conducting patient assessments. Two nurses stated guidelines would be useful in a litigious context as they would confirm the CHN conducted all proper assessments before considering discharge. Two nurses also stated guidelines would be useful to present to managers during caseload reviews and chart audits. If a manager questioned the length of time a patient received CHN services, the nurse could refer to the guideline and indicate the patient had issues which needed resolving prior to discharge.

       When asked whether they often experience uncertainty surrounding discharge, all CHNs indicated that they do not often experience uncertainty because they are used to relying on their own assessment skills. However, when they are uncertain, they indicated there are no resources to refer to other than co-workers or managers. If guidelines surrounding discharge were created, one nurse stated it would "significantly reduce any uncertainty and variability because there would be a physical list of criteria to assess, and we could all reference the same document". Other CHNs agreed that guidelines could be useful in coping with uncertainty surrounding discharge.

       All five nurses, the team leader, and the program manager indicated any guidelines surrounding discharge would need to be flexible to allow for situational variation, would need to be easy to use, and not be a part of mandatory patient charting. Nursing in the community is substantially different from acute settings as patients are serviced in their own homes on their own terms, thus there is always a degree of variability and unpredictability in service. One nurse expressed concern with the rigidity

of a checklist, suggesting instead that there be a threshold (e.g., 80% of criteria met) rather than having a patient check all criteria before discharge, as this would make the tool more flexible.

Four interviewees recommended a general discharge planning checklist or flow sheet encompassing broad assessment areas. The other interviewees indicated tools would be more useful if broken down by patient diagnoses, or some other distinguishing factor. Further, one nurse suggested the creation of general timelines for patient progress which would indicate typical recovery milestones to assess. The program manager recommended the creation of multiple tools: one for nurses, one for workload reviews, and one for managers conducting chart audits. She indicated that workload reviews are currently conducted informally at the discretion of individual managers and guidelines would help streamline the review process, ensuring all CHNs are held accountable and critiqued using the same standards. All interviewees agreed that a guideline would be most beneficial for casual nurses, novice nurses, and those orienting to community health, with two nurses further stating guidelines would be beneficial to everyone making patient care decisions in the community, if not on a daily basis, then as a reminder of best practices or guide when uncertainty arises.

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Implications for Project Development

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Results of these consultations mirror the findings from the literature review in that all participants indicated discharge planning is not a formal practice in community health nursing, but rather a process highly dependent on patient assessments and the attributes of individual nurses. The CHNs, team leader, and program manager all linked the subjective discharge process with variability in discharge practices between nurses. There was

consensus that variability in practice has the potential to negatively affect patients, workloads, and relationships between CHNs.

Similar to findings from the literature review, discharge guidelines and workload reviews were suggested by interviewees as potential interventions for reducing variability in practice. Specifically, suggestions included the creation of discharge guidelines which are flexible and focused primarily on identifying patient assessments to be completed prior to discharge. These findings, coupled with findings from the literature review and patient chart reviews, will be used to develop a series of recommendations for Eastern Health's Home and Community Care program surrounding discharge. By determining the factors that influence CHN decision-making and their conceptualization of appropriate discharge, each recommendation will be tailored to the needs of local nurses and patients. As confirmed by interview participants, there is a significant need for resource development in community health, particularly surrounding decision-making and discharge from service.

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Appendix A

Recruitment Email

Good Morning,

My name is Taylor Kerr and I am a community health nurse working in the Home and Community Care program in St. John's. I am in the process of completing my master's degree in nursing through Memorial University and for my practicum project I am compiling information about the process of discharging clients from the Home and Community Care program. So far in my work I have determined that in a hospital setting, patient discharge is often guided by policy and structured patient care plans, however, in community health no such discharge policies or guidelines exist to assist decision-making. This led me to question whether patients and nurses in community health would benefit from discharge planning educational materials or tools.

Having recently conducted a literature review of discharge planning practices in the hospital and community, my next step is to gather information directly from nurses, team leaders, managers, and liaison nurses such as yourself. I plan to conduct short, confidential interviews with various members of the community health team in order to gain insight into current discharge practices and to determine what influences the decision to discharge patients from community health services. The perspectives and recommendations provided throughout the interviews will help me determine whether discharge planning guidelines, tool, or processes would be beneficial for community health nurses and patients in Eastern Health.

The interviews are completely voluntary and there are no repercussions for not participating. If you are interested in taking part, I anticipate interviews will take twenty minutes to a half hour and they will be conducted in private at a time and location of your choosing. There will be no audio or video recording during interviews. I will take some notes by hand and all responses will be kept secured and confidential. Home and Community Care managers are aware of the project and is comfortable having interviews take place during work hours at offices in Zone One and Five.

If you wish to participate or have any questions about the interview process and the practicum project please contact me by email or phone. You may also contact the program manager. Thank you for your consideration and I look forward to hearing from you.

Taylor Kerr BNRN
Home and Community Care program

Appendix B

Questions for Key Informants:
Frontline Nurses and Team Leaders

1. What comes to mind when I use the term "discharge planning"?

2. Have you ever received specific education or training surrounding discharging patients from your caseload? If yes, what did it entail?

3. Can you describe the typical patient journey through Home and Continuing Care (e.g., for a patient post-hip replacement)?

    Probe: At what point during this process would you initiate discharge planning?

4.   What would lead you to determine that a patient is ready to be discharged? What factors would you take into consideration prior to discharge?

    Specific Assessment Factors:
    - Patient safety? (e.g., physical environment, ability to leave home, cognition)
    - Having a long term plan?
    - Patient reaching self-care potential?
    - Presence of a caregiver?
    - Specific patient attributes?

    System and Nurse factors:
    - Relationships between nurse and patient?
    - Workload and resource concerns?
    - Individual nurses' experience and approach to care?

5. Have you ever been uncertain about discharging a particular patient? What made you uncertain? How did you resolve this uncertainty?

6. Have patients or family members ever raised concerns surrounding their discharge from Home and Community Care that you are aware of? Describe.

7. Have you ever observed any variation in discharge practices? If so, do you think this is an issue that needs to be resolved? Should there be more consistency between nurses?

    Probe: How do you think we could reduce this variation?

8. Much of the literature on discharge planning recommends incorporating various types of guidelines for nurses. *present examples* How do you think guidelines would impact the discharge process in community health?

    Probes:
    - How would guidelines impact your practice specifically?
    - In what situations do you think guidelines would be most beneficial?
    - Any specific recommendations related to guidelines/tools/processes?

9. Other services evaluate their discharge planning by following up with patients (e.g., phone calls or surveys) and recording statistics such as hospital readmission rates. Do you think we should implement similar practices in community health? If so, what type of information should we gather?

10. Is there anything you wanted to discuss or recommend that we have not touched on during this interview?

Additional Questions for Team Leaders:

11. Can you elaborate on your role as a team leader when it comes to discharge planning?

    Probes: What kinds of interactions have you had with the nurses on your team related to discharge planning and decision making?

12. As team leader, you have access to the workload levels of each nurse on your team. Have you ever observed high/low workloads impacting the decision to discharge patients? Can you provide examples?

    Probes: Would high/low resource availability impact the decision to discharge? (e.g., staffing levels, wound care products)

13. As a team leader, what resources related to discharge planning would most benefit you and your practice?

Questions for Community Health Managers

1. What comes to mind when I use the term "discharge planning"?

2. Are you aware of any discharge related education or training available to frontline nurses? If yes, describe.

3. What factors would you consider important for nurses to assess prior to patient discharge?

   Specific Assessment Factors:
   - Patient safety? (e.g., physical environment, ability to leave home, cognition)
   - Having a long term plan?
   - Patient reaching self-care potential?
   - Presence of a caregiver?
   - Specific patient attributes?

   System and Nurse factors:
   - Relationships between nurse and patient?
   - Workload and resource concerns?
   - Individual nurses' experience and approach to care?

4. Are there any current evaluation practices surrounding discharge from services? (i.e., chart reviews? Performance reviews?)

5. If a frontline nurse was unsure about discharging a particular patient, what steps would you recommend they take?

   Probe: Would you consider nursing experience important in decision making surrounding discharge? As such, how should a newly hired or novice nurse navigate discharge planning in community health?

6. Have patients or family members ever raised concerns surrounding their discharge from Home and Community Care that you are aware of? Describe.

7. Have you ever observed any variation in discharge practices? If so, do you think this is an issue that needs to be resolved? Should there be more consistency between nurses?

   Probe: How do you think we could reduce this variation?

8. Much of the literature on discharge planning recommends incorporating various types of guidelines for nurses. *present examples* How do you think guidelines would impact the discharge process in community health?

   Probes:
   - How would guidelines impact novice nurses compared to senior nurses?
   - In what situations do you think guidelines would be most beneficial?
   - Any specific recommendations related to guidelines/tools/processes?

9. Is there anything you wanted to discuss or recommend that we have not touched on during this interview?

Appendix C
Health Research Ethics Authority Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review	☐	☒
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?	☐	☒
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.	☐	☐
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	☒	☐
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?	☐	☒
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?	☐	☒
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?	☐	☒
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?	☐	☒
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		1	4
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	☒	☐
9.	Is the project intended to define a best practice within your organization or practice?	☒	☐
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	☒	☐
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, Organization, or region, rather than using more general terminology such as rural vs. urban populations?	☒	☐
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?		
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		4	0
	SUMMARY – The sum of line A (A=1) is less than the sum of line B (B=4), therefore the purpose of the project is best described as quality/evaluation.		

Appendix D
Areas of Assessment Prior to Discharge

Assessment Area	Specific Assessments
Physical Healing	• Assess if wound healed • Assess if patient able to independently manage wound healing (see "Patient Independence") • Assess if all surgical hardware removed • Assess potential for other medical complications impacting healing such as infection, high blood pressure, obesity, etc.
Patient Safety	• Assess if patient lives alone • Assess if patient has caregiver or person to check in periodically • Assess if patient can complete activities of daily living independently: - Personal hygiene - Making meals - Toileting - Functional mobility
Environmental Safety	• Assess patient ability to leave house in an emergency • Assess patient access to key areas in home: - Kitchen - Bathroom - Bedroom • Assess patient ability to reach phone for emergency services • Assess for fire hazards if patient on home oxygen • Assess fall hazards in home - Stairs - Floor Rugs - Clutter • Assess need for assistive devices such as shower bar, extra railings, walker or cane, fall monitors • Assess whether home suitable for assistive equipment (e.g., doorways are wide enough for wheelchair or walker)
Patient Independence	• Assess if nursing care can be completed by patient independently: 1. Complete demonstration of procedure by CHN

Assessment Area	Specific Assessments
	2. Have patient complete procedure with CHN assistance 3. Have patient complete procedure independently with CHN observation 4. Have patient complete procedure independently • Assess patient understanding of their medical condition • Assess patient knowledge of post discharge complications (e.g., signs of infection) and the appropriate follow up action (e.g., contact either CHN, GP, or attend emergency department). • Assess client's ability to attend follow-up appointments and run errands required for daily living (e.g., grocery shopping, prescription refill)
Psychosocial Needs	• Assess patient's level of coping with diagnosis and treatment • Assess patient's willingness to be discharged from services • Assess nurse-patient relationship for signs of dependence by either party • Assess patient need for referral to social programs in the community

Appendix III

Chart Review Report

Recommendations for Discharge Planning in Community Health Nursing:

Chart Review Report

H. Taylor Kerr

Project Introduction and Background

This project was conceptualized in response to a noted variation in discharge

practices among community health nurses (CHNs) in Eastern Health. Patients with

similar demographics and diagnoses spend varying amounts of time on nursing caseloads

at the discretion of individual CHNs. As CHNs operate with a high level of autonomy and

make decisions that directly affect patient health outcomes (Community Health Nurses of

Canada, 2011), the lack of policy and guidance documents warrants further investigation.

Through the completion of a literature review on discharge planning in both

hospital and community settings, it was evident that the presence of a discharge planning

process in hospitals can positively affect patient outcomes upon discharge. This discharge

planning process includes assessment, goal-setting, planning, coordination, and

evaluation of outcomes, all of which are guided by standardized decision-support tools,

patient care plans, and hospital policy (Vat, Common, Laizner, Borduas, & Maheu, 2015;

Waring, Bishop, & Marshall, 2016).While no such discharge planning processes currently

exist in community health settings, it is probable patients being discharged from

community health services would benefit from a similar form of discharge planning.

Key informant consultations were conducted with five frontline CHNs, a

community health team leader, and a community health manager to explore the

perspectives, practices, and recommendations of these participants surrounding discharge

from community health. During the interviews, participants were asked to describe their

current discharge practices, the factors which affect discharge and decision making, and

the role of discharge planning tools. Overall, there was consensus that discharge planning

tools would be beneficial for all practitioners in community health as a way to standardize

patient discharge, reduce variability between practitioners, and support nurses' assessment and decision making skills.

To further inform the development of discharge planning tools, patient chart reviews were conducted to gather information on length of stay on nursing caseloads and factors affecting service duration in community health. The goal of these reviews was to determine the average length of time patients with a specific diagnosis received services from CHNs, and identify factors which either increased or decreased the duration of service. Although the intention of the chart reviews was to examine how factors identified within the literature review and consultations affect length of stay, many of these factors were not explicitly reported in patients' charts due to Eastern Health's documentation guidelines for CHNs. Thus, for the purpose of this review, factors affecting length of stay primarily consisted of post-operative complications (e.g., infection, delayed healing, or issues with pain control) as these were explicitly charted in discharge notes. Any pertinent information not captured in the listed post-operative complications was recorded in the "other" column of the data collection tool and examined during data analyses. Using the information gathered in this review, discharge planning tools and guidelines will be tailored to specific diagnoses seen in community health, presenting CHNs with approximate guidelines for service duration and potential complications to assess prior to discharge.

Chart Review Objectives

Specific objectives for this chart review were to:

1. Determine the average service duration for patients who underwent a hip replacement, knee replacement, or mastectomy; and

2. Determine the documented factors that influence the length of time patients

    spend on CHN caseloads.

Methods

In anticipation of conducting chart reviews, a referral identification tool was developed and emailed to support staff in each community health zone requesting they record the name, date, identification number, and diagnosis of incoming referrals from March 12th to April 13th, 2018. The purpose of the tool was to generate a list of pertinent referrals which would be used as a master list during the data collection period. A copy of the letter to support staff and the referral identification tool are included in Appendix A. This tool was reviewed and approved by my practicum supervisor Dr. Moralejo and the manager of each community health nursing zone prior to being sent to support staff.

The referral identification tool initially included four diagnoses (i.e., hip replacements, knee replacements, mastectomies, and bowel resections) however support staff reported only two referrals were received for bowel resections over the course of the referral collection period. As such, bowel resections were eliminated from the chart review process. A total of 73 charts were identified and reviewed for the remaining three diagnoses.

Chart reviews were conducted in my office at the Portugal Cove CHN site using the master list of referrals collected by support staff. Each referral was assigned an identification code to maintain patient confidentiality during data analysis. Codes indicated the zone in which the referral was received, but contained no confidential patient information. Each referral was reviewed in CRMS (Eastern Health's electronic charting system) to determine the patient's admission date, discharge date, diagnosis, and

any complications outside of routine care (e.g., post-operative infections, need for home support etc.). Data were recorded on a copy of the chart review tool included in Appendix B, then were transferred to an Excel spreadsheet for analysis. A trial review of seven charts, encompassing both routine and non-routine discharge, was completed to determine whether the data collection tools required any changes prior to the principal chart review. During the trial, the data were well-captured by the tool and no changes were required to the methods of the chart review.

Results from each of the three diagnoses (i.e., hip replacements, knee replacements, and mastectomies) were analyzed using simple descriptive statistics. I calculated the mean length of stay, the frequency of each complication, as well as a comparison of lengths of stay by patient characteristics and the occurrence of complications.

<center>**Ethical Considerations**</center>

Managerial approval for the chart review was granted by the Home and Continuing Care program. A completed Health Research Ethics Authority Screening Template, included in Appendix C, indicates this project does not require approval from the Health Research Ethics Board as it is a quality improvement project rather than research. Data collection was conducted on a password protected computer in my office at the Portugal Cove nursing site which is a secure building accessed only by Eastern Health employees. The master list of referrals and ID codes will be kept in this office until the completion of the practicum project at which point it will be securely shredded and any electronic data deleted. There will be no identifying patient information included in any documents included in this practicum project.

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Results

The aim of this phase of the practicum project was to gather data from patient charts surrounding discharge to explore themes from the literature review and consultations in a practice context. However, due to the nature of Eastern Health's documentation guidelines in community health, little descriptive information was available on each patient's circumstances and resources. Discharge notes were found to be brief, describing specific nursing care provided, but scarce details on the assessment and decision to discharge patients. Thus, the data analyses in this review primarily included an examination of length of stay in relation to factors such as age, gender, surgery, and complications, all of which were explicitly charted. The data were analysed separately by patient diagnosis.

For each diagnosis, charts were categorized into three types of nursing service: routine discharges with no follow up, routine discharges with follow up, and complicated discharges. The first category was defined as the discharge of a patient on the same day they had their staples or drains removed, as this is the earliest point patients can be discharged. The second category captured patients who had their staples or drains removed and then received follow up phone calls or visits, although did not suffer from any documented complications. The final category was defined as any patients who had issues which required an extended stay on CHN caseloads such as post-operative infections, wounds, or weakness. A full list of these complications is included in the chart review tool included in Appendix B. The following three sections describe the results for each diagnosis.

Knee Replacement Surgery

A total of 25 referrals were received for patients who underwent a total knee replacement. The average age for this group was 66 years (range: 45-87) and the average days spent on CHN caseloads was 12.8 (range: 6-32). Eleven of the patients were male (42%) and 14 were female (58%).

The 25 patients were further categorized into three groups: group 1 patients received routine discharge with no follow up, group 2 patients received routine discharge with follow up, and group 3 patients had a complicated discharge. Table 1 summarizes the key results for each group. Group 1 patients received an average of 11.3 days of service (range: 8 – 14), while group 2 patients received an average of 12.2 days (range: 6 – 15) and group 3 patients received an average of 22.6 days (range: 17 – 32).

Table 1

Total Knee Replacement: Discharge Type, Length of Service, and Patient Characteristics

	Group 1: Routine discharge with no follow up	**Group 2:** Routine discharge with follow up	**Group 3:** Complicated Discharge
Number of Patients	16 (64%)	6 (24%)	3 (12%)
Average Days on Caseload	11.3 Range: 8-14	12.2 Range: 6-15	22.6 Range: 17-32
Extra Service Days Compared to Routine Discharge	--	+0.9	+11.3
Average Age in Years	66.3 Range: 56-87	66.3 Range: 59-78	62.3 Range: 54-68
Gender	Males: 8 (50%) Females: 8 (50%)	Males: 2 (33%) Females: 4 (66%)	Males: 1 (33%) Females: 2 (66%)
Documentation of teaching by CHN	2/16 (12%)	2/6 (33%)	1/3 (33%)

The complications experienced by patients in group 3 were: delayed removal of staples due to excess drainage from the incision site, implementation of short term home supports for general weakness and difficulty with activities of daily living, and consultation with physiotherapy and the family physician for extreme post-operative pain. On average, these patients spent an extra 11 days on a CHN caseload compared to patients without complications.

The increase in service days for group 3 is explained by the nature of the complications they experienced, however there was no apparent explanation for the slight difference of 0.9 service days between groups 1 and 2. Based on the data, the decision to provide follow up care could be the result of variation in individual nursing practices or the result of assessment factors not captured in the electronic patient notes.

As shown in Table 1, there was no age difference observed between groups 1 and 2 (66.3 years), and group 3 patients were an average of 4 years younger than those who experienced routine discharge (average 62.3 years). Given that the differences in age or gender between groups were minimal, it is unlikely there is an association between these factors and increased or decreased service duration. I was also unable to find any associations between length of stay and the frequency of patient teaching as very few charts (12% - 33%) made reference to whether patient teaching occurred. However it does appear that patient teaching was more likely to be documented in groups 2 (33%) and 3 (33%) versus group 1 (12%).

Hip Replacement Surgery

A total of 35 referrals were received for patients who underwent a total hip replacement. The average age for this group was 65 years (range: 47-80) and the average

days spent on CHN caseloads was 9 (range: 2-22). Sixteen of the patients were male (46%) and 19 were female (54%).

The 35 patients were further categorized into three groups: group 1 patients received routine discharge with no follow up, group 2 patients received routine discharge with follow up, and group 3 patients had a complicated discharge. Table 2 summarizes the key results for each group. Group 1 patients received an average of 7.3 days of service (range: 2 – 11), while group 2 patients received an average of 11.6 days (range: 4 – 22) and group 3 patients received an average of 12.5 days (range: 11 – 14).

Table 2

Total Hip Replacement: Discharge Type, Length of Service, and Patient Characteristics

	Group 1: Routine discharge with no follow up	**Group 2:** Routine discharge with follow up	**Group 3:** Complicated Discharge
Number of Patients	22 (63%)	9 (26%)	4 (11%)
Average Days on Caseload	7.3 Range: 2-11	11.6 Range: 4-22	12.5 Range: 11-14
Extra Service Days Compared to Routine Discharge	--	+4.3	+5.2
Average Age in Years	65 Range: 47-80	65.2 Range: 56-75	67 Range: 54-72
Gender	Male: 10 (45%) Female: 12 (55%)	Male: 3 (33%) Female: 6 (66%)	Male: 3 (75%) Female: 1 (25%)
Documentation of teaching by CHN	8/22 (36%)	2/9 (22%)	0 (0%)

There were three different types of complications experienced by patients in group 3. Two patients had their removal of staples delayed due to excess drainage from the incision site, one patient had incisional gaping after staple removal which required follow up for wound care, and one patient was readmitted to hospital after two falls at home. The completion of a falls risk assessment was not recorded in the electronic notes for this patient, although it could have been completed and placed on the patient's physical chart. On average, these patients received an extra 5.2 days of service compared to patients without complications.

Again, the increase in service days for group 3 is explained by the nature of the complications they experienced; however there was no apparent explanation for the difference of 4.3 service days between groups 1 and 2. It is likely the difference is the result of variation in individual nursing practices or discharge assessment factors not captured in the electronic patient notes. As shown in table 2, there was minimal variation in age and gender between the three groups. There was also little evidence of patient teaching captured in the electronic notes; in fact, no patient teaching was charted for all four patients who had medical complications in group 3.

Mastectomy

A total of 13 referrals were received for patients who underwent a mastectomy in the data collection period. All (100%) patients were female, while the average age was 62 (range: 35-73), and the average service duration was 16.4 days (range: 3-32).

The 13 patients were further categorized into three groups: group 1 patients received routine discharge with no follow up, group 2 patients received routine discharge with follow up, and group 3 patients had a complicated discharge. Table 3 summarizes

the key results for each group. Group 1 patients received an average of 16 days of service (range: 10 – 22), while group 2 patients received an average of 13 days (range: 3 – 20) and group 3 patients received an average of 24.3 days (range: 15 – 32).

Table 3

Mastectomy: Discharge Type, Length of Service, and Patient Characteristics

	Group 1: Routine discharge with no follow up	**Group 2:** Routine discharge with follow up	**Group 3:** Complicated Discharge
Number of Patients	3 (23%)	7 (54%)	3 (23%)
Average Days on Caseload	16 Range: 10-22	13 Range: 3-20	24.3 Range: 15-32
Extra Service Days Compared to Routine Discharge	--	-3.0	+8.3
Average Age in Years	58.3 Range: 55-62	60.3 Range: 35-73	68.7 Range: 65-71
Gender	Male: 0 Female: 3	Male: 0 Female: 7	Male: 0 Female: 3
Documentation of teaching by CHN	2/3 (66%)	1/7 (14%)	0 (0%)

Group 3 consisted of patients who experienced a complication with their recovery. The complications were poor wound healing at the drain site, post-operative infection, and excess drainage that required follow up by the surgeon. On average, the patients with complications required an extra 13.5 service days compared to patients without complications.

Interestingly, group 2 patients, who received follow up visits after their drains were removed, had a lower service duration average than group 1 patients who received no follow up after drain removal. While this is an unexpected finding, the variable nature of Jackson Pratt drain removal may explain the discrepancy. Unlike staple removal, which is ordered for a specific post-operative date, drain removal is contingent on a patient's drainage levels and is highly variable. It is likely the small sample of patients included in group 1 had drains left in longer due to increased drainage compared to the sample from group 2.

While a gender comparison is not warranted in this group, the average age of patients who had routine discharge (group 1: 58.3 years) was over 10 years younger than those who experienced a complication (group 3: 68.7 years). This could indicate older women are more likely to need increased community nursing services after a mastectomy. Again, there was little record of patient teaching in the electronic notes with no patient teaching reported for all three patients with medical complications.

Discussion and Implications for Project Development

Overall, the information gathered in this chart review indicated there are not any substantial variations in discharge practices for patients who underwent a knee replacement, a hip replacement, or a mastectomy. However, there were two key issues identified that impact the development of recommendations for Eastern Health: the unexplained extension of services for patients with routine discharges, and the lack of information charted in electronic nursing notes.

First, the majority of patients (23 – 64% depending on type of surgery) were discharged at the point of hardware removal, or there was a clear reason for an extension

of services e.g., post-operative infection or poor healing. However, depending on the type of surgery, 24 – 54% of patients had extensions in service ranging from 3 – 22 days with no clear explanations for the extra service days. Once staples are removed and there are no medical complications, the patient is eligible for discharge. While it is unlikely managers or CHNs would consider this an excessive use of services, it remains unclear why these patients were kept on CHN caseloads for follow up beyond this point. As the charting method currently used by CHNs does not include enough information on the decision-making process to determine why patients were kept on longer, the suitable way to investigate the phenomenon is through the routine chart audits completed by community health managers. Currently, community health managers have no method of identifying instances where patients were kept on caseloads beyond their eligible discharge date; the current chart audit tool does not include any guide or frame of reference for service duration. However, incorporating average service durations such as those identified in this review (e.g., hip replacement patient: approximately 7 days of service + 5 days if complication present), would allow managers to identify instances of patients receiving extra services and explore those individual cases as appropriate during annual workload reviews. As this chart review only gathered data for three surgical diagnoses, further chart reviews would be helpful in developing average service durations for all common surgical diagnoses seen in community health.

The second issue identified, and a key limitation of this chart review, is the lack of information available in electronic patient charts. Ideally, information about patients' living situations, capacity, medical history, or any other non-medical contributing factors would be captured in the electronic charting system. However, as there are few guidelines

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surrounding documentation in community health, nurses can include or exclude any non-medical patient information at their discretion. As I encountered throughout the review, electronic patient notes were primarily limited to the details of specific nursing tasks completed or any important medical observations. This becomes problematic when services are provided to patients with no documented explanation, giving the impression that services and resources are not being utilized appropriately. Moving forward, it is possible that changes to charting guidelines, or the addition of a standard discharge charting tool, would better capture the patient's condition and help explain CHN decisions regarding follow up care.

Both of these key issues, the unexplained extension of services and the lack of information in nursing notes, represent aspects of the community discharge process requiring further investigation and improvement. Based on the findings in this review, recommendations can be made to Eastern Health's Home and Community Care program regarding the expansion of the managerial chart audit tool, a review of current charting practices and guidelines, the development of a discharge planning tool, and the continuation of patient chart reviews.

Conclusion

While variations in discharge practices are small, there are key aspects of the discharge process which could be improved upon. Moving forward, a report of findings and recommendations for Eastern Health's Home and Community Care program will be developed using the issues and implications highlighted in this report.

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Appendix A
Referral Identification Tool for Support Staff

Dear Support Staff Colleagues,

My name is Taylor Kerr and I am a community health nurse working in the Home and Community Care program in St. John's. I am in the process of completing my master's degree in nursing through Memorial University and for my practicum project I am compiling information about the process of discharging clients from the Home and Community Care program.

Having recently conducted a literature review of discharge planning practices in the community as well as interviews with several members of the community health nursing team, my next step is to gather information directly from patient files. I plan to review several patients' electronic CRMS charts to determine how long they received nursing services and whether there were any complications during their care. This will allow me to determine the average length of time patients spend on nursing caseloads and what factors affect the nurses' decision to discharge their patients. Using this information, the goal of my practicum project is to develop guidelines for community health nurses related to discharging patients from service.

My chart reviews will focus on the most frequent surgeries treated by community health nurses: bowel resections, hip and knee replacements, and mastectomies. As such, I have enclosed a copy of a data collection tool intended to keep track of the incoming referrals. Please take note of the diagnoses listed on incoming referrals from March 12th to April 13th 2018, looking for those clients who underwent a bowel resection, hip or knee replacement, or a mastectomy. Once identified, please record the initials of the client, their CRMS number, the date the referral was received, and which of the four surgeries they underwent. I have included an example of how to record this information in the top row of the enclosed tool.

Managers of the Home and Community Care program have granted me permission to gather patient information and complete these chart reviews for the purpose of developing discharge guidelines. All information gathered will be securely stored in my office in Zone One until the completion of the project at which point the documents will be shredded. If you have any questions or concerns related to the tool, or if you wish to discuss the project further, you can contact me anytime at taylor.kerr@easternhealth.ca or at 709-769-6099.

Your collaboration with chart reviews will be instrumental in the development of discharge guidelines for the nurses in Home and Community Care. My sincere thanks for your assistance with this phase of my project.

Taylor Kerr BN RN
Community Health Nurse
Eastern Health

Referral Identification Tool

Zone/Location: _____

Please document all referrals received between March 12th and April 13th 2018 for those patients who underwent a bowel resection, a hip or knee replacement, or a mastectomy. This information is typically located in the "Surgery/Treatment" section of each referral. Note that hip and knee replacements may be written on referrals as a 'THR' or 'TKR'. For each patient, please document the date, initials, CRMS number and type of surgery on the following tool. Please return by scanning through eastern health email to Taylor Kerr at taylor.kerr@easternhealth.ca by **April 16th, 2018**. For any questions or concerns please contact me by email at that address.

Referral Number	CRMS Number	Client Initials	Date Received	Type: Bowel Resection	Type: Knee Replacement	Type: Hip Replacement	Type: Mastectomy
Example	00001	T.K.	March 1		✔		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

Appendix B
Chart Review Tool

Patient ID Number:_____

Admission Date: _____   Discharge Date: _____

Total Number of Service Days: _____   Age: _____   Gender: M / F

Routine Discharge (No Complications): ☐

Diagnosis:

Complication	Present	Absent
Post-operative Infection		
Delayed Healing		
Delayed Hardware Removal		
Required Home Supports		
Required Referral to PT/OT		
Pain Control		
Bowel Control		
Readmitted to hospital		
Monitoring		
Other:		

Routine DC: Patient was discharged with no complications.
Post Op Infection: Patient acquired an infection which was treated and monitored through community health.
Delayed Healing: Patient required continued nursing visits for wound or incision care after hardware removal.
Delayed Hardware: Removal of staples or sutures was delayed for reasons related to the patient's condition (e.g., incision not well approximated).
Required HSS: Patient required home support services which were arranged and monitored by community health.
PT/OT Referral: Internal referral sent to physiotherapy or occupational therapy.
Pain Control: Patient required continued nursing visits for poorly controlled post-operative pain or higher than average pain levels.
Readmitted: Patient experienced complications which led to hospital readmission and continued community health follow up.
Monitor: Patient required continued nursing visits to monitor healing, coping, or other factor.
Other: Patient experienced a complication not included in data collection tool (text-based entry).

Health Research Ethics Authority Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review	☐☐	☐☐
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?	☐☐	☐☐
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.	☐☐	☐☐
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	☐☐	☐☐
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?	☐☐	☐
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?	☐☐	☐☐
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?	☐☐	☐☐
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?	☐☐	☐
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		1	4
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	☐	☐
9.	Is the project intended to define a best practice within your organization or practice?	☐	☐
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	☐	☐
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, Organization, or region, rather than using more general terminology such as rural vs. urban populations?	☐	☐
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?		
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		4	0
	SUMMARY **The sum of line A (A=1) is less than the sum of line B (B=4), therefore the purpose of the project is best described as quality/evaluation.**		

Interpretation:

- If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.

- If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).

- If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information can be found at: http://www.hrea.ca/Ethics-Review-Required.aspx.
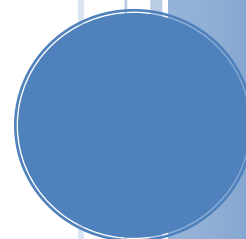
RECOMMENDATIONS FOR DISCHARGE PLANNING IN COMMUNITY HEALTH

A Report to Eastern Health

H. Taylor Kerr

July 2018

RECOMMENDATIONS FOR DISCHARGE PLANNING IN COMMUNITY HEALTH

Background

In partial fulfillment of a Master of Nursing degree, the past year of my studies has been dedicated to conducting my practicum project, which has provided me the opportunity to integrate and apply the advanced nursing practice competencies I have developed throughout my coursework. For my project, I explored the role of discharge planning in a community health context, focusing on the current discharge practices and the discharge related needs of the Home and Community Care program. This report provides an overview of my project inspiration, the key methods and findings, and my overall recommendations for Eastern Health's Home and Community Care Program.

The project was conceptualized in response to a noted variation in discharge practices among community health nurses (CHNs) in Eastern Health. Patients with similar demographic characteristics and diagnoses spend varying amounts of time on nursing caseloads at the discretion of individual CHNs. As CHNs operate with a high level of autonomy and make decisions that directly affect patient health outcomes the lack of policy and guidance documents warranted further investigation.

The project was conducted in three phases: a literature review of discharge practices in hospitals and community health nursing sites, consultations with key informants, and a review of community health patient charts, with the findings from each phase developed into a list of discharge recommendations and sample discharge tools for Eastern Health's Home and Community Care Program. This report represents an overview of each project component and program recommendations; the full project report is available in the Health Sciences Library research repository at Memorial University.

Literature Review

The literature review was conducted to obtain a comprehensive overview of discharge planning practices in community health and hospital settings. I emphasized identifying discharge planning practices and tools as well as factors affecting discharge decision making, and comparing the discharge planning processes of CHNs and hospital nurses. There was a vast difference in the amount of literature conducted in hospitals versus community. I was able to identify several hundred hospital-based studies, but only two qualitative studies on discharge from community health.

Through this review, it was evident that there was a clear disparity between discharge planning in hospital settings and community settings. Nurses in hospital settings have access to discharge planning tools such as checklists, flow sheets, and care plans when making discharge related decisions, while CHNs rely solely on personal experience and consultation with colleagues when planning for discharge. There are no discharge planning resources available in community health settings, although the two studies included in the review recommended developing such community-based guidelines.

The finding that community health nurses are lacking similar discharge planning resources compared to their hospital-based counterparts formed the foundation of the remainder of the practicum project and my recommendations to Eastern Health. It was apparent that nurses in the community would likely benefit from discharge planning tools or guidelines, and two community-based studies included in my literature review yielded extremely useful information about the potential development of such resources. The findings of these two studies were presented by the authors in the form of eight key assessment areas nurses consider important to assess prior to discharging a patient:

- Patient Safety
- Developing a Long Term Plan
- Reaching a Patient's Self-Care Potential
- Presence of a Caregiver
- Patient Attributes
- Relationships Between Nurse and Patient
- Workload and Resources
- Nurses' Experience and Approach to Care.

While each is described in greater depth in my literature review report, these broad assessment areas were essential in developing the questions and topics discussed with CHNs during the consultation phase of this project. Moving forward from the literature review to conducting the consultations, my goal was to transform these assessment criteria into a discharge planning tool for local CHNs.

Consultations with Key Informants

The purpose of conducting consultations within the Home and Community Care program was to determine the current discharge practices of frontline CHNs, determine the factors that influence their decision-making, and identify what information would be most beneficial in a discharge tool or resource. In all, consultations were conducted with five frontline CHNs, a community health team leader, and a community health manager.

Referencing the eight key assessment areas identified in the literature review, participants were asked to discuss their own key assessment areas for discharge, and identify the assessments most important to include in a discharge planning tool. CHNs responded with five broad assessment areas:

1. Physical Healing
2. Patient Safety
3. Environmental Safety
4. Independence With Care
5. Psychosocial Needs

During the interview, each assessment area was discussed in depth and, along with the assessment areas from the literature review, specific criteria and questions were developed for a discharge planning checklist.

Overall, nurses expressed concern over the lack of concrete discharge planning material available in community health, particularly for nurses who are new to the role. As nursing practice in community is largely autonomous, nurses felt it was important to have policy or guidelines to refer to when faced with a complicated situation. They also noted it would be beneficial to have discharge planning and expectations for discharge incorporated into the training and orientation of nurses who are new to community-based healthcare.

There was consensus that discharge planning tools would be useful for all practitioners in community health as a way to standardize patient discharge, reduce variability between practitioners, and support nurses' assessment and decision making skills. The recommendations included at the end of the report reflect these findings.

Chart Reviews

The next phase of the project was to conduct patient chart reviews. A total of 73 charts were reviewed over a one-month period and included any patients who underwent a total knee replacement, a total hip replacement, or a mastectomy. The data for each diagnosis were analyzed to determine the average length of stay in community health and the common complications which delay discharge from service.

The patients were categorized into three groups per diagnosis: group 1 patients were discharged directly after their staples or sutures were removed (i.e., a routine discharge) with no follow up, group 2 patients had a routine discharge with follow up in the form of phone calls or visits, and group 3 patients had a complicated discharge (e.g., they had a medical complication such as a post-operative infection). Table1 highlights the average number of service days for patients in each of the three groups.

Table 1: Average days on a CHN caseload by surgery type

	Group 1: Routine discharge with no follow up	Group 2: Routine discharge with follow up	Group 3: Patients who had explicit complications
Knee Replacement	11.3 (Range: 8-14)	12.2 (Range: 6-15)	22.6 (Range: 17-32)
Hip Replacement	7.3 (Range: 2-11)	11.6 (Range: 4-22)	12.5 (Range: 11-14)
Mastectomy	16 (Range: 10-22)	13 (Range: 3-20)	24.3 (Range: 15-32)

The data from the chart reviews indicated that the duration of service ranged from 2-32 days depending on surgery type. On average, 23 – 64% of patients were discharged directly after their staples or sutures were removed while 11 – 23% of patients were kept on caseloads for medical complications. The remaining 24-54% of patients in group two were kept on for extra visits or phone calls even though they were eligible for discharge at the time of staple removal. In each case, there was no documented complication or explanation for the extension of services for the patients in group 2.

Further complicating the lack of explanation for extra service days for group 2 patients, I found the electronic nursing notes to be very brief. The majority of notes excluding details about clients that are important to consider during discharge related decision making, such as client living situation, disposition, coping, support systems etc. It was difficult to collect informative data as each nurse included different information in their notes and assessments. For example, while client education is conducted frequently during home visits by CHNs, only 26% of electronic notes mentioned client education being provided. These findings informed the recommendations included in this report.

Discussion of Project Findings

In conducting each phase of this project, I was able to identify aspects of the community discharge process that are working well for patients, as well as discharge-related gaps and areas for improvement within the Home and Community Care program.

The information gathered from the literature review suggests that the presence of a discharge planning process in hospitals can positively affect patient outcomes upon discharge, and that it is probable patients being discharged from community health

services would benefit from a similar form of discharge planning. Therefore, my primary recommendations for nurses and managers are related to the development and implementation of discharge planning resources in community.

Through the consultations, it was evident that CHNs feel that discharge planning resources would positively impact their practice and improve the discharge process. The key assessment areas highlighted by interviewees were developed into a sample discharge checklist for surgical patients included in Appendix A. As well, several interviewees noted that discharge discrepancies between nurses and teams should be regularly reviewed by management. In collaboration with nurses, managers could develop strategies for increasing their ability to monitor discharge practices. For example, in Appendix B I have included a copy of the current managerial chart audit tool adapted to include a review of patient length of stay using the data gathered during chart reviews. This tool will allow managers to expand their current chart audit process to determine whether the patient was discharged after an appropriate length of time, and explore cases where patients received extended services. If the preliminary audit tool is beneficial, further chart reviews can be conducted to calculate average lengths of stay based on larger sample sizes, and for other commonly treated diagnoses in community.

In conducting the chart reviews, the discrepancy in service duration between groups 1 and 2, and the lack of information available in electronic nursing notes, indicate the importance of proper documentation and a need to review current charting practices. While it is likely CHNs had a rationale behind extending services for those patients in group 2, there was no documented explanation, and consequently it appears patients may have received services unnecessarily. Therefore, I have made recommendations related to documentation and evaluation of discharge planning practices.

Key Recommendations

Using information gathered throughout the literature review, consultations, and the client chart reviews, I make the following recommendations to the Community Support Program related to discharge planning in the community:

For management:

1. Form a community discharge planning committee to review current policy and practices, determine the discharge related needs of nurses and clients through extended consultations and workshops, and spearhead program changes.

2. Introduce a general discharge planning tool for CHNs in the form of a checklist, guideline, or policy. A proposed discharge checklist is included in Appendix A.

3. Develop the CHNs' knowledge and skills related to discharge planning:

    3.1 Incorporate education on discharge planning and assessment into orientation sessions for nurses who are new to community health.

    3.2 Incorporate an assessment of discharge practices in annual workload reviews.

4. Assess discharge practices:

    4.1 Adapt the current managerial chart audit tool. A copy of the tool with proposed changes is included in appendix B.

    4.2 Conduct a review of CRMS charting policies, with emphasis on the content of nursing notes, to avoid significant charting variations between nurses.

    4.3 Conduct further chart reviews over approximately 6 months to inform the development of surgery-specific guidelines which include average service durations, typical recovery milestones, most common complications, and surgery-specific discharge considerations.

For nurses:

1. Increase documentation surrounding the decision to discharge patients including any discharge-related assessments or concerns.

2. Incorporate a discharge planning tool into frontline nursing practice to promote positive patient outcomes.

3. Review discharge practices regularly and consult with colleagues when faced with a complicated client.

4. Discuss discharge planning expectations with colleagues and team leaders to ensure a similar standard of care is being provided.

Conclusion

This report reflects the culmination of my exploration into discharge planning in a community health nursing context. Beginning with the formation of a discharge planning committee, Home and Community Care program leaders can use the information and recommendations I have outlined to improve the discharge planning process and promote consistent, quality nursing care at home. I encourage CHNs, team leaders, and managers to collaborate, discuss the role of discharge planning in their workplace, and be active participants in the change process.

Discharge Checklist for Community Health Nurses

DISCHARGE CHECKLIST FOR SURGICAL PATIENTS

Initiate this checklist at the first nursing visit and continue to complete as appropriate throughout client care. Checking "YES" indicates discharge readiness for that criterion. Criteria where "NO" has been checked may require follow up prior to discharge from CHN services. If "NO" is selected, document the assessment, reasoning, and any related actions that may lead to a delay in discharge in the patient's electronic health record.

Patient Name: _____

Date of Assessment: _____

Assessment Completed by: _____

1. PHYSICAL HEALING	Yes	No
1.1 Have any wounds or incisions healed?	☐	☐
1.2 If no, can the client independently manage wound care?	☐	☐
1.3 Have all sutures or staples been removed?	☐	☐
1.4 There are no other medical complications requiring nursing management or follow up.	☐	☐
1.5 The client is medically stable or, if not, has been transferred to another medical professional for management and follow up.	☐	☐
1.6 The client has reached the pre-operative level of functioning or the highest achievable level of functioning for the condition.	☐	☐

Comments:

2. PATIENT SAFETY	Yes	No
2.1 The client lives alone but can function independently without assistance.	☐	☐
2.2 If not, does the client have a caregiver who is willing and able to check in periodically?	☐	☐
2.3 The client can complete activities of daily living independently or has a caregiver who can assist. Activities include but are not limited to: - Making meals - Personal hygiene - Toileting - Functional mobility	☐	☐
Comments:		

3. ENVIRONMENTAL SAFETY	Yes	No
3.1 The client is physically able to leave the house in an emergency.	☐	☐
3.2 The client has access to key areas of the home including: - Kitchen - Bathroom - Bedroom	☐	☐

3.3	The client is physically able to reach a phone for emergency services.	☐	☐
3.4	A fall risk assessment has been completed if warranted and the house has been assessed for fall related hazards including: - Stairs - Area rugs - Excessive clutter - Poor lighting	☐	☐
3.5	If the client is on home oxygen, there are no fire hazards in the home including open flame or tobacco use.	☐	☐
3.6	The client has assistive devices in place if necessary such as grab bars, extra railings, a walker or cane.	☐	☐
Comments:			

	4. PATIENT INDEPENDENCE	Yes	No
4.1	Nursing care be completed by the patient independently with adequate teaching.	☐	☐
4.2	The client has sufficient understanding of his or her medical condition.	☐	☐
4.3	The client has sufficient understanding of post discharge complications (e.g., the signs and symptoms of infection) and the appropriate follow up action (e.g., contact community health nurse, family doctor, or go to emergency department).	☐	☐

4.4	The client has the ability to attend follow up appointments and run errands required for activities of daily living (e.g., grocery shopping, prescription refills).	☐	☐
Comments:			

5. **PSYCHOSOCIAL NEEDS**	**Yes**	**No**
5.1 The client is coping well with diagnosis and treatment.	☐	☐
5.2 The client shows no signs of dependency on community health nurse.	☐	☐
5.3 The client is willing and agreeable to being discharged from services.	☐	☐
Comments:		

DATE OF ASSESSMENT:	CRITERION REQUIRING FOLLOW-UP:	DATE OF DISCHARGE:	CHN SIGNATURE:
Example	3.3	-	Jane Doe BNRN

Appendix B

Community Support Program Chart Audit Tool

Proposed changes to the existing tool are highlighted in <mark>yellow</mark>:

Criteria	YES	NO	Not Applicable	Comments
HARD COPY CHART				
Process and Procedures:				
1. Front Chart Cover: (a). Health Care Number (b). CRMS Number				
2. **End of Life Client:** Is there a copy of an Advanced Care Planning (ACP) Order Form (previously called a DNR) on chart?				
Documentation Guidelines:				
1. Admission Assessment / Nursing Intake/Assessment completed as per guidelines (first 1-2 visits) * Urban – used as a guide, evident in first note				
2. **Care Plans:** (a). Completed as per Documentation Guidelines? (b). Start dates entered (c). Stop dates entered				
4. **Assessment Tools: All used appropriately as indicated and completed as per requirements.** (a). Braden Scale (b). PPI / PPS Forms. (c). Falls Risk Assessment (d). Edmonton Symptom Assessment System and Canadian Problem Checklist (e). Discharge Planning Checklist				
Policy:				
1. **Working Alone Risk Assessment:** (a).Completed as per policy? (b).Was it updated as needed? (c). If risks were identified were they				

Criteria	YES	NO	Not Applicable	Comments
mitigated (d). What actions were taken? *see CRMS for Alerts Tab				
2. If there was evidence of paper based notes, where they properly linked to CRMS?				
3. **Paper Based Notes and Forms Are:** (a). Written legibly?				
(b). Written in non-erasable blue / black ink?				
(c). Free of spelling errors?				
4. Were all telephone / verbal orders signed within 48 hours? Not responsibility of the nurse, but note should state telephone/verbal order received.				
5. All pages of the paper chart contain client PPI (Health Care Number, etc.)				
Discharge Planning:				
1. The client received services over an appropriate duration for the diagnosis e.g., **Total Knee Replacements** - Routine: 12-13 days - Complication: Add 6 days **Total Hip Replacements** - Routine: 9 days - Complication: Add 3-4 days **Mastectomies** - Routine: 16-17 days - Routine: Add 3-4 days				
2. If services were provided beyond expected service duration, rationale was provided in notes (e.g., the patient requires an assessment by occupational therapy prior to discharge).				
CRMS ELECTRONIC FILE				
Policy:				
1. Demographics entered including				

Criteria	YES	NO	Not Applicable	Comments
(a). Name				
(b). Date of Birth				
(c). Health Care Number				
(d). Address				
2. (a). Referral Entered in CRMS				
(b). Appropriate Case Manager assigned.				
3. Was referral associated with service?				
4. Client characteristic complete?				
5. KIV's entered for :				
(a). Medical Orders				
(b). Re-assessments				
6. Were alerts entered in Alert Tab as required?				
7. Evidence of contact made within 24 hours of receipt of referral				
8. Evidence of secondary check documented in narrative note when administering High Alert Medications.				
8. Flow sheets are developed as per documentation guidelines				
9. Medical Orders entered as per policy				
10. Medication flow sheet has medical order transcribed as title				
11. Client Attendance Policy: if needed, used appropriately. Documentation evident in progress note.				
Documentation Guidelines:				
1. Provided education documented				
2. **Documentation Grammar:**				
(a). Objective data evidenced in the note?				
(b). Client's words are quoted, as needed?				
(c). Free of spelling errors				
3. Progress note is:				
(a). Clear				
(b). Concise				
(c). Lacks repetition				
4. Evidence to support 4 Eastern Health pamphlets given and discussed				

Criteria	YES	NO	Not Applicable	Comments
5. Notes are written in chronological order. * notes can be written in one service intervention, but time of completion should be in chronological order				
6. Medical abbreviations are used appropriately as per Documentation Guidelines				
7. CRMS Medication Tab completed as per documentation guidelines				
8. Nursing progress note links use of flow sheet				
9. Insertion of IV and/or change of site documented				
10. Documentation evident of contact and follow-up with other health care providers if necessary				
11. Discharge note denotes end of service with link to completed discharge planning checklist on main file if appropriate.				
12. End dates are entered for non-active client's – service closed				

Additional Comments:_____

Audit Completed By: _____