Is a pre-discharge checklist useful?

Abstract—A pre-discharge checklist of requirements for equipment, services, benefits and follow-up has been developed in a general rehabilitation unit. An analysis of 66 inpatients discharged after rehabilitation following a stroke or amputation within the past 2 years suggests that such a checklist is a useful tool in ensuring that patients are sent home with optimum services and support. It is also a simple way of recording discharge data for audit and quality control purposes. It may be of benefit to a wider range of hospital services.

Planning the discharge of disabled patients from hospital, so that requirements for services, equipment, benefits, outpatient therapy and follow-up may be identified and arranged, is an integral part of rehabilitation. The Community Care Act 1992 made discharge planning the responsibility of the Social Work (Services) Department but it can be incorporated effectively and efficiently into the pre-discharge case conference of the multidisciplinary team involved in the patient's rehabilitation.

We have developed a one-page checklist (Fig 1) to help the care team provide the usual appropriate support for patients after discharge from the rehabilitation unit. The form is completed by ticking the relevant boxes to indicate whether or not a particular piece of equipment or service is required and, if so, whether this has already been provided or requested from the relevant source. The name of the person responsible for making the requisite arrangements is entered in the last column.

Is the checklist useful?

We examined the casenotes of 100 patients, selected at random, who had been discharged from the unit since the introduction of the checklist in April 1992. If present in the notes, the data from the checklist were entered on a proforma. If no checklist could be found, data that would normally have been entered in the checklist were abstracted, as far as possible, from medical and paramedical notes and entered on the same proforma.

Patients were divided into two main groups on the basis of their diagnoses. One group of 34 patients had longstanding disabilities such as arthritis or chronic neurological problems. They were admitted for a particular purpose for a finite period of inpatient stay (usually 1–2 weeks) during which their requirements changed little. The other group comprised 39 patients who had undergone lower limb amputation and 27 who had had a cerebrovascular accident. Their abilities changed considerably while in the rehabilitation unit, and their requirements for equipment, benefits and services following discharge were quite substantial. Their data were separated into two subgroups depending on whether or not a discharge checklist had been completed. They were similar in terms of age, sex, diagnostic categories and length of stay. For the subgroup of patients for whom a checklist had been completed, significantly more services had been arranged ($p < 0.05$) than for those for whom this had not been done (Table 1). There was also a trend, which only just failed to reach significance, for the patients for whom the checklist had been completed to be referred more frequently for disability benefits.

Conclusion

This audit confirmed that completing a pre-discharge checklist significantly increased the number of referrals for the provision of services after discharge from our rehabilitation unit and that it was less easy to

Table 1. Average frequency of provision per patient

	Checklist completed ($n = 43$)		No checklist completed ($n = 23$)	
	Total items	Average per patient	Total items	Average per patient
Mobility Aids	82	1.9	43	1.9
Other aids and appliances	67	1.6	25	1.1
Benefits	45	1.0	10	0.4
Services	78	1.8	17	0.7*
Follow-up appointments	36	0.8	19	0.8
Outpatient therapy appointments	27	0.6	12	0.5

*$p < 0.05$

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Name ..... **Admitted** ...../...../.....
Unit No ..... **Discharged** ...../...../.....

Main Condition : .....
Other Conditions : 1) .....
2) .....
Discharged to :
Home [ ] Sheltered Housing [ ] Part 4 [ ] Nursing Home [ ] Other [ ]
Address : .....
.....
Suitable [ ] Not suitable [ ] Referred for rehousing [ ]
Lives alone [ ] Able relatives [ ] Disabled relatives [ ]

Home visit : Nil [ ] 1) ...../...../..... 2) ...../...../.....

Equipment :			**Responsibility of :**
Stick :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Crutches :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Zimmer :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Prosthesis :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Orthosis :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Wheelchair :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Bathing :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Specify			
Toilet :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Specify			
Commode :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Trolley :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Kitchen :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Ramp :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Alarm :	N/A [ ]	Referred [ ]	Supplied [ ] .....
Other			

Disability Benefits :

Attendance :	N/A [ ]	Applied [ ]	Receiving [ ] .....
D.L.A. :	N/A [ ]	Applied [ ]	Receiving [ ] .....
Other :			

Services :

Home Help :	N/A [ ]	Referred [ ]	.....
Meals on wheels :	N/A [ ]	Referred [ ]	.....
Community OT :	N/A [ ]	Referred [ ]	.....
Social Worker :	N/A [ ]	Referred [ ]	.....
Community ST :	N/A [ ]	Referred [ ]	.....
District Nurse :	N/A [ ]	Referred [ ]	.....
Community physio :	N/A [ ]	Referred [ ]	.....
Health visitor :	N/A [ ]	Referred [ ]	.....
Other :			

Investigations post discharge :

Test .....
Due ...../...../..... GP informed [ ] Nil [ ]

Follow up : **Action :**

Appointments :	Nil [ ]	This Hosp [ ]	Other	.....	
Day Care :	Nil [ ]	This Hosp [ ]	Other	.....	
OP Therapy :	Nil [ ]	PT [ ]	OT [ ]	Speech [ ]	.....
Psych [ ]	Social [ ]	Other :		.....	

Fig 1. Checklist for assessing the requirements of patients following discharge from a hospital rehabilitation unit

overlook referring them for disability benefits. If it is a useful reminder for staff within a unit which already takes a lot of care in planning discharges from hospital into the community, it should be even more useful in a busy general medical or surgical unit where attention to disability, handicap and discharge planning often has to take second place to more medically orientated aspects of discharge, eg drug prescription.

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