

Discharge Planning in a Community Hospital – A Multidisciplinary Approach

C Tan, B L Sng, J Long, L K Loh, R Liew, E Aw

ABSTRACT

The population of Singapore is ageing rapidly. Acute hospitals in Singapore are also experiencing an acute bed shortage. However, many elderly admitted to acute hospitals require a longer period of convalescence before they are able to go home. Community hospitals are most suitable to provide such care for the elderly patient. Patients could be discharged to the community hospitals to continue rehabilitation and convalescence. In addition this would also free the beds in the acute hospitals. However, there is a risk that without adequate discharge planning, the community hospitals would in turn also reach full capacity and no longer be able to accept patients. A discharge planning programme has been set up in a community hospital to address the following needs: 1) caring for a rapidly ageing population with increasing degrees of disability; 2) the shortage of beds in the acute hospitals; (3) the provision of holistic care and care-giver education, and 4) to prevent long term institutionalisation of the elderly as much as possible.

Keywords: discharge planning, quality assurance program, elderly, community hospital, holistic care

INTRODUCTION

St Luke's Hospital for the Elderly is a 223-bedded community hospital. It was set up in response to a need to serve the elderly in Singapore by eight foundation churches. Singapore's population is ageing rapidly and it also sees a high incidence of stroke disease. These together with the trend towards a nuclear family has resulted in the following situation: A large number of elderly patients with chronic functional disabilities in acute hospitals awaiting long-term institutional placement. In addition, with an increasingly ageing population, the elderly occupy a relatively high percentage of hospital beds, are substantial users of community support services after discharge and are at a high risk for poor outcomes after discharge⁽⁴⁾.

Families are unable to cope with the elderly at home for the following reasons:

- 1) among the younger generation both husband and wife work and are thus unable to care for the elderly at home;
- 2) many of the elderly are disabled requiring round the clock nursing care. This trend if allowed to

proceed, would inevitably result in the clogging up of hospital beds. In addition, many elderly not requiring nursing home care would be sent there as their families have difficulty coping.

St Luke's was therefore set up to serve two needs:

- 1) to provide an environment where the elderly could undergo a longer period of convalescence and rehabilitation in order to restore their highest level of functional capability.
- 2) to encourage care of the elderly in the community rather than long term institutionalisation.

DISCUSSION

In the first nine months after opening our doors in April 1996, we have received 889 referrals. The majority of these referrals were from the acute hospitals eg. Singapore General Hospital (SGH), National University Hospital (NUH), Tan Tock Seng Hospital (TTSH) and Alexandra Hospital (AH) (Table I). Of these referrals, we had 478 admissions (Table II). The main reason for referral was that of problems with self-care – primarily from stroke disease (Table III).

Table I – Source of referrals to St Luke's Hospital

Source of referrals	No. (%)
	(Total 889)
AH	118 (13.3)
NUH	185 (20.8)
SGH	251 (28.2)
TTSH	145 (16.3)
Others*	190 (21.4)

Others* Ang Mo Kio Community Hospital, Toa Payoh Hospital, Changi Hospital, community support services

Table II – Source of patients admitted to St Luke's Hospital

Origin of referral	No. (%)
	(Total 478)
AH	71 (14.8)
AMKCH	19 (4.0)
NUH	107 (22.4)
SGH	90 (18.8)
TPH	38 (7.9)
TTSH	81 (17.0)
Others*	72 (15.1)

* Others includes Changi Hospital, Polyclinics, Community Support services eg. Tsao Foundation

St Luke's Hospital for the Elderly Ltd
2 Bukit Batok St 11
Singapore 659674

C Tan, MBBS, MRCP (UK)
Geriatrician

B L Sng, BSSc
Medical Social Worker

J Long, RN
Nurse Manager

L K Loh, RN
Nurse Manager

R Liew, RN, DNE (NSW),
PSNC (Vic)
Director of Nursing

E Aw, MBBS
Medical Director

Correspondence to:
Dr C Tan

Table III – Primary diagnosis of patients admitted to St Luke’s (including readmissions)

Primary diagnosis of patients admitted to St Luke’s in 1 year	No. of patients (%) (Total 509)
Cerebrovascular disease eg. strokes	201 (39.5)
Hypertension	152 (29.9)
Diabetes mellitus	128 (25.1)
Ischaemic heart disease	125 (24.6)
Fractures	72 (14.1)
Dementia	70 (13.8)
Parkinson’s disease	37 (7.3)
Chronic obstructive lung disease	28 (5.5)
Arthritis	22 (4.3)

Given the overwhelming demand for our limited number of beds, a quality assurance program in discharge planning⁽⁴⁾ was instituted to:

- 1) maximise care input;
- 2) minimise the length of stay required to achieve the final goals⁽³⁾, and
- 3) co-ordinate the work flow of the various members of our care team.

Effective discharge planning facilitates the timely discharge of patients and ensures that appropriate care is available in the home to prevent re-admissions, lessen the burden of care on families, and reduce costs through minimising the length of hospitalisation⁽⁴⁾. In addition, we could minimise the waiting time for patients to be admitted to our hospital and be able to take in more patients from the acute hospitals and relieve their bed situation. For the vast majority of our patients, each had needs in many areas including: mobility, incontinence, feeding, medical problems eg. diabetes mellitus, hypertension and dysfunctional family dynamics (Table IV).

Quality teamwork

In order to address all the patients’ needs, a team approach is required⁽¹⁾. The team members include nurses, occupational therapists, physiotherapists, social workers, chaplain as well as doctors. All the members of our care team are equally essential in the success of the program. In addition to each member of the team providing care and input, there is also a

need to ensure that these occur concurrently rather than consecutively. In other words, rather than dealing with the patient’s various needs at different times, all their needs and problems are identified at the time of admission. Each member of the team would then sort out these problems concurrently. For example, the doctor and the nurse would manage the patient’s incontinence while the therapists would improve their mobility status. At the same time, the social worker would help the family plan for future placement.

A discharge plan program was therefore instituted in St Luke’s⁽⁴⁻⁶⁾. Three basic components essential for the success of this program are:

- 1) discharge planning begins at the time of admission;
- 2) the need for all members of the team to set goals: initial goals at the time of admission and final goals after a period of care and assessment, and
- 3) the need to communicate to other members of the team this information in order to co-ordinate the care and plan the final date of discharge.

1) Discharge planning begins at the time of admission

On arrival, patients are assessed for their functional, medical and social status which are then documented and needs in these areas identified. In many instances, this process has already begun prior to arrival at St Luke’s. The referral from the acute hospitals is screened by a multidisciplinary team which includes the geriatrician, social worker, therapy manager and nurse manager. The patient’s needs and expected final functional status are identified. This is communicated to the acute hospitals. The acute hospitals are also informed regarding the expected length of stay offered by St Luke’s. This is to allow family members to plan their care for the patient accordingly. This is especially important in relation to the social and home situation. Many of the relatives and patients do not have any plans for final placement of the patient after a period of rehabilitation in St Luke’s. Our social worker contacts the families of patients where a problem is anticipated from the initial referrals from the acute hospitals. Relatives are re-informed on arrival in St Luke’s of the estimated length of stay. They are also informed of the expected prognosis and functional status achievable.

An assessment of the needs of the patient and their caregiver is also carried out in order to draw up the various nursing, medical, social and therapeutic goals. A questionnaire (which is obtainable from the authors) is given to the relatives/caregiver to fill up on arrival in St Luke’s. This questionnaire has been drawn up to cover areas which would affect the patient’s ability to be discharged home. It also covers areas like caregiver stress and financial problems. All these factors would contribute to a delayed discharge in a particular patient. All the members of the team in St Luke’s would then use this information to better understand and address the needs of the patient and his family. The questionnaire would be a pointer to highlight possible problems delaying discharge.

Table IV – Patient characteristics

Patient characteristics	No. of patients (%) (Total 509)
Patients with 5 or more diseases	392 (77.0)
Patients with social problems requiring intervention eg. family conflict, home placement	241 (47.3)
Patients requiring assistance with ADL*	479 (94.1)
Patients requiring assistance with mobility	447 (87.8)
Patients with psychological problems*	168 (33.0)

* ADL: activities of daily living

Psychological problems eg. depression

2) Initial and final goals setting

All members of the team are encouraged to diagnose problems, prognosticate regarding final status achievable, set realistic goals and the time frame required to achieve such goals. This is true not only for the doctors but also for the therapists and nurses.

For example, if the patient has urinary incontinence, every effort is made to diagnose the cause of the incontinence together with the nurses. If the cause is that of chronic retention of urine, medication and therapy is instituted whenever possible. If bladder recovery is not expected within the period of stay, education of relatives regarding measures, eg. intermittent catheterisation would commence as soon as possible. Thus initial goals for the nurses and doctors would be: (a) to assess the cause and treat wherever possible the cause of the urinary incontinence and (b) institute caregiver education if required. Similarly for the physiotherapist and occupational therapist, initial goals would include mobilisation, an estimation of the final level of mobility achievable, eg. independent walking, wheelchair mobility, and activities of daily living (ADL) capability.

These initial goals are re-examined throughout the stay and final goals drawn up after approximately 4 to 6 weeks.

Throughout the entire stay, emphasis is placed on caregiver education, not only in terms of disease diagnosis and prognosis, but also education in how to care for the patient, especially, in nursing, physiotherapy and occupational therapy. Relatives are also educated regarding community support services available upon discharge from St Luke's. Studies have shown that stroke units are effective in improving patient functional status. However, the benefits are lost if there is no adequate follow-up and continuance of therapy after discharge^(2,7). Hence, as the aim of St Luke's is to keep patients at home in the community for as long as possible, caregiver education is an essential part of our care. This is true not only for our patients undergoing rehabilitation but also for the long-stay continuing care patients. We encourage relatives of our long-stay patients to bring them home for short breaks in the hope that as the patients improve, relatives might consider bringing them home eventually.

St Luke's has also started a home-care follow-up programme. Patients are contacted one to two weeks post-discharge by a nurse. The various needs of the patient requiring follow-up and monitoring are identified before discharge, eg. bedsores care and urinary continence. These areas are then monitored by the home-care nurse who then advises the relatives and patient. She also provides feedback to the team in St Luke's regarding the patient's progress. In this way, we hope to educate patients and their family members to seek help early rather than wait for a crisis. St Luke's also encourages respite admissions to prevent non-emergency admissions to the acute hospitals.

3) Communication between various members of the team

Communication between various members of the team is essential for the success of the discharge plan. Traditionally, multidisciplinary meetings are used to discuss progress of the patient and plan the discharge date of the patient. A conscious effort was made to minimise meetings. An advantage is that St Luke's is fully computerised. Therefore e-mail facilities are readily available. All members are encouraged to use e-mail to communicate with each other. In addition, for every patient, a discharge plan pathway (which is obtainable from the authors) is drawn up and placed in a prominent place in the patient's case folder. It is designed to encourage concise goals setting and updating in a format readily accessible to all members of the team.

Initial goals are filled in by all the members of the team within two weeks of admission. A provisional date of discharge is given wherever possible. This information is updated every two weeks especially if there is a new development. Final goals are then drawn up after four to six weeks and a final date of discharge planned. All this information is documented in the discharge plan pathway, readily accessible to all members of the team. Relatives and caregivers are also informed on admission and updated at regular intervals.

Where necessary, issues arising are discussed with specific members of the team rather than the need for all members of the team to meet at an appointed time and place. This could be done either through e-mail, or when meeting for other reasons. We have found communication via e-mail extremely useful for the following reasons:

- 1) there is no need to wait for the next meeting as meetings are usually held no more than once a week. All members of the team check their e-mail upon arrival at work and before leaving for home. Therefore, problems can be highlighted and resolved immediately without having to wait for the next meeting.
- 2) all staff would not have to take time out from their busy schedules to physically meet as members may have different timetables and work schedules.
- 3) discussions are confined to the issue at hand with contributions from each member of the team. The only disadvantage of this system is having to train members who are not familiar with the use of computers and e-mail.

CONCLUSION

St Luke's Hospital for the Elderly was set up to serve a need among the elderly in Singapore. However, in the first year since its opening, we have become more aware of how great this need is. The need for beds has been overwhelming. This need will continue to rise with the growth of the ageing population.

We have realised the importance of discharge planning, not only in order to maximise the care input

and minimise the length of stay in St Luke's but also to ensure that appropriate care is available at home to prevent re-admissions^(1,4-6). In addition, as the emphasis is on care of the elderly in the community, we hope to minimise unnecessary long term institutionalisation of the elderly⁽³⁾. In the last nine months since we started operations, we have had a total of 478 admissions and 160 discharges. The waiting time for admission subject to admission criteria is 24 hours. This is with an average of 70 beds as the wards were opened in stages. Of the 160 discharges, 127 (79.3%) were discharged home. In addition, of the patients who were expected to remain in St Luke's for life, 13 of them were discharged.

Through our discharge planning programme, we hope to continue to help as many elderly for as long as possible not only in terms of rehabilitation but also to remain with their families in the community. This would also indirectly expedite transfers from the acute hospitals and relieve them of their bed situation.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the invaluable assistance and advice of Professor Lee Hin Peng, Professor Poh Soo Chuan and Dr Aw Swee Eng.

REFERENCES

1. D'Addario V, Curley A. How case management can improve the quality of patient care. *Int J Quality Healthcare* 1994; 6:339-45.
2. Garraway WM. Management of acute stroke in the elderly: follow-up of a controlled trial. *Br Med J* 1980; 281:827-9.
3. Morton CC. Hazards of hospitalisation in the elderly. *Ann Int Med* 1993; 118:219-23.
4. Naylor M, Brooten D, et al. Comprehensive discharge planning for the hospitalized elderly. *Ann Int Med* 1994; 120:999-1006.
5. Rockwood K. Delays in the discharge of elderly patients. *J Clin Epidemiol* 1990; 43:971-5.
6. Victor CR, Vetter NJ. Preparing the elderly for discharge from hospital: a neglected aspect of patient care? *Age Ageing* 1988; 17:155-63.
7. Young JB. The Bradford community stroke trial: results at six months. *Br Med J* 1980; 82:829.