nrc HEALTH | Human Understanding
Behind every person is a story...

IMPROVEMENT RESOURCE

Discharge process

Version 2.2.1

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Discharge Process

The discharge process involves actions and communication to help patients successfully transition from their hospital stay to home or another facility. This process is critical to ensure patients are safe, have what they need to care for themselves outside of the hospital and have a positive last impression of their hospital experience.

Research and studies:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6598519/

https://health.gov/healthypeople/priority-areas/social-determinants-health

This Improvement Resource provides suggestions for enhancing the discharge process. Users of this resource are encouraged to use the *Reflection Questions* to facilitate open and creative discussions to design a process that can be owned, sustained, and appreciated by members of the care team and patients. Likewise, use this Resource to adapt these suggestions to other care settings such as Emergency Department, Outpatient Lab/Testing/Surgery, and Medical Practice visits.

Planning and Education

Discharge planning and education starts when patients are admitted. Right away,

- Assess the patients learning style, readiness to learn and preferred language.
- Identify a family member or friend who can be an active and trusted advocate for the patient.
- Determine how the patient's advocate can be included in conversations about the plan of care, especially when they are unable to be present in person.
- Learn as much as possible about the patient's environment and needs after leaving the hospital. Share this information with all members of the care team. Plan for (and anticipate) equipment, supplies, medications etc. that will be needed at home.

Coordination among the care team is essential to successful discharge planning. This entails expanding members of the care team when needed and communicating consistent information with the patient and their advocate. Members of the care team should share pertinent information about discharge throughout the hospital stay, without making patients feel they are being rushed to leave the hospital.

Reflection:

- What staff/roles are most often used in the discharge process? What additional staff/roles are needed?
- How do you leverage nursing practices such as huddles, care boards, bedside shift report and multi-disciplinary rounds to improve care team coordination and communication related to discharge?

Written and Verbal Communication

The discharge folder is a useful tool to organize educational materials and instructions. Maximize the utility of the folder through these practices:

- Make sure materials meet health literacy guidelines related to reading level, font size, spacing, etc.
- Avoid medical jargon and acronyms
- Offer materials in the patient's preferred language
- Include materials that are personalized for the patient, their medical condition and needs at home
- Make sure copies of materials are current and easy to read
- Bring attention to the folder during conversations and patient education – write notes, use a highlighter, and draw pictures.

Reflection:

- How do you use the electronic medical record and patient portal to improve discharge planning and education?
- How do you track patient education encounters, including what was shared and what additional educational needs exist?
- What is your process for developing or personalizing patient education?

The discharge folder alone is not enough to ensure a smooth transition from the inpatient stay. Clear, empathic verbal communication is necessary as well. Include these behaviors in discharge conversations:

- Sit down or orient yourself towards the patient to show you have time for the conversation
- Display positive body language such as comfortable eye contact
- Use the appropriate strength, speed, and tone of voice
- Include the patient's advocate in the conversation – in person or virtually
- Use plain language. Avoid medical terms and jargon
- Include interpreter services if needed
- Share the most important information as patients may be in pain, overwhelmed, or anxious to leave and unable to absorb lots of information
- Share written instructions or reference the discharge folder – highlight, write notes or draw pictures (as noted above)
- Invite patients to sign the discharge instructions to emphasize importance
- Acknowledge and attend to Social Determinants of Health
- Use Teach Back to check for understanding. For example:
    - "I want to be sure I explained your medications correctly. Can you tell me how you're going to take this medicine and how often?"
- Use Practicing Out Loud to match your actions and intentions.
    - Intention: I want you to be safe and cared for when you get home…
    - Action: so, let's talk about what help you'll need.
- Offer words of encouragement and reassurance
- Share how the patient can get ahold of the care team directly
- Let the patient know they will receive a clinical follow-up call and when to expect it
- Thank the patient

Reflection:

- What other behaviors lead to a positive discharge conversation?

Efficiencies and Throughput

Delays and other inefficiencies cause dissatisfaction with the discharge process. Evaluate how well your organization does at the following and use process improvement resources to address.

- Communicating correct discharge day/time
- Time to process orders
- Availability of patient transport
- Plan for medical equipment, supplies, and medications – having these available at discharge
- Scheduling follow-up appointments prior to discharge
- Using a discharge lounge
- Coordination with primary care providers

After Discharge

It is best practice to follow-up with patients quickly after discharge, within 24-48 hours. This follow-up enables organizations to identify and manage high-risk patients, reduce readmissions, increase patient satisfaction, support safe transitions, and create Human Understanding. Key components of a clinical follow-up call include:

- Verify understanding of the plan of care, including medications and symptoms to look for
- Confirm that patient has the help they need
- Assess pain
- Facilitate medical intervention
- Manage expectations
- Perform service recovery
- Harvest recognition of staff

Reflection:

- How do you manage follow-up of 100% of discharges?
- How do you ensure that follow-up occurs consistently?
- What systems do you have in place to track trends learned through discharge follow-up?

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The Human Understanding Institute was formed to help our partners turn aspiration into action by prioritizing what matters to patients, families, and care teams in the real world. Leveraging the breadth and depth of NRC Health datasets, our team combines expertise, experience, and evidence to generate insights that have strategic relevance to health systems and health plans, with a particular focus on human understanding and health equity. By fostering research, thought leadership, and collaboration, the Human Understanding Institute will be a catalyst for humanizing care in everyday practice.