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13. ABSTRACT (Continue on reverse if necessary and identify by block number) This project was a descriptive field study conducted as one component of the evaluation by the Center Discharge Planning Committee of a newly implemented Discharge Planning Program at Brooke Army Medical Center (BAMC). The study was designed to evaluate use of the Nursing Admission Assessment forms as a valid mechanism for determining the presence of one or more indicators of the need for discharge planning. The Discharge Planning Committee selected three trial wards to participate in a six-month study of the use of multidisciplinary rounds to effect a coordinated discharge plan for patients who demonstrated one or more of the indicators of the need for discharge planning as defined in the BAMC Memorandum - Discharge Planning. The researcher reviewed 267 nursing admission assessments during an eight-week period.. Utilizing a tool developed for the study, the researcher recorded which discharge planning indicators were identified from the nursing admission assessment. The results demonstrated that 157 patients (53 percent of the sample					
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population) had one or more indicators of the need for discharge planning.

When the minutes of discharge planning rounds were reviewed, two significant observations were made. First, it was noted that the researcher had found one or more indicators of the need for discharge planning for 100 percent of the patients presented in rounds. Additionally, the researcher had selected 112 patients with discharge planning indicators who were not presented in rounds. Analysis of the Social Work Service (SWS) discharge planning visits recorded on the Ambulatory Care Data Base Encounter Form showed that 72 percent of those patients with discharge planning indicators present who were not discussed in discharge planning rounds were seen by SWS. The study was unable to determine the discharge planning outcome of the remaining 28 percent and recommended further evaluation of this group of patients.

The study was unable to determine which specific indicators caused referral to discharge planning rounds, but the most frequently identified indicators obtained from the nursing assessment were those pertaining to catastrophic illness and associated functional disability. This study was quantitative rather than qualitative and concluded with recommendations to educate the staff about the discharge planning process, to critically evaluate the use of indicators as a screen for determining which patients need discharge planning, and to improve the quality of the functional assessment of patients.

... requires further evaluation

ended

A STUDY TO DETERMINE THE VALIDITY OF THE NURSING
ADMISSION ASSESSMENT (DA FORM 3888/3888-1) AS A
MECHANISM FOR IDENTIFYING THE PRESENCE OF ONE
OR MORE UNIVERSAL INDICATORS OF THE NEED
FOR DISCHARGE PLANNING

A Graduate Research Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration

by

Captain Ann Brazil, ANC

August 1987

NAME	ANN BRAZIL	✓
DATE	AUG 1987	✓
BY	D. G. W.	✓
UNIT	A-1	✓



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CHAPTER I

INTRODUCTION

Overview

Discharge planning is a component in the continuum of health care which is receiving a heightened degree of attention due to concerns about the cost-effective management of health care resources, the degree of quality of care provided, and the increasing litigiousness of the recipients of health care.

Discharge planning has been a recognized part of the transition from the acute hospital environment to home care since the early twentieth century, when the almoner in English hospitals served as the patients' advocate, coordinating posthospitalization needs with available community resources (Manchee, 1944). With the complex medical technology available today, many of the acute care procedures formerly performed only in the hospital are now done safely in the home. In addition to home care, there are many other options, to include adult day care, rehabilitation, hospice, and extended care facilities. The selection of and transfer to the most appropriate alternative care setting available to maximize patients' potential for health maintenance or recovery requires astute, personalized discharge planning beyond the traditional, perfunctory instruction in diet, activity, and

medication regimen. Still, though discharge planning is a shared responsibility among all health care professionals, the prevailing tendency is for social workers and registered nurses to assume the more prominent role in the process of discharge planning (Brown & Hartigan, 1985; Crittenden, 1983; McKeegan, 1981; Ratliff, 1981; Zarle, 1987).

The American Association for Continuity of Care (1984), an organization founded in 1982 to meet the professional needs of health care professionals involved with discharge planning, has defined discharge planning as an interdisciplinary process centered on the patient and the family or significant other to facilitate the transition of the patient from one level of care to another (p. 1). Discharge planning insures that preventive, therapeutic, rehabilitative, psychosocial, and medical needs are included in the assessment, planning, intervention, and evaluation process. This is the definition used in Brooke Army Medical Center (BAMC) Discharge Planning Memorandum 40-25 (see Appendix B).

Discharge planning strives for continuity of care wherein the treatment plan begun in one institution continues uninterrupted in another if the patient and the health care personnel plan cooperatively. Timely, comprehensive needs assessment is the cornerstone upon which the discharge planning process is initiated (Fortinsky, Granger, & Seltzer, 1981; Peabody, 1969).

The current primary texts on the subject emphasize that every

patient should be evaluated for the presence of discharge planning considerations, that the discharge planning process should be a coordinated effort among patient care providers working in consonance with the patient, and that early identification of discharge planning concerns is essential for timely disposition to the next appropriate level of care (e.g., see: American Hospital Association, 1984a; Birmingham, 1987; Brown & Hartigan, 1985; Crittenden, 1983; McKeehan, 1981; Ratliff, 1981; Zarle, 1987). The degree and the complexity of discharge planning are affected by many variables other than diagnosis, age, and functional assessment of the patient, to include availability of financial resources, family and friends support systems, community resources, and local, state, and federal regulations. It is these variables and others that mandate a unique discharge plan to meet the needs of each patient. The flow chart in Figure 1 depicts this ongoing discharge planning evaluation process.

The Joint Commission on Accreditation of Hospitals (JCAH) has required the presence of a mechanism for discharge planning in its Utilization Review Standard since 1966. In recognition of the relationship between discharge planning and current concerns about utilization management as part of quality assurance and consumer demands for enhanced continuity of care, the JCAH will be field testing a new standard specifically addressing discharge planning during the 1987-1988 time frame. The proposed

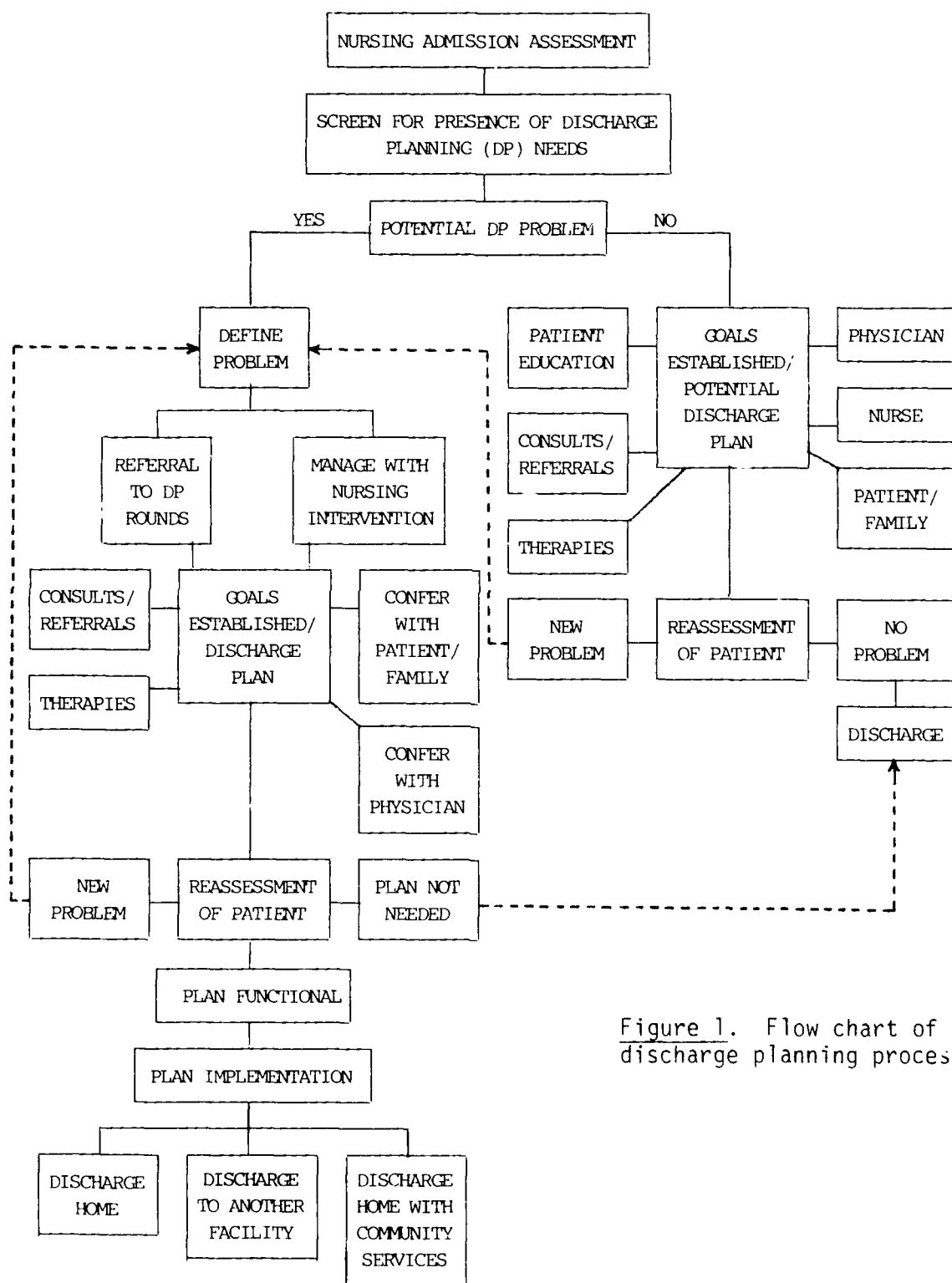


Figure 1. Flow chart of discharge planning process.

standard was developed by a task force from the membership of the American Association for Continuity of Care over a two-year period from 1984 to 1986. This researcher served as a member of the task force and shared the initial draft of the proposed standard with Department of the Army (DA) Health Services Command (HSC) in June 1985 in the hope that Army hospitals could begin to develop discharge planning programs in advance of the publication of the proposed JCAH standard (see Appendix C).

In response to concerns about the potential for a new JCAH standard related to discharge planning, HSC published a position paper in July 1985 relevant to the need for hospitals to formalize discharge planning programs, to include delineation of responsibilities of the health care professionals involved in the process. The position paper was written by the Community Health Nursing Consultant, who conferred with this researcher and the other nurses in the 1986-1987 class of the U.S. Army-Baylor University Graduate Program in Health Care Administration concerning current practices in discharge planning in military hospitals.

HSC Regulation 10-1, Organization and Function Policy, dated 31 March 1986, stipulates that, if Social Work Service is authorized in the hospital Table of Distributions and Allowances, it will provide, at a minimum, family advocacy and discharge planning services as part of its mission. Specifically, Social Work Service is directed to support interdisciplinary discharge planning

activities, to include assisting with the identification of patients whose diagnosis, problems, or psychosocial circumstances require discharge planning; providing, in cooperation with other disciplines, referral to community resources for patients who no longer require an acute level of care; and counseling of patients whose family or social problems prevent them from receiving the maximum benefits of medical care (DA, HSC, 1986, p. 4-21). Organization and Function Policy, however, does not specifically address discharge planning as one of the functions of nursing even in the absence of an organized social work service. The discharge planning responsibility of nursing is hidden within the general statement that clinical nursing service functions include provision of proficient and coordinated clinical nursing practices and support in diagnostic, therapeutic, preventive, restorative, and rehabilitative aspects of health care for patients (DA, HSC, 1986, p. 4-13). An Army hospital department of nursing (DON) has responsibilities related to discharge planning inherent in the standards of nursing practice as defined by the American Nurses' Association and DA Pamphlet 40-5, Army Medical Standards of Nursing Practice (DA, 1981). Both social work and nursing have responsibilities relevant to discharge planning specified in the JCAH manual, and the JCAH is the civilian, voluntary accrediting organization to whose standards military hospitals subscribe.

Army regulations mention discharge planning only as part of

the utilization review requirement written in the quality assurance section of Army Regulation (AR) 40-66, Medical Records and Quality Assurance (DA, 1987, chap. 9, sect. 8, p. 40). This regulation meets the present requirements of the JCAH (1986) Utilization Review Standard (p. 276), which was written as a response to the initial discharge planning mandate of the Medicare and Medicaid legislation of the mid-1960s (Crittenden, 1983, p. 2). The focus is on the presence within the hospital of an organized discharge planning mechanism which is evaluated as part of a hospital's utilization review program.

AR 40-66, however, is not in keeping with the current trends in discharge planning which are evolving from the impetus of diagnosis-related groups (DRGs) and prospective payment systems (PPSs). The literature is replete with articles outlining the impact of DRGs and PPSs on the development of discharge planning programs (e.g., see: Cahill, 1982; Rehr, 1986; Rossen, 1984). Preadmission screening for potential discharge planning concerns, requirements for written evaluations and anticipated discharge plans within 24 hours of admission, shorter patient stays resulting in more complicated coordination of skilled care needs with an alternative care setting, and phenomenal growth in the availability of home care services and other community resources are examples of trends affecting discharge planning (Coleman & Smith, 1985).

Subcommittees in the United States House of Representatives and Senate addressed the concern of inadequate discharge planning during the 1986 legislative session. Both the Omnibus Reconciliation Act and the Comprehensive Medicare Quality Assurance Act of 1986 have stipulated mandates for structured discharge planning programs with emphasis on review of the quality of the program (Birmingham, 1987; McBroom, 1986). The legislation also requires that the individual patient discharge planning evaluation and subsequent plan be developed by or under the supervision of a registered professional nurse, a social worker, or other appropriately qualified personnel. The evaluation should include functional capacity, nursing and other care requirements, and social and familial resources available to meet identified needs. To facilitate the evaluation process, the Health Care Financing Administration (HCFA) has been directed to implement a universal assessment form. As of April 1987, HCFA was continuing to work with members of the American Association for Continuity of Care on the development of a universal assessment form (Leavitt, 1987). Recommendations to standardize assessment and referral information have been ongoing since the inception of the Commission on Chronic Illness in 1949 (McKeehan, 1981, p. 11), but now Congress is turning suggestions into requirements.

The HCFA has directed professional review organizations (PROs) to focus on readmissions within specified time periods in order to

ascertain problems related to discharge planning attributable to previous hospitalization (Granatir, 1984, p. 8; Impact, 1986, p. 2). Funds have been allocated for PROs to conduct research for the purpose of determining the impact of DRGs and to ascertain whether or not patients are being discharged prior to the completion of an adequate posthospitalization plan of care. The Oregon Medical Professional Review Organization developed a discharge readiness scale which is being refined for use by hospital discharge planners to facilitate comprehensive assessment of patients (Bragg & Lovdale, 1986).

Conditions Which Prompted the Study

Military hospitals are not exempt from the scrutiny of Congress or from the pressure of both beneficiaries and regulatory agencies with regard to accountability and quality of care provided. Military hospitals are expected to provide a standard of care comparable to the civilian standard of care, and that is precisely what the Department of Defense (DOD) intends to prove through the results of the Generic Screening Program and the review of care conducted by the Commission on Professional Hospital Services, the organization contracted in 1986 to act as the PRO for the military. Review is focusing on readmissions under these DOD-directed review processes to ascertain discharge planning concerns.

An additional incentive for military hospitals to begin to

evaluate their discharge planning is the impending implementation of DRGs as part of a revision of the present antiquated budgeting system wherein hospitals are rewarded with funds and personnel based on heavy utilization of inpatient services rather than outpatient services. Further impetus may be provided at BAMC if the proposed new hospital is downsized from the present 690 acute care bed capacity to only 200 acute care beds. The anticipated date of completion of the new facility is presently projected to be 1993, when DRGs will have become incorporated into the military health care system. The significance of a smaller facility operating in a DRG system is that a well-organized, comprehensive discharge planning program will be imperative if the resulting higher acuity-of-care patients are to transfer from one level of care to another without detriment to the quality of care in terms of patient outcomes.

Articles or books about discharge planning authored by professionals associated with the Army are rare; Beale and Gulley (1981) and Ratliff (1981) are the only examples this researcher could find. There were only three members of the military attending the Continuity of Care Conference in 1984 when this researcher attended and participated in the initial discussion concerning a continuity of care standard of practice. Discharge planner is not a recognized military occupational specialty, though military hospitals are beginning to assign coordinating responsibility

to a person or a group (Beale & Gulley, 1981; Ratliff, 1981). BAMC did not have a well-organized discharge planning program as of 1985. This fact was recognized by key staff members within the organization, and, in early 1986, the Deputy Commander for Clinical Services directed the formation of the Center Discharge Planning Committee to address the issues involved in implementation of a discharge planning program. The committee chairmanship was shared between the physician chief of Physical Medicine, the chief of Social Work Service, and the chief of Physical Therapy. Other health care disciplines involved in the discharge planning process were designated as members of the committee.

Social Work Service reorganized departmental resources to enhance support of the discharge planning mission. A discharge planning coordinator was designated to supervise the activities of social workers assigned to specific wards where they personally interviewed each new admission to ascertain discharge planning concerns and to provide case management when indicated.

The Discharge Planning Committee met throughout 1986 to draft a new discharge planning policy wherein the responsibilities of all disciplines involved in discharge planning were defined. After rotating through the departments of the members of the Discharge Planning Committee and discussing discharge planning concerns, this researcher completed the revision of BAMC Memo 40-25 (see Appendix B). During the meeting held on 24 November 1986,

the new policy was approved requiring multidisciplinary ward discharge planning conferences as a component of the discharge planning program. The committee selected three wards with previously demonstrated high use of Social Work Service for a six-month trial of the multidisciplinary rounds process. The wards were 12A (Urology), 42H (Neurosurgery), and 43H (Oncology). The chiefs of Social Work Service, Physical Therapy, and Nursing formed a task force to determine the functional specifics of the discharge planning conference trial. A standard operating procedure was written and agreed upon as the procedure for conducting discharge planning conferences on the trial wards (see Appendix D). One of the concerns of the task force was the ability to demonstrate that the proposed concept would identify those patients whose discharge planning needs could best be addressed in the multidisciplinary conference. The nursing staff on each ward were to be responsible for identification of patients who demonstrated the presence of one or more universal indicators for discharge planning as defined in BAMC Memo 40-25. This researcher agreed to assist in evaluation of the implementation of the program by looking specifically at the identification of patients needing discharge planning as a routine part of the nursing process conducted during the admission assessment of each patient and as documented on DA Form 3888/3888-1, Medical Record--Nursing Assessment and Care Plan (see Appendix E).

Universal indicators for discharge planning are those diagnoses or conditions known to have a high-risk potential for needing discharge planning. As part of their utilization review plans, most civilian hospitals stipulate a list of categories of patients whose diagnosis or condition designates the case for discharge planning (Texas Medical Foundation, 1986). The American Hospital Association published a list of identification factors in its initial work, Introduction to Discharge Planning for Hospitals, published in 1984 (see Appendix F). The discharge planning memoranda reviewed from Walter Reed Army Medical Center, Letterman Army Medical Center, and Fitzsimons Army Medical Center all included the same list of universal indicators attached to BAMC Memo 40-25.

This study was conducted as only one part of the overall evaluation of the implementation of the revised discharge planning policy. It was conducted with the assistance and support of the chiefs of the Department of Nursing and Social Work Service, and the results were reported to the Discharge Planning Committee as partial fulfillment of that group's responsibility to evaluate discharge planning as part of the institutional quality assurance program.

Problem Statement

The study was conducted to evaluate the use of the Nursing Assessment and Care Plan (DA Form 3888/3888-1) as a screening

tool to identify patients who meet one or more of the universal indicators for discharge planning as defined in BAMC Memo 40-25. It was anticipated not that the nursing admission assessment would consistently uncover all of the discharge planning needs of a patient but rather that it could be utilized to determine one or more universal indicators of the need for further exploration of discharge planning needs via the mechanism of the multidisciplinary discharge planning conference.

Purpose of Study

The standards of nursing practice require that an individualized plan of care be developed for each patient, to include assessment, problem identification, intervention, and evaluation. In the Army Medical Department (AMEDD), the nursing history and assessment is documented on DA Form 3888/3888-1. From the data gathered during the initial assessment, a care plan, inclusive of problems and corresponding interventions, is developed. Discharge planning concerns are a specific part of the assessment addressed on DA Form 3888-1, but often this section is not completed (HSC Newsletter, 22 December 1986).

The nursing assessment is a continuous process that becomes more accurate as the knowledge of the patient deepens. An assessment is continuous, systematic, critical, and orderly. It is a method of collecting, validating, analyzing, and interpreting information about the patient's ability to understand his illness, his coping ability, his desires, his beliefs, and his plans. Input from patients, professionals, and families form the data base. The more complete the data base, the more likely that the variety of needs can be accurately identified. (Zarle, 1987, p. 20)

Assessment for the discharge plan begins with the admission assessment and continues throughout the hospital stay. A discharge plan is an integral part of any patient care plan and should not be considered a separate phenomenon (Allport, Campbell, Erickson, Finch, & Swain, 1985, p. 112; Peabody, 1969, p. 307). Every inpatient medical record should include a nursing assessment. The degree of completion varies. The patient question portion is usually complete; it is the care plan and discharge planning section of DA 3888-1 which the JCAH and the internal BAMC nursing chart review audits find incomplete. Both the care plan and the discharge plan require assessment and professional judgment on the part of the registered nurse; planning of patient care is within the scope of practice of the registered nurse and cannot be delegated. It was anticipated that this study would demonstrate that, through the data collected by means of the questions asked during the admission interview, discharge planning concerns could be readily identified. The literature supports the concept that, once nurses in the acute care setting realize their responsibility for continuity of care beyond the hospital setting, discharge planning is readily incorporated into their staff studies (Connolly, 1981; Dake, 1984; Hanson, 1986; Knight, 1986; Previte, 1979). This awareness promotes completion of the discharge planning portion of the care plan and enables the nursing staff to determine which patients need multidisciplinary discussion in

the discharge planning ward conference.

DA Form 3888/3888-1 was designed to facilitate documentation of the nursing process according to Army standards of nursing practice. Every Army nurse receives instruction in the purpose and the use of the form in the AMEDD Nursing Basic Training Course. All civilian nursing personnel are introduced to this form during the new employee orientation conducted by nursing education and training departments. Therefore, the assessment forms are a known entity. The results of this study will be used to maximize the use of assessment while enabling the nursing staff to fulfill their role in discharge planning as defined in BAMC Memo 40-25 without generating another patient interview requiring use of another form. There are many screening tools and functional assessment systems reported (e.g., see: Cucuzzo, 1976; Dale & Kitto, 1985; Rasmusen, 1984; Zarle, 1987), but these devices are all an elaboration of the basic admission assessment conducted by the nurse as the initial step in the nursing process. The basis for discharge planning is a thorough and accurate nursing assessment (Arenth & Mamon, 1985; McKeehan, 1981; Peabody, 1969; Ratliff, 1981; Schweisguth, 1986), and DA Form 3888/3888-1 provides the capability for a structured, comprehensive assessment.

The intent of this study was to promote utilization of existing data and prevention of the requirement for additional tasks in order for nursing to accomplish the function of identifying

patients' discharge planning needs appropriate for discussion in multidisciplinary discharge planning conferences.

Objectives

The objectives of this research were to:

1. Review current literature and regulations concerning discharge planning trends and practices with emphasis on the patient assessment component of discharge planning and the use of screening tools and methodologies for determining the presence of discharge planning indicators.
2. Develop a tool to record the presence of universal indicators found while reviewing the nursing admission history and assessment (DA Form 3888/3888-1) of each patient admitted to the wards involved in the study (see Appendix G).
3. Review nursing admission assessments (DA Forms 3888/3888-1) on the wards participating in the evaluation of discharge planning rounds under the direction of the Center Discharge Planning Committee.
4. Compare the patients identified as needing discharge planning from a review of the nursing assessment to the patients presented in discharge planning conferences as evidenced by the minutes of the rounds.
5. Develop recommendations, if indicated, for the Department of Nursing concerning the use of the nursing assessment in executing the responsibility of nursing to identify patients who need

discharge planning.

6. Provide the results of the study to the Chief, Social Work Service; the Chief, Department of Nursing; and the Center Discharge Planning Committee to utilize as part of the overall evaluation of the implementation of revised BAMC Memo 40-25.

Criteria

The criteria for this research included the following:

1. The documentation for the study was obtained from a review of the nursing admission history and assessment (DA Form 3888/3888-1) for the patients on the three selected wards and from no other portion of the inpatient medical record. This documentation formed the parameters for the decision as to the need for discharge planning for the subject patients by the researcher.
2. The assessment of study documentation was based on the discharge planning indicators identified in appendices A and B of BAMC Memo 40-25 (see Appendix B) and summarized on the data-retrieval tool developed for this study (see Appendix G).
3. The definition of discharge planning for the purposes of this study was made in accordance with that delineated in BAMC Memo 40-25 (see Appendix B).
4. The presence of only one discharge planning indicator was held to be sufficient to consider a patient for discussion in discharge planning rounds. It was anticipated that, in at least 95% of the cases, the nursing admission history and assessment

would reveal at least one universal indicator if the patient was a candidate for presentation at the ward conference.

5. The data gathered from the nursing admission assessments, to include the frequency distribution of the most commonly identified universal indicators and the percentage of total patients reviewed whose assessments demonstrated the presence of discharge planning indicators compared to those patients for whom no indicators were identified, were analyzed and summarized through the use of descriptive statistics.

Assumptions

For the purposes of this research, it was assumed that:

1. BAMC Memo 40-25 would not be revised or amended during the time period of the study.

2. Discharge planning ward conferences would be conducted and documented in accordance with the written standard operating procedure agreed upon by the participants (see Appendix D).

3. Nursing admission assessments (DA 3888) would be completed in accordance with AR 40-66, Medical Records and Quality Assurance (DA, 1987), and BAMC Department of Nursing Administrative Policy B-3 for each patient discussed in rounds.

Limitations

This research was constrained by the following factors:

1. The research period covered the time frame only of mid-March

1987 through mid-June 1987.

2. The researcher was limited to the documentation in the minutes of the discharge planning conferences conducted on BAMC wards 12A, 42H, and 43H and could not attend the conferences.

3. The research was limited to the determination of the patients who might have required discharge planning and was not concerned with the remaining components of the discharge planning process (i.e., development of a plan, implementation, and follow-up).

4. The researcher was limited to the documentation available in the nursing admission history and assessment (DA Form 3888/3888-1). No other part of the medical record was utilized to determine the presence of discharge planning universal indicators, and no discussion concerning the patients took place between the researcher and the unit staff.

5. The universal indicators for discharge planning were limited to those defined in BAMC Memo 40-25 (see Appendix B).

6. Social Work Service, not the researcher, was responsible for the recording of minutes of the ward discharge planning conferences and for publication of the agenda listing patients to be discussed in conference.

7. Nursing Service personnel, not the researcher, were responsible for completion of DA Forms 3888/3888-1.

8. The recommendations resulting from the study would be in keeping with the resources and the mission of BAMC and be in

consonance with the objectives of BAMC Memo 40-25.

Research Methodology

The methodology used to conduct this research included the following:

1. Collection of Data

a. A review was conducted of all applicable DA, HSC, and BAMC regulations, directives, memoranda, standard operating procedures, and Center Discharge Planning Committee minutes in order to determine which current requirements and practices were relevant to the discharge planning process.

b. A literature review was conducted focusing on discharge planning as a standard of care, methodologies utilized to ascertain those patients from among a given population who possessed universal discharge planning indicators, use of the nursing assessment as a mechanism for determining the presence of universal discharge planning indicators, and approaches to the development of individualized discharge plans.

c. Discussions were held with members of the Discharge Planning Committee concerning the discharge planning process as executed at BAMC. These discussions included representatives from Social Work Service, Nursing, Physical Therapy, Occupational Therapy, Physical Medicine, and Community Health Nursing.

d. Memoranda were written to the head nurses of the wards involved in the study to inform them that the researcher

would be reviewing the nursing admission assessments as part of a study pertaining to discharge planning. The memoranda were sent through the Chief of Clinical Nursing Service, who also serves in the capacity of coordinating all research within the Department of Nursing.

e. A tool was developed that reduced the number of indicators listed in the appendices of the BAMC Discharge Planning Memorandum (49) to a more manageable figure (18). This was done by eliminating duplication and combining like indicators. For example, rather than listing each catastrophic illness separately, one indicator was used to define catastrophic illness as any condition resulting in chronic, immobilizing, or terminal illness requiring use of extensive financial and psychosocial support and extensive nursing care resources. The tool also contained identifying information, to include patient name, last four digits of the patient's Social Security number, ward number, date of admission, date of review, age of patient, and diagnosis.

f. Arrangements were made with the secretarial staff responsible for filing minutes of the discharge planning conferences to duplicate one copy of each set of minutes and retain them for the researcher until such time as the data-gathering phase of the study was complete.

g. The patient population involved in the study were all patients present on wards 12A, 42H, and 43H at the onset of

the study and all additional patients present on the study wards during the researcher's weekly visits to the wards. The researcher visited each ward involved in the study on a weekly basis to review the information written on DA Form 3888/3888-1 for each patient present on the ward at that time. After the initial visit, the data sheets from the prior visit were compared to the census board. If a patient's name no longer appeared on the census board, the patient was assumed to be discharged regardless of whether the patient had been transferred, was on convalescent leave, had expired, or had been discharged and the data-retrieval sheet was removed from the active file. New data-retrieval sheets were then completed for each new patient whose name had not been on the census board previously. Data retrieval was performed during the evening shift from 5:00 p.m. to 7:00 p.m. on weekdays for Ward 12A and on each Sunday afternoon between 1:00 p.m. and 3:00 p.m. or between 4:00 p.m. and 6:00 p.m. for wards 42H and 43H. The selection of these times assured the researcher of access to the nursing admission history and assessment sheets when the ward staff were least likely to be using the folders in which the assessments were maintained. It should be noted that, because the medical record often accompanies the patient for consultation and treatments off the ward and because all other health care professionals concerned with the patient want access to the medical record, nursing assessments, care plans, treatment sheets,

and medication sheets are filed in folders separate from the remainder of the inpatient record. Thus, the researcher was not inadvertently exposed to information about the patients that could bias the decision about the presence or absence of indicators for discharge planning. The times selected for data gathering also precluded the researcher from being present on a ward either during discharge planning conference or when a social worker or a community health nurse would be present discussing discharge planning concerns with the nursing or the physician staff.

h. The monthly BAMC census report was obtained from the Nursing Methods Analyst in order to determine information about the average census and the average length of patient stay for the wards involved in the study.

i. Quality assurance audits of the degree of completion of the nursing assessment forms were reviewed with the DON Quality Assurance Nurse in order to determine the expected rate of completion of the 29 questions listed on DA Form 3888 and additional data recorded on DA Form 3888-1.

j. Patient contact records were reviewed from both Social Work Service and Community Health Nursing in order to determine which patients received discharge planning but were not presented in discharge planning rounds. Because Social Work Service annotates patient discharge planning records within the department only for those patients who require three or more contacts, the

researcher also reviewed data from the ambulatory care data base wherein all patient contacts were noted on Ambulatory Care Data Base Outpatient Encounter Forms by code.

k. The data-gathering time frame was determined by the accumulation of a sample size of 30 or more patients discussed in discharge planning conferences for whom the reviewer had completed a nursing admission assessment screen.

2. Recording of Data

a. All documents, journals, and books read were referenced.

b. The presence of universal indicators of discharge planning identified during the review of the nursing admission history and assessment were recorded on the study data-retrieval tool (see Appendix G) by circling the appropriate indicator. The researcher wrote in the spaces provided the following information: patient's last name and first initial, date of admission to the hospital, age, status (i.e., active duty, retired, or dependent), ward number, date of the review, expected location at discharge (i.e., duty, home, or alternate care setting), admitting diagnosis, and all other diagnoses and conditions listed in the history and assessment. The completeness of DA Form 3888/3888-1 was also noted. The bed assignment of the patient was recorded in the upper righthand corner in order to arrange the data-retrieval forms in the same order as the corresponding DA Forms 3888/3888-1

were positioned in the patient assessment folder in the wards.

c. Meetings with various hospital staff concerning the research project were recorded in the researcher's daily activity calendar.

d. Minutes of ward discharge planning conferences were recorded by Social Work Service personnel, who also published the agenda listing patients to be discussed in conferences. Completion of DA Forms 3888/3888-1 was accomplished by Nursing Service personnel.

3. Evaluation of Data

a. Minutes of the initial ward discharge planning conferences conducted the last week of January 1986 were reviewed to determine if the standard operating procedure for documentation of ward conferences (see Appendix D) was being followed. The minutes were in sufficient detail to accommodate this study and followed the format specified in the standard operating procedure. Minutes were not looked at again until May 1987, when it had been anticipated that a sufficient number of patients would have been discussed in order to have a sample size of at least 30 patients who had been both discussed in rounds and reviewed by the researcher. The data-retrieval time was extended until 1 June 1987 in order to achieve an adequate sample size.

b. The data-retrieval sheets were compiled in groups by ward and in subgroups denoting three conditions: (1) patients

whose nursing history and assessment revealed no universal indicators signifying the need for referral to multidisciplinary discharge planning rounds, (2) patients whose nursing history and assessment revealed the presence of one or more of the universal indicators of the need for referral to discharge planning rounds but who were not referred, and (3) patients with indicators of the need for discharge planning who were referred to rounds.

c. The data-retrieval sheets were screened to eliminate duplicate assessments conducted on the same patient during the same admission, which occurred when a patient was transferred off a study ward and returned or a patient went on convalescent leave and returned. Data-retrieval sheets were also screened to eliminate duplicates when patients were discharged and readmitted within the study period. Of the original 328 data-retrieval sheets completed, 297 remained after the removal of duplicates and readmissions.

d. The frequency with which each of the 18 different indicators occurred was determined both collectively for the 297 assessments performed by the researcher and by individual ward.

e. The minutes of the discharge planning conferences were screened and a listing made by ward of the individual patients discussed. The minutes, however, did not reflect the specific discharge planning indicator that had caused the patient to be referred to conference, as had been anticipated. Soon after

rounds started in January 1987, the format for minutes was standardized to a fill-in-the-blank type of format, and the indicators for which a patient had been referred for discharge planning were not specifically recorded.

f. The information gathered during the literature review was utilized along with the results of this study to develop recommendations for the Discharge Planning Committee to evaluate as part of that committee's responsibility to oversee the discharge planning program at BAMC.

CHAPTER II

LITERATURE REVIEW

There is a paucity of writing about discharge planning prior to the enactment of Medicare and Medicaid legislation in 1965, when discharge planning was mandated as an integral part of the utilization review requirement. Publications from the 1970s cited frequently as references in describing the process of discharge planning are the 1974 publication of the American Hospital Association (AHA) entitled Discharge Planning Guidelines, the National League for Nursing publication of 1976 entitled Discharge Planning for Continuity of Care, and the 1978 publication by Eide and Steffle entitled Discharge Planning Handbook. The cost-containment focus inherent in the utilization review programs of the 1970s forced hospitals to develop discharge planning programs that would expedite the process of identification of patients at risk of the need for discharge planning and then provide efficacious coordination of resources to best meet the recognized needs of those patients. Thus, guidelines and handbooks that described the rationale for and the methods of establishing a discharge planning program were published (e.g., see: Crittenden, 1983; David, 1973; McKeehan, 1981).

The advent of concurrent utilization review encouraged

delineation of those diagnoses for which discharge planning was prerequisite to discharge. Utilization review plans approved by local professional standards review organizations required hospitals to list those diagnoses and conditions commonly known to need discharge planning in order to keep the length of stay within acceptable limits. The admission review by the utilization review coordinator included an evaluation of the need for discharge planning. Therefore, references for implementation of utilization review programs included mention of discharge planning (e.g., see: Hospital Research and Educational Trust, 1974).

Annotated bibliographies demonstrate that most articles concerning discharge planning were published in nursing journals, hospital management publications, and rehabilitation services references (e.g., see: Brown & Hartigan, 1985; McKeehan, 1981). The AHA began publishing Discharge Planning Update, a newsletter-type reference, in 1979. The Continuity Care Coordinator (now titled The Coordinator), a monthly journal specific to the needs of continuing care professionals, was founded in 1981. These publications are excellent sources of information concerning legal aspects of discharge planning, methodologies for execution of the process, and descriptions of community resources which are usually written by practicing discharge planners, not research-oriented academicians. There is an acknowledged lack of studies conducted to ascertain how best to perform discharge planning

to achieve the best outcomes (Abramson, 1985; Johnson & Pachano, 1981; Kleyman, 1983).

Now that Congress is expressing increased concern about the quality of discharge planning, the Health Care Financing Agency is allocating funds for studies concerning the appropriateness of discharge planning (Bragg & Lovdale, 1986; Coe, Patterson, & Wilkinson, 1985; Granatir, 1985; Reamer, 1985). Also, health care professionals are evaluating their responsibility and capability in the areas of patient screening and assessment for discharge planning purposes (Allport et al., 1985; Carpenter, Hanley, Kroenke, Kussman, Pinholt, & Twyman, 1987; Claus & Ingman, 1981; Cunningham, 1984; Doten, Elkin, & Ryder, 1981; Munding, 1985; Reichelt & Newcomb, 1980).

The AHA (1984a) has included discharge planning as a patient right, and the JCAH (1986) has stipulated in the Accreditation Manual for Hospitals the specific discharge planning responsibilities of physicians, nurses, social workers, dieticians, and rehabilitation specialists in the standards for each of the aforementioned disciplines. The concern expressed in the literature is for the quality and the timeliness of the discharge planning needs assessment (e.g., see: Arenth & Mamon, 1985; Bragg & Lovdale, 1986; Churchill & Fromstein, 1982; Claus & Ingman, 1981; Coe et al., 1986; Cunningham, 1984; Dale & Kitto, 1985; Doten et al., 1971; Falvo, 1981; Fortinsky et al., 1981; Healy, Mason,

& Schweisguth, 1986; Johnson & Pachano, 1981; Mowry & Van Servellen, 1985; Rasmusen, 1984).

The current texts on the subject of continuing care have chapters devoted to assessment as the initial step in the discharge planning process. All patients are assessed by both physicians and nurses. The physician, utilizing the medical model, tends to focus on the illness or injury and is least likely to assess the patient for alternative care options (McKeehan, 1981; Peabody, 1969; Ratliff, 1981). The nurse conducts a holistic assessment as part of the development of individualized patient care plans. The nursing admission assessment is the basis from which nursing diagnoses are determined and an individualized plan of care established as part of the nursing process. Many authors subscribe to the theory that every staff nurse is a discharge planner because of nursing's responsibility to determine with the patient and significant others the education, the referrals, and the resources which will need to be coordinated to maximize the patient's ability to function within the limits of mental, psychosocial, physical, and economic considerations (e.g., see: Ambrose, 1973; Arenth & Mamon, 1985; Chisholm, 1983; Clausen, 1984; Coleman, Lebeda, & Smith, 1985; Connolly, 1981; Coon, LaMotte, & Stanton, 1981; Cucuzzo, 1976; Dake, 1984; Flores & Smeltzer, 1986; Habeeb & McLaughlin, 1979; Hanson, 1986; Healy et al., 1986; Johnson & Pachano, 1981; Knight, 1986; Moreland & Schmitt, 1974;

Mowry & Van Servellen, 1985; Peabody, 1969; Pilcher, 1986; Previte, 1979; Rehr, 1986).

It is acknowledged that discharge planning is every health care provider's concern, but the assessment by the nurse is uniquely instrumental in creating timely referrals to other disciplines (Dodge & Weinbach, 1974). Arenth and Mamon (1985) state that how accurately nurses assess patient discharge planning needs and how extensively the patient and family participate are the most critical factors in discharge planning. They recognize, however, that nurses may have a limited perspective, and therein lies the importance of the discharge planning team approach so well described by Edwards (1978) and the discharge planning rounds as discussed by numerous authors (e.g., see: Beale & Gulley, 1981; Connolly, 1981; Dake, 1984; Flores & Smeltzer, 1986; McKeehan, 1975; Pilcher, 1986).

The literature also provides insight into the use of multidisciplinary teams or rounds as a method of developing a discharge plan that utilizes the collective expertise of all health professionals involved in the care of the patient. McKeehan (1981) states that the success of discharge planning rounds is attributable to structure, product, leadership, and climate. Structure includes such components as physical setting, size of the group, frequency of meetings, promptness and length of meetings, and agenda. Product pertains to purpose of and preparation for the

meeting and follow-up of results. Leadership should not be autocratic but rather should guide the group toward achievement of goals. Climate has to do as much with human factors such as attitude and commitment as it does with the physical environment (McKeehan, 1981, pp. 86-87). Rounds are a valuable mechanism for sharing information about particular patients, and they serve as a mechanism to educate health care providers about discharge planning and the services and unique contributions of the various members of the health care team (David, 1973, pp. 41-43; Ratliff, 1981, pp. 24-25).

The selection of patients for discussion in multidisciplinary discharge planning rounds is often the responsibility of nursing. The holistic, comprehensive nursing admission assessment; the continuous supervision of the patient; and the coordinating function for the enactment of the medical plan of care, when combined with knowledge of the critical indicators for discharge planning, all serve to make the nurse the primary source of casefinding for team discussion during discharge planning rounds (Churchill & Fromstein, 1982; Coon et al., 1981; Cunningham, 1984; Knight, 1986; Rasmusen, 1986; Reichelt & Newcomb, 1980). Some authors express the view that discharge planning is primarily a nursing function particularly because of the initial and continuous assessment of the patient performed by the nurse and the nurse's unique ability to forecast clinical and functional assistance

requirements which will be needed upon transfer to the next level of care (Rowland & Rowland, 1984, p. 143).

The importance of an accurate assessment is well substantiated in the few studies available to date. Of particular importance is the functional assessment, an evaluation of the patient's ability to perform the activities of daily living, to include eating, ambulating, dressing, and bathing, with consideration of both physical mobility and mental acuity. A study conducted at BAMC by the Department of Medicine demonstrated that functional impairment is prevalent among the hospitalized elderly (age 70 and older) and that, though clinical judgment is useful in identification of severe impairment, both doctors and nurses do not readily identify moderate level impairment without the use of specific assessment tools (Carpenter et al., 1987). The need to make comprehensive assessments of patients' functional abilities is not only related to early diagnosis and treatment of certain illnesses but is also imperative to the appropriate selection of an alternative care setting that will maximize patients' potential for recovery or health maintenance (Fortinsky et al., 1981). The emergence of geriatric assessment centers as described by Besdine, Cumella, Epstein, Feldstein, Hall, McNeil, and Row (1987) is an indication of the importance of a valid assessment. As of 1985, there were 114 assessment centers in this country (p. 299). Other studies reaffirm the significance of early and

continuous assessment of the patient's functional abilities and potential needs in order to accomplish the purpose of discharge planning (Bragg & Lovdale, 1986; Coe et al., 1986; McKeehan, 1975).

There are tools described in the literature to insure a comprehensive analysis of a patient's capabilities and needs which are utilized separately and apart from the routine admission assessment performed as the initial step in the development of a patient care plan (Cucuzzo, 1976; Dale & Kitto, 1985; Doten et al., 1971; Fortinsky et al., 1981). There is also a trend to perform preadmission screening to determine eligibility for and appropriateness of hospitalization, with discharge planning needs evaluation as an integral part of the screen (Claus & Ingman, 1981; Coleman, Lebeda, & Smith, 1985; Flores & Smeltzer, 1986). At this time, military facilities are primarily involved with preadmission eligibility screening, but, with the impending transition to a DRG-type reimbursement, interest in preadmission screening for discharge planning may evolve.

Feather and Nichols note in their chapter of the 1985 National League for Nursing publication, Discharge Planning for Continuity of Care, that, although a tremendous amount of information has been collected about the health care system by governmental and private agencies, very little relates directly to discharge planning problems. They further note that most studies conducted fall into three categories: (1) manner of conducting discharge

planning at a single hospital, (2) comparisons of discharge planning programs within a single community, and (3) reports concerning discharge planning nationally. Most of the studies reviewed in Feather and Nichols' article were descriptive rather than analytical, with emphasis on structure of the discharge planning program. It has been established that the implementation of DRGs has caused hospitals to formalize the discharge planning process, to increase the number of personnel with specific responsibility for the process, and to institute the use of multidisciplinary rounds to facilitate the discharge planning process (pp. 73-77). Reichelt and Newcomb (1980) concluded in their study about organizational factors in discharge planning that the presence of a discharge planning coordinator enhances effective interaction between the hospital and the referral services and promotes development of program objectives and program evaluation but that the timely identification of patients needing discharge planning relies on the professional judgment of caregivers, primarily nurses (pp. 36-41).

The studies funded by grants from the HCFA demonstrate the increased need for discharge planning as the level of acuity of hospitalized patients increases due to the impact of DRGs. The primary implication derived from the study published by the Northwest Oregon Health Systems was the need for a systematic approach for screening patients, along with a discriminating assessment

of self-care limitation, in order to achieve an appropriate match between patient needs and continuing care resources (Coe et al., 1986, p. 15). The Oregon Medical Professional Review Organization study supports the Northwest Oregon study and further defines the type of assessment that will best identify patient discharge planning needs (Bragg & Lovdale, 1986).

The use of screens or lists of indicators to identify patients at high risk for discharge planning is frequently mentioned as an integral part of a successful discharge planning program (JCAH, 1986). The study by Bragg and Lovdale (1986) lists age, living situation, diagnosis, multiple previous admissions, and recent prior admissions as the most common criteria for casefinding. All lists of critical indicators are designed to assist the discharge planner in prioritizing which patients need planning. Fisher (1987) contends that, if more discharge planning was done for low-risk patients, those same patients would not become the high-risk, manpower-intensive discharge planning problems of the future. The point is made that there are many acutely and clinically ill patients today who are maintained with advanced technology and for whom there are few if any alternative resources. The discharge planner, in setting priorities, might do well to concentrate on prevention rather than focus primarily on catastrophic cases (pp. 12-16). This is a thought-provoking theory for which no other supporting literature was found. It is certainly a theory that warrants further study.

CHAPTER III

DISCUSSION

Research Design

This study concerned the evaluation of one of the components of a newly implemented program within an institutional setting. It was a descriptive field study rather than experimental research due to the fact that the researcher could not use the principles of randomization or active manipulation of the independent variables (i.e., the selection processes used by the nurses and the social workers to determine which patients should be discussed in discharge planning rounds). The researcher operated within the constraints of the study protocol, but the comparison group of nurses and social workers functioned within their normal work situation. This meant that the comparison group had access to more information about each patient and varying levels of interest in and knowledge of discharge planning and operated within the often hectic environment of the day shift ward routine, where the discharge planning conference can become a low priority concern when set against other aspects of patient care. In contrast, the researcher was able to establish times when data gathering was uninterrupted by the activities of the ward and full concentration could be applied to making decisions about the presence

or absence of universal indicators for discharge planning from the information available on the nursing admission history and assessment forms.

The researcher had no control over many variables that could have affected the results of the study. For example, the researcher could not determine the wards involved in the study, the people participating in discharge planning conferences from the trial wards, or the amount of orientation which the ward staff received on BAMC Memo 40-25 concerning discharge planning or the procedures for conducting discharge planning rounds. Further, though the nursing personnel were aware that the study involved reviewing data contained in the nursing admission history and assessment forms, the researcher had no direct influence on the degree of completion of the assessment forms or the quality of the content.

The assumption was made at the onset of the study that the discharge planning conference procedure would be followed. Procedures are customarily written with the expectation that they will be adhered to, and they are routinely reviewed to insure that they are operationally feasible given the current environment, to include consideration of resource utilization, applicable regulations, staff attitude, community standards, client expectations, and numerous other variables. The Discharge Planning Committee considered it prudent to monitor implementation of the new procedure

in order to determine if the procedure was achieving its intended purpose. This study will have benefit for BAMC if the results are used to improve the discharge planning process.

Research texts caution researchers that one of the greatest limitations of this type of nonexperimental research is the misinterpretation of data obtained in a real-world setting. The plethora of uncontrolled variables in such a situation make it difficult to establish strong relationships between variables. The research is limited to describing what exists but has little ability to infer precisely why a situation occurs (Hungler & Polit, 1983, pp. 176-182; Kerlinger, 1973, pp. 395-402).

The purpose of this descriptive study was to obtain information about the current status of a new phenomenon within the institution, the use of multidisciplinary discharge planning rounds, and, more specifically, the component concerned with the ability of the nursing staff to select appropriate patients for rounds based upon the information gathered during the nursing admission history and assessment as documented on DA Form 3888/3888-1. The objective was to describe the relationship between the information available on the nursing admission history and assessment form and the potential for the nursing staff to identify universal indicators for discharge planning rather than to infer cause-and-effect relationships. This study was designed to describe what existed in terms of frequency of occurrence rather than to

explore relationships between variables. Therefore, recognizing that the major limitation of this study was its inability to provide factual insight into why certain patients with universal indicators of discharge planning present were discussed in rounds and others were not, the study did achieve the objective of demonstrating that the nursing assessment can be used as a screening device for certain frequently occurring indicators. The strength of this study was its realism, the fact that nothing was structured or controlled in the ward environment, and thus the results can more readily be generalized to some degree to other wards within BAMC in which census, staffing, patient acuity, and charting policy compliance are comparable. Although the original intent of the study was not to discuss the quality of discharge planning, it is conceivable that some of the incidental findings and the resulting questions raised by the study will lead to a more efficacious discharge planning program.

Study Results

From the onset, there was considerable interest in the study from the Discharge Planning Committee, particularly from the members most directly involved in discharge planning rounds, those from the Department of Nursing and Social Work Service. Concern was frequently expressed that discharge planning be successful in the sense that patients who demonstrated the need for discharge planning were in fact receiving discharge planning. It was felt

that the first step toward a quality discharge planning program was access to the service by means of an effective screening system. This premise is often asserted in the literature and in the mandated requirements associated with care of Medicare and Medicaid patients (e.g., see: AHA, 1984 a & b; JCAH 1986; Hospital Research and Educational Trust, 1974).

Even though Social Work Service at BAMC has the coordinating function for formal discharge planning, it is recognized that nurses, due to their continuous contact with patient, family, physician, and other persons participating in the care of the patient, are in a more favorable position to learn the various expectations and plans of each of the health care providers concerning the after-care of the patient. The nurse also has the clinical expertise to determine what nursing care needs and adjuncts to the medical care plan the patient may require after discharge. For these reasons, it was determined that the ward nurses in conjunction with the assigned ward social worker would select patients for discussion in discharge planning rounds. The nurse was also designated as the leader of the conference. The social worker was chosen to record the minutes and to make annotations of specific discharge plans in the patient's medical record.

The wards selected for the study were chosen by the Discharge Planning Committee because of a history of a high volume of

discharge planning activity. Some pertinent characteristics of the study wards are detailed in Table 1.

Ward 12A contains Urology Service patients. It had the lowest average census, the shortest length of stay, and the largest number of admissions. The most frequent diagnosis encountered was transurethral prostatectomy and related procedures.

Ward 42H contains Neurosurgical Service patients. It had the highest average census, the longest length of stay, and the lowest number of admissions. Back problems and closed head injuries were the most common diagnoses.

Ward 43H contains patients on the Oncology Service. This ward had the highest bed capacity but maintained an average census of slightly less than that of Ward 42H. The average length of stay was only eight days. The most common diagnosis was cancer, with leukemia of one form or another being the most frequent type.

All three wards were routinely busy, and the staff did not have time to talk to the researcher other than to engage in social amenities. Therefore, it was not difficult to avoid discussion about discharge planning.

The documentation on the nursing admission history and assessment forms was generally complete. There was not one instance when DA Form 3888/3888-1 was not at least initiated. Even if it was noted that the patient had difficulty communicating or was unable to talk, there was sufficient information to determine

Table 1

Demographics of Wards Participating in Discharge Planning Study

Ward	Number of Beds	Average Census	Average Length of Stay	Average Age	Over Age 60		Most Common Indicator+
					Percent	Percent with Indicators	
12A Urology	28	15	4	56*	56	29	8
42H Neurosurgery	31	27	12	40	17	64	7
43H Oncology	35	26	8	57	54	88	12

Note. All figures are rounded off to the nearest whole number.

Note. Number of beds, average census, and average length of stay are from the Brooke Army Medical Center Census Report.

*Five pediatric cases were excluded from the Ward 12A average age calculation because pediatric cases were not present on the other wards.

+Identification of Indicators:

8. Presence of condition that negatively affects self-image, appearance, or sexuality.

7. Presence of condition requiring change in education, job, or role.

#12. Presence of catastrophic illness.

the presence of one or more of the universal indicators of the need for discharge planning.

Specific questions from DA Form 3888/3888-1 (see Appendix E) which were more likely to reveal the need for discharge planning were:

- 9. Reason for admission
- 13. Have you been hospitalized before? If YES, describe most recent hospitalization.
- 14. Do you have any other health problems? If YES, explain.
- 21. Do you need help with eating, bathing, dressing, or walking? If YES, explain.
- 29. Who do you have to assist you when you are discharged?

These questions identified the presence of diagnoses or conditions listed in the universal indicators and defined the effect on the patient's ability to function. The patient who listed no one available to assist upon discharge might have been identifying transportation as well as care provider problems.

The continuation form (DA Form 3888-1) (see Appendix E) provided valuable information concerning age, general appearance, skin condition, and emotional status. The latter three items may provide significant clues to how well a patient is coping with chronic or terminal illness. Comments about weight loss, poor skin integrity, and depression indicate the need for further evaluation. The reverse side of DA Form 3888-1 contains the problem list with expected outcomes and a section for recording

discharge considerations. There was usually something recorded in the care plan section, though the notations commonly appeared to be standardized by diagnosis or ward routine.

Ward 12A (Urology) utilized an overprint for a standard post-operative patient routine, to include discharge planning considerations concerning a patient's need to understand medications and diagnostic procedures. However, the section labeled Special Considerations (i.e., sociopsychological needs, limitations, disabilities, etc.) was usually blank. None of the six patients admitted with the diagnosis of impotence or infertility had mention made of counseling for sexual dysfunction, nor did any of the patients undergoing transurethral prostatectomies where impotence could be a complication.

Ward 42H (Neurosurgery) used a comprehensive assessment overprint that included such items as: level of consciousness according to the Glasgow Coma Scale, general systems review, motor strength and joint flexibility, mobility assessment, and long-term goals for standard neuromuscular nursing care. Problems were overprinted on the reverse of DA Form 3888-1. A discharge planning screen was used inconsistently. Because this screen was not part of the standard nursing admission assessment as recorded on DA Form 3888/3888-1, the researcher did not review these supplemental discharge planning screens but did note the presence or absence of the screen at the top of the study data-retrieval

sheet. Only 4 of the 14 patients presented in discharge planning rounds on Ward 42H had a discharge planning screen completed; the researcher did not see a relationship between the completion of the supplemental discharge planning screen and a referral to discharge planning rounds.

Ward 43H (Oncology) had no special adaptation of DA Form 3888/3888-1. The diagnosis alone qualified most patients for discharge planning; only 9 of 78 assessments reviewed on this ward did not reveal the presence of one or more universal indicators for discharge planning. Despite the concentration of patients at high risk for needing discharge planning, this ward cancelled discharge planning rounds during four of the eight weeks during which data retrieval was being performed. The minutes of the discharge planning conferences noted that the cancellation was due to patient care demands.

Review of the nursing admission history and assessment forms was done weekly on the same day for each ward. After the initial screening of all the patient assessments during the first week of the data-retrieval period, only the assessments of those patients not previously evaluated were screened during each successive visit. A total of 340 nursing assessments were reviewed, but, after eliminating 24 duplicates and 19 readmissions, the sample for the study was comprised of 297 individual patient admission assessment evaluations. The completion of duplicate

data-retrieval sheets was attributed to patients transferring in and out of wards, taking convalescent leave, and receiving changes in bed assignment within wards. No attempt was made to determine if readmissions were scheduled admissions or the result of inadequate prior discharge planning. Such evaluation would have represented a potential quality issue not within the scope of this study. It is significant that the evaluation by the researcher of the presence of discharge planning indicators was consistently reliable. In all cases, if an indicator was noted as present for one admission or review, that same indicator was found to be present during the completion of subsequent data-retrieval sheets. The only factor that varied was supplemental comments copied directly from DA Forms 3888/3888-1.

It was assumed that, at the conclusion of eight consecutive weeks of data retrieval, from 1 April 1987 to 31 May 1987, the number of patients presented in weekly ward conferences would exceed 30, based on the fact that rounds as documented during the last week in January averaged discussion of nine patients per week on the three wards. The minutes of ward conferences were obtained from Social Work Service and lists compiled by ward of the names and the last four digits of the patients' Social Security numbers for cases presented in rounds. At that time, several observations of importance to the study were made:

1. Conferences had been cancelled four times on Ward 43H

(Oncology) and three times on Ward 12A (Urology).

2. Sometime between the initial conferences in January 1986 and the conferences conducted during this study, the minutes of the conferences were streamlined into a limited, fill-in-the-blank format, and the specification of the indicator that had prompted the patient's case to be discussed in conference was eliminated from the minutes. Thus, this researcher could not correlate the indicators circled on the study data-retrieval sheet with the indicator that caused the nursing staff to refer the patient to discharge planning conference as had originally been anticipated.

3. The same patients were discussed week after week, thereby reducing the total number of different patients discussed.

There were 29 individual patients discussed in rounds on the three wards collectively. Despite the fact that the researcher did not evaluate all new admissions to the wards, there was a data-retrieval sheet completed for each patient discussed in rounds. Indicators of the need for discharge planning had been circled in 100% of the cases. The researcher had not anticipated being able to achieve this rate of predictability. Keeping in mind that the purpose of the study was to determine whether or not the nursing assessment as documented on DA Form 3888/3888-1 could be used as a reliable screen for ascertaining the universal indicators of the need for discharge planning, it was not essential

to the study to determine if the researcher's selection of a particular indicator matched the indicator by which a patient was selected by the nursing staff for discussion in the discharge planning conference.

In order to increase the number of patients involved in the analysis, minutes of the rounds conducted prior to 1 April 1987 and throughout the month of June 1987 were reviewed because many patients had prolonged hospitalizations and thus could have been discussed prior to 1 April 1987 and still remained in-house during the data-retrieval period. Likewise, some patients assessed prior to 31 May 1987 were discussed during June discharge planning conferences. By extending the time span of the minutes involved, the sample size for the patients discussed in discharge planning rounds was increased to 45.

As the pie chart in Figure 2 indicates, 15% of the patients screened by the researcher and determined to have one or more universal indicators of the need for discharge planning were actually presented in rounds. An additional 38% had indicators present but were not presented in rounds. Forty-seven percent of the assessments did not reveal the need for multidisciplinary discharge planning.

The next step was to analyze the data in an attempt to determine which indicators appeared to be the most frequently occurring among those patients presented in rounds. The discharge planning

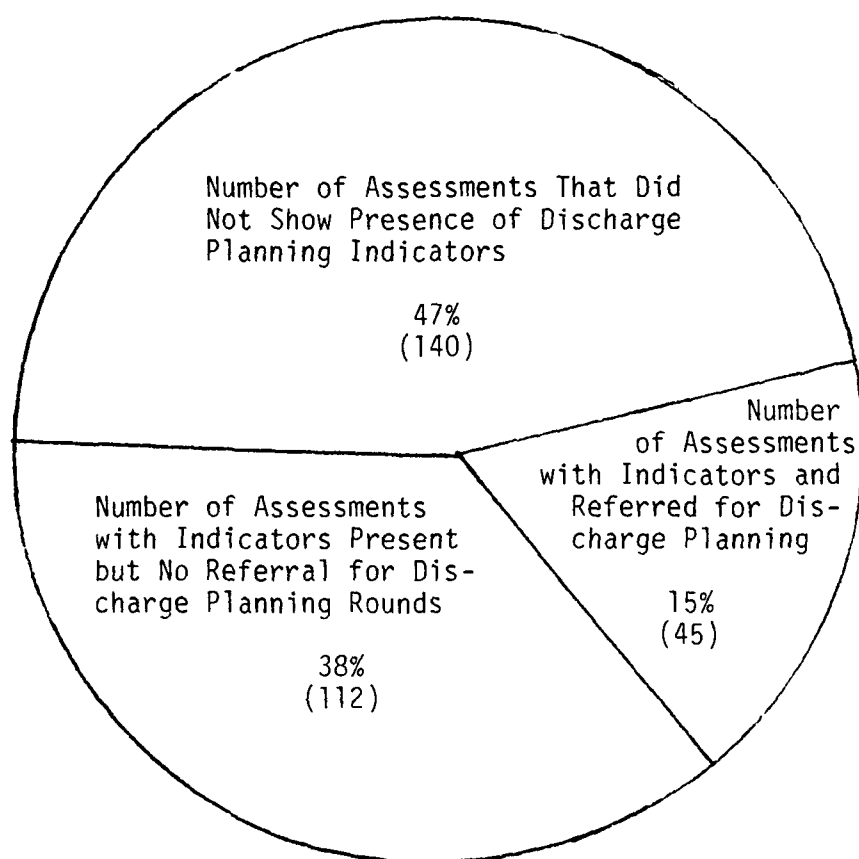


Figure 2. Percentage of 297 total assessments showing presence of discharge planning indicators.

indicators appearing on the data-retrieval sheet were as follows:

1. Admitted from a nursing home, a chronic care facility, or a foster home.
2. Presence of condition that will affect ability to return home (chronic brain syndrome; Alzheimer's disease; fracture of hip, pelvis, or multiple bones; impaired decision-making capability).

3. No known family or inadequate social and financial support system (over 65 and lives alone).

*4. Suspected victim of abuse, neglect, or violence (failure to thrive, malnutrition, dehydration, fractures, decubitus ulcers).

5. Exhibiting prolonged fear and/or anxiety about recommended medical procedures or fear of care of infant or child.

*6. Presence of problems for which medical compliance with treatment plan will hinge upon adequate housing and/or physical conditions.

7. Presence of a condition that will require a change in education, employment, and/or family role (care provider for disabled person).

8. Presence of a condition that will lead to problems that negatively affect self-image, physical appearance, and/or sexual functioning (colostomy, ileostomy, urostomy, mastectomy, amputation, burn, radical neck surgery, tracheostomy).

9. Presence of family problems that will directly affect care, treatment, and/or medical compliance (family unwilling or unable to take patient home).

*10. Patient's family/significant other exhibits behavior disruptive to treatment.

11. Nonresident of catchment area with condition that will affect ability to return home.

12. Admitted for treatment resulting from presence of

catastrophic illness (metastatic cancer, chronic renal failure, Parkinson's disease or other chronic disability, cerebrovascular accident/paralysis, head injury, neurosurgery, coma/chronic obstructive pulmonary disease).

13. In terminal stage of illness.

14. Hospitalization and/or medical compliance will depend upon specific concrete supports in the home (family unwilling/unable to take patient home).

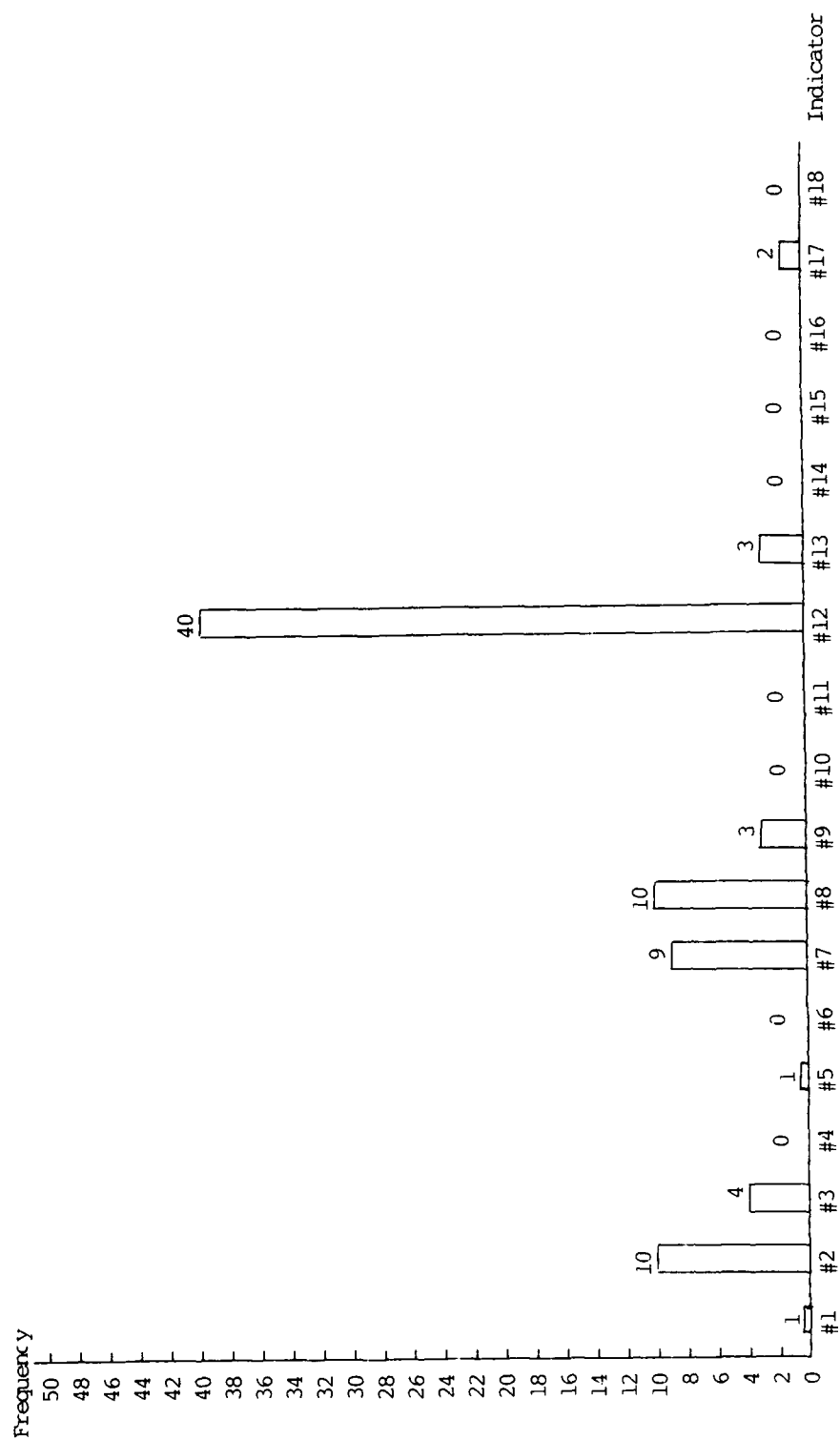
15. Need for medical equipment after discharge.

*16. History of noncompliance with previous discharge arrangements or medical plans.

17. Requirement for six or more medications routinely.

*18. Postpartum or newborn identified as high risk (single parent, teenage parent[s], prematurity, unexpected multiple births, no prenatal care, severe birth defects, for adoption or foster care).

Five indicators (marked above by an asterisk) were found not to be present in any of the 297 assessments performed during the study. Figure 3 graphically depicts frequency of occurrence of each indicator for patients referred to rounds. Indicator #12, pertaining to the presence of catastrophic illness, occurred four times more often than any other indicator. The next most commonly found indicators were #2, pertaining to the presence of a condition that could affect the patient's ability to return

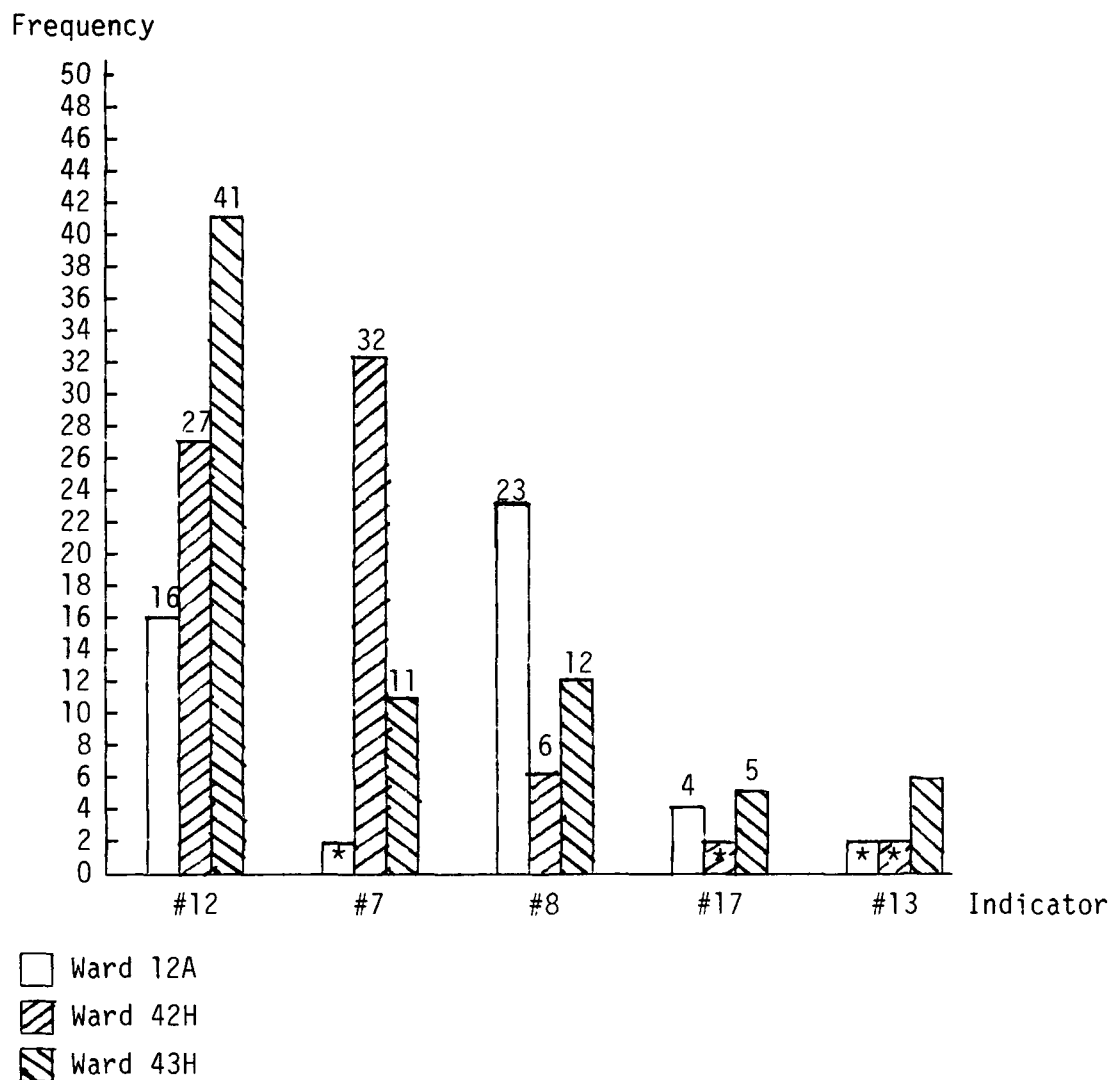


Note. Many patients had more than one indicator present.

Figure 3. Frequency of indicators present for patients referred for discharge planning.

home, and #8, pertaining to the presence of a condition that could negatively affect self-image. Indicators #2 and #8 occurred with equal frequency. Another recurring indicator was #7, pertaining to the presence of a condition that could require a change in education, employment, and/or family role. Other indicators appeared four times or less. This was not surprising with the predominant number of patients suffering from catastrophic illnesses where related indicators pertaining to the presence of negative self-image or change in job or family role occurred with a correspondingly high frequency. All screens reviewed in the literature contained one or more criteria relevant to catastrophic illness because of the propensity of these patients to utilize community resources (e.g., see: AHA, 1984a; Coe et al., 1986; Hanley, 1985; Texas Medical Foundation, 1986). The studies commissioned by the HCFA showed that DRGs related to illnesses and conditions of a catastrophic nature are at high risk for needing discharge planning (Bragg & Lovdale, 1986; Coe et al., 1986).

Figure 4 categorizes the frequency by ward of the five most common indicators circled on the 297 data-retrieval sheets. In addition to the three indicators previously described, #13, pertaining to patients in the terminal stage of illness, and #17, pertaining to patients who routinely take six or more medications, are listed. These indicators are also associated with catastrophic illnesses.



*No assessments denoted the indicator in question.

#12--Presence of catastrophic illness

7--Presence of condition requiring change in education, job, or role

8--Presence of condition that will negatively affect self-image, appearance, or sexual functioning

#17--Requirement for six or more medications per day

#13--In terminal stage of illness

Figure 4. Frequency distribution of selected indicators by ward.

The frequency distribution in Figure 5 categorizes the total number of assessments performed by ward differentiated by the number of cases where indicators were present and a referral to rounds was made and the number of times the cases were not presented in rounds despite the presence of indicators for discharge planning. The fact that approximately the same number of patients were discussed in rounds on each ward regardless of the total number of patients who met the criteria for eligibility for presentation in rounds was probably due to rounds being limited to 20 or 30 minutes once a week with an average of three patients presented each session. The presence of one or more indicators for discharge planning or of one particular indicator did not appear to influence the decision to discuss a patient in rounds.

In order to provide a more meaningful analysis of the data available from this study and to prevent inaccurate assumptions from being inferred, an effort was made by the researcher to determine just how patients were selected for presentation in rounds. Discussions with the Center Discharge Planning Coordinator revealed that, in order to gain physician support and participation in rounds, the decision was made to subjectively select patients that specifically required physician input to develop a discharge plan or that would be of particular interest to the physician. The rounds are viewed as a communication mechanism with physicians and a means to educate physicians about discharge planning. The

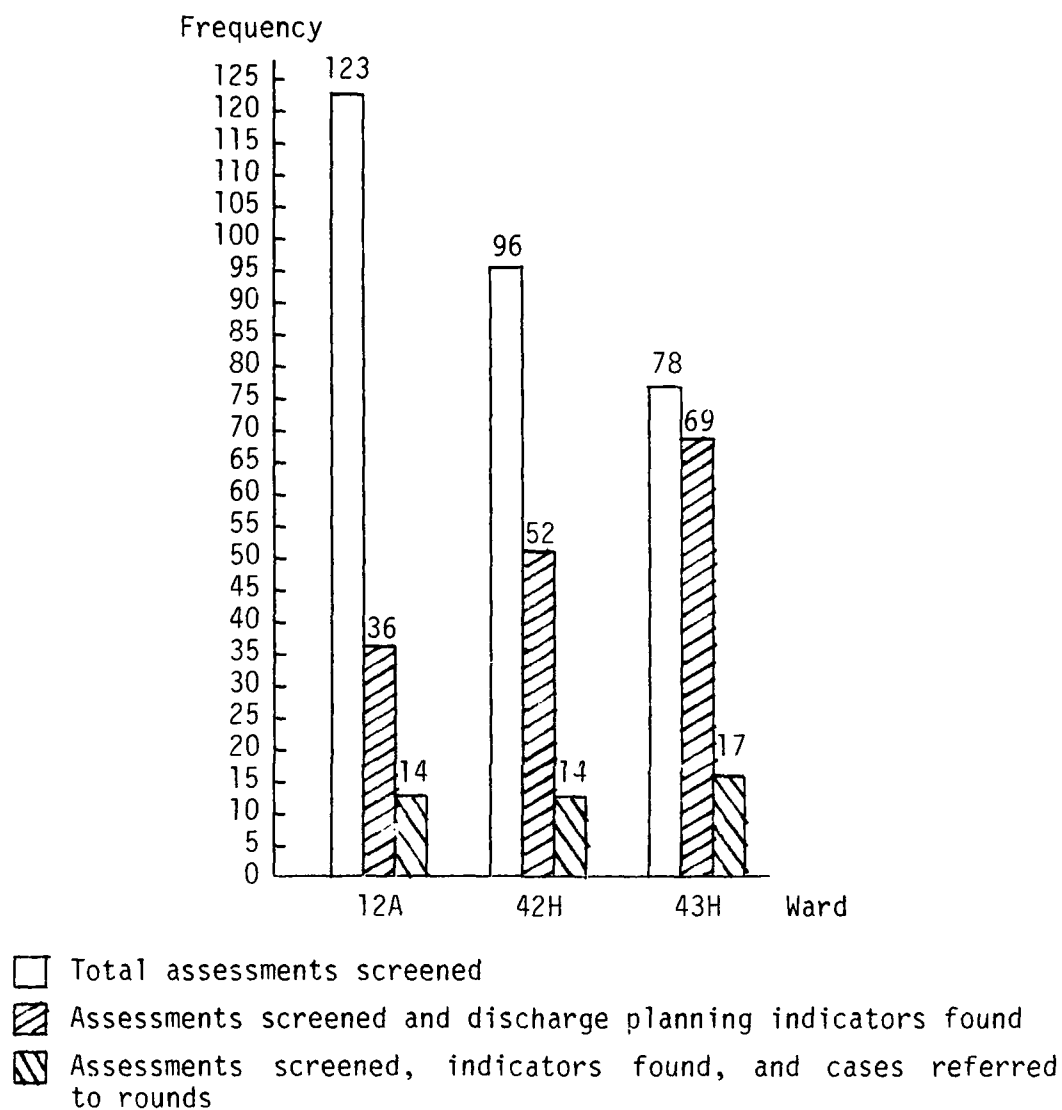


Figure 5. Frequency distribution of assessments with and without discharge planning indicators displayed by ward.

success of rounds is being judged by whether or not a physician is present.

A head nurse on one of the study wards related to the researcher at the conclusion of the data-gathering period that the

nursing staff feel that discharge planning is being accomplished with excellent communication between the assigned social worker and the nursing staff and thus the nursing staff see no need for or benefit from discharge planning rounds in terms of improved discharge planning.

Another pertinent comment made to the researcher during the data-gathering period came from an intern. The physician pointed to a patient's name on the bed assignment board who was a very complicated discharge planning case and commented that, if the researcher was interested in discharge planning, the patient in question would test the researcher's discharge planning skills as no one had been able to "get rid of" the patient. This remark relates to the attitude so well described in Mizrahi's (1986) book so aptly titled Getting Rid of Patients: Contradictions in the Socialization of Physicians, wherein she describes the internship rituals and the training processes of residencies that encourage intern and resident to view discharging patients as doing whatever one can think of to "get rid of" patients. Though the comments cited may not be representative of all staff members involved in the study, the literature supports the fact that knowledge of what discharge planning is and of attitudes about the process are significant variables to consider and address in order to implement a successful discharge planning program (e.g., see: Crittenden, 1983; David, 1973; McKeehan, 1981).

The researcher was also concerned about the large number of patients for whom discharge planning indicators were present but who were not selected for rounds. The pie chart in Figure 2 shows that 38% of the sample had indicators present but were not referred to rounds. It is important to note that this does not mean that the patients did not receive discharge planning. In order to determine if referrals were made, intake logs from both Social Work Service and Community Health Nursing were reviewed for the time period 14 March 1987-15 June 1987. There were only six referrals to Community Health Nursing from the wards involved in the study. Three of these patients had been discussed in rounds and three had not. The researcher had conducted an assessment for all six patients, with five of the six registering the presence of catastrophic illness.

Department policy concerning documentation of inpatient referrals by Social Work Service requires three or more inpatient visits before a department file is initiated. A more accurate picture of the degree of Social Work Service involvement was obtained by securing a computer printout of all inpatient Social Work Service contacts made for the purpose of discharge planning as documented on the Ambulatory Care Data Base Patient Encounter Form, better known as a "bubble" sheet. All patients seen for the specific purpose of discharge planning from the Urology, the Oncology, and the Neurosurgical Service from 15 March 1987 to

15 June 1987 were identified by the last four digits of their Social Security numbers, the date(s) of Social Work Service contact, and the inpatient medical service. There were 462 patients who received Social Work Service discharge planning contacts within the parameters previously described. Of this number, 116, or 25%, had multiple contacts reported. The researcher was able to match the last four digits of the Social Security number and the hospitalization time for 168 of the patients for whom bubble sheets were completed against corresponding data-retrieval sheets from the study sample.

Table 2 demonstrates by ward how many patients assessed by the researcher having discharge planning indicators present were in fact seen by Social Work Service staff for purposes of discharge planning. Collectively, 72% of the patients for whom the researcher had identified potential need for discharge planning in the group not referred to rounds were seen by Social Work Service staff for discharge planning. Additionally, 47 of the 140 patients assessed by the researcher as not having discharge planning needs as ascertained from a review of the nursing admission assessment were seen by Social Work Service personnel for discharge planning.

It was not within the purview of this study to ascertain what discharge planning needs were met by Social Work Service for this group of patients. Additional studies would have to

Table 2

Comparison of Discharge Planning Encounters by Social Work Service (SWS) as Documented by the Ambulatory Care Data Base with Patients Assessed for Discharge Planning Needs by the Research Data-Retrieval Tool

Ward	Patients with Indicators Present/Not Referred to Rounds		Patients with Indicators Present/Referred to Rounds		Patients with No Indicators Identified/Seen by SWS	
	SWS	Study	SWS	Study	SWS	Study
12A	15	of 55%	27	8 of 57%	23	of 33%
42H	34	of 90%	38	8 of 57%	12	of 26%
43H	38	of 68%	56	17 of 100%	6	of 66%
Total	87	of 72%	121	33 of 73%	47	of 33%

be conducted to evaluate any qualitative aspect of discharge planning. This study was quantitative and did not address qualitative issues specifically.

Summary

This study was concerned with use of the nursing assessment as a mechanism for screening patients for the presence of one or more universal indicators of discharge planning. It was conducted as part of the evaluation of the discharge planning process at BAMC. The implementation of the revised BAMC policy included the introduction of discharge planning rounds on three wards selected by the Center Discharge Planning Committee. Using the standard operating procedure (see Appendix D) to define the conduct of discharge planning rounds as a reference, the researcher wrote a study proposal with the assumption that the standard operating procedure would be followed. This assumption proved to be incorrect. The procedure was not adhered to in the following respects:

1. Lists of patients to be discussed in rounds were not published routinely in advance of rounds.
2. Minutes of rounds did not specify the discharge planning indicator(s) that caused the patient to be referred to rounds.
3. Discharge planning rounds were not held every week.
4. Patients were selected for discussion based upon whether or not the case would be of interest to the physician and not

according to the presence of universal indicators for discharge planning.

The researcher had predicted, as an independent evaluator of the presence of discharge planning needs, that patients with such requirements could be identified at least 95% of the time using the nursing admission assessment as the sole source of patient information. The study revealed that, in all cases of the patients presented in rounds, the nursing assessment as documented on DA Form 3888/3888-1 provided sufficient information for the researcher to be able to discern one or more indicators of the need for discharge planning. Whether or not the researcher and the ward nursing staff selected the patients for discussion in rounds based upon the same indicator(s) could not be determined from the information available.

An analysis of the frequency with which individual indicators were the reason for selecting a patient for discharge planning demonstrated that the presence of catastrophic illness and associated conditions was the most common cause for referral for discharge planning. The functional assessment-related questions on the nursing admission history and assessment were often the basis for determining the presence of an associated effect of the presence of catastrophic illness. Specific comments concerning weight loss, skin condition, emotional status, and presence or absence of a care provider were also helpful in evaluating

the impact of catastrophic illness and foreseeing the potential need for discharge planning.

Only 53% of the sample (N=297) were determined to evince discharge planning indicators using the nursing assessment as a screen. When only 15% of the patients with demonstrated discharge planning needs were presented in rounds, the study was broadened to include a limited investigation of the productivity data in the Ambulatory Care Data Base to determine whether discharge planning had been conducted in the absence of rounds. It appeared that at least 72% of the patients with indicators present but who were not discussed in rounds were seen by Social Work Service personnel.

An area for further study would be to assess what kind of discharge planning needs were present for those 47 patients seen by Social Work Service staff for whom the researcher was unable to identify indicators for discharge planning from the information available on the nursing assessment. The question would be to determine whether it was a matter of the quality of the assessment or the elimination of patients who in reality had discharge planning needs by the universal indicators as currently written.

CHAPTER IV

RECOMMENDATIONS AND CONCLUSION

Recommendations

The following recommendations were influenced by the researcher's cognizance of current practices and developing trends concerning discharge planning as described in the literature and the present execution of the discharge planning process within the organization and structure of BAMC as observed during a 12-month period. The recommendations were written to be in consonance with the Commander's commitment to establishing an effective discharge planning program and to be in keeping with the existing philosophies espoused by Social Work Service and the Department of Nursing in regard to assignment of professional responsibility for designated aspects of the discharge planning process.

The Center Discharge Planning Committee must recognize that any "efforts to make the discharge planning process more efficient can be effective only if the process is itself well understood" (Abramson, 1985, p. 4). The Discharge Planning Committee should be more assertive in the assumption of the responsibility it has to identify discharge planning learning needs, to develop plans to meet those needs, and to evaluate the results of educational efforts. An understanding of the current process of discharge

planning must be achieved by all health care professionals. Those care providers who are required to initiate and utilize the process must contribute to the ongoing evaluation of discharge planning, to include educational needs. Finally, if the process is to be maximally effective, patient and family must be aware of the discharge planning in order to enhance their participation.

Discharge planning rounds have been operational on the three trial wards for six months as an adjunct to the discharge planning needs assessment visits by the unit-assigned social worker and the ongoing evaluation by nursing. Prior to expansion of the concept of discharge planning rounds to other wards, a survey should be conducted to ascertain from those who participated in the rounds the answers to at least some of the following queries:

1. Did the staff feel that they were adequately apprised of the purpose and the conduct of discharge planning rounds?
2. What do they view as the benefits of rounds?
3. What suggestions could they offer to improve rounds?
4. How do they perceive patients are selected for rounds?

The establishment of multidisciplinary rounds may well be the optimal concept in theory, but rounds will fall short of achieving the intended purpose if those professionals required to attend rounds do not believe in this additional duty. Indeed, those involved in rounds should assist the Discharge Planning Committee in defining the purpose and the objectives for conducting

discharge planning rounds. Also, a mechanism should be developed to evaluate the conduct of rounds as part of the evaluation of the overall discharge planning program.

If the BAMC memorandum for discharge planning continues to advocate use of universal indicators of discharge planning, then the current list should be streamlined and purified to produce a manageable listing which can be readily referenced by the staff. Nursing units in cooperation with the associated medical services should develop diagnosis/condition-specific discharge planning indicators unique to their patient population. Monitoring of the identification of these indicators and resulting appropriate responses could be one of the critical indicators of the quality of care provided.

Nursing quality assurance monitors should continue to focus on the completion of the nursing admission history and assessment form, to include completion of the discharge planning portion. At some point, nursing staff must be accountable for noting their evaluation of patients' activities of daily living capability rather than merely recording the patients' statement of functional ability. As was noted in the functional assessment study conducted at BAMC and published in 1987, patients tend to overestimate their functional performance (Carpenter et al., 1987, p. 486).

The Discharge Planning Committee should continue to promote

the use of a functional assessment index by physicians. Nursing should continue to improve the quality of the nursing admission history and assessment, but not by means of a separate discharge planning assessment tool. Rather, nursing should concentrate its efforts on how to use the existing admission assessment data base to identify discharge planning needs.

If Social Work Service continues the performance objective of visiting each patient to determine the presence of discharge planning needs, the unit-assigned social worker should review with the nursing staff the nursing admission history and assessments rather than reviewing only the physician admission notes.

Recognizing that use of universal discharge planning indicators is an accepted mechanism by which patients are screened to determine those at high risk for needing discharge planning, care must be taken to insure that the screening system does not exclude patients who have discharge planning needs but do not possess one of the indicators. Part of the ongoing evaluation of the discharge planning program should constitute a random review of patients who do not meet the screening criteria. The review should concentrate on the quality of the patient admission assessment and the corresponding development of an individualized discharge plan. As an example, there were 47 patients for whom the researcher did not discern indicators for discharge planning needs based upon the information documented in the nursing admission

assessment who were seen by Social Work Service personnel for discharge planning. These 47 patient records could be evaluated to determine specifically what types of discharge planning were not identified by the use of universal indicators as a screen.

Conclusion

This study evaluated the use of the nursing admission assessment as a basis for screening patients for the presence of universal indicators for discharge planning, and the results of the study indicate that the nursing admission assessment can be utilized to ascertain those patients with catastrophic illness and associated impact conditions present. The study was unable to correlate a relationship between the identification of discharge planning indicators and referral to multidisciplinary discharge planning rounds. In response to the findings of the study, several recommendations were made which could have beneficial effects on the performance of the Center Discharge Planning Committee, on the conduct of discharge planning rounds, on the use of universal indicators for discharge planning, and on the monitoring and evaluation of the discharge planning process as an integral component of the patient care provided at BAMC.

By nature of being a field study, this project viewed discharge planning as it is currently conducted at BAMC. The study was done as part of the evaluation of a newly implemented discharge planning program. The recommendations were designed to

enhance the more comprehensive, qualitative evaluation of the discharge planning process which remains to be performed by the Center Discharge Planning Committee. Described in the study was a statement of what exists; the recommendations are a plan for what the future can be with the continued commitment of the BAMC staff to provide the optimal plan of care within available resources.

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APPENDIX A

DEFINITIONS

DEFINITIONS

Discharge planning is an interdisciplinary process centered on the patient and family or significant other to facilitate the transition of the patient from one level of care to another. Discharge planning insures that preventive, therapeutic, rehabilitative, and psychosocial as well as medical needs are included in the assessment, planning, intervention, and evaluation process.

Universal indicators for discharge planning are those diagnoses or conditions known to have a high-risk potential for needing discharge planning.

Catastrophic illness is any condition resulting in chronic, immobilizing, or terminal illness requiring use of extensive financial and psychosocial support and extensive nursing care resources.

Nursing assessment is a continuous, systematic, critical, and orderly method of collecting, validating, analyzing, and interpreting information about the patient's ability to understand his illness, his coping ability, his desires, his beliefs, and his plans.

APPENDIX B

BROOKE ARMY MEDICAL CENTER

MEMO 40-25

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
Fort Sam Houston, Texas 78234-6200

BAMC Memorandum
No. 40-25

12 March 1987

Medical Services
DISCHARGE PLANNING

1. PURPOSE. This memorandum prescribes policies, procedures, responsibilities, and administrative details for accomplishing discharge planning as an integral part of the continuum of patient care.

2. APPLICABILITY. This memorandum applies to all categories of patients and to all practitioners and services with responsibilities for the planning, implementation, and evaluation of discharge planning within Brooke Army Medical Center.

3. REFERENCES.

- a. JCAH Manual, current edition, UR Nursing Service Standards
- b. AR 40-61, Medical Logistics Policies and Procedures
- c. AR 40-66, Medical Record and Quality Assurance
- d. AR 40-121, Uniformed Services Health Benefits Program
- e. DA Pam 40-5, Army Medical Department Standards of Nursing Practice
- f. HSC Reg 10-1, Organization and Functions Policy
- g. BAMC Memo 40-118, Quality Assurance
- h. BAMC Memo 15-1, Hospital Boards, Committees, and Councils
- i. Department of Nursing Administrative Procedure B-6

4. EXPLANATION OF ABBREVIATIONS AND TERMS.

- a. CHN. Community Health Nurse
- b. BAMC. Brooke Army Medical Center
- c. SWS. Social Work Service

*This memorandum supersedes BAMC Memorandum 40-25, 29 March 1983.

d. PEBLO. Physical Evaluation Board Liaison Office

5. BACKGROUND. Continuity of care is one of the goals of a health care delivery system with discharge planning as a vital part of the system. Discharge planning is an interdisciplinary process centered on the patient and family or significant other for the purpose of facilitating the transition from one level of care to another. It ensures that preventive, therapeutic, rehabilitative, and psychosocial, as well as medical needs, are included in the assessment, planning, intervention, and evaluation processes. Every patient benefits from and has the right to comprehensive continuity of care within the available resources of BAMC. Army policy and the community standard of care require that the discharge planning process be well defined and organized to promote achievement of the optimal discharge plan for patients within the context of effective utilization management. Discharge planning as an integral part of the continuum of care is evaluated as part of the Center quality assurance program.

6. RESPONSIBILITIES.

a. The Commander has overall responsibility for the organization, implementation, and evaluation of discharge planning as a component of patient care provided at BAMC.

b. The Deputy Commander for Clinical Services will -

(1) Supervise and control the activities of the clinical services related to discharge planning as part of assigned medical education, quality assurance, and utilization management responsibilities IAW HSC Reg 10-1.

(2) Appoint the chairperson and co-chairperson of the Discharge Planning Committee IAW BAMC Memo 15-1.

c. Social Work Service will provide support for the interdisciplinary discharge planning process by:

(1) Designating a discharge planning coordinator to manage the discharge planning activities of unit based social workers, maintain weekly contact with the medical and nursing staff on each ward to assist with identification of complex discharge planning cases, identify case managers for complex discharge planning cases, and provide periodic reports to the Discharge Planning Committee concerning implementation and evaluation of the discharge planning program.

(2) Serving as a primary resource for identification of community resources.

(3) Serving as the primary provider of post-hospitalization follow-up for the purpose of determining the adequacy of discharge planning.

(4) Documenting discharge planning assessment interviews and resulting discharge plans in the medical record, as well as in department files.

(5) Including the component of discharge planning in the ongoing evaluation of the quality of SWS.

(6) Participate in the Discharge Planning Committee IAW BAMC Memo 15-1.

d. The Department of Nursing will provide support for the interdisciplinary discharge planning process by:

(1) Identifying discharge planning considerations as part of the initial patient assessment IAW DA Pam 40-5 and DNAP B1, 2, 3.

(2) Participating in the unit level discharge planning conferences.

(3) Communicating discharge planning concerns to the unit assigned social worker and/or the discharge planning coordinator. (A specific nurse may be appointed as the primary point of contact.)

(4) Including the component of discharge planning in the ongoing evaluation of the quality of nursing care.

(5) When appropriate, nursing units will establish critical indicators for the identification of discharge planning concerns.

(6) Participating in the Discharge Planning Committee IAW BAMC Memo 15-1.

(7) Making referrals as appropriate. Patients not requiring a multidisciplinary approach to facilitate discharge will receive appropriate teaching from a registered nurse prior to discharge.

e. Physical Medicine will provide support for the interdisciplinary discharge planning process by:

(1) Including discharge planning considerations in documented patient assessments and plans of care.

(2) Participating in discharge planning conferences as appropriate.

(3) Coordinating physical medicine, physical therapy, and occupational therapy discharge plans with the case manager.

(4) Participating as a member of the Discharge Planning Committee IAW BAMC Memo 15-1.

(5) Including discharge planning as part of the ongoing evaluation of the Physical Medicine/Rehabilitation Service.

(6) Making referrals to CHN and SWS as appropriate.

f. Community Health Nurse will provide support for the interdisciplinary discharge planning process by:

- (1) Providing referrals to appropriate community agencies for skilled nursing care for both inpatients and outpatients.
- (2) Maintaining knowledge of available community resources.
- (3) Participating in discharge planning conferences.
- (4) Including utilization of community health resources in their teaching mission.
- (5) Serving as primary evaluator of the quality of services provided by community home health agencies.
- (6) Serving as a member of the Discharge Planning Committee IAW BAMC Memo 15-1.

g. Directorate of Logistics will provide support to the interdisciplinary discharge planning process by:

- (1) Managing the Home Benefits/Home Loan Program IAW AR 40-61 and AR 40-121.
- (2) Participating as a member of the Discharge Planning Committee IAW BAMC Memo 15-1.

h. Directorate of Patient Administration will support the interdisciplinary discharge planning process by:

- (1) Managing the air evacuation office, to include coordination with physicians and case managers.
- (2) Screening all records for compliance with documentation standards for comprehensive discharge notes.
- (3) Responding to requests for medical record data by authorized extended care facilities, home care providers, and other health care facilities.
- (4) Providing assistance for patient care evaluation studies concerned with discharge planning.
- (5) Coordinating with physicians and case managers concerning the discharge planning needs of patients on the long-term patient roster and those processing through the PEBLO.

i. Directorate of Nutrition Care will provide support for the interdisciplinary discharge planning process by:

(1) Providing nutrition counseling in both the inpatient and out-patient settings.

(2) Coordinating with the physician and case manager when nutrition concerns are part of the discharge plan.

(3) Making referrals to SWS and CHN as appropriate.

(4) Participating as a member of the Discharge Planning Committee IAW BAMC Memo 15-1.

j. The medical staff of all services will provide support for the interdisciplinary discharge planning process by:

(1) Designating a physician for each discharge planning case who will document the discharge status as part of the admission assessment.

(2) Making timely referrals as appropriate.

(3) Participating in discharge planning conferences as appropriate to include acknowledgement of the conference note in the patient's medical record.

(4) Including discharge planning considerations in the ongoing evaluation of patient care as conducted by the generic screen and department specific chart review.

(5) Participation in the Discharge Planning Committee IAW BAMC Memo 15-1.

7. ADMINISTRATIVE DETAILS.

a. Documentation of plans for continuity of care and/or follow-up required after discharge will be provided in the medical record or SF 513 (progress notes) for every patient.

b. Documentation of the nursing assessment and plan of care to include discharge indications will be entered on DA Form 3888-1.

c. Any member of the health care team may initiate referrals to SWS or CHN.

d. The Discharge Planning Committee will serve as the planning and evaluation group for the Discharge Planning Program and will function IAW BAMC Memo 15-1.

e. Referrals for discharge planning will be initiated as soon after admission as possible to allow adequate time for non-physician health care providers to accomplish planning goals. Discharge planning cases usually include, but are not limited to, those categories of patients shown in Appendix

A (Criteria of Patient Categories/Diagnoses with Indications for Discharge Planning), Appendix B (Discharge Planning Screens), and Appendix C (Discharge Planning Screen for Drug/Nutrition Interactions).

f. Referral of all patients for coordinated, multidisciplinary discharge planning will be brought to the attention of the discharge planning coordinator through contacts/coordination with hospital staff, ward discharge planning conferences, or orders for discharge planning in the patient's chart. The Chief, Discharge Planning Section, Social Work Service will serve as the discharge planning coordinator. The coordinator will maintain contact on at least a weekly basis with the medical staff on each ward to assist in the early identification of patients requiring a coordinated team management approach to discharge planning. The coordinator will also determine who the case manager should be for each identified complex discharge planning case. This will be accomplished through collaboration with participants at ward case conferences and through consultation. The coordinator will provide periodic reports to the Discharge Planning Committee (see BAMC Memo 15-1) on implementation of discharge planning policy changes.

g. The discharge planning case manager will be a non-physician health care provider who coordinates with the physician, patient, family, hospital staff, and community agencies to ensure final formulation and implementation of the discharge plan. The case manager will review the medical record of the patient and establish contact with the attending physician. The case manager will interview the patient if possible and, when indicated, interview the family members and/or significant others. The case manager will then prepare a concisely written initial assessment of the patient, to include problems and life situation and recommended discharge plan with the approval of the attending physician. A post-hospitalization follow-up, by letter, telephone, or in person, will be made by the case manager within 10 working days after the patient's discharge to ensure implementation of the discharge plan and to assess the patient's need for additional services. A report of the follow-up will be made to the discharge planning coordinator, and a summary of follow-up activity will be provided periodically to the Discharge Planning Committee.

APPENDIX A

Criteria of Patient Categories/Diagnoses With
Indications For Discharge Planning

1. Universal indicators. The following represent a list of recommended indicators to define patients within the health care system who could benefit from discharge planning. Any patient:
 - a. Admitted from a nursing home, a chronic care facility, or a foster home
 - b. Whose condition will affect the ability to return home
 - c. With no known family or adequate social and financial support systems
 - d. Who is a suspected victim of abuse, neglect, or violence
 - e. Exhibiting prolonged fear and/or anxiety about recommended medical procedures
 - f. With identified problems whose medical compliance hinges on adequate housing and/or physical conditions
 - g. Whose condition will necessitate a change in education, employment, and/or family role
 - h. Whose condition has resulted in identified problems that will negatively affect self-image, physical appearance, and/or sexual functioning
 - i. Whose identified family problems directly affect care, treatment, and medical compliance
 - j. Or patient's family, who exhibits behavior which is disruptive to treatment
 - k. Who is nonresident of the catchment area and who has an illness which will affect the ability to return home
 - l. Admitted for treatment as a result of a catastrophic illness
 - m. In the terminal stages of illness
 - n. Whose hospitalization and/or medical compliance depends upon specific concrete supports in the home
 - o. Postpartum or newborn identified as high risk
 - p. Requiring the use of medical equipment after discharge

2. General categories/diagnoses of patients that usually indicate a need for discharge planning.

a. Social

- (1) Admitted from a nursing home
- (2) Elderly, living alone, no known relatives
- (3) Over 65, living with an incapacitated person
- (4) Family unwilling or unable to take patient home on discharge
- (5) Any patient admitted but not permanently assigned to the local catchment area

b. Medical/surgical. Any of the following conditions that may require long-term care in another health care facility.

- (1) Failure to thrive, malnutrition/dehydration
- (2) CVA or paralysis
- (3) Fracture of the hip, femur or pelvis, or multiple fractures
- (4) Metastatic cancer
- (5) Organic brain syndrome
- (6) Chronic renal failure
- (7) Head injury/surgery or coma
- (8) Parkinson's disease or other chronic disability
- (9) Amputation
- (10) Colostomy or diverting surgery
- (11) Tracheostomy
- (12) Severe decubitus ulcer

3. Specific service indicators. The following are not universal indicators, but rather apply to a particular service. (These, in addition to the universal indicators, can be incorporated into the audits.)

a. Medical. All universal indicators

b. Neurology

- (1) All universal indicators
- (2) Any patient whose illness impairs decision-making capacity

c. Newborn nursery

- (1) All universal indicators
- (2) Infants who are not expected to live or who have been born with abnormalities
- (3) Infants who are premature or of unexpected multiple births
- (4) Infants whose parents are considering adoption or foster care or who have a questionable ability to provide care for an infant
- (5) Infants who develop unexpected illnesses

d. Obstetrics/Gynecology

- (1) All universal indicators
- (2) Patients under 18 years of age
- (3) Patients having unexpected multiple births or premature infants
- (4) Patients who have received no prenatal care
- (5) Patients who exhibit excessive worry about infant care
- (6) Patients with a history of drug abuse
- (7) Patients being worked up or treated for sexually transmitted diseases
- (8) Patients who deliver infants with anomalies
- (9) Patients without a spouse or a support system in the catchment area

f. Pediatrics

- (1) All universal indicators
- (2) Suspected failure to thrive and/or congenital anomaly
- (3) Suspected abuse/neglect

g. Psychiatry

- (1) All universal indicators
 - (2) Patients being referred to other community agencies or resources or being transferred to other military facilities
- h. Surgery. All universal indicators

APPENDIX B

Discharge Planning Screens

1. Elderly who live alone
2. Teenage parents
3. Cerebral vascular accident
4. Elderly orthopedic patients to include prosthetic patients
5. Amputees
6. Chronic progressive debilitating diseases
7. Alcoholism
8. Head or spinal cord trauma
9. Neurological conditions with severe dysfunction
10. Renal dialysis
11. Child abuse/neglect
12. Spouse abuse
13. Children with serious illnesses, injury, or chronic progressive diseases, or death of a hospitalized child
14. Multiple social problems
15. Chronic mental illness
16. Adult patient unable to care for self
17. Patient transferred from a nursing home or another medical treatment facility
18. Chronic obstructive pulmonary disease
19. Complicated fractures
20. Terminally ill patients
21. Patients prescribed six (6) or more medications
22. Complicated deliveries resulting in premature birth, birth defects, or death
23. Ostomy patients
24. Coronary bypass patients

APPENDIX C

Discharge Planning Screen
for
Drug-Nutrient Interactions

JCAH requires that patients be given instruction on drug-nutrient interactions prior to discharge. The following drugs have been identified by BAMC physicians as having potential for problems in respect to drug nutrient interaction. Request patients' records be screened prior to discharge for the following drugs:

Tetracycline
Warfarin
Erythromycin Sterate
Penicillin V Suspension
Digoxin Capsules
Erythromycin Ethylsuccinate Suspension
Theophylline
Cephalexin Capsules
Metronidazole Tablets
Minocycline
Isotretinoin

Names and ward number of patients who will be discharged on the above drugs should be forwarded to Clinical Dietetics Branch for appropriate action. Counseling will be documented in the patient's record.

The proponent of this memorandum is the Social Work Service. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to the Commander, BAMC, ATTN: HSHE-SW, Fort Sam Houston, Texas 78234-6200.

FOR THE COMMANDER:

OFFICIAL:

B. K. HELTON
Colonel, MS
Chief of Staff



DEBORAH K. KNICKERBOCKER
Captain, MS
Chief, Administrative Services

DISTRIBUTION:

A plus
10 to Social Work Service

APPENDIX C

PROPOSED JOINT COMMISSION ON ACCREDITATION OF
HOSPITALS STANDARD FOR CONTINUITY
OF CARE

PROPOSED JOINT COMMISSION ON ACCREDITATION OF
HOSPITALS STANDARD FOR CONTINUITY OF CARE

PHILOSOPHY

Continuity of care is an integral part of the health care delivery system which includes physicians' offices, clinics, health maintenance organizations, hospitals, home health agencies, extended care facilities, and rehabilitation centers. The discharge planning process is an interdisciplinary approach that is centered on the patient and family or significant other to facilitate the transition of the patient from one level of care to another. It insures that preventive, therapeutic, rehabilitative, and psychosocial as well as medical needs are included in the assessment, planning, implementation, and evaluation process. Every patient benefits from and has the right to quality, coordinated continuity of care within available resources as an integral part of total patient care.

PRINCIPLE

Each hospital shall have in operation an organized continuing care program that assists with the provision of timely, achievable, quality discharge plans for patients utilizing available resources. The goals of the program shall be compatible with the goals of the hospital for high quality and effective patient care.

STANDARD I--ORGANIZATION

There shall be evidence of a well-defined, well-organized interdisciplinary program designed to enhance continuity of care. Written policies and procedures that reflect optimal standards of practice shall guide the provision of continuity of care. The program shall be in accordance with the goals and objectives of the hospital.

STANDARD II--DISCHARGE PLANNING PROCESS

Discharge planning is an ongoing, interdisciplinary process. Each hospital department that has a direct effect on patient care shall

enhance continuity of care through the appropriate utilization of hospital services, institutional facilities, and community resources. The discharge planning process shall be integrated and coordinated by health care professionals.

STANDARD III--PATIENT/FAMILY/
SIGNIFICANT OTHER PARTICIPATION

Patients and/or family and significant others shall be informed and shall have access to health care professionals who will provide individualized, goal-directed discharge planning. Informed, patient-centered decision-making is an essential component of the planning process.

STANDARD IV--DOCUMENTATION

There shall be clear documentation of the discharge planning process in the patients' permanent medical records. Documentation is to include but not be limited to patients' continuing care needs and the discharge planning process.

STANDARD V--REVIEW AND EVALUATION

There shall be mechanisms for the regular review and evaluation of the quality and the appropriateness of continuing care practices and functions. Such mechanisms shall be designed to attain optimal achievable standards of continuity of care.

STANDARD VI--PROFESSIONAL PREPARATION

Continuing care professionals shall be prepared through appropriate education and orientation programs for their responsibilities in the provision of discharge planning. Health care professionals shall show continued efforts to maintain a high level of current knowledge in the field of continuity of care so as to meet both the patients' and the hospital's needs within the health care delivery system.

Taken from: Access, 5(2).

APPENDIX D

WARD DISCHARGE PLANNING CONFERENCE

STANDARD OPERATING PROCEDURE

WARD DISCHARGE PLANNING CONFERENCE

STANDARD OPERATING PROCEDURE

Ward discharge planning conferences will be held in accordance with the following policies:

1. Ward discharge planning conferences will be held every week at the same time.
2. The time of the conference will be determined by the ward head nurse and will remain constant.
3. The physician of record for a patient who is to be discussed at the conference, the ward head nurse, and the social worker for that ward are required to attend the conference.
4. Other health care providers for patients to be discussed will be invited and encouraged to attend in order to provide the best comprehensive care.
5. The social worker will be responsible for maintaining the list of patients to be discussed for discharge planning. Potential discharge planning cases should be brought to the attention of the social worker by all health care providers (e.g., ward nurse, physician, etc.) for inclusion as early as possible after admission.
6. The discharge planning coordinator will insure that other professionals involved (or professionals who should be involved) in the cases to be discussed are notified to attend the ward discharge planning conference.
7. The ward discharge planning conference is not to duplicate other teaching/case conferences but rather is intended to provide a task-oriented, problem-solving, coordinated venue to develop and implement multidisciplinary discharge planning. As such, the discussions should be limited to only those patients who have discharge planning risks.
8. The ward head nurse will chair the ward discharge planning conference.
9. The ward social worker will take minutes of meetings and compile a short patient-by-patient discharge plan which will

be submitted to the Discharge Planning Coordinator, Social Work Service (SWS). The Discharge Planning Coordinator will be responsible for insuring implementation of the plan.

10. The ward social worker will be responsible for entering the results of the ward discharge planning conference in each patient's record following the meeting. This notation will include recommendations for discharge with delineation of responsibilities for each care provider and actions to be taken with responsibilities delineated.
11. The Discharge Planning Coordinator, SWS, will develop a quality assurance monitor that will permit continuous review of inpatient records to evaluate the discharge plan for (a) appropriateness, (b) timeliness, and (c) implementation. Problems surfaced by this monitor will be brought to the attention of the Brooke Army Medical Center Discharge Planning Committee for resolution.
12. The Discharge Planning Coordinator, SWS, will develop a discharge planning record within the SWS that will permit rapid information access and provide for improved discharge planning and posthospital evaluation.
13. The Discharge Planning Coordinator, SWS, will develop a method of evaluating the test of the ward conference system on the three wards under consideration. This test will include, but not necessarily be limited to, a survey of health care providers involved in the test. Possibly some form of patient survey should be developed. Length of stay and resolved problems may also be addressed as test monitors.
14. Evaluation procedures currently planned are:
 - a. Comparison of patients listed for discussion at the ward conference to a criterion for high risk by an independent observer. This is to measure the success of screening for discharge planning.
 - b. Comparison of the recommendations made for the patient by the ward case conference and those recommendations made by an independent panel based upon case material. This is to measure the validity of the recommendations of the case conference.
 - c. During the next two months, as the program gets underway, an evaluation of outcome (posthospital) will be developed using computerized tracking (i.e., readmission, adjustment, rehabilitation, etc.).

APPENDIX E

DA FORM 3888/3888-1

NURSING HISTORY (Continued)	YES	NO
19. Do you have any problems with your bowels (diarrhea, constipation, or other)? Aids used? If YES, explain.		
20. Do you have any problems with urinating (frequency, burning, urgency or other)? If YES, explain.		
21. Do you need help with eating, bathing, dressing, or walking? If YES, explain.		
22. Do you have any difficulty with seeing, hearing, speaking? Any special aids used (glasses, hearing aid, crutches, cane, other)? If YES, explain.		
23. Do you have any particular likes and/or dislikes we should know about to provide care for you or any religious or cultural practices you would like us to respect? If YES, explain.		
24. Do you smoke? If YES, type and amount?		
25. Do you drink alcoholic beverages? If YES, amount and frequency?		
26. What do you normally do for hobbies, recreation, etc?		
27. How do you usually handle and react to situations which upset you?		
28. Do you have any special concerns or requests that will help us to make your hospital stay easier? If YES, explain.		
29. Who do you have to assist you when you are discharged?		
SIGNATURE (Nurse)	DATE	

MEDICAL RECORD - NURSING ASSESSMENT AND CARE PLAN

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

DEMOGRAPHIC DATA

1. LOCAL ADDRESS	2. LOCAL TELEPHONE	3. LANGUAGE
	4. RELIGION	5. OCCUPATION

ADMISSION DATA

6. DATE	7. TIME	8. NEXT OF KIN
9. REASON FOR ADMISSION		10. INFORMANT

NURSING HISTORY	YES	NO	INSTRUCTIONS: USE PATIENT'S OWN WORDS WHEN POSSIBLE. USE ITEM NUMBER FOR EACH RESPONSE.
11. What has the doctor told you about your illness?			
12. What plans does the doctor have for you?			
13. Have you been hospitalized before? If YES, describe most recent hospitalization.			
14. Do you have any other health problems? If YES, explain.			
15. Did you take any medications or treatments before your admission? If YES, name, frequency, reason, last time taken, meds brought to hospital.			
16. Do you have any allergies or sensitivities? If YES, explain and describe reaction.			
17. What is your usual eating pattern? Number of meals? Snacks? Diet restrictions?			
18. Do you have any trouble sleeping? If YES, explain. Aids used?			

PATIENT'S IDENTIFICATION	REGISTER NO	WARD NO
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INSTRUCTIONS: Number and initial each recording and indicate Long(L) and Short(S) term goals.

[illegible]

DISCHARGE CONSIDERATIONS:

Patient-Family Teaching:

Special Considerations: (Sociopsychological needs, Limitations, Disabilities, etc.)

Other:

Post Hospital Disposition:

MEDICAL RECORD NURSING ASSESSMENT AND CARE PLAN (Continuation)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

ADDITIONAL ASSESSMENT DATA

SIGNATURE (Nurse)

DATE

PATIENT IDENTIFICATION

APPENDIX F

IDENTIFICATION FACTORS

IDENTIFICATION FACTORS

The following list consists of criteria which may be initially used in screening to identify patients who require assistance with discharge planning. A tool of this type should be reevaluated periodically for currency and pertinence.

- Patients older than 72 who live alone or with an invalid.
- Patients younger than 18 suspected of being abused or neglected.
- Out-of-town patients who must remain in town or return frequently for outpatient cobalt or radiation treatment.
- Patients who do not have relatives and who are unable to give information at the time of admission.
- Patients transferred to the hospital from a nursing or a foster home.
- Chronically ill patients who are being rehospitalized.
- Patients with a condition likely to cause increasing impairment.
- Patients with a terminal illness.
- Adult patients who are unable to care for themselves.
- Patients who may need special equipment at home.
- Obstetric patients who are requesting adoption services, who have had a complicated pregnancy or delivery and are from out of town, or who are mentally retarded.

The following admitting diagnoses (catastrophic or life-threatening illness) also qualify as criteria to identify patients who require assistance with discharge planning:

- Cerebrovascular accident/transient ischemic attack.
- Congestive heart failure.
- Chronic obstructive pulmonary disease.
- Diabetes mellitus.
- Kidney dysfunction/renal failure.
- Paralysis (quadriplegia, hemiplegia, paraplegia).
- Orthopedic problems that limit the patient's ability to complete activities of daily living or that occurred as a result of the patient's decreased ability to ambulate.
- Parkinsonism.
- Rheumatoid arthritis (disabling, crippling, or severe).
- Senile dementia, senility, and senile brain syndrome or organic brain syndrome in which inadequate coping is demonstrated.
- Terminal cancer (metastatic).
- Schizophrenia (chronic).

It is helpful to consider both categories of criteria when identifying a high-risk patient.

Taken from: Introduction to Discharge Planning for Hospitals
by the American Hospital Association, 1984b, Chicago.

APPENDIX G

STUDY DATA-RETRIEVAL TOOL

A review of the medical record/nursing assessment (DA Form 3888/8888-1) reveals the presence of the following: (Circle those numbers applicable to this case)

Dx:

1. Admitted from a nursing home, a chronic care facility, or a foster home.
2. Presence of condition that will affect ability to return home (chronic brain syndrome; Alzheimer's disease; fracture of hip, pelvis, or multiple bones; impaired decision-making capability).
3. No known family or adequate social and financial support system (over 65 and lives alone).
4. Suspected victim of abuse, neglect, or violence (failure to thrive, malnutrition, dehydration, fractures, decubitus ulcers).
5. Exhibiting prolonged fear and/or anxiety about recommended medical procedures or fear of care of infant or child.
6. Presence of problems for which medical compliance with treatment plan hinges upon adequate housing and/or physical conditions.
7. Presence of a condition that will require a change in education, employment, and/or family role (care provider for disabled person).
8. Presence of a condition that leads to problems that negatively affect self-image, physical appearance, and/or sexual functioning (colostomy, ileostomy, urostomy, mastectomy, amputation, burn, radical neck surgery, tracheostomy).

9. Presence of family problems that directly affect care, treatment, and/or medical compliance (family unwilling or unable to take patient home).
10. Patient's family/significant other exhibits behavior disruptive to treatment.
11. Nonresident of catchment area with condition that will affect ability to return home.
12. Admitted for treatment resulting from presence of catastrophic illness (metastatic cancer, chronic renal failure, Parkinson's or other chronic disability, cerebrovascular accident/paralysis, head injury, neurosurgery, coma/chronic obstructive pulmonary disease).
13. In terminal stages of illness.
14. Hospitalization and/or medical compliance depends upon specific concrete supports in the home (family unwilling/unable to take patient home).
15. Need for medical equipment after discharge.
16. History of noncompliance with previous discharge arrangements or medical plans.
17. Requiring six or more medications routinely.
18. Postpartum or newborn identified as high risk (single parent, teenage parent(s), prematurity, unexpected multiple births, no prenatal care, severe birth defects, for adoption or foster care).