EMERGENCY NURSES ASSOCIATION

Position Statement

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Safe Discharge from the Emergency Department

Description

Millions of patients are seen in the emergency department (ED) annually for various reasons,[1] and it is essential that these patients receive appropriate preparation for their return home in order for them to properly manage their recovery.[2] A large minority of ED patients return to the ED frequently and account for a disproportionately sizable share of overall costs and visits.[1] ED discharge failure, such as ED return within 72 hours or more, poor compliance, and/or lack of comprehension of discharge instructions, carries significant clinical implications for patients, including unfinished treatments and progression of illness.[2] The Agency for Healthcare Research and Quality (AHRQ) defines a high-quality ED discharge as containing three main characteristics:[2]

- Education of the patient on their diagnosis, prognosis, treatment plan, and anticipated course of illness
- Post-ED discharge care, which may include medications, home care for injuries, medical equipment or devices, additional diagnostic testing, and further healthcare provider evaluation
- Coordinated ED care within the context of the healthcare system including other referrals, social services, or other types of follow-up services.

The transition to home after discharge is a time of high-risk for patient noncompliance and communication failures.[3–9] There are various barriers that exist in the ED environment that may hinder the discharge process, and there are certain risk factors for discharge failure.[2] In addition, emergency nurses provide discharge instructions in an environment that is less than optimal for teaching and learning.[11,12] Materials used for discharge can include wording at an education level above the average patient's eighth grade reading level.[12–14] Clear relationships have been reported to exist between the patient's understanding, the thoroughness of discharge instructions, and hospital readmission rates.[15–17] Additional studies measuring the effectiveness of discharge instructions have revealed that the length of the average patient-provider communication at discharge is four minutes[11] and up to 78% of patients did not clearly understand their instructions.[3,5,12] As a result, it has been suggested that improvements to the discharge process may contribute to fewer costly acute care visits and lead to better patient outcomes.[4,10,15] Other research has linked the quality of discharge instructions to overall patient satisfaction.[10,11]

There is little research surrounding the safe discharge for at-risk patient populations, for example, patients who are impaired (due to treatment received for their illness or injury), patients who have received narcotic or sedative medications during their treatment, elderly patients who live alone, and patients who presented as a danger to themselves or others.[7] As a result, there are no simple answers to some of the legal and ethical questions related to discharge.[18–24] For instance, is the healthcare team responsible for a patient's safe transport home? Does the nurse have any responsibility for safety conditions in the patient's home or community? Is it possible to determine when it is safe to discharge a patient who has

received narcotic pain medication or sedatives? There are many issues of concern with discharging a patient safely from the ED that require more research and clearer hospital policies created by interprofessional teams. Emergency nurses have an opportunity to be more involved in the discharge planning process, the creation of clear policies and procedures, and the responsibility to ensure a patient's safety while being discharged.

ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Discharge instructions are an essential yet complex element of quality patient care and one of the most patient-centered functions that emergency nurses facilitate.

2. Accurate documentation of the delivery of nursing care, outcomes, and discharge process is key to supporting safe practice.

3. Emergency nurses work collaboratively with all members of the interprofessional team, as well as external organizations such as law enforcement agencies or community social services, to create a framework for safe patient transition into the home or community environment.

4. Emergency nurses collaborate with all members of the interprofessional team to develop policies, procedures, and practices that address the safe discharge of patients who arrive under the influence of substances or who are treated with narcotic or sedative medications.

5. Emergency nurses use resources, tools, and established best practices to assist in the provision of patient teaching, including the use of interpreter services and written discharge instructions in their preferred language (if required) and that meet the patient's and/or caregiver's health literacy level.

6. Emergency nurses advocate for and participate in evidence-based research to address the essential elements of a safe, comprehensive, and quality discharge from the ED.

Background

The safe discharge planning process begins as soon as the patient arrives in the ED. Screening for issues of concern, behavior, and/or medical problems that may impact a safe discharge can be identified at various times of the patient interaction, including during triage and/or initial assessment or during continued reassessments. According to AHRQ, social risk factors for discharge failure include lack of insurance, homelessness, lack of sufficient patient income, lack of primary care provider, poor comprehension or health literacy, and minority race/ethnicity.[2] Medical risk factors for discharge failure

include alcohol or substance dependence, psychiatric illness, physical or cognitive impairment, various and chronic medical conditions, patient age (advanced and younger), and patient sex (male).[2] Certainly, many of these risk factors are correlated, and it is challenging to determine the separate contribution of each risk.[1,2] What is known is that these factors place ED patients at risk for a variety of poor outcomes, including ED revisits, poor prescription compliance, insufficient primary care provider follow-up, and poor comprehension of discharge instructions.[2] Several screening tools have been developed to predict patients at risk for discharge failure such as the Rowland Questionnaire, the Triage Risk Stratification Tool (TRST), Identification of Seniors at Risk (ISAR), the Runciman Questionnaire, and the Hegney Tool.[2] However, a majority of the tools have low specificity, underscoring the difficulty in predicting discharge failures.[2] Thus, more research is needed to provide a better understanding of risk factors and validated screening tools to assist in predicting potential discharge failure.

Patient education occurs throughout the continuum of patient care as emergency nurses use multiple opportunities during patient-nurse interactions as teachable moments; nevertheless, the actual time of discharge is crucial to patient safety and understanding of instructions.[4,5,11] Safe discharge also ends with a focused nursing reassessment to determine the clinical condition of the patient upon intent to discharge.[25] The Joint Commission defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions"[6(p4)] – significantly impact the safe discharge.[3–6,12–14,16,18,26] The Joint Commission and the National Quality Forum both recommend the use of plain language and teach-back techniques to promote patient understanding and foster active participation from the patient in a comfortable, nonthreatening environment.[6,26–30] The opportunity for emergency nurses to teach and empower patients and/or caregivers during the discharge process is a significant component of safe practice and quality patient care.[4,6,11,22] Patients who feel engaged from the beginning are more likely to understand and adhere to their discharge instructions.[5,6,23,26,28,29]

There are tools and resources available to assist nurses with safely discharging a patient.[8,17,31–33] One example is a telephone call-back or texting program designed to help ensure that the patient understood their discharge plan or medications [8,10,17,31–33] A multitude of interventions have been tested and implemented in EDs to help improve the discharge process. Some other interventions include ED-initiated or made appointments, prescription assistance programs, transportation assistance, coordinated care, care bundles, and drop-in group appointments.[2] In general these interventions tend to be successful, some more than others, but no one intervention has been shown to be successful on its own.[2]

Another aspect of safely discharging a patient from the ED includes facilitating the best form of communication. Most ED's use certified interpreters or programs that facilitate communication with a patient who does not understand the education due to language differences. Each hospital has their own resources, policies, procedures, and protocols for facilitating language lines or certified interpreters including sign language. It is important for the emergency nurse to be familiar with the available resources in their hospital/facility and to use the appropriate services when needed.

The discharge process is complex, involving nursing judgment, critical thinking, and decision-making. It also requires objective measures to evaluate the process.[2] Establishing and using metrics can also help in evaluating the impact of any particular intervention that has been implemented. Some measurable data that may be helpful in evaluating the safe discharge process might include 72-hour return rate; ED visits per month, quarter, and year; patient comprehension of ED discharge instructions; and satisfaction with the ED discharge process.[2] Other metrics that may be helpful include percentage of follow-up telephone calls made within 48 hours of high-risk patient discharge, rate of outpatient clinic visits within one week of the ED visit, and rate of medication compliance.[2] Evaluating the discharge process through metrics is one way an ED can help to assess successful and safe discharge processes.

Emergency nurses are accountable for legal consequences of their discharge decisions.[18,22–24] In some states, legal consequence may range from breach of confidentiality, duty to warn, duty to report, and ethical issues.[22–24,34] For example, a legal issue was recently mandated in California and was passed as legislation that made it a violation to discharge a homeless person from a hospital when the weather was below a certain temperature.[22–24,34] This law also mandated that the patient be offered a meal (unless contraindicated), and if needed, weather appropriate clothing, and an appropriate supply of medication.[18,22] While legal consequences for discharge decisions might not be applicable in all states, it is essential for emergency nurses to be familiar with their own state laws and nurse practice acts.

Each patient is unique with needs that are equally unique. Discharge policies and procedures vary by institution, but each is designed with patient safety in mind. Everyone discharged from the ED deserves a well-planned discharge process that includes an assessment of their clinical stability, assures their understanding of instructions, and ensures safe transportation to their home or to the care of a capable caregiver.

Resources

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