# Complete Summary

## GUIDELINE TITLE

Discharge planning for the older adult.

## BIBLIOGRAPHIC SOURCE(S)

Zwicker D, Picariello G. Discharge planning for the older adult. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 292-316. [36 references]

## GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Discharge planning and home follow-up of elders. In Mezey et al., (Eds). Geriatric nursing protocols for best practice. Springer Publishing Company: New York.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Hospitalization-associated acute deconditioning and functional decline

### GUIDELINE CATEGORY

Management
Prevention
Risk Assessment

### CLINICAL SPECIALTY

Geriatrics
Nursing
Pharmacology
Physical Medicine and Rehabilitation

## INTENDED USERS

Allied Health Personnel
Hospitals
Nurses
Pharmacists
Physical Therapists
Social Workers
Students

## GUIDELINE OBJECTIVE(S)

- To describe assessment parameters for discharge planning in each of the following: functional status, cognition, depression, and caregiver support
- To identify the elderly most at risk for poor postdischarge outcomes
- To define specific care interventions for effective discharge planning
- To discuss potential outcome measurements for comprehensive discharge planning

## TARGET POPULATION

Older adults being discharged from acute care to the home, long-term care, or subacute care environments

## INTERVENTIONS AND PRACTICES CONSIDERED

### Risk Assessment/Prognosis

1. Assessment on admission
    - Functional status
        - Activities of daily living (ADL) and instrumental activities of daily living (IADL)
        - Functional Independence Measure (FIM™)
    - Cognitive status and depression
        - Mini-Mental Status Exam (MMSE)
        - Short-form Geriatric Depression Scale (GDS-SF)
    - Verbal/written questions to patient and family/caregiver to assess:
        - Formal and informal support systems
        - Knowledge deficits regarding health care needs
        - Home environment
        - Patient and family psychological, socioeconomic and cultural factors

### Prevention/Management

1. Strategies to ensure continuity of care (the 4 Cs):

- Communication
    - Verbal communication of health status and discharge plan with patient and family/caregiver, and multidisciplinary team
    - Written documentation provided to patient and family/caregiver, providers, and institutions
- Coordination of services/case management
- Collaboration with all discharge team members
- Continual reassessment due to potential for change in condition

2. Patient and family/caregiver teaching, guidance, and counseling
3. Referral to appropriate services (e.g., home health, meals on wheels, therapy)

### MAJOR OUTCOMES CONSIDERED

- Hospitalization rates for elderly
- Length of hospital stay
- Number of emergency room visits following discharge
- Hospital readmission rates for elderly

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline and Pubmed were the electronic databases used.

### NUMBER OF SOURCE DOCUMENTS

45

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

### METHODS USED TO ANALYZE THE EVIDENCE

Review

### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

# RECOMMENDATIONS

## MAJOR RECOMMENDATIONS

### Assessment

- Initiate assessment for discharge planning process at time of admission; continue to reassess throughout hospitalization.
- Focus on those older adults at high risk for poor postdischarge outcomes.
- Assessment should include:
    - Functional status (ability to complete instrumental activities of daily living [IADL] and activities of daily living [ADL] and/or functional independence measure [FIM])
    - Cognitive status (ability to participate in discharge planning process and ability to learn new information)
    - Psychological status of patient, particularly depression screening
    - Patient's perception of self-care ability
    - Physical and psychological capabilities of family/caregiver
    - Knowledge deficits regarding health care needs postdischarge
    - Environmental factors of postdischarge setting
    - Caregiver formal and informal support needs
    - Nine core caregiving processes that ensure family caregivers can provide care smoothly and effectively (see Table 16.3 in the original guideline document)

- Review of medications and simplification of regimen
- Prior link to community services

**Implementation of the Discharge Plan**

- General principles
  - The discharge plan should be tailored to individual patient and family/caregiver needs.
  - Assessment findings will guide intervention strategies.
  - Assessment findings will determine educational and other home health requirements after discharge.
  - Assessment data may predict potential discharge outcomes.
  - Discharge planning should begin at admission due to shortened length of stay and complexities of the population.
  - The discharge plan should be tailored to individual patient and family/caregiver needs.
- Strategies to ensure continuity of care (the 4 Cs: communication, coordination, collaboration, continual reassessment)
  - Communication
    - Communication should occur multidirectionally.
    - Communication should occur between the multidisciplinary team and the patient and family/caregiver.
    - Communication with formal and informal prehospital caregivers should be at admission, ongoing, and prior to discharge.
    - Barriers to communication need to be eliminated.
    - Communication of medical care needs to continue between hospital and community medical provider.
    - Written communication
      - Document assessment findings and home care needs on an interdisciplinary record
      - Summarize hospital course, particularly the following:
        - Include actual or potential sequelae
        - Presentation of unusual symptoms or significant change in status since admission
        - Specific symptom management required (i.e., pain postsurgery and effective management)
        - Medication review and difficulties for patient/family
        - Psychosocial adaptation to stress of illness
        - Anticipated outcomes
        - Advanced directive discussions or decisions
    - Verbal communication of health status and discharge plan with:
      - Patient, family and/or caregiver
      - Primary provider who will follow after discharge
      - Multidisciplinary experts
      - Referrals (e.g., home health agency, other providers of care)
  - Coordination of services/case management
    - Case manager or designated team member should coordinate the multidisciplinary team in the discharge planning process.
    - Case manager will link the person with the most appropriate services postdischarge.

        - Case manager should ascertain understanding of all communication with patient and family/caregiver.
        - Communication should be clear between hospital case manager and home health provider and/or any community resources.
    - Collaboration
        - Multidisciplinary team members should be used for specialized assessments, recommendations, and case conferences.
        - Advanced practice nurse or registered nurse (RN) expert in geriatrics may collaborate with team and provide home follow-up.
        - Designate a case manager or nurse expert in geriatrics to coordinate discharge plan.
        - Family or caregiver can provide information about past experiences, potential barriers, and biopsychosocial needs of the patient.
        - Referrals should occur in-hospital, when possible, to limit transfers from home environment.
    - Continual reassessment
        - The discharge planning process is dynamic, not static.
        - Status of the patient may change rapidly in this population, requiring frequent reassessment.
        - Change in condition should be communicated to all team members.
        - Home care needs change as the assessment is clarified and as the patient status changes.
- The Discharge Planning Process
    - Develop the plan to meet unique needs of each individual patient and family/caregiver.
    - Communication with prehospital formal and informal caregivers should be at admission, ongoing, and prior to discharge.
    - Involve the patient and family throughout discharge planning process.
    - Yield to patient and family wishes and preferences for optimal outcomes.
    - Health teaching, guidance, and counseling (potential areas to address):
        - Gear teaching to specific learning needs of elderly patient.
        - Describe required care related to presenting problem.
        - Describe diet restrictions, and discuss patient preferences.
        - Discuss medication actions and side effects.
        - Discuss symptom management.
        - Define when to call for help.
        - Discuss maintenance of hydration and nutritional status.
        - Delineate signs of a change of condition and whom to report to.
        - Discuss what to report or do in an emergency.
        - Discuss whom to contact in an emergency.
        - Clarify activity level and ability, with a focus on safety and mobility.
        - Discuss and/or clarify advanced directives and care wishes of patient.
        - Verbally review written discharge instructions and follow-up.
    - Treatments and procedures (potential areas to address):
        - Special procedures/care: wound care, tube feedings, hydration etc.

    - Discuss how and when to administer medications.
    - Discuss activities of daily living (ADL) interventions: mobility, transfers, gait training.
- Surveillance interventions (potential areas to address):
    - Ensure adequate functional status before discharge or refer for appropriate home care needs.
    - Evaluate system-specific physical assessment related to problems or potential problems.
    - Monitor primary problem and potential sequelae.
    - Offer iatrogenesis prevention during hospital course.
    - Functional and cognitive status should be continually monitored.
    - Medication understanding, management capabilities, and side effects should be ascertained.
    - Transportation access and availability should be ensured.
    - Family/caregiver abilities evaluated continually
    - Psychosocial issues that may affect transition need to be assessed.
- Case management (potential activities of Case Manager)
    - Refer to consultants/providers as needed, preferably while in-hospital.
    - Address questions/concerns from patient, caregiver, and health providers.
    - Provide caregiver with contact numbers of care providers (primary care and home health agency, physical therapy and occupational therapy).
    - Provide follow-up care appointments and contact information.
    - Ascertain access to transportation services.
    - Provide information on other community resources.
    - Assess risk for potential poor discharge outcomes (see Table 16.1 in original guideline document) to ensure appropriate discharge services are utilized.
    - Ensure that caregiver support needs are met.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

#### Benefits for Patient and/or Family Caregiver

- Health status will be maintained or improved; including functional and cognitive status, nutrition, emotional status, and physical status.
- Iatrogenic events will be avoided, such as falls and secondary infections.
- Complications will be minimized, such as decline in function.
- Knowledge of self-care will be improved.
- Caregiver competence and confidence will be increased.
- Patient self-perception of health will improve.
- Disease-specific outcomes, such as blood glucose within expected range, will improve.
- Caregiver and/or patient will be able to reiterate discharge plan and implement in home.
- Follow up appointments will be maintained, with transportation easily accessible.
- The number of new patients that become depressed post-discharge will decrease.

**Benefits for Providers**

- Acute care nurses can identify discharge assessment needs, intervention strategies, and follow-up of elderly patients.
- Acute care nurses will increase knowledge base regarding unique learning needs of the elderly population.
- Acute care nurses will accurately identify patients at high risk for poor outcomes, who benefit most from home care referrals and are referred most often.
- Multidisciplinary team members will collaborate on a regularly scheduled basis.
- A change of status will be communicated among team members.
- Primary medical provider and hospitalist will communicate medical care needs with each other.

**Benefits for Institution**

- The number of hospital readmissions and emergency room visits will decrease.
- Morbidity and mortality rates of patients discharged to home will decline.
- Rating of caregiver and patient satisfaction with care will be high.
- Cost containment will improve.

### POTENTIAL HARMS

Not stated

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better
Staying Healthy

### IOM DOMAIN

Effectiveness
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Zwicker D, Picariello G. Discharge planning for the older adult. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 292-316. [36 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2003

### GUIDELINE DEVELOPER(S)

Hartford Institute for Geriatric Nursing - Academic Institution

### GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

### SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

### GUIDELINE COMMITTEE

Not stated

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Discharge planning and home follow-up of elders. In Mezey et al., (Eds). Geriatric nursing protocols for best practice. Springer Publishing Company: New York.

## GUIDELINE AVAILABILITY

Copies of the book *Geriatric Nursing Protocols for Best Practice*, 2nd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

## AVAILABILITY OF COMPANION DOCUMENTS

None available

## PATIENT RESOURCES

None available

## NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 26, 2004.

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