

# Improving The Discharge To Assess (D2A) Pathway in Gloucestershire



## Project Team

### Clinical Leads:

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## About the Project

Discharge to assess (D2A), Home First models are core element of the Hospital Discharge and Community Support Guidance (DHSC 2022). For most people, leaving hospital at the earliest appropriate time to continue their recovery at home leads to the best outcomes. Some people require an extended period of assessment to identify their longer term needs. These often take place in D2A beds, which are beds in care home settings.

Implementation of pathways, policies and procedures has been challenged owing to a design phase concurrent with winter pressures and the COVID 19 pandemic. This has led to disparities in provision of care, assessment and rehabilitation across the units, with challenges in communication between the agencies support the pathway.

There are high rates of extended length of stay (some above 6 months) and readmission to hospital. In some cases patients who would benefit from palliative care are not being identified and supported early enough. At the core, patients and families are left unclear about the next steps and faced with delays to reach a suitable outcome for the patient.

## Aims & Objectives

**Aim:** To improve the health and social care outcomes of people using the D2A pathway

### Objectives:

- 1) Establish a clear picture of individuals who are in D2A beds by June 2023
- 2) Reduce average length of stay for individuals in D2A beds by end of end of September 2023.
- 3) Increase use of co-designed information sharing mechanisms by end of September 2023.
- 4) Increase access to rehabilitation therapy by end of July 2023

## Measures Used

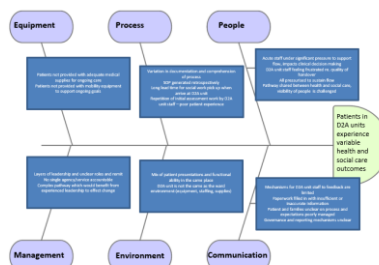
### Qualitative:

- Interviews with care home staff, Adult Social Care and Therapists.
- Theme analysis of issues identified by staff in D2A units and multi-disciplinary team
- Observations in D2A units

### Quantitative:

- Length of Stay per patient
- Median Length of Stay per unit
- Readmission rates per unit
- Discharge outcome (e.g. home versus permanent care)

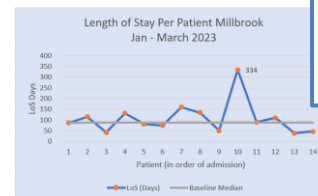
## Quality Service Improvement and Redesign (QSIR) Tools: Methodologies used and contribution to your project



Fishbone (cause and effect) diagram of the challenge



Qualitative data streams to generate current and future state map via stakeholder engagement



Baseline run charts generated to identify variation in length of stay



Potential shift relating to commencing improvement work Jan 2023? Not enough data points yet!

Case Study: Therapy

**The Person and their Circumstances:**  
Aged 67 with Full Medical History including:  

- Heart and Spinalcine
- Arthritis
- Panic Attacks
- Anxiety
- Seniors Falls

**Social History:** Lived alone with support from family with personal care. The individual had been sleeping in their wheelchair in the bed up to admission due to not being able to transfer between bed and chair. Family were supporting the individual to remain living at home however when their plans were discussed in hospital, they felt that this was no longer sustainable.  
**What Happened Next:**  
14/03/2023. Admitted to Gloucester Royal Hospital  

- Multiple Falls from Motorised Wheelchair
- Respiratory Pain.

**Referral and Assessment:**  
Therapy hardware to Care Home via TACB form. Assessed as unsafe using the Sara Steady, Moving ability to Health Services who identified it was the ICT. ICT has accepted the referral.  
 Care Needs Assessment completed by Care Staff state that at the point of admission, the Resident was to be cared for in bed as they found sitting out a chair or wheelchair uncomfortable. Specifically states that they would like to be able to sit out of bed for short periods.  
 20/3/2023. Social Worker referred to the ICT for an OT assessment, this was declined with the advice that it is the Acute Hospital Therapy Team who are responsible. SW Team escalated this to Health Services who identified it was the ICT. ICT has accepted the referral.  
 09/04/2023. Care Home notes indicate that a referral to ICT was completed.  
 12/04/2023. ICT advised to say they will assess in the days. Email sent to SAC to advise that the ICT do not have the resource to provide Therapy into D2A beds and that the understanding is that it should come via the hospital.  
**Outcomes and Benefits:**

- The lady has remained in bed since admission to the Care Home.
- The Resident has only been mobilised once since being in the Care Home, this was on care staff could change the mattress.
- Family have made changes to the property to enable the Resident to return home although we are unclear what these changes are.
- Family and the Resident are frequently asking what is happening, when she will be seen by a Physiotherapist, and when she can go home.

Case studies generated to illustrate lived experience and support engagement in improvement challenge

## Project Outcomes, Progress and Impact

Current state mapping has illustrated the following themes for future improvement work:

- Communication:** Increasing quality of data captured on referral form and discharge summary, expectation management for patients and families, care staff clear on feedback and escalation processes
- Rehabilitation:** Ensuring rehabilitation potential and goals are recorded and communicated, ensure equipment provided prior to transfer to D2A unit, open communication channels between acute and community therapy teams
- Clinical:** Ensure medical supplies and documentation relating to escalation status are transferred with the patient
- Service Delivery:** Reducing lead time of social work allocation, reducing lead time for assessment and brokerage proceedings to support movement from D2A unit

### Next Steps:

- Translation of root cause analysis themes for extended length of stay into drivers and test of change with stakeholder group
- Stakeholder engagement to co-design guidance and pathways
- Establish processes to increase consistency in care plans, medication, palliative care needs

## Learning for the Improvement Community

There needs to be oversight of every individual's care needs to ensure support from system partners is received which will improve quality of care and enable individuals to reach their full potential.