A Comprehensive Discharge Approach for the Elderly in Psychiatric Settings

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ABSTRACT

The financial state of hospitals is negatively impacted by the burdens of patients returning to the hospital setting due to unresolved issues upon discharge. The elderly population is identified as one of the highest utilizers of care contributing to a significant burden in our healthcare systems. This vulnerable group requires an extensive of services while in the hospital to ensure their success upon discharge. A comprehensive approach to the discharge process begins on the day of admission, continues throughout the course of hospitalisation, and at the time of discharge. This plan includes: (a) identifying and preparing for a patient’s anticipated healthcare needs, (b) implementing a patient-centered approach that meets the individual needs of the patient, (c) assessing and recommending plans of care from the multidisciplinary team members, (d) providing education and support to patient, family, and caregiver(s), and (e) actively engaging the patient, family, and caregiver(s) in the process. The goal of this project is to integrate a comprehensive discharge process that will result in a decrease rate of recidivism among the elderly patients hospitalised in psychiatric units. It is also expected that hospitals that provide a comprehensive discharge approach to this population will not only achieve a reduction in financial spending but also improvements in patients’ satisfaction scores from their hospital experience. With the implementation of this performance improvement project, the cost is expected to range between $18,732.00-$26,760.00 in potential savings, promoting financial stability, and gains to the organisation.

KEYWORDS: elderly patients, healthcare, patient discharge, psychiatric

INTRODUCTION

Psychiatric units provide care and treatment to individuals with mental health needs. The elderly population encompasses an exclusive set of individuals requiring intensive treatment strategies because of their vulnerable states for potential relapse. Many of these individuals not only present with mental health conditions but several other co-morbid conditions that either result from or co-exist with their mental health issues. It is equally necessary to identify the specialized needs of this vulnerable group with treatment modalities that are encompassed in their discharge process to promote mental and physical health prior to leaving the hospital setting.

Frequent re-hospitalisations are common among the elderly population and have contributed to these individuals becoming a part of the revolving door effect, also known as the frequent fliers. Hartocollis3 found that emergency rooms are overcrowded with these frequent fliers and an estimated 15% to 20% of those over the age of 65 years old accounted for these visits. It is important to explore the reasons why this vulnerable population is not being managed effectively on an outpatient basis as evidenced by their continued presentation to emergency room setting. An identifiable issue that has led to the revolving door effect is a lack of education and passive participation in their discharge planning process while in the hospital.5

Foss examined the discharge process and found it to be a vulnerable portion of the patient’s hospital stay that necessitates a quality assessment and evaluation...
to help the patient manage outside of the hospital setting. There are many facets to the discharge process such as: (a) identification of primary caregiver(s), (b) exploration of home health nursing support, (c) assessment of necessary medical equipment, and (d) the patient’s understanding of instructions that facilitate adherence upon discharge. Factors that contribute negatively to the patient’s discharge process include: (a) poor coordination among family members and the multidisciplinary health team members, (b) lack of understanding and participation in discharge instructions, (c) poor support systems that were not identified while in the hospital, (d) cultural barriers that impact their compliance, (e) fear of asking questions about their discharge, (f) noncompliance with prescribed medication regimens, and (g) lack of follow up care with their primary healthcare providers upon discharge. These factors unfavourably impact the patient’s ability to manage and succeed outside of the hospital, thus resulting in the recidivism of patients to the hospital settings.

There are limited programs geared specifically to the fragile, elderly population. A usual standard discharge of care exists for patients admitted to the psychiatric facilities without consideration of age and cognitive status to follow discharge education presented to them at the time of discharge. Standards of care exist where nurses explain discharge instructions to the patient at the time of discharge. The elderly population may have difficulty understanding the instructions given to them and have reluctance to vocalize their need for clarification. They then return to their home settings with instructions they either did not understand or agree with, thus increasing the potential for re-hospitalisation. This is a huge barrier to the success of this group due to cognitive and learning deficits compared to other patients in the same setting. These limitations must be identified and a comprehensive treatment approach must be implemented to increase chances of success. A comprehensive discharge process that takes into account the needs of the elderly population such as: inviting caregiver(s) and families to be interactive participants of the plan, addressing barriers to learning or comprehension throughout hospitalisation, and assessing home health needs are key components to ensure successful outcomes where recidivism to the hospital setting is minimised among these psychiatric patients.

Instituting new policies and procedures to any organisation is successfully achieved when there is buy-in from all members involved. Identified leaders and key stakeholders can facilitate the integration of change through identifying, proposing, and providing supportive measures that will promote the action of change. Significant members essential to the project are: identified leaders such as a Clinical Nurse Leader (CNL), unit champions, unit council team members, nurse manager, multidisciplinary providers of care, Chief Executive Officer (CEO), patients, family members, and caregiver(s).

Identified leaders like the CNL or unit champions impart the required leadership to guide the process in an organised and efficient fashion. Unit council members will authorize and support the project that will improve upon the current discharge process. The nurse manager will provide approval, autonomy, and support to the staff throughout the journey of change. Multidisciplinary team members will work collaboratively with one another to develop and follow a comprehensive and patient-centered approach to discharge planning. The CEO will likely support this improvement process because it results in a decline of readmission rates among the elderly population. This paves the way to cost reductions in a financially burdened healthcare organisation while still maintaining quality care. Finally, patients, family members, and caregiver(s) are imperative to the success of this project because they provide baseline information that identifies areas needing improvements to the current discharge process. It is equally important for family and caregiver(s) to be actively involved in the discharge planning and recommendations. They will be invited to meet with a member of the multidisciplinary team such as a nurse or social worker to discuss any concerns about the patient’s discharge. This is to ensure the patient will have the help, support, and necessary resources upon discharge. This valuable exchange of information and collaboration lays the foundation for process development that will reduce readmission rates to the hospital setting.

The goal of this performance improvement project is to implement a comprehensive discharge process that will decrease the rate of recidivism to the hospital setting. The aim statement is to reduce the rates of readmission among the elderly population in psychiatric settings by 25% after 3 months of implementation of a comprehensive discharge process.

MATERIALS AND METHODS

In order to meet this goal, objectives will need to be clearly outlined. These objectives include: (a) a comprehensive assessment of discharge needs at the time of admission, (b) inviting patient, key family members, and caregiver(s) to actively participate throughout the discharge process, (c) ensuring all members of the multidisciplinary team members collaborate with one another regarding the discharge plan, and (d) creating, providing, and supporting a comprehensive discharge plan that is agreed upon by the patient, family members, and caregiver(s) to ensure success of the patient upon leaving the psychiatric setting.

Many times family members approach nursing staff about the care, treatment, and discharge plans for their loved-ones. Nurses who are engaged members of the discharge process are able to provide the information, reassurance, and support family members seek. This introduces a trusting relationship with patients, family members, and caregiver(s) through the implementation of a patient-centered care model. Patients and family members will actively participate in an agreed upon plan for the patient to achieve optimal results upon discharge. It is imperative for all members of the team to understand that their collaborative role in the discharge process is vital to the success of the patient.
A plan for variance control will be identified using cost measure containment strategies. The project will be led and implemented in a way that minimally disrupts daily patient care delivery and minimises organisational costs. The use of emails, bi-weekly meetings, and implementation processes that have strong evidence-based research will be integrated as part of the plan for variance control. The designated change agent will confirm that each task is completed before moving onto the next stage of the project. A 25% reduction in readmission rates is targeted for the elderly population after 3 months of implementation of this project. Buy-in from members of the team along with methodological approaches will be instituted as part of the process to control for variances.

Projected Resource Requirements

The following areas are projected resource requirements that will be necessary to meet the training needs for this project: (a) time to collect baseline data on patients readmitted to the psychiatric setting within 30–45 days of discharge prior to implementation of project, (b) time to collect data from current patient satisfaction scores prior to implementation of project, (c) time for development and implementation of a discharge care plan that ensures interactive processes between patients and multidisciplinary team members, (d) implementing a process during treatment by team meetings where discharge recommendations and goals are agreed upon by the multidisciplinary team members, and (e) identifying days and time periods for inviting family members to meet with nurses or social workers to discuss discharge concerns. Members responsible for specific tasks will frequently report their progress to the change agent. This process can be done through emails, brief encounters to exchange information, and input about the progress and direction of the project. With the ongoing support from the nurse manager, nurses will be given time away from the bedside to learn the specific processes necessary to implement this performance improvement project.

Information Flow

Prior to implementation of this project, specific information will need to be obtained for baseline data. Data on readmission rates and current patient satisfaction rates will need to be analysed. This information will be gathered from the nurse manager and clinical coordinator of the unit. There are also council members who will contribute to the flow of information, as they will be given specific tasks for this project. These invested key members will streamline the flow of information where the daily operation of the unit will not be disrupted.

Time and Cost Summary

Time away from the bedside has been identified as a major resource requirement to the successful implementation of this quality improvement project. Time must be allotted to educate all members of the healthcare team on project development, implementation, urgency, and necessity of this new practice. It is necessary for team members to understand not only the need, but also the value of this project.

Training periods are identified as a means of educating nurses about the newly instituted discharge process. Members of the team who will require training of this new practice included: nurses, physicians, physical therapists, respiratory therapists, occupational therapists, pharmacists, social workers, dieticians, and other identified members of the team. At least three presentations are needed to educate members on the institution of this project, why it is being implemented, and to ensure compliance of the comprehensive discharge process.

Data Collection Methods

Data will be collected on the readmission rates over the past 3 months and current patient satisfaction scores as baseline data. After implementation of the project, readmission rates and patient satisfaction scores will be compared against the original baseline data to measure improvements. A discharge care plan will be created and instituted where multidisciplinary team members can collaboratively write recommendations. The discharge care plan will include ongoing interaction with the patient, family members, and caregiver(s) throughout the patient’s hospitalisation. As with all care plans, it will be the responsibility of the nursing staff to ensure the discharge care plan is addressed on a daily basis.

Proposed Budget

A cost benefit analysis also demonstrated financial savings with the implementation of a comprehensive discharge process. According to Malcolm, readmissions are a major problem in the US healthcare system. This is primarily due to a patient’s lack knowledge about their disease process and the necessity of adherence to their treatment plans. Patients also do not understand the importance of following up with their primary care physicians. A comprehensive discharge process results in favourable outcomes to the patient care experience. When positive patient outcomes are achieved through an interactive discharge process, the potential for readmission back to the hospital setting is decreased. This reduction in recidivism maintains the hospital’s profitability.

The cost for unit council members to work on quality improvement projects is included as part of the budget for hospitals. It is expected that multidisciplinary team members will require a total of two hours training for the discharge process. This will be implemented over the course of 2 weeks. Time away from daily patient care activities to participate in the training is expected to total $2,370.00 for all members of the team. Since the average length of stay is about 10–14 days, the daily cost to the hospital when a patient is readmitted averages around $2,676.00. The cost of training will pay for itself with the prevention of a patient
returning to the hospital for just one day. The benefits of training necessary to implement this project clearly justify the need. This organisation can expect around $18,732.00–$26,760.00 in potential savings from a patient being readmitted to the psychiatric unit.

**DISCUSSION**

The success of this new discharge process will be demonstrated when readmission rates among the elderly, psychiatric patients decreases by 25% after 3 months of project implementation. A decrease in re-hospitalisations to the psychiatric unit provides the evidence supporting the effectiveness of this newly implemented practice, supporting a reduction in the revolving door effect due to adherence of their discharge instructions. Satisfaction surveys should address teaching, active involvement from the patient in the discharge process, and understanding of instructions given. A positive satisfaction survey in these areas also provides supportive evidence supporting this new practice for discharge. It is also imperative to provide nurses with encouraging feedback to maintain their enthusiasm. Once this process is embedded on the unit and positive patient outcomes are observed, sustainability is likely the long-term effect.

Variance control measures must also be accounted for in the event the goal of 25% reduction in readmission rates is not met. This will involve conducting a Plan, Do, Study, Act (PDSA) where processes can be more closely observed and evaluated. There may be several PDSAs required to meet the original stated goal of this project. It will be necessary to continue revisiting this process for ongoing improvement strategies as new evidence becomes available for best practices.

**CONCLUSION**

It is evident that the bulk of chronic utilizers of the healthcare system are identified as the elderly population. They have become a part of the revolving door effect due to their frequent re-hospitalisations. Their care has largely gone unmanaged due to their lack of understanding and compliance with discharge instructions upon leaving the hospital setting. It is therefore essential for healthcare providers to identify potential barriers to a patient’s discharge early in the process and to review the discharge instructions concurrently while the patient is in the hospital setting. By implementing specific action-based strategies that emphasize a well-rounded discharge process, the patient can be successful outside the hospital setting.

It is equally important to understand that despite the promotion of effective measures to prevent re-hospitalisations, there are still those that will chronically revolve in and out of the hospital setting. As for those who are capable of following a solid discharge plan, this affords them the opportunity to be successful in their home setting, maintain a level of independence in their care, and spend their days involved in community activities rather than in the hospital setting. As we continue to move toward a new era where patient-centered care is essential and prioritized, supportive measures must be in place for patients to achieve successful outcomes. Their successful outcomes will be demonstrated as the burden of healthcare costs is reduced and a decrease rate of recidivism is observed in the psychiatric settings.

**REFERENCES**

