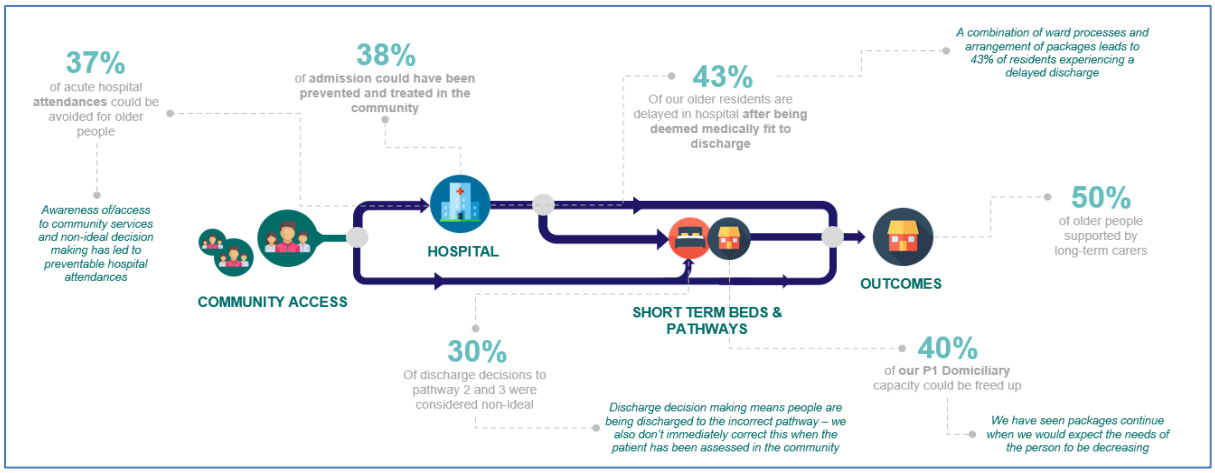
November 2023 – Discharge Special

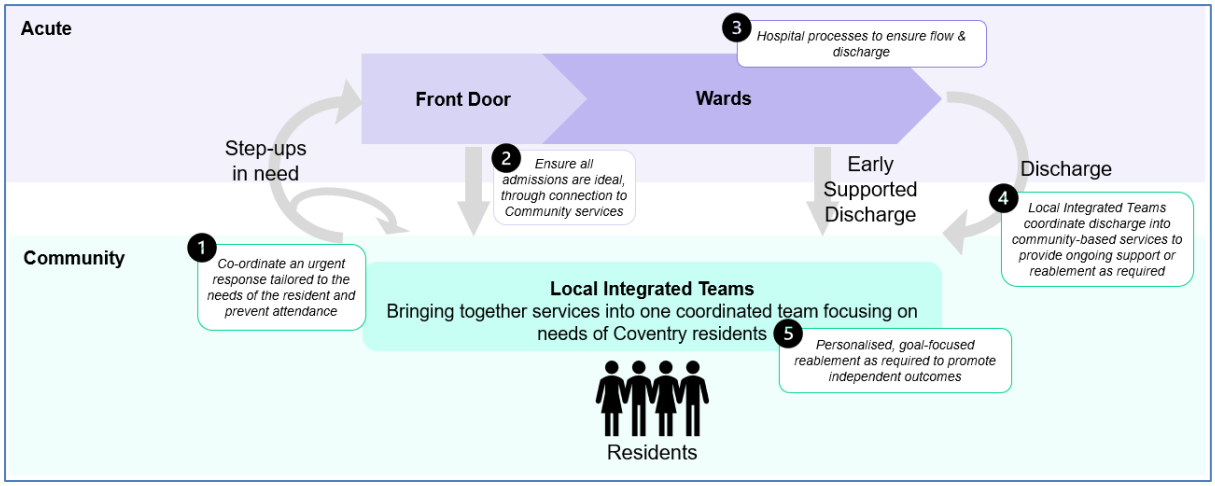
Improving Lives Programme - an introduction

The Improving lives Programme is a Coventry Care Collaborative programme delivered in partnership between UHCW, CCC and CWPT, and other health and social care partners in Coventry. The programme is about fundamentally changing the way we support people in Coventry with an urgent need; **people's experience of health & social care won't be dictated by the services we have, but rather by what they need.**



A diagnostic in December 2021 identified opportunities to improve the experience and outcomes for residents in Coventry. Result showed that over 40% of our older residents are delayed in hospital after being deemed MFFD, leading to increased deconditioning, and higher risk of falls, developing pressure ulcers and contracting secondary infections. The findings from the diagnostic helped to inform the areas of the programme.

<u>Improving Lives Programme Areas:</u>



The Improving Lives work has been focusing on three main areas:

1) **Developing Local Integrated Teams (LITs)** within the community that have the capabilities to urgently respond and support a resident's needs, including incorporating Health and Social care skillsets that previously would have been an isolated service (Hopsital@Home), Urgent Community Response, Reablement). LITs have ensured consolidation of person-centred goals, which promote independent outcomes.
2) **Driving further admission avoidance at the Front Door** through a greater focus on the identification of patients that could be supported at home. New ways of working at the Front Door have already seen a reduction in admissions throughout the trial period.

3) **Improving hospital flow and discharge in the wards** through:
    a. Effective **Board Rounds**, which showed a reduced length of stay by a day in the initial trial area.
    b. Promoting weekend discharges and nurse-led decision making through **Criteria Led Discharge.**
    c. Identifying patients suitable for **Early Supported Discharge** with virtual ward function of the LITs.
    d. Setting up a **Community Led Discharge Model** that supports "discharge-to-assess" which has already shown to reduce post-MFFD length of stay by half on the trial wards.

Once embedded across the Hospital, these ways of working will have a significant benefit on the patients we care for, the demand and capacity of the Coventry system and the workload for yourselves.

Improving Lives Programme - Patient and Staff testimonials

There are videos available for those that would like to learn more about the impact that the Improving Lives Programme, please click here to view.

Rebecca Hill, Ward Manager: Improving Lives trial on Ward 20

Ward 20 has been involved with the Improving Lives trial which has involved the whole Multidisciplinary Team. We have increased multidisciplinary attendance at Board Round, including Pharmacists and members of the Integrated Discharge Team. Having the wider Multidisciplinary Team involved has allowed for tasks to be identified and prioritised to help patient flow. This has led to improved support with patient care and discharge planning.

Discussing discharge pathways has led to the wider nursing and medical team having increased understanding of the discharge pathways and the next steps required. This has also helped to enhance patient experience. The Patient Information Form (PIF) has been well supported by the Therapy and Integrated Discharge Team, and Nursing staff have also been involved with completing these. This form can be completed jointly or individually by both Therapy and Nursing staff which is useful as it has allowed for shared working.

Afternoon Board Round has now been fully embedded and is proving useful in supporting discharges. It allows the Multidisciplinary Team to update each other, identify any outstanding tasks and allocate them accordingly. This work allows us to identify any changes to medically fit dates so that they can be updated promptly on Ward/ Board view, ensuring that the date is visible and accurate. Conversations around discharge are also able to occur sooner, helping with early identification. All of this work ultimately helps us to improve patient flow and safe discharge.

Paula Hewitt, Gerontology ACP, Care of the Elderly: Improving Lives Trial

The aim of the Frailty Same Day Emergency Care (FSDEC) unit is to offer treatment and management plans for frail older people within our unit. Our objective is to deliver a streamlined approach to clinical practice on the same day, therefore reducing admissions and the need for hospital beds, which will ultimately benefit the hospital and our older patients.

Referral pathways into the FSDEC are via the Emergency Department (ED), GPs, and the GP liaison service. The Advanced Clinical Practitioner (ACP) team are currently working on a direct access pathway for West Midlands Ambulance Service. The intention is to reduce ED presentations and prevent frail patients with acute care needs being in the ED for long periods of time, which can lead to deconditioning and unnecessary hospital stays.

Frail older people often present with a range of issues, signs and symptoms which can be non-specific. Examples are falls delirium and polypharmacy, which often indicate underlying medical or social issues. Our goal is that our frail older adults are offered a holistic assessment by senior clinician as soon as possible. Our purpose is to improve outcomes and reduce time spent in hospital. We structure our assessment using the Comprehensive Geriatric Assessment (CGA) which has been developed and adapted for our service by the Care of the Elderly ACP team.

We have also recently changed the way we collect data from patients, their families and carers. As well as this, an electronic patient satisfaction survey has been developed by the ACP team which can be accessed online.

The FSDEC unit has been in operation since 1/12/2022. Our statistics indicate that we have prevented approximately 43% of patients being admitted to a hospital bed; 36.8% have been admitted to the acute frailty unit for a short stay bed; 15.2% have been admitted to a care of the elderly bed and 4.8% have been signposted to a speciality bed. We are proud that our older population can be seen and treated within our speciality to enable the best care possible.

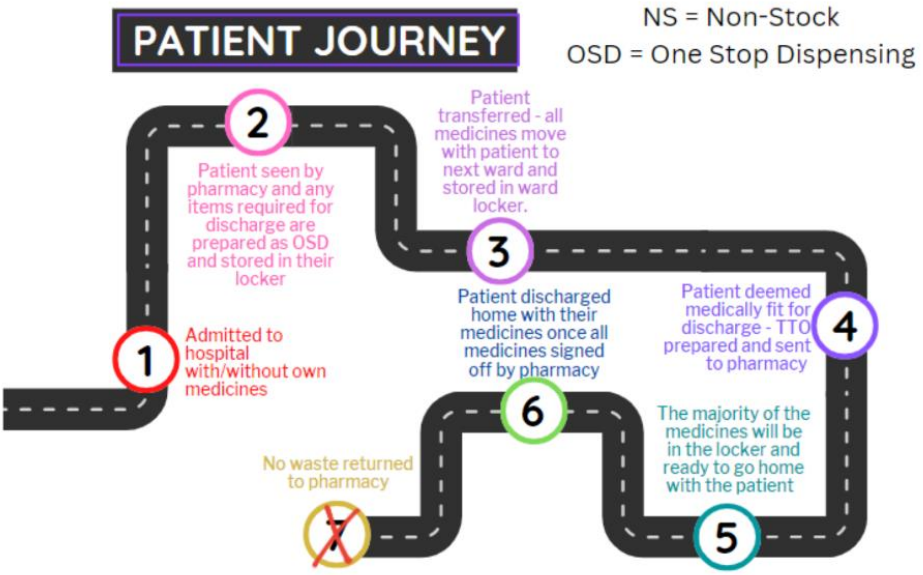
One Stop Dispensing set to roll out on all adult wards

One Stop Dispensing (OSD) refers to dispensing of the inpatient and discharge medication as a single supply on admission, already labelled with administration instructions for the patient. Patients may bring a supply of their own medication into hospital. Following assessment by Pharmacy the medication(s) can be used during their inpatient stay and/or at discharge. These medications will be stored in designated lockable lockers at the patient's bedside.

The benefits of OSD include:

- Improved patient safety through reduction of missed doses
- Improved patient safety through reduction of "SALAD" errors as prevents mis-selection (**S**ound-**A**-**L**ike-look-**A**like-**D**rugs)
- Improved patient experience secondary to reduced waiting times on discharge and aim to minimise avoidable delays around dispensed medicines
- Streamlined medicines administration round
- More efficient discharge process and streamlined patient flow, therefore reducing bed pressures and delays in discharge
- Reduced duplication of medication being supplied – removing waste and cost

New process



OSD has recently been piloted and rolled out on Ward 20 and 20A. It is planned to be rolled out across the adult base wards over the next couple of months. The project will be implemented with the support of Pharmacy, aiming to further improve our patient's experience, reduce waste during a medication round and provide patients with TTO's in a timely manner on discharge.

Effective Discharge and the role of the Integrated Discharge Team

Discharge planning begins soon after patients arrive in hospital to ensure that patients can leave hospital when they no longer require acute care. Leaving hospital when the time is right enables patients to maintain muscle strength, mobility, functional independence and reduces the risk of exposure to hospital acquired infections. In most cases this will be the patients' own home, where they can recover and regain independence.

It is essential that patients are actively involved in discharge planning and the hospital team should encourage patients to ask why they are in hospital, what is going to happen today and tomorrow, what extra help they may need to leave hospital and when they will be leaving. Where patients have indicated that they require support for discharge and have not been in receipt of services prior to admission, they are referred to the Integrated Discharge Team (IDT) via board round/WardView at the earliest opportunity.

The Integrated Discharge Team (IDT) are a team of Nurses, Occupational Therapists and Discharge Assistant Practitioners that will assess and coordinate the discharges for those patients requiring care and support. Patients are allocated to the most appropriate practitioner based on their needs; from a functional decline due to an acute health need, to a rapid deterioration of a patients' health condition. The case manager will work in partnership with the patient, the Local Authority, the Integrated Care Board (ICB), primary care and the voluntary sector to determine where and how these needs can best be met. Patients are discharged via the least restrictive option where possible, which in most circumstances is the patient's home, with short term care and support. Where patients' needs are unable to be met at home they are allocated a bed in the most suitable environment for an assessment of their long term needs to take place in the community.

IDT recognise the important role families and carers have in supporting people with the transition from hospital into the community, where appropriate ensuring they are involved in the decision-making process and keeping them informed and involved with the discharge plans.

IDT proactively participates at the majority of board rounds and are a source of advice and education to the wards on discharge pathways, escalating delays to discharge and supporting flow across the trust.

IDT are currently working with system partners on a transformational 'Improving Lives' program to enhance the discharge experience for patients, assessing and treating people closer to home, and maximising patients' outcomes. This is an exciting opportunity for the team to truly integrate. The trial is currently working across 2 wards, enabling the community to be actively involved in discharge so patients can leave the hospital as soon as they are medically optimised.

Improvement project to increase Patient flow for IOL on Antenatal Ward

Louise Clarke – Consultant Midwife

In September 2022 the induction of labour (IOL) guideline was reviewed, and new processes were introduced. There had been a significant increase in pregnant people undergoing an IOL and at the highest this reached 40% of our service users. This resulted in reduced patient flow through the department and poor patient experience; delays for the women to start the IOL process and to get to the Labour ward leading to increased length of hospital stay.

As a result, changes were made to the process.

The first change was that pregnant people were given a date for the IOL but not a time to attend. Depending on bed availability, the patients were called before 10am to advise them of the time to attend. Previously, when they were given a time at time of booking, this often led to lengthy waits for the patients before a bed was available, and the process commenced.

The second change was that patients who had a previous vaginal birth were offered prostin gel, where 2 doses are given 6 hours apart, as opposed to the propess pessary which gives a much slower release of the prostaglandin pessary and stays in for 24 hours, thus speeding up the process for those women who have had previous births.

The third change was employing an IOL flow midwife who had an oversight of the patients coming in, ensuring medication was prescribed before they arrived, and who had overall responsibility for contacting the patients and keeping them updated.

Benefits to Patients and Service Improvements

- Improved patient experience and reduction in complaints
- Length of time stay reduced resulting in cost saving for bed stay, improving flow
- Use of prostin gel has resulted in more women going into labour and not requiring an Artificial Rupture of Membranes (ARM)
- Cost improvement in using Propess versus Prostin
- Improved communication between departments and the Multidisciplinary Team
- Improvements made to counselling women for IOL and managing expectations
- Reduction in long wait times to get to Labour ward for ARM from average of 4-5 days to now 1-3 days

Our Next Steps:

· New IOL process and guideline has been in place since November 2022. Therefore, as part of PDSA, a re-audit will be undertaken in June 2023 to look at length of stays

· Implementation of IOL flow midwife 7-day week service to improve communication between areas and service users this will:

- Enhance the IOL experience for service users
- Ensure they understand the procedure
- Have an opportunity to attend a pre-IOL clinic to discuss the process and have a membrane sweep
- Offer an element of continuity during the IOL process
- Ensure the IOL are prioritised effectively

Why there's no place like home for our patients

To help us improve outcomes for our patients we are launching an external campaign called 'There's no place like home' in the coming weeks.

The campaign aims to empower patients and their families with the confidence to continue their recovery in a familiar environment, at home and it aligns with the Trust's internal focus on the Improving Lives programme, which you can find out more about here.

Research has shown that patients that recover at home, once they no longer require dedicated care from hospitals, achieve better outcomes, and patients that stay in hospital for long periods of time can experience functional decline in their mobility, fitness levels and muscle strength, making it more difficult for them to regain independence.

We will be asking for your help by having early conversations about discharge with patients and their relatives about why being at home can have a positive impact on their long-term wellbeing.

To helps us do this, colleagues are asked to focus on planning patient discharges from the point of admission which will help us improve flow across our hospital sites.

Teams are also asked to ensure we're utilising Board Rounds to talk about patients' discharge plans and actively progressing patients towards their estimated date of discharge; we're preventing delays to discharge through proactive discharge planning and championing criteria-led discharge and we're actively considering whether someone's needs could be best met outside of our acute hospital setting, through early supported discharge.

Search for the 'Planning together: leaving hospital when the time is right' leaflet on the eLibrary on TrustNav for further detail on this and look out for further information on the Improving Lives programme for internal updates.

Restful Night Pledge launch

Rest and sleep are important for recovery and wellbeing. In our hospitals, there are times at night when noise and lights can disturb our patients.

To help minimise any disturbances, we will be introducing the Restful Night Pledge for colleagues and patients across the Trust.

From Monday 4th December, ward areas will be visited to launch the pledge and we ask that everyone gets involved.

The Restful Night Pledge asks that colleagues provide a restful environment at night by:

- Being sensitive to patients who need time to rest and recover.
- Encouraging patients to turn devices off or on silent mode.
- Having conversations with colleagues away from patients whenever I can.
- Wearing soft soled shoes.
- Closing doors and bins softly.
- Answering call bells, alarms, and telephones as quickly as possible.
- Dimming the lights or switching them off if they are not needed.
- Performing patient observation checks only when necessary.

Latest DAISY Award Honourees

Click the following links read about our latest DAISY Award Honourees, the Enhanced Care team and Bethany Goodman