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STRATEGIC GUIDE

to Implementing A Discharge Hospitality Center

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PART TWO

IMPLEMENTATION Guide

EXECUTIVE SUMMARY

A patient's delayed access to an inpatient bed can result in emergency department overcrowding, lack of appropriate care, or the need to be transferred to another hospital, all leading to concerns about patient safety.

Over the years, to address these and other patient flow issues and capacity constraints, hospitals have experimented with establishing Discharge Lounges or Discharge Hospitality Centers (DHCs). These areas are set aside in hospitals to allow discharged patients to vacate their inpatient room while they wait elsewhere for final discharge departure.

This paper outlines suggested criteria to consider for implementing a successful Discharge Hospitality Center, including:

01 PROJECT STRUCTURE
02 DESIGN
03 PATIENT ELIGIBILITY
04 SCREENING ASSESSMENT
05 LOCATION/SPACE CONSIDERATIONS
06 TECHNOLOGY
07 FEATURES AND EQUIPMENT
08 STAFFING

THIS RESOURCE HAS BEEN DEVELOPED AS A REFERENCE SHOULD YOU DECIDE TO INVESTIGATE THE FEASIBILITY OF A DHC FOR YOUR ORGANIZATION.

DEFINING YOUR SCOPE: DISCHARGE LOUNGE AND DISCHARGE HOSPITALITY CENTER

Known originally as a Discharge Lounge, these areas have traditionally been simple in process to implement, features, and functionality: a location in the hospital generally accepting patients following medical clearance, completion of medication education and communication of discharge instructions. In this case, the patient is typically only waiting for transportation.

Today's Discharge Hospitality Centers (DHC) have grown larger with more services and amenities. Depending on the organization, nurses in the DHC may communicate discharge instructions, ensure medication delivery, arrange transportation, provide post-procedure observation, etc. based on the identified needs of the individual patient. DHCs can also provide post-procedure observation and monitoring for ED patient discharges as well as inpatient discharges.

Overall, there exists a great deal of diversification within the definition, location, goals and designs of a DHC, including team/patient acceptance, which can impact the desired return on investment in a DHC. Other use cases for discharge areas that have been implemented include:

- Discharge areas specifically for ED patients or patients with a pre-scheduled procedure to free up capacity in those areas [1]

- Discharge areas that focus on increasing the quality of the discharge process (offering enhanced discharge education, review of instructions, scheduling follow-up appointments and more in an attempt to reduce readmissions.) [1]

Irregardless of what the area is called or specific services rendered, the overarching benefit of a DHC is to provide space where patients can wait for final departure — between the time the provider enters the discharge order to when the patient is ready to leave the nursing unit to the point the patient is ready to leave the hospital - without occupying an inpatient bed.

STEPS TO SUCCESS: IMPLEMENTING YOUR IDEAL DISCHARGE HOSPITALITY CENTER

PROJECT/DESIGN STRUCTURE

Most organizations designate an interdisciplinary leadership team to assist with structure and design of the DHC. It is important that these teams include representation from nursing leadership, medical staff, hospital operations, support (EVS/Transport), house supervisors and front-line nursing units. In organizations with a Patient Flow Governance Council, the DHC project team will generally function under the direction of that Council. Representatives and departments such as Building and Grounds, Process Improvement, Ancillary Services, etc. are included as appropriate. Creating a standard project plan, starting with goals and desired outcomes contributes to a solid foundation for this work.

DESIGN

The specific use case will determine the physical design of a DHC as the goals and desired outcomes dictate the needs. Knowing the patient population, clinical requirements, and desired amenities of those being served by the DHC is paramount to defining the use case and design. If the goal is to improve patient satisfaction in addition to freeing beds faster for incoming patients, the design will need to reflect that with additional amenities such as food and beverage, Wi-Fi access, games, magazines, television, iPads, etc. DHCs meant to serve only patients needing final transportation arrangements may be simpler, reflecting the style of a family waiting room with monitoring by the hospital team.

PATIENT ELIGIBILITY

Eligibility criteria must be established before implementation to support the intended use of the DHC. These criteria can vary across organizations. However, they are generally focused on ensuring, first and foremost, patient safety, as well as quality care. Taking eligibility into consideration will help determine not only the services offered, but also the equipment needed. If the desire is to house self-sufficient patients only awaiting transportation, only limited supplies may be necessary. However, if non-ambulatory patients are deemed eligible, it may be necessary to consider availability of durable medical equipment and other necessary services or supplies.

Patient eligibility criteria (sample):

- 18 years or older
- Activity levels up to one assist with the use of a gait belt
- Those that require:
  - Completion or last dose of intravenous antibiotics or blood products
  - Specialized education prior to discharge
  - "Meds to beds" (Pharmacy delivery of discharge medication)
- Medication administration or blood glucose monitoring with insulin administration
- Those that are waiting for:
  - Delivery of home medical equipment or oxygen
  - Transportation

SCREENING ASSESSMENT: PULL OR PUSH

Once eligibility criteria are determined and approved, a variety of structures exist for screening of potential DHC candidates. Overall, these processes fall either into 'pull' or 'push' models, with 'pulling' noted as being generally more effective in terms of DHC utilization, efficiency, and engagement. In this case, assessment criteria are developed based on the identified DHC goals and eligibility considerations. Team members, generally RNs from the DHC, evaluate the predicted and pending discharges from each applicable unit for DHC use. Confirmed discharges should be evaluated as well. In some cases, this assessment is a cooperative effort between Unit RNs and DHC RNs, with the Unit RNs noting which patients may meet DHC criteria at the time of pending discharge, while DHC RNs review and approve these patients for the DHC. In addition to the visibility of the patient's DHC status on-unit and in the DHC, there may be a brief conversation regarding DHC use by patient during the 'bed capacity huddle' and/or the unit's interdisciplinary rounds. Approved patients are then 'pulled' to the DHC ideally by the Transportation team as soon as all discharge tasks are complete (per hospital policy) freeing up the room to be cleaned and made ready for the next patient. Mapping out this assessment, identification, and communication plan ahead of time is integral in creating an effective transfer and utilization process.

LOCATION AND SPACE CONSIDERATIONS

Perhaps the most important consideration for location is proximity to the area designated for discharge departure, whether that be the main hospital lobby or another location. While

the amount of square footage needed will depend on the desired features, anticipated use, and amenities of the DHC, there are a few standard important considerations for all DHCs. These include:

- Including enough space and equipment for computer workstations, medical supplies and refreshments, as well as shelving for reading material, games, and other creature comforts

- Allocation of space for the DHC team should be located in an area with clear visibility to the entire Center

- The placement of at least one electronic, HIPAA-compliant, wall monitor can aid in patient flow by displaying patient discharge status and departure timeframes that will support at-a-glance access to information, while reducing caregiver cognitive load.

- Take time to determine the number of patients that can safely be cared for in the allotted space at one time

- Lastly, from a safety standpoint, an area should be designated for wheelchairs, walkers, IV poles, etc., which is required from a safety standpoint.

Restroom access within the DHC is optimal, however if not feasible, the Center should be located as close as possible to accessible restrooms. The aesthetic of many DHCs is that of a comfortable living room, with spaces designed for conversation, watching TV, reading, etc. while waiting for departure.

In the planning phase, to determine days and hours of operation, it is helpful to map out the discharge flow pattern for each unit considered appropriate for DHC use. Typically, prior the implementation of a DHC, discharges begin to occur in the late morning, and peak in mid to late afternoon (1100-1800). It is important to realize that the hours of DHC operation may need to shift as the benefits of the Center begin to impact patient flow and operations. Reviewing the current discharge flow for each unit before, during and following implementation will be helpful to setting and adjusting hours of operation, while tracking DHC impact on hospital-wide patient flow.

INTEGRATING TELETRACKING TECHNOLOGY

Providing access to the electronic medical record (EMR) and the operational platform utilized to support patient flow and capacity management are important to the team assigned to the DHC. Access to the EMR allows DHC team members to easily review and evaluate patients that may meet DHC eligibility criteria. Access is also necessary for charting if final discharge education is to be completed at the Center or a need exists to access the patient's medical record. The patient flow operations platform must support hospital-wide communication of discharge status, patient needs prior to discharge, probable discharge time, transportation support and a designated attribute for 'discharge to DHC.'

Use of TeleTracking's® Real-Time Locating System (RTLS) solution during this phase of care (AutoDischarge) can further support timely patient discharge. The use of AutoDischarge technology ultimately shortens the time from discharge patient departure to bed readiness for the next incoming patient. An RTLS bracelet automatically notifies care team members in real-time of the patient's location at discharge, whether they are in the DHC or departing from the Main Lobby. This notification also triggers the empty bed as 'dirty' and ready to be cleaned for the next incoming patient. Having this occur as soon as the patient crosses the departure threshold further decreases the time needed to ready the vacated room for the next patient and removes the need for nursing notification to EVS. This process not only decreases lost bed time, but also reduces patient wait time for admission.

DHCs are ever evolving to meet the needs of both patients and team members:

"One of our metrics to ensure success is utilization percentages from each floor. We then use the baseline to be sure they are consistent in their utilization and don't fall below. We had poor utilization from Ortho and when we spoke to them, they said the chairs in the lounge were at the incorrect angles for surgical joint patients. We called the manufacturer and worked with the units Occupational Therapist to develop wedges for the patients at the right angles to use when the ortho patients came to the lounge. This resulted in increased utilization. A few months later, their utilization dropped again, and they said it was because the staff in the lounge weren't educated in mobility of joint patients, and they were worried the patients would be injured transferring from chair to wheelchair to car. We worked with the Ortho PT/Mobility Tech for a week to train all of the Departure Lounge staff on proper transfer techniques for joint repair patients. Ortho is now one of our largest utilizers."

— SARASOTA MEMORIAL HOSPITAL

FEATURES AND EQUIPMENT

Selection of the equipment and amenities available in a DHC are dictated by intended purpose and goals agreed upon during the design phase. Reclining chairs, wheelchairs, tables and support equipment such as walkers are all standard. However if the goal of the DHC is to serve as a location to complete treatments such as the final administration of IV antibiotics, patients may require beds or stretchers, IV poles, pumps, etc. Amenities such as snacks, drinks, reading material, board games, puzzles, TVs, etc. are also generally made available. Other items to consider include educational materials, tablets, and other necessary discharge items.[2,3]

STAFFING

Staffing can be accomplished using a variety of models. RNs, LPNs, Med Techs and Aides have all been utilized in staffing since DHCs first emerged in the 1990's. Given the importance of appropriate screening and selection of DHC patients, plus the potential need to complete remaining tasks or provide education in the DHC prior to departure, RN utilization has increased in recent years. To meet staffing challenges, some Centers have successfully utilized 'light-duty RNs'[3] and/or 'emeritus RNs' to supplement regular staffing. Depending on the size and scope of the Center, patient care technicians, social workers, pharmacy technicians, transporters, and volunteers may support the assigned clinical team and provide additional services before final discharge.

CONCLUSION: ADOPTION AND COMMUNICATION IS CRITICAL

Even with an optimal physical design and state-of-the-art technology, a DHC will only be successful if team members adopt the concept. It is important that there is universal buy-in and support prior to the Center's opening to ensure a successful launch and to achieve the desired patient and organizational outcomes. Initially announcing the opening of a DHC with associated information such as goals, design/development team members and timeline is important. It is also important to make sure the hospital team understands the value the center provides not only to the patient but to the hospital, the hospital team and the community served. Clear parameters around patient eligibility, team expectations and overall benefits should be made available to all involved. Organizational emails, newsletters, and stand-up meetings are just a few ways you can provide team members with the "why" behind the development and use of the Center to begin socializing the concept and achieve team engagement.

Once determination of eligibility, location, resources, and other factors are complete and communicated to key stakeholders (nursing staff, medical staff, transportation, environmental services, etc.), a patient/family satisfaction survey should be developed and offered to each eligible patient to monitor trends, impressions of care, and service. Once the center is up and running, it is important to continuously share process improvement metrics, patient success stories and any feedback on areas of improvement. Being open and transparent has shown to not only improve the services offered but also increase adoption and utilization of the DHC. [2,3]

DHCs are ever evolving to meet the needs of both patients and staff:

"Have a dedicated team that staffs the DHC increases success. First six months of operation our DHC, with float RNs staffing it, had less than 20 patients in it total. First three months of having a dedicated staff the DHC had 369 patients utilize it. These dedicated RNs knew the process and worked to ensure the DHC was used. When not in the DHC they were out completing discharges and admissions. This dual role benefitted not only the DHC but the inpatient RNs."

— UPSTATE UNIVERSITY HOSPITAL

MEASUREMENT OF OUTCOMES

The measurement success process should be designed at the time of project inception and modified or expanded as the DHC matures. Once DHC outcome goals and targets are developed, it will be important to link individual team process measures to those outcomes.

Building a 'scorecard' with aligned outcome and process goals serves to create the initial body of measurement to track trends, identify operational gaps, and visualize opportunities for improvement. Patient, family, and team feedback collected and reviewed over time will provide a comprehensive view of the impressions, and perhaps issues, which need evaluation and resolution.

Sample process and outcome metrics include: [1, 2, 3]

PROCESS

- DHC Utilization (by day of week, hour of day)
- Number of Patients Screened Appropriate for the DHC vs. Number Departing from the DHC
- EVS Total Turn Time (Sending Units)
- Transporter Total Trip Time (DHC Discharges)
- Admit "Order to Arrival" to Nursing Unit (pre/post DHC)
- Discharge "Order to Arrival" in DHC
- Average Patient Time in DHC
- Time of Unit Discharge by Hour of Day

OUTCOME

- Impact on ED Boarding (and other access areas)
- Patient Satisfaction with Discharge Process (HCAHPS - Hospital Consumer Assessment of Healthcare Providers & Systems)
- Patient/Family Satisfaction with DHC Use
- Team Member Satisfaction with DHC
- Hours of Lost Bed Time Saved by Unit
- ED Boarding and/or Diversion Rate
- Readmission Rate (DHC Patients vs. All Other Discharges)

Various journal articles have highlighted research related to patient flow improvement interventions, including DHCs, stating they are underused in the United States and typically deployed only temporarily during occupancy surges or when required by law or policy.[1] However, it should also be noted that in one study[1], the percentage of patients reporting that the DHC better prepared them for care at home was greater than 90% which shows the relative effectiveness these Centers can have on patient outcomes.

In today's environment with minimal hospital capacity, staffing challenges, lack of open beds and high rates of ED boarding, now may present the ideal time to re-evaluate the potential benefits of implementing a DHC. With thoughtful, comprehensive design and implementation, and an approach to measuring outcomes appropriately, Discharge Hospitality Centers have been shown to help smooth patient flow and improve capacity for incoming patients.

1. Franklin, B., Vakili, S., Huckman, R.S., Hosein, S., Falk, N., Cheng, K., Murray, M., Harris, S., Morris, C.A., & Goralnick, E. (2020) The Inpatient Discharge Lounge as a Potential Mechanism to Mitigate Emergency Department Boarding and Crowding. Annals of Emergency Medicine. 75(6), 704–714.

2. Emmerling, S.A., Fisher, M.C., & McGarvey, J. (2020) The Use of a Patient Discharge Lounge and the Impact of 30-Day Hospital Readmission. JONA: The Journal of Nursing Administration. 50(11), 590-597.

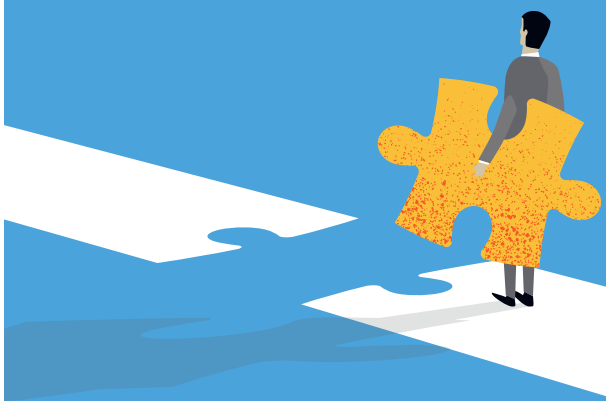
3. Barone, M., Miller, J., Long, M.S., Buckles, J., Hain, P., Dubovsky, A., High, H., De La Cruz, P., Williams, M., & Coleman, B. (2022) Implementing a Departure Lounge: A Strategy to Improve Patient Flow and the Discharge Process. JONA: The Journal of Nursing Administration. 52(3), 129-131.

GET STARTED

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