Introducing criteria-led discharge in an acute medical unit

What was the problem?

In acute medical units (AMUs) across England fewer patients are discharged on weekends because of a lack of medical staff to review patients (NHS Improvement, 2019, NHS Improvement, 2017). Currently all patients in Tameside General Hospital who are potentially suitable for discharge over the weekend, are identified by the nursing team on a Friday and seen by the discharge team on a Saturday and Sunday. An average of 11.9 patients are discharged each weekday compared to 9.2 over the weekend.

This discharge team usually consists only of one consultant and one junior doctor to cover approximately 272 medical inpatient beds, and these ward rounds often occur later in the day. This results in delays to discharge, often overnight until the pharmacy department is open.

What was the solution?

The trainee advanced clinical practitioner introduced a criteria-led discharge (CLD) project to the AMU of Tameside General Hospital. It ran for eight weeks with 23 patients selected for project inclusion. Average discharge rates prior to project implementation were 11.9 discharges on a weekday and 9.2 on a weekend. Following the introduction of criteria-led discharge, average weekend discharges rose to 14.25 discharges.

Criteria-led discharge (CLD)

CLD is an enhanced clinical role where a designated member of the multidisciplinary team (MDT) accepts discharge responsibility for a patient, ensuring that specific criteria as defined in a consultant plan are met (Lees-Deutsch and Gaillemin, 2018; NHS Improvement, 2017a; NHS Improvement, 2017b).

NHS guidance recommends some degree of CLD in all areas of the NHS and many regard it as a high impact intervention that can improve the patient journey by expediting discharge as long as certain criteria are met, and ultimately improving patient flow throughout the hospital (Lees-Deutsch & Gaillemin, 2018, NHS Improvement, 2017b, ACI, 2016, DOH, 2004).

CLD is not a new concept. It is routinely performed in many elective surgical settings, where specified targets such as blood loss, mobilisation and laboratory results must be achieved to trigger discharge (Lees-Deutsch and Gaillemin, 2018; NHS Improvement, 2017b, *Gotz et al*., 2014). Because of the unplanned and emergency nature of unscheduled care there can be no 'one size fits all' approach, so CLD is infrequently used (Lees-Deutsch and Gaillemin, 2018, Lees-Deutsch and Robinson, 2018).

What were the challenges?

The main barrier to implementation was an initial lack of engagement from junior medical staff who complete the necessary discharge paperwork. Most agreed that completing discharge medications and letters before patient discharge would improve continuity and safety, but some argued it would result in discharge summaries being completed before the full details of the discharge were known. NHS guidance states that discharge letters should be completed within 24 hours of discharge to promote patient safety, prompt referrals and ultimately create continuity of care (NHS England, 2017) but this is often not achieved (Waring *et al*., 2014) and completing the letters in advance improves the prospect of meeting this target.

Another concern identified during the first week of implementing CLD were differences in opinion about patients' suitability for CLD. During the planning phase it was agreed that, in line with current guidance, criteria should be specific, absolute and easily understood by the individual taking responsibility for the discharge (NHS Improvement, 2019, Lees-Deutsch &

Gaillemin, 2018, Lees-Deutsch & Robinson, 2018, NHS Improvement, 2017). During the first week of implementation, some of the patients identified for inclusion by the lead consultant were not suitable for CLD as, although the criteria were easily defined, they involved clinical competencies, such as radiology interpretation, that non-medical staff did not possess. However, this limitation was quickly identified, and the rationale for patient exclusion communicated to the consultant, ensuring that over the duration of the project, the patients identified were suitable.

The initial project plan involved implementation on the AMU potentially resulting in some patients being lost to follow-up if they moved to other wards in the hospital. To mitigate this, the integrated assessment unit (IAU) was included in the project. Patients in the IAU are usually suitable for discharge within 24 hours so this would allow continued flow from the emergency department (ED) to AMU and IAU staff were keen to participate, anecdotally echoing frustrations about weekend discharge. Incorporating IAU into the project meant that no patients identified for CLD were lost to follow-up by moving to a ward not included in the pilot.

What were the results?

The initial pilot project was successful with 19 of the 23 patients selected for CLD (an 82.6% success rate). Only one of those 19 was readmitted, and this occurred 23 days after the initial discharge and was not related to the previous presentation.

Fourteen of the patients successfully discharged (74%) had had their regular medication changed or started on new medications while they were in hospital. Advance completion of the discharge medication prescription meant the workload for the pharmacy staff has been more evenly spread, improving patient safety and staff morale.

It is estimated that using CLD on the 23 patients included in the study saved 13 hours for the discharge ward over the eight weeks. Based on the average extra inpatient night cost for the financial year 2017/2018, where an additional inpatient night's stay is estimated to cost £346 (NHS Improvement, 2018), the introduction of criteria-led discharge over the eight week period meant for the 19 patients successfully discharged, who were discharged two nights earlier, this saved the hospital an estimated £13,148. This figure is likely to increase as it does not account for necessary medical reviews before discharge and represents a potential saving of more than £85,000 per year for the AMU.

Monitoring weekend discharges facilitated by CLD highlighted a further unanticipated advantage. SAFER guidelines state that 33% of patient discharges should be completed

before midday to improve patient flow (NHS Improvement, 2017) as this has been shown to reduce hospital crowding and improve performance against ED targets (Khanna *et al*, 2016). When a patient was discharged via CLD, discharge letters and medications were completed in advance, reducing the time spent waiting for medications and paperwork and facilitating attainment of this target. Although they didn't yet meet the SAFER target, patients who were discharged by CLD completed their hospital journey by midday 15.8% of the time, in comparison with the 3.5% of those discharged by regular methods and 68.4% of CLD discharges were completed by 3pm in comparison with 7.9% in the regular methods group.

What were the learning points?

- Stakeholder engagement (eg business managers) is vital to ensure support and identify other departments which can be incorporated into the study.
- Pharmacists acting as second checkers for discharge criteria improves accountability for medicines.
- Advance completion of discharge letters by the ward team improves continuity of care between primary and secondary care.
- Discharges completed by a doctor who knows the patient and their journey reduces the risk of medication errors on discharge and improves continuity of care by ensuring onward referrals are completed in advance.
- CLD helps to manage expectations, allowing patients to be quickly discharged when criteria are met.
- CLD frees nursing staff to care for patients rather than chasing discharge jobs.
- Discharges occur earlier in the day.

Next steps and sustainability

This pilot project was successful in increasing weekend discharge rates on the AMU, received excellent feedback from the staff involved and saved an estimated £13,148 over the eight-week implementation period.

The hospital plans to introduce CLD to seven medical wards and ensure that all staff are proficient in the implementation facilitating additional discharges and increased financial savings. It would also improve patient safety by ensuring that where possible, discharges are completed by a doctor who knows the patient and their journey well, reduce strain on the pharmacy department, and free up time in the medical team to care for other patients (Bowen *et al*., 2014; Gotz *et al*., 2014).

Want to know more

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 Publication code: SL 39/20