

Good practice in Earlier Discharge

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Council of Social Service
of New South Wales

NCOSS

NCOSS Discussion Paper



NCOSS

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Executive Summary

Background

The Good Practice in Earlier Discharge project was an overview of good practice in effective discharge from hospital with particular emphasis on the needs of four target groups: people with a chronic illness, people with a mental illness, older people and carers.

The project was undertaken through a literature review and broad consultation with a variety of community interests. It built upon an earlier NCOSS project, which resulted in the *Earlier Discharge: issues paper* (NCOSS, 2000).

In undertaking this work, NCOSS is focusing on the challenge of improving care for consumer in an environment of earlier discharge rather than reviewing the policy shift to shorter hospital stays, same day surgery and avoiding hospital admissions.

Project findings

Feedback from focus groups indicated that problems within the discharge process occurred mainly through lack of coordination, communication, collaboration and understanding between Government agencies and community service providers.

Consultations emphasised the lack of consistency between policy and practice in Area Health Services. There was also concern about the lack of data on outcomes of discharge, including both the health outcomes and whether or not services identified in the discharge plan were actually provided.

The project found a welcome focus on coordination in some parts of the health system, and efforts to involve GPs. It also found an ongoing problem of cost-shifting from acute hospitals to the community sector.

Chronic illness:

Focus group participants emphasised the importance of a holistic approach to discharge from hospital of people with a chronic illness. Commonly for this population group, community care is being resumed rather than commenced. People with a chronic illness commonly have complex and changing needs, particularly when their illness is episodic or progressive.

People with a chronic illness often have difficulty accessing generic services because their needs bridge different Government agencies. This target group often requires coordinated care in relation to all aspects of their lives, not just health issues.

Participants welcomed strategies to assist consumers and carers with absorbing information, such as videos.

Mental illness:

The project heard consistent reports of discrimination from all levels of services provision, and commonly from staff with limited knowledge of or confidence about mental health matters. This pointed to an urgent need for training.

Participants called for an emphasis on a planned and coordinated approach to care for people with a mental illness, with adequate time made available for the flexible coordination role to be performed. Positive examples of coordination included joint protocols between Area Health Service Mental Health services and local HACC providers, and with other Government agencies.

Older people:

The project found that as hospital admissions for older people are often not planned, their post-discharge services need careful planning. Comprehensive discharge planning is particularly important for those at risk of readmission or increasing dependency. Effective communication between hospitals and community services is a key factor in avoiding discontinuity of post-discharge care.

Participants emphasised that communication with consumers needs to be effective as older people may not challenge or complain due to fear of reprisal, or may not admit that they don't understand. The Client Information and Referral Record (CIARR) 'yellow book' was seen as an example of good practice, but creation of yet another booklet was not supported.

Carers:

Focus group participants reported that incorrect assumptions are often made about carers' willingness and ability to provide care, and carers are often overlooked in the discharge process. There was strong emphasis placed on the value of systemically involving carers in the whole care process.

Participants also emphasised that the capacity and willingness of carers can change over time. Ideally, follow-up of carers should occur at the same time as consumer follow-up.

The Carers NSW assessment tool, 'The Carers Profile', was seen as valuable.

Examples of good practice

The project listed a number of examples which focus group participants had identified as good practice. These range from emergency meal pack for people discharged from hospital, to the discharge process tool used by individual hospitals.

Ideas for future development

Ideas for future development identified during the project include a user friendly guide to hospital discharge for consumers and carers, and strategies for improving the discharge process within hospitals.

1. Background

In September 2000, NCOSS conducted a project about earlier discharge from NSW hospitals and published a paper entitled '*Earlier discharge' issues paper*². During the course of this project, which was funded by NSW Health, NCOSS was able to consult with a range of community groups including: consumer organisations, carer organisations, NGOs which provide services (and advocate for their communities), community health staff, hospital based social workers, and other organisation with an interest in promoting consumer interest and participation in the health system.

In undertaking this work, NCOSS focused on the challenge of improving care for consumer in an environment of earlier discharge rather than reviewing the policy shift to shorter hospital stays, same day surgery and avoiding hospital admissions.

The project concluded that the system-wide shift to earlier discharge from public hospitals to the community is creating a high level of community concern. There is extensive anecdotal evidence of gaps in the continuity of care which is impacting on the health of consumers and creating new demands for families and friends who act as carers.

The project also found that planning processes were not effectively responding to consumer needs. A central problem is the lack of clarity about which government agency is responsible for providing care in the community to consumers who have been discharged. While this remains unclear, consumers are continuing to fall through the gaps. The project found a need for a state wide community care strategy and identified the lack of clarity about the responsibilities of NSW Health, and the former Ageing & Disability Department (now Department of Ageing Disability & Home Care) as a key issue.

The following is a summary of consistent themes that were highlighted during the earlier discharge project:

- Lack of co-ordinated policy framework for community care which clearly describes the responsibility of NSW Health and the Department of Ageing, Disability and Home Care (DADHC);
- Poor implementation of NSW Health policies at Area Health Service (AHS) level;
- Misguided assumption by NSW Health service providers about the criteria for access to and availability of community services;
- Health financing arrangements which give individual hospitals and NSW Health in general, no incentive to effectively manage discharge into an unsupported home environment and no penalty if they fail to do so;
- Competing target groups within the community care field;
- Major gaps in planning processes within NSW Health and other agencies;
- Lack of infrastructure to support community input into the health debate; and
- Lack of useful data to identify gaps in the continuum of care post-discharge.

Following the completion of the *Earlier Discharge issues paper*, NCOSS sought funding from NSW Health for further work on earlier discharge issues. NSW Health did provide funding and that became this project, the Good Practice in Earlier Discharge Project.

2. Methodology

The NCOSS Good Practice in Earlier Discharge Project was a project to investigate issues in good practice in continuity of care between hospitals and the community. It was intended to build on the work undertaken by NCOSS in 2000 which resulted in publication of the *'Earlier discharge' issues paper*¹. The current project particularly targeted good practice in relation to people with a chronic illness, people with a mental illness, older people and carers.

The Good Practice in Earlier Discharge Project received funding from NSW Health to employ a project officer for a three month period to undertake the research.

In the first phase of the project NCOSS undertook a literature review of good practice in earlier discharge. NCOSS also used the results of the Earlier Discharge Issues Paper Project and feedback from two community forums that were held together with the launch of Earlier Discharge Issues Paper. These forums were conducted in November 2000 and were held at Central Sydney and Western Sydney and involved approximately 250 people from Area Health Services administration, community health services, community organisations (including Home and Community Care (HACC) and health funded NGOs), other government agencies, local government and consumers.

During the second phase of the project, NCOSS consulted widely and used varied methods of data collection. NCOSS held focus groups with each of the target populations: people with a chronic illness, people with a mental illness, older people and carers. Over 70 health and community sector workers, consumers and carers were consulted through focus groups during June and July 2001.

NCOSS sought input through discussions with the following forums: HACC Issues Forum, Aged Care

Alliance, and the Forum of Non-Government Agencies (FONGA). In July 2001, NCOSS held a focus group with Department of Veteran Affairs staff at their request and this involved over 20 staff. A further focus group was held at Westmead Hospital during July 2001 which involved social workers, care coordinators and discharge planners. NCOSS also met with individuals from the NSW Cancer Council, AIDS Council of NSW, and the Mental Health Coordinating Council.

Focus group participants were asked the following questions:

- What features make an excellent discharge plan?
- When and how should a discharge plan be developed for people with a chronic illness, people with a mental illness, older people and carers?
- Who should be involved in the plan?
- What are the special considerations for people with a chronic illness, people with a mental illness, older people and carers?
- What issues impact upon carers?
- Are you aware of existing good practices? What makes it a good practice?
- How should NCOSS use this information?

Participants provided NCOSS with numerous examples of good practice in earlier discharge. Given the project resources, it was not possible to effectively investigate and assess their respective claims. It was decided to list the examples which appeared, on the limited information available, to be productive strategies to ensure continuity of care across the hospital-community interface and to allow readers to further investigate those which they found of interest.

3. Literature Review

The project undertook a brief literature review on effective discharge from hospital.

There is extensive research surrounding discharge planning and effective discharge process. Discharge planning is central in planning and organising continuity of care³.

Evidence shows that the diversity in practice mainly results from differences in the definition of discharge planning and the scope of outcomes measured.

NCOSS prefers the definition of discharge planning proposed by the Council on the Ageing (COTA) Victoria. COTA Victoria defines discharge planning as the process through which people, hospital and community based services can work together to establish structures and networks which facilitate care across a range of services required⁴. This definition is preferred because it refers to all the players involved in departure from hospital and provision of care in the community rather than focusing on the production of paperwork and the narrow set of players involved in clinical care or exclusively hospital based care.

The process of discharge planning is commonly confused by lack of clarity about who is responsible for completing and coordinating the discharge plan. This was highlighted in a study of discharge planning in Western Australia⁵ which identified that:

- Doctors thought that doctors should co-ordinate discharge planning;
- Nurses thought that nurses should co-ordinate discharge planning;
- Allied health care providers had the most inconsistent views across hospitals, however in teaching hospitals they favoured doctors as the co-ordinators and in non-teaching hospital, they favoured nurses. Some allied health care providers some thought that allied health personnel should co-ordinate. The data suggests that this might reflect the different hospital practices,
- Most service providers favoured inter-disciplinary planning but doctors were overall the least enthusiastic about this,

- Doctors decided readiness for discharge on clinical data,
- Consultation with patients and their carers was lacking, and
- Discharge often occurred unexpectedly because beds were needed.

Studies about positive discharge planning consistently indicated the need for a nominated discharge co-ordinator that oversees the discharge process for consumers who are in the loop. The attributes of a discharge co-ordinator that are identified include:

- clinical knowledge
- assessment skills
- organisational skills
- communication
- effective and broad community networks.

The studies consistently concluded that the role of the discharge co-ordinator is to co-ordinate the discharge planning process, reinforce the roles and responsibility of the team member, ensure team members are committed to the discharge planning process, and incorporate the discharge plan into the patient's regular care.

It is important to recognise the differing roles in completing the discharge process. This includes recognising the differences between developing a discharge plan versus providing services in accordance with that plan. All aspects of the discharge process need to be completed to ensure an effective outcome.

The Centre for Health Outcomes & Innovations Research (CHOIR) at the University of Western Sydney Macarthur conducted a project titled "Improving post acute care outcomes for older people"⁶. The project tested the hypothesis that:

effective discharge planning and provision of appropriate post acute, community based services, will improve functional gain quality of life and perceived health outcomes for older people and prevent re admission to hospital.

Some conclusions from the CHOIR study included:

...that older people did not experience discharge in an orderly, planned process. Therefore it is important both in principle and for reasons of more effective achievement of outcomes to include older people in decision and planning processes.

...when people returned home, social and community care needs were more evident than personal care needs, contrary to the almost exclusive attention given to personal care in hospital process.

In its review of current Australian Literature in the area of discharge planning, the CHOIR project highlighted:

- The lack of homogeneity amongst the population;
- The importance of co-ordination of services and the needs for collaboration with those being discharged to improve continuity of care;
- The need for the discharge planning process to begin on admission rather than when the consumer is approaching discharge;
- Discharge planning needs to be a multidisciplinary team effort;
- The lower cost of community care when compared with acute or residential care;
- 85% of people aged 60 years are discharged to their own homes; and
- about a quarter of older people discharge from acute care hospitals take up community services, with community nursing being the common service used.

A study by Coulton *et.al.*⁷ reported that the negative perception of patients of the discharge process, such as feelings of being rushed and lack of choice and control, has an impact on post hospital well being and the ability to remain out of the costly secondary sector. Furthermore this study concluded that too often the quality of discharge planning is judged solely on the efficiency of the service organisation and documentation, and not on individual consumer outcomes.

A review conducted by the Victorian Department of Human Services⁸ identified that there are problems at present in Australia with both the adequacy and the organisation of post hospital services. These issues include:

- Lack of knowledge by hospitals of the services available to consumers in their local communities;
- Services spread across several levels of government and across diverse agency sponsorship;
- Lack of knowledge by consumers on what is available and where to go;
- Barriers to transport, availability and cost of services including allied health services;
- Services such as domiciliary assistance which have been organised in the past to do particular tasks are having difficulty adapting to both the volume and variety of new work being demanded by them;
- Inadequate levels of funding available for the provision of domiciliary services leading to cuts in services and the establishment of priorities which excludes many consumers who need assistance;
- Pressure on services provided under HACC faced with funding constraints, many of the states have not matched the Commonwealths HACC growth so that there is significant shortfall between funding available and services requested. Australian Institute of Health & Welfare estimates that only 50% of HACC demand is being met;
- Areas labelled under the HACC program as 'no growth' are where domiciliary nursing and home help services are experiencing increased demand as a result of post acute hospital services and palliative care;
- Ad hoc development of post hospital services leading to significant duplication and gaps in services; and
- Absence of any overall policy or planning or responsibility for adequate co-ordination and development of post hospital services.

4. Broad outcomes

4.1 Project Findings

The feedback from the focus groups indicated that the problems within the discharge process occur mainly through a lack of co-ordination, communication, collaboration and understanding between Government agencies and community service providers.

Whilst it would appear that much research has been undertaken on practices and protocols for discharge planning, our research has shown little evidence of consistency in practice and little proof that all practices actually achieve intended outcomes. There is little follow up post-discharge and issues of readmission are poorly documented. The gap between hospitals and community is exacerbated by poor communication between service providers and the consumer.

There are, however, some areas in the health system which recognise how vital the link is between acute hospital and community care and have developed a range of mechanisms to enhance practices. These mechanisms range from Co-ordinated Care Meetings (similar to Aged Care Assessment Team meetings but with the involvement of key community and community care services), the development of terms of reference and guidelines for partnerships, and consumer care meetings. All of these allow flexible and innovative approaches to care. Similar to Co-ordinated Care and Community Options, these projects adopt a brokerage model tailoring needs on an individual basis and purchasing services accordingly.

In addition, there is an increased emphasis on General Practitioner (GPs) as providers of care co-ordination. This is apparent both in Co-ordinated Care Trials and with the Enhanced Primary Care Initiatives. Informants indicated that there is ongoing concern about assigning a care co-ordination role to GPs, because there is a widespread concern at GPs ability to respond to social needs and identifying the complex array of social services required to meet these needs. The Reinvestment Strategy (which has been developed by the Health Care in the Community Working Group, under the NSW Health 2000 Government Action Plan) emphasises the primary role of GPs in community care, despite the lack of evidence to support the many initiatives to involve GPs in co-ordinated service provision.

NCOSS has concluded that effective discharge planning should be a partnership between the consumer, their carers, the hospital, GPs and community providers. It is about addressing the 'whole' person's situation not just the disease or illness. At present the rhetoric of shared responsibility, within a whole of government approach, means that no agency is primarily responsible for resourcing and servicing community care and community health on a continuum. Hospitals generally consider that their responsibility has ceased when a discharge plan has been prepared. There is no review process to determine whether or not the care prescribed in the plan has been provided or whether it met the consumers needs.

Consistent with the findings in the Earlier Discharge Issues Paper, this project has clearly identified that cost shifting from acute hospital care to the community sector is occurring without any commensurate shift of resources. Consumers continue to fall through the gap between hospital and community as no agency is taking responsibility for the discharge process in its entirety.

Throughout this project NCOSS heard of many examples where poor communication and documentation resulted in inappropriate and ineffective discharge plans. One focus group participant spoke of costly delays of up to ten days for admission forms and discharge summaries to be received internally within the hospital mailing system.

On the basis of this evidence, NCOSS would strongly recommend the development of a standard referral form and a comprehensive discharge plan. Discharge plans should encompass all areas of the consumer and carers needs and also to be flexible in addressing new and changing issues. Ideally, discharge plans should be developed at the time of initial consultation, with health service providers prior to admission or immediately upon admission.

4.2. NCOSS response to NSW Health Effective Discharge Policy

At the same time that NCOSS was consulting and developing this project, NSW Health was disseminating a Draft Policy on Effective Discharge Planning⁹ to the

public for comment. Whilst comments were sought from a limited number of agencies, these resulted in minimal changes to the final document.

Key elements of the document were:

- Targets for risk screening of 100% of booked patients prior to admission, and 100% of emergency patients within two days of admission
- Targets for development of a discharge plan of 100% booked patients prior to admission, 100% of emergency admissions within two days of admission, and 100% of patients admitted to critical care areas within two days of transfer out of the critical care area.
- An audit of discharge practices at a selected samples of public hospitals in 2001.
- A workshop to share examples of best practice following completion of the audit.
- Development of regular reporting against targets for effective discharge planning, to commence in July 2002. It is expected that future performance targets which measure the outcomes of effective discharge.

NCOSS, in consultation with key community groups, identified the following issues and concerns with the draft policy on Effective Discharge Practice:

- NCOSS is concerned that although policies have been and are being developed to address issues such as earlier discharge they are not endorsed nor adopted across the whole community sector.
- There continues to be a lack of uniformity across Area Health Services in addressing the issue of earlier discharge
- Whilst hospitals may have written policies about discharge planning or hold discharge planning meetings, there is no process to ensure that these processes lead to effective discharge planning practices nor that the services were actually delivered.
- NCOSS welcomes the introduction of a standardised discharge risk screening tool and believes this may assist in facilitating early notification or referral to community care providers. However NCOSS is concerned that existing tools used by NSW Health services, could be substituted for the 'new' standardised tool. NCOSS believes this will result in continued confusion, inconsistency of practices and ineffective processes. NCOSS supports the development of a uniform policy for the use of a risk screening tool.
- The Effective Discharge Policy does not detail clear processes or responsibilities regarding the completion of the discharge plan. NCOSS is concerned that responsibility regarding the completion of a discharge plan has not been aligned to a certain position or positions and that discharge planning may occur on an ad hoc basis.
- The Effective Discharge Policy does not support the inclusion of the patient and carer in the development

and monitoring of the discharge plan. NCOSS strongly affirms that patients and carers should be involved at all stages of development and monitoring of the plan.

- NCOSS welcomes NSW Health's decision to audit discharge practices and measurement of discharge targets. However, NCOSS is concerned that consumers are not being included in the audit process.
- Whilst the draft Effective Discharge Policy identifies an audit on a "limited number of hospitals" it does not provide detail about the exact number of hospitals involved nor the criteria for choosing participating hospitals. NCOSS strongly urges NSW Health to, firstly, audit all hospitals within NSW and, secondly, ensure that audits are in line with accepted qualitative and quantitative research methods.
- NCOSS is concerned that at no stage throughout the draft Effective Discharge Policy are there guidelines or processes for working with community care and community service providers in the development and implementation of the discharge plan. NCOSS strongly recommends that non-government community service providers, consumers and carers be involved in the process of designing discharge planning services across NSW as well as in the development and monitoring of individual discharge plans.
- NCOSS is concerned that the shift to earlier discharge is occurring at the same time as implementation of 'de-institutionalisation' strategies for people with a mental illness. While these are welcome changes, the transition from institutional care to community based care increases the pressure on existing care services, and may leave people homeless. The flow on effects result in community health services spending ever larger amounts of time on community care for people leaving hospital, resulting in fewer resources for their core work of primary health care and community development.
- NCOSS is concerned that there is no transparent, public information regarding the cost savings for hospitals in relation to earlier discharge.
- Unless community care services receive increased funding to address earlier discharge, problems are merely being shifted by NSW Health rather than addressing them.

4.3 NCOSS input into the Government Action Plan

During the life of the project, issues in earlier discharge were under consideration in a number of committees in the Government Action Plan.

The Health Care in the Community Working Group was examining strategies for reinvestment in health services in the community. The Chronic and Complex Care

Implementation Group was rolling out the Priority Healthcare Program to improve care for people with a chronic illness.

NCOSS was a member of these committees and raised the issues which emerged from the project in these forums. Neither of these committees had completed their work at the time of writing.

After the completion of the consultation phase of the project, the Models of Care Implementation Working Group commenced work on the hospital discharge process. NCOSS was a member of this group and was participating in the committee's Discharge Planning Reference Group at the time of writing.

“There is little follow up post-discharge and issues of readmission are poorly documented.”

5. Target groups

From the work undertaken in the Earlier Discharge Issues Paper Project, NCOSS identified four key target group areas which required further investigation: people with a chronic illness, people with a mental illness, older people, and carers. These were chosen as the four main areas for investigation in this study.

5.1 People with a Chronic illness

Similar to the diversity in the definition of discharge planning, confusion exists around the definition for chronic illness.

Regardless of the scope of definition, there are some clear issues impacting upon chronically ill people in relation to discharge. The chronic illness focus group emphasised the importance of a wholistic approach to people with a chronic illness. Often individual discharge plans can be more complex, as it relates to more than just recovery. Focus group participants commented that care is often being resumed, not commenced and requires regular evaluation and monitoring.

People with chronic illness and particularly those with diseases that are progressive or episodic in nature, may have complex and changing needs. They may have difficulty accessing appropriate generic services because the service they need may bridge different Government Departments e.g., HACC, Department of Ageing, Disability and Homecare (DADHC), Aged Care Assessment Team (ACAT) services and Community Health palliative care.

The focus group reported that people who are younger than 65 may have difficulty accessing support through Comprehensive Assessment Services (presently available to older people through ACAT services). These Comprehensive Assessment Services may be the only option to facilitate ongoing care in the home and avoid inappropriate nursing home placement.

Informants emphasized that chronically ill people often see a series of health care professionals which can confuse genuine continuity of care. The fragmentation of the human service system does not encourage delivery of best possible care.

The chronic illness focus group and others reported that access to information is especially vital for people with a chronic illness. Often the emotional state of the client or carer limits their ability to absorb information. Some examples of good practice have included communication cards (available in languages other than English), an audiotape of a health consultation, fact sheets and videos. In addition the active involvement of GPs is highly encouraged, as is access to support groups, for both consumers and carers.

Informants commented that chronic illness can affect every aspect of an individuals' life, sometimes for very long periods of time. In view of this, they argued that the co-ordination of consumer health and well being should cover all aspects of their life, including social security benefits, employment opportunities, travel arrangements, aids and equipment, health needs, education, credit facilities. These all need to be carried out with a flexibility that allows a person to alter their lifestyle as circumstances change. Without this approach the essential difference between people with chronic illness and other consumers of health services is not addressed.

5.2 People with a Mental illness

Informants reported that the focus of policy, planning and implementation around community care has mostly been about frail aged people and people with disability. Increasingly the care needs of people with mental illness and chronic illness need to be integrated into an overview of community care/health services.

Focus group participants reported that discrimination against people with a mental illness exists in all levels of service provision and mostly from staff who are not confident or knowledgeable about mental health matters. This stigma and lack of understanding highlights an urgent need for community and workforce training, education, and awareness of issues affecting people with a mental illness.

Feedback from the mental illness focus group highlighted that a planned and co-ordinated approach to care is vital for people who experience mental illness. Appropriate care co-ordination takes time and can alter on a daily

basis, depending upon the degree of support required by the consumer or their carer.

An example of good practice of care co-ordination of people with mental health issues is operational in the Hunter area, where joint protocols have been developed between the Area Health Service Mental Health and HACC services. This strategy has been further extended in the Hunter and links have been developed between government agencies in health and housing, and other agencies such as NGOs.

The focus group reported that a wholistic approach to care is required for people who have a mental health condition which addresses the whole person, and not just the illness.

5.3 Older people

Members of the older people focus group identified as a key issue for older people that often they don't plan for an illness or condition to occur and therefore their recovery rate can be dependent upon the immediate provision of support services.

Naylor *et.al.*¹⁰ concluded that frail elderly are more likely to experience increased lengths of stay in acute care, notwithstanding the fact that the majority of elderly patients return to their previous living arrangements. Those who require long term residential care are often viewed by hospital providers as 'bed blockers' or 'social admissions'. Comprehensive discharge planning, with the ability to ensure that continuing needs are met, has benefits for older people who are at risk of delayed discharge or readmission and increasing dependency. Effective targeting of services is important to ensure that the consumer is receiving the most appropriate and least disruptive care.

Throughout the study undertaken by CHOIR¹¹, members of the Council on the Ageing (COTA) focus group identified several areas where lack of communication between hospital and community services lead to discontinuity in post discharge care. These included not being visited at home by the same support worker twice, having to repeat information to a variety of support workers who visited them, feeling they were having their privacy invaded by strangers, receiving contradictory advice and information and having parts of their care routine omitted because information was not being shared between support workers.

Feedback from focus groups reiterated that older people require clear and concise communication, as all people do. More often than not, older people will not admit that they do not understand nor will they challenge or complain about a service due to fear of reprisal.

Many people identify the Client and Information Referral Record (CIARR) booklet as an example of good practice for older people. The 'yellow booklet', as it is referred to, acts as a central assessment and referral tool amongst

"Informants commented that chronic illness can affect every aspect of an individuals' life, sometimes for very long periods of time."

HACC services for the level of community care that is required. This concept has been extended to Commonwealth community services. The CIARR allows for accurate and correct client information to be available at all times because this information is kept by the consumer.

Further extensions of this concept could include a more detailed carer profile (refer to the Carer Profile developed by Carers NSW¹²) and information on medication, and an ability to track any changes. Research has supported the necessity for accurate and constant updating of medication records and changes to personal circumstances.

Whilst NCOSS supports the extension of the CIARR booklet, it does not support the creation or duplication of another booklet type. The recently launched Health Record booklet by the Chronic and Complex Care Implementation Group (a reform initiative under the 2000 NSW Government Action Plan for Health) is an example of this duplication of personal health records.

4.4 Carers

Much research has been conducted around the value and role of carers in relation to ensuring an effective discharge process, with the aim of reducing hospital readmission rates. However, whilst carers play a vital role in the consumer's recovery, often they are overlooked in the discharge process and many incorrect assumptions are made about both their willingness and ability to care. Considering that existing HACC services only meet a small portion of their care needs, the role of the carer is vital in any discharge process and must be included to ensure quality and timely recovery.

Feedback from all consultation identified that carers must be systematically involved in the whole care process and not just at the discretion of the service provider. It is important not to over empower carers above the consumer, as individual dignity must be respected at all times.

Informants emphasized that when considering carer involvement, it is important to determine both capacity and willingness to care. Any assessment of carers must

be reviewed regularly, as their ability to care can often change. Ideally follow-up of carers should occur at the same time as consumer follow-up.

By considering the needs of carers, carers distress is minimised and the consumer remains supported in their home environment.

Carers NSW Inc. has developed a comprehensive and appropriate assessment tool for carers: The Carer Profile¹³. This provides a framework for assessing the ability and needs of carers.

6. Good practice in earlier discharge

6.1 Examples of Good Practice in Earlier Discharge

This project has identified that networking/communication and input from key individuals are fundamental to the success of effective discharge practices. It is clear that to meet the underlying objective of effective care requires a commitment from all parties to conduct, implement and monitor a plan which addresses individual needs. Components of effective discharge practices have included: good communication between all parties, strong leadership and adequate resources.

Listed below are some examples of existing good practices identified via focus groups. The examples are those provided by individuals and organisations consulted and there were insufficient resources to assess their respective claims during a three month project. Therefore, NCOSS has developed this list to enable readers to contact relevant organisations if they are wanting to follow up these examples:

■ **Emergency meal packs- Meals On Wheels**

A partnership in the Blue Mountains between hospital and community has involved in Meals on Wheels providing emergency food packages to the hospital for people discharged early from hospital. These packages provide enough food for 2 days and allows Meals on Wheels 2 days for assessment and access to its broader program.

■ **Transport protocols between health and community transport**

Draft protocols have been developed by health and community transport providers in relation to transport requirements for people who are discharged from hospital. The aim of these protocol is to reduce the existing burden upon community transport providers who are inundated with hospital discharges. For further information contact your local community transport provider.

■ **Transition teams for intense case management**

These resulted from the Co-ordinated Care Trials. They involve an 8 week intervention program to provide short term case management via a multidisciplinary team to enable consumers to stay

in home and return to home. These programs have operated on the Mid North Coast and Hunter Area Health Services.

■ **Flying team and rapid response teams**

These are specialist teams which respond to individual needs which are diverse and immediate. They are normally made up of a range of health and community professionals and result in effective outcomes however they are only implemented on a very short term basis. These initiatives have been utilised in the Northern Sydney Area Health Service.

■ **Shared Care for Older People Project (SCOPP)**

This was designed to establish greater co-operation between aged care services and General Practitioners in the care of older people. It includes personal information; past medical history; patient assessment on entry to SCOPP; activities of daily living; medical specialist involved in care; community services section; health services record; medication and other useful information. This project has been operational in South Eastern Area Health Service.

■ **Co-ordinated Care meetings with brokerage dollars**

These consists of a coordinated approach to care. It involves health and community professionals coordinating a case plan and utilising a brokerage pool concept to most effectively address individual needs. This model has been trailed on the mid North Coast and Central Sydney.

■ **Client and Information Referral Record (CIARR) Booklet, also known as 'the yellow book'**

This is a personal health record which ensures that information is accessible and up to date. It is currently being adapted in different formats throughout other health areas. This is an initiative of DADHC.

■ **Medication Record - Combined Pensioners Association**

Similar to the CIARR booklet for tracking personal information, this booklet tracks a history of medication and any changes.

■ A Discharge Planning Resource Kit for Hospital and Day Surgery

This tool whilst predominantly for war veterans has generic aides which could be modified for the broader community. This was developed by the Commonwealth Department of Veteran Affairs.

■ The Discharge Process at The Alfred Hospital (Melbourne)¹⁴

This tool details the key components to discharge process at the Alfred. It includes:

- A Care Assessment Tool (CAT) A two page referral form which has individualised referral for a variety of Allied Health disciplines and other speciality nursing consultants
- Discharge Information/Communication Tool: a 1 page form which acts as a reference for every team member to ascertain what has been organised for the patients discharge. This letter is given to all patients on discharge. It provides the patient with contact persons and phone numbers, appointments, a convenient time for follow up phone call and written instruction that can be used as a reminder or reference.
- Patient Call Back Data Sheet: This document is used when follow up call to patients is made after discharge.
- Discharge Planning Pointers: Details pointers regarding; initial 24 hours; during admission; 48 hours prior to discharge; on the discharge day.

The Alfred Hospital is a member of Bayside Health and operates in Victoria.

6.2 Other Related Programs

Post Acute Care

The Post Acute Care (PAC) program was established in Victoria in 1996 to address changes in HACC services provision. The tightening of HACC services has meant that they may be no longer able to provide post-acute services for people who have been discharged from hospital early. PAC provides additional services for individuals who require them to improve the links between hospital and other health and community care providers.

A recent study by Department of Human Services Victoria examining the outcomes of the PAC program for older patients concluded that the program is viable and cost effective approach to improving the transition of older patients from hospital to the community. Readmission rates were reduced, where readmission occurred length of stay was reduced and there was a general improvement in patients' quality of life.

Older people at risk of admission

The following are two initiatives that provide rapid response to older people at risk of admission to hospital

who have either presented at an emergency department or are likely to do so:

The GP Homelink: This program aims to avoid 'unnecessary' hospital admission for older person at risk of admission to hospital by working with GPs to provide short-term intervention and homecare services at no cost to the patient or GP with a co-ordinator assessing the person and determining eligibility to service mix.

The Emergency To Home Outreach Service at Flinders Medical Centre in South Australia in partnership with the Royal District Nursing Services and Southern Domiciliary Care and Rehab Service and is focused primarily on older people. It receives referrals from the Emergency Departments, local GPs and ambulance services and aims to provide support for people to manage at home or in a respite facility for up to seven days as an alternative to hospital admission.¹⁵

Carelink

With the introduction of the Commonwealth Carelink Centres, consumers and health professionals are now provided with a one-stop shop concept for accessing relevant community services information. The dilemma is whether Carelink centres will fill the gap between health and community services without adequate resourcing. Whilst the centres' role is to inform on availability and options for community support, in many cases there will be no service to refer to. Service providers and consumers have informed NCOSS of waiting times of 12 months for some community care services. Other community care services have completely closed their books and are no longer accepting new clients.

Comprehensive Assessment

The introduction of comprehensive assessment throughout the HACC program provides some opportunity to provide a more coordinated approach to care. Whilst it is still in its very early stages HACC service providers are viewing comprehensive assessment as a worthwhile and desirable strategy. However it is a strategy only accessed by the HACC target group and not implemented across the broader community.

Issues which may impact upon the successful implementation of the program are:

- the appropriateness of Aged Care Assessment Team (ACAT) assessment for people with a disability
- issue of consent and confidentiality
- issue of addressing carers' needs
- time and resource requirements for coordinating service providers
- clarity of roles and responsibilities between service providers.

Carer Profile

It is essential that the needs of carers are considered when coordinating care for the consumer. Carers NSW have developed a carers profile to assist service providers and health professional in this task. The following areas need to be considered in developing a carer profile:

- carers goals for themselves and their hopes for the person being cared for
- current strengths in the caring relationship': what the carer currently does and the time it takes
- current pattern of responsibilities and time commitments
- supports that are currently received (formal and informal)
- respite needs (home, community, residential)
- other unmet needs
- caring capacity (carer's perception of the caring situation, their attitude towards continuing and their ability to continue to provide care)
- health impacts (current and future)
- emotional impacts (acute or chronic problems of emotional adjustment)
- social impact (the social needs and the social support that are currently available and utilised)
- carers own work, domestic, family and relationship responsibilities and how the caring responsibilities impinge on these; the attitudes of family members, employers and significant others
- sleep impact
- financial impact (to determine need of referral to government agencies such as Centrelink or charitable bodies; the impact of fee for service charges)
- the environment of caring (the physical environment both inside and outside the home, taking into account occupational health and safety issues)
- the need for personal support (e.g. support groups, formal counselling, peer support)
- alternative emergency care plans (in the event of illness, accident or other emergencies)
- information and training needs (identify gaps in carer's skills, knowledge and supports)
- alternative emergency plans (considering provisional plans for future care)
- each assessment should include action plans and time frames for reassessment.

6.3 Ideas for future development

Throughout the development of this project, NCOSS has developed and identified some practical tools to assist service providers, consumers and carers during the discharge process.

Attachment 1 details a user friendly guide for consumers and carers 'Being discharged from hospital- what you

"... networking/communication and input from key individuals are fundamental to the success of effective discharge practices."

need to know' highlights what is a discharge plan and who is involved. It also includes a series of trigger questions of what you need to know about the discharge process. These questions are:

- What is my discharge date?
- How long will I take to recover?
- What do I need to do to help my recovery?
- How will I get home?
- What medication do I have to take and how often?
- Are there any special things I should do that will help my recovery process?
- Who can I contact if I have any questions or concerns?
- Has a follow-up (outpatients) appointment been made?
- What community care services have been identified for me on my discharge plan?
- Who is going to arrange for them to be delivered?
- Who do I contact if they are not provided?

Attachment 2 details the basic steps to completing the discharge process including specific ideas from target groups. This resource has been modified from existing practices at The Alfred Hospital in Melbourne.

7. Conclusion

Although much research has surrounded discharge planning and practices, there are few fully documented and evaluated examples of good practice. NCOSS would like to see further work done to record and disseminate good practice in effective discharge, both in the hospital system and in community organisations.

The development and adoption of good practices in effective discharge is dependent on adequate resourcing. This is a major issue for services in the community which are bearing the brunt of cost-shifting from hospital services to the community.

When considering good practices in earlier discharge the necessity for appropriate, immediate and effective assessment continues as a priority. Although some have told NCOSS that effective discharge planning is about focusing on the wellness of a person rather than their illness this report has highlighted that successful discharge planning occurs via co-ordination, communication, collaboration and an understanding between Health and other service providers.

NCOSS remains concerned at the gap between policy and implementation in discharge practices in NSW Health. Effective monitoring is required to overcome the present arrangements in which the extent to which effective discharge policies are implemented appears to be at the discretion of Area Health Services.

NCOSS maintains its concern that reducing costs rather than improving care or improving health is driving these radical changes in the health system. Any financial benefits from earlier discharge from hospital should not come at a cost to effective of health services and client outcomes.

Endnotes

- ¹ Reedy L, Bragg R. *'Earlier discharge' issues paper*. Sydney: Council of Social Service of New South Wales (NCOSS), 2000.
- ² Reedy L, Bragg R. *'Earlier discharge' issues paper*. Sydney: Council of Social Service of New South Wales (NCOSS), 2000.
- ³ Australian Pharmaceutical Advisory Council. *National guidelines to achieve the continuum of quality use of medicines between hospital and community*. Canberra: Commonwealth Department of Health and Family Services, 1998.
- ⁶ McCallum et.al. *Improving post acute care outcomes for older people*. Campbelltown: Centre for Health Outcomes and Innovations Research (CHOIR), 1998.
- ⁷ Coulton CJ, Dunkle RE, Chow J, Haug M & Vielhaben DP. 'Dimensions of post hospital care decision making. Factor analytic study.' *The Gerontologist* 1998; 28:218-223.
- ⁸ Health Services Research Unit (Department of Epidemiology and Preventative Medicine Facility of Medicine, Monash University). *Identifying and developing performance indicators based on processes of care associated with effective discharge planning*. Effective discharge strategy: Performance indicators development project discussion document. Melbourne: Department of Human Services Victoria, 2000.
- ⁹ NSW Health. Draft Policy on Effective Discharge Planning. Sydney: NSW Health, 2001.
- ¹¹ McCallum et.al. *Improving post acute care outcomes for older people*. Campbelltown: Centre for Health Outcomes and Innovations Research (CHOIR), 1998.
- ¹² Carers NSW Inc., Members of the Carers Coalition. *Carer profile*. 1998.
- ¹³ Carers NSW Inc., Members of the Carers Coalition. *Carer profile*. 1998.
- ¹⁴ The Discharge Process at The Alfred- (2000) A member of Bayside Health, Melbourne Australia
- ¹⁵ Patient Management Taskforce. *Improving hospital care for older Victorians*. Melbourne: Department of Human Services Victoria, 2001.
- ¹⁶ NSW Health Council. *Report of the NSW Health Council: A better health system for NSW*. Sydney: NSW Government, 2000.

Bibliography

- Australian Pharmaceutical Advisory Council. *National guidelines to achieve the continuum of quality use of medicines between hospital and community*. Canberra: Commonwealth Department of Health and Family Services, 1998.
- Carers NSW Inc., Members of the Carers Coalition. *Carer profile*. 1998.
- Commonwealth Department of Veterans' Affairs. *Discharge planning for veterans and war widow(er)s in NSW: A discharge planning resource kit for hospitals and day surgeries*. 1997.
- Coulton CJ, Dunkle RE, Chow J, Haug M & Vielhaben DP. 'Dimensions of post hospital care decision making: A factor analytic study.' *The Gerontologist* 1998; 28:218-223.
- Department of Human Services Victoria. *Performance indicators of effective discharge*. Melbourne: Department of Human Services Victoria, 2000.
- Driscoll AM. 'Managing post discharge at home: an analysis of patients and their carer perceptions of information received during their stay in hospital.' *Journal of Advanced Nursing* 2000; 31(5):1165-1173.
- Eagar K, Owen A. *Towards a national HACC client classification centre for health service development*. Wollongong: University of Wollongong, 2001.
- Elgie C. 'Discharge Planning.' *Nursing Management* 1998; 4(8):10-11.
- Fine M. *Coordinating health, extended care and community support services: issues for policy makers and service providers in Australia*. Discussion Paper 80. Kensington: Social Policy Research Centre (UNSW), 1997.
- Hagan P, Cooper C. *Some characteristics of hospital admissions and discharges: older Australians*. Occasional Papers, New Series No. 8. Canberra: Commonwealth Department of Health and Aged Care, 1999.
- Health Services Research Unit (Department of Epidemiology and Preventative Medicine Facility of Medicine, Monash University). *Identifying and developing performance indicators based on processes of care associated with effective discharge planning*. Effective discharge strategy: Performance indicators development project discussion document. Melbourne: Department of Human Services Victoria, 2000.
- McCallum et.al. *Improving post acute care outcomes for older people*. Campbelltown: Centre for Health Outcomes and Innovations Research (CHOIR), 1998.
- McKenna H, Keeney S, Glenn A, Gordon, P. 'Discharge planning: an exploratory study.' *Journal of Clinical Nursing* 2000; 9(4):594-601.
- Nankervis J. Taking carers issues into account in discharge planning. Presentation to Victorian Effective Discharge Planning Group meeting, 2 February 2001.
- Nazarko L. 'Improving discharge: the role of the discharge co-ordinator (care of older people).' *Nursing Standards* 1998; 12(49):35-37.
- NSW Health Council. *Report of the NSW Health Council: A better health system for NSW*. Sydney: NSW Government, 2000.
- Patient Management Taskforce. *Improving hospital care for older Victorians*. Melbourne: Department of Human Services Victoria, 2001.
- Reiley P, Lezzoni L, Phillips R, Davis RB, Tuchin L, Calkins D. 'Discharge planning: comparisons of patients and nurses perceptions of patient following hospital discharge.' *The Journal of Nursing Scholarship* 1996; 28:143-147.
- Scott J. *Up close and personal: informing and involving consumers in coordinated care*. *Health Issues* 49, 1996.
- Professional Documents Recommendations for the peri operative care of patients selected for day care surgery *Australian and New Zealand College of Anaesthetists Review* 2000; 15
- The Discharge Process at The Alfred- (2000) A member of Bayside Health, Melbourne Australia

Attachment 1

Being discharged from hospital? What you need to know...

What is a discharge plan?

The process of planning for needs after discharge from hospital or another facility. Effective discharge planning begins at admission or before when possible.

Who can be involved?

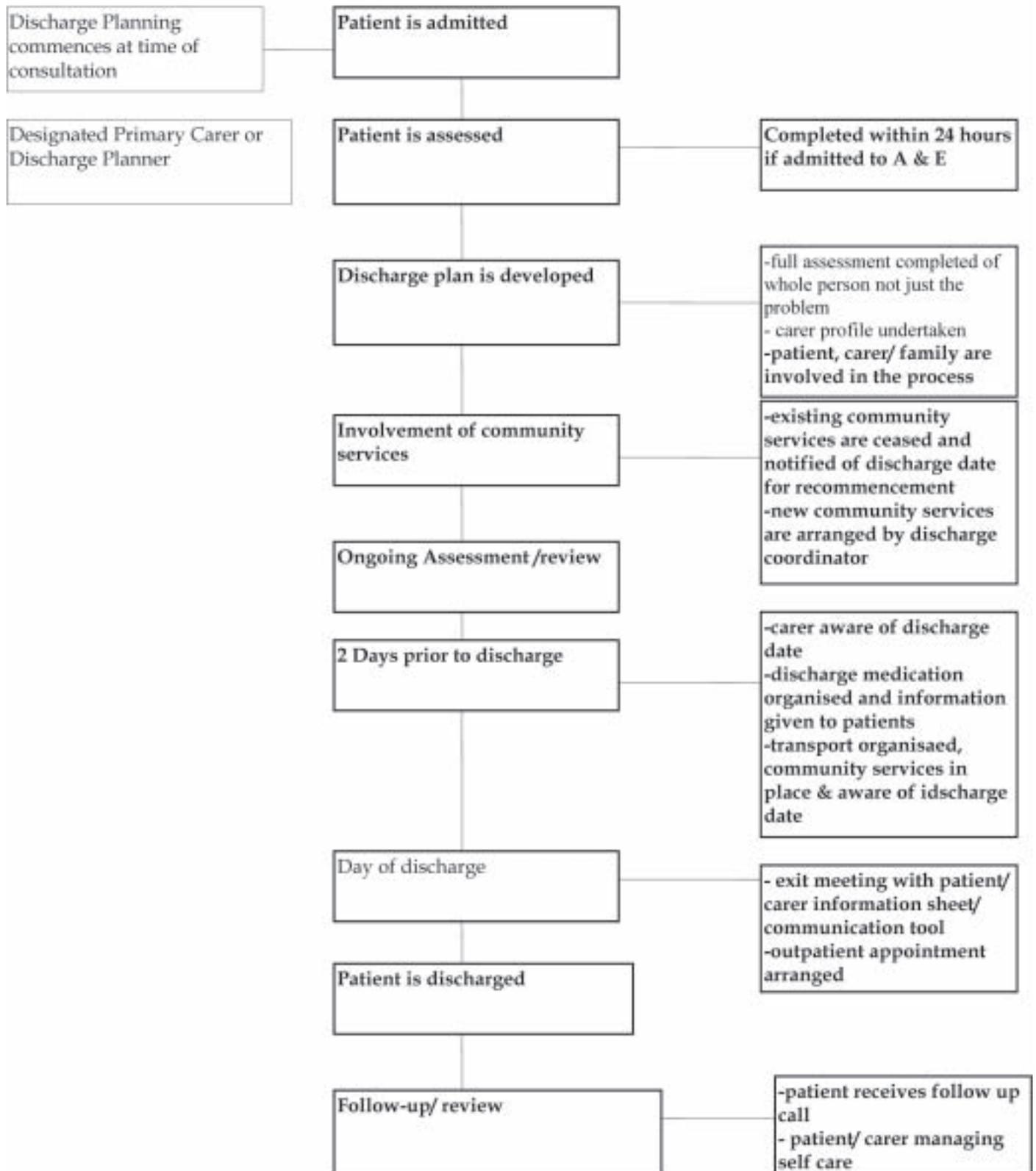
For each discharge plan the people involved will be different depending on the needs of the consumer. Some examples of who may be involved include; consumer, carer, GP, nurses, care co-ordinators, social workers, occupational therapists, community health, community services, aged care assessment teams, and HACC services

Some questions you may need to ask:

- What is my discharge date?
- How long will I take to recover?
- What do I need to do to help my recovery?
- How will I get home?
- What medication do I have to take and how often?
- Are there any special things I should do that will help my recovery process?
- Who can I contact if I have any questions or concerns?
- Has a follow-up (outpatients) appointment been made?
- What community care services have been identified for me on my discharge plan?
- Who is going to arrange for them to be delivered?
- Who do I contact if they are not provided?

Attachment 2

A GOOD PRACTICE EXAMPLE OF THE DISCHARGE PROCESS:



Adopted from "The Discharge Process" - The Alfred Melbourne