Meeting NICE Guidance 27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs

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Overview

• Current Landscape
• NICE Guideline 27 + Quality Standard 136

• Discharge planning in practice – the challenge
• Implementation of recommendations

• Delivering person-centred care
• Can it be done?
Current Landscape
Current Landscape
Current Landscape
“One man told Age UK staff, ‘When I hear the term ‘bed blocker, I feel like a blob of tomato ketchup, and someone’s banging on the bottom of the bottle.’” (Chief Executive, Age UK Derbyshire)
Overarching principles of care & support during transition

- Person-centred care
- Communication and information sharing

Supporting infrastructure
Training & development

NICE guideline [NG27]
Published date: December 2015

Before admission
- Care plan
- Share contact info
- What to expect

Admission
- Communicate & share info
- Est. Hospital based MDT
- Assessment & care planning

During stay
- Recording Handovers – review & update
- Specialist care
- Keep daily routines

Discharge
- Discharge coordinator
- Communicate & share info
- Discharge planning
- Early supp. discharge
- At risk of readmission
- Carers
- After transfer
List of quality statements

Statement 1. Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.

Statement 2. Older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.

Statement 3. Adults with social care needs who are in hospital have a named discharge coordinator.

Statement 4. Adults with social care needs are given a copy of their agreed discharge plan before leaving hospital.

Statement 5. Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.
Transition between inpatient hospital settings and community or care home settings for adults with social care needs (both ways)

NOT JUST ......
Delayed transfers of care

But using the guideline to improve one should help the other…?
Solutions?

• Improving Flow and Outcomes for Older People
  – Specialist input
  – Timely access to MDT Assessment
  – Comprehensive Geriatric Assessment
  – Frequent Review
  – Patient and Carer involvement
## Outcomes

**Patients with ≥ 1 marker of frailty**  
*Sept 2013 (pre-COPE) vs Sept 2014 (post-COPE)*

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<tr>
<th>Outcome</th>
<th>Sept 2013. n=217</th>
<th>Sept 2014. n=225</th>
<th>RR(95%CI) p-value</th>
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<tr>
<td>SB Geriatrician (n)</td>
<td>27.2% (59)</td>
<td>47.6% (107)</td>
<td>RR 1.75(1.35-2.26), p&lt;0.01</td>
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<td>Mean time to Geriatrician (days)</td>
<td>0.88</td>
<td>0.49</td>
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<td>Evidence of CGA (n)</td>
<td>13.4% (29)</td>
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<td>Mean LoS (days)</td>
<td>9.53</td>
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<td>Direct d/c from AMU (n)</td>
<td>29.0% (63)</td>
<td>42.2% (94)</td>
<td>RR 1.44(1.11-1.86), p=0.006</td>
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<td>New d/c to higher level care (n)</td>
<td>16.4% (33)</td>
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<td>F/U with community team (n)</td>
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<td>30-day mortality (n)</td>
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Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone
Clinical Medicine 2016 Vol 16, No 1: 19–24
Authors: Joanne K Taylor, Olivier S Gaillemin, Amy J Pearl, C Sean Murphy and Jennifer Fox

http://www.clinmed.rcpjournal.org/content/16/1/19.full
Evolution of Services / Processes
Evolution of Services / Processes
Evolution of Services / Processes
Iteration
Iteration
Communication

- Black and White

- Grey
- Grey
- Grey
- Grey

“We’re obsessed by complexity and we forget to do the simple things, like talking to someone.”
The future

• QI focus?
  – Opportunity for multiple mini QI projects

• Increase focus on Patient vs Flow outcomes
• Transitions of care both ways
• Challenges of “truly seven-day working”
• Integrated IT?
Thank You

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Ageing can cause:
- reduced bone mass
- reduced muscle strength
- problems with blood pressure control
- hearing and visual impairment

Stand up for INDEPENDENCE and ask yourself the following...

1. Does my patient know who I am and where they are?
2. Does my patient need the IV fluids?
3. Does my patient need to be in bed with the cot sides up?
4. Does my patient need the catheter?
5. Is my patient constipated?
6. Could my patient sit out in a chair?
7. Does my patient need help with eating and drinking?
8. Does my patient need their glasses or hearing aid to help them communicate?
9. Have my patient’s medications been reviewed?

By asking yourself these questions you can:
- Increase the chance of your patient going back to their own home
- Help them recover more quickly and reduce the need for ongoing support
- Reduce the risk of harm from falls, infection, delirium (acute confusion) and blood clots.