

Acute Prioritization Over Transitional Preparation: An Observational Study of Discharge Planning in the Emergency Department

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Abstract:

Discharge planning must commence during emergency department admission to ensure continuity of care. Ineffective transitional preparation frequently leads to patient deterioration, medication errors, and increased hospital readmissions. This study evaluated the implementation of discharge planning within the emergency department of Jember Regency Hospital. Researchers employed a descriptive cross-sectional case study design to assess nursing practices. The sample included five emergency nurses and five patients across priority levels one through three. Data collection utilized direct observation and structured Guttman-scale checklists over five days. Findings revealed optimal execution during the initial patient admission phase, specifically regarding comprehensive healthcare needs assessment and interprofessional collaboration. Conversely, the preparatory phase exhibited significant clinical deficiencies, particularly in patient education concerning activity regulation, medication adherence, and dietary management. Critical patients prioritized for immediate life-saving interventions frequently bypassed these educational components. The final discharge and transfer phases demonstrated high compliance with logistical protocols, including medical order verification and transportation coordination. Systemic barriers, including high patient acuity, unpredictable emergency workflows, and the absence of standardized documentation templates, severely restricted comprehensive educational interventions. Emergency discharge planning requires urgent structural reforms to integrate proactive patient education directly into acute care workflows. Hospitals must develop standardized electronic protocols to enhance nursing standards, reduce preventable readmissions, and ensure seamless continuity of care across all patient priority levels.

Article info:

Submitted:

30-01-2026

Revised:

21-05-2026

Accepted:

10-06-2026

Published:

03-08-2026

Keywords:

continuity of patient care, discharge planning, emergency nursing, interprofessional collaboration, transitional care

DOI: <https://doi.org/10.53713/htechj.v4i4.629>

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INTRODUCTION

Discharge planning is a fundamental component of continuous patient care, designed to ensure seamless transitions from healthcare facilities to home environments (Williams et al., 2026). This comprehensive process encompasses coordinated activities to prepare individuals for post-hospitalization recovery (Rahayu et al., 2025). Healthcare institutions globally recognize this approach as an essential strategy for reducing medical errors and minimizing healthcare expenditures (Imhof et al., 2026).

The implementation of this critical process within the Emergency Department frequently remains suboptimal due to the overwhelming prioritization of acute medical conditions (Putri et al., 2021). Emergency nurses routinely face intense clinical demands that require them to prioritize

immediate physiological stabilization (Golcuk et al., 2026). Discharge planning becomes a secondary priority during the initial resuscitation phases. Such oversight creates a fragmented approach where vital preparatory steps are bypassed.

Inadequate transitional preparation is consistently associated with the rapid deterioration of patient health conditions and an increased risk of physical impairment following hospital release. Patients leaving the emergency setting without comprehensive educational guidance frequently experience severe medication errors (Gorlick et al., 2025). This lack of structured continuity ultimately increases the likelihood of unplanned return visits. These adverse outcomes impose significant burdens on patients while straining healthcare institutions (Charan et al., 2025).

Contemporary healthcare frameworks emphasize that effective discharge planning requires structured communication and early initiation during the very first patient assessment (Elmore et al., 2024). Modern clinical guidelines require nurses to systematically evaluate environmental factors and cognitive readiness immediately upon patient arrival (Surendran et al., 2024). Advanced care models integrate interdisciplinary collaboration from the moment of admission to ensure therapeutic interventions align with the home environment (Jones et al., 2022). These practices transform discharge planning into a continuous therapeutic intervention.

Current literature extensively covers discharge planning protocols in stable inpatient wards, yet empirical evidence detailing specific operational barriers within high-acuity emergency settings remains notably scarce (Kempton et al., 2026). Existing studies predominantly focus on standardized educational interventions in elective surgical units. Researchers have yet to fully capture the real-time execution rates of discharge-planning components across different patient-priority levels (Bechir & Bechir, 2025). This distinct lack of targeted observational data prevents administrators from developing evidence-based emergency protocols.

This study introduces a novel observational evaluation of the entire discharge planning continuum within a regional emergency department. By using a structured checklist, the research provides an unprecedented, granular view of how nurses perform specific preparatory tasks during clinical shifts (Tacbas et al., 2022). The integration of direct observation allows for a comprehensive mapping of both documented practices and verbal educational interventions. This methodological approach offers fresh empirical insights into the practical realities of emergency nursing.

The primary objective of this research is to describe and analyze the implementation of discharge planning at Jember Regency Hospital. Documenting these specific operational processes will directly inform the development of standardized electronic templates and triage-specific educational guidelines. Addressing this critical knowledge gap is essential for reducing preventable hospital readmissions and improving patient satisfaction (Cyrus et al., 2022). The findings will ultimately serve as a baseline for future quantitative studies to measure the effectiveness of discharge planning.

METHOD

This study employed a descriptive cross-sectional case study design. The research was conducted in the Emergency Department of Jember Regency Hospital, Indonesia. Data collection was carried out between December 2025 and January 2026, with participant recruitment and observations conducted from January 4 to January 8, 2026. The study population consisted of all 27 nurses working in the emergency department. Five nurses were selected using purposive consecutive sampling based on predefined eligibility criteria. The implementation of discharge planning was assessed using an observation checklist adapted from previously published research. The instrument employed a Guttman scale with dichotomous ("Yes" or "No") response options. Data

were collected through direct observation of nurses during routine patient care, complemented by brief interviews to clarify observed practices when necessary. Descriptive statistical analysis was performed to summarize the implementation of discharge planning. The findings are presented as frequencies and percentages. Institutional permission to conduct the study was also obtained from Jember Regency Hospital prior to data collection.

RESULTS

The implementation of discharge planning at the time of patient admission to the Emergency Department (ED) by ED nurses at Jember Regency Hospital involved five patients classified under priority levels P1–P3, each managed by five assigned nurses.

Table 1. Implementation of Discharge Planning

Discharge Planning	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Total
	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	
	Priority 1 (P1)	Priority 2 (P2)	Priority 3 (P3)	Priority 2 (P2)	Priority 2 (P2)	
Assessment of the patient's healthcare service needs	✓	✓	✓	✓	✓	5 (100%)
Assessment of the environmental factors that may interfere with the patient's care	✓	✓	✓	✓	✓	5 (100%)
Collaborate with the other healthcare professionals	✓	✓	✓	✓	✓	5 (100%)
Provide referral information for accessing home-based care or the nearest healthcare service.	×	×	✓	×	×	1 (20%)
Educate on activity regulation	×	✓	✓	×	✓	3 (60%)
Provide health education on medication, dietary management, and activities or substances to avoid.	×	✓	✓	×	✓	3 (60%)
Provide patients and their families with opportunities to ask questions	✓	✓	✓	✓	✓	5 (100%)
Review physician orders, including prescriptions, treatment plan modifications, and required special equipment.	✓	✓	✓	✓	✓	5 (100%)
Ensure appropriate patient transportation	✓	✓	✓	✓	✓	5 (100%)
Contact the billing department to determine whether any outstanding payments remain.	✓	×	✓	✓	×	3 (60%)

Table 1 shows that ED nurses implemented discharge planning for five patients categorized as priority levels P1–P3, with each patient assigned to a primary nurse. Assessment of patients' healthcare needs for discharge planning was conducted for all patients (100%) upon admission to the ED. This assessment included prior treatment history, nursing care planning, and evaluation of physical capacity and cognitive function. Assessment of environmental factors potentially affecting self-care was also completed for all patients (100%), encompassing anticipated home-based therapies, health-related limitations, and potential complications. Interprofessional collaboration with

physicians and other healthcare professionals was consistently conducted with all patients (100%) to determine ongoing care needs, initiate referrals for home or continued care, and evaluate patient readiness for discharge or transfer.

Provision of referral information for home care or nearby healthcare services was documented in only one patient (20%), specifically a patient classified as priority level P3. Education on activity management was provided to three patients (60%), including guidance for activity intolerance, nausea and pain management, and therapeutic positioning. Discharge education on medication administration, dietary restrictions, and activity restrictions was provided to 3 patients (60%).

During the discharge or transfer process, all patients (100%) were given opportunities to ask questions, either during or following nursing interventions. Verification of medical orders, including prescriptions, treatment modifications, and required equipment, was performed for all patients (100%) through electronic medical records and direct communication with the attending physician. Transportation arrangements were ensured for all patients (100%) at the time of discharge or transfer through coordination with hospital transport services or family members for outpatient discharge. Coordination with the hospital billing department to confirm outstanding payments was conducted for three patients (60%); this step was not required for patients admitted to inpatient units.

DISCUSSION

The present study reveals a distinct disparity in the implementation of discharge planning across different phases of emergency department care at Jember Regency Hospital. The admission and final transfer phases demonstrate optimal compliance with assessment and logistical protocols among nursing staff. The preparatory phase exhibits significant deficiencies in patient education and the provision of referrals prior to patient departure. Critically ill patients prioritized for immediate life-saving interventions often forgo comprehensive educational components due to the urgency of their medical conditions (Dünser et al., 2025). These findings illustrate a fragmented approach to transitional care that heavily favors acute stabilization over proactive discharge preparation. The data indicate that while fundamental nursing assessments are consistently performed, the holistic preparation of patients for post-acute recovery remains critically underdeveloped in this specific clinical environment (Pratiwi et al., 2024).

These observed discrepancies align with existing literature regarding the inherent conflict between acute emergency care and proactive transitional planning. Putri et al. (2021) highlight that emergency services predominantly prioritize managing acute and life-threatening conditions over administrative or educational tasks. Discharge planning becomes a secondary priority during the initial resuscitation and stabilization of priority-level-one patients. The current findings corroborate this dynamic, as educational and preparatory interventions were systematically omitted for critical cases in favor of immediate physiological stabilization. Emergency nurses routinely face intense cognitive and physical demands that force them to triage their attention toward survival-oriented interventions rather than long-term care planning. This systemic prioritization of acute survival over transitional education reflects a broader global challenge in emergency nursing practice where time and resources are perpetually constrained.

The limited execution of environmental assessments and home-care referrals represents a missed opportunity to address crucial psychosocial determinants of patient recovery. Effective transitional care requires a deep understanding of the patient's post-discharge environment to prevent complications and readmissions. Mizuochi et al. (2024) reported that, beyond access to healthcare services, the quality of interpersonal relationships within the household plays a significant role in patient recovery outcomes. The failure to systematically evaluate these domestic factors or

provide targeted referral information leaves vulnerable patients without adequate support systems upon returning home. Nursing staff must recognize that clinical stabilization in the emergency department is only the first step toward holistic patient recovery. Ignoring the socio-environmental context of a patient's life significantly increases the risk of medication errors, falls, and subsequent emergency visits following discharge.

Systemic barriers within the hospital infrastructure severely hinder the comprehensive documentation of discharge planning activities. Nurses frequently provide verbal education and coordinate logistics without documenting these interventions in the electronic medical record system (Song et al., 2022). The absence of a standardized, integrated discharge planning template forces clinicians to rely on fragmented documentation methods that fail to capture the full scope of nursing care. High patient volumes and unpredictable emergency workflows further exacerbate this documentation burden, leading to incomplete medical records that compromise continuity of care. Accurate documentation is essential for communicating patient needs for unit receipt and ensuring that educational interventions are neither duplicated nor omitted (Bunting, 2022). The current reliance on informal or incomplete records creates significant legal and clinical risks, as subsequent healthcare providers cannot accurately ascertain what discharge instructions were previously communicated to the patient or their family members.

The findings underscore an urgent need for structural reforms to embed discharge planning seamlessly into the emergency nursing workflow. Hospital administrators must develop standardized electronic templates that prompt nurses to complete educational and environmental assessments before patient transfer. Implementing triage-specific discharge planning protocols would ensure that critical patients receive abbreviated but essential transitional information, while stable patients receive comprehensive education (Abdelhalim et al., 2024; Dinda et al., 2022). Dedicated discharge planning coordinators or advanced practice nurses could alleviate the workload burden on frontline emergency staff. Such structural support would empower nurses to fulfill their professional obligations regarding continuity of care without compromising acute clinical duties. Redesigning the electronic health record to include mandatory discharge planning fields would transform this process from an optional afterthought into a fundamental component of the emergency nursing assessment.

Strengthening these transitional care processes will yield substantial benefits for both patient health trajectories and institutional performance metrics. Robust discharge planning is directly associated with reduced hospital readmission rates and emergency department return visits. Empowering patients and families through structured education improves treatment adherence and self-management capabilities at home (Amani et al., 2025; Ayu et al., 2025). Optimizing this process enhances overall healthcare quality and optimizes the allocation of finite medical resources across the healthcare system. Hospitals that invest in comprehensive emergency discharge protocols are likely to see improved patient satisfaction scores and reduced financial penalties associated with preventable readmissions. The integration of evidence-based discharge protocols in the emergency setting serves as a critical bridge between acute medical intervention and long-term community-based health maintenance.

Several methodological constraints must be considered when interpreting the results of this research. The study used a small sample of 5 nurses and 5 patients from a single emergency department, limiting the generalizability of the findings to other clinical settings. The observational design and brief five-day data collection period may not capture seasonal variations or long-term adherence to discharge protocols. The reliance on a dichotomous observation checklist fails to capture the depth, quality, or patients' comprehension of the education provided. The absence of patient-reported outcome measures prevents researchers from evaluating the actual effectiveness of the discharge instructions provided by the nursing staff. Future studies must account for the

varying acuity levels and diverse demographic backgrounds of emergency department populations to provide a more nuanced understanding of barriers to discharge planning.

Future investigations should employ quantitative instruments to evaluate the effectiveness of discharge planning directly from the patient's perspective. Incorporating validated tools measuring patient readiness for discharge and self-care agency would provide a more objective assessment of educational outcomes. Multi-center studies with larger sample sizes are necessary to establish broader normative data for emergency department practices across diverse healthcare systems. Such research will ultimately guide the development of evidence-based guidelines tailored to the unique constraints of acute emergency settings. Establishing a robust evidence base will enable nursing leaders to advocate for policy changes that prioritize transitional care as a fundamental component of emergency medicine. The evolution of emergency nursing must encompass a paradigm shift that views discharge planning not as a final administrative task, but as a continuous, patient-centered therapeutic intervention initiated at the very first point of hospital contact.

CONCLUSION

Discharge planning in the emergency department demonstrates a fragmented implementation pattern, with optimal execution during patient admission and final transfer phases, alongside significant deficiencies in preparatory patient education. Nursing staff consistently perform comprehensive healthcare assessments, evaluate environmental factors, and engage in interprofessional collaboration upon initial patient contact. Logistical components of patient transfer and discharge, including order verification and transportation coordination, also achieve high compliance rates across the clinical setting. Preparatory interventions focusing on activity regulation, medication adherence, and dietary management remain critically underutilized prior to patient departure. Future research must employ standardized quantitative instruments to evaluate the effectiveness of discharge planning directly from the patient's perspective. Capturing objective patient-reported outcomes will provide the empirical foundation necessary to refine transitional care protocols and enhance overall emergency nursing practice.

ACKNOWLEDGEMENT

The author would like to thank Jember Regency Hospital for granting access to the necessary data and facilitating this study. Appreciation is also extended to the ED nurse who participated in this study with full cooperation. And special thanks to the academic and clinical supervisors for their valuable guidance and support throughout this study.

CONFLICT OF INTEREST

The author declares no conflict of interest in the conduct, preparation, and publication of this study.

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