Discharge to Assess in Tower Hamlets

2016-17

Breaking paradigms, creating ambition, raising the bar

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Our mission

To implement an integrated 'discharge to assess model (D2A)' for older people in Tower Hamlets so that they are discharged from hospital as soon as they are medically stable, rather than staying on the ward waiting for further social and functional assessments to take place.

AADS and Discharge to assess – history and where we are now

- *CCG funded a D2A pilot in 2015-16*
- *Other winter resilience schemes running in parallel – AAT, H@H, out of hours hospital social work*
- *Merged to re-launch as AADS in September 2017*
- *No step-down beds*
- *Spot-purchase pathway possible for people likely to need CHC and nursing home*
- *Increased patient flow from the Royal London Hospital due to increased capacity in the scheme*

AADS and Discharge to assess – history and where we are now

- *Currently D2A is a pathway within AADS and has:*
  - *2 Social Workers, 4 OTs, 2 physios, 3 nurses, 1 RSW*
  - *2 case finders/screeners (one nurse, one therapist)*
- *7 day service 8-6pm, up to 6 weeks community input*
- *The full social care assessment process will usually start two weeks post discharge to fully address the change in needs*
- *Most packages provided by the Reablement Team and support the goals set by the Therapists*
- *Short-term night care possible*

Where we are now and where we want to be

- *Success with more complex patients*
- *Evidence required to demonstrate the level of success achieved for the patient e.g. CHC checklist/bespoke assessment at start and end*
- *KPI's include readmission rates (review at 30 and 90 days post discharge), preferred discharge destination*
- *Reduction in on-going support costs at the end of the patient's time on the scheme expected*
- *Recent data for 94 people - 23% have reduced or no care needs), readmissions for D2A patients within 30 days = 16%*

What else do we expect to achieve?

- *Improved recovery as people are assessed in their own home in a familiar environment*
- *Improved experience for patients and their families*
- *Reduction in delayed discharges, LOS*
- *Reduction in CHC assessments and residential and nursing home placements – one AADS patient admitted to residential home (of 300 patients)*
- *Savings in the long-term*

Patient story

- *89 year old woman, known to district nurses for over 2 years*
- *Admitted to hospital following a fall, readmitted 2 weeks later after a 2nd fall; had UTI and slipped off the chair*
- *Osteoarthritis, severe kyphosis and mild cognitive impairment*
- *8 children who are supportive, lives alone*
- *Care package 4 x day, OT worked closely with carers, social worker increased to double handed care, physio involved*
- *Sleeping in a recliner chair for 4 years as found this more comfortable than a bed, DNs monitor pressure areas*
- *AADS OT discussed ordering a floor height hospital bed after 2nd fall, which patient agreed to and also fall-out mat*
- *Now back at day centre 3 x week, OT ordered new specialist wheelchair (arrived 2 months later), reviewing transfer aids*

Patient story - outcomes

- *Remained at home in preferred place of care*
- *Avoided residential or nursing home care*
- *Returned to Day Centre*
- *No falls since November 2016*
- *Able to respond to changes in motivation/preferences with regard to accepting rehabilitation*

Patient story

- *63 year old woman, diabetic, refused amputation of foot, non-weight bearing, in hospital for 5 weeks*
- *Therapy, DN and social work input then readmitted and had above knee amputation - 4 weeks in hospital, refused Lambeth rehabilitation unit*
- *Reablement support, partner also with her*
- *Challenges: home on 2 levels, not wheelchair accessible, declined bedside commode, minor adaptations unsuccessful, chest pain*
- *Supported to consider available choices (often refused), brief (4 days) admission since amputation, at home since December, regaining independence*