A guide for registered nurses

Why not home? Why not today?

Evidence shows it's much better for a patient's physical and mental wellbeing to leave hospital as soon as they are medically optimised for discharge.

This is why it's really important we do everything we can to enable our patients, particularly older people, to continue their recovery in their own home environment or, for those few who cannot go straight home from hospital, within a care location most suited to their needs.

You have an important part to play in making this happen. And there are a number of practical actions you can take to help get patients to the best place for them.

The evidence

There's lots of evidence to show that patients recover better at home once their treatment in hospital is complete. Patients who stay in hospital longer than is necessary may face issues including:

- **35% of 70-year-old patients experience functional decline** during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%.[1]
- **48% of people over the age of 85** die within one year of hospital admission.[2]
- Exposure to the risk of **healthcare-associated infections.**

[1]Guide to Reducing Long Hospital Stays, June 2018.

[2]Imminence of death among hospital inpatients: Prevalent cohort study. David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, 17 March 2014.

How you can make a difference

NHS England and NHS Improvement has worked with a number of partners to identify five key principles which can help ensure that patients are discharged in a safe, appropriate and timely way.

The principles relate to different stages of a patient's stay: some to the moment of admission, some to their time on a ward and some to the end of their stay.

1. **Plan for discharge from the start**
2. **Involve patients and their families in discharge decisions**
3. **Establish systems and processes for frail people**
4. **Embed multidisciplinary team reviews**
5. **Encourage a supported home first approach**

Underneath each key principle are specific actions that you can take as a registered nurse.

By following these actions and thinking **"Why not home? Why not today?"** every day, we can reduce length of stays and get patients to the best place for their recovery.

1. Plan for discharge from the start

- Fully understand your patient's cognitive, functional and social status before and on admission.
- Make reducing unnecessary patient waiting a priority. View patients' time as the most important currency in healthcare.
- Ensure patients have undergone a holistic needs-based assessment, not just a clinical assessment.
- Think "Why not home? Why not today?" every day. Challenge if a patient really needs to be in hospital for the treatment they require.
- Encourage colleagues to record an Expected Date of Discharge, and Clinical Criteria for Discharge, so it's clear when patients are clinically optimised for discharge.
- Consider criteria-led discharge.
- Proactively involve nursing associates and healthcare support workers

2. Involve patients and their families in discharge decisions

- Plan discharge before admission with the patient and their families or carers.
- Ask all patients (and family members or carers for cognitively impaired people) the four questions listed below so they know their plan:
  1. Do I know what is wrong with me or what is being excluded?
  2. What is going to happen now, later today, and tomorrow to get me sorted out?
  3. What do I need to achieve to get home?
  4. If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?
- Encourage all patients to get up, dressed and moving to reduce the risk of deconditioning. Ask your patient's loved ones to support you with this.
- When appropriate, explain the risks of long-term hospital stays (versus going back to their normal residence or a non-acute hospital setting) to patients and their families or carers.
- Ensure arrangements are made for patients so that they can get into their home and that heating and food will be available following discharge.

3. Establish systems and processes for frail people

- Ensure people with frailty are identified as early as possible and there's an effective frailty process that delivers an early holistic assessment.
- Ensure people with frailty are assessed by an appropriate professional before admission.

4. Embed multidisciplinary team reviews

- Be present and actively contribute to daily board and ward rounds.
- Review each of the following areas every day: physical health status, mental health status, medication needs, functional ability (mobility, personal care and continence), nutritional and hydration status and ongoing support required for discharge. Proactively share this information with all members of the multidisciplinary team.
- Encourage a weekly review of all long stay patients that involves multidisciplinary team members visiting wards to help unblock constraints. Implement effective escalation processes where there are unnecessary patient waiting times. (See page 29 of Reducing Long Hospital Stays Guide for more information.)
- Ensure relevant improvement measures are readily accessible for front line teams so they can see how they're doing. Encourage teams to use information to make decisions.

5. Encourage a supported home first approach

- Think #homefirst and consider support at home or with intermediate care.
- Encourage colleagues to assess patients' needs in a non-acute setting (preferably their normal place of residence) rather than in an acute hospital setting.
- If discharge to assess at home is not possible, explore alternative community options.