Interim Management and Support

Effective Approaches in Urgent and Emergency Care

Paper three - Whole system priorities for the discharge of frail older people from hospital care

Introduction

The successful discharge of frail older people following an emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector.

In organising discharge pathways, a "whole systems" approach is important. This should aim to anticipate and promptly respond to potential bottlenecks or obstacles, smooth patient flow, and recognise the interdependency between partners.

Paper one[1] in this series highlights the importance of clinical processes with a proven record in enhancing patient flow within acute hospitals, such as early senior review, expected date of discharge (EDD), and clinical criteria for discharge. This paper focusses on good practice for complex discharges. Implementation will reduce bed occupancy, lessen cost and harm events and increase patient satisfaction.

1. Develop hospital 'front-end' services

- The presence of one or more frailty syndromes - *immobility, delirium/dementia, polypharmacy, incontinence or end-of life-care* - should trigger a detailed comprehensive geriatric assessment (CGA). This should start within two hours (14 hours overnight) - either in the community, a person's own home or as an in-patient, according to the patient's needs and as recommended in the *SilverBook*[2].

- Ambulatory emergency pathways, with access to multidisciplinary teams, should be available with a response time of less than four hours for older people who do not require admission but need on-going treatment (e.g. in a Clinical Decisions Unit)[2].

- Hospitals should ensure early consultant review. Good practice is to involve geriatricians in 'front-end' assessment – for example, reviewing all frail elderly patients on the day of their admission or in the morning for overnight admissions, possibly following initial assessment by a nurse or therapist.

- Dedicated multidisciplinary teams including therapists should be set up to work across the emergency department (ED) and acute medical unit (AMU) rapidly to assess and arrange care at home where this will avoid admission. Cover should extend into evenings and weekends and there should be access to community-based services out of "office" hours.

- Local health and social care partners should agree to allow read-only access for acute staff to community and social services patient databases in order to expedite care planning.

- Agreement should be reached to allow existing social care packages to be kept open, equipment to be readily available, and community services ready to 'pull' patients out of acute hospitals, seven days a week.

2. Proactively approach prolonged hospital stays

- It is important to identify all patients at risk of potentially long stays using a suitable risk tool (like the ALICE screening tool[4]) and to agree an appropriate care plan and review arrangements.

- All prolonged hospital stays above a defined level (e.g. 14 or 21 days) should be reviewed to expedite action and identify trends. This is in addition to reviewing delayed transfers reported via SITREPs. Two key questions should be asked:

    a. What needs to be done now to expedite safe discharge?
    b. What could or should have been done earlier in the patient's stay to prevent or mitigate a long length of stay?

- Regular progress-chasing meetings should take place at least twice-weekly to review all prolonged stays. Attendees should include NHS community services and social services staff, who are briefed on relevant patients.

- Use an escalation policy for "extended" stays above locally defined thresholds. For example, for over 25-day (or the 95th centile of the LOS profile for the site) stays, require the clinical team leading care to present case details to the Clinical Director or divisional leadership team.

3. Encourage a 'pull' approach to acute discharges

- To encourage forward planning, share patients' expected date of discharge and clinical criteria for discharge and information on complexity with community services, patients and their relatives. [5]

- Require wards to invite the patient's district nurse or community matron to the final MDT meeting before discharge for complex and/or frail inpatients. Consider involving them earlier – many of these patients are at risk of admission and so could have a 'discharge plan' even before admission.

- Agree clear expectations about assessment and response times. Monitor these and incorporate them in commissioning specifications for NHS community services.

- Undertake emergency readmission case-note audits regularly, involving NHS community and social services staff. Share learning with senior managers, clinicians and commissioners.

4. Involving social services care management

- Ensure there is a social service input into the on-site multi-disciplinary team for complex discharges and that assessments are not delayed until a patient is deemed 'medically fit'.

- Work with partners to secure local agreement that all referral processes (e.g. for continuing health care) have been made as simple as possible (i.e. simple, short documentation that is quickly and easily completed).

- Allow simple, single-call processes for restarts of existing care packages for short-stay discharges. Ensure that for complex care packages there is same or next day funding approval.

- Ensure that the legal requirement of Section 2 and Section 5 notifications from acute trusts to social services to share patient information (and the required response standards) are understood and initiated by ward staff. Seek feedback from social care that Section 2 referrals are appropriate to optimise social workers' time. Embedding care managers with wards encourages a proactive and co-operative approach.

- Maximising weekend discharges should be seen as a whole-system issue, requiring co-ordination between partners. Ensure the availability of social workers, NHS community services and hospital therapists (particularly where they work across the hospital/community interface) matches any increased focus within an acute trust on weekend discharges.

Section 2 and 5 notifications: a brief overview

The Community Care (Delayed Discharges) Act 2003 places duties upon the NHS and councils in England to communicate about the discharge of inpatients. This applies, by statute, to acute care only, but the approach represents good practice for community hospital inpatients as well.

The NHS is required to notify councils of any patient's,"…likely need for community care services", and of their proposed discharge date. This is done through "Section 2" and "Section 5" notifications respectively (named after the sections in the Act).

A Section 2 requires an NHS body to notify social services of a patient's likely need for community care services after discharge. The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality requirements and to minimize bureaucracy, It is a trigger for assessment and care planning. The Act sets out the requirement for social services care management to assess within three days.

A Section 5 notifies social services of the proposed date of the patient's discharge. Patients and carers should be informed of the discharge date at the same time as, or before, social services. In addition, as good practice, hospital staff may give social services an early indication of when discharge is likely, to help with planning, but a formal discharge notification must be issued to give confirmation of the intended date.

Further details about the full provisions of the Act are set out the relevant DH Health Service Circular. [12]

5. Standards in community hospitals

- Ensure community hospitals work to clear operational standards regarding discharge, including using consultant-approved care plans, expected discharge dates and clinical criteria for discharge. Local systems for reviewing prolonged stays are particularly important. Patients should not remain in community hospital beds where pathways exist for them to be cared for in their own homes.

- Similar standards of early and proactive discharge planning[1] should apply in community hospitals as in acute care – and be monitored and specified by commissioners.

- Good practice is that social services' standards in community hospitals for time to undertake assessment should mirror the three-day Section 2 time-frame in acute settings.

6. Seek feedback on patients' discharge experiences

- Ensure regular patient and carer feedback is sought about discharge arrangements.[6]

- Encourage community services to highlight any concerns about the quality of an acute hospital discharge. Clarify expectations about how long responses should take and how mutual learning will be shared and spread.

7. Prioritise dementia care

- Adopt a philosophy that seeks to manage people with dementia assertively, with risks identified and managed, rather than compounded by even short-term hospitalisation.

- Promote staff awareness about dementia care in acute hospitals[7]. Poor recognition and response by staff increases the risk of a damaging patient experience and significantly longer lengths of stay[8] across medical and surgical specialties.

- Promote cultural change using key themes: developing a psychiatric liaison service; documentation that encourages consideration of cognitive impairment [9]; staff awareness training; dementia-friendly environmental changes; a common assessment tool; nutritional support; and appropriate ward-based activities, like reminiscence.

- Use the national audit for dementia care in general hospitals to measure progress[10].

8. Care home support

- Undertake an audit of patients admitted to hospital from care homes as emergencies. This will help identify themes about how the risk of admission can be minimised and enable the design of advanced care planning with an appropriately skilled response.

- Develop programmes to enhance specialist input to and competences within care homes[11].

- Work through the local social services provider forum with care homes to minimise delays in home managers' assessments prior to discharge. Build a prompt response into contracts for local authority-funded placements.

- Develop advice around discharge arrangements to care homes and involve them in local escalation planning.

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References

1. Effective Approaches in Urgent and Emergency Care: Paper 1 – Priorities within acute hospitals, ECIST, 2011
http://www.nhsimas.nhs.uk/fileadmin/Files/IST/ECIST_-_Priorities_within_Acute_Hospitals_2011.pdf

2. *Quality Care for Older people with Urgent and Emergency Care Needs*, June 2012
http://www.bgs.org.uk/index.php?option=com_content&view=category&layout=blog&id=207&Itemid=888

3. Existing older people's assessment and liaison models show benefit in terms of reduced length of stay and improved outcomes. For example:
*The older persons' assessment and liaison team 'OPAL': evaluation of comprehensive geriatric assessment in acute medical inpatients,*Age and Ageing
http://ageing.oxfordjournals.org/content/36/6/670.full.pdf

4. The ALICE screening tool is a five point rating, with a score of three or above indicating complexity. It is available on page 24 at
http://www.plymouthhospitals.nhs.uk/ourorganisation/freedomofinformation/classesofinformation/Documents/policies/clinical_governance/CLISAFPOL3292VulnerableAdultsPolicy.pdf

5. Ideally, patients should be able to answer four simple questions: i) What is wrong with me; ii) How will it be fixed and if it can't be fixed what are my choices; iii) When will I be discharged; iv) What do I need to be able to do to be discharged. There is scope to share expectation about expected date of discharge with patients and carers - for example using the NHS Institute welcome card and sample posters at
http://www.dqvdocumentdesigner.nhs.uk/

6. Patient and carer views can be regularly sampled to provide themes for learning. As a process this is best done, with PALS services, four to six weeks after discharge; by post, with a mixture of simple set questions and free text space.

7. David Nicholson letter of 1st April 2010 re dementia care
(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116314.pdf)

8. *Counting the Cost: Caring for People with Dementia on Hospital Wards*, Alzheimer's Society (2009) at http://alzheimers.org.uk/countingthecost

9. A good example of documentation that encourages consideration of cognitive impairment is theAlzheimer's Society *This Is Me* proforma*: This is Me*, Alzheimer's Society at
http://alzheimers.org.uk/site/scripts/download_info.php?fileID=849

10.Royal College of Psychiatry National Dementia Audit
http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/dementia/nationalauditofdementia.aspx

11..Enhancing specialist input to and skills and competences within care homes has been undertaken by incentivising systematic GP input, developing professional development support and opportunities for care homes, and through the use of advanced care planning for all residents. Examples at: http://www.bgs.org.uk/index.php?option=com_content&view=category&id=171&Itemid=721

One of the most effective in terms of measured impact is Sheffield: http://www.bgs.org.uk/index.php?option=com_content&view=article&id=1941:casestudysheffield&catid=194:casestudies&Itemid=820

12. HSC 2003/009 : LAC (2003)21 is at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4064939.pdf

A useful general resource is *Achieving timely "simple" discharge from hospital: a toolkit for the multi-disciplinary team*, Department of Health, 2004.

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