Reducing delays in the discharge process on an Acute Medical Unit

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Introduction

Staff and patient feedback highlighted issues surrounding delays to discharge. Patients were spending long periods of time waiting to go home following a decision to discharge by the medical team. Nurses felt unable to expedite these discharges as they were appropriately prioritising the care of existing patients. As a result, patients often waited until the end of the day to be discharged, which impacted upon the capacity of our Acute Medical Unit (AMU).

The Care Quality and Innovation targets in 2016-17 stated that ‘there is considerable evidence for harm caused by poor patient flow. Delay leads to poor outcome, financial pressures and reduces the emergency department’s ability to respond to needs.’ An audit conducted in our AMU revealed that 14% of patients were meeting this target. NHS Improvement recommends that 33% of discharges should be completed by 12 midday on any given day.1

To improve this figure, a quality improvement project was initiated to develop a dedicated discharge team.

Box 1: Discharge Team Interventions

1. Potential discharges were listed on white boards in each area of AMU to prompt early review by the consultant.
2. A dedicated pharmacist with prescribing accreditations drafted discharge letters for these patients.
3. A team of senior nurses were appointed to resolve hindrances to discharge. This was achieved by:
   - Liaising with multidisciplinary team (e.g. physiotherapy) to expedite reviews
   - Chasing pending investigations and prompting the medical team
   - Communicating with next of kin and care homes
   - Communicating directly with patients to pre-empt delays
   - Arranging transport home
   - Arranging transfer to discharge lounge when appropriate
   - Collecting medication to take home

Method

Electronic patient records were examined to describe discharge performance. However, a distribution analysis found these data were unreliable. Regardless of when the patient was discharged, the nursing team were completing the discharge process at the end of their shift. This is being addressed through staff training and support.

To ensure accuracy, prospective data were manually collected every day and analysed to assess the impact of the interventions on the NHS improvement target of 33% of discharges completed before midday.2

Results

Over the 12-month period approximately 4,800 discharges (or 400 per month) were facilitated by the discharge team.

As mentioned previously, 14% of patients were discharged before midday. Data collected six months after the process was started found 27% of discharges occurred before 12 midday (a 13% improvement) as summarised in Figure 1. The audit is currently being repeated to compare current performance against the NHS improvement target.

During the 12-month quality improvement process, mean time of discharge improved from 14:56 to 13:16. Figure 2 shows over the same period, time between discharge decision and patient discharge improved from 289 minutes to 75 minutes (a reduction of nearly 75%).

Bed capacity on AMU has improved through the effective use of a Discharge Lounge, which sent home 172 patients as opposed to 51 patients in a similar period.

Figure 3 estimates the cost of employing a discharge team compared to the cost of a patient occupying a bed space awaiting discharge showing substantial saving.

Discussion

The introduction and development of a dedicated discharge team has markedly improved the speed at which patients are discharged from our AMU. This has increased capacity and facilitated flow through the AMU. In addition, the cost of implementing this project (including cost of additional of staff) is markedly less than the estimated bed occupancy savings.

Anecdotally, the team has improved patient satisfaction and the morale of nursing staff. This is being explored with a formal survey. However, over the course of the twelve-month period, nursing staff have become reliant on the discharge team. As a result, issues have been noted when the team is not present. Ongoing work is planned to resolve the variable patient flow this causes by allocating new members of staff to shadow the discharge team.

Figure 2: Decision to discharge time

Figure 3: Cost analysis per 12h shift

Annual Savings = £171,000

References