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REVIEW OF HOSPITAL DISCHARGE

JILL FOREMAN, VICKI INGHAM & CLAIRE EVANS

Stockton-on-Tees
BOROUGH COUNCIL

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INTRODUCTION

Jill Foreman – Senior Clinical Professional, *North Tees & Hartlepool NHSFT*

Vicki Ingham – Team Manager, *Stockton Borough Council*

Claire Evans - Senior Social Worker, *Stockton Borough Council*

- Discharge Policy & Local Steering group arrangements
- Hospital discharge data
- Communication
- Transport & Medication
- Discharge Pathways including the role of the Assessment Reablement Team
- Working relationships / Communication and our work with carers and voluntary sector agencies
- Discussion

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INTERAGENCY DISCHARGE POLICY

Policy Title: Interagency Discharge Policy
Reference and Version No: C75 Version 2
Author and Job Title: Steve Pett – General Manager Specialist Services Rachel Blackmore – Operational Manager In Hospital Care Executive Lead – Director of Operations
Validated By: Discharge Steering Group
Ratified By: Patient Safety Committee
Date Issued: 9 May 2018
Date for Review: 8 May 2021
Related Documents: C46 Adult Safeguarding C50 Safeguarding Children HR75 Cardiac Resuscitation Policy IC3 Infection Control Policy EF8 Use of Taxis Policy C53 Mental Capacity/Deprivation of Liberty Safeguards (DoLS)Policy C76 Patient Choice Policy C7 Caring for the Palliative Care Patient Rapid Discharge of a Dying Patient Protocol C20 Policy for the Safe and Secure Handling of Medicines Management National Policy Framework for NHS Continuing Healthcare and NHS – funded Nursing Care Care Act 2014
This Policy is Intended for: All Staff Groups

Policy Summary

This policy sets out general principles and specific procedures for the discharge of patients clarifying roles and responsibilities of health and social care professionals with consideration of people with additional needs. Maintaining the respect and dignity of patients their relatives and carers is of paramount importance throughout the discharge process.

- One policy for discharges from across our Hospitals
- Shift to an Integrated Discharge Team (2017)
- Review of documentation – electronic notification
- New discharge pathways
- Local discharge steering group
- Multi agency groups
- Performance – quality of discharges, length of stay, delayed discharges

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WHAT DOES THE DATA TELL US?

Stockton data

- Between April 2019 – January 2020
- 24,846 discharges of Stockton residents during this time
- On average 74 discharges per day between 10th January – 2nd February 2020

Address3	Count of CRN	Count of CRN2
Stockton-On-Tees	44.87%	19452
Hartlepool	30.87%	13381
Billingham	10.62%	4603
Peterlee	4.79%	2077
Yarm	1.82%	791
Middlesbrough	1.50%	650

Date	Admission	Discharges
10/01/2020	182	169
11/01/2020	91	81
12/01/2020	119	96
13/01/2020	164	125
14/01/2020	195	131
15/01/2020	133	127
16/01/2020	169	127
17/01/2020	158	150
18/01/2020	93	89
19/01/2020	86	79
20/01/2020	157	146
21/01/2020	160	166
22/01/2020	139	157
23/01/2020	147	141
24/01/2020	160	167
25/01/2020	106	115
26/01/2020	104	86
27/01/2020	195	152
28/01/2020	159	163
29/01/2020	163	152
30/01/2020	162	148
31/01/2020	149	179
01/02/2020	91	106
02/02/2020	93	76

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WHERE DO OUR PATIENTS GET DISCHARGED FROM?

Front of House

- Accident & Emergency
- Urgent Care Centre

Non elective areas

- Emergency admission & discharge – initial assessment / ambulatory care
- Discharge following a stay on a Hospital ward

Elective / planned areas

- Discharge following a planned stay on a unit or ward area University Hospital of Hartlepool / University Hospital of North Tees

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DISCHARGE LOUNGE

April 2019 to September 2019

- 1605 patients accessed the lounge in the time period
- On average 268 patients per month (approximately 11 patients per day)
- The highest number of discharges occur on a Monday
- Discharges increase in the afternoon period with a peak between 17:00 and 18:00
- The number of patients discharged per day via the discharge lounge ranges from 1 – 30
- The highest number of patients in the Lounge at any one time was 15

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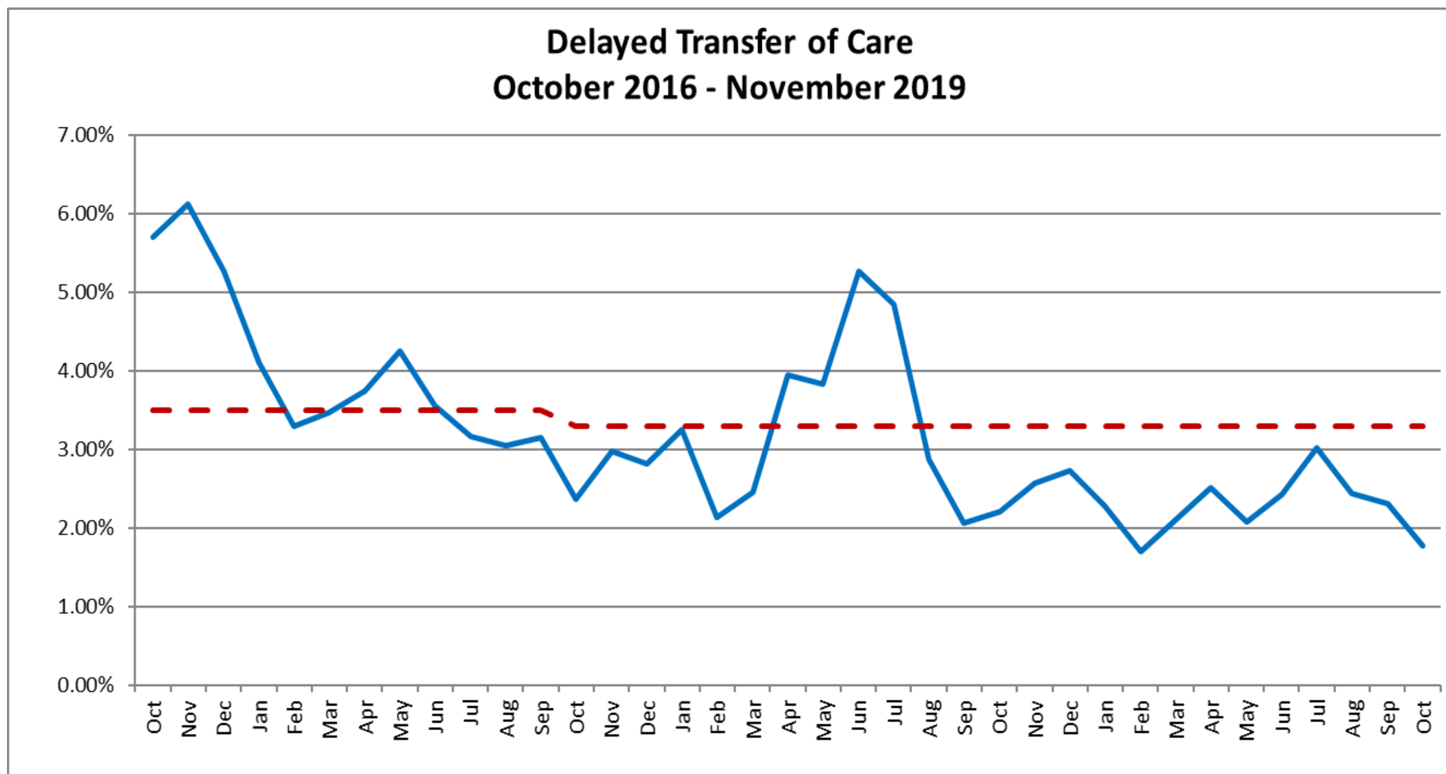
DELAYED DISCHARGES



- Consistently below the target of 3.5%
- Multi agency task & finish group to work together to solve problems and refine discharge pathways
- Weekly audits to work proactively rather than reactively
- Daily situation reports shared and actioned

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COMMUNICATION

- Planning discharge from admission
- Adult core document – captures social history, carer information, any concerns
- Medication reconciliation
- John's campaign – Visiting times (7 day Services)
- Supporting relatives who cannot visit
- Drop in sessions – discharge focussed
- Ward teams – daily huddles, multi disciplinary team
- Written information – bespoke leaflets (procedure specific), new services, next steps
- Carer support – liaising with North East Ambulance Service
- Discharge summaries

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Ward 42 ‘Drop In’ Sessions

Held 3 x week; Mon: 13.30-15.30, Tues: 17.00-19.00 and Thurs: 13.30-15.30

Opportunity for families and carers to discuss:

Ward care, Discharge planning and Therapy needs with the Ward Matron, Senior Occupational Therapist and Integrated Discharge Team.

We were able to discuss all of our worries and concerns and feel we were listened to. Consequently we felt a lot more confident about our relatives care on this ward.

A very helpful service. I was informed about my mothers care, well needed service. Excellent.

We felt "well informed" about the care given and future progression of care.

There was a very clear explanation about plans for discharge.
Very helpful!

Excellent this is a wonderful service. Gives a thorough insight of patients condition. I felt much better and positive after the session.

Please ask for further information

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MEDICATION

- Ward pharmacy teams on adult wards at UHNT, available Monday to Friday 9am to 5pm
- Following the prescription being written by doctor/nurse prescriber, ward pharmacist will check the prescription for accuracy and clinical appropriateness
- Once authorised, pharmacy technical staff will speak to the patient, check medication in bedside lockers (patient's own supplies or those supplied in hospital) and check what they may have at home
- Any medication that needs to be supplied will be issued to the patient, with a minimum supply of 7 days
- Where needed, patient will be given information on any new medication
- If compliance aids are being used, where no changes have been made pharmacy will contact patient's community pharmacy to check on available supplies. If inadequate supply or changes made, hospital pharmacy will make a new pack.
- Weekend discharges processed through dispensary at UHNT between the hours of 9am-4pm on Saturday and 10am to 3pm on Sundays.

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TRANSPORT HOME

- Own transport – family / friends
- Volunteer Driver Service – Home but not alone scheme
- Discharge Ambulance Service – feedback monthly
- Specialist transport
- Public transport
- Incident reporting system – capture and share learning

https://youtu.be/ZeXjADFPZs0

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PATIENT JOURNEY – HOME FIRST APPROACH

PATHWAY 1 – RETURN TO USUAL PLACE OF RESIDENCE	PATHWAY 2 – SHORT STAY PLACEMENT	PATHWAY 3 – COMPLEX DISCHARGE PATHWAY

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STOCKTON ON TEES BOROUGH COUNCIL: GREEN / AMBER PATHWAY

Assessment Reablement Team (ART)

Assessment Team part of Reablement Services, undertaking assessments to facilitate hospital discharge. Assessments support identifying suitability for:

- Reablement Services (in your own home)
- Rosedale Assessment Unit
- Rosedale Rehabilitation Unit

Support/Intervention provided is free for up to 6 weeks. Your requirement to receive a service may be reviewed at any time.

If it is identified that a long term care package is required to meet your assessed care needs; a Care Act Assessment will be completed by the Adult Social Care Team.

This will involve a financial assessment to determine contribution towards the cost of your care and support.

- Electronic Discharge Notification (Referral) received from Integrated Discharge Team
- Triage completed by ART Duty Worker and telephone discussions with IDT
- Communication with Family / Carer / Social Worker etc as outlined within the referral
- Liaise with Ward staff in order to plan and facilitate ward visit to support discharge planning
- Review computer database to support knowledge and awareness of existing support services

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STOCKTON ON TEES BOROUGH COUNCIL: ASSESSMENT & SUPPORT PLANNING

- ART Assessment completed with client / patient – Person-centred and independence / strengths-focussed
- Nursing, Medical and Therapy updates obtained from key involvements
- Identify current assessed needs, strengths and potential risks (with appreciation of fluctuation)
- Existing support structures in place prior/following hospital admission - consideration of informal and formal care arrangements
- Explore / Offer Carer Assessment / Referral to Carer Services in required

Adult Admission Nursing Documentation

CRN/ Hospital No:
NHS Number:

Pre-admission social summary

Is the patient independent? ☐ Yes ☐ No

Where does the patient reside? ☐ Home ☐ Residential Home ☐ Nursing home

Formal/ Informal support in place	Any Concerns / Safeguarding Issues

Does the Patient live alone? ☐ Yes ☐ No

If no, who do they live with? ....

Discharge Pathway Decision (to be completed when it is deemed appropriate to refer to services)

Pathway 1- Home safe sooner	**Pathway 2 – Intermediate 24 hour care**	**Pathway 3 – Complex Discharge Pathway**
☐ Patient is known to Services and can return to their usual place of residence with existing arrangements or an increase in support. ☐ Patient is unknown to Services and requires further assessment to return to their usual place of residence (own home/care home).	☐ Patient cannot go home via pathway 1 and requires further period of assessment / rehabilitation in a short stay placement.	☐ Patient requires further assessment to consider ongoing health needs.

Rationale for pathway decision:

....

Patient consent obtained? ☐ Yes ☐ No

If no, has family/carer been consulted? ☐ Yes ☐ No ☐ N/A

If consent not obtained please state why, e.g. lacks capacity, refuses to sign (refer to sharing information policy)

Patient's signature: .... Date: .... Time: ....

Print name (BLOCK CAPITALS): ....

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STOCKTON ON TEES BOROUGH COUNCIL: ASSESSMENT & SUPPORT PLANNING

Short / Long Term Interventions:

- Reablement Services / Period of Assessment / Discharge to Assess / Ongoing Social Worker involvement / Decline Assessment
- Care Home Navigator
- Onecall / Assistive Technology
- Housing Occupational Therapy Referral
- Aids / Adaptations / Equipment
- Community Therapy Interventions
- Voluntary Sector
- Welfare Rights
- Easy-read leaflets provided on services

OneCall

Information on the services we provide.

What is OneCall?

OneCall can provide a variety of sensors placed around the home linked to a unit which is monitored 24 hours a day, 365 days a year by our staffed customer support centre, allowing swift action to be taken should an incident occur.

A wide range of sensors are now available that manage risks within the home enabling people to live safely and independently for longer in their own home. The range of sensors provide greater reassurance and protection of users by managing a diverse range of risks.

What are the benefits?

Instant response - Our skilled operators respond to your call and get you the help you need, when you need it. We are one of the few community alarm providers who will respond with trained officers to incidents that don't require medical attention.

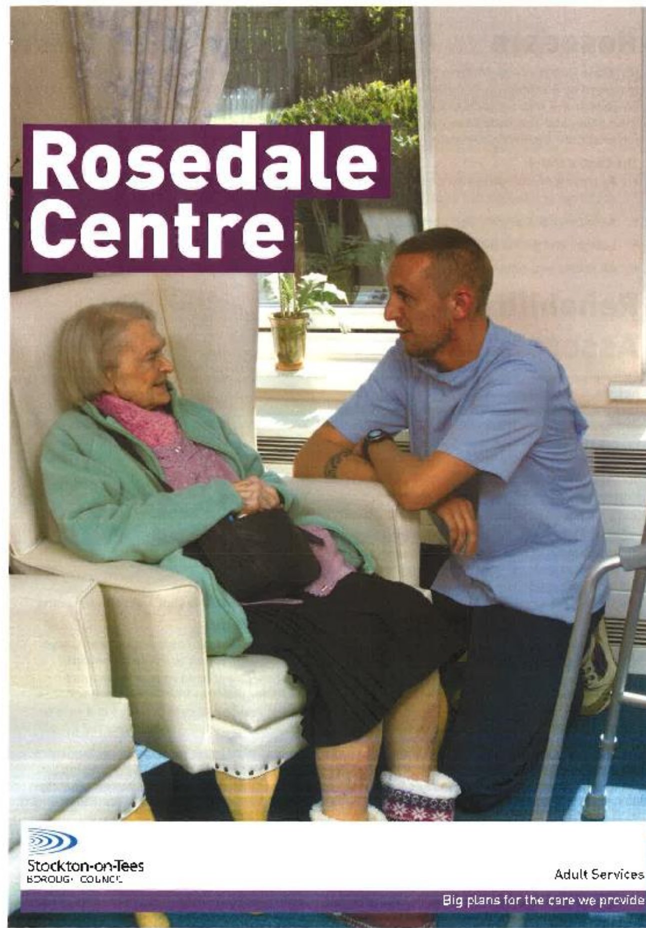
Personal Service - We offer a friendly, helpful and dignified bespoke service.

We won't leave you - Our staff will stay on the line with you until help arrives.

Complete reassurance - We offer assistance 24 hours a day, 7 days a week, 365 days a year.

Stockton-on-Tees Borough Council

Big plans for helping our communities prosper



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STOCKTON ON TEES BOROUGH COUNCIL: COMMUNICATION / WORKING RELATIONSHIPS

- 12pm Daily Integrated Discharge Team Briefing
- SBC Weekly Duty Worker to promote continuity of care planning
- Designated IDT Staff covering key wards
- Assigned direct mobile contacts to all SBC & NHS Frontline Staff
- 1:1 Staff Supervision & Weekly Team Meetings – communications escalated between organisations as appropriate
- Monthly Informal Management Catch-up sessions
- Structured, Planned Stakeholder Meetings across multi-agencies
- Direct, open and honest dialogue

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DISCHARGE TO ASSESS/ TRUSTED ASSESSOR

- All referrals assessed and considered for short term services by ART – identified longer term care needs
- Reactive service and usually seen on same day
- Collaborative working between health and social care professionals – liaising with Occupational Therapy, physiotherapy, ward staff
- Open communications between clients, family members, carers
- Rapid response from care providers – same day if appropriate
- Training workshops between health and social care to ensure positive and person-centred care planning

INVOLVING OTHERS…VOLUNTARY SECTOR & CARERS

- Home from Hospital Team – Five Lamps
- Volunteer driver service
- SBC Carers Service
- Family members/ carers
- Over 55's forum
- Signposting & internal/ external referrals (District Nurse, Harbour, One Call, Social work & Multidisciplinary Service)

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RED PATHWAY

- Supporting clients to make longer term decisions at the right time, in the right place – less unnecessary time spent in hospital
- Taking a person centred approach – involve everyone!
- Supporting client, family and carers through the 'process' with regular meetings, discussions and reassurance
- Listen to what the client wants and make it happen where we can - together

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THANK YOU

Questions & Discussion