

# Nursing role in elderly person discharge planning



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Title: Critically discuss the role of the nurse in the planning and implementation of safe discharge for the hospitalised elderly person.

1. define your understanding of discharge planning linking it to the ageing process and the reasons why older people are more susceptible to poor discharge planning.

The NHS is effectively a rationed service with a finite limit on its resources. Coast points out that one of the major limiting factors which determines the overall ability of the NHS to deliver appropriate healthcare is the number of beds which are available at any given time (Coast et al. 1996)

A direct consequence of this statement is the realisation that the availability of beds in the NHS as a whole is a reflection on the bed occupancy and also the efficiency with which potential patients can get into these beds. (Costain et al. 1992). It also directly follows that the efficiency with which patients can be safely discharged back into the community (or to other destinations) has a profound impact on the overall availability of beds for new patients.

A patient's discharge is ultimately dependent on an enormous number of interdependent variables, not the least of which are their physical, mental, emotional and financial state. (Gould et al. 1995). Clearly other factors such as their support networks and the availability of appropriate carers may play a critical role. If we accept that the elderly are more likely to be dependent as a demographic group, then it is clear that all of these issues must be addressed in a timely and positive fashion before a typical elderly patient can be safely discharged from hospital.

If we accept that it is not ideal or practical for all of these factors to be assessed by one healthcare professional, then best practice would suggest that it is appropriate to assimilate information that is available from a number of different agencies in order to allow a proper evidence based decision to be made. (Sackett, 1996). Common clinical practice is to invoke the help of a multidisciplinary discharge team.

In the context of this essay, we should note that the elderly may face a number of different discharge options and the multidisciplinary discharge team should ideally consider all of them as appropriate. We shall not discuss them all in detail here, but provide an overview of the most commonly utilised options.

Victor & Nazareth (et al 1994) point to the fact that multidisciplinary discharge planning may be subsumed by expediency in some cases where some immediately attractive schemes such as discharge to a nursing home may be employed as it requires only a modest investment of planning time but effectively shifts the patient sideways out of an acute hospital bed. Such options may appear to be attractive in the short term but the implications for the elderly patient and their family can be profound if they are not explored properly prior to discharge. (Stojcevic N et al. 1996)

Some centres utilise the mechanism of nurse-led inpatient rehabilitation care for the elderly who no longer require medical attention, but this does not address the issue of releasing hospital beds. (Steiner 1997)

The elderly, as a group, may frequently fall into a category where they are not quite well enough or independent enough to be discharged home but yet

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are not really ill enough to remain in hospital. (Closs et al. 1995). In these circumstances the multidisciplinary discharge team may consider the option of a Hospital at Home which acts effectively as a transition stage where help at an enhanced level can be provided in the short term which allows the elderly patient to be safely discharged from hospital thereby releasing the bed for another acutely ill patient and the original patient can recuperate in their own home until well. (Fulop et al. 1997)

Martin points to the fact that, in order to be effective, a multidisciplinary discharge team needs to ensure that appropriate facilities are put in place in a timely fashion prior to patient discharge. (Martin et al 1994). Failure to do this will render the whole scheme less than optimally effective, as the patients may not get the full range of appropriate facilities, not derive appropriate benefit and this may culminate in premature or unnecessary readmission to hospital, which is effectively a waste of resources. (Pound et al. 1995)

Richards (et al 1998) has provided an exemplary tour de force of the issue with a randomised controlled trial of a large cohort of patients. Their main outcome markers were, excess mortality, quality of life, cost and patient acceptability. (Coast et al. 1998) The paper is actually both long and detailed but the main findings were that all of the parameters that were measured (with one exception), showed no adverse effect of an early discharge. The differences were that there was a greater expression of patient satisfaction with the Hospital at Home scheme. (Wilson et al 1997)

2. Anatomy and physiology of the ageing process should be briefly explained.

The anatomy and physiology of aging are two subjects which are specialties in themselves and we do not presume to attempt to cover them in any detail in this essay. Russell points out that older adults are not simply a more aged version of a younger adult, they have distinct metabolic and anatomical differences that alter (for example) their nutritional requirements. As humans age their variability in nutritional need becomes greater rather than narrower. (Russell R M 2000). This type of change can be demonstrated in the fact that the older adult generally maintains their ability to absorb macronutrients well into advanced years but they lose the ability to absorb a wide variety of micronutrients. (van Asselt D Z et al. 1998)

Other areas where the aging adult is demonstrably different from the young adult is in the state of their DNA which undergoes progressive oxidation from free radicals throughout life. This has repercussions with regard to a number of disease processes such as diabetes mellitus and many types of cancer. (Gilchrest B A et al. 1997)

There appears to be a pre-programmed reduction in mitochondria content of tissues as they age. This is manifest in a number of clinical ways. Reduced strength and energy together with muscle wasting are frequent accompaniments of advancing years and may be one of the most significant factors in the rehabilitation of the elderly person. (Navarro A et al. 2007)

3. In this assignment it is important to define and discuss your understanding of ageism and ageist attitudes in relation to appropriate discharge planning.

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There are many studies which explore the subject of ageism in clinical practice. They reveal a stereotypical belief that older people are “ dull, disagreeable, inactive, and economically burdensome” (Spence D L et al. 1998)

These attitudes are still encountered in some healthcare professionals who may categorise lives into discrete stages as a means of charting progress. The expression “ Act your age” suggests that one has to comply with the cultural (rather than biological) expectations of a stage in life. These stages are commonly associated with economic power with the 40s and 50s usually being considered to be the pinnacle of life as such people tend to have good health and are most likely to have robust financial resources. (Schroots J J F 1998)

Engendering positive feelings about older people will help to produce a climate of better care for the elderly. (Puckett J M et al. 1999)

In terms of the multidisciplinary discharge team, one should clearly be aware of the fact that the elderly have different needs, requirements and abilities. The belief that this equates with a lesser status and a lower level of expectation should be actively challenged. There is no rational reason to expect an 80 yr old to be less entitled to dignity and a good quality of life than a 30 yr old.

If we consider the Rudd study (Rudd et al 1997) we can point to a hard evidence base to support the concept that active multidisciplinary discharge planning can actually produce an improvement in the quality of life indicators for the elderly if ageist stereotypes are actively challenged. It is <https://assignbuster.com/nursing-role-in-elderly-person-discharge-planning/>

fair to observe that this particular study utilised a particularly wide-ranging and apparently forward thinking multidisciplinary discharge team, but the results achieved are impressive by any analysis.

4. Explore the role of the nurse in relation to multi disciplinary team working in planning safe discharge.

By its very nature, the multidisciplinary discharge team is made up of members from a number of clinical disciplines. The role of the nurse is multifactorial. Very often the nurse is the lead organiser in the team. (Lindley et al 1995). In addition to this, the professional role of the nurse often will allow a special insight into the dynamics of the caring and support networks outside of the hospital environment. It is part of the professional nursing requirement that the nurse should also act as the patient advocate (in common with other clinical disciplines) and as such should speak up for the patient if she believes that a clinical or social need is being unfulfilled. (Roper et al. 1983)

5. consider the psychological psychosocial impact that appropriate discharge planning could have on the older person and their family.

Because of the increased likelihood of physical frailty, secondary morbidity and financial insecurity in this demographic group, increased dependence is more likely to be found in the elderly. This dependence is almost certain to be increased in the short term in the immediate aftermath of a hospitalisation. This will inevitably have a significant impact on the psychological well-being of both the patient and their carers. Depression is commonly seen (but less commonly recognised) in the elderly as they may

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struggle to cope with the demands of daily living which are also likely to be more acute after an in-patient spell. (Roper et al. 1983). Anxiety is another commonly experienced entity in both the patient and their carers as, to a degree, if planning has not been adequately carried out or inadequately explained, they may be concerned about how they are going to manage. Intuitively one can suggest that both of these factors can be significantly reduced with appropriate pre-discharge planning and intervention. (Drummond et al. 1995).

6. Appraise strategies in health promotion and rehabilitation with regard to discharge planning that can assist the older person and their family.

This is potentially a vast area as there are a great many papers which have looked at the efficacy of the multidisciplinary discharge team in the discharge planning process. As illustrative examples we can consider some of them.

The Mahoney paper suggests that the basic minimum input for a multidisciplinary discharge team should be a nurse and an occupational therapist and that these core workers should have the ability and discretion to co-opt additional specialists such as physiotherapists, geriatricians, social workers and psychologists as they feel appropriate. (Mahoney et al 1965)

Specific types of patient discharge may require specific modifications of the basic plan. Ball produced a tour de force in his paper on discharge of the elderly from a coronary care unit, (Ball et al. 2003) where patients were allowed to go home earlier than they might normally have been allowed home but with the proviso that specific teams of specialist nurses were

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available to reassess the patient in their own home and consider direct readmission if required. The team referred to in this study was comparatively unusual insofar as it was comprised six nursing staff but with different skills and experience and they referred the patients to other members of the team only if they felt that more expert input was required.

Many papers consider the role of the occupational therapist as a specific and vital entity in the discharge planning process. Gilbertson (et al. 2000) considered the various impacts that each individual professional had on the overall effectiveness of the eventual discharge and came to the conclusion that the impact of the discharge process (as measured by the Barthel quality of life indicator) was influenced by the input of the occupational therapist more than by any other individual category of healthcare professional. In making this statement, we should note that the authors were conducting a study into the discharge of stroke patients and therefore their findings may not be completely generalisable across the entire spectrum of patient discharge.

We should also note that these benefits, which were detailed at some length in the analysis section of the trial, were only demonstrable on a comparatively short term basis. Their six month follow up after discharge showed that the patients had returned to the pre-admission status of quality of life. This, in itself, should not be considered as a negative finding as ultimately, it is one of the purposes of hospital admission to try to maintain or improve a patient's quality of life

In passing, we should also note that the Logan study (Logan P A et al. 1997) produced a similar trial structure and concluded that the Social Worker had an equally important part to play in the successful discharge of the patient.

7. your discussions should address inter disciplinary practice, relevant research and government policies (including the national service framework for older people).

## Discussion

There are a great many studies that have been consulted in preparation for this essay. An overview would suggest that it is best practice to carefully assess, consider and then implement an appropriate discharge package for each patient. This has the advantage of minimising physical, psychological and practical trauma for the patient and their carers but also, (as Hensher observes) it can reduce the incidence of readmission in the immediate post-discharge period. (Hensher N et al. 1999)

The National Service Framework for the elderly makes a number of good practice recommendations together with targets and goals that have a specific impact on the whole of the discharge process. (Rouse et al. 2001). Arguably one of the most significant recommendations is the implementation of the multidisciplinary discharge team process although there is no specific recommendation as to how the team should be comprised. A number of papers have examined the impact of the various differential structures of the teams and have come to differing conclusions. We have cited some of these already but some, such as the huge STUC trial suggest that, in specific consideration of the elderly, the prime determinant of whether a patient was

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going to eventually cope at home or not was their ability to transfer “ successfully and reliably” from chair to chair and to a large extent, this was dependent on the availability of physiotherapy input. (STUC 1997)

To conclude, we should perhaps detail the structure and facilities of the “ ideal” discharge team as outlined by the STUC authors.

A hospital based outpatient clinic, geriatric day hospital, generic domiciliary physiotherapy and speech and language therapy, hospital outpatient physiotherapy, and the usual community resources. The maximum level of home care available in the study area to all patients was three one hour visits daily by a home help for personal care, meals on wheels, and community nurse visits for specific tasks.

In addition this paper also quotes details of the additional measures that were also available for the patients:-

Patients randomised to the community therapy team remained in hospital until the required package of social services care could be organised and any home adaptations undertaken whereas a store of commodes, high chairs, and toilet frames was kept by the team to expedite discharge. The patients were assessed for rehabilitation needs before discharge in conjunction with the hospital based therapists to set initial objectives and to ensure continuity of care. After discharge, patients were given a planned course of domiciliary physiotherapy, occupational therapy, and speech therapy, with visits as frequently as considered appropriate (maximum one daily visit from each therapist).

In addition to all this input, the paper comments that each patient was assessed by the team on a weekly basis for up to three months to ensure optimum utilisation of resources

The team's input base was detailed as:-

- i) Senior physiotherapist grade 1 with neurological training,
- ii) Senior occupational therapist grade 1,
- iii) Speech and language therapist,
- iv) Therapy aide.
- v) Nurse
- vi) Consultant physician

To conclude, we can consider a very valid point made by Haines (T P et al. 2004) who suggests that if proper multidisciplinary assessments take place in admission units as well as prior to patient discharge, it is quite possible that some cases may not actually need hospital admission in the first instance.

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