

An ethnographic study of knowledge sharing across the boundaries between care processes, services and organisations: the contributions to 'safe' hospital discharge

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Plain English summary

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Patient safety remains a health policy priority. Despite advances in research and policy, studies continue to find worryingly routine levels of patient harm. This study focuses on the threats to patient safety associated with hospital discharge. It suggests that hospital discharge is a highly complex process involving multiple clinicians and stakeholders, operating in various settings. The quality and safety of these interactions can be related to the extent of knowledge sharing between stakeholders; where stakeholders openly share knowledge, they can better co-ordinate their work and reduce the complexity of hospital discharge. This study aims to identify interventions and practices that support knowledge sharing across care settings and thus promote safe hospital discharge by mitigating system complexity.

The study shows how hospital discharge does not occur as a single or isolated event, but rather through a complex series of situations and opportunities for knowledge sharing. However, these situations vary according to a number of key factors, such as the range of people involved, the types of resources they have access to and the level of leadership. The study also shows that stakeholders perceive a wide range of threats to safe discharge associated with falls, medicines, infection, clinical procedures, equipment, timing and scheduling, and communication. Drawing upon this research evidence, the report develops lessons for policy-makers and service leaders to support knowledge sharing, especially between health and social care agencies, and thereby mitigate system complexity and promote discharge safety.

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