Continuity of care. Patient support from hospital-to-territory care plan: protected hospital discharges

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Abstract

Purpose – To facilitate the reception and care of discharged patients, streamlining processes at the University Hospital and promoting a seamless transition to continuity of care services post-discharge.

Design/methodology/approach – Hospitalised patients undergo the Blaylock risk assessment screening score (BRASS), a screening tool identifying those at risk of complex discharge.

Findings – Pre-pandemic, patients with a medium-to-high risk of complex discharge were predominantly discharged to their residence or long-term care facilities. During the pandemic, coinciding with an overall reduction in hospitalisation rates, there was a decrease in patients being discharged to their residence.

Originality/value – The analysis of discharges, with the classification of patients into risk groups, revealed a coherence between the BRASS score and the characteristics of the studied sample. This tool aids physicians in decision-making by identifying the need for a planned discharge in a systematic and organised manner, preventing the loss of crucial information.

Keywords Continuity of care, Integrated care, Hospital discharge, BRASS index, Discharge planning, Health promotion

Paper type Research paper

Introduction

Patients and their families often struggle to comprehend the regulations within a hospital environment, as the healthcare landscape has progressively become more intricate over the years from an organisational standpoint. Consequently, there is a need to simplify the process of Safe Hospital Discharge by consolidating all relevant information for patients and their families throughout their treatment. This involves identifying the tipping points that may disrupt the process.

Safe Hospital Discharge (DOP) encompasses a series of actions constituting an organised transition from one set of care to another. It is particularly applied to "fragile" individuals,

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children, older patients and those suffering from various chronic diseases, functional impairments and/or disabilities. Patients due for discharge may need medical supervision, nursing care and/or rehabilitative care scheduled by a set of integrated care of varying duration, supplied at home or in a location different from the hospital (Shepperd *et al.*, 2013). The primary goal is to ensure the continuity of care and support (Dimla *et al.*, 2023). Additionally, this research extends its scope to include abandoned infants or minors without familial connections, ensuring their placement in a family home or facility to guarantee ongoing support.

Social workers in hospital environment address the aforementioned categories, as detailed in our Hospital Social Service Report Form (Supplementary 1). Hospital-based social workers need to acquire specific knowledge related to diseases, their consequences on patients' lives and their families, future perspectives, potential disabilities and the psychological and social impact (Odiard, 1997; Sun *et al.*, 2023).

The discharge process for the elderly involves a comprehensive health and social assessment, considering factors such as pre-hospitalization living conditions, blood tests to detect malnutrition, relational situations, signs of abandonment, behavioural traits, depression, cognitive impairment and motor degeneration affecting basic vital functions (Dotti, 2015; Agerholm *et al.*, 2023).

The process of Safe Hospital Discharge requires meticulous organisation, effective coordination and clear communication between the hospital and on-territory services. Uncoordinated and discontinuous exchange may cause patients to encounter risks that are largely described in the literature (Hunter *et al.*, 2013; Rosman *et al.*, 2015). The most frequent ones are the return to the hospital after 30 days of discharge and the inappropriate use of emergency services.

Prompt identification of "complex" discharges is crucial for the early activation of integrated social-healthcare processes, reducing recovery time and minimising adverse events for patient safety, such as pressure injuries, falls and nosocomial infections (Bert *et al.*, 2023).

Key aspects and tipping points of the discharge process include suitability for discharge, recognising risk factors for early hospital return, bidirectional communication between the hospital and territory, authorisation and preparation of patients and their families for transfer and involvement of the general practitioner (GP) or primary care paediatrician.

This planned and pre-ordered discharge process facilitates various types of transitions to different care facilities, catering to specific needs and circumstances. These include integrated home care services, palliative care, placements in family houses or communities, care for homeless adults, home care for HIV patients, non-hospital rehabilitation, long-term care facilities, psychiatric rehabilitation, neuropsychiatric facilities for minors, educational facilities, special reception units, assisted living for older individuals and those with disabilities and non-hospital hospice care.

Ensuring a safe discharge becomes especially critical when transitioning between rehabilitation facilities, preventing interruptions in care intensity. Collaboration between experts, services and families is essential to tailor care plans to meet health and functional autonomy needs.

However, challenges arise, including bureaucratic difficulties, organisational issues and prolonged waiting times, particularly affecting families and patients without familial support. As the number of patients without family connections, foreign/migrant patients and homeless patients increases, unsuccessful cooperation between hospital and territory may lead to early or unplanned discharges and irregular extensions of hospitalisation.

The overarching goal of this project is to effectively receive and provide post-discharge care for patients at the University Hospital. This involves simplifying the discharge process and enhancing access to treatments after leaving the hospital.

Specific objectives of the project include:

(1) Observing, collecting and interpreting the needs of discharged patients.

(2) Educating and advising patients and their families about on-territory services.

(3) Facilitating a consistent exchange of information between needs and on-territory services.

(4) Guiding the selection of different types of services.

(5) Categorising expressed and unexpressed needs.

(6) Supporting the admission of patients with complex social and healthcare issues by fostering customized and combined care plans to prevent inappropriate hospitalisation and delay admission for "fragile" patients to maintain their usual living circumstances for an extended period (Hyde *et al.*, 2000; Preyde *et al.*, 2009).

Methods

During the period spanning from 1st January 2018 to 31st December 2021, within the departments of the University Hospital, the social worker documented 233 patients using the Hospital Social Service Report Form (Supplementary 1). This process included conducting a Blaylock risk assessment screening score (BRASS) index evaluation at the time of assessing the health issue that led to hospitalisation and nearly at the time of discharge. Both the social worker and the nurse provided the BRASS Index.

The BRASS index (Supplementary 2) "has been realised as a part of the discharge planning for patients over the age of 65. While revising the literature and conducting fieldwork in geriatrics and gerontology, authors Blaylock and Cason (1992) established the following aspects: age, functional status, cognitive status, social support and life conditions, number of past hospitalisations/A&E admissions and number of present medical disorders. They also included behavioural patterns, mobility, sensory impairment and the number of medications; even if they are not related to functional and cognitive status, they are relevant for the elderly. The authors' expertise suggested that if the patient had taken a large quantity of medicine, there would have been a high risk of noncompliance with the therapeutic plan".

For this study, the BRASS index was employed to identify adult patients at risk of long-term hospitalisation or "complex" discharge. There was also an attempt to adapt it for minors. Data were collected by completing the scale, conducting interviews with patients or their relatives/caregivers and in the case of abandoned children, completing the scale by considering medical conditions at birth.

The BRASS index assesses the ten aspects mentioned above. The evaluation categorises patients into three risk classes: low (0–10), medium (11–19) and high (20–40).

Following the completion of the BRASS index, the social worker, along with the adult patient or their relative/caregiver and the physician, determines the type of discharge. The physician receives medical records for discharge, including the form from the Local Health Unit (ASL – Azienda Sanitaria Locale) based on the patient's residence, the regional form "multidimensional assessment of adult and older people – cognitive and functional assessment (Svama/B)" or "multidimensional assessment of people with a disability – specialised assessment for access to local services (Svamdi/B)". Specific forms are provided for adult patients in a vegetative state or in a minimally conscious state – those affected by stroke or with a broken thigh bone. The physician creates a brief clinical report and fills out a form to request the admission of discharged adult patients to rehabilitation or long-term facilities.

The completed, signed and stamped forms, along with the patient's approval (or that of those responsible for them) and their identity card, are delivered to the social worker. The social worker provides an accompanying note and submits the entire documentation to the Health Director, the "Porta Unica di Accesso" (PUA) and the local Social Services.

Subsequently, consultants from the services are contacted to establish a network for the adult patient, determining and supporting discharge at home or in residential buildings. Once

approval for access to the inpatient facility is received, the discharge date can be arranged. Discharge to ADI (return to residence by launching integrated home care services) requires authorization from the ASL. On the day of discharge, the patient is either sent home or via ambulance to the residential building. In some cases, patients may require transportation by car for humanitarian reasons.

Results

The study covers the years from 2018 to 2021, with a notable decrease in patients' hospitalisation during the last two years due to the SARS-CoV-2 pandemic.

Figures 1 and 2 depict patients reported for discharge planning (DOP). Respectively, they illustrate the total number of DOP patients and the disparity between adult and minor DOP patients.

For each year, the following variables were considered: the number of DOP cases, risk classes for "complex" discharge – analysed both collectively and individually for each year – the type of DOP in 2018 and 2021, the area of origin (medical, children, critical and surgical areas), the number of DOP patients considering the duration of assignment categorised by specific ranging levels and the age groups of adult patients.

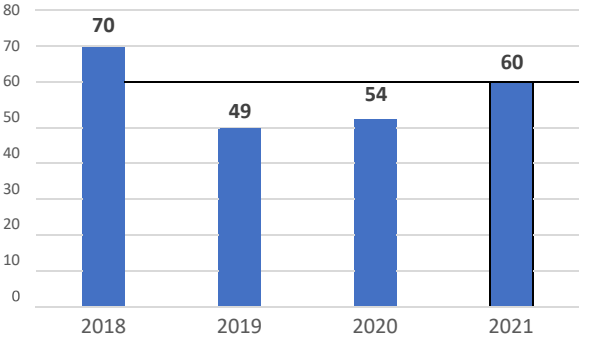

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Figure 1.
Continuity of care.
Years 2018–2021

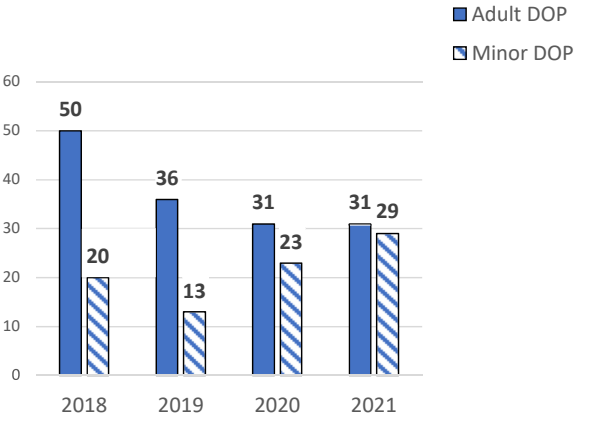

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Figure 2.
Adult DOPs vs minor DOPs. Years 2018–2021

Specifically, the percentage of patients requiring DOP represents approximately one-third of admitted patients: 36% in 2018, 28% in 2019 and 33% in 2020 and 2021. Before the pandemic, DOP requests predominantly originated from adult patients; however, during the pandemic, the number of requests from adults and minors became equal (Figure 2).

Concerning the type of DOP, for all years examined, DOP to Assisted Living Facilities (ADI) prevails, followed by DOP for rehabilitation and long-term care facilities, specifically before the pandemic years; during the pandemic, there was a decrease. Notably, during the last year, requests for DOP to child neuropsychiatric therapeutic facilities for minors rapidly increased. The data described above can be attributed to the high pre-pandemic number of adult patients' hospitalisations compared to the low number during the pandemic. Conversely, neuropsychiatric disorders in children increased during the pandemic.

Figure 3 illustrates risk classes acquired through the BRASS index applied for all years examined. For each year, it indicates that patients at high risk of "complex" discharge were prevalent before the pandemic. However, during the last year, there was an increase in medium-risk patients.

Figures 4 and 5 compare risk classes and types of discharge. Before the pandemic, DOP to ADI and residential buildings – including Special Reception Units (SUAP) and hospices – were in the high-risk class. During 2020 and 2021, DOP and ADI were in the high and medium-risk classes, while child neuropsychiatric therapeutic facilities for minors, classified as medium risk during all years and surpassed ADI during the last year.

Considering the area of origin of DOP patients, in 2018, the number of patients was evenly distributed across the areas. In 2019, patients from the medical field prevailed. During the pandemic years, the children's area was the prevailing one and accounted for half of DOP patients.

Regarding the duration of assignment for DOP patients, the following ranging levels have been classified by the number of days: <5 light load, 6–10 moderate load, 11–20 heavy load and

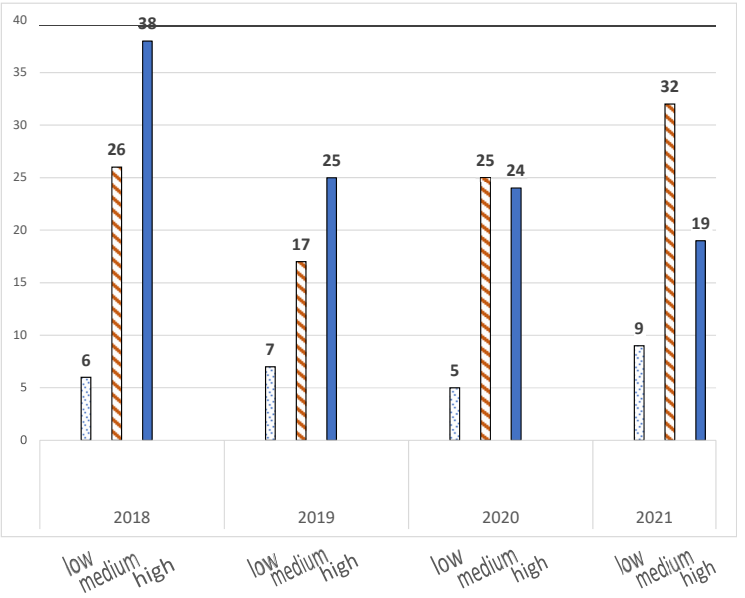

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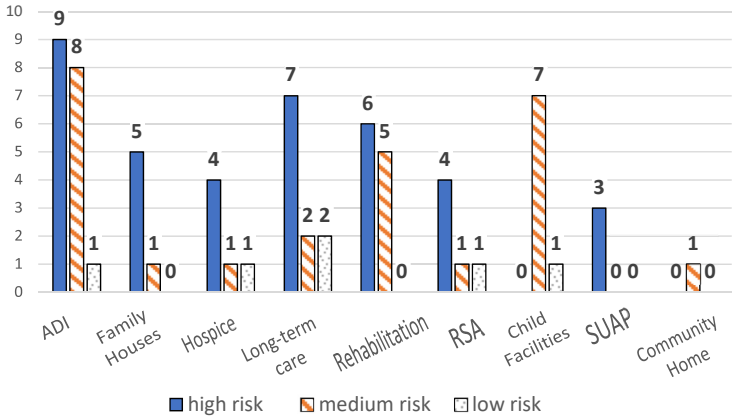
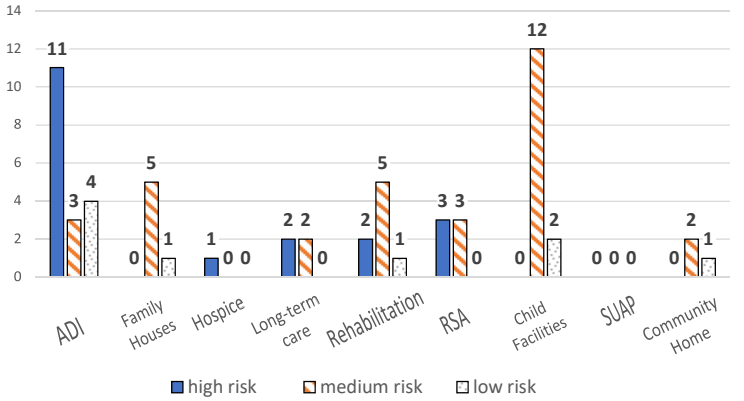
Figure 3.
BRASS index: risk classes. Years 2018–2021



Source(s): Authors' own work

Figure 4.
DOP and risk classes. Year 2018



Source(s): Authors' own work

Figure 5.
DOP and risk classes. Year 2021

>20 ultra-heavy load. Before the pandemic, ultra-heavy loads were the most numerous, suggesting longer planning and arrangements for discharge. However, during the pandemic, ultra-heavy loads decreased and light loads increased, indicating a more rapid discharge process.

In conclusion, considering the age groups of DOP patients during the years examined – which only include adult patients – in 2018 and 2019, DOP patients younger than 55 years old outnumbered those aged 65–79 years. In the subsequent pandemic years, adult hospitalisations decreased, but the prevailing age groups remained the same. Considering the gender of DOP patients, since the number of males and females is equal, the variable is not considered relevant.

Discussion (limitations and implications for practice)

In each instance where the BRASS index was employed, continuity of support for older and fragile individuals as well as child patients, was assured through prompt recognition and

documentation of "complex" circumstances in healthcare, social and social-health domains. This led to an enhancement of resource utilisation by guiding the appropriate use of on-territory services. Effective and collaborative working methods were promoted, fostering communication and coordination between the University Hospital, the "Porta Unica di Accesso" (PUA) point of care and general practitioners (GPs)/paediatricians.

Precise and detailed management of connections with the territory is crucial to ensuring a safe and swift discharge, particularly for the introduction of necessary resources (Jacob and Poletick, 2008). Managing chronic and complex cases effectively involves a holistic assessment of healthcare needs, with a focus on the social and environmental living conditions of the family. This approach helps prevent family burnout and premature, unnecessary returns to the hospital (Glasper, 2012; Hansen *et al.*, 2011).

Moreover, the University Hospital bears a legal responsibility towards patients to protect individuals by ensuring the fulfilment of their needs post-discharge. Collaboration among all professionals involved is essential to conducting a comprehensive and enhanced assessment based on their specific duties (Preen *et al.*, 2005).

Communication and information aspects are particularly crucial, given the often complex and, at times, chronic medical circumstances that have significant consequences for the lives of patients and their families. In some cases, cultural norms and family relationships or friendships may not provide sufficient support to patients and their caregivers.

Education plays a pivotal role; all caregivers undergo comprehensive training delivered by nurses, both in the hospital and on the territory. Nurses emphasise the importance of sharing detailed information, supported by demonstrations of procedures and exercises to enhance knowledge (Carroll and Dowling, 2007).

From admission, communication is aimed at helping patients and their families recognise the disease and the consequences of therapy. Knowledge must be adapted to patients and their families, addressing their questions and considering their cultural norms. Foreign patients must be treated with respect, with measures in place to prevent the involvement of intermediaries beyond language matters.

Mutual education is equally crucial among experts involved in the discharge planning (DOP) process, irrespective of their expertise – healthcare, welfare, psychology or mediation. The primary objective is to empower families and give greater authority to the chosen programme.

Through collaboration among individuals involved, the establishment of a planned and communal process for the management of hospitalisations and complex discharges has allowed greater efficiency and suitability in the medical care area.

The involvement of a social worker supported healthcare professionals and nurses, streamlining the discharge process and managing available resources to foster support between residents and on-territory services.

The BRASS index proves to be easily organised and provides valuable data to identify "complex" discharges, with high-risk patients frequently being discharged to their residence, including assisted living facilities (ADI), contrary to assertions in cited research (Mistiaen *et al.*, 1999). However, it is noted that "the index seems not enough responsive to identify patients who may have issues after discharge, probably because the older people are not properly identified during the collection of data at admission, and their conditions may worsen during hospitalisation, especially if long-term".

The recommendation is for the BRASS index to be employed both upon admission to the University Hospital and when the patient is due for discharge. Challenges arise when applying the BRASS index to child patients, as it may be less adaptable to their needs (Zarovska *et al.*, 2018). For older patients, frequent evaluations during extended hospitalisation may mitigate observed complexities in assessing functional status, recognising the dynamic nature of their conditions because "the evaluation, especially if

rigid – even when complex or helpless – guarantees consideration towards every single person and suggests confidence on the elderly's capabilities and their chances of substantially reacting to a care project" (Trabucchi, 2003).

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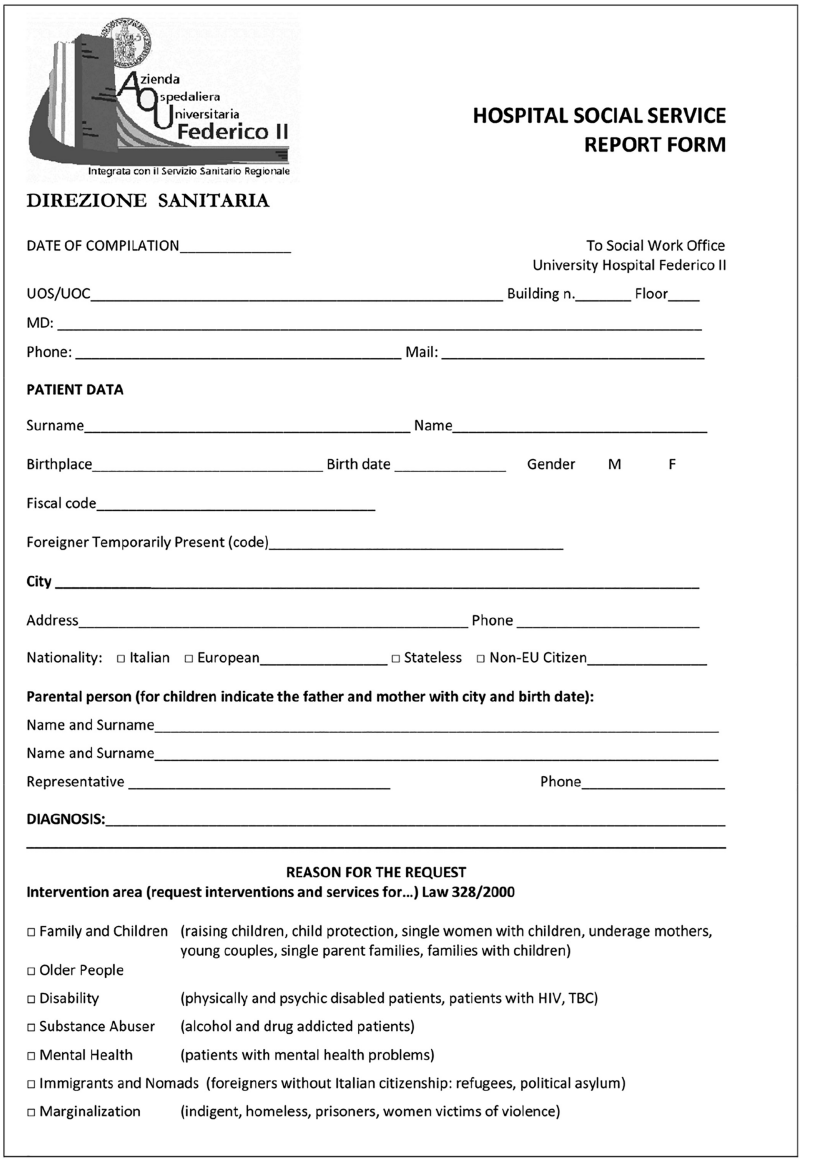
Supplementary 1



Azienda Ospedaliera Universitaria Federico II
Integrata con il Servizio Sanitario Regionale

HOSPITAL SOCIAL SERVICE REPORT FORM

DIREZIONE SANITARIA

DATE OF COMPILATION_____

To Social Work Office
University Hospital Federico II

UOS/UOC_____ Building n._____ Floor____

MD: _____

Phone: _____ Mail: _____

PATIENT DATA

Surname_____ Name_____

Birthplace_____ Birth date _____ Gender M F

Fiscal code_____

Foreigner Temporarily Present (code)_____

City _____

Address_____ Phone _____

Nationality: □ Italian □ European_____ □ Stateless □ Non-EU Citizen_____

Parental person (for children indicate the father and mother with city and birth date):

Name and Surname_____

Name and Surname_____

Representative _____ Phone_____

DIAGNOSIS:_____

_____

REASON FOR THE REQUEST

Intervention area (request interventions and services for...) Law 328/2000

□ Family and Children (raising children, child protection, single women with children, underage mothers, young couples, single parent families, families with children)

□ Older People

□ Disability (physically and psychic disabled patients, patients with HIV, TBC)

□ Substance Abuser (alcohol and drug addicted patients)

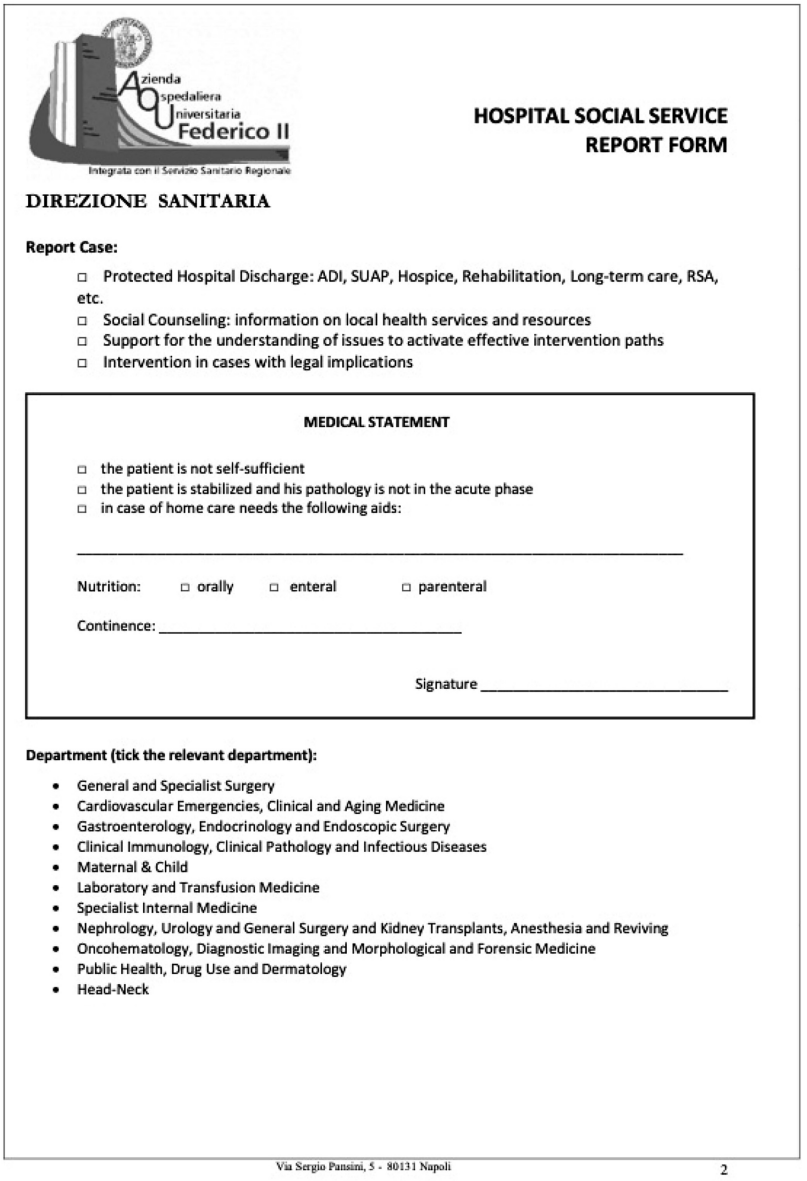
□ Mental Health (patients with mental health problems)

□ Immigrants and Nomads (foreigners without Italian citizenship: refugees, political asylum)

□ Marginalization (indigent, homeless, prisoners, women victims of violence)

Figure A1.
Hospital social service report form

(*continued*)



Azienda Ospedaliera Universitaria Federico II
Integrata con il Servizio Sanitario Regionale

HOSPITAL SOCIAL SERVICE REPORT FORM

DIREZIONE SANITARIA

Report Case:

- □ Protected Hospital Discharge: ADI, SUAP, Hospice, Rehabilitation, Long-term care, RSA, etc.
- □ Social Counseling: information on local health services and resources
- □ Support for the understanding of issues to activate effective intervention paths
- □ Intervention in cases with legal implications

MEDICAL STATEMENT

- □ the patient is not self-sufficient
- □ the patient is stabilized and his pathology is not in the acute phase
- □ in case of home care needs the following aids:

_____

Nutrition: □ orally □ enteral □ parenteral

Continence: _____

Signature _____

Department (tick the relevant department):

- General and Specialist Surgery
- Cardiovascular Emergencies, Clinical and Aging Medicine
- Gastroenterology, Endocrinology and Endoscopic Surgery
- Clinical Immunology, Clinical Pathology and Infectious Diseases
- Maternal & Child
- Laboratory and Transfusion Medicine
- Specialist Internal Medicine
- Nephrology, Urology and General Surgery and Kidney Transplants, Anesthesia and Reviving
- Oncohematology, Diagnostic Imaging and Morphological and Forensic Medicine
- Public Health, Drug Use and Dermatology
- Head-Neck

Via Sergio Pansini, 5 - 80131 Napoli 2

Source(s): Authors' own work

Figure A1.

Supplementary 2

FIGURE

Blaylock Discharge Planning Risk Assessment Screen

Circle all that apply and total. Refer to the Risk Factor Index.*

Age
- 0 = 55 years or less
- 1 = 56 to 64 years
- 2 = 65 to 79 years
- 3 = 80 + years

Living Situation/Social Support
- 0 = Lives only with spouse
- 1 = Lives with family
- 2 = Lives alone with family support
- 3 = Lives alone with friends' support
- 4 = Lives alone with no support
- 5 = Nursing home/residential care

Functional Status
- 0 = Independent in activities of daily living and instrumental activities of daily living

Dependent in:
- 1 = Eating/feeding
- 1 = Bathing/grooming
- 1 = Toileting
- 1 = Transferring
- 1 = Incontinent of bowel function
- 1 = Incontinent of bladder function
- 1 = Meal preparation
- 1 = Responsible for own medication administration
- 1 = Handling own finances
- 1 = Grocery shopping
- 1 = Transportation

Cognition
- 0 = Oriented
- 1 = Disoriented to some spheres† some of the time
- 2 = Disoriented to some spheres all of the time
- 3 = Disoriented to all spheres some of the time
- 4 = Disoriented to all spheres all of the time
- 5 = Comatose

Behavior Pattern
- 0 = Appropriate
- 1 = Wandering
- 1 = Agitated
- 1 = Confused
- 1 = Other

Mobility
- 0 = Ambulatory
- 1 = Ambulatory with mechanical assistance
- 2 = Ambulatory with human assistance
- 3 = Nonambulatory

Sensory Deficits
- 0 = None
- 1 = Visual or hearing deficits
- 2 = Visual and hearing deficits

Number of Previous Admissions/ Emergency Room Visits
- 0 = None in the last 3 months
- 1 = One in the last 3 months
- 2 = Two in the last 3 months
- 3 = More than two in the last 3 months

Number of Active Medical Problems
- 0 = Three medical problems
- 1 = Three to five medical problems
- 2 = More than five medical problems

Number of Drugs
- 0 = Fewer than three drugs
- 1 = Three to five drugs
- 2 = More than five drugs

Total Score:

*Risk Factor Index: Score of 10 = at risk for home care resources; score of 11 to 19 = at risk for extended discharge planning; score greater than 20 = at risk for placement other than home. If the patient's score is 10 or greater, refer the patient to the discharge planning coordinator or discharge planning team.
†Spheres = person, place, time, and self.

Source(s): Blaylock & Cason (1992)

Figure A2.
Blaylock risk assessment screening score (BRASS index)