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An exploration of the barriers that influence the patient discharge experience: A multidisciplinary team perspective

BACKGROUND

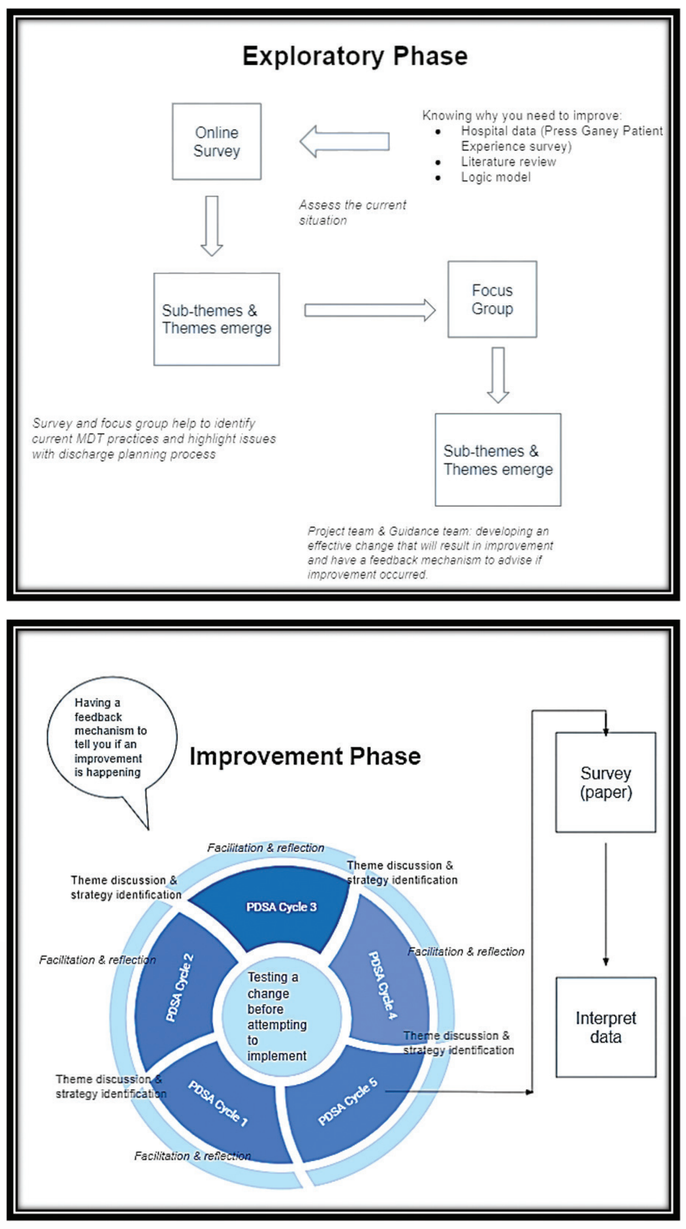
The research provides an example of nurses taking the lead to facilitate and conduct quality improvement research as indicated by Flynn et al. (2017). The impetus for the research came from the study hospital's Press Ganey Patient Experience Surveys which demonstrated a decline in patient satisfaction with the discharge planning process, predominantly linked to; (i) instructions regarding care at home (ii) help arranging home care services and (iii) preparation for discharge throughout patients stay.
The research is based on the premise that the multidisciplinary team coordinate, collaborate and communicate effectively to address as many aspects of care as possible to provide the best discharge experience for patients. The circumstances of patients can change at any time so flexibility of the multidisciplinary team when approaching patients care is vital. Previous research suggests the discharge experience of patients is impacted negatively when the multidisciplinary team fail to collaborate effectively to meet their discharge planning needs.

AIM

The aim of this research is to understand the factors that impact the multidisciplinary team working collaboratively in a private hospital to proactively streamline patient's discharge.

Research question

How can the multidisciplinary team work collaboratively to streamline patients discharge in a private hospital?
To identify and test strategies to improve the multidisciplinary teams discharge planning practices, this research was performed in two phases.
The phases were: the **Exploratory Phase** and the **Improvement Phase**.



METHOD

A mixed-method design (Liamputtong 2019) was adopted underpinned by an Improvement Science methodology (Marshall, Pronovost & Dixon-Woods 2013) using the Plan-Do-Study-Act cycles (PDSA) (Langley et al. 2009) and employing a range of data collection techniques including surveys and focus group. Two surveys were used at different points in this research. An online survey in the Exploratory Phase and a paper-based survey in the Improvement Phase. The online survey was used to understand current discharge practices of the multidisciplinary team and the paper-based survey was used to establish and assess whether there had been a change in practice by the multidisciplinary team following the completion of the PDSA cycles. A focus group was used to build on the information obtained from the multidisciplinary team responses in the online survey and there were five PDSA cycles used to test strategies identified by the multidisciplinary team for improvement.

COMMUNICATION BOARD

The Project Team believed the communication board would be a useful tool to improve communication between the multidisciplinary team. The strategies explored within the Improvement Phase of the research focused on promoting consistent use of the communication board by the multidisciplinary team.

KEY FINDINGS

KEY FINDING 1: INCREASED ACCESS to DISCHARGE PLANNING EDUCATION

- Members of the multidisciplinary team expressed that a lack of education and a lack of understanding of the discharge planning process impacted their ability to prepare patients effectively for discharge home.
- This key finding generates new insights into how members of the multidisciplinary team perceived that they could improve their skills and knowledge in the discharge planning process.
- Engaging in education will equip the multidisciplinary team to have successful discharge planning outcomes with patients.
- Education could assist the multidisciplinary team to manage patients and their family and carers expectations surrounding discharge more effectively and help them to simplify the discharge process.
- Targeted education would improve communication consistently between the multidisciplinary team and between patients and their family or carer.

KEY FINDING 2: HIERARCHICAL and OCCUPATIONAL BOUNDARIES

- Hierarchical and occupational boundaries were found to impede the multidisciplinary team clinical practice, in particular the practice of the RNs and the allied health professionals.
- The multidisciplinary team perceived the action of preparing patients for discharge home was beyond their control and they were consequently unable to optimise the discharge process for patients.
- The factors that contributed to placing the other members of the multidisciplinary team into this vulnerable postion include:
  - The actions of Visiting Medical Officers (VMOs) e.g the timely setting of discharge dates
  - The activities of patients which included negotiating discharge times
  - Hospital processes specifically related to a lack of resources as well as the culture of the hospital.

KEY RECOMMENDATIONS

This research has provided evidence that a combination of approaches must be used by hospitals to enhance the multidisciplinary team skills and knowledge to foster effective collaboration to streamline patients discharge home. Subsequently, this research has five recommendations.

RECOMMENDATION 1
Prior to initiating quality improvement research in healthcare consistent collaborations between multidisciplinary teams, academics and consumers are established. This step will assist to breakdown silos and create genuine partnerships to design, undertake and interpret improvement science research.

RECOMMENDATION 2
Explore the efficacy of the information captured on the communication board by the multidisciplinary team. The findings in this research highlighted members of the multidisciplinary team did not capture all discharge planning information on to the communication board.

RECOMMENDATION 3
Implement discharge protocols and policies to support members of the multidisciplinary team to lead in the decision-making around patient discharge. Developing comprehensive care plans and streamlining discharge protocols and policies that specifically target defined roles for each individual member of the multidisciplinary team is essential.

RECOMMENDATION 4
This research recommends hospitals must focus on hospital in the home initiatives (Allen et al. 2018; Botwinick 2017; Byrne, Leighton & Malone 2018; Federman et al. 2018; Levine et al. 2020; Smith et al. 2015) and evidence-based strategies that focus on members of the multidisciplinary team taking the lead in discharge related decisions (Lees-Deutsch & Robinson 2019).

RECOMMENDATION 5
Address the language and phrasing used by each multidisciplinary team member initiating discharge plans with patients.