Original Article

Patient and Caregiver Experience of Hospital Discharge from an Acute Medicine Unit via the Discharge Lounge: A Qualitative Case Study

L Lees-Deutsch, B Gough, J Yorke & AL Caress

Liz Lees-Deutsch
PhD. MSc. BSc. Nursing (First Class Hons). PG Dip. R.G.N.
Consultant Nurse and Lecturer and NIHR 70 @70 Nurse Research Leader
Acute Medicine Unit, Heartlands Hospital, University Hospitals Birmingham, West Midlands, UK
Institute of Clinical Sciences, The University of Birmingham, Birmingham, West Midlands, UK

Brogan Gough
BSc (First) Biomedical Sciences
Trainee physiologist in neurophysiology
St Woolos Hospital, 131 Stow Hill, Newport, NP20 4SZ

Janelle Yorke
Professor of Nursing
University of Manchester, Division of Nursing, Midwifery and Social Work, School of Health Sciences, Oxford Road, Manchester
The Christie NHSFT, Wilmslow Road, Manchester, M20 4BX, UK

Ann-Louise Caress
Professor of Nursing
Room RG 24 Ramsden Building, School of Human and Health Sciences, The University of Huddersfield, Queensgate, Huddersfield, HD1 3DH

Correspondence
Liz Lees-Deutsch
PhD. MSc. BSc. Nursing (First Class Hons). PG Dip. R.G.N.
Consultant Nurse and Lecturer and NIHR 70 @70 Nurse Research Leader
Acute Medicine Unit, Heartlands Hospital, University Hospitals Birmingham, West Midlands, UK
Institute of Clinical Sciences, The University of Birmingham, Birmingham, West Midlands, UK
Email: liz.lees-deutsch@nhs.net
lizleesdeutsch@icloud.com

Abstract

Discharge lounges enable the swift movement of patients imminently awaiting hospital discharge, to free beds without delay. This Qualitative Yin-Style Case Study describes the patient and caregivers experience of transition from an Acute Medicine Unit (AMU) to a discharge lounge and staff perspectives, as organisers of this process. Audio-recorded, interviews and focus groups were undertaken. Data were analysed using Framework Analysis. Lack of patient-centeredness in moving patients to the discharge lounge emerged with three themes: 'moving the problem'; 'being moved' and 'feeling removed'. Patients were transferred at accelerated speed. Communications between staff, patients and carers were abruptly curtailed. Patient transfer from AMU to a discharge lounge is a transitional stage in the acute discharge process and must be adequately communicated.

Keywords

Case Study, Patient Discharge (MeSH), Discharge Lounge, Discharge Process, Patients, Caregivers

Key points

- Older patients moved from AMU to a discharge lounge, prior to discharge, do not report this experience positively.
- If waiting times are optimized for discharge medications and transport patients are less likely to need to move to a discharge lounge, prior to discharge.
- Early communication to patients and their caregivers regarding possible transfer to a discharge lounge would help to prevent anxiety regarding this transition, especially amongst older patients.
- The brevity of length of stay on AMU, plus transfer to a discharge lounge results in a failed understanding of, and adjustment to, their new health status [being unwell to being well enough to go home] for some patients.

Introduction

Uninterrupted patient flow from the emergency department (ED) to Acute Medicine Units (AMU) is critical to maintain patient throughput.[1] To expedite patient discharge in AMUs, activities within the discharge process often take place in parallel (Figure 1).[2,3,4] Decisions underpinning discharge are often made pending blood results, therapy review to enable the multidisciplinary team to proceed without further Consultant review. Despite changes to improve the process of obtaining patient medications for discharge this is frequently the longest aspect of the process and once ready, often signifies the collective readiness for discharge. Moreover, as the rapidity of bed turnaround is pivotal to flow, AMUs use hospital discharge lounges to accommodate their patient's pre discharge. This study focuses on the experiences of patients admitted to AMU who were transferred to a discharge lounge; their caregivers prior to discharge from hospital and AMU staff responsible for patient transfers. To our knowledge it is the first study to illuminate patient and caregiver perspectives regarding the discharge lounge in the discharge process.

Background

A systematic search of several databases namely, CINAHL, HDAS, HMIC, HBE, BNI, PubMed and Social Care On Line was undertaken to ascertain previous work regarding discharge lounges (Table 1). Hospital discharge lounges have been

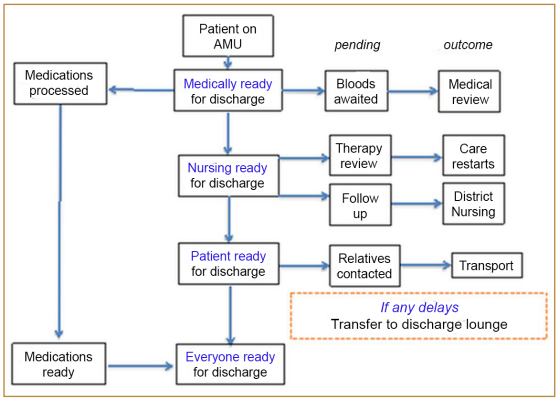

Figure 1. The discharge process on the AMU

Table 1. The literature search process

Search process	Description
Search terms	• Patient discharge (MeSH term) • Hospital AND Hospital Management • Bed Management OR Capacity Management • Discharge Lounge • Transit Lounge • Discharge Facility • Patient AND Carer Experience AND discharge Lounge
Electronic databases searched	• CINAHL • HDAS (Healthcare databases advanced search) • HMIC (Health Management Information Consortium) • HBE (Health Business Elite) • BNI • Pub Med & Medline • Social Care on Line
Manual search	Reference lists of all selected articles were searched to identify other relevant papers.

in existence in developed countries since the late 1990s.[5,6] Lounges aim to address any rate limiting steps in the discharge process. On the day of discharge these are usually completion of discharge paperwork; prescription and dispensing of take home medications and the organization of patient transport.[7] If these aspects cannot be optimised, a solution other than "blocking" a bed is required. A noted solution globally is the transfer of the patients to a discharge lounge, this until the necessary actions to allow discharge from the hospital itself are achieved.[8] In the UK a discharge Lounge[9] has been described as:

'a safe and pleasant environment for patients who no longer need their hospital bed but are awaiting the completion of various practical arrangements before they can be fully discharged'

(Corrigan et al, 2016 p.58)

While discharge lounges can positively impact on timely bed availability[5] the literature indicates some operational perspectives create problematic issues, which influence staff attitude to discharge lounges.[6] Issues such as: '*location of lounge and criteria'* and '*lack of communication to hospital staff*' contributed to cessation of staff prepared to transfer patients to the lounge. Corrigan et al[7] cited that staff '*felt reluctant to transfer patients*' and '*actively chose not to send patients there'* (p14). Whereas despite such issues, Zimmerman felt that staff should *'sell the features of the discharge lounge* (on and above) *the patient's own room'* (p343).[10] In one instance, the introduction of a lounge, decreased time waiting in ED from over 6 hours for 24.6% of patients, to 15.85%.[5] Moreover, patient discharges before noon were also increased from 33.8% to 41%. Hence, the whole point of using a discharge lounge is to 'reduce unnecessary bed occupation time' for patients (Shim et al, 2016, p387).[11] To date there is a dearth of literature that explores the patient and caregiver experience of this process.

Methods

Design

Meleis's Theory of Transitions[13] was selected to assist in the interpretation of data as it frames different types of transition: situational (divorce), organizational (moving into a nursing home) or health. For example, health transition may involve moving from being ill to being well, it concerns how the passage from one state to another is experienced and what responses are triggered. Hence the main components comprising the theory, are (1) the nature of the transition (2) the transition conditions/ dimensions and (3) the patterns of response. All transitions have common properties, such as, the timespan it takes to transition and critical points or stages involved.

A single site Explanatory Case Study design, after Yin[12] was used to enable 'how' or 'why' questions surrounding the complexities of patient discharge specific to the context of an acute medicine. A Case is described by Yin[12] as a study conducted in a 'real life context,' which facilitates the study of 'complex phenomena' (p13). One of the strengths of this approach is the adaptability of designs to meet the practical and theoretical aspects which are to be included. The theory or theories used are a critical element of a single Case Study and is used to identify the extent to which the results are generalizable to other similar settings.

Five sub units of analysis were selected; the term 'sub units' refers to embedded aspects of the Case where analysis can be drawn. In this study these were elements of the acute discharge process, namely: the ward round, patients and caregivers, AMU staff, Discharge Coordinators and early discharge strategies (e.g., discharge teams).

In keeping with a Yin-Style Case Study,[12] a proposition was developed to declare the original impressions of the researcher and *'to direct attention to topics of interest within the scope of the study'* (p22).[12] Proposition: The barriers and facilitators for patient discharge from the acute medicine unit are greatly influenced by available hospital capacity and how busy the AMU is at any point in time.

Table 2. Maximum Variation Strategy

End Point (s) (Where patient is being discharged to)	**Individual social circumstances** (Who they live with)	**Possible care component (s) on discharge from AMU** (Possible care input)
Group 1: Own home (Warden Controlled accommodation. Bungalow, House or Flat)	Lives alone With partner With parents With children	No care needed Partner a carer Discharge to assess scheme Intermediate care Social care Care package Mental health team.
Group 2: Homeless (on street) No fixed abode (friends) Homeless Hostel		
Group 3: Residential or Nursing Home	Previously resided	

Sampling

Patient and carer participants were purposively sampled according to a maximum variation strategy with the goal of recruiting 20 patient/carers.[14] The strategy enabled twenty types of patient discharge to be identified, depending on individual circumstances in the end point and care needs: from home with no changes, to home with complex care needs (Table 2). Patients were excluded if they were not likely to be imminently discharged, were acutely ill or dying. 41 Staff participants were purposefully sampled according to their role in expediting patient discharge. Clinical gatekeepers extended invitations to patients according to the study protocol. Patients were given written participant information. Invitations to participate in the study were extended to AMU staff through email, including participant information.

Written consent was received from patients, caregivers before interviews and staff before focus groups.

Data collection

Data were collected through audio-recorded, semi-structured interviews and exploratory heterogeneous focus groups, undertaken by the lead author. Topic guides with interview questions were developed and pilot tested (Table 3). All audio recordings were anonymised at the point of transcription, and pseudonyms applied.

Data coding and analysis

As a PhD student, my professorial supervision team provided guidance to aid my interpretation and analysis of the data. Ideas were conceptualized during the transcription process; reading and re-reading of the manuscripts continued extensively. A coding manual with a comprehensive list of codes and sub codes was produced. Framework Analysis[15] was used to organise the data. The Framework was produced deductively (research questions and literature review) and inductively through, coding and categorisation, to establish the core themes both within and across data sources. NVivo qualitative data analysis software[16] (version 11.2) was used to aid the organisation, management and retrieval of the data. Convergent and divergent aspects of the data were established and connections across the data matrices were identified and described. To ensure authenticity of data, both interview and focus group participants were offered a summary of their transcript, enabling them the opportunity to confirm whether or not they were in agreement with interpretations made.

Ethics and governance approvals were gained through a staged process commencing with the University of Manchester Research Ethics Committee (UREC No: 15408:10/2015: Sponsor ref: 15202), who granted permission for the Focus Groups with staff. This was followed by NHS REC permission to undertake interviews with patient and

Table 3. Interview questions

Interviews (with patients and caregivers)	**Question 1:** Describe the process of going home from the acute medicine unit. Describe the process of being transferred to the discharge lounge What worked well about the process What worked less well about the process
Focus Groups (with staff)	**Question 1:** Describe your involvement with the acute discharge process What are the Barriers and Facilitators in the process

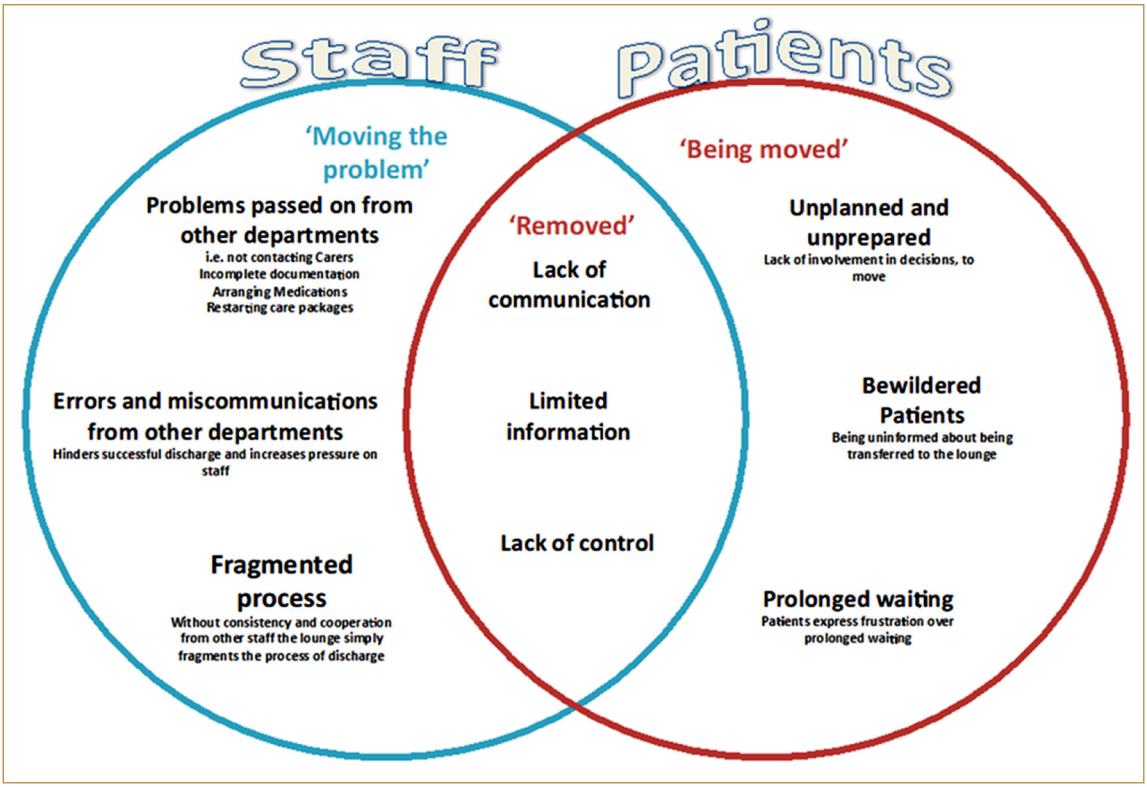

Figure 2. Summary of patient and carer perspectives regarding the discharge lounge

carers (REC permission: 15/LO/86 with R&D site permission, Ref: 2015028NG).

Findings

Characteristics of Sample

Twenty patients (11 male and 9 female) and eight caregivers (2 male and 6 female) participants were interviewed. Patients were aged 22 to 101 and caregivers were aged 55 to 83 years. Fifteen patients were aged above 72 years and their caregivers were often older. Caregivers comprised wives, husbands, daughters and a mom. While non-English speaking patient and caregivers were included in this study, none were recruited. During the period of recruitment, all patients in the AMU and awaiting transfer to nursing home had significant cognitive impairment precluding them from participating in the study. All interviews were conducted within a few days of hospital discharge and each interview took from between 25 to 60 minutes. Forty-one staff participants (eleven males and thirty females) were recruited across six focus groups, aged between 22 and 60 years of age, NHS Bands 5 to 8a. Focus Groups comprised nurses, doctors, therapists, pharmacists, a psychiatrist, social workers and discharge coordinators, each having between 5- 9 participants, lasting 45 to 70 minutes

Three major interrelated themes were identified as '*moving the problem', 'of being moved' and 'being removed'*, which are interpreted through the lens of Transition Theory[13] Within these themes were distinct perspectives from staff, patients and caregivers. Figure 2, summarises the main findings.

'Moving the problem'

Data contributing to this theme originated from staff that worked in the AMU and the hospital discharge lounge. These are problems passed from other wards or departments. AMU staff indicated patients waiting to go home, 'blocked beds' and created their problem. Conversely, for the discharge lounge staff, unfinished tasks related to the patient's discharge, constituted the problem. Frustrations are expressed from both perspectives.

A nurse in the AMU summarised the pressures faced in an AMU:

"It's quite difficult because we can't keep patients here for long after they are told they can go [by the Doctors], if we do let them wait for relatives, then we are blocking beds needed for ED patients… we just need beds and quickly… I suppose it can surprise patients … It's probably not a great service, but that's reality on an AMU".

Nurse, Focus Group (FG) 2

Staff working in the lounge regularly had to rectify problems they felt should have been resolved prior to moving the patient. One participant described:

'*There are too many cooks, passing the buck [problems or jobs] to someone else, rather than individual staff on individual wards dealing with issues as they arise'.*

Nurse, FG 4

Consequently, instead of assisting the efficiency of the discharge process, moving patients to the lounge was seen as a way of moving the problem on. Issues also related to a perceived lack of understanding from AMU staff regarding the nature of the work carried out in the lounge:

"We might take a bed bound patient at 8 O'clock (8am) and then they might not be picked up by ambulance crew until 4 O'clock (4pm), we are then doing full nursing care and feeding patients, just like a ward".

Nurse: FG 2

The urgency to create bed capacity necessitated moving patients to the lounge, often at short notice, which exacerbated problems associated with completing all aspects related to an episode of care. The implication was that AMU staff lacked appreciation regarding how much remaining work was needed to thoroughly check aspects of care were in place, e.g., families were aware, nursing homes were ready, in order to complete the patient's discharge after being moved to the lounge. Invariably all of this work involved significant time to chase up. Hence although older patients are considered medically fit for discharge on transfer to the lounge, if their end point is perhaps a nursing home, their dependency level is likely to be far greater than someone returning to their own home.

'Of being moved'

This theme arose predominantly from patients and caregivers, who described being moved at speed, with little or no notice to the discharge lounge, which caused them unnecessary anxiety. Staff described poor communications due to transfer to the lounge and how this disjointed the process of going home.

Highlighting the lack of prior notice of being moved to the lounge, a patient stated:

"One minute you are sat there minding your own business, the next minute your being wheeled along to a place you have never heard of (laughs)".

Sole interview with patient: IW 20

While a caregiver expressed her concerns in relation to her cognitively impaired mother's move to the lounge:

"I don't think she should have been moved, because I told them [the staff] I was on my way to fetch her and I even said, how long I would be. So, it was quite stressful for me to make sure that the lounge staff had done everything… I had originally discussed with ward staff. You know, I felt totally responsible for making sure everything had been done from the ward because Mom can't join in with the conversation anymore".

Joint Interview: SB & MB 29

Equally, staff working in the lounge described the repercussions of such speedy patient transfers out from AMU, where families are not always informed of the move:

"Often when patients arrive they ask us to let their family and sometimes carers know that they are going home, then when we do call the family, they have no idea that their relative is due for discharge"

Nurse FG 4

The repercussions of speedy transfers to the lounge were also confirmed in focus group discussions between pharmacists and nurses:

"Even the family don't know, do they, you phone them up and they are not aware the patient is going home that day, let alone having gone to the lounge, which is then hard because you have to explain".

Pharmacist, FG 4

Moving patients to the lounge created an additional stage in the discharge prior to leaving hospital for patients and their caregivers. The speed of the move from AMU caused anxiety and exacerbates any issues that are not fully resolved prior to the move for patients, carers and staff.

'Being removed'

This theme relates to the patient's experience of being physically removed from the AMU to the discharge lounge and how they felt once in the lounge. Both patients and staff express similar sense of frustration.

A typical experience was this patient's description of the suddenness of being removed from the AMU.

"Towards the end of my stay, I started to feel like I was in the way. They definitely wanted me out, but I couldn't go anywhere until the wife was ready to have me back. Then all of a sudden I was being packed up and moved. To be honest, I didn't know where I was going, other than they needed the bed quickly and needed me out of the way…"

"I knew nothing about him being ready to come home. It did feel like one big rush and at our age [82 and 88], we can't react. I couldn't get things together properly because they didn't tell me the plans. I went to the AMU to talk to the nurses, but he had already been moved".

Joint Interview patient and caregiver: FGP & AEP 27

The sense here is that this discharge was under review (pending), but that the communication with the patient regarding their discharge and move to the lounge was not explicit or pre planned, but reactionary according to bed capacity.

The move from AMU for some patients was often followed by a lengthy wait in the lounge and these patients expressed a sense of frustration:

"They come and pick you up from the ward to go to that lounge, which is alright, but you seem to wait a hell of a long time there… everyone [patients in the lounge] is like dummies and nobody talks."

Interview: AS & JS-22

The time spent by patients waiting in the lounge was attributed to waits for medications or transport, or, in the case of the longest waits, to relatives working full time, who could only come at the end of their working day. Although patients were frustrated by waits, staff in the lounge expressed further ramifications that, although infrequently, waiting time extended to beyond the time of community care provision. The direct consequence was that some patients could not be discharged:

"I've had so many cancelled discharges where by the time the ambulance has turned up [to the discharge lounge]*, say 5 O'clock, the social workers have gone for the day and I can't find out who the care provider is, to see if we can change the call time"*

Nurse FG 1

The patient situations described indicate that the process of their removal to the discharge lounge separates patients from staff they are familiar with and introduces a new environment patients and their carers are not familiar with, which creates some instances of initial stress. Waiting time spent in the lounge exacerbated patients' feelings about being removed from the ward and, paradoxically, the time spent by the patient waiting in the lounge sometimes annulled the original discharge plans.

Discussion

The study findings supported the pre-study proposition. Despite the speed to empty a hospital bed being essential, the process of patient discharge from AMU typically involved several periods of time spent waiting (Figure 1). Waits arose from organisational issues such as, dispensing of medications and the availability of hospital transport or where relatives were awaited to collect patients. Consequently such patients were more likely to be moved to the lounge, if these aspects are not optimised.

None of the older patients and carers interviewed cited positive aspects of their experience of transfer to the discharge lounge. The perception of these patients was one of being 'pushed out' of the AMU and 'too soon', which fractured patient connections developed with AMU staff. Patient moves are at times reactionary, according to the bed state and are at odds with being part of a pre-planned approach to patient discharges from hospital. This situation where patients were moved through different settings of in-patient care has been previously compared to being 'parcels' or being moved to a 'parking place', en route from hospital to home[4] (p10). Pressure (from lack of bed capacity) in one part of the acute discharge process amplifies the urgency to move patients at speed to the discharge lounge and is an anxiety provoking aspect of the discharge process, especially for older patients.[17] The experiences described here highlight the consequences of the way this AMU used the discharge lounge, at speed, often without adequate patient or caregiver preparation. Early explanation regarding the discharge process for patients admitted to AMU and their caregivers may allay patient and carer anxieties by better preparing their expectations of the discharge process.

Staff working in the discharge lounge perceived that the organization's performance indicators[18] aimed at reducing crowding in ED meant that outstanding patient discharge issues from the AMU were hurriedly relocated to staff in the lounge, for resolution. Lounge staff also felt that communication about these was poor. Tying up the loose ends in the discharge lounge, rather than prior to transfer from the AMU is understandably identified in this study as inefficient by staff and patients and their caregivers, alike. Hence, the consequences of moving patients to the lounge can be fractured communications and a lack of cohesiveness of the discharge plan for patients, caregivers and staff.

Meleis' transitions theory[13] has added a new insight into the experience of patients, caregivers and staff and the discharge lounge as part of the acute discharge process. Being admitted to and discharged from hospital are recognised to be a major life transitions.[19] In this case study, during the short time between being admitted and discharged, the status of patients was medically deemed to have changed

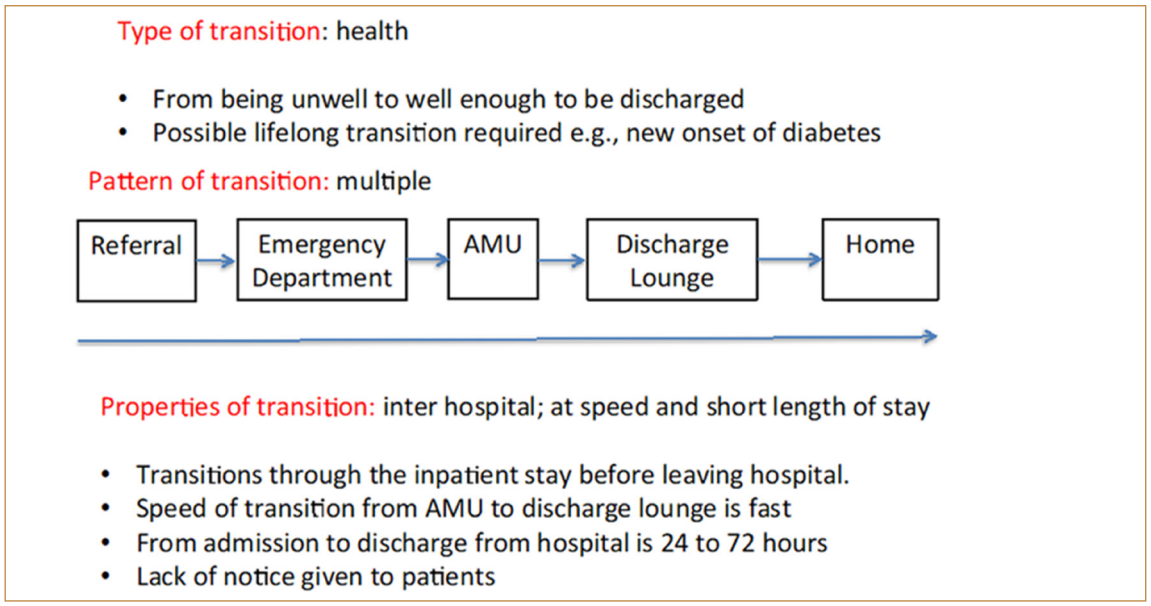

Figure 3. Acute medicine: transfers and transitioning for patients and carers

quickly from 'being unwell' to 'well enough' to go home from AMU. Although patients are well enough to be discharged, they need to adjust to this understanding of their health status, and sometimes, regardless how short their length of stay, to potential lifelong health transitions this may entail.[2] The older patients and caregivers in this study also described the 'properties of transition'[12] - how being prepared for discharge and ready for transfer to the lounge, was overlooked in the urgency to create bed availability. Consequently their 'patterns of response' were exacerbated, mostly through poor communications and hastened speed in transfer to the lounge (Figure, 3).

Owing to the 'pattern of transition' conditions described, it is proposed, patients admitted and discharged from an AMU remain 'in health transition' throughout their in-patient stay in AMU and due to speed of transition and sudden break in continuity of care from the AMU setting, these patients have not all realised 'a *transition to a fairly stable state*'. This type of health transition from an AMU, with the accompanying circumstances is not described in the current literature and is likely to become an increasingly pressing issue globally, given the increasing volume of patients admitted as an emergency.[20]

This was a single site case study conducted in the UK. Although single site studies lack large-scale generalizability, this study was conducted within an exemplar acute medicine unit incorporating core features advocated in national guidance.[21] This means that data from this study is comparable across medium to large acute medicine units in the UK developed using these guidelines.

Conclusion

Overall the patients and caregivers in this study expressed a lack of positive experience in being transferred to the discharge lounge. They felt removed from AMU to the lounge at accelerated speed, with little or no prior preparation or notice. This gave them feelings of powerlessness eliciting anxiety. The perception of lounge staff was that problems, in the form of unfinished tasks from the AMU are moved to them to sort. National U.K. guidance mandates that the discharge process and planning should be patient-centred with a focus on good communication.[22] This study's findings suggest that the current acute discharge process in acute care is at odds with this, requiring close attention and action to rectify issues, which relate directly to the discharge lounge.

High numbers of patient admissions and scarce bed capacity are a frequent occurrence in the AMU. Moving patients at speed without adequate explanation, gave rise to some of this study's findings. Discharge lounges clearly play a part in relieving some of the pressure on patient flow throughout a hospital to create timely bed capacity. Therefore the decision to move patients to the lounge should be part of a well-executed acute discharge process. However, our findings suggest that to be adequately prepared, patients and caregivers must be informed about the discharge process, on admission, to an AMU. This would enable an improved quality of patient and carer experience aligned with the close time proximity between admission and discharge. Moreover, this would empower some patients to make alternative arrangements, negating the need to be transferred to a discharge lounge prior to discharge from hospital.

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Conflicts of Interest

The authors have no conflicts of interest to declare.

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