DISCHARGE PLANNING

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48% of over 85s die within 1 year of hospital admission.

Your last 1000 days: If you had 1000 days to live, how many would you want to spend in hospital?

What is The Last 1000 Days?

The Last 1000 Days is a philosophy for drawing attention to patients' time. It is widely recognised that the elderly, the chronically ill, and those with life limiting conditions are the same people who spend the most time in healthcare settings. These are the very people who have the least time to waste.
Brian Dolan

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Staying in hospital is bad for patients – acute or community, it leads to.

- Deconditioning
- Harm (HAPs / Falls /confusion)
- and for many patients **never returning to their homes** after their hospital admission

Why it is important to ask and listen!

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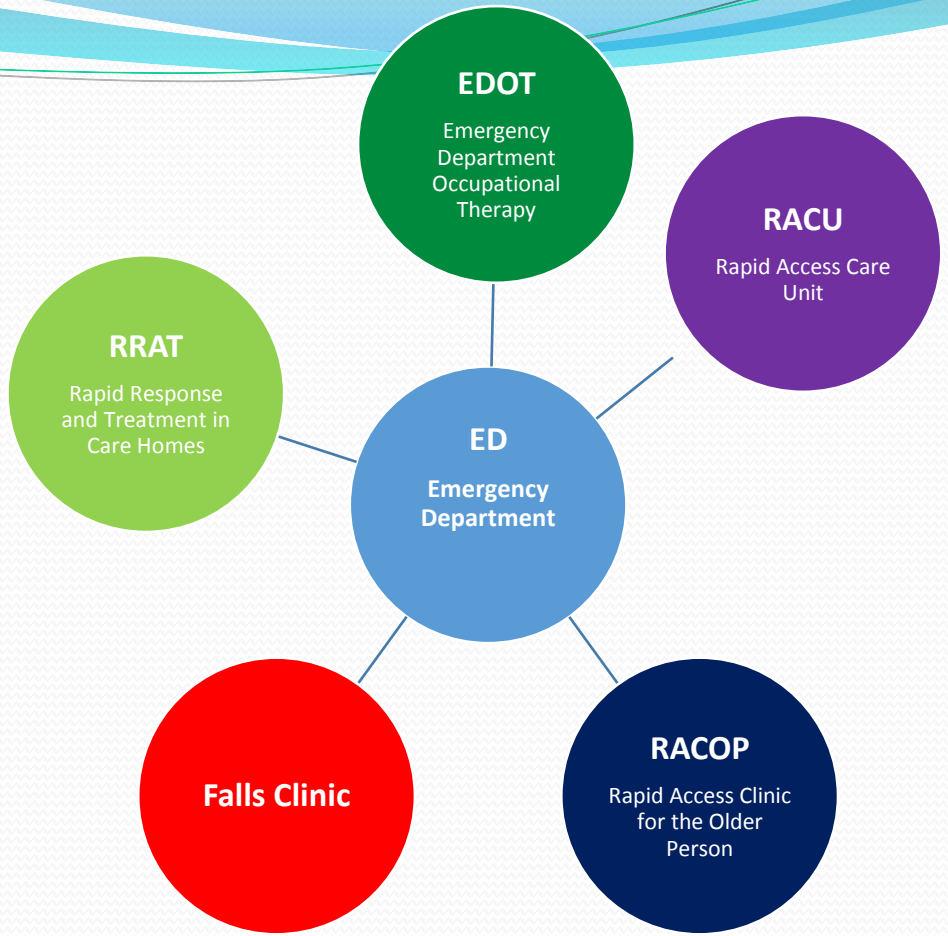
Admission avoidance

- Falls Frailty Response
- Frailty Practitioners
- ED OTs- referral to Community Rapid Response teams
- Work with RRaTS
- Ambulatory clinics – RACOP, Falls Clinics
- Community Hospitals
- Social workers in 6 days a week- early review



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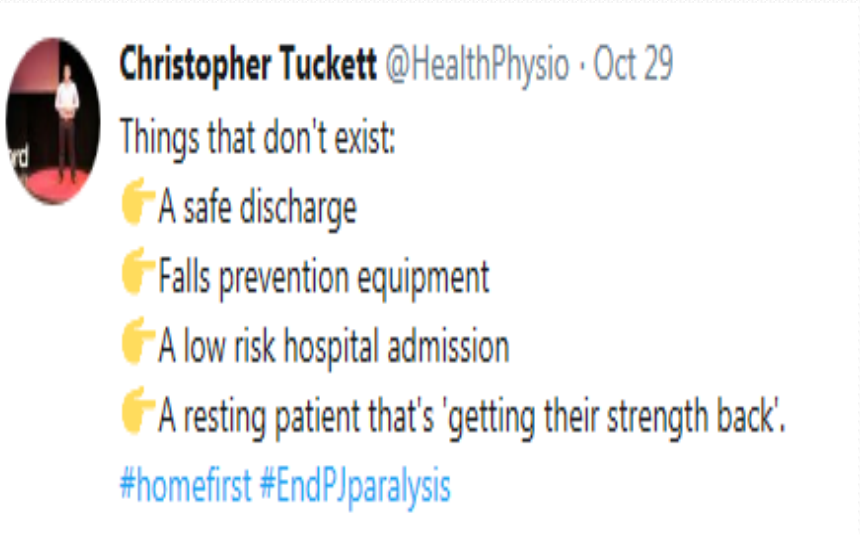
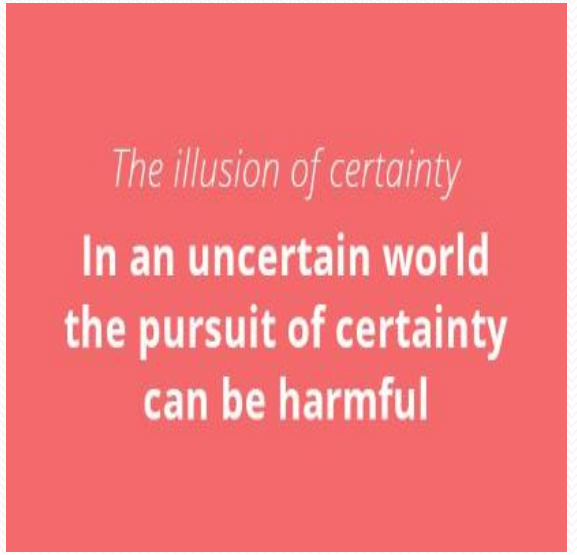
Home First

- Important to set **clear expectations from start**
- Working to the principle that **no one should leave their home in an ambulance and never see it again**

Patients can answer the following questions?

- What is wrong with me
- What will happen next?
- When can I expect to go home?





Social <u>workers</u>

- Can often work flexibly to aim for **#HomeFirst**
- With good justification may provide:
  - Night sitting
  - Temporary 24 hr care
  - Extra care housing - usually used in preference to Care Homes

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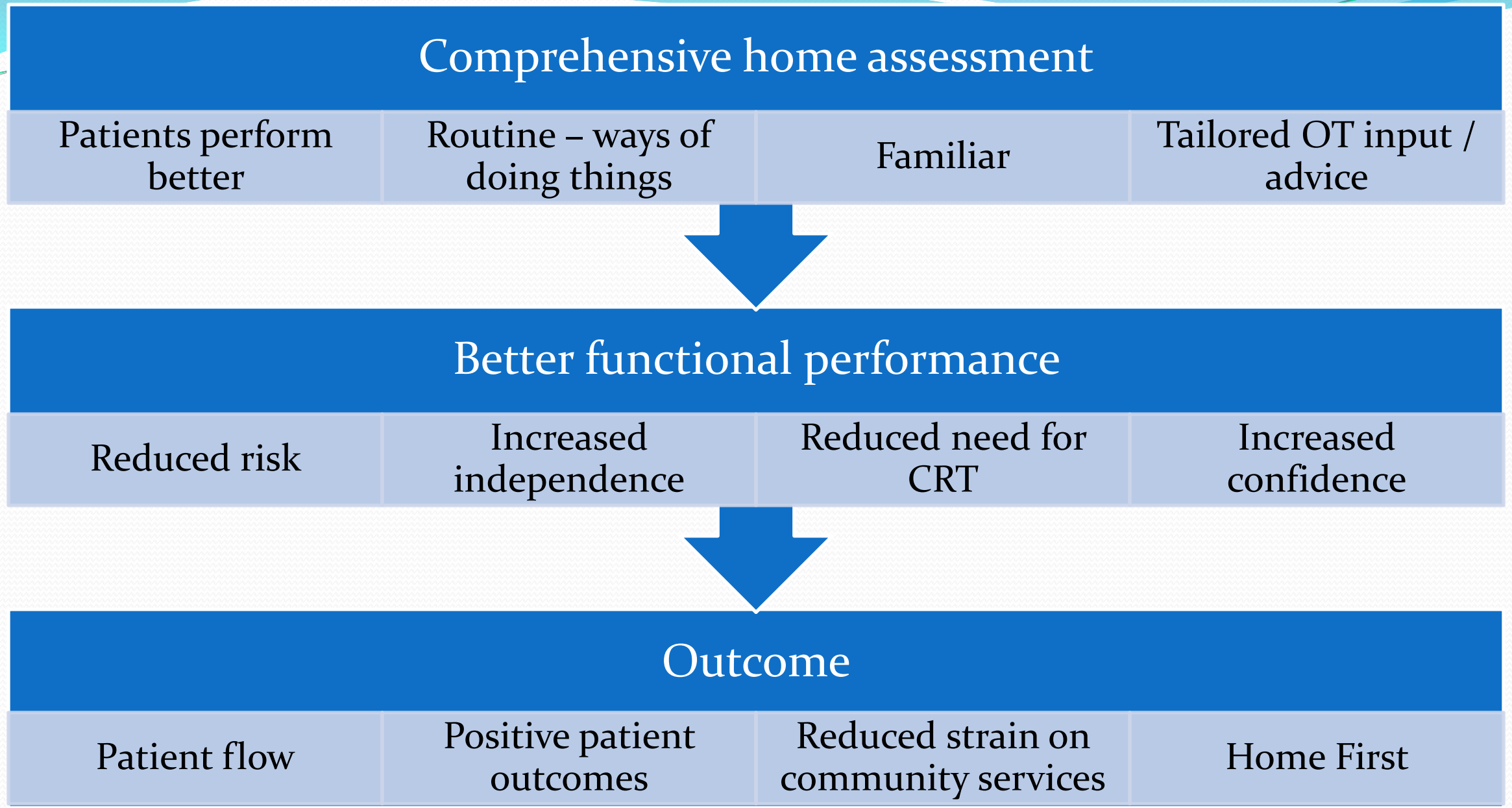
Early Supported Discharge Team

Early Supported Discharge

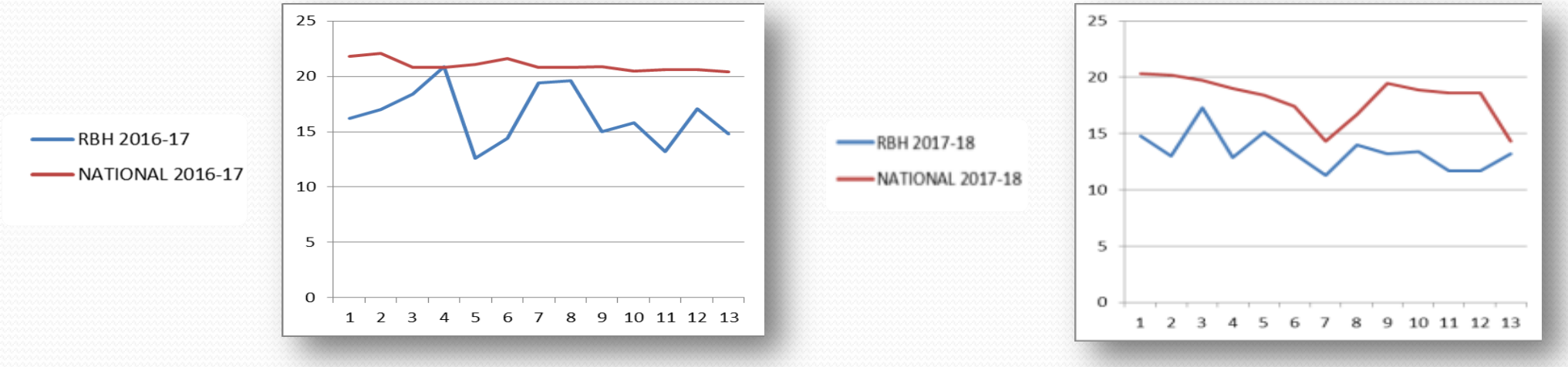
- Home First ethos
- Comprehensive home assessment
  - **More accurate** assessment than in hospital
  - Often any issues can be addressed **‘there and then’**

“Right care, right place, right time”


Comprehensive home assessment
Patients perform better
Routine – ways of doing things
Familiar
Tailored OT input / advice
Better functional performance
Reduced risk
Increased independence
Reduced need for CRT
Increased confidence
Outcome
Patient flow
Positive patient outcomes
Reduced strain on community services
Home First

Results -1 year pilot

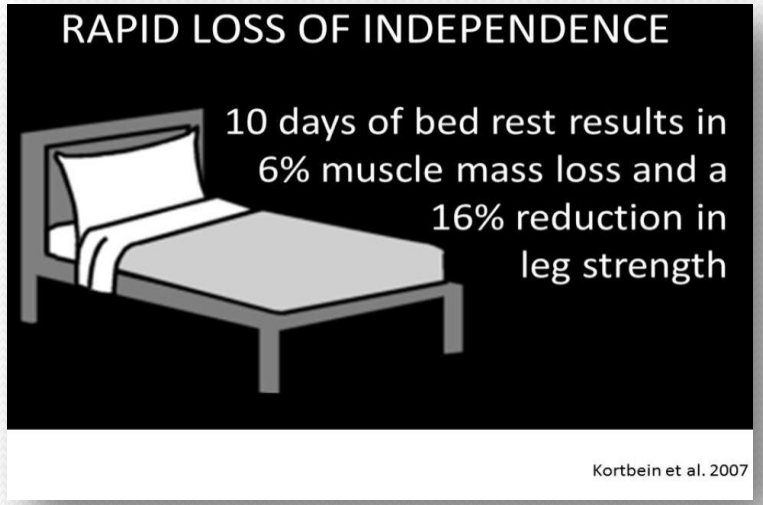
- **The length of stay on the HFU reduced by 3.1 days**, 4.7 days below the national average (NHFD, 2018)



- Length of stay per patient was **reduced by an average of 3.75 days**
- Reduced strain on community services
- Positive feedback from patients -
  - **100%** of patients were satisfied with the quality of the service provided at home
  - **97%** of people who received the service felt it helped their long term recovery

Therapy Led Projects Enhancing the Delivery of Care at RBH

Preventing Deconditioning



Cake & Shake

- **Adelaide Project**– patient & staff survey to improve Therapy, wellbeing and support on the ward

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Neuro Therapies Outlier Pilot

November 2018 – April 2019

Proposal: A neuro therapy service to provide specialist neuro therapy input to patients with complex neurological impairment. The service is for in patients on wards within the Royal Berkshire Hospital – though not on the Neurological Rehabilitation Unit (Caversham Ward) or the Acute Stroke Unit.

Aim:

- To provide enhanced specialist input for patients with complex neurological impairment in a timely manner. This includes advice, assessment, therapeutic intervention and support with discharge planning.
- To facilitate the most appropriate patient pathway and support patient flow.
- To work with and support ward staff to provide specialist input and develop clinical skills.

Staffing

Lee Bailey
Full-time
Band 6 Physiotherapist

Amy O'Neill
Full-time
Band 6
Occupational Therapist
(from Jan 2019)

Based within the NRU therapy team and clinically supported by senior staff and the MDT team on NRU

KPIs

KPI's will be monitored on the Patient Flow Onward Flow KPI Dashboard

- Audit/analysis of the service pilot supported by Patient Flow Transformation Team
- Outcome measures: E-RCS /Barthel/Berg
- Patient/ carer experience measure e.g.: friends and family/questionnaire
- LOS for this cohort of patient in the Trust
- LOS on Caversham Ward
- LOS on NRU wait list for Caversham ward.
- Response rate for referrals to service (target 24 hour response rate Monday – Friday) – Orders report
- Staff experience measure – beginning and end of pilot
- DToC for this cohort of patient - IDS
- Discharge destination from Caversham NRU

Referrals

Via EPR Referrals Tab
'Referral – Neuro Outlier Therapy'

Referrals triaged and put on appropriate pathway

- Patient referred to NRU
- Outlier team visit for specialist Neuro-therapeutic input
- Outlier new stroke fast access for specialist Neuro-therapeutic input
- Advice and support for complex discharge planning

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Equipment – can trial in hospital first

- Life Line grab bags
- Mattress turners – Toto, Komfi tilt. Reduced need for Nursing homes.
- Single handed care – eg Turners with belt
- Telecare- patients with dementia

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Trusted Assessor project - OTs are now Trusted Assessors

- Trusted assessor means that Social Services do not to reassess but they trust our assessment. The care plan (page 4 of the section 2) is based on this – think what information carers need to know and make sure all included – 24 hours a day

- W.Berks reported on audit that **95%** of care plans **were accurate** and did not need to be adjusted post discharge.

- Trusted assessor programme – assessed for care then right sized once home

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Care Home Liaison

- Care Home liaison
- RRAT
- Red Bags

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Voluntary sector

Available now-

- Home from Hospital schemes
- Social Prescribing and Community Navigators
- PaTH- (prevention of admission to hospital service) 5 days a week Red Cross wheelchair accessible vehicle.

Winter pressures schemes. Jan - March

- Prevention of Admission to Hospital Service increased to 7 days per week

- Red Cross– supporting more complex patients to return home.

- Hospital Voluntary sector navigators- collecting referrals for Community voluntary support at home

- Hospital Befrienders – working with the Care Crew – Burghfield, Mortimer, Woodley

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What will you do to help patients be home for Christmas?
#red2green
#last1000days