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# Bridges and Barriers: Patients' Perceptions of the Discharge Process Including Multidisciplinary Rounds on a Trauma Unit

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# Bridges and Barriers: Patients' Perceptions of the Discharge Process Including Multidisciplinary Rounds on a Trauma Unit

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## **Abstract**

Discharge planning is a complex process and ideally begins early in the patient stay. Despite evidence about the importance of discharge readiness, there is limited literature about the patient's view during this transition. The goal of this study was to explore patient perspectives about the discharge process, including multidisciplinary rounds. Multidisciplinary rounding is a process where care providers from various specialties meet to communicate, coordinate patient care, make decisions, and manage responsibilities. The theme found was "bridges and barriers to discharge." Participants identified timelines and tasks, communication, social support, and motivation as helpful and medical setbacks, insurance limitations, and infrequent communication as hindrances to the discharge. Future research is recommended examining efficacy of various discharge models and examination of communication and support throughout hospitalization.

When patients experience an acute illness or traumatic event, the health care team must be responsive to the individual needs of the patient and collaborate to provide high-quality care during the inpatient stay. The team must also prepare the patient for the transition to home or to the next level of care. The health care team, especially direct patient care providers like nurses, must assess the discharge needs of patients from admission to the hospital until discharge disposition. Without collaboration between physician teams, ancillary providers, nursing team, and patient, comprehensive care and preparation for needs posthospitalization can be overlooked. To enhance collaboration and communication among the health care team and the patient, many institutions have instilled the multidisciplinary rounding (MDR) process.

From the nursing perspective, discharge planning is seen as an integral part of the care continuum. Discharge planning begins on the day of admission and occurs daily until the patient is ready to return home or transition to a different level of care. Although not always a linear process, components of discharge readiness include optimal pain control, mobility, bowel milestones, and dietary tolerance, as well as overall understanding of medical condition and care required.

These elements of discharge planning are reviewed regularly with the patient and his or her family; however, patients are not always able to provide direct feedback to all members of the health care team. Nurses, as direct caregivers, have important contributions

to enhance the multidisciplinary assessment of discharge readiness; however, it is also important to understand the patient perspective about discharge planning to decrease fear, anxiety, symptoms exacerbation, and subsequent readmission.

## **Background/Significance**

The Center for Medicare and Medicaid Services has put a strong focus on decreasing readmission rates and the subsequent withholding of reimbursement for hospitals.<sup>1</sup> With this in mind, it is important that a patient be discharged when deemed appropriate by not only the multidisciplinary team, but also the patients themselves. The patient needs to perceive that he or she has sufficient care resources and is able to function after discharge. This helps decrease symptom exacerbation and potential readmission. To achieve this, the multidisciplinary team must be diligent in communicating to the patient and the rest of the team. The team must also provide care and achieve outcomes in a timely manner, ensure the patient can meet physical, emotional, and medical goals, and consider the patient's support system to assess if it is adequate all prior to the patient leaving the hospital. Only through a collaborative effort between physicians, nursing, ancillary providers, and patients can this be fully achieved.

Through a team "rounding" approach, the communication between and among caregivers will be optimized to meet the goals mentioned above. O'Leary et al.<sup>2</sup> surveyed physicians and nurses about the rating of communication after initiation of structured interdisciplinary rounds (SIDRs) on a telemetry inpatient unit and found that, on the structured interdisciplinary round unit, 100% of physicians and 88% of nurses rated communication as high or very high in comparison with 88% of physicians and 44% of nurses on the control unit.<sup>2</sup> Although this study did not include the patient perception or patient outcomes, the results support the increased level of communication and collaboration of the multidisciplinary team through the rounding process.

Beyond increasing communication among the team members and patient, MDR also ensures the patient is medically, emotionally, and physically ready for discharge. This can potentially decrease difficulties postdischarge as well as shorten length of stay (LOS)

through well-coordinated care and communication. Beque et al<sup>3</sup> conducted a retrospective study of 3 077 thoracic surgical patients with cancer to assess the effects of multidisciplinary rounding (MDR) on LOS, patient satisfaction, admission to postdischarge facility, and the use of home care or hospice services in comparison with patients who did not have MDR.<sup>3</sup> The results noted a decreased LOS in the MDR group (5.3 compared with 6.5;  $P < .01$ ) as well as slightly higher (not statistically significant) patient satisfaction scores when looking at "likelihood of recommending hospital," "overall care," "staff working together," and "overall assessment" domains.<sup>3</sup> This helps support the use of rounding in the hospital setting to promote well-coordinated care that may decrease LOS and increase patient satisfaction.

Previous work has also placed positive emphasis on the involvement of family or other support persons in the rounding process. Schiller and Anderson<sup>4</sup> evaluated the rounding process in the intensive care unit that occurred near trauma patient's bedside and included the family. Surveys of families revealed that they would recommend this rounding style to other families and emphasized the importance of being able to ask questions.<sup>4</sup> Although this was a small sample size and other limitations were present in the study, it highlights the importance from the family perspective that support system involvement is beneficial to the care and rounding process. Although multidisciplinary rounding is not the only avenue to increase team communication and improve patient care and outcomes, the reviewed studies support the use of rounding in acute settings.<sup>2-6</sup> In the trauma and surgical fields, where complex medical conditions and various medical teams are collaborating on care, rounding may enhance the discharge process and subsequently reduce other factors such as lengths of stay, patient dissatisfaction, and miscommunication among teams, patients, and support systems.

The importance of patient perspectives on discharge is documented in the literature; however, patient perception has predominately been measured with quantitative tools to assess patient reports of discharge readiness.<sup>5</sup> The purpose of this research was to explore the patient's perspective of the discharge process using qualitative methodology for a more robust description of patient perception and needs. Attention to the patient's perspective has the

potential to provide insights about patient preparation for discharge and prevention of posthospital complications.

## **Theoretical Framework**

This study utilizes Meleis' middle range theory of transition. This conceptualization of transition defines a holistic understanding of the conditions that influence the transition experience for patients.<sup>7</sup> In the case of this study, patients are transitioning through their trauma or emergent surgery hospitalization via the discharge process to prepare them to move to their next level of care and recovery.

Transitions theory consists of 4 core concepts—nature of the transition, transition conditions, patterns of the response, and nursing therapeutics.<sup>8</sup> Even though types of transitions may vary, there are some commonalities such as transitions occur over time and the process of transitioning involves flow, development, and change. The discharge process exemplifies these aspects of transitioning and is dependent on the patient's situational factors such as overall health and understanding, nursing and interdisciplinary interventions, and patient response. Meleis<sup>8</sup> proposes in her theory that the nature of the transition can either facilitate or hinder the patient's pattern of response. Thus, exploration of the patient's perspective on the discharge process may provide insights to support future development of nursing and interdisciplinary team interventions.

## **Methods**

A qualitative, descriptive survey design was used in this study to describe the discharge process from the perspective of the patient. The research question was how do patients describe their discharge process experience?

This question is based on the assumption that patients value and/or appreciate the opportunity to be included in the rounding process and that multidisciplinary rounding is beneficial to patients. A semistructured interview guide was designed to obtain the participants' perspective.

Participants were recruited from a 32-bed inpatient intermediate care surgical/trauma unit in a Midwest academic medical

center. The discharge flow coordinator, a staff nurse on the inpatient unit who oversees daily discharges, would inform a member of the research team the room numbers of patients being discharged each day. A research team member would then introduce himself or herself to the potential subject and fully explain the study and time involved for the patient. Once the subject understood and consented, the interview was performed in the patient's room, at a convenient time for the patient, on the day of discharge.

### *Setting/Sample*

A convenience sample was used on the basis of those patients who were being discharged or close to being discharged and met the following inclusion criteria—English-speaking patients who were discharged Monday through Friday between 8:00 AM and 9:00 PM. Patients were excluded from the study if they were non-English speaking, confused or comatose, or too ill to participate. A total of 14 participants were included in the study, 3 were male and 11 were female. The majority of participants were Caucasian with ages ranging from 19 to 91 years. Length of stay in the hospital ranged from 1 to 41 days. Of the 14 interviews, 6 were with participants assigned to the trauma service, and 8 were assigned to the acute care surgical service.

The acute care surgical service cares for patients with acute surgical needs such as appendicitis, complex hernias, and the management of abdominal fistulas. The trauma service cares for patients requiring surgical interventions related to a trauma. At this Midwestern academic medical institution a multidisciplinary team of providers, nurses, dietitians, therapists, social workers, and case managers convened twice weekly. The acute surgical service met at the patient's bedside, whereas the trauma service met in an interdisciplinary conference room. Although, understanding the differences between the 2 rounding processes was not an aim of the study, for clarity, a description of the rounding processes is provided so as to note this variation.

## *Procedure*

Education was provided to all members of the team on the purpose of the research, methodology, procedure for multidisciplinary discharge rounding, and expectations of multidisciplinary team members directly caring for the patients who were study participants. Once the discharge flow coordinator informed the research team of a potential qualifying participant, and consent was obtained, the interview was conducted at a mutually agreeable time. Interviews lasted 10 to 20 minutes. The interviews were audio recorded and responses transcribed verbatim. The researchers also completed field notes during the interview process.

The institutional review board for the protection of human subjects approved this study. Written informed consent was obtained from all participants in the study. No protected health information was collected from the participants.

## **Data Analysis**

An exploratory design using thematic analysis was used to gain insight into patients' perspectives of the discharge process. The participants are classified as T for trauma patients and A for acute care patients in the narrative analysis. Members of the research team read each transcribed interview to find repeating concepts or themes. To maintain rigor, strategies for monitoring and improving intercoder agreement, the research team then met to discuss individual findings and collaborate on the themes created. This ensured saturation was met, and no additional concepts were found in the transcribed interviews. Two of the members are experts in qualitative analysis review, adding to the strength of the thematic analysis and data results.

## **Results**

The overarching themes related to patients' perceived readiness for discharge were the aspects of care that either helped or inhibited discharge. This theme was termed "Bridges and Barriers to Discharge." The term "Bridges" was described by the participants as steps or tasks that enabled patients to get to the point of discharge.

The subthemes for bridges included “timelines and tasks to accomplish to move towards goals,” “frequent communication with the team,” “social support,” and the “motivation to get to discharged.” “Barriers” were seen as uncontrollable factors that made discharge challenging. Subthemes associated with barriers to discharge included “medical setbacks,” “insurance limitations,” and “infrequent communication with the medical team.” A visual illustration of the themes and subthemes described is found in Figure 1.

## *Bridges*

A bridge illustrated an event or events that needed to occur in order for discharge to happen. In some cases, these were tasks or items that the patient could perform or agree to, with the perception that it would increase the likelihood of discharge. These were actions that were a means to an end in many patients' eyes.

The main part about the discharge was...the key to the bridge...was to have the bone surgery. (T)

Well, they want to make sure, the nurses and the doctors want to make sure that I am comfortable and that I have everything I need to have before I go home. (A)

Bridges were also described as key learnings required for the discharge process:

A lot of people talked to me about whatever I needed to learn. The pharmacist came and explained all the medications. And the discharge nurse came and described what I needed to know. (A)

## *Timelines and Tasks*

Participants in the study described a set of timelines and tasks that were essential for getting over various “bridges” to the discharge process. The majority of the participants described point in time

interactions with various members of the health care team rather than a fluid discharge process.

So that (wound) isn't leaking anymore so that's off the checklist that we need to get ready to move. (T)

So every morning it was something I had to do. (A)

Participants also viewed physical and occupational team members as gatekeepers to the discharge process. If the patients were able to meet the goals that had been mutually set forth by various therapists, for example, they were 1 step closer to discharge.

I had to be able to get out and walk with the walker. Up and down the hall, which I did...pretty soon, I was down at the end of the hall where you turn. (A)

...Physical therapy and occupational therapy. They wanted me. Originally the plan in all their opinions I was going to go to inpatient rehab, but I had done...made a lot of recovery since then especially so all of the therapists decided that I would be able to go home and then do outpatient. (T)

Many participants talked about the importance of the timeline with the actual discharge from the hospital. Participant A04 explained why speed is a critical component of the discharge.

The one thing I would like, from any discharge from any hospital, is speed. When you are told you can be discharged you want to go home. You want to go home now. So, what I would like to see is that once they come in and they say you can be discharged and they have papers, and my husband will pick me up at 5. Fine. I want those papers signed and everything so I can get out of here at 5. Or whatever time. You know. I don't want to have to wait while they are getting the papers. I don't want to have to wait while somebody is doing something else.

## *Frequent Communication*

Participants described frequent communication with the health care team, and these interactions increased patient knowledge about timelines and expectations for discharge.

So every morning they had their agenda. The first morning when they came in before the operation they told me all about the operation. What was going to take place. What it would look like... So this morning they all came in and it was about getting ready to go home. They said we think this is going to happen today, but we would like for you to have a bowel movement. (A)

The communication from the health care team was described by a trauma participant as:

It was a very clear, simple discussion about me moving on and hopefully discharge to the next level of my health care...So they were all in the loop of communication with me getting into the rehabilitation center, each providing for me and caring for me.

Communication was usually triggered by efforts to get to the next phase of care, and the majority of participants reported that communication was "thorough" and described the ability to freely ask questions.

## *Social Support*

Social support was described by many participants as an important component of discharge. Although this may not speed up or impede the discharge process, participants clearly felt that social or family support was an essential component to feeling comfortable leaving the hospital. This included family, friends, a pastor, and the network of a support community at a prior care facility.

I'm just glad my mom and my sister will be here to understand and hear things. (A)

My twin sister is a nurse and she has been sleeping here and taking care of me. My mother is next door with my

younger sister who was also a part of the accident. So I have two nurses in the family. They both are very enforcive in trying to be in on everything for us. And they are always around so they were notified when I was notified. (T)

I'm very satisfied because I'm going back to where I was waiting to be released from. The care that I was getting was basically; well it taught me how to walk again and how to handle my health problems I had at that time. I had friends; we all were like a big family. We would talk to one another about our problems and we would try to help and cope with one another...And I started talking to her and she talked straight for two hours. She really unloaded...She finally found someone that she could talk to that would listen. So it made me feel good that I could help someone else instead of just sit there all day. (A)

### *Motivation to Get to Discharge*

Participants who described motivation to participate in care articulated excitement with milestones that led them to discharge. This was captured best by participants who shared the importance of self-directed learning and motivation for the discharge process:

But I got better at preparing for it. And to take a shower...it was fun! (A)

To try and be as effective as I possibly can, as independent as I possibly can. (T)

I've been on this planet a lot longer than people give me credit for so I know what's coming. You can only prepare so much. You plan for the worst and hope for the best. I know it's not going to be easy. It's what you make of it. (T)

Participants who did not articulate motivation to accomplish tasks that would help move them closer to

discharge articulated fears about discharge. I don't feel like I'm quite ready or that I'm quite there. I think that looking forward to being discharged it's going to be very difficult and painful. (T)

In contrast, an acute care participant had a different perspective about discharge. She shared the following:

Now it is today, so I am even more excited. So then I had to sit back and think, you know it is probably more on me. But I do understand everything I need to do. And I know exactly what I need to do when I get home. And I have a paper back up. And I have papers here, and this, and this, and this (showing discharge paperwork). Yeah, I have a lot of back up.

## *Barriers*

Participants described barriers as aspects of care that hindered their discharge from the hospital. These barriers included medical setbacks, insurance limitations, and infrequent communication with the team.

### *Medical Setbacks*

Participants articulated frustration or disappointment when medical setbacks delayed discharge or changed the timeline of events associated with the discharge process. One participant shared this experience:

They started talking about it on Sunday. And then it (surgery) was supposed to be on Tuesday, then all of a sudden it was Wednesday because of my white blood count, now it was Monday, Tuesday. Then it was Wednesday. Then all of a sudden it was today. And it all had to do with my white blood count. (A)

Other participants described other challenges related to changes in medical condition:

My blood pressure was up, down. Kind of weird. I don't understand that. Probably what I went through.

Definitely the stress had something to do with it, but it was like, time to get vitals. Wake me up. So then I feel the pain again. Then I can't get to sleep. Then I gotta call the nurse to get something that numbs the pain so that I can go back to sleep....but that was the only frustrating part... (T)

Participants were very conscious of dates and times related to their perceived "bridges" to discharge. When timelines were modified, participants articulated frustration. Surgery was considered a major bridge for many of the participants. When a surgical intervention did not occur along the predicted timeline, participants were disappointed.

Well there was one time when there was miscommunication when we thought the surgery was gonna be on. We thought it was gonna be on Monday and then on Monday they said it wasn't going to be on Monday, then it was on Monday. So there was a little bit of miscommunication there... (T).

And in the last couple of days starting asking about it (surgery) because clearly I knew that would be forthcoming and they were like, well we don't have any dates for you but it won't be till, you know we will give you a time. And then it will be well, it's going to be later today and then it's like well, we are going to find you a room tomorrow. (T)

### *Insurance Limitations*

Insurance was sometimes a barrier to discharge, preventing a participant from getting to a certain facility or getting access to support care in the home. A trauma participant described the "black box of health insurance" and a "nebulous process." Another participant explained:

They were waiting for the insurance to be approved so that was one of the barriers to get past that bridge...I don't know why it was a slow process for insurance to

get approved but that was one of the main things we were all kind of waiting on. (T)

### *Infrequent Communication*

Communication was a critical action that supported or hindered the discharge. When participants perceived communication as frequent, discharge was highly anticipated and celebrated. A participant shared this.

They (the medical team) took a lot of time. They really do....I was able to participant not only in the discharge process but in doing for myself....I talked to everybody...They come in and they have a big conversation with you. The nurses are right here with them. It seems to me that they know their job and the doctors know their job. And then they tell them what to do for us. (A)

In contrast, when communication was not frequent, participants expressed frustration. One participant stated, "I would have liked to talk to my doctor a little bit more so that he could explain the surgery a little bit better to me." (T)

Participants also reported the discharge as coming up suddenly and poor communication about discharge. "I didn't expect it (discharge) to come up so quick!" (T)

Initially, when I first got here it was like here is a list of names of places...and all that conversation kinda dropped off. And again, that was a couple of weeks ago where they were going to move me right away and it's like well, we need a decision right away. And then it's kind of like all that other conversation kinda just dropped out...And like I was saying there was all the sudden conversations about where do you want to go but without any time frames for decision making until it was like, it looks like you are ready to move today... (T)

This participant also described thoughts about a better way to outline discharge:

...I think that somehow there ought to be some way to graph it, you could be one of these three people...these are the possible options you have based upon where you fall. Because again, I don't know where I am along that timeline type situation.

## Discussion

Despite two different rounding processes, patients' responses in the interviews demonstrated similar understanding of their goals set by members of the multidisciplinary team. Patients in both groups described what was to be accomplished prior to discharge. Their perceived readiness for discharge was primarily based on achieving the goals identified by the multidisciplinary team. Patients described their role as responding to the actions of the team, not necessarily as a collaborative partner—other than collaborating to accomplish designated tasks that were needed to achieve discharge status. All patients in the study described the discharge process as random events that needed to be resolved to reach discharge.

Conversely, nurses tend to view the discharge process as a continuum that begins at admission and ends upon discharge. Despite the nursing definition of discharge as a process, the nursing activities related to discharge may not always be visible to the recipient of care,<sup>9</sup> and thus the patient may or may not be aware of interdisciplinary team efforts to prepare the patient for the discharge transition. Although the nursing profession places great emphasis on the discharge process and its influence on patient outcomes, it is unclear how patients perceive this process or their desires to be involved in the process. This explorative study was initiated to gain insight into the patient's perspective and to better understand the influence of multidisciplinary rounding on the discharge process.

Our analysis revealed an overarching sense of “Bridges and Barriers” to the discharge process. Patients described that barriers must be overcome to progress to the bridges that will enable them to go home. Participants in this study viewed the discharge process as short-term steps or tasks to be completed toward the end of their hospital stay that would enable them to leave the hospital. The patient's stepwise view of discharge in this study is in contrast to

nursing's fundamental concept of patient care as a continuum. Nurses understand the care process as more of a "big picture" and are able to focus on both short- and long-term goals and objectives.

## *Bridges*

Perceived "bridges" or discharge facilitating factors not only enabled patients to meet discharge expectations but also empowered the patient and motivated them to participate. When a patient had control over an outcome, such as progressing to solid foods or ambulating successfully down a hall, he or she was empowered to be involved and took an active role in facilitating discharge. Elements such as timelines and tasks, communication, social support, and motivation were identified as helpful "bridges" to meeting discharge expectations.

Another important bridge was frequent and successful communication provided from the multidisciplinary team. When a patient was well informed of changes in the medical plan or updates on anticipated discharge disposition, he or she felt involved in care and was able to verbalize questions or concerns. In contrast, those patients who did not receive frequent communication felt rushed, apprehensive, and unclear about how and when the discharge process would occur. In addition, several patients expressed concern that the discharge itself was unexpected. This finding is concerning as previous literature demonstrates unmet patient needs have been associated with higher rates of complications and hospital readmission.<sup>5,10</sup>

Patients also verbalized the positive aspects of family and social support. This meant the family member could listen and help to absorb the information from the medical team and ask questions or provide physical and emotional support. Involving family or friends in the discharge process was seen as an important and reassuring aspect from the patient's perspective. In the literature, family involvement is associated with increased discharge readiness and satisfaction.<sup>4,10</sup> Thus, family members may provide an important aspect of support and care when transitioning from the hospital to the home environment.

## *Barriers*

When events or tasks did not occur in the anticipated sequence, the patient verbalized that a barrier was experienced. Medical setbacks such as infection or surgery, insurance barriers, and infrequent communication with the interdisciplinary team led to discharge delays and perceived hurdle to accomplishing the final destination of discharge from the hospital. As long as communication occurred on a frequent basis from any member of the health care team, patients verbalized satisfaction in the discharge process. The only negative responses based on the discharge process were in relation to lack of information, delays due to medical/insurance problems, or sudden communication of impending discharge.

Although the specific reasons for these perceived bridges and barriers are not clear through this qualitative exploration, it may be the unique responses of the patient and his or her personal and situational factors. This is reflected in the Meleis' transition theory that the nature of the transition can either facilitate or hinder the patient's pattern of response.<sup>7</sup> As Coffey<sup>11</sup> noted, there is a personal dimension of the concept of transition and conditions that include specific physical and cognitive indicators relative to each individual patient. In addition, each patient brings with him or her specific perspectives that influence the discharge process. This is supported by the results of this study where patients identified their individual barriers and bridges and variations in their preparation and understanding of their own discharge processes. Use of this theory enhances our understanding of the multidimensional nature of patients' transition period related to the discharge process.

## **Limitations**

Limitations of this study include a lack of generalizability of study findings and interview challenges in the complex inpatient hospital environment. In addition, the rounding processes differed in the acute care surgical service (at patient bedside) and trauma surgery service (interdisciplinary conference room). Making comparisons between these groups is not feasible with this study design; however, participants' descriptions and resulting themes were consistent.

## Conclusions And Implications

Although the link between patient perception of discharge readiness and nurse/multidisciplinary team perception is not a new research topic, the findings of this study give some insight into what patients perceive to be important to them in the discharge process. The emphasis patients place on the events or tasks associated with discharge is important to understand. In addition, the multidisciplinary rounding process did not emerge as a major influence on the patients' perspective, rather the frequency of communication, success of tasks and timelines, and support from family or friends were most influential.

In the previous literature, nurses report greater patient discharge readiness in comparison with patient reports.<sup>12</sup> This stresses the importance of why trauma nurses and the multidisciplinary teams need to have a better understanding of what factors are important to patients during the discharge process and incorporate these needs into rounding and interactions with patients. From the findings in this study, placing emphasis on the tasks and timelines through frequent communication may help the patient experience more bridges than barriers in the discharge process. This may include assigning tasks through discharge teaching that focuses on patient-centered actions that maximize their autonomy.

The knowledge gained from the patient narratives may facilitate strategies for successful discharge. Future studies that examine interventions for frequent and consistent communication, as well as interventions that support patients to perform tasks toward discharge, would be beneficial. By facilitating patient-centered tasks through checklists or other avenues, patients may maintain more control of some factors in the discharge process as well as continue to be empowered as an active member of the team.

## Key Points

- Patients perceive “bridges” such as completing timelines and tasks, frequent communication, family/friend social support, and motivation were identified as helpful to meeting discharge

expectations and also empowered the patient and motivated them to participate.

- Challenges such as insurance limitations, infrequent communication, and medical setbacks, while not all controllable, were perceived as “barriers.”
- The multidisciplinary rounding process did not emerge as a major influence on the patients' perspective, rather the frequency of communication, success of tasks and timelines, and support from family or friends were most influential.
- Future studies that examine interventions for frequent and consistent communication, tools to capture patient accomplishments, as well as interventions that support patients to perform tasks toward discharge are recommended.

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**Figure 1.** Barriers and bridges to discharge

