EVALUATION OF PROFESSIONAL PRACTICE IN HEALTHCARE ORGANISATIONS

HOSPITAL DISCHARGE PLANNING

NOVEMBER 2001

Department for Evaluation in Healthcare Organisations
FOREWORD

The French law of 31 July 1991 introducing hospital reform made the National Agency for the Development of Evaluation in Medicine (ANDEM) responsible for encouraging the assessment of professional practice and introducing quality improvement programmes. This is now one of the most important remits of its successor, the National Agency for Accreditation and Evaluation in Health (ANAES), which was established by the law of 24 April 1996 and decree of 7 April 1997.

Studies of patient care in public and private healthcare organisations (HCOs) show that discharging a patient from an HCO is a key stage in the care process. It is a care procedure that needs to be planned well before the date of discharge.

The discharge planning process involves several factors, such as the making of arrangements, discharging the patient with their personal belongings from the HCO, and providing information for the patient, their family and the professionals involved in their healthcare, to ensure continuity of care. The continuing care provided outside the HCO has to meet the patient’s needs. Improving this process requires a multiprofessional, patient-centred approach, in which everyone has a defined role.

At the request of healthcare professionals from different care sectors, and with their involvement, ANAES’ Department for Evaluation of Clinical Practice has produced clinical practice standards for the planning of discharge from HCOs which reflect a high level of professional competence and has provided methods and tools for assessing and improving the quality of the discharge process.

As the accreditation of HCOs enters a phase of major development, I trust that this ANAES guide will help professionals in HCOs improve quality of care and patient safety, in line with their own goals and with the expectations of patients and society as a whole.

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INTRODUCTION

Discharge planning is a stage in the care pathway. Quality discharge planning is the type of preventive and educational measure that patients, professionals and health insurance organisations now expect.

People are very vulnerable during the discharge period, as they lose their status as hospital patients looked after by a team of readily available medical and paramedical professionals. From being dependent, they suddenly become responsible for their own health. The discharge process must therefore be conducted in a highly professional way. It is a genuine care procedure that ensures continuity of care and sets up warning and protective systems.

The act of admission to an HCO establishes a legal relationship between the HCO and the patient. By virtue of a public law principle, this relationship can only be broken by an opposite action, i.e. discharge, which must obey specific rules. Discharge is pronounced by the director of the HCO at the request of the doctor heading the department, or his/her representative. Patients preserve their status as users for as long as their stay is medically justified. When this is no longer the case, the costs of the hospital stay will cease to be covered by health insurance organisations (1).

This report uses the following definition of hospital discharge: discharge of a patient from an HCO, on or against medical advice, when the patient then returns home, is moved to another department, or is transferred to another HCO at the end of their stay. This definition excludes discharge from a day hospital, after outpatient care, after emergency care in an accident and emergency department, or after a consultation. Discharge because the patient has died is not dealt with.

The aim of this report is to provide healthcare professionals with a tool to help them improve the hospital discharge planning process. Current knowledge about hospital discharge planning and conditions is reviewed (Annex 1) and examined under the headings

(i) discharge planning
(ii) information required
(iii) continuity of care.

Each of these headings is dealt with according to three aspects of quality:

(i) perceived quality is the quality experienced by the patient, and is a function of the quality they expect and the quality actually delivered;
(ii) expected quality is the quality expected by patients, and is governed by their healthcare needs and their previous experience as a user of the healthcare system. The professionals who look after the patient after discharge also have expectations;
(iii) desired quality is defined by healthcare professionals and by the legislative authorities.
Quality criteria to evaluate the discharge process have been established using these elements and are presented in two sections:

(i) the first states whether they are based on legal obligation or professional consensus,

(ii) the second presents them in the form of an evaluation grid.

Ways of improving discharge planning are suggested. An example of the application of the ANAES PAQ (Quality Assurance Programme) method is given in Annex 2.
BACKGROUND

French PMSI\(^1\) data ([www.le-pmsi.fr](http://www.le-pmsi.fr)) for 1998 show that there were a total of 14,413,300 discharges after short-term treatment in a public or private HCO. These may be broken down as follows:

- 13,160,000 (91%) returns home,
- 244,400 (1.7%) deaths,
- 447,200 (3.1%) transfers to another HCO or to follow-up or rehabilitation care,
- 79,300 (0.5%) transfers to another HCO or to long-term care or nursing home,
- 416,200 (3.3%) transfers to short-term care facilities,
- 63,300 (0.4%) transfers to another HCO or to a psychiatric unit,
- 2,900 (0.02%) transfers to an unspecified facility.

In 1993 the number of discharges against medical advice rose to 55,700, i.e. 0.4% of hospital stays. Distribution of discharges by age range was:

- 2,024,000 (14%) patients under 18 years,
- 7,890,500 (55%) patients between 18 and 64 years
- 4,498,800 (31%) patients over 65 years.

However, discharge is not just an administrative statistic. It also involves the practical and material aspects of leaving an HCO. First-hand reports by carers, patients and their family illustrate various facets of their experience of discharge and how it was planned (2-5):

“… One of my long-standing elderly patients had been admitted to hospital yet again, this time at my request. I felt it was becoming difficult for her to remain at home. From my point of view, one of the purposes of this hospital stay had been to arrange for her to go into a home. I had discussed this with her and her family … I thought everything had been arranged, but in the end, disagreements within her family meant she was discharged early and sent home. I felt this was very risky for her, and that it couldn’t be a long-term solution in these circumstances …”

“… Sometimes, in the nursing home I run, we are not informed that one of our residents is coming back after a stay in hospital. This means that the conditions of their return are less than ideal. Their loss of autonomy or the need for specific types of care, for example, may pose a problem if our home doesn’t have the right resources for the patient’s new needs …”

“… My mother, who’s 73, was due to leave hospital, but nobody could tell me at what time … I am amazed that it took a whole day (and a whole evening) to fetch my mother from hospital, take her home and settle her in properly.”

“… My wife was finally told she could leave hospital at 1 pm … First I had to take the flowers out to the car, and then come back to collect my wife from the hall. I had to make three journeys with the flowers and the presents. What with waiting for lifts and the journeys, the whole thing took an hour …”

\(^1\) PMSI = the French national computerised medical information system program
“… When I went to see my general practitioner after I was discharged, he didn't even know I’d been in hospital... Had anyone told him?”

“… I came home on Friday and my doctor came to see me the following Tuesday. He said he would have come earlier, but he didn't know I was out of hospital …”

“… I was told I could leave hospital and that if I felt well enough I didn't have to have someone with me, I could go home under my own steam ... It was very strange, one minute I was a patient and the nurses were taking care of me, and the next I was finding my own way out and calling myself a taxi …”

“… They never told me I was going home. They telephoned my friend the day before, but they didn't tell me. The house smelt stale, and there was nothing to eat. My friend took care of everything, but I think they should have let me know …”

These experiences raise a number of issues. The duties and responsibilities of carers and the rights and responsibilities of patients need to be clarified. The question of whether hospitals can, or should, replace families in managing the discharge process needs to be addressed. The best solution might be for both parties to be involved and to work together to produce a discharge plan.
The discharge process ends the hospital stay. For discharge to go smoothly, planning needs to start as soon as possible after admission, or even during the pre-admission period.

I. PERCEIVED QUALITY

Perceived quality is the quality experienced by the patient.

I.1. Effect of discharge planning on number of readmissions

A number of authors feel that inadequate discharge planning directly or indirectly increases early readmission, whether or not this is related to the reason for the original hospital stay (6,7):

- A study at Grenoble University Hospital (8) in 1997 showed that in 43 of the 469 cases analysed, patient readmission was due to inadequate management during the original hospital stay:
  - inadequate tests or treatment (19 cases),
  - iatrogenic or nosocomial complications (17 cases),
  - patient discharged too early or post-hospital follow-up inadequate (7 cases).
In 10 cases readmission was due to poor patient compliance with diet or treatment (9 cases) or with proposed medical follow-up (1 case).

- A one-year study in the department of pulmonary medicine at Limoges University Hospital (9,10) showed that in 21 of the 40 cases analysed, patient management was a problem:
  - inappropriate treatment (2 cases),
  - excessive anxiety when the patient returned home (3 cases),
  - recurrence of active illness linked to a decision to early discharge of patient (6 cases),
  - patients in a terminal condition (7 cases)
  - deterioration in general health making it unwise for the patient to return home, after poor assessment of the severity of the situation (3 cases).

In contrast, a number of studies seem to show that introducing a discharge planning care protocol reduces readmission rates, particularly for elderly patients.

- A UK study (11) in a population of elderly subjects supported at home during the fortnight after discharge showed that hospital readmission rates within 18 months of discharge were significantly lower in the study than control group (17.1 days spent in hospital during this period compared with 30.6 days for patients in the control group).

- A more recent trial in two university hospitals in Pennsylvania (12) studied a discharge planning and home follow-up protocol for elderly patients considered to be at risk for poor outcomes after discharge (patients aged 80 years or older, no support at home, multiple disease states, history of depression, moderate to severe handicap, multiple hospital admissions during last 6 months, history of hospital stay lasting more than 30 days, poor compliance with treatment, etc.). A total of 363 patients were enrolled in the study (186 in the control group and 177 in the intervention group). Results showed that more patients from the control
group were readmitted to hospital at least once by week 24 after initial discharge (37.1% compared with 20.3% in the intervention group); fewer patients in the intervention group had multiple readmissions (6.2% compared with 14.5%); and mean number of hospital days per patient by week 24 after the hospital discharge was lower in the intervention group (1.53 compared with 4.09). Time to first readmission was longer in the intervention group (p < 0.001).

I.2. Effect of discharge planning on costs

The direct financial impact of using the discharge planning and home follow-up protocol in elderly at-risk patients was measured in the same trial (12). Expenditure was measured from reimbursements for health services within 6 months of discharge. Costs were $1.2 million in the control group and $0.6 million in the intervention group.

Similarly, a study (13) of the cost-effectiveness of a discharge planning programme for elderly patients (providing information and education for the patient, their families and carers, simplifying and explaining treatment for better compliance, working within an interdisciplinary team and liaising with non-hospital carers) showed a significant reduction in hospital care costs in the intervention group compared with the control group, and also in comparison with the year before the programme was introduced.

Information obtained from the patient and from healthcare professionals inside and outside the hospital, and knowledge of the infrastructure, can be used to see that the best decisions are taken concerning discharge, in terms of the patient’s healthcare needs, their social and environmental situation, and the cost of the various options. Several studies have emphasised the benefit of including a social worker in the team who has been specially trained in managing patients with serious chronic illness (e.g. AIDS) or complex psychosocial problems (e.g. dementia) (14,15).

The patient and their family should be informed of the financial consequences of the options chosen, be aware of the costs of the solutions proposed and be involved in the decision. Healthcare users’ indifference to financial aspects of care has probably contributed to increased costs (16).

An example of healthcare costs generated by poor discharge planning can be seen in Japan, where a superstition that is still very much alive affects the timing of hospital discharge. Patients prefer to be discharged on certain “lucky” rather than “unlucky” days of the week and ask for discharge to be postponed until the next “lucky” day. The study (17) noted that: the number of discharges increased at certain times; mean age was higher for patients leaving on “lucky” days; there was a marked and medically unjustified increase in length of hospital stay among elderly women for whom the “lucky” day belief is particularly widespread. Hospital teams often complied with their requests in order to avoid the risk of damaging their relationship with the patient and the possible psychological consequences of ignoring beliefs. The prolonged hospital stay was in effect a placebo. The study also noted that risk of nosocomial infection increased with prolonged hospital stay and that, as the organisations which reimburse healthcare costs turned a blind eye to the practice, patients were not aware of the extent of costs incurred.
I.3. Is there any benefit in early discharge?

Mean hospital stay has reduced over a number of years as patients have been discharged earlier and earlier. It was 8.7 days in 1986 and 6.9 days in 1998. Scott et al. (18) felt that the reduction in hospital stay (reduced on average by 53% between 1970 and 1987 in France) was due to a number of factors such as changing practice, improved techniques, change in the way hospital stays are reimbursed, introduction of management techniques, development of outpatient surgery, increased pressure to reduce hospital budgets, and a desire to increase the number of admissions.

Published studies express mixed opinions about the real benefit of early discharge:

- Townsend (19) felt that early discharge is often the result of various types of pressure, i.e. pressure to reduce length of hospital stay at all costs, to release a bed for an emergency admission, and to reduce the waiting list. Nevertheless, several factors offset this trend, such as the increasing age of the hospital population and the large number of elderly patients living alone without home support. Patients are admitted to hospital for a shorter time but more often.

- A compilation of three early discharge schemes implemented in Australia (18) (a fractured hip management programme in elderly patients in an orthopaedic unit, an early discharge programme for mothers and newborns in an obstetric unit, and a continuing community cancer care programme) found that, although early discharge does reduce the mean hospital stay, it only rarely reduces the costs incurred. The reduction in hospital stay does not always compensate for the costs of the scheme. In all three cases, it was difficult to evaluate the efficacy and cost-effectiveness of the scheme.

- A trial (20) carried out in London in a population of 167 patients to study the economic consequences of early discharge after stroke found that mean hospital stay was reduced to 12 days compared with 18 days for the control group who received conventional care (p=0.0001); there was in increase in number of units of therapy with physiotherapists, occupational therapists, speech therapists, hospital physicians and general practitioners; readmissions rate was the same in both groups of patients; costs related to hospital stay decreased, but were matched by the increased costs of non-hospital care. The economic results of the trial need to be mitigated even if such a scheme is cost effective and may provide alternative forms of treatment where inpatient capacity is limited.

II. **EXPECTED QUALITY**

*Expected quality is the quality that satisfies the expectations of patients and the healthcare professionals who care for them after discharge.*

II.1. Planning

Discharge planning can only be effective if it begins at or even before admission, with a probable discharge date or time established at an early stage. Avoiding late and rushed planning allows the patient and their family to prepare for the transition from hospital to home.
This is the time when medical certificates to cover absence from work should be prepared and completed so the patient can receive benefit, as the document stating that the patient is in hospital ("bulletin de situation") alone does not authorise their payment.

When a patient has been diagnosed with a long-term illness, health insurance organisations need to be approached as early as possible during the hospital stay so that the patient benefits from complete cover for their stay.

The most important obstacle to successful discharge is often felt to be lack of planning, which is mainly due to the reduced length of hospital stay (21). Early discharge reduces the time available for educating the patient and their family, coordinating home care, learning good compliance with treatment prescribed, sending information to the doctor designated by the patient, and arranging subsequent follow-up. Patients leave with an increasing degree of dependence, placing new burdens on non-hospital care. If needs are not met or have been poorly assessed before discharge, the outcome is poor, i.e. early readmission to hospital, use of emergency services, or death (7,22).

Lack of coordination between different departments and disciplines in an HCO is another obstacle to effective discharge planning. The key to effective coordination is to make individuals within teams aware of the importance of planning. When patient turnover is rapid, planning allows carers to make more efficient arrangements and improve patient care. Improving the planning process will require a change of attitude in short-stay units to take account of all the factors that affect a patient's well-being rather than just the illness itself, as happens at present. Written documents will also need to be used for discharge planning (6).

### II.2. Involvement of patients and their carers in discharge planning

It is generally agreed that it is useful to decide on a probable discharge date at an early stage, and that the patient should be involved in the decision. Choosing a suitable discharge date is a factor in patient satisfaction (23). Patients want their choices and preferences to be taken into account and their carers to be informed of any decisions taken (5).

The patient’s family and carers also want to be more involved in discharge planning. Family members often look after patients once they have returned home. They need to be given information and to be prepared for the task. If the patient cannot return home, they need to be informed about options for admission to another institution.

Patients, their families and carers feel that being rushed at discharge, which often takes place after a long wait for a prescription or transport, heightens anxiety (3).

Information given to the family or to carers should always respect medical confidentiality and should be given with the patient’s consent.

### II.3. Use of non-hospital structures and institutions

The literature implies that there are too few follow-up structures to meet demand for palliative care and long-stays, that there are problems gaining access to them, and
that knowledge is lacking about their specific features. All this prevents patients and their families being given the right information (6).

A study of the needs of elderly people leaving hospital investigated discrepancies between “ideal discharge” and “practicable discharge”, and reasons for these discrepancies (24). An ideal discharge was defined as “the type of discharge best corresponding with the patient's current and foreseeable medical requirements, and with their wishes and those of their family and carers in the theoretical situation that all support resources at home and all the institutions cited are available”, while the practicable discharge took account of “the support actually available (at the patient's home or in institutions), the patient's state of health, their motivation and the motivation of their family and carers”.

Practicable discharge did not meet the definition of an ideal discharge for reasons related to:

- the structures (61% of cases): no places available in a nursing home, long-stay unit (if the patient was very dependent) or follow-up HCO providing rehabilitation care; overloading of home care services (meal delivery, help with housework, community nurses);
- the people involved: return home restricted because the family is uncooperative or the patient's state of health has not yet stabilised (probably unrealistically, the literature did not identify financial problems as a limiting factor); lack of cooperation by patients, their family and carers in the event of discharge to a nursing home or long-stay unit.

The study thus highlighted the problems of overload in residential and care homes for the elderly and of working in cooperation with patients and their families. Both problems are worse when the patient is discharged to long-stay care because of advancing illness or severe dependence. The hospital's social department may be able to help with finding a solution or arranging alternative temporary forms of care.

Early contact with the patient's own doctor is even more important for these patients, to produce a “life plan” which takes all these factors into account.

The working group found there was a lack of knowledge of follow-on care structures, their specific features and whether they are actually able to provide the right level of care for patients. In some cases, if the discharge process requires follow-up and care unavailable in these structures, the patient ends up being readmitted to hospital shortly afterwards.

### III. DESIRED QUALITY

*Desired quality is the quality defined by professionals and by the legislative authorities.*
III.1. Clinical practice guidelines

III.1.1. Discharge planning

A study of discharge planning at Montreal General Hospital produced the following recommendations (6):

• **Planning for discharge.** This should begin the day the patient is admitted or even before admission if the patient is not being admitted as an emergency. The length of stay should be anticipated even before admission to hospital and likely problems with discharge should be identified at an early stage.

• **Anticipation of the physical and psychosocial needs of the patient and their family.** A questionnaire completed on admission can identify at-risk patients who need particular attention and who will require structured discharge planning.

• **Effectiveness of planning and competence of those involved.** There should be a control system to check whether what has been undertaken is consistent with what was planned. Discharge planning should be discussed regularly during interdisciplinary meetings with community and home care services. Ideally, the discharge coordinator should be a nurse, i.e. someone at the centre of the interaction between the care team, the patient and the patient’s family.

• **Partnership with the patient and their family.** The patient and their family must be given all the information they need to be involved in the discharge planning. This information should cover the implications of the disease, financial aspects of care, and the rights and responsibilities of all involved. The family of at-risk patients should be asked to come in 24 to 48 hours after admission to pinpoint problems and expectations, in anticipation of discharge. An information leaflet may be given to patients on admission and at discharge. The information given at discharge should explain the different options for admission to an institution, nursing home, or follow-up facility providing rehabilitation care. Patients should have access to information produced by sources outside the hospital (associations) and should attend meetings with the team to prepare for the transition from hospital to home.

• **Communication and consistency between departments, the patient and their family.** The patient should be given a clear picture of the role and responsibilities of each person involved in the discharge procedure and know what to expect from each of them.

• **Resource management, especially for at-risk patients.** (a) Discharge planning for psychiatric patients who are very desocialised and not integrated into traditional care structures needs to be very well structured, and patients need to be supervised when they have left hospital. (b) Many patients who need palliative care spend a very long time in hospital before dying there and need to benefit from appropriate discharge strategies. (c) The lack of long-stay beds leads to unnecessarily prolonged periods on short-stay hospital wards; both temporary and intermediate solutions need to be found to this problem.
Resource management depends on knowing the services on offer by each structure, so they can be related to patients' needs, and the limitations of these services. Acquiring such knowledge needs more contact between the various establishments and people involved.

**III.1.2. Planning for a return home**

Predischarge visits. *Returning home after a stay in a protected hospital environment poses problems for some categories of patients such as the elderly and patients with motor deficits.* Predischarge visits home are often suggested by physiotherapists and occupational therapists so that the patient's needs can be assessed and the home adapted, making the transition from hospital to home easier (25). A meta-analysis of studies on predischarge visits tried to establish their impact on patients' lives and any cost benefits (26). The visits seemed to have some benefits but there were no randomised trials on their effectiveness with regard to several factors: best timing, who should be present, which patients benefit most, and whether visits impact on quality of life, reduce admissions to institutions, prevent falls, are cost-effective, and have a positive psychological effect on the patient and their family.

*Discharge leave.* The working group emphasised the benefit to some patients of “discharge leave” which allows the patient to resume contact with their familiar environment and spend a few hours at home. This provides them with a better understanding of the problems that might occur when they leave hospital.

*Use of a checklist.* An audit in a general rehabilitation unit has confirmed the value of using a checklist when planning for the return home of patients with disabilities. Such a list records all the patient's needs in terms of equipment, services, non-hospital staff, and follow-up procedures (27).

*Choice of discharge date.* Elderly and vulnerable patients who require continued care should not be discharged home the day before a weekend or holiday (21,28).

**III.1.3. Benefit of care networks**

The aim of a network is to coordinate services around the patient. It focuses not only on the people involved in the care process, but also on the relationships between them. It links professionals working inside and outside the hospital, thus improving quality of care and resource use. It optimises each individual’s role, ensures continuity of care, and thus reduces unnecessary hospital readmissions. Networks operate on a multidisciplinary basis which means that all those involved have to communicate with each other (identifying each contributor’s role, establishing standard record sheets, introducing common protocols, and so on). They depend on cooperation between establishments, and between the medical and social professionals both inside and outside the hospital. Networks have a role to play in post hospital patient care and during planning for the patient’s return home, by providing a coherent pathway for prevention, care, evaluation and follow-up (29).

Accreditation was established in France by the law of 24 April 1996 reforming public and private hospital services. All HCOs must enrol in the accreditation procedure. The care provided by the HCO is assessed against a professional standard, which at the present time is the Accreditation Manual.

The Manual contains a specific standard on discharge planning in the section Organisation of Patient Care (OPC):

OPC- Standard 12: *The patient’s discharge is planned and coordinated.*

Other standards referring to organisation of patient care (OPC), patient rights and information (DIP), and logistics management (GFL) may also apply to discharge planning:

- OPC- Standard 4: *Care is planned on the basis of an initial and ongoing assessment of the patient's condition.*

- OPC- Standard 5: *The patient's specific needs are identified and taken into account.*

- DIP- Standard 3: *Patients are given clear, understandable and appropriate information about the conditions relating to their hospital stay.*

- GFL- Standard 8: *The HCO has security systems and staff to cover property and personal safety.*

III.3. Legal provisions

Discharge planning must take account of provisions specific to certain categories of people cared for in HCOs. These will often require planning to begin at a very early stage. Similarly, discharge after compulsory hospitalisation needs to be planned meticulously.

III.3.1. Patients who are minors

A hospital acts as the legal guardian of a minor, by delegation of parental authority (Article 1384 of the Civil Code). A minor may normally only be discharged to their father, mother or guardian, or if this is not possible, to a person designated in writing by one of these. This person must be able to produce a document confirming their identity. The rules for main and local hospitals stipulate that individuals to whom the child is returned must be informed of their imminent discharge (Article 63 of decree no. 74-27 of 14 January 1974) (30). The administrative authorities of the hospital should be informed, e.g. by telephone, if the minor has permission to leave the HCO unaccompanied (31).

In the case of a child who has come to the HCO on their own and whose parents cannot be contacted, the juvenile court judge should be informed if the parents cannot be reached within
a few hours, particularly if the child is young or appears to be in a condition of danger. The HCO may be held responsible if it has not:
- tried to contact the parents;
- satisfied itself that the parents did not object to the child leaving home alone;
- taken the necessary measures if the child has absconded;
- informed the judge, if appropriate.
The HCO would be held responsible on the basis of poor exercise of its duty as guardian, or even of inadequate supervision.

A newborn should leave hospital with its mother unless there are medical reasons to the contrary, or the child has been abandoned or is the subject of a legal decision. The reason for this rule lies in legally unresolved family conflicts (if the parents are separated, or if a legal separation is pending).

III.3.2. Legally incapacitated adults

The law of 3 January 1968 (32) provides for the protection of an incapacitated person over the age of majority “who is made incapable by a deterioration in his or her personal faculties of taking care of his or her own interests”. It applies to patients with mental illness and all those whose problems “prevent the expression of their will”, whether these problems are the result of an illness, infirmity or weakness due to age.

- **Protection of the court**: This is an immediate temporary measure designed to protect patients whose deterioration in mental faculties is minor or temporary, or before the implementation of either of the two regimes below. It allows a complete or partial nullity action as the protected person cannot then harm themselves. However, a patient under the protection of the court continues to exercise all their civil and civic rights.

- **Protection**: This concerns a patient who needs “to be advised and supervised in actions of civil life” and provides long-lasting but flexible protection tailored to the individual. Patients can continue to manage their financial affairs.

- **Guardianship**: Under this regime, the patient is continuously represented by another person. The patient is deprived of their civil, civic and legal rights. When a patient under guardianship is discharged, the measures to be taken are the same as for minors.

III.3.3. Military personnel

Although the rules are the same as for discharge of an adult civilian, the “bulletin de situation” (statement that the person is in hospital) should be sent to the head doctor at the military hospital and to the senior officer of the unit (possibly the gendarmerie) to which the patient belongs.

III.3.4. Destitute persons

HCOs provide continuity of care “satisfying themselves that at the end of their hospital treatment or stay, all patients have access to the living conditions required for continuation of their treatment. At discharge, they will send patients who do not enjoy such living conditions to structures which will take into account the precarious
nature of their situation” (Article L.711-4-5 introduced into the Public Health Code by the law of 29 July 1998 dealing with exclusion).

III.3.5. Released prisoners

The remits entrusted to the public hospital service within detention units include measures, in terms of both care and rights of access to care, to be applied before the discharge of released prisoners (Circular no. 45 of 8 December 1994) (33).

The prison UCSA units (consultation and outpatient care units) render prisoners accountable for undergoing regular care by handing them:
- a letter for their doctor giving the name and contact details of the doctor who treated them in prison, and medical data;
- a prescription to avoid interruption of treatment;
- a document produced by the hospital service giving them information about their rights with regard to access to care and useful addresses near their home (e.g. places for free medical advice, HIV screening centres, alcohol abuse centres, and centres dealing with medical and psychological problems).

The administration department and the rehabilitation and probation service should see that released prisoners have all the necessary documents for medical and social care after discharge (identity card, certificate of membership of CPAM\(^2\) in their place of residence, rights to benefit statement, etc.). Rights are maintained for 3 years after release, except for foreigners.

Since 1986, the regional medical psychology service (SMPR) or a designated public psychiatric unit provides psychiatric care for prisoners within the prison environment. When a prisoner requiring psychiatric follow-up is discharged, the general psychiatric service located near the released prisoner’s place of residence should be contacted by the SMPR to arrange post-detention follow-up.

III.3.6. Compulsory hospitalisation

Compulsory hospitalisation (law of 27 June 1990 (34)) mainly applies to patients with mental illness, who often suffer from decreased discernment as a corollary of their illness, and refuse care.

Hospitalisation at the request of a third party. This arises when the patient’s disorder precludes their giving consent and yet their condition requires immediate treatment combined with supervision in a specialist hospital environment. A handwritten request for admission is then signed by a third party (family member, close friend, or person acting in the patient’s interest) and two detailed medical certificates are made out. The patient’s discharge is pronounced:
- by the doctor who establishes that the reasons for the hospital stay at the request of a third party are no longer valid;
- by order of the prefect in the absence of legal certificates (initial certificates, “immediate” certificate produced within 24 hours by a psychiatrist belonging to the HCO, “fortnightly” certificate confirming the need for continued hospitalisation);

\(^2\) CPAM = State Health Insurance Scheme
at the request of the trustee, spouse, partner, close relation, person who made the request for admission, person authorised by the family council, or the psychiatric hospitalisation commission for the département (35).

**Automatic hospitalisation.** This is an administrative measure taken by the prefect (or by the mayor or commissioner of police in the event of immediate danger) which concerns patients threatening public order and safety. A detailed medical certificate must be made out. An immediate certificate is issued within 24 hours by a psychiatrist belonging to the HCO where the patient is hospitalised, followed by “fortnightly”, then monthly, certificates confirming continuation of the placement.

Discharge is pronounced by order of the prefect at the request of a psychiatrist or the psychiatric hospitalisation commission for the département. Unless confirmed by the prefect, the temporary order made by the mayor or commissioner of police becomes void after 48 hours. In the case of automatic hospitalisation following dismissal of a case (by application of article 122-1 of the Penal Code, which establishes mental deficiency in law), discharge may only be pronounced by the prefect after two independent confirmatory psychiatric expert reports have been produced.

Trial discharges may be decided:
- by the doctor at the HCO in the event of hospitalisation at the request of a third party,
- by the prefect on receipt of a written proposal, with reasons, from a psychiatrist in the event of automatic hospitalisation.

Duration may be up to 3 months, and is renewable.

### III.4. Ambulance transport

Transport by ambulance has to be considered when a patient is discharged home or transferred. “Ambulance transport is [...] any transport for a person who is ill, wounded or giving birth, for reasons of care or diagnosis, on medical prescription or in the event of a medical emergency, that is provided using specially adapted terrestrial, aerial or maritime means of transport” (Article L.51-1 of the Public Health Code).

Because the use of ambulance transport is regulated, compliance with certain rules is necessary. Public HCOs must comply with the following:
- the hospital should provide the patient with the supporting justification needed for the cost of transport to be covered by health insurance. The medical order specifies the least expensive method compatible with the patient’s condition (article L.322-5 of the Social Security Code);
- the patient may choose the company providing transport home or to another HCO. The hospital should give them a list of transport companies in the region, if required;
- the HCO should arrange transport schedules to avoid waiting that is incompatible with the patient’s state of health (1).

However, in the case of temporary transfer to another HCO for tests, for example, or if the patient is being moved from one department to another within the same HCO:
- the HCO is responsible for transport and chooses the transport company;
- the HCO pays the cost of transport, included in its fees.

In the case of a patient staying in a rehabilitation centre or convalescent home after surgery, transport is paid for by:
- the HCO to which the patient is being admitted if it has been ordered at that HCO’s request;
- the HCO the patient is leaving if it has been ordered by the department where surgery took place (and not by national health insurance, contrary to previous legislation).

In other cases, the patient pays transfer costs but these may be covered by their health insurance fund, according to the terms of the decree of 6 May 1988 (article R.322-10 of the Social Security Code).

IV. SPECIAL SITUATIONS

In some cases discharge may take place under conditions considered unsatisfactory by both professionals and patients. These forms of discharge have been defined in legal terms and should nevertheless be planned as far as possible.

IV.1. Discharge against medical advice

Discharge against medical advice has been defined within the legal framework described in the French law on Bioethics, law no. 94-653 of 29 July 1994 (36), article 16-3 of the Civil Code, article 36 of the Code of Medical Ethics, and articles 60 and 42 of Decree no. 74-27 of 14 January 1974 (30).

In the Accreditation Manual, it is the subject of standard 6 in the section “Patient rights and information” (37): “Patients may leave the HCO at any time after they have been informed of any risks they may incur....”.

In practice, this means dealing with the administrative, medical and legal dimensions of such an action:
- The doctor should tell the patient (or the parents of minors) in clear, honest terms what are the risks they incur. If the patient continues to refuse care, these risks should be put in writing (respecting professional confidentiality). The patient should sign this document in the presence of a third party caregiver;
- if the patient refuses to sign this ‘discharge of responsibility’, a declaration of refusal should be produced, again in the presence of a third party caregiver;
- if the doctor sees that the patient is not fit to give their consent, the patient should be protected by a compulsory hospitalisation order;
- the patient's own doctor should be notified if possible; they should be given details of the conditions under which the patient was discharged and be sent a letter emphasising that there is a need for treatment and that the patient may revoke their decision; finally, steps should be taken to ensure that the patient's return home is satisfactory.
IV.2. Absconding or discharge without the department's knowledge

The HCO may be held responsible on the grounds of inadequate supervision, particularly of a minor or of a person who is protected, incapable, or whose behaviour is agitated or likely to put them in danger. The following measures should be taken:

- **internal procedures**: have the immediate surroundings of the ward and HCO searched; inform the duty administrator; produce a standard document for the patient record, the director, the patient's own doctor, and the family if appropriate;

- **external procedures**: these concern minors and protected persons, and should complete internal measures (calling the police or gendarmes; informing the family or guardian; informing the patient's own doctor).

IV.3. Discharge by disciplinary order

This exceptional measure is rarely used. It consists of depriving the patient of their status as a user, by officially pronouncing their discharge. The head of department sends the director of the HCO a written report giving details of the patient’s unacceptable behaviour. The patient may reply to the accusations made against them, after which the director of the HCO will make a decision, giving their reasons, and notify the patient in writing.
INFORMATION REQUIRED

Many audits of patient discharge have described problems with communication and information.

I. PERCEIVED QUALITY

Perceived quality is the quality experienced by the patient.

I.1. Patient education

After discharge, many patients have to take medicines about which they need information and education. The learning phase should begin early during the hospital stay, particularly if they are to be discharged to their own home. It should cover:
- taking the medicine;
- side effects;
- drug interactions;
- things to look out for;
- signs which should lead them to seek urgent medical help;
- ways of ensuring good compliance.
This type of education should improve the patient’s compliance with treatment, and in some cases avoid readmissions.

A study by French regional pharmacovigilance centres in 1998 showed that 13% of hospital admissions to public hospital medical wards because of drug side-effects were related to bleeding in patients taking vitamin K antagonists prescribed whilst they were either in- or out-patients (38). This demonstrates that patients need to be given full information about their treatment. In the case of inpatients, HCOs are responsible for this.

Patient education may also cover:
- aspects of monitoring, e.g. blood glucose monitoring for insulin-dependent diabetics;
- aspects of care, e.g. breast care for breastfeeding mothers;
- aspects of diet, e.g. for patients with hypercholesterolaemia;
- hygiene, e.g. checking feet by patients with diabetes or arterial disease;
- specific types of care, e.g. for patients with a stoma or tracheotomy.

I.2. Continuity of medical information: the hospital report or discharge letter

Information needs to be sent to partners outside the hospital, or staff in other HCOs in the case of transfers, to ensure continuity of care and the quality of the patient’s treatment after discharge.

The hospital report (or discharge letter) is a key item in the medical record. It contains the most important information recorded during the hospital stay, the proposed treatment and elements of subsequent medical follow-up, and is an important tool for communication between doctors.
Several studies have looked at the information to be included in the discharge letter. A quality improvement initiative at Grenoble University Hospital (39) studying 960 stays in a medical or surgical unit in 1993 found that:

- 84% of records contained a discharge letter;
- 43% of letters were signed by an interné (equivalent to senior house officer);
- 85% of letters were sent to the patient’s own doctor;
- 54% of letters were produced in less than 8 days.

The factors influencing the discharge letter were related to:

- the hospital stay: the longer the hospital stay, the more complete the letter and the shorter the time taken to produce it; a letter was written more often when the patient had been sent by their doctor than when they had been admitted via the accident and emergency department; a letter was produced in 99% of transfers to another HCO, 85% of returns home and 83% of internal transfers;
- the unit: activity indices (number of beds and admissions/year were inversely proportional to how often a discharge letter was included in the record) and resource indicators (number of computers, secretaries and doctors in relation to number of admissions).

The main problems with the discharge letter relate to content and promptness.

Content. Doctors consider the following information most important (40):

- details of discharge treatment (frequency of administration, dosage and proposed duration);
- significant results of tests done during the hospital stay (negative as well as positive results);
- recommended or proposed follow-up procedures;
- what the patient had been told about their diagnosis.

They also want to be informed of the prognosis for the illness, as patients often ask them about this, and of the patient’s destination (home, institution etc.). According to one report (41), accurate details of the patient should be given (name, address, date of birth, hospital admission number, dates of admission and discharge) and contact details for the person responsible for the patient and for the person who wrote the letter. The issue of who should write the discharge letter is often raised. The letters should be carefully read and checked by the doctors who have been treating the patient, to reduce the number of errors (42,43).

Promptness. The maximum acceptable time between the patient’s discharge and receipt of the discharge letter varied depending on the study. The time most commonly accepted was 8 days, which in France corresponds to a legal obligation (article R.710-2-6 of the Public Health Code). A solution sometimes proposed was giving a copy of the hospital report to the patient, who would give it to their doctor at their next visit (43,44).

Several teams have addressed improvements in the form and content of discharge letters, and the time taken to send them. They have shown that computer tools can be useful in producing standard letters, and the value of faxing letters for faster delivery (45-49). A standard structured format of the hospital stay faxed to the patient’s doctor had the following advantages over the narrative form: quicker to produce,
easier to read and to extract information, data suitable for audit purposes, and delivery in under 48 hours.

However, identifying the patient’s doctor and inserting his or her accurate details in the record is still a problem. The French legal framework does not exclude sending the letter by fax but precautions are needed, such as obtaining the doctor’s permission to fax medical information and ensuring that their fax machine is located in a place where confidentiality can be guaranteed. If a wrong number were entered and the document were sent to a third party, this would be misconduct for which the HCO sending the fax would be responsible. Sending documents by fax does not replace the obligation to send the original documents to the patient’s doctor (article R 710-2-6 of the Public Health Code).

II. EXPECTED QUALITY

Expected quality is the quality that satisfies the expectations of patients and the healthcare professionals who will look after them after discharge.

II.1. Need for information

Patients and their families would like more information from and better communication with the care team. They feel that the information they are given is often inadequate, unclear, too late and too rushed (51). They are often unwilling to put questions to members of the care team, or to ask them to repeat instructions. They would prefer to have one person in the team as their main contact (3).

The need for information concerns:
- the illness itself;
- its implications on activities of daily living (can I drive? can I take a bath when I have an indwelling catheter? etc.);
- medicines that have been prescribed, and any side effects;
- warning signs and symptoms that could suggest a possible relapse or mean that they should see their doctor;
- financial aspects of their treatment;
- practical advice about diet or health education in the broad sense.

Patients want supporting written information so that they do not forget instructions given at a time when they may have been under stress or weak. They want information to be given in language they can understand, and they want it to be reiterated. Written information should complete, and not be a substitute for information given orally. Information should be given to patients when in hospital to give them time to take it in.

II.2. Role of patients’ associations

The development and increased numbers of patients’ associations reflect changes in the attitudes of patients, their family and carers who nowadays want to be involved in the management of the illness and to be informed and educated (52). These associations provide:
- practical assistance (practical information, useful addresses, advice on daily matters);
- information via leaflets and newsletters;
- moral support for patients and families;
- aid for research through fund-raising;
- preventive action by acting as valued partners for patients and carers.

Caregivers need to be told of the associations so that they can in turn inform their patients and arrange meetings, if desired. These associations provide valuable assistance to healthcare professionals, as they often act as information relays that give patients another view of their illness. They arrange encounters between people with the same illness and provide psychological and technical support for patients returning home. Some of them have become real partners of healthcare professionals in educating patients.

II.3. **Dealing with problems on a patient’s return home or during transfer**

Caregivers should not underestimate how distressing it may be for some patients to leave a healthcare environment, where there is always a nurse or doctor on call, to go home where they feel less protected (3). Moral and emotional support is needed to help these patients relinquish their status as a patient. Users reproach hospital teams for ignoring foreseeable symptoms that often appear during the first few days after discharge home (25):
- inadequate pain control;
- insomnia;
- transit disorders;
- problems with toileting and personal care;
- problems taking medicines;
- behaviour problems for young children.

Transfer between or within HCOs means a change of place, medical and paramedical teams, and hospital routine for the patient. Such a transfer is itself a care procedure ordered by a doctor and involves care, social and administrative teams. Transfers often make patients anxious. The process is complex and may generate problems such as lack of information, poor coordination between teams, and lack of organisation by the receiving HCO, transmission of nosocomial infections, etc. When a patient is transferred within the same HCO, a common record can be used to optimise transmission of information.

The following recommendations were formulated from a quality initiative to improve transmission of information and transfer conditions in Haute-Normandie in France (53):

- **Effective information:**
  - is honest, concise, concerted, individualised, made secure to protect confidentiality, written, reliable, and completed by oral information;
  - informs the patient and the patient’s family and carers about the purpose of the transfer, details of the receiving organisation, and financial aspects of care;
  - informs the receiving HCO about medical, paramedical and social aspects of the patient’s care and of the purpose of the transfer;
  - provides the originating HCO with information about the organisation of the unit receiving the patient and the services offered.
The involvement of all concerned is crucial, i.e. nurses, social workers, physiotherapists, patient’s own doctor, and home care services. Ambulance drivers have an important role and must be given appropriate information (correct mode of transport, timetables, rules of hygiene, safety, and patient comfort).

- The transfer must be planned and incorporated into the care plan:
  - the transfer must be anticipated and discussed with the patient and their family;
  - named contacts are given for each transfer;
  - legal obligations are complied with.

- The procedure must be evaluated:
  - the contents of the transfer dossier are checked on departure and on arrival, using a standard list of administrative, medical, paramedical and social items;
  - the satisfaction of the various partners is measured (satisfaction questionnaire);
  - internal audits are carried out.

III. DESIRED QUALITY

Desired quality is defined by healthcare professionals and by the legislative authorities.

Healthcare professionals and the legislative authorities have proposed frames of references for the information that must be given during the hospital stay and at the time of discharge.

III.1. Accreditation Manual

A number of sections of the Accreditation Manual contain standards that may apply to the discharge planning process, detailing the information that needs to be recorded in the patient’s file or given to the professionals who will provide follow-up care:

Patient rights and information (DIP)

DIP- Standard 3: Patients are given clear, understandable and appropriate information about the conditions relating to their hospital stay.

DIP- Standard 4: Patients are given clear, understandable and appropriate information about their care and condition.

DIP- Standard 5: The patient's consent and/or that of their family and close friends is required for any procedure concerning them.

DIP- Standard 6: The patient's privacy, personal dignity and liberty are respected throughout their stay or consultation.

DIP- Standard 7: Patients are assured that all personal, medical and social information, and details of their private life, are kept confidential.

Patient records (DPA)
DPA- Standard 1: The healthcare organisation formulates and implements a patient record policy for all its activity sectors.

DPA- Standard 3: Information contained in the patient record is covered by the rules of confidentiality.

DPA- Standard 5: The information contained in the patient record ensures that care is coordinated between professionals and between activity sectors.

**Organisation of patient care (OPC)**

OPC- Standard 5 (already cited in the previous section): The patient's specific needs are identified and taken into account.

OPC- Standard 12 (already cited in the previous section): The patient's discharge is planned and coordinated.

**Quality management and risk prevention (QPR)**

QPR- Standard 2: There is a quality management process in place which takes account of customers’ needs.

**Specific prevention programmes and transfusion safety (VST)**

VST- Standard 4: The HCO observes the rules governing transfusion safety.

**III.2. The Hospital Patient’s Charter (54)**

The Charter contains provisions which describe the information to be given to patients, their family and carers: “[…] The doctor must give simple, accessible, intelligible and honest information to all patients. Doctors and paramedical staff should be involved in giving the patient information, each within their own area of competence, so that the patient can participate fully, notably in treatment decisions concerning them and how these decisions will be implemented on an everyday basis.”

**III.3. Legal provisions**

**III.3.1. Information for the patient’s own doctor**

The patient’s own doctor should be informed at an early stage so that they can monitor the patient: “Public HCOs and private HCOs implementing the public hospital service should inform the practitioner nominated by the patient or by their family in writing when the patient was admitted to the HCO (date and time) and to which department. They should invite him/her to provide the department with useful information on the patient and to express their wish to be kept informed of changes in the patient’s state of health, if appropriate” (Decree no. 92-329 of 30 March 1992) (55).
III.3.2. Hospital report

The hospital report contains the most important information from the medical record. It is an essential communication tool and a summary of the patient’s stay in the HCO. It is a compulsory element of the medical record (Article R.710-2-1 of the Public Health Code).

III.3.3. Health record

All patients aged over 16 years should have a health record which is used to liaise between the various healthcare professionals “in order to encourage continuity of care” (Law no. 96-345 of 24 April 1996) (56). Doctors who provide care for the patient should enter any comments relevant to medical follow-up, mentioning in particular any procedures carried out and major tests and treatment. This should be done in compliance with ethical principles and with the patient’s agreement.

Application decree no. 96-925 of 18 October 1996 (57) stipulates that the health record of a hospital inpatient should be completed:
- in public HCOs and private HCOs participating in the public hospital service, by the practitioner responsible for each medical unit which provided care for the patient or by a member of the medical team of that unit appointed by the responsible practitioner;
- in other HCOs, by the doctor or doctors who have provided care for the patient.

At the present time, the health record is rarely used and has not fulfilled its purpose. Patients rarely carry it and doctors do not ask for it.
CONTINUITY OF CARE

When a patient leaves an HCO, the organisation must ensure that the patient has everything they need to enable them to receive the care their condition requires.

I. PERCEIVED QUALITY

Perceived quality is the quality experienced by the patient.

Published studies relating to continuity of care after a hospital stay address the prescribing of medication to be taken after the stay. This is a very important part of continuity of care as the patient often does not see their own doctor until some time later. The general opinion is that the quality of prescription writing and the explanations accompanying the prescription improve compliance with treatment.

One study examined the form and relevance of 100 discharge prescriptions in the Internal Medicine Department at the Cochin Hospital, Paris (58). The main mistakes in prescription writing, which affects how well they are understood by the pharmacist and patient, were:
- poor writing: illegible handwriting, spelling mistakes, abbreviations;
- carelessness that may cause confusion about drug names and dosage;
- no details on dose, duration of treatment and concomitant diet.

Another study, which analysed a questionnaire sent to 9 community pharmacists and 43 hospital prescriptions presented in a pharmacy over a two-week period (59), found the following problems with prescriptions:

Not made out properly:
- prescriber’s name not given or illegible (75% of cases);
- departmental stamp not present (75% of cases);
- problems contacting the prescriber (65% of cases).

Incomplete:
- drug dosage not given, where several were possible (90% of cases);
- equipment to administer drug not mentioned (e.g. needles for insulin injector pen).

Imprecise:
- treatment duration not given;
- details of medical devices (size, diameter, code numbers) not given. A quarter of the pharmacists questioned also raised the problem of differences in the features of devices available inside and outside hospitals;
- prescriptions submitted to community pharmacists included medicines which are reserved for hospitals and have to be supplied by a hospital pharmacy;
- prescriptions for drug dosages available only inside and not outside hospitals;
- specific protocols were not always applied (restricted prescription, médicaments d’exception\(^3\), narcotics);
- medicines prescribed were not yet available on the market.

Other shortcomings:

\(^3\) Médicaments d’exception = category of drugs formerly only available in France from hospital pharmacies, now available under strict conditions from local pharmacies and reimbursable by health insurance schemes.
- prescriptions for products not covered by social security under the French TIPS system (interministerial scale of fees for health services). These products are not reimbursed by the complementary health insurance schemes and, in addition, not all patients have complementary cover. In these circumstances, financial assistance may be obtained from various bodies via the HCO’s social welfare department;

- problems caused by hospital discharge on Saturday afternoons when the pharmacist did not have the prescribed medicine available, as there are no deliveries on Saturday afternoons.

Other aspects related to the quality of discharge prescriptions were raised by members of the working group:

- non-compliance for some drugs with the indications in marketing authorisations;
- poor use of ordonnances bizones⁴;
- changes in or cancellation of previous prescriptions not clearly specified;
- the problem raised during a hospital stay by the patient continuing self-medication;
- frequent discrepancies between the treatments specified in the discharge letter given to the patient and in the letter subsequently received by the patient’s doctor;
- no planning of prescriptions for drugs from the hospital pharmacy leading to unnecessary trips by the patient; no information on where the drug can be obtained;
- forgetting to order tests needed for treatment follow-up;
- patient not informed about possible drug interactions with analgesics they may be taking as self-medication.

II. EXPECTED QUALITY

Expected quality is the quality that satisfies the expectations of patients and the healthcare professionals who will look after them after discharge.

II.1. Discharge prescriptions

The discharge prescription (58,59) should:

be legible:
- if possible, the prescription should be typed,
- names of products and dosage should be written in capitals,
- the name and capacity of the person writing the prescription should be written in capitals so that they can be identified by the community pharmacist if there are any problems;

specify relevant medicines: if possible, the medicines prescribed should be ones with which the patient is familiar to avoid mistakes over names and doses;

encourage good compliance:
- the hospital discharge prescription should contain only a few medicines,
- medicines should be prescribed for only a short time to encourage the patient to go and see their doctor soon,

⁴ Ordonnances bizones = two-part prescriptions for long-term illness which are reimbursed 100%.
- the prescription should be explained to the patient. Written information may also be given for some medicines, e.g. vitamin K antagonists, in which case someone should check that the patient understands the information.

The pharmacist should be warned before the patient is discharged if a specific medicine is to be prescribed, especially at weekends.

The patient’s medical record could include details of the pharmacist they usually go to.

In English-speaking countries, discharge medication is often supplied directly from the hospital pharmacy, for a varying length of time. This practice is very convenient for the patient; its quality is improved by having prescriptions written and sent to the pharmacy 24 hours before the patient is discharged (60).

Many patients leave HCOs while they still need painkillers. Prescriptions should be for painkillers that are appropriate for the severity of pain.

Discharge prescriptions do not always refer to medicines alone; instructions about diet should not be forgotten. In this case, the patient needs to be given information, and, to be effective, it should be given at an early stage during the hospital stay. Involving the HCO’s dieticians often improves the quality of information given. If patients are given written information, they are less likely to forget details or make mistakes.

II.2. Continuity and transition

Patients want their own doctor to be informed early of their discharge and of the results of the hospital stay. They also want a list of telephone numbers, for the hospital, department, social worker, and the healthcare professionals who looked after them (5).

The potential benefits for the patient of telephone follow-up after they have returned home have been described (25,61). Telephone follow-up is allowed by law (Article 53 of the Medical Ethics Code) but is not classified as a medical procedure. It is a rapid, cheap and effective way of ensuring that no new problems have arisen, of giving advice and answering questions not raised in hospital, of continuing to educate patients, their families and carers, and of keeping a link between hospital and home that reassures or comforts the patient. It can also be used as a tool for assessing the quality of care and the discharge process, in cooperation with the patient’s doctor.

II.3. Hospital at Home

Hospital at Home services (HAH) have an important role in continuity of care. Their role in relation to other individuals in the care system is defined in Circular no. DH/EO2/2000/295 of 30 May 2000 (62). HAH services look after patients with serious, acute or chronic, active and/or unstable illness who would otherwise be inpatients in an HCO. Patients can receive care while remaining within their normal environment. They, their families and carers often see this as a factor in quality of life.

The relationships between HAH services and the HCO departments which use them need to be well defined to avoid interruptions in patient care. Agreements between
them should cover treatment plans, procedures for liaising with the patient’s own doctor, readmission to hospital and management of emergencies.

A patient is admitted to the HAH service on the basis of a formal treatment plan which sets out all the clinical, psychological and social care their condition requires. The plan is produced jointly by the HCO doctor prescribing the HAH service and the coordinating doctor from the HAH care team. It is revised while the patient is in hospital and at the time of discharge by the patient’s own doctor in conjunction with the coordinating doctor of the HAH care team and, if necessary, the social welfare department. The coordinating doctor should approve the patient’s admission to the HAH service in the light of information supplied by the patient’s own doctor(s) and/or the hospital doctors. The paramedical team should assess how much care is required and approve the care plan.

When the patient is discharged to an HAH structure, the hospital doctor should:
- send the patient’s medical information to the coordinating doctor at the HAH service and the patient’s own doctor;
- produce a treatment plan in association with the HAH team;
- undertake to follow-up the patient at hospital level and readmit them to hospital, if necessary.

III. **Desired Quality**

*Desired quality is defined by healthcare professionals and by the legislative authorities.*

III.1. **Accreditation Manual (37)**

The Accreditation Manual contains a number of references that apply to the organisation of continuity of care, which should be taken into account when a patient is discharged.

*Organisation of Patient Care (OPC)*

OPC- Standard 4: *Care is planned on the basis of an initial and ongoing assessment of the patient's condition.*

OPC- Standard 5: *The patient's specific needs are identified and taken into account.*

OPC- Standard 6: *Patient care is coordinated within the various clinical activity sectors.*

OPC- Standard 7: *Continuity of care is ensured.*

OPC- Standard 12 (already cited in previous sections): *The patient's discharge is planned and coordinated.*

*Patient Records (DPA)*
DPA- Standard 5: *The information contained in the patient record ensures that care is coordinated between professionals and between activity sectors.*

**Specific prevention programmes and transfusion safety (VST)**

VST- Standard 4: *The HCO observes the rules governing transfusion safety.*

III.2. **The Hospital Patient’s Charter (54)**

The Charter states that “[…] HCOs should provide for continuity of care at the end of the patient’s treatment or stay.”

III.3. **Legal provisions**

**III.3.1. Patient record**

Decree no. 92-329 of 30 March 1992 (55), relating to the medical record and to information for persons admitted to public and private HCOs and modifying the Public Health Code:

- specifies the documents that must be produced at the end of each hospital stay, “i.e., a hospital report, which in particular includes the discharge diagnosis; discharge prescriptions; if appropriate, the summary sheet contained in the nursing care record”;
- stipulates that at the end of every hospital stay the documents mentioned above “together with any other documents considered to be necessary, are sent within a period of eight days to the practitioner that the patient or the legal representative will have nominated to ensure continuity of care. Copies of these documents should be made and kept in the patient record […] During the hospital stay, the head of department should communicate all important information relating to the patient’s condition to a nominated practitioner […] who makes a written request for this information.”

Circular no. 88 of 15 March 1985 (63), relating to publication of the nursing service guide, contains a guide dealing with the care record. It states that: “[…] The summary sheet is additional to the medical hospital report. It gives the nurse’s name, and is dated and signed by the nurse. A photocopy should be sent to anyone who is taking over the patient’s care, and it then becomes a liaison sheet.” It should include:

- a description of the patient’s condition at admission;
- changes during the hospital stay, including problems arising, objectives pursued, and action undertaken, etc.;
- an assessment of the hospital stay.

“[…] The hospital summary concerns nursing care […], current treatment […] and the condition of the patient being cared for.”

**III.3.2. Medical prescriptions**

“When writing prescriptions, the doctor should ensure insofar as possible that they are as clear as necessary, that they can be understood by the patient, their family
and carers, and that they are followed properly” (Article 34 of the Medical Ethics Code).

III.3.3. Written information about administration of a labile blood product

If a patient has been given a labile blood product during their hospital stay, this information should be given to them in writing (Article R 710-2-7-1 of the public health code). It should be communicated to the holders of parental authority for minors and to the guardian for incapable individuals.
**EVALUATION CRITERIA**

Criteria have been classified into two categories:

(i) major criteria derived from official texts or from the Accreditation Manual,

(ii) criteria cited in the literature as the subject of consensus among professionals.

<table>
<thead>
<tr>
<th>Before a planned hospital stay or at the time of admission</th>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
</table>
| 1. Cooperation established (telephone contact, written documents)  
  between external actors and hospital carers to decide:  
  - objectives of the hospital stay,  
  - patient’s normal environment (social insertion, supportive care,  
    housing conditions, etc.)  
  - future plans. | Accreditation Manual OPC 4 (37) | |

<table>
<thead>
<tr>
<th>During the hospital stay</th>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Organisation – Comfort – Convenience</strong></td>
<td>Accreditation Manual OPC 12 (37)</td>
<td></td>
</tr>
</tbody>
</table>
| 2. Discharge planning started as soon as possible during the hospital stay  
  (or before admission in the event of planned hospital stay). | Accreditation Manual OPC 4 and 5 (37) | |
| 3. Discharge plan updated during the hospital stay. | | |
| 4. Patient’s situation assessed regularly, in relation to discharge, at the  
  following levels:  
  - somatic,  
  - mental and emotional,  
  - cognitive,  
  - disability and dependence,  
  - social. | Accreditation Manual OPC 4 and 5 (37) | |
| 5. Patient’s personal life plan taken into account. | | X |
| 6. Family’s and carers’ point of view concerning patient’s life plan taken  
  into account. | | X |
| 7. Discharge plan discussed by doctor with the care team. | | X |
| 8. Discharge plan discussed with social worker. | Accreditation Manual DIP 3 (37) | |
| 9. Discharge plan compatible with patient’s resources. | | X |
| 10. Social worker asks for any financial assistance patient will need and to  
    which they are entitled. | Accreditation Manual DIP 3 (37) | |
| 11. Visit to patient’s home arranged to assess housing situation. | | X |
| 12. Patient’s housing adapted if necessary to patient’s requirements:  
  - handrails fitted,  
  - aids fitted in toilets,  
  - doorways enlarged to allow a wheelchair to pass through. | | X |
### Hospital discharge planning

<table>
<thead>
<tr>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
</table>

- shower installed instead of bath,  
- carpets removed,  
- temperature-control taps fitted.  

13. Home care services:  
- HAH,  
- nursing care,  
- physiotherapy,  
- personal carer for toileting,  
- home help for household tasks and shopping,  
- meal delivery,  
- telephone alarm system,  
- shopping delivery arranged with local shopkeepers,  
- library,  
- visits from volunteers, etc.  
  - are planned,  
  - are suggested to patient and family,  
  - are arranged if appropriate.  

14. Specialist equipment prescribed and ordered in advance to be available at home the day the patient is discharged:  
- walking sticks or crutches,  
- walking frame,  
- wheelchair,  
- commode,  
- hospital bed,  
- commode,  
- mattress,  
- rails,  
- electrical patient lift,  
- pill containers etc.  

15. Patient and family offered an opportunity to visit follow-on HCO*  
*Follow-on HCO: HCO to which patient is being transferred: long stay, follow-up care and rehabilitation care, nursing home etc.  

16. Parents’ (or guardian’s) written permission is included in the record when a third party comes to fetch a minor on discharge.  

17. Schooling planned for children when they leave hospital.  

18. Discharge at the end of the week avoided or planned according to the availability of carers (family and friends) to welcome an elderly person home.  

19. Planned discharge date and times compatible with reception of patients at home or in follow-on establishment.  

20. Method of transport planned.  

21. Vehicle reserved if necessary.  

22. Appointment made or telephone contact arranged, as required.  

### II - Information – Communication

23. Patient and/or patient’s family and carers subscribe to discharge plan.  

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*38*
Hospital discharge planning

<table>
<thead>
<tr>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Patient and/or patient’s family and carers notified in advance of date and time of discharge.</td>
<td>Accreditation Manual OPC 12 (37)</td>
</tr>
<tr>
<td>or Parents of (or person legally responsible for) a child notified in advance of date and time of discharge.</td>
<td>Article 63 of decree no. 74-27 of 14 January 1974 (30) Accreditation Manual OPC 12 (37)</td>
</tr>
<tr>
<td>25. Patients’ own doctor’s details given in their record.</td>
<td>Accreditation Manual DPA 5 (37)</td>
</tr>
<tr>
<td>26. Patient’s own doctor informed of date and time patient was admitted and to which department.</td>
<td>Article R 710-2-8 of the Public Health Code</td>
</tr>
<tr>
<td>27. Patient’s own doctor informed of patient’s condition at their request.</td>
<td>Article R 710-2-8 of the Public Health Code</td>
</tr>
<tr>
<td>28. Usual external actors informed in advance of date of discharge: - HAH service, - community nurse, - home help, - physiotherapist, - neighbours, if appropriate, - etc.</td>
<td>X</td>
</tr>
<tr>
<td>29. Information available about associations to help patients with serious or chronic disease.</td>
<td>X</td>
</tr>
<tr>
<td><strong>III - Continuity of care</strong></td>
<td></td>
</tr>
<tr>
<td>30. Patient’s own doctor notified of their return home.</td>
<td>Accreditation Manual OPC 12, DPA 5 (37)</td>
</tr>
<tr>
<td>31. Measures taken to ensure that the prescription can be filled at the time of discharge.</td>
<td>Accreditation Manual OPC 12 (37)</td>
</tr>
<tr>
<td>32. Usual external actors recontacted day before discharge.</td>
<td>X</td>
</tr>
<tr>
<td>33. Follow-on HCO warned in advance of patient’s transfer.</td>
<td>X</td>
</tr>
<tr>
<td>34. Follow-on HCO informed of patient’s care needs.</td>
<td>X</td>
</tr>
<tr>
<td>35. New mothers given education: - about the baby: - caring for the baby, - monitoring its state of health, - feeding the baby; - about caring for herself (perineum, breasts etc.).</td>
<td>X</td>
</tr>
<tr>
<td>36. In the event of early discharge of mother and baby from the maternity ward: - medical criteria permitting early discharge satisfied: - for the mother, - for the child; - telephone follow-up arranged; - home visits offered during the first few days after discharge; - the mother has accurate contact details for an individual.</td>
<td>X</td>
</tr>
</tbody>
</table>
## Day of discharge

### I - Organisation – Comfort – Convenience

<table>
<thead>
<tr>
<th></th>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>Method and time of transfer confirmed with the transport company.</td>
<td>X</td>
</tr>
<tr>
<td>38</td>
<td>Administrative and practical details dealt with in line with the patient’s mobility level.</td>
<td>X</td>
</tr>
<tr>
<td>39</td>
<td>Patient’s personal effects and/or objects deposited in a safe box collected.</td>
<td>Accreditation Manual GFL 8 (37)</td>
</tr>
<tr>
<td>40</td>
<td>Schedules complied with.</td>
<td>X</td>
</tr>
<tr>
<td>41</td>
<td>Contents of patient record verified.</td>
<td>X</td>
</tr>
<tr>
<td>42</td>
<td>Patient record filed.</td>
<td>X</td>
</tr>
<tr>
<td>43</td>
<td>Patient record closed and sent at time of discharge to person responsible for transport.</td>
<td>Accreditation Manual OPC 12 (37)</td>
</tr>
</tbody>
</table>

### II - Information – Communication – Education

<table>
<thead>
<tr>
<th></th>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
</table>
| 44 | Patient (and/or family and carers) informed in clear language subsequent follow-up and surveillance | Accreditation Manual DIP 3 and 4 (37)  
                              | Hospital Patient’s Charter (54) |
| 45 | Patient’s understanding of the following checked:                            | Accreditation Manual OPC 5 (37) |
|    | - how to take medicines,                                                     | X                      |
|    | - signs and symptoms to look out for,                                        | X                      |
|    | - precautions to take when resuming everyday activity,                       | X                      |
|    | - dietary and lifestyle advice,                                              | X                      |
|    | - monitoring of state of health.                                             | X                      |
| 46 | Patient (and/or family and carers) given written instructions for monitoring and prevention of relapse. | X                      |
| 47 | Patient completes discharge questionnaire, if willing.                       | Accreditation Manual QPR 2 (37) |

### III - Continuity of care

#### A - Discharge documents

<table>
<thead>
<tr>
<th></th>
<th>Major criteria</th>
<th>Professional consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Discharge prescription:</td>
<td>Accreditation Manual OPC 12 (37)</td>
</tr>
<tr>
<td></td>
<td>- ready at time of departure,</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>- legible,</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>- given by doctor directly to patient and/or to patient’s family or carers,</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>- explained to patient and patient’s family or carers,</td>
<td>Article 34 of the Medical Ethics Code</td>
</tr>
<tr>
<td></td>
<td>- contains name of doctor responsible for patient during hospital stay, and contact details.</td>
<td>X</td>
</tr>
<tr>
<td>49</td>
<td>Orders for further investigations</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>- ready at time of departure,</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>- legible,</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>- given by doctor directly to patient and/or to patient’s family or carers,</td>
<td>X</td>
</tr>
<tr>
<td>Major criteria</td>
<td>Professional consensus</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>- explained to patient and/or to patient’s family or carers.</td>
<td>Article 34 of the Medical Ethics Code Article R 710-2-7-1 of the Public Health Code Accreditation Manual VST 4 (37)</td>
<td></td>
</tr>
<tr>
<td>50. Patient given written record that they have received a transfusion, if applicable.</td>
<td>Accreditation Manual VST 4 (37)</td>
<td></td>
</tr>
<tr>
<td>51. Patient’s own doctor informed that they have received a transfusion, if applicable.</td>
<td>Accreditation Manual VST 4 (37)</td>
<td></td>
</tr>
<tr>
<td>52. Patient informed of need to monitor specific lab values after a transfusion, if applicable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. Appointments for care (dressings, removal of sutures, etc.) and consultations made and patient informed.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>54. Hospital summary including diagnoses and discharge treatment given to patient.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>55. Nursing record or nursing care summary given to patient or included in record in the event of transfer.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>56. Transport voucher completed and signed.</td>
<td>Article L 322-5 of the Social Security Code</td>
<td></td>
</tr>
<tr>
<td><strong>B - Discharge medication</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58. Medicines prescribed on discharge available at home when the patient returns there, or in the follow-on HCO.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
IMPROVING THE PROCESS

Hospital discharge planning begins well before the actual discharge, at or before admission. It is a complex, multi-phase process involving many professions and can only be improved by a multiprofessional approach. In view of the range of services involved, improvements concern both professional interventions and administrative interfaces (e.g. a properly written prescription is a professional intervention, the sending of a hospital report is part of the administrative interface). They concern not only professional practice, but also the formal and informal links between professionals and departments.

For a discharge to be successful, the views of many people have to be taken into account:
- the patient;
- the patient’s family and/or carers;
- doctors and professional caregivers from the HCO;
- non-hospital doctors and professional caregivers;
- administrative professionals;
- social workers;
- professionals at the institution the patient is being transferred to, if applicable.

These individuals do not all share the same concept of a successful discharge, and their criteria may differ without being mutually exclusive. They are each other’s customers and suppliers (according to the customer-supplier relationship model for processes). Their participation in a quality improvement initiative has to be seen in the light of this dual relationship.

An initiative to improve the discharge process should involve representatives of all those directly involved, both inside and outside the HCO, as a successful discharge has to plan for a patient’s future after they have left the HCO. This can be done either by including all those involved in a working group, or by questionnaires, interviews, focus groups etc. How an individual participates will depend on the degree of representation desired for each type of person involved, the available administrative options, and the type of improvements sought. For example, representatives of HCO staff could take part in a working group, whereas focus groups or interviews could be arranged for individuals outside the HCO. It might be possible to include an HCO users’ representative in the working group.

It is best to use a process-based approach to improve the discharge process, e.g. the ANAES PAQ method (*Programme d’Amélioration Qualité*, i.e. a continuous quality improvement programme). Other methods may be used during the course of the project as required, such as clinical audit (64), a problem-solving method (65) or a review of the relevance of care (65). These methods may be useful in improving certain stages of the discharge planning process. They may also be used alone for specific targeted projects.

The methods most relevant for use in discharge planning are shown in Figure 1.
Fig. 1. Methods that can be used in discharge planning

**Project management**

A project management system must be used in all quality improvement projects, irrespective of the method chosen. Such a system allows the project to be monitored closely by both the project leader and the steering committee and covers everything that contributes to the smooth running of the project (organisation, logistics, project timetable, resources allocated, etc.) (Fig. 2).

**Fig. 2.** Diagram of the 7 facets of project management (Source: Maders & Clet, 1995 (66)).

Special attention needs to be given to establishing a communication process to ensure the durability of the project.

I. **PROCESS-BASED APPROACH - THE ANAES PAQ\(^5\) METHOD**

ANAES’ PAQ is a continuous quality improvement method based on the study of processes. A process is analysed to identify areas requiring improvement and those
Hospital discharge planning

with a satisfactory quality level. In this approach, the evaluation criteria can be used at different stages, with different objectives. The PAQ method can be used on its own to improve the quality of the process or combined with other methods that focus on a specific point within the process. It is particularly appropriate for studying a process as complex as hospital discharge planning because it analyses the administrative interfaces between departments and takes full account of customer-supplier type relationships. It has 4 stages (Fig. 3) (65, 67).

![Fig. 3. Stages in the ANAES PAQ method (65,67).](image)

**II. CLINICAL AUDIT**

Clinical audit is a method of assessment which aims to improve care practices by measuring their quality and results against agreed standards, using predetermined criteria. Audits are particularly relevant in focusing action on a professional practice and may be incorporated into process analysis, thus offering a methodical approach to the practice.

As part of a project to improve hospital discharge planning, clinical audit uses the criteria proposed in the first part of this guide to identify areas that need to be improved. It is used to produce a “quality diagnosis” of a process by measuring discrepancies between actual and expected values for the criteria. The limitations of the method are mainly related to the design and implementation of plans for improvement.

An audit may be used alone or may be incorporated into a process analysis method. It has 6 stages (Fig. 4) (64, 65).
III. PROBLEM-SOLVING METHOD

The problem-solving method focuses on a specific problem for an in-depth analysis of the problem, its causes and possible solutions. It can be used alone or as part of a process-based approach.

Within the context of improving hospital discharge planning, it could be useful in situations that need to be explored very thoroughly. However, it can only explore one problem at a time. If many problems have been identified in a discharge process, it might be time-consuming to work on each problem consecutively. It might also lead to a loss of consistency in the whole project. It has 9 stages (65).

IV. REVIEW OF RELEVANCE OF CARE

A review of relevance of care is an indirect assessment of a care process. The method is primarily a comparative approach which assesses whether care and hospital duration are appropriate for patients’ needs. The assessment may cover indication and initiation or continuation of care. Its purpose is to define a set of explicit criteria which, if any one of them is present, show that the care or day of care is appropriate. It also seeks reasons to explain the presence of inappropriate care or periods of care (65).

Within the context of improving hospital discharge planning, the method may identify unjustified days of care, and therefore delayed discharge and the reasons for the delay. Causes of unjustified days may be treated as problems or as part of a
process-based approach. It may be appropriate to use this method later in the project when process improvements have already been put in place.

V. TOOLS

Many tools can be used in projects to improve the discharge planning process, irrespective of the method used. However, the following might be particularly useful:
- satisfaction surveys, which obtain the opinions of people outside the HCO, as well as people within the HCO if they cannot be part of a working group;
- focus groups, which collect information from customers. They can be used to assess the needs and expectations of both external and internal customers;
- performance indicators and control charts which are used to monitor the implementation of improvement measures and their results.
REFERENCES


21. Soliman A. Discharging our duty? Elder Care


34. Loi n° 90-527 du 2727 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d'hospitalisation (1). Journal Officiel; 30 juin 1990.


ANNEXES
ANNEX 1. SEARCH STRATEGY

The MEDLINE, HealthSTAR and EMBASE databases were searched for the period 1990-2000. Searches were limited to French and English language publications. The search strategy consisted of:

Clinical practice guidelines and consensus conferences

The initial key words: Patient discharge OR hospital discharge
were combined with: Practice guidelines OR guideline(s) OR Recommendation(s) (in the title)
OR Consensus development conference.
? 50 references were obtained from MEDLINE, 10 from HealthSTAR and 27 from EMBASE.

Meta-analyses and literature reviews

The initial key words were combined with: Meta-analysis OR Meta analysis OR Review literature.
? 13 references were obtained from MEDLINE and 2 from EMBASE.

Audits

The initial key words were combined with: Audit OR Management audit OR Medical audit OR Nursing audit.
? 42 references were obtained from MEDLINE, 12 from HealthSTAR, 8 from EMBASE and 35 from CINAHL.

Management of hospital discharge

The initial key words were combined with: Management (in the title).
? 31 references were obtained from MEDLINE, 23 from HealthSTAR and 19 from EMBASE.

Cost of hospital discharge

The initial keywords were combined with: Cost allocation OR Hospital cost OR Hospital charge
OR Economics hospital OR Financial management hospital OR Hospital billing OR Hospital Finance OR Hospital purchasing OR Hospital running cost OR Economics.
? 44 references were obtained from MEDLINE, 26 from HealthSTAR and 9 from EMBASE.

The French literature

A search was made of PASCAL from 1990 and of the Banque de Données de Santé Publique (BDSP) from 1995.
? 17 references were obtained from PASCAL and 22 from the BDSP.

A supplementary search was made of French and European legislative texts.
ANNEX 2. EXAMPLE OF THE APPLICATION OF A PROCESS-BASED APPROACH

The discharge process can be analysed in general terms for the HCO, as certain points are common to all patients, but it should also be broken down according to:
- type of disease (e.g. the quality criteria for discharge differ for diabetic patients and patients discharged from an orthopaedic ward);
- category of patient (elderly, children, etc.);
- the social situation of the patient (homeless, etc.).

In some cases, depending on the size of the HCO, the quality improvement initiative will be first introduced in a few care units to keep it manageable, and then extended to further units. All the improvement measures established in the first units will not be appropriated by the others as some will be specific to particular units. The new units will define those that are appropriate for them. Measures concerning common parts of the process could be applied to the whole HCO, but only after validation by everyone concerned by their implementation, so that they are fully accepted and used.

I. STAGE 1: IDENTIFYING THE PROCESS

Stage 1 is a key stage that involves choosing the subject, defining the responsibilities of the people involved in the initiative and establishing a project management system.

A steering committee has to be formed (Table 1) or an existing equivalent structure designated. The steering committee should represent decision-makers in the HCO as it will monitor the progress of the project, decide on allocation of resources if necessary, and validate measures to be implemented.

In the present example, the process or segment of the process to be studied has to be defined in precise terms (Fig. 5), and a decision taken on the units or departments where work will begin. The process in question is studied from preadmission up to the day of discharge, with the medical department studied first. A working group that includes all concerned is set up (Table 2) and a project leader is chosen. During stage 1, the evaluation criteria may be used to check that no-one in the process has been overlooked.

Table 1. Example of composition of the steering committee

<table>
<thead>
<tr>
<th>Steering committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. C.</td>
</tr>
<tr>
<td>D. F.</td>
</tr>
<tr>
<td>Dr. A. G.</td>
</tr>
<tr>
<td>L. D.</td>
</tr>
<tr>
<td>J. R.</td>
</tr>
<tr>
<td>Dr. P. J.</td>
</tr>
<tr>
<td>C. B.</td>
</tr>
</tbody>
</table>
Fig. 5. Example breakdown of the discharge planning process.
Table 2. Example of composition of the working group

<table>
<thead>
<tr>
<th>Working group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. P. J.</td>
<td>Head of medical department</td>
<td>Project leader</td>
</tr>
<tr>
<td>C. B.</td>
<td>Senior nursing manager, medical department</td>
<td>Project leader</td>
</tr>
<tr>
<td>Dr. J. B.</td>
<td>Doctor</td>
<td>Member</td>
</tr>
<tr>
<td>B. C.</td>
<td>Social worker</td>
<td>Member</td>
</tr>
<tr>
<td>F. D.</td>
<td>Nurse, Medical Unit 3</td>
<td>Member</td>
</tr>
<tr>
<td>L. D.</td>
<td>Head of Admissions Department</td>
<td>Member</td>
</tr>
<tr>
<td>C. G.</td>
<td>Healthcare manager, Medical Unit 2</td>
<td>Member</td>
</tr>
<tr>
<td>Dr. L. M.</td>
<td>Interne en médecine [equivalent to senior house officer]</td>
<td>Member</td>
</tr>
<tr>
<td>S. M.</td>
<td>Nurse, Medical Unit 2</td>
<td>Member</td>
</tr>
<tr>
<td>Y. N.</td>
<td>Manager responsible for methods - Quality Department</td>
<td>Member</td>
</tr>
<tr>
<td>F. P.</td>
<td>Healthcare manager, Medical Unit 3</td>
<td>Member</td>
</tr>
<tr>
<td>H. T.</td>
<td>Member of staff, Admissions Department</td>
<td>Member</td>
</tr>
<tr>
<td>L. V.</td>
<td>Pharmacist</td>
<td>Member</td>
</tr>
</tbody>
</table>

The working group did not include anyone from outside the HCO. Outsider involvement included:
- semi-directed interviews by telephone with doctors and nurses who would care for the patients after discharge;
- interviews with some patients and families;
- a questionnaire produced after the interviews. For 4 weeks this questionnaire was sent at discharge to all patients or their families, with a telephone reminder a week after discharge to ask for it to be returned.

II. STAGE 2: DESCRIBING THE PROCESS

Stage 2 describes the process, includes an analysis to identify problem areas, finds and analyses causes, and identifies points to be improved. It also identifies areas that are working well. The evaluation criteria may be used at this stage to evaluate the process described and thus define areas where improvement measures need to be implemented.

II.1. Description

The existing process is described by everyone involved so that it is as close as possible to what actually happens. A process description is then produced by the working group and validated by all involved.

The discharge planning process can be broken down into segments (e.g. preparing the patient, preparing the documents to go with them, etc.) and illustrated by a flowchart (Fig. 6).
II.2. Identifying problem areas and collecting data

One has to analyse problem areas that may occur during the course of the process as it actually happens, find out why they occur (which may not always be obvious), measure how often they occur, and propose targeted measures for the most common problems.

Problem areas may be analysed using the Who, What, Where, When, How, Why (WWWWHW) tool. The aim is not to be exhaustive but as factual as possible. This analysis often needs to be completed by an objective measure of the causes for the problem. Tools such as Pareto diagrams can be used to visualise and rank these causes by frequency of occurrence (Fig. 7).

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3 Summary sheets for all tools mentioned in this annex (flowchart, WWWWHW, Pareto diagram, Cause-effect diagram, Multicriteria diagram) are given in the ANAES document “Méthodes et outils des démarches qualité pour les établissements de santé” (Methods and tools for quality initiatives in healthcare organisations) (65).
Fig. 7. Example of Pareto diagram applied to scheduling discharge in ambulance: causes for delays in discharge

A Pareto diagram shows the relative importance (ranking) of the causes that have been identified. The underlying principle is that a large part of the problem can be solved by dealing with a small number of causes. In the above example, problems with documents that accompany the patient and the transport voucher together account for more than 80% of the causes for delays in hospital discharge.

II.3. Analysing causes of problems

Sometimes the cause of the problem becomes obvious when describing the process, and the problem can be corrected immediately. However, a detailed analysis is often needed to find the real cause of the problem and an appropriate solution. Other tools or other methods are then required. A cause-and-effect diagram is very useful at this stage of the process to identify and display the reasons for problems.

Figure 8. Example cause-and-effect diagram showing reasons for problems with documents to be sent with the patient.
III. **STAGE 3: CONSTRUCTING A NEW PROCESS**

Stage 2 demonstrated and quantified weak points in the process and looked for the causes of problems. These problems need to be ranked in order to establish priority areas for improvement. Care should be taken to avoid implementing more than one improvement measure at a time so that the effectiveness of each can be measured. This also encourages their acceptance and use.

III.1. Describing criteria

During stage 3, criteria which contribute to the quality of the various parts of the process are defined. This is where the evaluation criteria in this guide are very useful, as they list all the criteria which contribute to successful discharge. Criteria are classified as:

(i) *Major criteria*, e.g. patient given written record that they have received a transfusion, if applicable.

(ii) *Professional consensus criteria*, e.g. appointments for care (dressings, removal of sutures, etc.) and consultations are made; the patient is informed.

III.2. Establishing priorities

The process description often identifies many points that could be improved but all cannot be improved at once. Priorities must be established. The criteria defined in this guide can help establish these priorities. For instance, the first issues to tackle may be those involving non-compliance with legislation. However, other criteria may be used to establish priorities. A multicriteria diagram may be a useful decision-making tool.

![Figure 9. Example of multicriteria diagram for prioritising points to be improved](image)

### Weighting of criteria

<table>
<thead>
<tr>
<th>Weighting of criteria</th>
<th>Non-compliance with legislation</th>
<th>Risk to patient</th>
<th>Lack of organisation in the department</th>
<th>…</th>
<th>Total</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription for discharge medication not ready at time of departure</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>13</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Hospital summary not given to patient</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient not given written instructions for follow-up and prevention of relapse</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge letter not given to patient</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III.3. Selecting areas for improvement

The choice of areas for improvement should be validated by the steering committee (or equivalent body) in liaison with the director of the HCO. The board must validate and support these areas because they may involve administrative changes which will impact on professionals not involved in the project, or on the entire HCO, and because improvement in some areas may incur costs in relation to measures to be implemented.

The choice of improvement areas leads to the definition of measures to be taken. These measures are decided by members of the working group whilst liaising with and informing...
Hospital discharge planning

all those concerned by the changes. There should be a timetable for implementing the measures.

Examples of areas for improvement
- Improving the availability of all documents sent with the patient at the planned discharge time.
- Improving collection of the patient’s personal effects.
- Making administrative and practical procedures easier for patients.

Examples of measures to be implemented

AREA: Improving the availability of all documents sent with the patient at the planned discharge time.
- Measure 1: Documents to be given to the patient on discharge are prepared the day before the planned discharge date.
- Measure 2: Documents to be given to the patient are validated and/or signed by the doctor during the morning ward round before discharge.
- Measure 3: Documents to be given to the patient are validated and/or signed by the unit healthcare manager the morning before discharge.
- Measure 4: The unit healthcare manager or nurse checks the morning before the patient is due to be discharged that documents to be given to the patient are available.

IV. Stage 4: Improving the process

Stage 3 defined the new process to be introduced to improve patient discharge. Stage 4 consists in implementing the measures defined and measuring their efficacy.

IV.1. Implementing improvement measures

Implementation of improvement measures does not have to await stage 4. Certain measures can be introduced immediately during the description process. However, stage 4 is important for scheduling measures to be introduced and prioritising them. Measures should be introduced one at a time so that the effectiveness of each can be measured. In addition, the HCO’s capacity for change needs to be taken into account, and measures introduced gradually to ensure they are accepted and implemented.

A multicriteria diagram may be used to establish priorities for implementing measures. Criteria may be economic (e.g. cost), technical (e.g. feasibility) or social (e.g. acceptability by staff).

The desired improvement may lead to the identification of a number of different measures and, in this case, several solutions can be tested to decide which will be most effective. Testing should be small scale and over a short period. Selected measures should have proven efficacy.

The new process has to be defined formally to establish it and to ensure that all those involved will accept and implement it.

At Stage 4, the evaluation criteria can be used to check that each measure corrects a point in need of improvement.
For each improvement measure, there should be clearly defined responsibilities, specific deadlines, and monitoring indicators. An action sheet may be used to ensure that the work is traceable and to measure the results obtained.

### ACTION SHEET

**PROJECT:** Improve discharge planning  
**Title:** Planning for discharge from pre-admission period  
**Description of measure:** Arrange for a summary sheet of documents to be supplied on discharge to be distributed  
**Date launched:** 01 February 2001

**Person responsible for follow-up:** V. H., Head of Admissions Department

**Other persons involved:**  
1. A. C., administrative staff  
2. L. D., administrative staff  
3. A. L., administrative staff  
4. M. J., administrative staff  
5. N. V., administrative staff

**Aims**  
At discharge, patients should have everything needed for discharge to take place.

**Anticipated result**  
All patients coming for a preadmission visit have a list of the documents they will need so that they can be discharged.  
When a patient is given the list of documents required for discharge, their purpose is explained to him or her.

**Stages of the action**  
1. Make a list of documents required at the time of discharge (5-11 February)  
2. Produce a summary sheet (12-25 February)  
3. Test the sheet (26 February -18 March)  
4. Amend the sheet (19- 25 March)  
5. Routinely distribute the sheet to all patients coming for a preadmission visit (from 26 March)

**Record and recommendations**

<table>
<thead>
<tr>
<th>Date completed</th>
<th>Result obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Qualitative:</td>
</tr>
<tr>
<td>Observations</td>
<td></td>
</tr>
</tbody>
</table>

### IV.2. Monitoring the effectiveness of actions

The effectiveness of each action should be measured. A measure that is simple to monitor and easy to understand should be used to encourage its acceptance. The action should be measured by the person responsible for it, who is coordinating its implementation, and who is directly affected by the intended improvement.

To start with, the measure will be monitored at short intervals but, once it becomes standard procedure in the HCO, monitoring will be spaced out (Fig. 11). More global indicators that enable monitoring of several actions can then be put into place (Fig. 12).

At this stage, the evaluation criteria may be used to check that the actions are improving results.
IV.3. Project assessment evaluation

The project should be assessed to decide whether the objectives defined at the outset have been achieved. If not, new actions may be defined to improve the part of the process which will make it possible to achieve these objectives. At this stage, the standard may be used to compare the new process with the guidelines. This makes it possible to define points which should be covered by the new improvement in actions.
Hospital discharge planning
### ANNEX 3. – EVALUATION GRID

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before a planned hospital stay or at the time of admission:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Cooperation established (telephone contact, written documents)</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>between external actors and hospital carers to decide:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- objectives of the hospital stay,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- patient’s normal environment (social insertion, care of support,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>housing conditions, etc.),</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- future plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(tick ‘No’ if any single element is missing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>During the hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I - Organisation – Comfort – Convenience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Discharge planning started as soon as possible during the hospital</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>stay (or before admission in the event of planned hospital stay).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Discharge plan updated during the hospital stay.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>4. Patient’s situation assessed regularly, in relation to discharge,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>at the following levels:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- somatic,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- mental and emotional,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cognitive,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- disability and dependence,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- social.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(tick ‘No’ if any single element is missing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Patient’s personal life plan taken into account.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>6. Family’s and carers’ point of view concerning patient’s life plan</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>taken into account.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Discharge plan discussed by doctor with the care team.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>8. Discharge plan discussed with social worker .</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>9. Discharge plan compatible with patient’s resources.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>10. Social worker asks for any financial assistance patient will need</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>
### Hospital discharge planning

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Visit to patient’s home arranged to assess housing situation.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>12. Patient’s housing adapted if necessary to patient’s requirements:</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- handrails fitted,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- aids fitted in toilets,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- doorways enlarged to allow a wheelchair to pass through,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- shower installed instead of bath,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- carpets removed,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- temperature-control taps fitted, etc.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>13. Home care services:</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- HAH,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- home nursing care,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- home physiotherapy,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- personal carer for toileting,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- home meals delivery,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- telephone alarm system,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- shopping delivery arranged with local shopkeepers,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- home library service,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- visits from volunteers,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- etc.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>14. Specialist equipment prescribed and ordered in advance to be available at home the day the patient is discharged:</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- walking sticks or crutches,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- walking frame,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- wheelchair,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- commode,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- hospital bed,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- mattress,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- rails,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- electrical patient lift,</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- pill containers etc.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>15. Patient and family offered an opportunity to visit follow-on HCO*.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>16. Parents’ (or guardian’s) written permission is included in the record when a third party comes to fetch a minor on discharge.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>17. Schooling planned for children while they are in hospital.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>18. Discharge at the end of the week avoided or planned according to the availability of natural carers to look after an elderly person at home.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>19. Planned discharge date and times compatible with reception of patients at home or in follow-on establishment.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>20. Method of transport planned.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>21. Vehicle reserved if necessary.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>22. Appointment made or telephone contact arranged, as required.</td>
<td></td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>
* Follow-on HCO: HCO to which patient is being transferred: long stay, follow-up care and rehabilitation care, nursing home etc.
### Hospital discharge planning

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>II - Information – Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Patient and/or patient’s family and carers involved in the discharge plan.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>24. Patient and/or patient’s family and carers notified in advance of date and time of discharge.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>25. Patients’ own doctor’s details given in their record.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>26. Patient’s own doctor informed of date and time patient was admitted and to which department.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>27. Patient’s own doctor informed of patient’s condition at their request.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>28. Usual external actors informed in advance of date of discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HAH service,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- community nurse,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- home help,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- physiotherapist,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- neighbours, if appropriate,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- others.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Information available about associations to help patients with serious or chronic disease.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td><strong>III - Continuity of care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Patient’s own doctor notified of their return home.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>31. Measures taken to ensure that the prescription can be filled at the time of discharge.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>32. Usual external actors recontacted day before discharge.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>33. Follow-on HCO warned in advance of patient’s transfer.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>34. Follow-on HCO informed of patient’s care needs.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>35. New mothers given education:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- about the baby:</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- caring for the baby,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- monitoring its state of health,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- feeding the baby, [should be just a comma]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- about caring for herself (perineum, breasts etc.).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(tick ‘No’ if any single element is missing)</td>
<td></td>
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</tr>
<tr>
<td>36. In the event of early discharge of mother and baby from the maternity ward:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- medical criteria permitting early discharge satisfied:</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- for the mother,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- for the child.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- telephone follow-up arranged;</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- home visits offered during the first few days after discharge;</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- the mother has accurate contact details for an individual.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Criteria</td>
<td>YES</td>
<td>NO</td>
<td>Not applicable</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td><strong>Day of discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I - Organisation – Comfort – Convenience</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>37. Method and time of transfer confirmed with the transport company.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>38. Administrative and practical details dealt with and carried out in a way appropriate to the patient’s mobility level.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>39. Patient’s personal effects and/or objects deposited in a safe box collected.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>40. Schedules complied with.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>41. Contents of patient record verified.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>42. Patient record filed.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>43. Patient record closed and sent at time of discharge to person responsible for transport.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td><strong>II - Information – Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. Patient (and/or family and carers) informed in clear language about procedures for discharge and subsequent follow-up.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>45. Patient’s understanding of the following checked:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- how to take medicines,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- signs and symptoms to look out for,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- precautions to take when resuming everyday activity,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- dietary and lifestyle advice,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- monitoring of state of health.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>46. Patient (and/or family and carers) given written instructions for monitoring and prevention of relapse.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>47. Patient completes discharge questionnaire, if willing.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td><strong>III - Continuity of care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A - Discharge documents:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>48. Discharge prescription:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ready at time of departure,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- legible,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- given by doctor directly to patient and/or to patient’s family or carers,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- explained to patient and patient’s family or carers,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- contains name of doctor responsible for patient during hospital stay, and contact details.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(tick No if any single element is missing)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
## Hospital discharge planning

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>49. Orders for further investigations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ready at time of departure,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- legible,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- given by doctor directly to patient and/or to patient’s family or carers,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- explained to patient and/or to patient’s family or carers. (tick ‘No’ if any single element is missing)</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>50. Patient given written record that they have received a transfusion, if applicable.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>51. Patient’s own doctor informed that they have received a transfusion, if applicable.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>52. Patient informed of need to monitor specific lab values after a transfusion, if applicable.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>53. Appointments for follow-up care (dressings, removal of sutures, etc.) and consultations made and patient informed.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>54. Hospital summary including diagnoses and discharge treatment given to patient.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>55. Nursing record or nursing care summary or nursing care summary sheet given to patient or included in record in the event of transfer.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>56. Transport voucher completed and signed.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>57. Patient’s own doctor receives the following within eight days of patient’s discharge:</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- hospital report,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- prescriptions written at discharge,</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>- nursing summary sheet</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>

**B - Discharge medication:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>58. Medicines prescribed on discharge available at home when the patient returns there, or in the follow-on HCO.</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>
ANNEX 4. - EXTRACTS FROM THE ACCREDITATION MANUAL

PATIENT RIGHTS AND INFORMATION (DIP)

DIP - Standard 3

Patients are given clear, understandable and appropriate information about the conditions relating to their hospital stay.

DIP.3.a. The healthcare organisation ensures that patients who do not speak French have a means of expressing themselves and being understood.

DIP.3.b. Patients are given practical information about their stay in hospital.

DIP.3.c. Patients are given information about the administrative aspects of their care, fees and the total amount of the patient's financial contribution (if any).

DIP.3.d. Patients are given information about the function and identity of the members of staff who will be involved in their care.

DIP.3.e. The healthcare organisation encourages any measures to help the patient to receive assistance from the social services.

DIP - Standard 4

Patients are given clear, understandable and appropriate information about their care and condition.

DIP.4.a. Patients or their legal representatives name the people whom they would like to be given information.

DIP.4.b. Health professionals give patients or the person(s) nominated by them information about the patient's condition and the care proposed for him (her); they encourage patients to ask for information.

DIP - Standard 5

The patient's consent and/or that of their family and close friends is required for any procedure concerning the patient.

DIP.5.a. The patient's informed consent is required for all medical procedures (unless the patient's condition requires a procedure to which they are not in a position to consent); when consent is requested, the patient is given information about the benefits and risks of the planned procedures.

DIP.5.c. A patient who is a minor gives his or her opinion, which is taken into account as far as is possible. Apart from certain specific provisions, the holders of parental authority give their consent in writing.

DIP - Standard 6

The patient's privacy, personal dignity, and liberty are respected throughout their stay or consultation.

DIP.6.a. Patients are examined and given an opportunity to have their questions answered in conditions of privacy which are conducive to a personal discussion.

DIP.6.b. Patients keep their personal effects with them throughout their stay in hospital [...]. Arrangements are made for patients to store their personal effects and retrieve them.

DIP.6.g. Patients may leave the healthcare organisation at any time after they have been informed of any risks they may incur, unless this would contravene regulations. A request for a patient to leave against medical advice is formally documented by the healthcare organisation.

DIP - Standard 7

Patients are assured that all personal, medical and social information, and details of their private life, are kept confidential.
Hospital discharge planning

DIP.7.b. Professional secrecy is assured and the mechanisms needed to ensure this are developed by the healthcare organisation.

PATIENT RECORDS (DPA)

DPA- Standard 1

The healthcare organisation formulates and implements a patient record policy for all its activity sectors.

DPA.1.a. Information is collected for each patient to ensure continuity of care.
DPA.1.c. There is a policy in place to ensure that the confidentiality of records and information concerning the patient is maintained, particularly when identifiable information must be exchanged between professionals for diagnostic and treatment requirements.
DPA.1.d. The healthcare organisation has a system to ensure that patients have a right of access to their records via a practitioner who is freely chosen by the patient.

DPA- Standard 3

Information contained in the patient record is covered by the rules of confidentiality.

DPA- Standard 5

The information contained in the patient record ensures that care is coordinated between professionals and between activity sectors.

DPA.5.f. After the patient has been discharged, the record contains the final report of his or her stay, and of any specific requirements for follow-up.
DPA.5.g. The doctor nominated by the patient is sent a written document which should arrive in sufficient time to allow for continuity of care.

ORGANISATION OF PATIENT CARE (OPC)

⇒ Coordination of care

OPC- Standard 4

Care is planned on the basis of an initial and ongoing assessment of the patient's condition.

OPC.4.a. Any data obtained from previous consultations, previous hospital stay or admission to an emergency service are available.
OPC.4.b. The patient's needs are identified and taken into account.
OPC.4.c. Further investigations and care are scheduled after a medical examination has been done.
OPC.4.e. The patient's condition is assessed regularly and his or her care is adjusted, if necessary.

OPC- Standard 5

The patient's specific needs are identified and taken into account.

OPC.5.b. Acute or chronic pain and mental distress are looked for, prevented and managed.
OPC.5.d. Patients are educated about their disease and its treatment.
OPC.5.e. Patients receive health education which is appropriate to their needs.

OPC- Standard 6

Patient care is coordinated within the various clinical activity sectors.

OPC.6.d. During the patient's stay in hospital, their referring doctor is kept informed.
Hospital discharge planning

**OPC- Standard 7**

**Continuity of care is ensured.**

*OPC.7.e.* Continuity of care is provided between activity sectors.

*OPC.7.f.* Patient transport is arranged between activity sectors to ensure continuity of care in compliance with the rules of hygiene, quality, safety, and confidentiality.

**Discharge**

**OPC- Standard 12**

**The patient’s discharge is planned and coordinated.**

*OPC.12.a.* Discharge planning begins when the patient is admitted, and is updated throughout his or her hospital stay.

*OPC.12.b.* Patients are oriented to the care circuit appropriate to their situation.

*OPC.12.c.* Discharge is arranged jointly with the patient and the patient's carers.

*OPC.12.d.* When they are discharged, patients have the information and documentation they need to ensure continuity of care.

*OPC.12.e.* The patient's referring doctor is informed when the patient returns home; if the patient's condition requires specific follow-up, the doctor is informed of their discharge beforehand.

*OPC.12.f.* Continuity of care is provided when patients are transferred.

**LOGISTICS MANAGEMENT (GFL)**

**GFL- Standard 8**

The healthcare organisation has security systems and staff to cover property and personal safety.

*GFL.8.a.* The healthcare organisation has a system for looking after patients' property.

**QUALITY MANAGEMENT AND RISK PREVENTION (QPR)**

**QPR- Standard 2**

There is a quality management process in place which takes account of customers’ needs.

*QPR.2.a.* The organisation takes steps to discover the requirements and level of satisfaction of patients and referring physicians.

**SPECIFIC PREVENTION PROGRAMMES AND TRANSFUSION SAFETY (VST)**

**VST- Standard 4**

The healthcare organisation observes the rules governing transfusion safety.

*VST.4.e.* Information is given to patients who have received a transfusion, and they are monitored; the patient's own doctor is informed.