Developing discharge practice through education
Module development, delivery and outcomes

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S U M M A R Y

In England (UK) the discharge of patients from hospital is a source of constant scrutiny from primary care trusts in order to reduce the patient length of stay in Hospital. To support nurses in practice a part time, post registration discharge practice education module was developed entitled Facilitating Timely Patient Discharge. It was the first of its kind to be accredited at degree level (level 6) during 2006. University evaluation of the module involved an academic assignment based on a 3000 word case study. Projects in practice were integrated to enable the students to apply theories to clinical practice. This aspect was driven by an organisational impetus to demonstrate learning back in practice to the benefit of Heart of England Foundation Trust (HEFT). Students self assessed their individual ability pre and post the discharge module using questionnaires citing 17 areas of discharge practice analysing knowledge and ability. They demonstrated an increase in knowledge and ability in key areas such as; understanding complex discharge and teaching discharge practice to peers. Although these were not formally included in the outcomes or evaluations they may inform future module development and design of delivery. The questionnaires were designed and developed with support for projects in practice from the Foundation of Nursing Studies in London.

Introduction

This article discusses the development of a part time, post registration discharge practice education module including its content, delivery and outcomes. The module is entitled, Facilitating Timely Patient Discharge.

This title was devised to align with the national multi-professional toolkit (Department of Health, DH, 2004b) and to endorse the proactive multi-professional concept of discharge practice. It was aimed at a range of practitioners working in health and social care settings, detracting from an approach focussed solely on ‘nursing’ or ‘medicine’ (Gair and Hartery, 2001; Opic, 1997).

The module was validated by the Birmingham City University in the UK and upon successful completion 12 degree level university academic transferrable credits are awarded. This module can be selected on the Dimensions in Healthcare pathway – a new and flexible approach to learning beyond registration, linked to the National Health Service (NHS) Knowledge and Skills Framework (KSF), used to design job descriptions nationally, initiated by the Department of Health (DH, NHS KSF, 2004). The KSF framework describes the knowledge and skills required for different pay banding for registered staff from band 5 (junior posts) to Band 8 (senior posts).

Background

There has been a renewed and lasting focus upon discharge practice throughout NHS Trusts over the past decade (DH, 2003). For nurses, this focus was promulgated by the ten key roles for nursing, one of which was ‘leading admission and discharge of patients’ (DH, 2000). Further momentum originated from the NHS focus on reducing length of stay and the introduction of ‘Lean’ principles.

Lean is a method used to reduce wastage through overlaps and unnecessary steps in manufacturing processes (DH, 2007). Its principles are being integrated by managers into NHS for the discharge of patients, to standardise the discharge process throughout Hospitals. One key area of standardisation is the completion of Discharge Checklists 24/48 h before the patient is discharged or transferred to another setting.
Similarly, senior clinical practitioners have worked fastidiously to analyse the nurse’s training needs required to discharge patients from Hospital (DH, 2004b; Lees, 2007). A training needs analysis system was developed for all Hospital wards to analyse individual training needs (Lees and Emmerson, 2006). Despite this, prior to the delivery of the education module, a structured and sustainable approach to dischargerate education supporting both strategic and operational perspectives of discharge practice (at ward level), had not been achieved. Nevertheless, the organisation benefited from previous work undertaken to analyse the training needs, which consequently informed the content and speakers on this inaugural module.

The literature review

How education is traditionally delivered

The Heart of England Foundation Trust (HEFT) is not too dissimilar to other acute trusts, in terms of its traditional approach to education delivery. Nursing education and training was delivered primarily from a Practice & Professional Development Team. There were informal links to the knowledge and skills framework (DH, NHS KSF, 2004) governance, operational or quality agendas but a lack of clarity in terms of assessing the impact of education back into practice (Griscti and Jacono, 2006). The gradual reduction of practice development posts nationwide reflects the urgent need to demonstrate links between improvements in clinical care and practice to the professional development agenda and education. Moreover, as the Nursing and Midwifery Council (NMC) aims to move nursing to an all graduate profession by 2015, this further enhances the need for greater collaboration NHS providers and Higher Education Institutions (HEIs) to ensure registered nurses have access to the appropriate level of academic courses to maintain their professional registration (Staines, 2008).

NHS organisations and the need to shape the future of post-qualifying/CPD education.

During 2006/07 all NHS organisations suffered serious losses in terms of educational funding, stretching what was left to cover the growing demand for education and learning to support professional development (Kendall-Raynor, 2007). A number of white papers describe the future in terms of service redesign, improved efficiencies and productivity, all supported by a workforce fit for purpose. The redesign of services, care closer to home and the changed payments by commissioning and payment by results processes (PBC and PBR) clearly indicates the need for a step change in the way that staff care for patients and deliver services. It can only be achieved where strategic and local practices bring service development and redesign together with education and from this a different system of practice and delivering education (Valentine, 2004; Roberts, 2007). Continuing professional development is strongly advocated as one way of improving the care delivered (Hughes, 2005). Nonetheless, releasing staff to attend courses is becoming increasingly difficult and the benefits realised from education delivery. Nursing education and training was delivered to demonstrate links between improvements in clinical care and practice to the professional development agenda and education. Moreover, as the Nursing and Midwifery Council (NMC) aims to move nursing to an all graduate profession by 2015, this further enhances the need for greater collaboration NHS providers and Higher Education Institutions (HEIs) to ensure registered nurses have access to the appropriate level of academic courses to maintain their professional registration (Staines, 2008).

NHS organisations and the need to shape the future of post-qualifying/CPD education.

Commissioned education to shape strategic direction

Commissioned modules of educational activity, secured on our behalf by the local Strategic Health Authority (SHA), generally reflect a wide range of clinical or managerial diplomas, degrees and masters modules (Roberts, 2007). Recent work with a local university provider has demonstrated that these traditional commissioned modules, made on our behalf by the SHA, can be adapted or completely redesigned to reflect identified clinical need and translated into accredited educational activity (Burke, 2006). At Birmingham City University the Dimensions in Healthcare pathway helps to facilitate this by enabling the student to structure their learning along the pathway to integrate with professional roles. An example of this can closely aid clinical need and educational activity is seen in the students accessing a research module which they individually design to meet their learning and professional requirements. This clearly places the onus on NHS organisations to articulate their requirements, and help support the development of education that nursing staff require; to ensure safe nursing practice (Valentine, 2004). Delivering the discharge training module on site at HEFT, has enabled us to respond to an area of concern, provide accredited training in-house and demonstrate clear mechanisms to measure its impact, through improved confidence and skills in discharge practice.

Changing face of practice development, outcomes based on key performance indicators and nursing audit

Changing face of practice development, outcomes based on key performance indicators and nursing audit

So how do we change practice development in order that its value and worth are recognised within the organisation? In an environment of reducing educational funds and value for money, it is key that practice development mirrors the requirements of both nursing (excellent care to patients) and the organisation (in terms of service development and redesign), and developed with clear links to deliverable outcomes. Using the evidence demonstrated through nursing audit systems, it was evident that further work was required to improve the knowledge and skills to deliver effective discharge practice. As a direct consequence 40 places were funded, accessible by multi-professional staff, delivered onsite from our local University, to support the development of a range of skills to support effective discharge practice.

Defining learning

Defining learning

In order to define what learning was expected to take place on the module it is necessary to define what learning is (Breddoes-Jones, 2005). Learning can be ‘an activity where acquisition of knowledge or skills may take place’ (Jarvis, 1995; Beddoes-Jones, 2005), or ‘whenever a learner adopts a new attitude or behaviour through interaction with their environment’. In this case it is likely that both perspectives will have taken place, but learning in
practice is a dynamic activity involving both organisational and individual change, thereby difficult to precisely extrapolate (Senge, 1990). Regardless of the definition, there is an expectation that education will change or modify nurse’s knowledge in practice (Griscti and Jacono, 2006). It is perhaps more accurate to quantify learning in practice (Quinn, 2000; Beddoes-Jones, 2005; Griscti and Jacono, 2006; Kirkpatrick, 1998).

**Box 2. Demonstrating knowledge and ability at three levels**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>Level (1)</td>
<td>Some knowledge of the subject, not able to work independently yet and need further training.</td>
</tr>
<tr>
<td>Level (2)</td>
<td>Good knowledge of subject, able to work independently but would prefer training</td>
</tr>
<tr>
<td>Level (3)</td>
<td>Full knowledge of subject, able to work independently competent and need no further training.</td>
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</table>

**Developing the module**

The module development commenced in 2005; innovative ideas were generated from practice settings within the HEFT shared with Birmingham City University. Such a collaborative approach is commensurate with the educational remit of a consultant nurse post, ‘influencing and developing new education modules’ (Manley, 1997, 2000a). Nevertheless, the concepts education, training and teaching, are frequently used synonymously and the difference between each is not well understood. While there are obvious inter-relationships, in order to maximise the expertise of the consultant nurse their time/focus is certainly better directed upon developing educational modules and measuring the outcomes (Manley, 2000b). For example, a consultant nurse cannot possibly have expertise to teach all sessions of the discharge module which require multi-disciplines (Opic, 1997). In this case however, the collaboration was entirely appropriate and involved using the expertise of the University to guide the assessment strategy and outcomes; alongside the expertise of the consultant nurse to determine content, speakers, mode of delivery preferred to deliver service development and organisational outcomes (Manley, 2000b).

**New ways of supporting learning in practice**

New ways of learning are being adopted nationwide in nurse education in England. At Birmingham City University an interactive E-learning tool entitled ‘Moodle’ is used (Saxon, in Lees, 2007).

E-learning encourages practitioners to think critically and independently about their practice through self-directed learning which can be remotely accessed at times convenient to the student while meeting continuing professional requirements, the future for higher education (DfES, 2003). Access to the University Moodle website was facilitated although not to the extent originally envisaged. For example, numerous video clips were in development, such as multi-disciplinary team meetings, ward rounds, patient shift handovers and patient discharge assessments (Howatson-Jones, 2004). Nonetheless, these proved prohibitive to develop, requiring new funding and substantial time commitment on and above that available. Moreover, HEFT needed to get the module underway; hence it was decided to adopt a traditional approach to learning with guest speakers [practitioners] delivering lectures and workshops on the HEFT Hospital site. The Moodle website supported links for the each of the practitioners, with a forum to share learning out of the classroom setting.

**Content of the sessions**

The aim of the module was to promote the understanding of theory, principles and specific tools underpinning discharge planning in practice. The theories encompassed in the module were adapted from industry, change management models, patient rehabilitation and whole systems approaches. Critical to the success of the module was for the students to see the interrelationships rather than simple cause and effect and seeing processes of change rather than single events. The theory integrated can be applied within many different areas of a Hospital and contrasted ‘dynamic’ complexity (the relationship between things) with ‘detail’ complexity (details about things). The learning outcomes were designed to provide the students with knowledge and understanding and experience of putting this into a practical context through the application of theory in practice, regardless of clinical setting (Ywye and Mc Clenahan, 2000).

Key areas included to facilitate the module aim were:

- Related current health and social policy.
- Changing patterns of care provision and new services effective / in the discharge process.
- Understanding the discharge process and principles.
- Patient centred/patient led approach.
- Professional accountability involved in complex discharge.
- Decision making principles.
- Change management theories.

Some of theories used and how they were integrated within the module sessions are discussed below (Senge, 1990).

**Application of theory to practice: learning principles**

The principles of preparation and planning for the discharge of patients from hospital was explored in the context of two theories; ‘discharge as a process not a single event’ and ‘consequences’ of a poor patient discharge from hospital (Booth and Davies, 1991 and Armitage, 1981). A guest speaker from primary care described the consequences of a poor patient discharge from Hospital; that enabled students to understand key aspects of planning that had been overlooked.

The theory of constraint was taught (Goldratt and Cox, 1993), namely, that the speed of any process is determined by the speed of the longest/slowest step. Using this theory, the students spent one session of the module exploring the discharge process, mapping the whole (to reveal overlaps and unnecessary processes in practice (Lean, DH, 2007). This was reported by the students as enabling them to take a step back and look into what activities they do in everyday practice and plan/do things differently starting with the longest step.

The theory underpinning goal setting (Young et al., 1999) to improve discharge planning and placement was explored and applied in one session by exploring case studies (Brown, 1992). The aim was to improve the reality and patient involvement with goal setting within care planning, back in practice.

Clinical decision making models (Sullivan and Decker, 2000; Brown, 1992) were introduced and analysed in the context of decision making and effective delegation using cases from practice settings. The aim was to focus the practitioners on common elements of discharge practice, such as hand offs between practitioners and indecision in practice, to bring about a reduction in these elements occurring in practice and see the impact of poor decision making from a patient perspective.
Delivery of the module

A problem faced by Trusts, is the difficulty in releasing clinical staff from their place of work (Ayer, 1998; Chapman and Howkins, 2003). When revisiting the delivery the module team explored the options and benefits of a modified approach; delivering the module away from the University to maximise student uptake and attendance (Ayer, 1998). It was agreed to deliver the module on site, at the Hospital and to deliver each session over 3 h per week. The students were expected through project and assignment work to demonstrate developments in practice which have had a direct impact on the care they deliver (Chapman and Howkins, 2003). The advantage of this approach compared to learning at a University highlights one of the many ways to potentially close the theory practice gap, through experienced practitioners providing the ‘know how’ rather than ‘know what’ (Cave, 1994). Furthermore, it should allow for the introspection of processes used against outcomes of the module. Ultimately, integrating capacity management and ward practice will only be effective if there is a unification of the ultimate goal, ’proactively and safely discharging patients from Hospital’.

Module sessions

The module sessions were facilitated by practitioners (guest speakers) working in secondary, primary and intermediate care settings. Twelve guest speakers taught on the module (Table 1). Examples of the sessions included were; governmental policy, supporting the political, social and economic advances in discharge practice; patient centred care, involving patients in their discharge practice, complex discharge practice and estimating dates for discharge.

Participating students

Invitations were extended to experienced nurses and allied health professionals throughout the Heart of England Foundation Trust. The rationale for inviting experienced healthcare practitioners was that they needed to go back to practice and positively influence practice. Moreover, discharge practice is a multi-professional responsibility and it was envisaged that the students would learn and develop on the course from the sessions but also from each other. The first group of 16 students were all nurses based within the local Acute Trust with a lack of interest from health care professionals. Nevertheless, some 6 months later, the second module attracted four occupational therapists and one physiotherapist, in addition to nurses.

Administration

Any trust considering the development of an on-site course will need to provide on site administrative support. The administrative support represented the greatest challenge throughout the entire module; the organisation of rooms, invitation of speakers and volume of student queries anticipated were underestimated. Tutorial support for academic writing was provided by the university module team. Students accessed support frequently and this was perhaps intensified (compared to a University) by the practice based coordinator being easily accessible on the same Hospital site as the students.

Developing the assessment strategy

The assignment

An academic assignment was set as a 3000 word case study, written at Level 6. The rationale underpinning the approach was to enable Birmingham City University to assess the academic outcome, accredit the students with twelve points at degree level and link the work to practice issues. Case studies require the consideration of storytelling which is a traditional means of sharing information and in doing so develops student skills to become a more reflective practitioner (McDrury and Alterio, 2007).

The satisfaction survey

The University administered a satisfaction survey to assess content and delivery of the programme. The survey is a standardised feedback format to enable a consistent approach across all courses offered within the University prospectus. It comprises of eleven questions where students were invited to rate each statement from strongly agree to strongly disagree (Textbox 1). Additionally, the university needed to quality assure the content and speakers in order for continued validation at the University.

<table>
<thead>
<tr>
<th>Box 1. The university feedback questions.</th>
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<tbody>
<tr>
<td>1. The aims and objectives for the module were clearly explained</td>
</tr>
<tr>
<td>2. The assessment requirements were made clear</td>
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<tr>
<td>3. The module was well structured</td>
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<tr>
<td>4. The assessment reflected the learning outcomes</td>
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<tr>
<td>5. The module was sufficiently challenging</td>
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<tr>
<td>6. A variety of learning methods were used</td>
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<tr>
<td>7. The resources for the module were satisfactory</td>
</tr>
<tr>
<td>8. The module was enjoyable</td>
</tr>
<tr>
<td>9. The module was relevant to me</td>
</tr>
<tr>
<td>10. The methods used have helped to facilitate my learning</td>
</tr>
<tr>
<td>11. The module was non-discriminatory, i.e. delivery, content, assessment</td>
</tr>
</tbody>
</table>

Organisational projects

In addition to gaining the credits at degree level, the module aimed to link theoretical perspectives through the implementation of a small scale change in discharge practice in their clinical areas (Ywye and Mc Clenahan, 2000; Chapman and Howkins, 2003). The change implemented was not included in the assessment strategy and thereby not assessed by the University. Nevertheless, the projects were incorporated into the course expectations at the outset of the module, to engage theory in practice for the benefit of the students and the NHS organisation (Senge, 1990; Booth and Davies, 1991; Armitage, 1981; Sullivan and Decker, 2000; Brown, 1992). Making organisational projects implicit to the outcome of the module was a unique approach to changing discharge practice in clinical areas of practice adopted by the trust (Ywye and Mc Clenahan, 2000).

Developing the questionnaires

Questionnaires were devised to assess improvement in student knowledge and ability before and after the module. The purpose of
the self assessment was to enable students to visualise the individual learning that had taken place as a result of the module. In total, 17 common areas of discharge practice informed the self assessment statements. The results were not integrated into the University assessment strategy or feedback shared, they were used for the students benefit only. Pre assessment focussed upon ‘what level of knowledge they felt they have’. Post assessment focussed upon the same areas, this time used to demonstrate where they felt they had made improvement. The results are not shared within the article but the questionnaires developed during 2005 with the aid of a Foundation of Nursing Studies grant (FoNs) are available upon request (Foundation of Nursing Studies, 2004).

Evaluation of the module results

Throughout the module student attendance was not compulsory for every session, which resulted in part and full module attendance. The rationale was to facilitate adult learning where the student can decide if they needed to attend the lecture or not.

Student assignments

From the 16 students who started the course, only 8 students decided to complete the academic assignment. Of these, 5 students passed and 3 failed the assignment. The students who passed all achieved 60% or above, 1 student submitted late obtaining the pass mark of 40%. The subjects they selected to integrate within their case studies ranged from incorporating an estimated date for discharge, achieving the Trust’s 1 pm discharge target, demonstrating benefits of patient information, examining the reasons for failed patient discharges and improving the process of requesting tablets to take home. The 3 students who failed did not demonstrate enough skills at degree level (level 6) to achieve a pass.

The university satisfaction feedback

The students did not rate any of the statements with disagree or strongly disagree. Where students were asked to comment on their positive responses, two themes were dominant “being able to look back and reflect on practice” and “encouraging and developing good multi-disciplinary team practice”. Appreciation was also shown in relation to networking and variety of speakers on the module. Following suggestions from the students two new guest speakers were included on the second module; mental health liaison nurse and a nursing home manager. Other comments related to the module being very useful, interesting and motivating and a second comment was ‘the module could be very valuable for pre registration students’; this point was noted for possible future development.

Individual student results have not been shared as agreement to share this information was not sought. Instead the group results from Band 5, 6 and 7 nurses have been analysed for improvement in knowledge and ability within each banding. The results revealed a dichotomy; the senior nurses (band 7) demonstrated a trend to estimate no improvement in their knowledge and ability post the module. The senior nurses stated that they thought of learning ‘as difficult to quantify and a life-long process’, they experienced difficulty critically reflecting upon their own practice, although they felt they reinvested the learning and ‘gave back to the system that had educated them’ through nursing (Hughes, 2005; Jarvis, 1995). The intermediate nurses (band 6) reported some change in knowledge and ability, while the junior (senior band 5 nurses) demonstrated consistent improvement across nearly all questionnaire statements. The exception was confidence, where they indicated no improvement over the module. Paradoxically, confidence and knowledge/ability are coterminous and provide rounded ability to perform a role; yet confidence may not be easy to critically reflect upon (Hughes, 2005) or perceived as important as knowledge and ability in the practice setting.

The nurses in the intermediate nurses group (band 6) and junior nurses (band 5), talked of learning purely as a mechanism ‘for getting promotion’ and ‘a reward for their hard work’ and a need to show improvement for their individual performance reviews (DH, NHS, KSF, 2004b). The NHS Knowledge and Skills Framework is meant to provide a fair and objective framework on which to base review and continuing development needs for all staff. Not only could these results demonstrate a difference in their level of maturity (Knowles, 1990 cited in Quinn, 2004) it may also serve to demonstrate difference between humanist and behaviourist types of learning throughout its multifaceted domains of achievement (Quinn, 2000). Moreover, it is possible that the behaviourist competencies emerging, combined with the progressive nature of the NHS Knowledge and Skills Framework (DH, NHS, KSF, 2004b) linked to pay rewards, may have contributed towards the difference in attitude and overall tendencies when self assessing and scoring.

Limitations

In the spirit of adult education students are allowed to attend lectures where they feel learning is needed, hence it is not possible to measure the extent to which incomplete attendance may have adversely influenced the results of the case study assignment mark awarded, or their self assessment using the questionnaires.

Table 2

<table>
<thead>
<tr>
<th>Area where project was based</th>
<th>Project choice</th>
</tr>
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<tbody>
<tr>
<td>Cardiology</td>
<td>HEFT 1300 h discharge target</td>
</tr>
<tr>
<td>Respiratory (two students shared project)</td>
<td>Patient information leaflets</td>
</tr>
<tr>
<td>Discharge lounge</td>
<td>Improving Transport links</td>
</tr>
<tr>
<td>Acute medicine (two students, different projects)</td>
<td>(1) Discharge tablets to take home</td>
</tr>
<tr>
<td>Trauma and orthopaedic</td>
<td>(2) Changes to the discharge care plan</td>
</tr>
<tr>
<td>Elderly care (two students, different projects)</td>
<td>Patient progress boards*</td>
</tr>
<tr>
<td>General medicine</td>
<td>(1) Estimate date of discharge</td>
</tr>
<tr>
<td></td>
<td>(2) Using the discharge checklist</td>
</tr>
</tbody>
</table>

* This project has subsequently been published in a Nursing Journal, which demonstrates a genuine commitment to improve discharge practice.

Individual organisational projects (changes)

Ten work based projects were implemented in clinical practice settings (Table 2). A significant factor influencing the choice of project was the Trust’s discharge standard, which is part of a yearly review process known as, CSAR (clinical standards audit review). The CSAR includes measures to audit the ward’s compliance against key factors of the discharge process, such as, completion of a discharge checklist, discharge information given to patients and achieving discharge by 1 pm. Each of the projects demonstrated that they had applied relevant aspects of theory in practice, in particular, the theory of constraints proved the most popular (Senge, 1990; Chapman and Howkins, 2003; Cave, 1994; Goldratt and Cox, 1993). For example, when students demonstrated this theory combined with process mapping, two clinical areas were able to identify where and what changes were needed to improve the discharge process (Chapman and Howkins, 2003).

Individual student improvement

Individual student results have not been shared as agreement to share this information was not sought. Instead the group results from Band 5, 6 and 7 nurses have been analysed for improvement in knowledge and ability within each banding. The results revealed a dichotomy; the senior nurses (band 7) demonstrated a trend to estimate no improvement in their knowledge and ability post the module. The senior nurses stated that they thought of learning ‘as difficult to quantify and a life-long process’, they experienced difficulty critically reflecting upon their own practice, although they felt they reinvested the learning and ‘gave back to the system that had educated them’ through nursing (Hughes, 2005; Jarvis, 1995). The intermediate nurses (band 6) reported some change in knowledge and ability, while the junior (senior band 5 nurses) demonstrated consistent improvement across nearly all questionnaire statements. The exception was confidence, where they indicated no improvement over the module. Paradoxically, confidence and knowledge/ability are coterminous and provide rounded ability to perform a role; yet confidence may not be easy to critically reflect upon (Hughes, 2005) or perceived as important as knowledge and ability in the practice setting.

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Permission to share the individual results from the questionnaire was not sought from the students and these could not be shared.

Conclusion

Modernising nursing careers offers one framework in which nurses will train, develop and apply life-long learning in the future (O’Dowd, 2007). It is also feasible, that as workforce and service redesign priorities gather pace, education funding routes could also change to a position where funding is directed away from professional development and toward workforce and service reconfiguration. Only by truly reflecting the clinical and service needs together into the commissioning process, as demonstrated with the discharge practice module, can education remain on course with the pace of change (Burke, 2006). Clinical priorities however differ from ward to ward, consequently so do the education commissions submitted by the ward leaders. For this reason there may never be sufficient uptake of the module on each ward to ensure the critical mass of nurses with the skills to deliver effective discharge practice. Influencing the leaders of wards to the ongoing educational needs of their staff and the outcomes from the patients perspectives must be adopted as they way forward to adopt a homogenous approach to delivering the educational agenda. Crucially, only a combination of appropriately commissioned educational modules and an innovative strategy to enable change in discharge practice at ward level, will assist Trusts to achieve the efficient discharge of patients from hospital (Manley and McCormack, 2003; Rycroft-Malone et al., 2002; DH, 2007; Roberts, 2007).

In future the results identified from the questionnaires could be used to design the module for specific student groups, thereby providing a bespoke module. This in turn could negate the need for students to attend a whole module concentrating instead upon specific areas of knowledge or confidence where deficits were identified. There may also be an optimal point in the nurse banding to undertake clinically focussed courses; the caveat being unless the practitioners are actively participating in a clinical role. This would indicate that instead of recruiting senior nurses (band 7) to such modules, as they have numerous management and administrative calls upon their time; perhaps senior band 5 and band 6 nurses may benefit more, remaining focussed upon using their skills in practice setting (Hughes, 2005). This new discharge module may prove to be the catalyst to small scale changes to discharge in practice at the Heart of England Foundation Trust (Ywye and Mc Clenahan, 2000). The ten organisational projects in practice contributed to small scale changes in the discharge process from the student back in the practice setting (Chapman and Howkins, 2003). Furthermore, the students were able to experience the reality of making changes to discharge practice in a clinical setting rather than a classroom. Ultimately revisiting the changes made in practice at the time of this module to assess if they continue to be embedded may reveal the extent of integrated learning principles. Notwithstanding, this module has demonstrated case studies and the application of projects in practice is possible albeit on a small scale.

Recommendations:

1. Currently discharge practice is not integrated into pre registration nursing education. This needs to be integrated in future.
2. In future the patients’ perspective of their discharge experience should be included.
3. Study days could be used to present a condensed version of the module for organisations finding it difficult to release staff from clinical areas.

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