CANT A STANDARDISED PROCEDURE INFLUENCE THE PROCESS AND OUTCOMES OF DISCHARGE FOR OLDER HOSPITAL PATIENTS?

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Introduction. Leaving hospital can be a cause of anxiety, particularly if you feel ill-prepared. Yet this is reported to be the experience of many older people (Harding J, Model M. J R Coll Gen Pract 1989;39:17-20. Jones D, Lester C. Age Aging 1994;23:91-96). This study evaluated the influence of a standardised discharge procedure on discharge processes and patient and carer outcomes.

Method. We conducted a randomised controlled study on 10 wards in medicine and surgery, 2 of which were controls (with no intervention in the second phase). A cohort of 508 older patients (65+) was evaluated under existing procedures (phase 1), measuring the recording of discharge preparation information, length of stay, readmission, satisfaction with discharge preparation, changes in cognitive/physical functioning and in morale. A standardised procedure was implemented, after which a second cohort of 508 patients (phase 2) was evaluated in the same way.

Results. Improvements were found between phases 1 & 2 in the recording of discharge preparation information (e.g. an increase from 41% to 84% of discharge aims recorded) and aspects of satisfaction with discharge preparation (e.g. an increase from 56% to 71% of patients who reported a discussion held about their discharge (p<0.01) and an increase of 13% to 30% of carers asked about help at home (p<0.05) under the new procedure). Other process and outcome measures did not change significantly.

Discussion. The introduction of standardised guidelines for discharge from hospital can effect change. Some improvements in process and outcome were achieved but barriers to change must be addressed if comprehensive improvements are to be attained.

STANDARDISED NURSING ADMISSION ASSESSMENT AND THE COMPLETENESS OF NURSING RECORDS

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Comprehensive assessment is the recognised cornerstone of good practice of health care of the elderly. While medical records address the medical problems of elderly admissions, nursing records address how functional problems will be addressed and form the basis of the nursing care plan. An evaluation of implementing the MDS/RAI in the United States showed more complete nursing records associated with improved quality and outcome of care [1]. We have previously reported wide variation in the completeness of nursing records [2]. Audit of the nursing records of 77 patients in 6 rehabilitation wards in 2 elderly care hospitals showed that overall 45% of items were complete with wide variation between wards. We replaced the current assessment instrument with a comprehensive standardised instrument (the MDS/RAI) in one ward and re-audited the nursing records 3 months later.

The nursing records of all 24 inpatients in each of 2 wards in 1 hospital were audited by a research nurse using Senior Nurse Monitor. Ward 2 had been using the MDS/RAI for 3 months. Each ward was audited on a single day and the results input into a proprietary software package. The completeness of the records on 16 key items was analysed and compared with the initial audit.

Completeness of records improved from 23% to 35% in ward 1, from 35% to 97% in ward 2. Items on physical function and continence were complete in 48% before and 56% in ward 1 and 61% before, 96% after in ward 2, items on cognitive function and psycho-social matters in 22% before and 20% after in ward 1 and 15% before, 92% after in ward 2.

There was a clear improvement in completeness of records after introduction of the assessment instrument. Nurses were enthusiastic about using the new instrument and want to continue using it. Standardised assessment records could have significant benefit in assessing older people against criteria for continuing care, both in reducing the duplication of assessment and ensuring equity between different hospitals and services using the instrument for routine assessment.