Perspective

# Patient Safety and Quality of Hospital Discharge

Jennifer Flatman*

*Department of Nursing, Rehabilitation Hospital, Riyadh, Saudi Arabia*

## DESCRIPTION

Discharge of patients from hospitals is a complex and difficult process, accounting for more than 35 million discharges annually in the United States. Preventing preventable readmissions can radically improve both the patient's quality of life and the financial well-being of the healthcare system. Researchers in the field of transitions of care evaluate the effectiveness of different approaches to improving the discharge process. The classification scheme for classifying these interventions is to consider them as follows Pre-discharge intervention (patient education, discharge planning, medication coordination, follow-up appointment schedule). Post-discharge interventions (follow-up phone calls, communication with outpatient providers, home visits) and bridging interventions (transition coaches, patient-centric discharge instructions, clinical continuity between inpatient and outpatient settings). Hospital discharge describes the point at which inpatient hospital care ends, with on-going care transferred to other primary, community or domestic environments. Reflecting this, hospital discharge is not an end point, but rather one of multiple transitions within the patient`s care journey. The organization and provision of this transitional care typically involves multiple health and social care workers, who need to be coordinate their specialist activities so that patients receive integrated and, importantly, safe care. The inherent complexity of coordinating large number of workers, often based in distinct organizations, leads to the view that hospital discharge can be a vulnerable, time dependent and high risk episode in the patient pathway. A prominent example of this complexity is `delayed discharge`, where the patient remains in hospital because of the failure to appropriately coordinate care between agencies. Nearly 30% of older people experience some delay in their hospital discharge, which is known to expose patients to additional hospital related risks, create emotional and physical dependency, incur additional hospital costs and restrict the availability of inpatient beds. In parallel, premature discharge or discharge without appropriate arrangements for onward care can also lead to complications for patient recovery. The problem of late discharge and poor planning presents a broader challenge of integrating health and social welfare. In analysing the causes of these delays, points out many common factors, including Social welfare care Lack of release evaluation and planning, Insufficient notice of dismissal, Insufficient patient and family involvement, Excessive reliance on informal care, Lack of attention to the special needs of vulnerable groups. In light of this and other evidence, policies have repeatedly attempted to improve discharge planning, especially the integration of health and social welfare institutions.

Patient safety is largely informed by theories and research within the fields of ergonomics and human factors. In broad terms, this suggests that performance mistakes are not necessarily brought about by individual negligence, malice or incompetence, but more often by pressures located within the work environment. This line of reasoning makes the distinction between `active` and `latent` errors. The former refers to individual slips, mistakes or omissions that lead to patient harm the latter to the unsafe conditions that create, enable or exacerbate the potential for active error or patient harm. This can include poorly designed working arrangements, poor defence and early warning mechanisms or an overreliance on automation. This approach suggests that risk reduction should attend, not to individual performance alone, but to the upstream factors that make performance error prone, for example by standardising task design, improving team cohesion and communication, alleviating situational ambiguity and recognising the influence of resource management and culture.

This `systems approach` to patient safety has been articulated through policies such as To Err is Human and An Organization with a Memory, and developed through major programmes of applied health research. For example, it has been used to highlight how a range of `task`, `team`, `situational` and `organizational` factors contribute to frontline clinical safety of specific relevance to this study, this conceptualisation of safety draws attention to the way health care is organised and delivered through a system of interdependent elements interacting to achieve a common goal. Based upon these ideas, various strategies have been promoted to better understand and address the threats to patient safety. These include, for example, the use

of incident reporting procedures that allow clinicians to share their clinical risk experience and facilitate learning of the root cause of the entire system, recognizing risks, and Unprovoked organizational learning 100 and a variety of safety-enhancing interventions such as ICT and disposable devices that limit insecure behavior. The "human factors" approach provides a framework (based on Vincent 101) for conceptualizing and investigating threats to safe dismissal.

We point out that hospital discharge and patient safety, hospital-to-community discharge, are located in a complex and fragile systems including a large number of heterogeneous workers that interact in a dynamic and non-linear way. Policy and research emphasize the need for improved integration, especially in discharge planning and care transitions. However, this integration remains problematic given the complex and dynamic patterns of interaction and the diverse institutional settings in which nurse professional's work. Communication and collaborative decision-making ideas are often cited as the basis for integration. This study extends this idea by suggesting that knowledge sharing can support enhanced integration and collaboration between exchangebased system workers. Therefore, knowledge sharing is presented as a source of security (and threats) within the complex system associated with discharge and requires further empirical understanding.