Discharge case study
University Hospitals of Leicester NHS Trust

Electronic Systems improvement to enable safe and timely patient discharge

Overview

University Hospitals Leicester Foundation Trust (UHL) provides acute care services to the one million residents of Leicester, Leicestershire and Rutland also providing specialist care in cardio-respiratory diseases, cancer and renal disorders for an even larger population. Care is spread over several sites (the General, Glenfield and the Royal Infirmary) and UHL employs over 12,000 staff.

The aim of the initiative was the implementation of an IT system called Nerve Centre to support the tracking of patients through the hospital from admission to discharge or transfer of care. All patient information and details are on the system and are pulled from the admission assessment unit data. Additional information is then added contemporaneously during the inpatient stay. Use of Nerve Centre drives the patient pathway in a proactive and comprehensive way.

Background

UHL realised that patient safety was likely to be compromised by the length of time it was taking for patients to be safely discharged and that the length of time in hospital in itself was increasing the risk to patients.

Understanding the problem

UHL had recognised that there was a national and local problem with the clinical handover of patients at discharge or transfer of care. There was an acknowledgement of the risk of information and communications getting lost both between patients transferring from ward to ward in the hospital and also on leaving the hospital.

Multiple issues were highlighted such as Emergency Department (ED) performance and breaches, the risk of falls, infections and other adverse incidents the longer patients remained in hospital, and problems with the handover itself. Staff felt that they were being “beaten with a stick” and held to account when the systems were in fact in need of improvement. There was a teleconference call system but it was seen as a task to be delivered rather than a welcome active vehicle to enable patients transfer. There was little engagement from partners.
The atmosphere was in danger of becoming blameful and a fresh look was needed to approach the problems and resolve how patient care was provided and how patients moved through the system.

It was decided that some diagnostics on the situation was needed and so in 2013-2014 external support to help break down the pathway and explore why it was not working was utilised.

**Solutions**

The new system is described by UHL teams as being “all about patient safety”.

The lynchpin of the new way of working is focussed around the new IT system called Nerve Centre. Very large screens have been placed on the wards to display all the patient information. An interactive IT system allows changes to be made so that staff can see at a glance patient status and what tasks and actions are needed before a patient can leave the hospital. There is an expectation that all groups of staff (physiotherapists, nurses, occupational therapists, pharmacists, doctors etc.) involved in patient care will amend the information held on an ongoing basis so that the information is always up to date.

A Standard Operating Procedure (SOP) was developed and there is strict adherence on a daily basis to the SOP.

All tasks for doctors overnight go onto the system. Other information such as demographics etc. are also added. The following sections are used:

- Name
- length of stay
- city or county resident
- EDD / Medically fit for discharge / date medically fit for discharge
- am discharge plan / reason for pm discharge plan
- TTO status/suitable for LGH
- Definite discharge today
- Suitable for discharge lounge
- Transport required?

All this information is formally discussed at the 11:00 daily teleconference call. All ward discharge co-ordinators are expected to phone into the main office in a meeting where there are all the discharge to assess team, representatives from County and City social care, community hospital providers ,home and housing teams. The meeting is chaired by a Lead Nurse or AHP and input to the system is live. The meeting is very actively managed with “confirm and challenge” with every patient.

The meeting follows a set format where each patient’s information is up on the screen ward by ward. The information is scanned and a conversation starting with whether there are any empty beds on the ward, whether the consultant round has taken place and if there are any definite discharges that day. These are then
discussed in detail to ensure the discharges are safe. (The case study author witnessed several discussions specifically about the safeguarding issues surrounding some of the patients concerned and actions being taken).

Questions are asked about whether any other patients are medically fit and any delays are challenged and actions to unblock situations discussed. Where there is a problem one of the Intensive community response team members or the discharge to assess team members are allocated to follow up the problem with ward staff.

The meeting is very solution focussed with active input from social care to try and get patients transferred as soon as is safely possible.

The whole culture has shifted in the last year or so and the staff work on the principle of “home first” as the initial option and all possible solutions are explored to get the patient home followed by other care solutions if that proves impossible.

The patient and relatives are much more actively involved in the process and they are made aware on admission of the aims and goals surrounding their expected date of discharge and they are updated if any changes are made to this plan.

Despite increasing admissions and ED attendance (up by 9% in June 2015 and 7% in July 2015) UHL has the third most improved ED in the Country and the Trust have succeeded in closing 72 beds since January 2015.

Impact and outcomes

There is a much more proactive approach and culture to transfer of patients since 2013 recognising that hospital is only suitable when patients need treatment and that there are many disadvantages and safety issues where patients have lengthy hospital stays. This robust approach has led to positive ward closures.

Patients
- It was reported that before the changes, on average there had been 15 a day re-beds (patients prepared for discharge that day having to be given beds at the end of the day as their transfer became postponed). This is now seen as a zero tolerance and never event for the hospital.

Patients are involved in the discussion about their transfer much earlier in their hospital stay and home is seen as the first option and aim, which is what the majority of patients want.

The handover is much more rigorous and searching which removes errors and makes discharge a much safer experience.

Whole System
- The new IT system drives the process and the whole system has improved.

Staff have embraced this whole system approach and there is compliance and buy in at the daily teleconference call from all agencies and all wards involved.
Further Quality Improvements and Spread

- Roll out of Nerve Centre to the community hospitals across Leicestershire is planned.
- A new tracking system for frail older patients is being planned as a sub set of all admissions.

Top Tips

- Capture information and plan discharge as early as possible after admission.
- Encourage all members of the MDT to participate and input data.
- Make sure the system is updated on all patients on a daily basis.
- The sharing of all information is vital.
- Keep the discharge plan active continuously.
- Engage the patients and relatives in the discussion with the principle of “no decision about me without me”.
- Use SOPs to reduce variability.
- You need the IT and infrastructure to make it work and partners need the infrastructure too.

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Themes

- Discharge Liaison Service
- **Electronic systems and records**
- Policies and systems that link health and Social Care
- Systems that involve patients in their care
- Systems that ensure provision of high quality information