Strengthening Discharge Communications in Galway University Hospitals

Bringing Hospital Staff and Service Users together to Co-design Quality Improvements in Health Services

Background and context

Discharge communication

Hospital discharge is a time of transition in the patient's care, involving communication between the various hospital staff, with community health services, and with patients and their carers.

Clear communication at discharge is important in order to:

- Prevent medication mistakes
- Improve patient safety and overall experience
- Help avoid hospital re-admission

Suirbhé Náisiúnta ar Eispéireas Othar Cónaitheach | National Inpatient Experience Survey

The National Inpatient Experience Survey has found that discharge/transfer is the lowest-rated stage of care.

"We will work to ensure that each patient receives the correct amount of information they need on discharge and that our patients are proactively included in their plans around discharge"

- Galway University Hospitals (GUH), December 2024

Experience-based Co-design (EBCD)

EBCD is a method used to improve health services. In EBCD, service users (SUs) and staff identify priority issues and co-design solutions.

EBCD stages completed in our project

- SUs and staff were interviewed about their experience
- A video of SUs' experience was created
- Group events were held, the video is shared
- Priority areas were defined and co-design groups formed
- Co-design meetings were held
- Solutions were defined and tested

This project

A co-design group was formed around each of the three priority areas:

1. Medications
2. Discharge summary
3. Patient profiling

Medications co-design group

Aim: to improve communication around discharge medications

Group members

Service users
- 2 Patients
- 1 Representative from Family Carers Ireland

Staff
- 2 Pharmacists
- 1 Consultant
- 1 Medical intern
- 1 Medical social worker

Researchers
- 1 Principal investigator
- 1 Research assistant

Meetings 6 meetings were held: February-May 2025

Issues identified

- Mistakes on discharge prescriptions
- SUs were unsure of their discharge medications

Designing a solution together

1. **Double-checking** discharge prescriptions, recording and correcting errors
2. **Explaining** discharge medications using communication guidelines

Communication guidelines for staff

Plain Language: Use everyday language, avoiding medical jargon

The Teach-Back tool: Ask SUs to explain back important information about their discharge medications in their own words

Testing the solution in GUH

The process was tested in two wards from May-August 2025

Results 38 prescriptions were double-checked

40% of the prescriptions had mistakes

56 errors were recorded

Errors involved 26 types of medication

The double-check took 15 minutes on average

- 95% of the time, staff spoke with SUs about discharge medications
- 82% of the time, the Teach-Back method was used

Reactions and recommendations

Participating staff
- Prescription errors were reduced
- SU safety was improved

SU co-design group members
- Will the solutions become part of discharge practices in GUH?

Discharge Summary co-design group

Aim: to improve communication with service users of their discharge plans

Group members

Service users
- 3 Patients
- 1 Carer
- 1 Family member

Staff
- 2 Senior Nurse managers
- 1 Dietician
- 1 PALS lead
- 1 MSW
- 1 Porter

Researchers
- 1 Principal investigator
- 1 Research assistant

Meetings 4 meetings were held: February-May 2025

Issues identified

- Details of hospital stay were hard to keep track of
- SUs were unsure of the discharge plan

Designing a solution together

Updating GUH discharge booklet:

- Layout and language of booklet improved according to Health Literacy Dos and Don'ts

Examples of changes made to Discharge Booklet

- ✓ More images
- ✓ Less text
- ✓ Plain English
- ✓ Active voice

Section to note Doctor's name

"My Notes" and "My Medicines" sections

Testing the solution in GUH

The revised discharge booklet was tested on two wards in June 2025

Results Staff surveys (12) and 2 discussions on wards

92% of nurses found the booklet helpful

The booklet was easy to include in workflow

SUs received the booklet warmly

Helped standardise discharge communication

- Booklet not always suitable at time of admission
- Some concerns around SUs recording their medications
- Staff shortage can result in less time to explain booklet

Reactions and recommendations

Senior nursing staff

- Plan to launch the updated discharge booklet with some further edits

Patient Profiling
co-design group

Aim: To improve communications of SU living situation and needs when planning discharge

Group members

Service users
- 2 Patients
- 1 Carer

Staff
- Discharge Co-ordinator
- 1 MSW
- 1 OT
- 1 PT
- 1 CNM

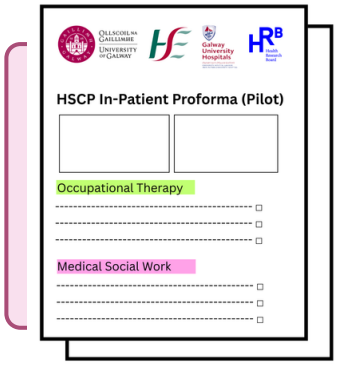
Researchers
- 1 Principal investigator
- 1 Research assistant

Meetings 6 meetings were held: March-August, 2025

Issues identified

- SUs' living situation and needs not always considered when planning discharge
- HSCP notes difficult to locate in SU chart

Designing a solution together



HSCP in-patient proforma

- Dedicated, editable record for OTs' and MSWs' notes
- New section in patient chart

Examples of HSCP proforma sections

- Home environment
- Risk assessment
- Social
- Assistive equipment
- Emotions
- Falls history

Testing the solution in GUH

The HSCP proforma was tested on one ward in September 2025

Results: Staff evaluation of proforma (2 OTs, 2 MSWs)

- The HSCP proforma is easy to find in SU chart
- The proforma covers all the necessary information
- Staff shortage made testing difficult
- Not all HSCPs were involved in testing

Reactions and rcommendations

- Need expansion to include all HSCP disciplines in the proforma
- Further testing in GUH
- Greater buy-in from hopsital to bring into routine practice

The co-design process
How did it go?

The co-design process was evaluated in three different ways:

A survey to evaluate the Experience-based Co-design process

Group discussions of the Experience-based Co-design process

Evaluation surveys after each of the service user, staff, and joint service user-staff meetings

"It was a great experience and I feel privileged to have been involved" - SU

"I had forgotten the great value of looking at problems in this way" - Hospital staff

"The experience was [...] eye opening on information given" - SU

Thank you for respecting my opinion and always trying to work on a solution when barriers arose" - Hospital staff

Participation

High participation and commitment: members attended almost all meetings

Barriers and facilitators

- ✗ Competing commitments
- ✓ Inclusivity, accessibility

Collaboration

- Viewpoints were well-balanced
- Members felt their opinions were valued and acted on
- Members felt meaningful partnership in their groups

Process quality

- Good facilitation
- Members were comfortable sharing views and experiences

Learning

- Increased understanding of the issues being addressed

Value and impact

- Expectations were met
- Members would recommend EBCD to others

Recommendations going forward

- Group membership: Aim for broad representation of staff groups
- Good communication: clear expectations around scope and timeline

We would like to acknowledge and thank:

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- Galway University Hospitals
- The Health Research Board

Do you have any questions?

Contact hprc@universityofgalway.ie

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Ollscoil na Gaillimhe University of Galway

HRB Health Research Board

HPRC Health Promotion Research Centre

HSE