Improving The Discharge To Assess Pathway

Working closely with system partners to diagnose and explore barriers to discharge prior to initiating pathway improvements.

Background

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.

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

Method/Design

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. The project group undertook an extended diagnostic phase to truly understand the complex nature of prolonged length of stay in an intermediate care setting. This included establishing and capturing data relating to length of stay, hold stakeholder workshop to map the current discharge to assess pathway, using qualitative methods to map emotional touch points in the process, pareto style analysis to prioritise pathway improvements.

Measurement

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

Learning

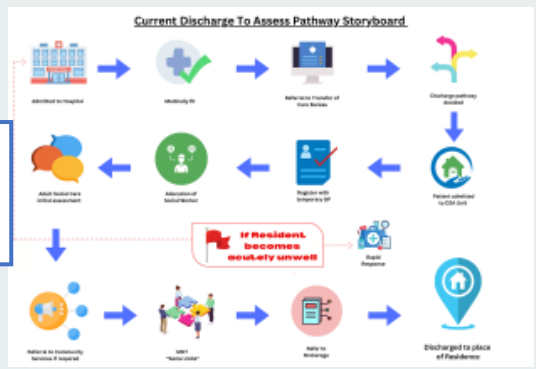
Current state mapping has illustrated the following themes for future improvement work:

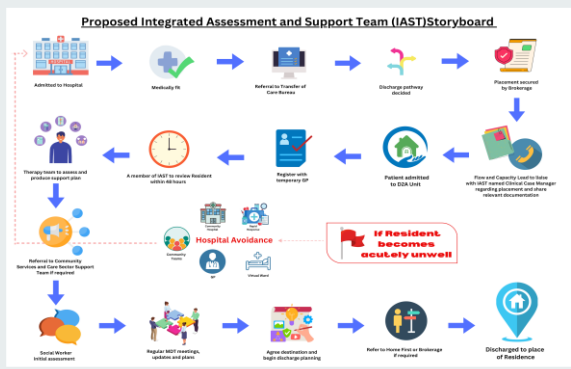
Communication: Increasing quality of data captured on referral form and discharge summary, expectation management for patients and families, care staff clear on feedback and escalation processes

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

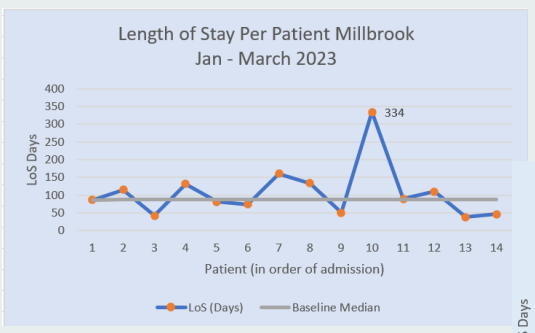
Clinical: Ensure medical supplies and documentation relating to escalation status are transferred with the patient

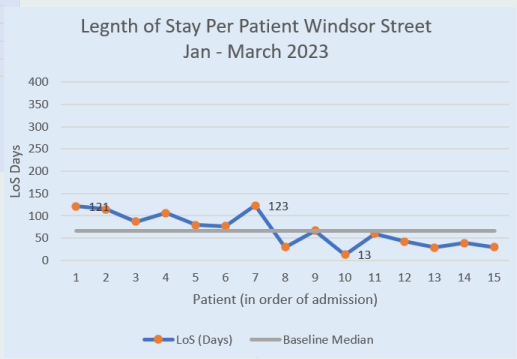
Service Delivery: Reducing lead time of social work allocation, reducing lead time for assessment and brokerage proceedings to support movement from D2A unit





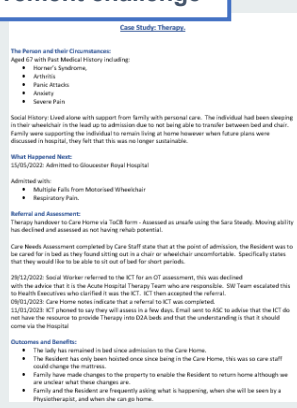
Qualitative data streams to generate current and future state map via stakeholder engagement.

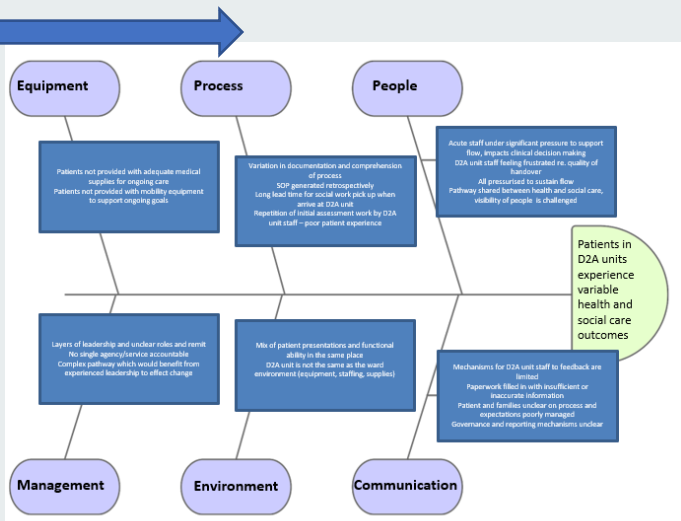




Baseline run charts generated to identify variation in length of stay

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





Fishbone (cause and effect) diagram of the challenge

Conclusion and 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

Tools and/or Models Applied

- Fishbone diagram
- Storyboarding – qualitative data
- Stakeholder engagement
- Time-series data represented in run charts

Contacts: For more information, contact ***One Gloucestershire Improvement Community*** at: glicb.improvement-community@nhs.net