

# BMJ Open Initiatives for improving delayed discharge from a hospital setting: a scoping review

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## ABSTRACT

**Objective** The overarching objective of the scoping review was to examine peer reviewed and grey literature for best practices that have been developed, implemented and/or evaluated for delayed discharge involving a hospital setting. Two specific objectives were to review what the delayed discharge initiatives entailed and identify gaps in the literature in order to inform future work.

**Design** Scoping review.

**Methods** Electronic databases and websites of government and healthcare organisations were searched for eligible articles. Articles were required to include an initiative that focused on delayed discharge, involve a hospital setting and be published between 1 January 2004 and 16 August 2019. Data were extracted using Microsoft Excel. Following extraction, a policy framework by Doern and Phidd was adapted to organise the included initiatives into categories: (1) information sharing; (2) tools and guidelines; (3) practice changes; (4) infrastructure and finance and (5) other.

**Results** Sixty-six articles were included in this review. The majority of initiatives were categorised as practice change (n=36), followed by information sharing (n=19) and tools and guidelines (n=19). Numerous initiatives incorporated multiple categories. The majority of initiatives were implemented by multidisciplinary teams and resulted in improved outcomes such as reduced length of stay and discharge delays. However, the experiences of patients and families were rarely reported. Included initiatives also lacked important contextual information, which is essential for replicating best practices and scaling up.

**Conclusions** This scoping review identified a number of initiatives that have been implemented to target delayed discharges. While the majority of initiatives resulted in positive outcomes, delayed discharges remain an international problem. There are significant gaps and limitations in evidence and thus, future work is warranted to develop solutions that have a sustainable impact.

## INTRODUCTION

A delayed hospital discharge (known as alternate level of care (ALC) in Canada and delayed transfer of care in the UK) occurs when a patient is medically approved to be discharged, but remains in hospital for non-medical reasons (eg, waiting for a long-term care bed to become available or to transfer

## Strengths and limitations of this study

- To our knowledge, this is the first scoping review to identify best practices for delayed discharges involving a hospital setting.
- The Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews Checklist was followed.
- A comprehensive search of peer reviewed and grey literature was conducted.
- A critical appraisal of the interventions was not performed.

home with services).<sup>1</sup> While waiting for their next destination, patients' level of care and activation often decrease or stop entirely. Delayed discharge can result in hospital patient flow issues (eg, emergency service backlogs, cancelled surgeries, delays in medically necessary care),<sup>2</sup> increased healthcare costs,<sup>3</sup> an increased risk of functional decline,<sup>4 5</sup> falls,<sup>6</sup> hospital-related adverse events (eg, medication error, exposure to infectious disease),<sup>6 7</sup> mortality,<sup>8</sup> as well as poor patient and family experiences.<sup>9</sup>

Patients who experienced a delayed discharge in previous studies exhibited the following characteristics: female,<sup>10</sup> older,<sup>10 11</sup> physically or cognitively impaired.<sup>4 12–15</sup> Patients have also shown to exhibit aggressive behaviours,<sup>16</sup> use assistive devices<sup>17</sup> and have psychiatric conditions,<sup>10</sup> neurological disorders<sup>15</sup> and/or multimorbidity.<sup>17</sup> In addition to these patient-level factors, there are a number of system-level factors that contribute to delayed discharges, including long wait lists for long-term care facilities,<sup>5 17–19</sup> rehabilitation or other postacute care (eg, home care),<sup>11 12 20–23</sup> the lack of culturally and religiously diverse long-term care facilities,<sup>15</sup> limited or absent hospital services on weekends<sup>24</sup> and organisational delays (eg, administrative delays, delayed assessments).<sup>24 25</sup> There are also



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different pressures and priorities across sectors, with little incentive to work together as a system. For example, while hospitals may be focused on efficiency and throughput, community-based organisations may be focused on empowerment, longer-term quality of life outcomes and working at a pace that works for patients and families. The funding structure of hospitals and healthcare systems can also have an impact on overall patient flow, including discharge delays. Although there is wide variation in funding structures within and across countries, there is potential for funding to either incentivise or disincentivise timely hospital discharges.<sup>26–30</sup>

The combination of patient-level and system-level factors contributing to delayed discharges can also have a large financial impact on patients, families, healthcare providers and the healthcare system.<sup>3</sup> A recent systematic review reported that delayed discharges cost approximately £200–565 (\$C320–\$C900) per patient, per day.<sup>3</sup> Further, it was estimated that the National Health Service (NHS) (England) spends £820 million (\$C1.3 billion) every year on patients who have a discharge delay.<sup>31</sup> Similarly, a recent report from Canada stated that three hospitals located in Ottawa, Ontario, spend approximately \$C250 000 per day (combined) on patients occupying beds at a level of care they no longer require.<sup>32</sup> In addition to large costs for hospitals and healthcare systems, delayed hospital discharges can result in out-of-pocket costs for patients and families.<sup>33</sup> Increased out-of-pocket costs, in addition to the other uncertainties associated with a delay, can heighten stress for patients and families, contribute to poor experiences and compromise quality of life.<sup>9</sup>

Overall, delayed hospital discharges are problematic internationally, highlighting a need to identify best practices and current initiatives that are concentrating on solutions to this complex problem. To date, the majority of published literature on delayed discharge has focused on risk factors and characteristics of patients who experience delayed discharge. There has been a limited focus on initiatives that address the delayed discharge problem. Therefore, the purpose of this scoping review was to examine peer reviewed and grey literature (literature published through non-traditional means) for initiatives that have been developed and/or evaluated for delayed discharge from a hospital setting, with the goal of identifying best practices for reducing delayed discharge. A scoping review methodology was appropriate for addressing this goal, in order to identify the types of available evidence on this topic, examine key characteristics relating to initiatives for delayed discharge and to identify knowledge gaps.<sup>34</sup>

## METHODS

This review followed the scoping review methodology outlined by Levac *et al.*<sup>35</sup> as well as the recently developed Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (see online

supplemental table 1).<sup>36</sup> A protocol for this scoping review was developed in consultation with a librarian at the University of Toronto, with continuous input from members of the research team.

### Stage 1: identifying the research question

The research question developed to lead this scoping review was: what is known in the literature about initiatives (eg, strategies, programmes, interventions) that have been developed, implemented and/or evaluated for delayed discharge involving a hospital setting? The two main aims were: (1) to review what delayed discharge initiatives entail (eg, characteristics, outcomes) and (2) to identify gaps in the literature in order to inform future studies.

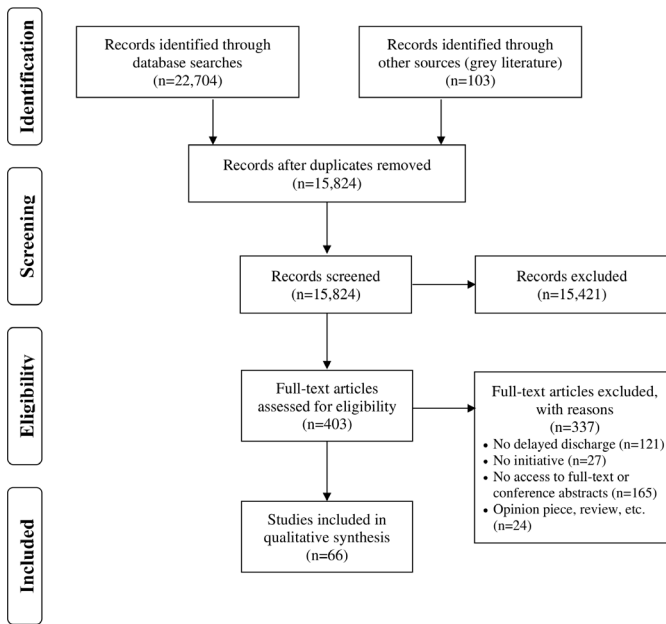
### Stage 2: identifying relevant articles

The search strategy was developed with a librarian at the University of Toronto and through consultations with an advisory group and collaborators who have experience in clinical practice or administration (see online supplemental table 2 for Medline search strategy). Each search strategy was adapted for the specific database using appropriate command line syntax and indexing. The following are examples of keywords searched using Boolean operators, proximity operators, wild cards and truncations: ALC, delayed discharge, delayed transfer, bed blocking, strategy, model, intervention, programme, policy.

Electronic databases were searched for relevant articles. The following electronic databases were searched on 16 August 2019: MEDLINE (Ovid Interface), EMBASE (Ovid Interface), AMED (Ovid Interface), Cumulative Index to Nursing and Allied Health Literature (EBSCO Interface) and Cochrane Library. Grey literature was searched on the following databases and repositories: OpenGrey, Health Services Research Projects in Progress, UpToDate, Community Research and Development Information Services and TSpace, as well as on numerous national and international healthcare and government websites. We also reached out to key stakeholders, including members of our advisory group, to send us relevant reports and presentations.

### Stage 3: study selection

For inclusion, articles (peer-reviewed and grey literature) were required to meet the following criteria: (1) focused on delayed discharge, (2) included an initiative to address delayed discharge, (3) involved a hospital setting, (4) published between 1 January 2004 and 16 August 2019 and (5) peer-reviewed or grey literature. We focused our inclusion on initiatives involving a hospital setting because this is where the problem of delayed discharges surfaces. Articles were excluded if they met any one of the following criteria: (1) focused on changing the threshold/timing of discharge (early discharge), (2) books, book chapters, opinion pieces or editorials, (3) grey literature that did not sufficiently describe the initiative implemented (eg, implementation process, location, population, impact);



**Figure 1** PRISMA flow diagram of included articles. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

(4) protocols, trial papers or chart reviews or (5) conference abstracts or articles without an accessible full text. Articles were excluded for criteria one (changing the threshold/timing of discharge) because the rationale for having an earlier discharge was often focused on other factors such as cost-savings by reducing length of stay, rather than specifically addressing a delayed discharge. Articles were excluded if they met criteria two (books, book chapters, opinion pieces or editorials) to eliminate articles with potential personal biases and summaries of peer-reviewed literature. Grey literature that did not provide sufficient details on the initiative (such as lacking a description of the components of the initiative) were excluded. Articles published more than 15 years ago, before 1 January 2004, were excluded to ensure the initiatives included in this scoping review were relevant to more current health service practices.

Articles identified from the database searches were imported into EndNote X9, a reference management software, where they were deduplicated following Bramer's method.<sup>37</sup> The initial database searches identified 22 704 articles, which were reduced to 15 824 following deduplication (figure 1). The titles and abstracts of the articles were reviewed on Covidence, a software platform for systematic and scoping reviews.<sup>38</sup> The research team (LC, KK, SJTG, KMK and JK) independently screened the titles and abstracts of 40 articles to test their agreement. The reviewers had a good per cent agreement (85%), so the remaining articles were divided among the team and screened by single reviewers (LC, KMK and JK). All disagreements were discussed in-person by the reviewers until a consensus was reached; minor revisions were made to the eligibility criteria to ensure clarity and consistency. Following title and abstract screening, articles were

reviewed at the full-text level. Thirty full-text articles were independently screened by the research team (LC, KK, SJTG, KMK, JK and MA) to test their interrater agreement. The remaining full-text articles (peer-reviewed and grey literature) were double screened by four reviewers (LC, KMK, JK and MA).

#### Stage 4: charting the data

The data were charted by two reviewers (LC and KMK) using a data extraction form in Microsoft Excel. The form was developed and tested by the research team in a series of team meetings prior to the extraction of all data. We conducted spot checking of extracted data from 15% of the included articles to ensure completeness and accuracy of the extracted data. Any questions that arose during the charting process were discussed by the team. Charted data contained the following information: general information, study characteristics, population characteristics, initiative characteristics, characteristics of delayed discharge, study outcomes and conclusions.

#### Stage 5: collating, summarising and reporting results

Microsoft Excel was used to conduct a descriptive quantitative analysis of the included articles, as well as facilitate qualitative thematic analysis. The thematic analysis of the charted data was an inductive and iterative process, in which the team (LC, SJTG, KMK and KK) met in-person to discuss high level concepts and identified common themes across the included articles. When reviewing the extracted data, we found that the strategies appeared to cluster into core categories, which aligned with a conceptual framework developed by Doern and Phidd.<sup>39</sup> This framework classifies policy instruments/tools along a continuum (from those that are least coercive like information sharing to those that are more coercive like public ownership or, in our case, new infrastructure). We deductively applied Doern and Phidd's categories to classify our findings, with some minor adaptations. The five adapted categories were not mutually exclusive and included: (1) information sharing (live information sharing and documented recommendations); (2) tools and guidelines; (3) practice changes; (4) infrastructure and finance and (5) other (see table 1 for category descriptions and examples). The categories assisted with the organisation and presentation of the data.

#### Stage 6: consultation

The research team presented findings of the scoping review to key stakeholders (eg, hospital staff, patient and caregiver partners) through the planning process and analysis of results. These meetings were used to inform search terms, gather relevant documents, obtain feedback on the categorisation/organisation of initiatives, as well as identify knowledge gaps in order to develop targeted and actionable recommendations for future practice, policy and research.

**Table 1** Categories, descriptions and examples of initiative categorisation

Category name	Description	Examples
Information Sharing A—live sharing B—recommended initiatives— calls to action	<ul style="list-style-type: none"> <li>▶ A—information sharing through in-person or technology-based communication (synchronous communication)</li> <li>▶ B—information sharing through documents which share suggestions, recommendations or for information purposes (motivation)</li> </ul>	<ul style="list-style-type: none"> <li>▶ A—rounding, team meetings, one-on-one communication</li> <li>▶ B—examples: suggested strategies (or ‘calls to action’) which ranged from recommending investments in new long-term care beds, increasing funding for behavioural supports, audits and reports, encouraging team building</li> </ul>
Tools and guidelines	<ul style="list-style-type: none"> <li>▶ Tangible/concrete guides to inform practice</li> <li>▶ Implemented tool/guidance document that is being used in the healthcare system</li> </ul>	▶ Toolkits, guidelines, escalation processes, frameworks
Practice changes	▶ A change in how care is delivered	▶ Nurse-led discharges, roles of providers and/or composition of team are organised differently
Infrastructure and finance	▶ Tangible structural or financial changes	▶ Financial penalties/incentives, building more hospital, rehabilitation or long-term care beds
Other initiatives	▶ Different initiative that does not fit into any of the above categories	▶ Statistical models (predictive modelling)

### Patient and public involvement

An advisory council (patient and caregiver partners), along with providers, managers and organisational leaders identified the lack of understanding about the state of evidence around best practices for delayed discharges, which informed the research question for this scoping review. The advisory council was involved with planning meetings where they provided feedback on the search terms and analysis. Results will be disseminated to the advisory council through presentations and a lay summary.

## RESULTS

### Study characteristics

The database search identified 15 824 unique articles that were screened for eligibility; following title/abstract and full-text review, 66 articles were included in this scoping review, 49 articles from the database searches and 17 articles from the grey literature searches (figure 1). The majority of included articles were quantitative studies (n=34), with a few qualitative (n=5), mixed methods (n=6) or other designs (policy analyses, reviews, case studies and presentations; n=21). There was a large variety of study designs, with few randomised trials and prospective studies. Most initiatives were evaluated (n=42), with different types of evaluations such as process evaluations and outcome evaluations. The UK (n=21), USA (n=18) and Canada (n=17) were the most common countries where studies were conducted. Based on the year of publication, there was a fairly even distribution of peer-reviewed articles across the years of inclusion (from 2004 to 2019); however, the majority of grey literature was published in the last 10 years. Table 2 describes the characteristics of included articles.

The initiatives most commonly targeted adults and older adults; however, there were some initiatives targeting the paediatric population. Specific characteristics of the study population (ie, age, sex, gender, ethnicity/race, income level, education, marital status, household composition, employment status, comorbidities) were not reported in the majority of articles. Most peer-reviewed articles (n=31) defined a delayed discharge; however, there was a wide variety of definitions for these terms (see online supplemental table 3). The most common definition for delayed discharge was when a patient was identified as medically ready for discharge, but remained in hospital. Table 3 describes the initiative characteristics.

Based on Doern and Phidd’s adapted framework,<sup>39</sup> we categorised the included initiatives as: information sharing (n=19); tools and guidelines (n=19); practice changes (n=36); infrastructure and finance (n=10); or other (n=3), which are described in detail below (see figure 2). Numerous articles used a combination of categories in their initiatives (eg, information sharing and practice change).

### Information sharing

The information sharing category included initiatives that promoted communication, leadership from senior staff and information exchange within or across organisations.<sup>2 40–55</sup> The majority of information sharing initiatives included team meetings and huddles to facilitate communication through in-person interactions between staff, and less often between staff and patients/families.<sup>40 41 43 44 46</sup> Information sharing was promoted between multidisciplinary teams and patients to improve length of stay and continuity of care. For example, Adlington *et al* implemented Plan Do Study Act cycles during weekly quality improvement meetings, in which driver diagrams

**Table 2** Characteristics of included articles

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
<b>Database searches</b>						
Adlington (2018) <sup>40</sup>	UK	Reduce length of stay, bed occupancy and delays in discharge and promote care in the appropriate setting among functional older adults on a psychiatric ward	Quantitative Quality Improvement	Older adults (65+) on psychiatric ward	NR	<ul style="list-style-type: none"> <li>▲ Daily rounds and management focusing on long-stay patients were effective in improving length of stay and bed occupancy</li> <li>▲ Sustained improvements needed support from the quality improvement programme and community team</li> </ul>
Ardagh (2011) <sup>63</sup>	New Zealand	Identify 10 common challenges and promising initiatives relating to patient flow and emergency department overcrowding	Qualitative NR	NR	NR	<ul style="list-style-type: none"> <li>▲ To improve patient flow and emergency department overcrowding the following are needed:               <ol style="list-style-type: none"> <li>a. a comprehensive, systematic approach</li> <li>b. changes to resource usage</li> <li>c. sharing of expertise and experience</li> </ol> </li> </ul>
Arendts (2013) <sup>68</sup>	Australia	Determine if hospital length of stay for older patients is reduced when an allied health intervention is introduced in the emergency department (ED)	Quantitative Non-randomised prospective pragmatic study	ED patients (65+) diagnosed with one or more of six conditions (cerebrovascular insufficiency; fractured neck of femur; cardiac failure; myocardial ischaemia; exacerbation of chronic airways disease; respiratory tract infection)	3572	<ul style="list-style-type: none"> <li>▲ Multidisciplinary allied health team assessment in the emergency department has no benefit in reducing hospital length of stay</li> </ul>
Baumann (2007) <sup>65</sup>	UK	Identify the factors causing good discharge practice performance and organisation of services	Qualitative Descriptive	Health/social services staff with managerial involvement in discharges	42	<ul style="list-style-type: none"> <li>▲ Future research needs to explore the impact of the identified issues on patients, families and staff</li> </ul>
Behan (2005) <sup>93</sup>	UK	Explore the experience of service users across the UK during the first 6 months of the implementation of the Community Care (Delayed Discharges) Act	Qualitative Explorative	NR	NR	<ul style="list-style-type: none"> <li>▲ Fines have resulted in a reduction of delayed discharges</li> <li>▲ The act has brought health and social care together</li> </ul>
Béland (2006) <sup>69</sup>	Canada	Assess the transformation of the organisation and delivery of health and social services with additional interventions for frail elderly people	Quantitative Randomised controlled trial	Frail elderly	1309	<ul style="list-style-type: none"> <li>▲ Changing delivery of care for frail elderly persons is feasible</li> <li>▲ Integrated care can reduce hospital and nursing home use, without impacting cost</li> </ul>
Blecker (2015) <sup>70</sup>	USA	Evaluate the impact of a weekend hospital intervention on care processes, clinical outcomes and length of stay	Quantitative Interrupted time series observational study	Non-obstetric patients hospitalised	57 163	<ul style="list-style-type: none"> <li>▲ Increased care on weekends may contribute to improved hospital flow, without negatively impacting clinical outcomes (30-day readmissions and mortality)</li> </ul>

Continued

Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Boutette (2018) <sup>71</sup>	Canada	Serve frail elderly patients at risk of deconditioning and/or disability, caused by prolonged hospitalisation	NR Review/ description of programme	Frail older patients who are at risk of deconditioning and/or disability	NR	<ul style="list-style-type: none"> <li>▶ Key features of the model: proactive, restorative, collaborative and integrated, client-centred and cost-effective</li> </ul>
Bowen (2014) <sup>72</sup>	UK	Demonstrate that nurse-led discharges can improve efficiency on a short stay surgical ward, without impacting patients safety	Quantitative Case study	Adult ear, nose, throat patients having routine, elective, short stay surgery	265	<ul style="list-style-type: none"> <li>▶ Improved efficiency around discharge of elective short-stay ear, nose, throat patients</li> <li>▶ 95% of ear, nose, throat patients (for simple discharge) are discharged on time</li> </ul>
Boyd (2017) <sup>41</sup>	USA	Explore the leadership strategies used by hospital business administrators to reduce delayed discharges and improve profitability	Qualitative Multiple case study	Hospital administrators	3	<ul style="list-style-type: none"> <li>▶ Effective leadership from hospital administrators contributes to positive outcomes for patients, staff and the economy</li> </ul>
Brankline (2009) <sup>47</sup>	USA	Provide the appropriate level of care and patient choice when the patient is medically ready for transfer	Quantitative Pilot study	Medical floors with primarily elderly patients who require nursing home placement after discharge	25	<ul style="list-style-type: none"> <li>▶ Improved information exchange between hospitals and nursing homes</li> </ul>
Brown (2008) <sup>64</sup>	USA	Determine if the length of patient stay is reduced in the postanaesthesia care unit when nurses use discharge criteria	Quantitative Prospective clinical study	Adult, ASA physical status I, II, and III patients (18+) requiring general anaesthesia	1 198	<ul style="list-style-type: none"> <li>▶ Decreased postanaesthesia care unit length of stay and discharge delays while maintaining patient status</li> </ul>
Burr (2017) <sup>56</sup>	Canada	Develop a framework that would support ALC avoidance strategies across the Toronto Central Local Health Integration Network	Case study Case study	ALC patients	3 hospitals	<ul style="list-style-type: none"> <li>▶ ALC avoidance reduces burden on patients, families and providers</li> <li>▶ Long-term solutions to improve patient flow and avoid ALC should be sustainable and align with other initiatives</li> </ul>
Caminiti (2013) <sup>42</sup>	Italy	Evaluate the effectiveness of a strategy aimed to reduce delayed hospital discharge	Quantitative Cluster, parallel group, randomised trial/quality improvement	Hospital units: geriatric, medicine, long-term care	3 498	<ul style="list-style-type: none"> <li>▶ Physician direct accountability can reduce unnecessary and avoidable hospital days, especially when delays are within staff control</li> </ul>
Chidwick (2017) <sup>54</sup>	Canada	Discuss concepts and ideas that led to lowest ALC days in the province	Mixed methods Quality improvement	ALC patients	NR	<ul style="list-style-type: none"> <li>▶ Improved patient flow and reduced ALC days through the implementation of a multidimensional approach</li> </ul>
El-Eid (2015) <sup>73</sup>	Lebanon	Assess the effectiveness of the Six Sigma method in improving discharge processes	Quantitative Pre and post-intervention study	NR	17 054	<ul style="list-style-type: none"> <li>▶ Six Sigma can have a positive and sustainable impact on patient flow and length of stay</li> <li>▶ Discharge delays should be addressed through principles of Six Sigma, rather than institution-specific interventions</li> </ul>

Continued

Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Gaughan (2015) <sup>61</sup>	England	Investigate the reduction in hospital bed-blocking due to a greater supply of nursing home beds or reduced costs	Quantitative Statistical modelling - Empirical analysis	Patients waiting for hospital discharge	NR	<ul style="list-style-type: none"> <li>▶ Improved coordination between health and long-term care is essential for addressing delayed discharges</li> </ul>
Graham (2012) <sup>74</sup>	UK	Evaluate the effect of the laparoscopic nurse specialist on patient discharge	Quantitative Retrospective comparison	Laparoscopic cholecystectomy and laparoscopic inguinal hernia repair patients	128	<ul style="list-style-type: none"> <li>▶ Nurse-led discharge may increase discharge postlaparoscopic surgery without impacting patient care</li> </ul>
Gutmanis (2016) <sup>65</sup>	Canada	Outline change strategies and their impact health system transformation and those living with responsive behaviours and their family members	Mixed methods Quality improvement	Individuals with responsive behaviours	NR	<ul style="list-style-type: none"> <li>▶ Improved coordination and communication across sectors</li> <li>▶ Provided healthcare providers with learning opportunities</li> </ul>
Henwood (2006) <sup>48</sup>	UK	Examine the partnership between health and social care by exploring issues with hospital discharges	Case study Case study	Inpatients	NR	<ul style="list-style-type: none"> <li>▶ Addressing and improving delayed discharges requires partnerships between health and social care and a whole systems-based approach</li> </ul>
Holland (2016) <sup>57</sup>	USA	Report the development and evaluation of a discharge delay tracking and reporting mechanism	Quantitative Practice improvement project	Inpatients	NR	<ul style="list-style-type: none"> <li>▶ Discharge delays can be reduced if system and process breakdowns are identified and addressed</li> </ul>
Katsaliaki (2005) <sup>102</sup>	UK	Describe a project investigating potential care pathways for elderly people after discharge from hospital	Quantitative Discrete-event simulation, simulation model	Inpatients	NR	<ul style="list-style-type: none"> <li>▶ Simulation is a suitable methodology for recording and evaluating the new postacute packages</li> </ul>
Lees-Deutsch (2019) <sup>66</sup>	UK	Identify core characteristics of patient discharge criteria, recorded in clinical management plans or case notes	Quantitative Systematic observational retrospective review	Patients discharged from the acute medicine unit and short-stay units	50	<ul style="list-style-type: none"> <li>▶ Criteria-led discharge may be suitable for select patients in improving timeliness of discharge</li> </ul>
Levin (2019) <sup>84</sup>	Scotland	Examine the impact of Intermediate Care and the 72-hour target on delayed hospital discharge	Quantitative Controlled interrupted time series design	Patients aged 75+	107 022	<ul style="list-style-type: none"> <li>▶ Immediate impact on days delayed, but increasing rates days delayed over time suggests that Intermediate Care services may need to be adapted</li> </ul>
Lian (2008) <sup>58</sup>	Singapore	Develop methods to reduce the hospital length of stay for premature infants by 30%, within 6 months	Quantitative Retrospective review	Premature infants	78	<ul style="list-style-type: none"> <li>▶ Discharge planning should begin on hospital admission</li> <li>▶ Nurses should coach parents to prepare them to care for their infant at home</li> </ul>
Maessen (2008) <sup>75</sup>	Netherlands	Assess the effect of enhanced recovery after surgery programme on discharge delays	Quantitative Retrospective/ prospective study	Patients undergoing elective colorectal resection	173	<ul style="list-style-type: none"> <li>▶ Additional recovery statistics should be added as outcomes of the ERAS programme</li> </ul>

Continued

Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Mahant (2008) <sup>59</sup>	Canada	Determine if an audit-and-feedback intervention reduces delayed discharge in a general paediatric inpatient unit	Quantitative Prospective observational study	Paediatric inpatient	3194	<ul style="list-style-type: none"> <li>▲ Reduced inappropriate hospital days, without impacting readmission rates</li> <li>▲ Identified processes that impact inappropriate hospital days</li> </ul>
Mahto (2009) <sup>76</sup>	UK	Determine the effect of a diabetes outreach service on delayed discharges and avoidable admissions	Quantitative Cross-sectional audit	Acutely admitted patients with diabetes	137	<ul style="list-style-type: none"> <li>▲ The restructured hospital diabetes outreach service improved outcomes for inpatients with diabetes</li> </ul>
Maloney (2007) <sup>49</sup>	USA	Develop a web-based software application used to facilitate timely patient discharge	Quantitative Quality improvement pilot project	Inpatients	NR	<ul style="list-style-type: none"> <li>▲ Healthcare information technology can facilitate bed management efficiencies</li> <li>▲ Improved coordination and overall inpatient flow</li> </ul>
Manville (2014) <sup>95</sup>	Canada	Determine if providing interdisciplinary care on a transitional care unit will result in improved clinical outcomes and lower structured retrospective chart audit costs	Quantitative Before-and-after structured retrospective chart audit	Elderly ALC patients (70+)	135	<ul style="list-style-type: none"> <li>▲ Improved health functional outcomes, delivered at a lower cost</li> </ul>
Meehan (2018) <sup>77</sup>	UK	Explore patients' experiences of hospital discharge with the discharge to assess scheme	Qualitative Descriptive	Patients discharged through discharge to assess	30	<ul style="list-style-type: none"> <li>▲ Patients and caregivers reported positive and negative experiences with the scheme, but it may be beneficial in improving outcomes for some patients</li> </ul>
Moeller (2006) <sup>60</sup>	Canada	Assess patient and physician-related barriers to discharging patients who have met objective criteria	Mixed methods Retrospective assessment	Patients with community-acquired pneumonia	31	<ul style="list-style-type: none"> <li>▲ Patients outcomes can be improved by standardising care through a critical pathway</li> <li>▲ Patients with poor functional capacity (using the Hierarchical Assessment of Balance and Mobility) may need additional services to improve discharge time after clinical stability</li> </ul>
Mur-Veeman (2011) <sup>61</sup>	The Netherlands	Explain the theory of buffer management and discuss related previous assumptions	NR Review/ theoretical paper	Bed blockers	NR	<ul style="list-style-type: none"> <li>▲ To practically apply buffer management, current routines, principles and beliefs should shift to focus on flow between organisations rather than within one organisation</li> </ul>
Niemeijer (2010) <sup>62</sup>	Netherlands	Reduce the average length of stay to create more admission capacity and reduce costs	Mixed methods Efficiency improvement project (retrospective and prospective data collection)	Trauma patients	2006:1114 2007:1124	<ul style="list-style-type: none"> <li>▲ Lean Six Sigma is effective in reducing length of stay and improving financial efficiency in trauma care</li> </ul>

Continued



Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Panis (2004) <sup>78</sup>	Netherlands	Reduce inappropriate hospital stay by adjusting patient logistics, increasing efficiency and providing comfortable surroundings	Quantitative Retrospective cohort study	Mothers of newborn patients	2889 days of hospital stay of gynaecology and obstetrics patients	<ul style="list-style-type: none"> <li>Discharge criteria can reduce inappropriate patient stays related to discharge processes</li> <li>Shifting maternity care to outpatient settings can reduce hospital length of stay</li> </ul>
Patel (2019) <sup>43</sup>	USA	Evaluate the impact of team-based multidisciplinary rounds on discharge planning and care efficiency	Mixed methods Quality improvement initiative	Dissatisfied patients with delayed discharge	1584	<ul style="list-style-type: none"> <li>Multidisciplinary discharge rounds can improve discharge efficiency, length of stay and 30-day readmissions</li> </ul>
Ali Pirani (2010) <sup>44</sup>	Pakistan	Emphasise the role of nurses to determine factors leading to a lack of discharge planning	NR Review/ summary	Those experiencing delayed discharge	NR	<ul style="list-style-type: none"> <li>Nurses play a key role in delivering patient-centred care and can improve discharge planning processes</li> <li>Nurses must have the appropriate knowledge about discharge planning and have the ability to communicate, coordinate and educate patients</li> </ul>
Qin (2017) <sup>103</sup>	Australia	Identify which barriers to discharge influence hospital occupancy when targeted by a hospital-wide policy	Quantitative Simulation modelling	NR	NR	<ul style="list-style-type: none"> <li>Hospital occupancy rates and overcrowding can be improved by improving discharge processes</li> </ul>
Rae (2007) <sup>96</sup>	New Zealand	Illustrate how the Delayed Discharge Project solved a bed crisis and controlled expenditure	Quantitative Continuous quality improvement project	Acute general medical	20034	<ul style="list-style-type: none"> <li>The project altered staff behaviour around patient discharge resulting in a better use of resources</li> <li>The system crashed 2 years post-implementation</li> <li>There is too much focus on length of stay and bed allocations leading to poor decision making</li> </ul>
Roberts (2013) <sup>50</sup>	Australia	Undertake a preliminary trial of the Goal Length of Stay tool at a rehabilitation centre	Quantitative Prospective study	Inpatients in two units: SRU or BIRU	202	<ul style="list-style-type: none"> <li>The programme did not reduce length of stay and was perceived negatively by staff</li> </ul>
Sampson (2006) <sup>79</sup>	UK	Describe bed occupancy data in people with diabetes before and after the introduction of a diabetes inpatient specialist nurse service	Quantitative Retrospective study	Diabetes inpatients	152 080	<ul style="list-style-type: none"> <li>Diabetes inpatient specialist nurse reduced excess bed occupancy</li> </ul>
Shah (2007) <sup>97</sup>	England	Examine the impact of the Community Care (Delayed Discharge) Act on bed occupancy and length of stay in Geriatric Medicine (GM) and Old Age Psychiatry (OAP) services	Quantitative Retrospective study	Inpatient - specialties of GM and OAP services	NR	<ul style="list-style-type: none"> <li>More patients were admitted to GM services and had a shorter length of stay than OAP</li> </ul>

Continued

Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Sobotka (2017) <sup>51</sup>	USA	Describe a hospital-to-home transitional care model	Case study Illustrative case design/ review	Paediatric inpatient	1	Transitional care programmes can improve care for vulnerable populations by reducing health and developmental differences
Starr-Hembrow (2011) <sup>80</sup>	Canada	Minimise the number of post-acute patients transitioning from hospital to long-term care and develop an integrated plan for appropriate care and placement	Quantitative Quality improvement	ALC patients	NR	Inter and intra-professional collaboration is important to standardise discharge processes, build trust and respect and improve coordination of care
Sutherland (2013) <sup>45</sup>	Canada	Describe structural challenges to reduce the impact of ALC patients and to propose policy alternatives that could reduce occupancy	NR Discussion and debate article	ALC patients	NR	A collaborative approach combining the three strategies should be considered to address ALC
Taber (2013) <sup>61</sup>	USA	Test a programme to improve length of stay, delayed discharges and early readmissions for kidney transplant recipients	Quantitative Observational study	Adult kidney transplant recipients	476	Improving medication safety post kidney transplant can improve clinical outcomes (acute rejection and infection rates, readmission rates)
Udayai (2012) <sup>82</sup>	India	Reduce patient discharge time through a Six Sigma project	Quantitative Time motion study	Cash patients	NR	Improving discharge time allowed for more patients to be managed, improving revenue Leadership support and employee participation were essential for success
Williams (2010) <sup>52</sup>	Australia	Examine the impact of a critical care outreach service on frequency of discharge delay from the intensive care unit	Quantitative Prospective cohort study	Patients discharged from the ICU	1123	The critical care outreach role did not decrease delayed discharges Reducing delays requires a collaborative approach focusing on hospital flow, rather than just the discharge process
Younis (2011) <sup>53</sup>	UK	Compare the effect of an enhanced recovery programme with preoperative stoma education on the number of patients with prolonged hospital stay	Quantitative Prospective study	Patients undergoing anterior resection with the formation of a loop ileostomy	120	Pre-operatively integrating stoma management education into an enhanced recovery programme can reduce delayed discharges
<b>Grey literature</b>						
Anonymous (2008) <sup>99</sup>	USA	Create an expedited discharge fund to pay for goods and services inhibiting a patient's discharge (medical equipment, medication and transportation)	N/A News article	Uninsured patients	NR	Patients can be safely discharged through support from the discharge fund
Anonymous (2010) <sup>46</sup>	USA	Improve patient flow through initiatives that decrease length of stay and increase capacity	N/A News article	NR	NR	NR

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Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Calveley (2007) <sup>83</sup>	UK	Create a tier of support to reduce the unnecessary and costly occupation of hospital beds	N/A Review	NR	NR	<ul style="list-style-type: none"> <li>Healthcare solutions should be developed in partnership with health and community service providers</li> </ul>
Manzano-Santaella (2009) <sup>100</sup>	UK	Analyse the relationship between Payment by Results and the Delayed Discharges Act	N/A Policy analysis	NR	NR	<ul style="list-style-type: none"> <li>Quantitative measures (days delayed and costs) conflict with the social aspects of overall health and well-being</li> </ul>
Krystal (2019) <sup>86</sup>	Canada	NR	Mixed methods Continuous quality improvement and evaluation	Medically and socially complex and frail elderly	100+	<ul style="list-style-type: none"> <li>Engaging partners early in the conception of the programme was critical to its success</li> </ul>
Walker (2011) <sup>2</sup>	Canada	Develop recommendations of care for frail Canadians	N/A N/A	NR	NR	<ul style="list-style-type: none"> <li>Community supports should be increased to keep people in their home as long as possible</li> <li>Programmes and services should be aimed at restoration and reactivation</li> </ul>
North West Community Care Access Centre (2011) <sup>88</sup>	Canada	Create a fact sheet of the benefits of staying at home and using Wait at Home (enhanced home care services while people wait for long-term care)	N/A N/A	Seniors waiting for LTC placement	NR	<ul style="list-style-type: none"> <li>Staying home provides benefits for seniors including fewer risks (germs/ viruses) and a familiar setting compared with the hospital</li> </ul>
Toronto Central Community Care Access Centre (2015) <sup>67</sup>	Canada	NR	N/A N/A	NR	NR	<ul style="list-style-type: none"> <li>This framework can help improve results around ALC avoidance and management</li> </ul>
Province of New Brunswick (2017) <sup>92</sup>	Canada	Identify priority strategic initiatives and implement community support orders across the province	N/A Annual report	NR	NR	NR
NHS Improvement (2018) <sup>94</sup>	UK	Create a how-to guide explaining implementation approaches to reduce length of stay	N/A Guide	NR	NR	<ul style="list-style-type: none"> <li>Clinical leadership is essential for implementing these initiatives</li> </ul>
Starr-Hemburrow (2010) <sup>91</sup>	Canada	Improve patient flow through the implementation of change management initiatives	Quantitative Quality improvement	NR	NR	<ul style="list-style-type: none"> <li>Culture change requires support and attention to be sustained over time</li> </ul>
LHIN Collaborative (2011) <sup>87</sup>	Canada	Help support patients in their homes for as long as possible by providing them with community supports	N/A Implementation guide and toolkit	Patients (specifically high needs seniors)	NR	<ul style="list-style-type: none"> <li>Home First should be implemented as a system-wide approach</li> </ul>

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Table 2 Continued

Author (year)	Country	Objective	Method Study design	Participants	Sample size	Key conclusions
Shah (2011) <sup>90</sup>	Canada	Ensure the appropriate community resources are in place to support the patient on discharge	N/A Implementation guide and toolkit	High need seniors (75+)	NR	▶ Key success factors included: eliminating long discharge processes, having engaged leadership, having measurable targets, monitoring performance and educating patients and providers
Central East LHIN ALC Task Group (2008) <sup>84</sup>	Canada	Understand the impact of delayed discharges in the Central East regions of Ontario (reviewing data, reading reports, initiating a pilot study, developing a patient flow map)	N/A Report	ALC patients	NR	▶ ALC is a complex issue and requires coordination across sectors ▶ Implementation of the recommendations will help to reduce ALC days and improve patient flow
Adams, Care & Repair England (2017) <sup>98</sup>	UK	Assist older patients in returning home from hospital quickly and safely	Case study Case study	Older patients	1	▶ Large savings for the health system can be generated with the implementation of this intervention
Shah (2010) <sup>89</sup>	Canada	Describe the Home First approach, a philosophy for reducing ALC	Quantitative Quality improvement	Elderly patients	NR	▶ Allows patients the opportunity to regain independence and return home ▶ ALC solutions need a collaborative, cross-sectoral approach
Joint Improvement Team (2013) <sup>85</sup>	Scotland	Identify 10 action items to transform discharge processes	N/A Quality improvement/ stakeholder engagement	N/A	NR	▶ There are a number of factors to successfully reduce delays

ALC, alternate level of care; BIRU, brain injury rehabilitation unit; GM, geriatric medicine; ICU, intensive care unit; N/A, not applicable; NR, not reported; OAP, old age psychiatry; SRU, stroke rehabilitation unit.

**Table 3** Initiative characteristics

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
<b>Database Searches</b>					
Adlington <sup>40</sup>	Quality improvement programme ► Weekly quality improvement meetings with driver diagrams to implement Plan Do Study Act cycles	Older adults (≥65) on psychiatric ward	Hospital Mile End Hospital (Leadenhall Ward), 26 beds	Information sharing live	► Length of stay was reduced from an average of 47 days to 30 days ► Bed occupancy was reduced from 77% to 54%
Ardagh <sup>63</sup>	10 promising initiatives ► Special beds, hospital operations planning, discharge planning, access to imaging, responsive acute secondary services, pathways for acute patients, acute demand mitigation, enhanced ED layout, enhanced ED senior staffing, engagement of staff	NR	Hospitals	Tools and guidelines Practice changes	► Identified top 10 challenges and 10 promising initiatives related to patient flow and emergency department overcrowding
Arendts <sup>68</sup>	Allied health assessment ► A comprehensive assessment of patients by an allied health team within hours of presentation to the hospital through the emergency department	Patients (≥65) diagnosed with one or more of six predetermined conditions	Hospitals Two Australian tertiary hospitals	Practice changes	► No benefit in reducing hospital length of stay
Baumann <sup>55</sup>	N/A ► Qualitative study to identify factors associated with low rates of delayed discharges	Health/ social services staff with managerial involvement in discharges	Hospitals (6 sites) 4 southern sites, 2 northern sites	Initiatives described touch on all categories	► 6 high-performing hospital sites identified issues impacting delayed discharges (capacity, internal hospital efficiencies and interagency efficiencies) ► Resources and teams to prevent avoidable admissions ► Discharge teams to support nurses' discharge planning, ► Systems for monitoring and communicating patients' progress, ► Patient choice protocols ► Ensure availability of responsive transportation and discharge lounges
Behan <sup>93</sup>	Community Care (Delayed Discharge) Act 2003 ► Local authorities are financially responsible (payments) to acute hospital when patients remain in hospital because community care arrangements have not been made	NR	7 areas across the UK	Infrastructure and finance	► National decrease in delayed discharges between 2003 and 2004
Béland <sup>69</sup>	Integrated care ► Community-based multidisciplinary teams who provide integrated care and coordinate health and social service	Frail elderly	Community service centres/ organisations	Practice changes	► Significant (50%) reduction in the number of patients in the integrated care group that became ALC ► No significant differences in utilisation or costs between groups ► Increased caregiver satisfaction

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Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Blecker <sup>70</sup>	7 day hospital initiative <ul style="list-style-type: none"> <li>Increased hospital services on the weekend (eg, diagnostic imaging, weekend discharges, physician and care management services)</li> </ul>	Non-obstetric hospitalised patients	Hospital Tisch Hospital, 705 beds	Practice changes	<ul style="list-style-type: none"> <li>Decreased average length of stay by 13%</li> <li>Increased proportion of weekend discharges by 12%</li> <li>Decreased 30-day readmissions</li> <li>No changes in mortality</li> </ul>
Boutette <sup>71</sup>	Subacute care unit for frail elderly <ul style="list-style-type: none"> <li>Subacute care in a restorative environment (integrated care and restoration)</li> </ul>	Frail older patients who are at risk of deconditioning associated with a long hospitalisation	Hospitals Ottawa Hospital; Perley and Rideau Veterans' Health Centre	Practice changes	N/A
Bowen <sup>72</sup>	Nurse-led discharge <ul style="list-style-type: none"> <li>Allows nurses to facilitate discharge based on specific criteria that was developed to guide the discharge process (also allows for discharge in evenings and on weekends)</li> </ul>	Adult ear, nose, throat patients having routine, elective, short-stay surgery	Hospital University Hospital of South Manchester	Practice changes	Significant reduction in rate of delayed discharges in both audits
Boyd <sup>41</sup>	Communication and leadership <ul style="list-style-type: none"> <li>Efficient communication and leadership from hospital administrators</li> </ul>	NR	Hospitals (2) Part of a hospital conglomerate in Chicago	Information sharing live	Strategies for improving delayed discharges and reducing financial burden included efficient communication and effective leadership
Brankline <sup>47</sup>	Technology-assisted referrals <ul style="list-style-type: none"> <li>The use of technology to improve information exchange and processes, increase data accuracy and produce documents</li> </ul>	Elderly patients who require nursing home placement after hospital discharge	Academic Medical Centre	Information sharing live Tools and guidelines	<ul style="list-style-type: none"> <li>Decreased length of stay and improved timely discharges of patients resulted in cost savings</li> <li>Increased communication within and between the hospital and nursing homes</li> </ul>
Brown <sup>64</sup>	Discharge criteria <ul style="list-style-type: none"> <li>Nurse implementation of predetermined discharge criteria (activity, respirations, pulse, blood pressure, pain, etc)</li> </ul>	Adult, ASA physical status I, II, and III patients, 18 years or older, requiring general anaesthesia	Hospital Postoperative recovery area of a large, tertiary-care, academic hospital	Tools and guidelines Practice changes	<ul style="list-style-type: none"> <li>Decreased length of stay in the post-anaesthesia care unit by 24%</li> <li>Reduced discharge delays with nurse-led discharge</li> <li>No change in adverse events (airway obstruction, reintubation, arrest)</li> </ul>
Burr <sup>56</sup>	ALC avoidance framework <ul style="list-style-type: none"> <li>A framework of strategies to reduce ALC numbers and promote ALC avoidance</li> </ul>	ALC patients	Hospitals (3) 1. Michael Garron Hospital 2. Humber River Hospital 3. Toronto General Hospital	Tools and guidelines	<ul style="list-style-type: none"> <li>(1) MGH — exceeded ALC target by 20%, reduced number of ALC patients waiting for long-term care</li> <li>(2) HRH — culture shift after implementation of ALC framework recommendations</li> <li>(3) TGH — improved number of ALC admission avoidance cases</li> </ul>
Caminiti <sup>42</sup>	Physician accountability <ul style="list-style-type: none"> <li>Physician motivation and accountability through monthly reports and audits (can compare their length of stay results to other staff)</li> </ul>	Hospital Units: geriatric, medicine, long-term care	Hospital University Hospital of Parma, 1267 beds	Information sharing live	<ul style="list-style-type: none"> <li>Reduction in unnecessary, avoidable hospital days</li> <li>No significant changes in 30-day readmission or mortality</li> </ul>

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Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Chidwick <sup>54</sup>	Change ideas ► Identification of change concepts, followed by the development and implementation of change ideas to promote behaviour change	ALC patients	Hospital William Osler Health System	Practice changes Tools and guidelines Information sharing live	► Lowest ALC days in Ontario ► Eliminated ethical errors, improved patient discharge experience and decreased patient confusion
El-Eid <sup>73</sup>	Hospital throughput project using Six Sigma Methodology ► The use of Six Sigma Methodology to implement electronic patient requests, a floor clerk and a billing officer	NR	Hospital (tertiary care teaching hospital) American University of Beirut Medical Centre, 386 beds	Practice changes	► Significant reduction in length of stay post-intervention ► Decreased discharge time (2.2 hours to 1.7 hours)
Gaughan <sup>101</sup>	Increasing supply of nursing home beds ► The use of modelling to explore the effect of increased supply of nursing home beds or lower prices of nursing home beds on bed blocking	Patients waiting for hospital discharge	Hospital	Other initiative	► Increasing home care beds by 10% would decrease social care delayed discharges by 6%–9%
Graham <sup>74</sup>	Nurse-led discharge ► Nurse-led discharge following list of criteria (that each patient must meet)	Patients receiving laparoscopic cholecystectomy and laparoscopic inguinal hernia repair	Hospital Leicester Royal Infirmary	Practice changes	► Nurse-led discharge group were significantly more likely to be discharged on the day of surgery ► No significant difference in readmission rates or patients seeking primary care postdischarge
Gutmanis <sup>65</sup>	Behavioural Supports Ontario ► A quality improvement initiative for older adults with responsive behaviours through the identification of change strategies and knowledge translation best practices	Individuals with responsive behaviours	South West LHIN	Practice changes Tools and guidelines	► Decreased ALC care cases among persons with behavioural needs ► Improved perceptions from families and clients around patient care
Henwood <sup>48</sup>	Change Agent Team ► A team partnership between health and social care to explore the issues around delayed discharges	Inpatients		Information sharing live Tools and guidelines	► The Change Agent Team helped support implementation of contingency arrangements at the local level
Holland <sup>57</sup>	Tracking and reporting system ► Development and evaluation of a discharge delay tracking and reporting mechanism	Inpatients	Hospital (academic medical centre)	Tools and guidelines	► Individual patient discharges may be improved by tracking factors that cause delays ► Nurses took the time to provide comments regarding patient delays
Katsaliaki <sup>102</sup>	Intermediate care services ► Statistical simulations to investigate potential care pathways and associated costs	Inpatients	Hampshire Social Services	Other initiative	► 500 new places will help to balance the demand and capacity for intermediate care services by avoiding a deterioration of delay times

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Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Lees-Deutsch <sup>68</sup>	Criteria led discharge - Selection of Patients for Efficient and Effective Discharge <ul style="list-style-type: none"> <li>▶ Patient discharge is guided by a set of clinical criteria; once the patient meets the criteria, a member of the team can facilitate discharge</li> </ul>	Patients discharged from the AMU and both short-stay wards areas	Hospital (acute medicine service with four clinical practice changes)	Tools and guidelines	<ul style="list-style-type: none"> <li>▶ 27 patients were suitable for criteria led discharge, 23 were not</li> <li>▶ Mean wait time for the 27 suitable patients prior to discharge was 4 hours and 51 min</li> <li>▶ Discharge delays were often caused by system delays</li> </ul>
Levin <sup>64</sup>	Step-up intermediate care units <ul style="list-style-type: none"> <li>▶ A bridging service between hospital and home for individuals ready for discharge from acute care; allows for recovery and regaining of independence</li> </ul>	Aged 75+	Hospital	Infrastructure and finance	<ul style="list-style-type: none"> <li>▶ Reduced bed days delayed</li> <li>▶ Rate of days delayed increased over time</li> </ul>
Lian <sup>58</sup>	New discharge guidelines for premature babies <ul style="list-style-type: none"> <li>▶ Development of new discharge guidelines for premature neonates</li> </ul>	Premature infants	Hospital Singapore General Hospital	Tools and guidelines	<ul style="list-style-type: none"> <li>▶ Reduced median duration of hospitalisation from 58.2 days to 34.9 days</li> <li>▶ Cost savings of \$6174/infant</li> </ul>
Maessen <sup>75</sup>	Enhanced recovery after surgery <ul style="list-style-type: none"> <li>▶ Reduction in the postoperative recovery period to reduce overall hospital length of stay</li> </ul>	Patients undergoing elective colorectal resection	Hospital	Practice changes	<ul style="list-style-type: none"> <li>▶ No significant difference in proportion of patients with a discharge delay post-ERAS programme</li> <li>▶ Approximately 90% of patients pre and post-ERAS were not discharged on the day discharge criteria/ functional recovery were met</li> </ul>
Mahant (2008) <sup>59</sup>	Medical Care Appropriateness Protocol-audit and feedback <ul style="list-style-type: none"> <li>▶ A tool that provides information on hospital bed use (qualified and nonqualified hospital days)</li> </ul>	Paediatric inpatients	Hospital Hospital for Sick Children	Tools and guidelines	<ul style="list-style-type: none"> <li>▶ Significantly lower risk of inappropriate hospital days</li> <li>▶ During the intervention, 33% of bed days were nonqualified, compared with 47% pre-intervention</li> <li>▶ No change in 48-hour readmission rate</li> </ul>
Mahto <sup>76</sup>	Hospital diabetes outreach service <ul style="list-style-type: none"> <li>▶ A service to prevent admission through a number of strategies (improved access to services, management of medical problems, early discharge planning, organisation of follow-up care)</li> </ul>	Acutely admitted patients with diabetes	Hospital New Cross Hospital, 700 beds	Practice changes	<ul style="list-style-type: none"> <li>▶ Reduction in bed occupancy, inappropriate admissions, delayed discharges and effective discharge planning</li> </ul>
Maloney <sup>49</sup>	Patient tracker <ul style="list-style-type: none"> <li>▶ A web-based application to facilitate the discharge process by enhancing communication between disciplines</li> </ul>	Inpatients	Hospital Primary Children's Medical Centre	Tools and guidelines Information sharing live	<ul style="list-style-type: none"> <li>▶ Decreased number of cancelled surgeries, median emergency department length of stay and average number of inpatient admissions</li> </ul>
Manville <sup>95</sup>	Transitional care unit <ul style="list-style-type: none"> <li>▶ A rehabilitation-style unit with enhanced nursing and rehabilitation services for elderly patients</li> </ul>	Elderly ALC patients (70+)	Hospital St Joseph's Hospital, 22-bed transitional care unit	Infrastructure and finance	<ul style="list-style-type: none"> <li>▶ Improved health outcomes and discharge disposition, decreased length of stay and costs per patient</li> </ul>

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Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Meehan <sup>77</sup>	Discharge to Assess ► Patients who require care support are discharged home, or to the community, for a needs assessment in their personal environment	Patients discharged through D2A	Hospital	Practice changes	► Assists with early and effective hospital discharge ► 60% of patients and caregivers reported a positive experience with D2A ► Communication was noted as an issue
Moeller <sup>60</sup>	Critical pathway ► Criteria for the management and discharge of patients admitted with community-acquired pneumonia	Patients with community-acquired pneumonia	Hospital Queen Elizabeth II Health Sciences Centre, 637 beds	Tools and guidelines	► 58% of patients with a prolonged length of stay felt they were ready to go home once reaching clinical stability, compared with 92% of patients without a prolonged length of stay ► Hierarchical Assessment of Balance and Mobility score at clinical stability was significantly associated with physicians' and families' assessment of the patients' discharge readiness
Mur-Veeman <sup>61</sup>	Buffer management ► A tool that aims to balance patient flow between hospital and nursing homes by maximising patient throughput	Bed blockers	Hospital to nursing home (intermediate care department)	Tools and guidelines	► The lack of cooperation is an inhibitor of buffer management ► Efforts should focus on improving cooperation between providers
Niemeijer <sup>62</sup>	Lean Six Sigma ► An initiative based on Lean Six Sigma to reduce length of stay, improve discharge procedures, create admission capacity and reduce costs	Trauma patients	Hospital University Medical Centre Groningen, 1339 beds	Tools and guidelines	► Average length of stay of all patients (surgical and trauma) decreased by 2.9 days post-intervention ► Average length of stay of trauma patients decreased by 3.3 days
Panis <sup>78</sup>	Dutch evaluation protocol ► Altering discharge procedures to assess inappropriate hospital stay, efficiency and patient logistics	Mothers of newborn patients	Hospital Maternity unit of 17 beds (715 total hospital beds)	Practice changes	► Reduction in inappropriate patient stay by 6.1% ► Decrease in length of stay by 0.7 days
Patel <sup>43</sup>	Multidisciplinary team-based structure for discharge rounds ► Interventions based around multidisciplinary team-based discharge planning rounds (afternoon huddles, pilot teams for physician continuity)	Dissatisfied patients with delayed discharge	Hospital University of Colorado Hospital, 673 beds	Information sharing live	► Higher proportion of patients discharged before noon, lower length of stay and 30-day readmission rate in pilot team compared with control
Pirani <sup>44</sup>	Nurse participation and patient and family involvement ► Communication between the nurse and patient/ family to promote continuity of care and coordination of services	Those experiencing delayed discharge	NR	Information sharing live	► Enhancing nurse involvement in the discharge planning process can improve delayed discharges
Qin <sup>103</sup>	Simulation modelling ► Statistical simulations to explore patient flow and different discharge strategies that could reduce hospital occupancy	Varies based on model	Hospital Flinders Medical Centre (FMC)	Other initiative	► Hospital occupancy can be significantly reduced, with a reduction from 281.5 to 22.8 days in the best scenario (instantaneous discharge for 24 hours)

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Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Rae <sup>96</sup>	<p>Delayed discharge project</p> <ul style="list-style-type: none"> <li>Local authorities are financially responsible (payments) to acute hospital when patients remain in hospital because community care arrangements have not been made</li> </ul>	Acute general medical patients	Hospital Dunedin hospital	Infrastructure and finance	<ul style="list-style-type: none"> <li>Mean length of stay decreased by 2.6 days (from 6.5 to 3.9 days)</li> <li>Decreased costs of service delivery by \$2.4 million</li> <li>Bed numbers decreased by 24 (from 56 to 32)</li> <li>No change in readmission rates</li> </ul>
Roberts <sup>50</sup>	<p>Royal Rehabilitation Centre, Sydney, goal length of stay tool</p> <ul style="list-style-type: none"> <li>A tool that reports the length of stay benchmark figures on an individual patient basis</li> </ul>	Inpatients in two units: SRU (stroke rehabilitation unit) or BIRU (Brain Injury Rehabilitation Unit)	Hospital Hampstead Rehabilitation Centre, 128 beds	Tools and guidelines Information sharing live	<ul style="list-style-type: none"> <li>Total discharge delays from the 2 units totaled 6311 days</li> <li>Length of stay was not decreased</li> <li>Negative perceptions of the programme from staff</li> </ul>
Sampson <sup>79</sup>	<p>Diabetes inpatient specialist nurse</p> <ul style="list-style-type: none"> <li>Diabetes management, based on structured group education, for all diabetes inpatients</li> </ul>	Diabetes inpatients	Hospital Norfolk and Norwich University Hospital NHS Trust, 989 beds	Practice changes	<ul style="list-style-type: none"> <li>Decreased mean excess bed days by 0.7 days (from 1.9 to 1.2)</li> </ul>
Shah <sup>97</sup>	<p>Community Care (Delayed Discharge) Act 2003</p> <ul style="list-style-type: none"> <li>Local authorities are financially responsible (payments) to acute hospital when patients remain in hospital because community care arrangements have not been made</li> </ul>	Inpatient - specialties of Geriatric Medicine (GM) and Old Age Psychiatry (OAP) services	Hospitals	Infrastructure and finance	<p>GM:</p> <ul style="list-style-type: none"> <li>Decreased median and mean length of stay</li> <li>Increased number of finished episodes (inpatient discharges)</li> <li>No relationship with number of bed days</li> </ul> <p>OAP:</p> <ul style="list-style-type: none"> <li>Increased median and mean length of stay</li> <li>Decreased number of finished episodes (inpatient discharges)</li> <li>Increased number of bed days</li> </ul>
Sobotka <sup>51</sup>	<p>Hospital-to-home transitional care programme at AHK</p> <ul style="list-style-type: none"> <li>A programme to support and educate families on providing care for medically stable children at home</li> </ul>	Paediatric inpatient	Transitional and Respite Centre Almost Home Kids	Practice changes Information sharing live	<ul style="list-style-type: none"> <li>2 months following support at AHK, the patient transitioned home to be cared for by his mother and home care team</li> </ul>
Starr-Hemburrow <sup>80</sup>	<p>Home First</p> <ul style="list-style-type: none"> <li>A programme designed to help keep patients in their homes (with community supports) for as long as possible; focusing on providing access to needed services</li> </ul>	ALC patients	Hospitals	Practice changes	<ul style="list-style-type: none"> <li>Rate of ALC patients decreased by at least 50% across the region of study</li> </ul>
Sutherland <sup>45</sup>	<p>Build more; integrated care; and Financial incentives</p> <ul style="list-style-type: none"> <li>Three strategies to improve ALC impact on hospitals (build more beds, integrated care, financial incentives for post-acute providers)</li> </ul>	ALC patients	Hospitals	Information sharing recommendation document	<ul style="list-style-type: none"> <li>N/A</li> </ul>

Continued

Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Taber <sup>81</sup>	<p>Comprehensive interdisciplinary improvement initiative</p> <ul style="list-style-type: none"> <li>▶ A programme implemented by a multidisciplinary team to improve length of stay, delayed discharges and early readmissions through key initiatives</li> </ul>	Adult kidney transplant recipients	Hospital Medical University of South Carolina	Practice changes	<ul style="list-style-type: none"> <li>▶ Delayed discharges decreased by 14%</li> <li>▶ Readmission rate (7 day) decreased by 50%</li> <li>▶ Acute rejection and infection rates decreased</li> </ul>
Udayal <sup>82</sup>	<p>Improvement in discharge process - Six Sigma</p> <ul style="list-style-type: none"> <li>▶ The implementation of strategies using Six Sigma to improve discharge processes (billing hour, patient audits, office executive, priority for discharge, ward boys, discharge process flow)</li> </ul>	NR	Hospital	Practice changes	<ul style="list-style-type: none"> <li>▶ Discharge time was decreased by 21% (from 247 to 195 min)</li> <li>▶ Patients had improved satisfaction with the discharge process</li> </ul>
Williams <sup>52</sup>	<p>Critical care outreach role</p> <ul style="list-style-type: none"> <li>▶ The implementation of a critical care outreach role to facilitate communication between ICU and ward staff</li> </ul>	Patients discharged from the ICU	Hospital Royal Perth Hospital, 22-bed ICU (570 total beds)	Practice changes Information sharing live	<ul style="list-style-type: none"> <li>▶ Delayed discharges increased by 4% (from 27% to 31%)</li> </ul>
Younis <sup>53</sup>	<p>Enhanced recovery programme</p> <ul style="list-style-type: none"> <li>▶ A programme post-colectomy surgery to improve stoma management and expedite discharge time</li> </ul>	Patients undergoing anterior resection with the formation of a loop ileostomy	Hospital Single district general hospital	Practice change Information sharing live	<ul style="list-style-type: none"> <li>▶ Average length of stay decreased by 6 days</li> <li>▶ Significant decrease in percent of patients experiencing delayed discharge due to independent stoma management</li> </ul>
<b>Grey literature</b>					
Anonymous <sup>99</sup>	<p>Expedited discharge fund</p> <ul style="list-style-type: none"> <li>▶ A hospital fund to pay for services that are holding up a patient's discharge (medical equipment, pharmaceuticals, physical and occupational therapy, transportation, etc.)</li> </ul>	Uninsured patients	Hospital Iowa City, University of Iowa Hospital, 700 beds	Infrastructure and finance	<ul style="list-style-type: none"> <li>▶ A patient from a rural area was provided with \$40/week for medications and gas to travel to a hospital that provided specialised wound care</li> <li>▶ A social worker found a group home for a patient with a mental health diagnosis for a patient who had no social support or funding</li> </ul>
Anonymous <sup>46</sup>	<p>Meetings</p> <ul style="list-style-type: none"> <li>▶ Daily and weekly meetings to discuss issues with patient throughput and strategies for eliminating barriers</li> </ul>	NR	Hospital University of Cincinnati Health University Hospital, 693 beds	Information sharing live	<ul style="list-style-type: none"> <li>▶ Decreased average length of stay by 5.34 hours</li> <li>▶ Increased accuracy of predicting next day discharges from the medical/surgical units by 40%</li> </ul>
Calveley <sup>83</sup>	<p>Tiered community-based services</p> <ul style="list-style-type: none"> <li>▶ Three tiers of services to allow for people to be cared for in their own homes or residential units, instead of in hospital</li> </ul>	NR	Hospital Four Seasons Healthcare, 18 000 beds	Practice changes	<ul style="list-style-type: none"> <li>▶ NR</li> </ul>

Continued



**Table 3** Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Manzano-Santaella <sup>100</sup>	<p>Payment by Results and Delayed Discharges Act</p> <ul style="list-style-type: none"> <li>▶ Payment by Results pays providers a fixed price for each individual case, while with the Delayed Discharges Act, local authorities are financially responsible when patients remain in hospital because community care has not been arranged</li> </ul>	NR	NR	Infrastructure and finance	<ul style="list-style-type: none"> <li>▶ Payment by Results and the Delayed Discharges Act are related policies</li> </ul>
Krystal <sup>86</sup>	<p>Southlake@Home</p> <ul style="list-style-type: none"> <li>▶ A team designed to meet the patients care needs through partnerships with community and primary care (integrates primary care, hospital care and home and community care to develop a personalised care plan)</li> </ul>	Medically and socially complex and frail elderly	Hospital Southlake Regional Health Centre	Practice changes	<ul style="list-style-type: none"> <li>▶ Reduction in ALC days (average of 10.6 days)</li> <li>▶ 1088 ALC days avoided</li> <li>▶ Positive patient and provider experiences</li> </ul>
Walker <sup>2</sup>	<p>Recommendations for improving care for the ageing population</p> <ul style="list-style-type: none"> <li>▶ Numerous recommendations to improve ALC in acute and community care ranging from proactively identifying patients at risk of decline in primary care to making hospitals more 'senior friendly.'</li> </ul>	NR	NR	Information sharing recommendation document	<ul style="list-style-type: none"> <li>▶ NR</li> </ul>
North West Community Care Access Centre <sup>88</sup>	<p>Wait at home</p> <ul style="list-style-type: none"> <li>▶ Allows seniors to get their healthcare needs from their home through a variety of services for a up to 90 days</li> </ul>	Seniors waiting for LTC placement	NR	Practice changes	<ul style="list-style-type: none"> <li>▶ NR</li> </ul>
Toronto Central Community Care Access Centre <sup>67</sup>	<p>ALC avoidance framework</p> <ul style="list-style-type: none"> <li>▶ To create a standardised approach to avoid delayed discharges through 12 leadings practices and associated strategies (identifying a date of discharge, engaging with substitute decision makers, etc)</li> </ul>	NR	NR	Tools and guidelines	<ul style="list-style-type: none"> <li>▶ NR</li> </ul>
Province of New Brunswick <sup>82</sup>	<p>ALC collaborative committee</p> <ul style="list-style-type: none"> <li>▶ A committee developed to identify and implement priority strategic initiatives</li> </ul>	NR	NR	Information sharing live Practice changes Infrastructure and finance	<ul style="list-style-type: none"> <li>▶ Reduction in percentage of acute hospital days used by patients waiting for discharge from 19.6% to 17.5%</li> </ul>

Continued

**Table 3** Continued

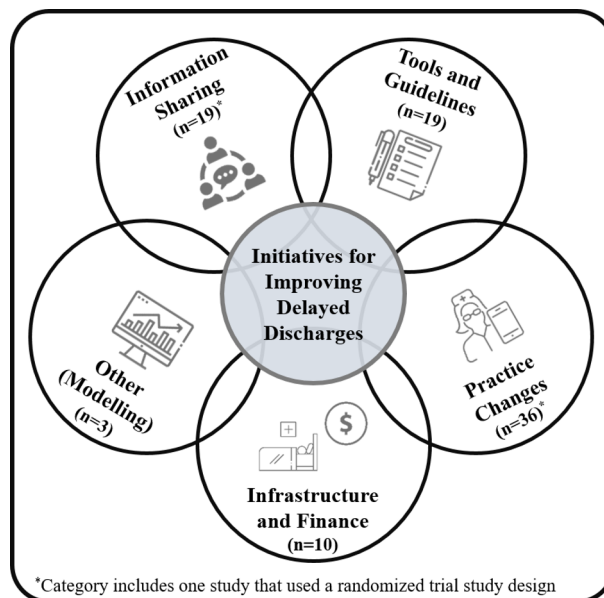
Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
NHS Improvement <sup>104</sup>	SAFER patient flow bundle ► A tool to reduce delays for patients on inpatient wards  Red2Green days ► A tool to reduce unnecessary waiting by patients  Long-stay patient reviews ► Weekly reviews of long-stay patients (>20 days), to help address obstacles that are delaying discharge  Multiagency Discharge Event ► Review of individual patient journeys by bringing together senior staff from health and social care	NR  NR  NR  NR	NR  NR  NR  NR	Information sharing recommendation document	► Most effective when used with Red2Green days ► Supports decision making by allowing staff to visualise plans ► A board (electronic or white) should act as a focal point for rounds  ► Weekly long-stay patient reviews can reduce the number of inpatients with a length of stay >20 days by up to 50%  ► Greatest impact on patients with a length of stay >6 days
Central East LHIN ALC Task Group <sup>54</sup>	Home First ► A programme designed to help keep patients in their homes (with community supports) for as long as possible by connecting patients to their needed resources	NR	Hospital Halton Health Services, 459 beds	Practice changes	► Percent of ALC (acute) reduced from 22%–28% to 4%–6%
Adams, Care and Repair England <sup>58</sup>	Home First ► A programme designed to help keep high needs seniors in their homes (with community supports) for as long as possible and involve the family in care	Patients (specifically high needs seniors)	NR	Practice changes	► NR
Shah <sup>89</sup>	Home First ► A programme designed to help keep patients in their homes (with enhanced home care supports) as they wait for long-term care	High need seniors (75+)	Trillium Health Partners, various community and long-term care organisations	Practice changes	► 2-fold reduction in monthly average of ALC patients ► 30.5% reduction in number of ALC to LTC hospital referrals
Joint Improvement Team <sup>85</sup>	► NR	ALC patients	9 community hospital corporations, 14 hospital sites and a mental health centre in one Ontario region 1642 beds across the facilities	Practice changes	► Expected to reduce ALC days by 30% over the next 3 years
Adams, Care and Repair England <sup>88</sup>	West of England care and repair ► Enables older patients to return home from hospital quickly and safely by organising and repairing home (cleaning, clearing clutter, small adaptations)	Older patients	West of England Care and Repair	Infrastructure and finance	► Substantial cost savings in hospital bed days, housing interventions and hospital staff time

Continued

Table 3 Continued

Author	Initiative Description/content	Target population	Setting	Initiative category*	Results
Shah <sup>89</sup>	Home First <ul style="list-style-type: none"> <li>▶ A programme designed to help keep patients in their homes (with community supports)</li> </ul>	Elderly patients	Hospital/ community in Mississauga Halton Local Health Integration Network	Practice changes	<ul style="list-style-type: none"> <li>▶ The equivalent of 35 acute care beds have been saved over 2 years</li> <li>▶ 250 people have been diverted from LTC placement</li> </ul>
Joint Improvement Team <sup>85</sup>	Home First – 10 actions to transform discharge <ul style="list-style-type: none"> <li>▶ Actions to improve the pathway from hospital to home focusing on achieving safe, timely and person-centred care</li> </ul>	NR	NR	Practice changes	<ul style="list-style-type: none"> <li>▶ Factors in reducing delays include: identifying estimated date of discharge, using a framework for admissions, transfers and discharges, appointing a provider for coordinating the patients discharge plan, screening for frailty, using transitional and intermediate care services, adopting a home first culture</li> </ul>

\*Initiative category is based on Doern and Phidd's adapted framework Hosseus and Pal.<sup>39</sup> AHK, almost home kids; ALC, alternate level of care; D2A, discharge to assess; ED, emergency department; ERAS, enhanced recovery after surgery; GM, geriatric medicine; HRH, Humber River Hospital; ICU, intensive care unit; LHIN, local health integration network; LTC, long-term care; MGH, Michael Garron Hospital; N/A, not available; NR, not reported; OAP, old age psychiatry; TGH, Toronto General Hospital.



**Figure 2** Categories of initiatives for improving delayed hospital discharges.

(visual displays) were used to share information with the multidisciplinary project team on issues affecting length of stay and hospital bed occupancy.<sup>40</sup> This information was used to guide practice changes aimed at improving communication during the discharge process (daily rounds, focusing on long-stay patients), bed management (nursing support to prevent deterioration) and community services (email updates and involvement of care coordinators). The majority of initiatives shared information though in-person communication; however, some used technology. Caminiti *et al* used technology-assisted communication to develop reports and audits to motivate and hold physicians accountable,<sup>42</sup> as in some health systems, physicians play a key role in designating patients as having a delayed discharge. Profiles for each physician were created monthly using hospital administrative data (containing length of stay, number of patients discharged that month). All information sharing initiatives resulted in positive outcomes (eg, reduced length of stay and a decrease in delayed discharges).

### Tools and guidelines

The tools and guidelines category included initiatives with actionable, concrete steps or processes in the form of tools, guidelines and models to inform practice.<sup>47–50 54–67</sup> Physicians and multidisciplinary teams (eg, nurses, social workers, discharge planners) frequently implemented tool and guideline initiatives. A promising initiative within this category included the ALC Avoidance Framework, developed by Burr and colleagues, with the goal of preventing ALC designations and reducing ALC rates.<sup>56 67</sup> This framework contains 12 leading practices, with specific strategies for organisational assessment. Some of the leading practices include: providing patients and substitute decision makers with an estimated date of discharge, identifying high-risk patients of becoming

ALC and implementing escalation processes for the management of ALC challenges. Additional initiatives focused on improving patient flow through criteria-led discharges (discharging patients once a predetermined set of criteria had been met) and critical pathways/discharge guidelines.

The majority of initiatives categorised as tools and guidelines had positive results,<sup>47–49 54–60 62 64–66</sup> which included a reduction in hospital days and length of stay. However, one initiative, the Goal Length of Stay Tool, did not have positive outcomes on length of stay.<sup>50</sup> This initiative incorporated information sharing into a computer-based programme to identify patients whose length of stay exceeded their benchmark figure. It had no change on length of stay and was perceived negatively by staff because they did not believe the benchmark figure was an accurate representation of a patient's current functional status and readiness for discharge.

### Practice changes

This category included initiatives that altered how usual care was delivered.<sup>51–55 63–66 68–92</sup> Common practice change initiatives included hospital-based, nurse-led discharges and cross-sectoral transitional programmes (eg, Home First, Discharge to Assess, Hospital to Home). Most were implemented by nurses and multidisciplinary teams. Nurse-led and criteria-led discharges often involved a predetermined list of criteria (clinical parameters) that a patient was required to meet in order to be discharged from hospital by a member of the discharge team. For example, Graham *et al* conducted a retrospective study (N=128) to compare nurse-led and doctor-led discharge (standard discharge pathway) postlaparoscopic surgery.<sup>74</sup> For nurse-led discharge, the patient had to meet 13 pre-established criteria (stable vital signs and comparable to baseline on admission; achieved optimal mobility; minimal nausea, vomiting and dizziness; adequate pain control; received written and verbal instructions about postoperative care, etc). When compared with the doctor-led discharge group (n=64), patients in the nurse-led group (n=64) were significantly more likely to be discharged on the day of surgery. In comparing reasons for the success of the nurse-led model, the authors did not tie to patient factors but rather the ready availability of the nurse specialist who was able to implement the clearly outlined discharge criteria (specific for nurse-led discharge) much more quickly than the doctor-led group (who did not use such criteria).

Another unique example of a practice change initiative was the 7-day Hospital Initiative implemented by Blecker *et al*.<sup>70</sup> The purpose of this observational study was to evaluate the impact of increasing weekend staff (hospitalists, care managers, social workers) and services on length of stay, percent of patients discharged on weekends, 30-day readmission rate and in-hospital mortality rate. This multifaceted intervention resulted in a decreased average length of stay, an increased proportion of

weekend discharges and no impact on readmission rates or mortality.

The majority of initiatives categorised as a practice change resulted in positive outcomes on length of stay and rate of discharge delays. However, there were several initiatives that were perceived negatively by patients,<sup>77</sup> or had no change<sup>68 75</sup> or a negative impact<sup>52</sup> on study outcomes (increase in delayed discharges). Meehan *et al* explored patient experiences with a programme (Discharge to Assess) that discharged patients who were clinically ready but still required support, in order for their needs to be assessed in their own environment (ie, at home).<sup>77</sup> Negative experiences were described by participants (patients and caregivers) who indicated feeling ignored, had poor communication with their healthcare providers and were not involved in the decision-making process. Negative outcomes were also identified in Williams *et al* prospective cohort study.<sup>52</sup> This study evaluated the impact of a critical care outreach role on delays in discharge and identified that discharge delays from the intensive care unit increased over the study period with the implementation of this role. The authors emphasised the importance of a multifaceted and collaborative approach (involving multiple stakeholders/ team members), focusing on patient flow throughout the hospital in order to address the numerous factors impacting delays.

### Infrastructure and finance

The infrastructure and finance category included initiatives that involved tangible structural or financial changes (eg, building more long-term care beds to facilitate the transition of patients out of hospital, financial penalties for remaining in hospital after being medically ready for discharge).<sup>55 92–100</sup> The Community Care (Delayed Discharges) Act in the UK was an initiative identified in multiple articles.<sup>93 96 97 100</sup> This initiative required local authorities to make payments to acute hospitals when patients could not be discharged because appropriate community care arrangements had not been made. Although this measure was not necessarily enforced, it created incentive for the hospital and community to work together more collaboratively. Additionally, transitional care units<sup>94 95</sup> and discharge funds<sup>98 99</sup> were common initiatives implemented to address delayed discharges among elderly patients. Transitional care units focused on rehabilitation to promote recovery and the regaining of independence, while discharge funds paid for services that were preventing the patient from being discharged or returning home (eg, medical equipment, medications, transportation, home repairs). All initiatives categorised as infrastructure and finance had positive results on study outcomes, including reductions in discharge delays, length of stay and cost.<sup>93–98</sup>

### Other initiatives

The other initiatives category included statistical and predictive modelling of initiatives to improve delayed discharges.<sup>101–103</sup> These models explored the impact of

increasing the supply of nursing home beds,<sup>101</sup> potential care pathways for the elderly and reimbursement costs<sup>102</sup> and discharge strategies to reduce hospital occupancy.<sup>103</sup> Gaughan *et al's* modelling and empirical analysis identified that increasing the supply of long-term care beds can decrease delayed discharges caused by a lack of social care.<sup>101</sup> Their models further emphasised the importance of communication between hospitals and the long-term care sector to reduce social care delayed discharges. Similarly, Katsaliaki *et al* used discrete-event simulations to determine care pathways and associated costs, in which they identified that adding new beds in hospital or intermediate care could reduce delay times.<sup>102</sup>

### Recommended initiatives: calls to action

Several articles were not evaluations but reports or reviews consisting of recommended initiatives to address delayed hospital discharges, which often combined a number of the categories illustrated above.<sup>2 45 92 104</sup> Sutherland and Crump outlined three key solutions for improving delayed discharges in Canada: building more acute and postacute care beds, increasing integrated care and creating financial incentives to improve the quality, quantity and effectiveness of healthcare.<sup>45</sup> The authors discussed challenges and limitations to implementing each of these options and emphasised that a potential solution to addressing delayed discharges was to combine the three strategies. Another Canadian report developed recommendations for providing care to the ageing population and those experiencing a delayed discharge.<sup>2</sup> Walker outlined recommendations for improving primary care, the care continuum and senior friendly acute care, responding to special needs populations (eg, persons with mental health concerns, addiction and neurological conditions, on dialysis or ventilators), and implementing an 'Assess and Restore' model (a programme to help patients maintain or regain functional independence, transition to home and remain in the community for as long as possible).

The NHS improvement (UK) also released a guide in 2019 on reducing long hospital stays.<sup>104</sup> This guide contained several recommendations for tackling delayed discharges including: a patient flow bundle (a tool to reduce delays for patients on inpatient wards), Red2Green Days (a visual tool to reduce unnecessary waiting by patients by supporting the rounding process), long-stay patient reviews (weekly reviews of long-stay patients (>20 days), to help tackle obstacles that are delaying discharge) and multiagency discharge events (review of individual patient journeys by bringing together senior staff from the local health and social care system).

## DISCUSSION

The purpose of this scoping review was to identify best practices for reducing delayed discharges, examine the characteristics of identified initiatives and develop recommendations for future work. Based on the 66 included articles, our findings showed that: (1) initiatives are

focused on quantitative outcomes, with limited assessment of the impact on patient, caregiver and provider experiences; (2) the sustainability of initiatives overtime is not measured (3) there is a lack of important contextual information reported (eg, population characteristics, setting, implementation processes) and (4) there are inconsistencies in how delayed discharges are defined.

This review highlighted where the majority of efforts around addressing delayed discharges have been placed. Practice change was the most common categorisation of initiatives (n=36), followed by information sharing (n=19) and infrastructure and finance (n=19). All initiatives categorised as information sharing and infrastructure and finance reported positive outcomes. Despite reporting positive outcomes, many information sharing initiatives promoted communication between staff, with a limited number targeting communication with patients and families. Additionally, there were more initiatives implemented in a single sector (eg, in hospital) in comparison to cross-sectoral initiatives (eg, hospital and home care).

Length of stay was the most common outcome measured in this scoping review, with a limited number of articles exploring patient, caregiver and provider experiences. For example, could it be considered a success if an initiative does not result in a reduced length of stay, but allows patients to obtain broader goals related to their care (ie, being able to return home) or enhance their care experience? Qualitative methods, including the capturing of patient, caregiver and provider experiences, would allow for a deeper exploration and understanding of success from the perspectives of different stakeholders involved in the initiative.<sup>105-107</sup> Experiential evidence on whether an intervention is working is required. As noted in our review, a tool developed to better understand delayed discharge was deemed irrelevant by care providers who felt that the tool captured the wrong information.<sup>50</sup> Therefore, capturing providers' experiences and perspectives are essential in understanding effectiveness of strategies as well as uptake. Most articles included in this scoping review used a quantitative study design, with limited articles using mixed methods or qualitative approaches; thus highlighting a key focus for future research.

The majority of initiatives had an intervention or follow-up period of 1 year, but this ranged from 4 months to 3 years. Based on the limited number initiatives with a follow-up period of longer than 1 year (n=8), there is a need for more formal evaluations with longer follow-up periods to measure the sustainability of initiatives over time. For example, Shelton *et al's* Integrated Sustainability Framework consists of five categories of factors associated with the sustainability of interventions across different contexts and settings: outer context (eg, policies, leadership, funding), inner context (eg, culture, mission, funding), intervention characteristics (eg, cost, adaptability, benefit), processes (eg, partnership, training/support, planning, capacity building) and implementer and population characteristics (eg, implementation skills/expertise, attitudes/motivation).<sup>108</sup>



Shelton *et al* recommended prospective, multi-level and mixed methods study designs for studying the impact and sustainability of interventions. Overall, the initiatives included in this scoping review had positive short-term impacts, but it is unclear if these outcomes are maintained over time. This emphasises the need to design and implement interventions with sustainability in mind.

The majority of categories of initiatives resulted in positive outcomes; however, initiatives classified as practice change had the most mixed outcomes (positive, negative and no change). Practice changes often require a greater number of resources and are more complex to implement than static solutions (ie, hosting daily rounds, developing a framework, etc). A recent systematic review (2018) conducted by Geerligs *et al* identified implementation barriers and facilitators of patient-focused, in-hospital interventions,<sup>109</sup> highlighting the complex interplay of factors that can impact implementation. Three domains, with the potential to impact the implementation process, were identified: system (environmental context, culture, communication processes and external requirements), staff (commitment and attitudes, understanding and awareness, role identity and skills, ability and confidence) and intervention (ease of integration, face validity, safety and legality and supportive components). Thus, it is important for interventions to be nimble and adaptable to support the changing need of patients, caregivers, providers, organisations and policy contexts over time.

It was also unclear if some initiatives moved problems from one sector to another. For example, adding more intermediate care beds may alleviate pressures in acute care in the short-term but eventually also be at full capacity if community resources are not available. The 7-day hospital discharge initiative highlighted in this review, improved hospital throughput but had no impact on re-admissions,<sup>70</sup> suggesting that thinking beyond one sector is required. It is encouraging that most practice change initiatives resulted in improved outcomes, but more clarity is needed to understand what the trade-offs were, as well as how to scale-up the successful initiatives.

Health systems also need to consider their broader goals around delayed hospital discharge—should it only be about reducing delays or should we place an equal focus on optimising patient and caregiver experiences and outcomes? The health system context, including the funding environment, will ultimately shape what interventions get implemented and how they are sustained over time. Some interventions may be considered low value in some countries and contexts and high value in others. Additionally, certain initiatives may be more effective in different environments, as variations in the number of hospital and long-term care beds per capita, infrastructure financing and degree of integration across sectors may impact the outcomes of an initiative. Future research needs to better understand why some strategies may thrive in some environments and not others.

Another key finding identified in the scoping review was the lack of information and details on the implementation

strategy (how strategies were implemented, over what time period, how implementation challenges were dealt with), setting (where was it implemented) and population characteristics (who was it implemented for). The implementation of initiatives can be impacted by differences in healthcare system structure and funding. Further, this contextual information is essential for both understanding outcomes, scaling-up and sustainability of interventions because it is not only important to know if the intervention was effective, but also for whom and in what context it was effective.<sup>110 111</sup>

Finally, this review highlighted a lack of consistency in how delayed discharge was defined, both within and across countries. While there was one definition that was used more frequently (a patient was identified as medically ready/fit for discharge, but remained in hospital), there can be different interpretations of when a patient is considered ‘medically fit’ and who makes this decision. Inconsistent definitions can lead to variations in the reported rates of delayed discharge, which can further impact the perceived applicability and effectiveness of an intervention. Our finding was echoed in a narrative review conducted by Glasby *et al*, who further explained the challenges differing definitions create when attempting to compare findings.<sup>112</sup> In order to mitigate these challenges, it is critical to be more consistent around how delayed discharges are defined.

### Future work

From this review, we have identified areas for future research. First, patient, family and provider needs and experiences should be explored during the development and implementation of initiatives aimed at improving delayed discharges. Patient and family engagement is both important and recommended by healthcare and government organisations; however, they are often excluded in the development and write-up of best practice guidelines.<sup>113</sup> Second, evaluation studies that track outcomes over a longer period of time should be conducted to study the sustainability of initiatives over time, how they are adapted (developmental evaluations), as well as their impact on other sectors (eg, primary and community care). Third, initiatives should be implemented and integrated across sectors (hospital, primary care and home and community care) to help get at the root of the problem and ensure the implementation of an initiative in one setting does not simply shift the problem to another. Fourth, a review should be conducted to assess the state of knowledge around initiatives that are more upstream in nature (eg, hospital admission avoidance, emergency department diversion and delivery models that proactively address the health and social care needs of individuals in community settings). Finally, there is an opportunity for future research to consider a realist review of the literature on delayed hospital discharge to understand the context, mechanisms of impact, outcomes and theories of change, given that addressing a delayed discharge is a complex problem. As a first step, we sought to include



interventions that included hospitals, and this revealed a single sector and reactive approach to addressing delayed discharge.

### Limitations

There are a few limitations of this review that should be noted. It is possible that some relevant articles were missed because the search was limited from 1 January 2004 and 16 August 2019 and conducted in English. Our search strategy was comprehensive and we conducted an in-depth search of grey literature to minimise the potential of missed articles. While we did not limit the inclusion of articles to the English language, our search strategy was in English, so there is a possibility that articles published in different languages were not identified. We excluded studies that changed the threshold/timing of discharge (early discharge), as they often focused on cost-savings. We acknowledge that some of these initiatives may have transferable lessons to address discharge delays, and thus, note their exclusion as a potential limitation of this review. Although it is not a requirement for scoping reviews,<sup>36</sup> the interventions in this review were not critically appraised, and thus, we cannot make recommendations on which interventions should be scaled up. Given concerns with regression toward the mean, especially for quality improvement projects, any positive results need to be interpreted with caution. Health systems are complex, evolving environments, where various iterations of strategies are regularly implemented, but not necessarily formally reported or published. Future work by our team will include a process evaluation on how strategies are actually implemented in different health system contexts, as well as why they work or do not work.

### Ethical considerations

There are a few ethical concerns associated with scoping reviews to be noted. These concerns include authorship, transparency and plagiarism. All authors met the International Committee of Medical Journal Editors' recommended criteria for authorship and author order was based on overall contribution to the review. We clearly outlined our methods at each stage of the scoping review to ensure transparency and replicability. We also acknowledged individuals who contributed to the review, but who did not warrant authorship. Lastly, when reporting the results of individual studies, we wrote them in our own words and cited appropriately to avoid plagiarism.

### CONCLUSIONS

This scoping review identified a variety of initiatives addressing delayed discharges across five categories: information sharing, tools and guidelines, practice changes, infrastructure and finance and other. The majority of initiatives were focused on practice changes and many incorporated more than one category. Initiatives were often implemented in a single sector, rather than across sectors. It appears that many strategies implemented in

hospitals including communication huddles, nurse-led discharges, home first programmes and building more infrastructure had positive short-term impacts. Many initiatives that led to positive outcomes were implemented by a multidisciplinary team and included a number of components (eg, monthly reports and education). The success of these initiatives is based on a service-led definition of success (effective use of hospital resources), rather than success from the patient and family perspective. This highlights the need to shift to a more patient-centred approach that focuses on improving outcomes and experiences, rather than system and hospital outcomes (ie, length of stay and hospital occupancy) alone. Despite the number of unique initiatives aimed at addressing delayed discharges, current strategies may not be getting at the root of the problem (initiatives/intervention prior to hospital admission) and there is a need for solutions to this problem that have a long-term and sustainable impact.

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