Home First
Resilient Discharge Programme

Manchester Local Care Organisation
Trafford Local Care Organisation
NHS Manchester University NHS Foundation Trust
MANCHESTER CITY COUNCIL
TRAFFORD COUNCIL

Back to Basics

Discharge Support Guide

Useful guidance, tools, case studies and contacts to support staff with strength-based discharge planning.

1. Introduction and how to use this guide

Home First
Resilient Discharge Programme

At MFT we have a **Home First** ethos. That means that we want our patients to be able to go back home as soon as possible after they have received the care they need from us and are medically fit for discharge.

The hospitals work closely with our colleagues in the community in Manchester and Trafford Local Care Organisations to do this. As well as providing MFT's NHS community health services, the LCOs are our link into adult social care through their integrated way of working across Manchester and Trafford.

Why Home First?
Being discharged back home quickly when it's safe to do so is important for several reasons:

- As well as people naturally wanting to be back where they live, there's lots of evidence that staying in hospital longer than needed is not good for them. It can lead to **deconditioning** and a loss of independence, particularly amongst our older patients
- If a patient is in hospital when they do not need to be it prevents patients who need a bed being admitted in a timely way, creating **bottlenecks** and pressures in the system
- We also want patients to be independent and get **the right level of care out of hospital** - permanent bed based care in the community should be the last resort for patients.

That's why discharge planning and the Home First ethos is so important. Home First isn't just about getting patients home from hospital quickly, it's about them retaining their independence, or as much independence as possible.

Home First is everyone's responsibility
Discharge planning needs to start as soon as a patient is admitted to hospital. It is everyone's responsibility. We want every patient to have the right care wrapped around them after they leave hospital which is why we need to work in this way.

To support this work a **Resilient Discharge Programme** is in place with the LCO's, local authorities and other partners.

It's a Manchester and Trafford system-wide programme looking at how we change behaviours, improve systems and optimise how we work for our patients.

Back to Basics work
One of the key elements of this is a Back to Basics programme, working with ward staff to take a fresh look at discharge planning, adopt the Home First ethos and better plan with community and other services.

Over the last few months, work has taken place with several wards to look at how we do this and make simple steps to change how we can work so discharge happens in a timely way every time. The introduction of the Hive EPR has also given us opportunity to better support discharge planning.

This booklet aims to share some of the learning and approaches we've taken with those wards to give all staff a guide on what steps can be taken.

It includes practical steps, case studies and ideas for your teams to use. Please take the time to read and use the ideas. There are also useful contacts if you need further support from the Resilient Discharge Programme team.

2. Discharge terminology

There are several things that are useful to know about discharge and terms you need to understand so you can best plan for a patient's discharge from hospital and know the options that are available in the community.

This includes terms like Discharge to Assess (sometimes called D2A) and 'pathways' – the different options that we have when it comes to the amount of support a patient might need once out of hospital.

You might also hear these referred to as P Zero, P1, P2 and P3.

Identifying which pathway a patient might need as soon as possible really helps to plan discharge in advance.

Things to consider

- **It is often possible to estimate what level of care or what pathway a patient will need at admission or early into their hospital episode** - that allows us to start planning for their discharge, for example engaging with discharge planning teams to identify a place for them if they are likely to need Pathway 2 or Pathway 3 care
- **Getting the pathway right is important** - the strength based approaches to care outlined in this guide will help to make sure that happens. Where possible we want the patient to be supported to be as independent as they can be out of hospital - that can mean using Technology Enabled Care and other community offers to reduce the level of physical care they need.

Discharge Pathways - a guide

Discharge to Assess (D2A) - An approach to intermediate care in which people are discharged from hospital as soon as medically ready so that long-term assessment can take place at or close to home instead of waiting to have that assessment while still in hospital.

Pathway 0 - People who can go home with no additional care needs. This might include going back to an existing package of care or placement or some support from the community (e.g. district nursing, community therapy, voluntary sector etc).

Pathway 1 - People who need additional short-term support at home. This might include short-term therapy, nursing or medical support to get back to independence. For those with less rehab potential, P1 is also used to trial a package of care in the short-term to assess longer-term needs.

Pathway 2 - People who need a period of rehab in a bed-based service. Bedded care is only for people who are not safe between care visits in the community. Some people will go to a rehab community bed to recover, reable and rehabilitate. Others might go to an interim bed while home care is sourced, a social issue is resolved, or to assess whether they need a long-term bed.

Pathway 3 - People discharged to long-term bed-based care. P3 is often for people who have had a life changing event, have been through other pathways multiple times or are approaching the end of their life and may sadly be likely to quickly decline.

1 Strengths Based Practice

Strengths based practice is a key part of effective discharge.

It is about **reframing** how we talk and think about patients and starts with looking at strengths. We know that once initial medical treatment has been provided, an acute hospital setting is not the best place for people to recover and recuperate.

Individuals will feel at their most 'disabled' and vulnerable whilst in hospital so this shouldn't be our baseline for making decisions about discharge. We need to take a bigger picture approach.

A strengths based approach instead **looks at what the patient wants to do and can do**, how they lived before coming into hospital, what support they have at home and setting outcomes and goals. This also reduces the formal care that they need out of hospital.

Strengths based practice is:

- Identifying the most enabling and least restrictive option to support a patient, relative to their needs
- Supporting patients, and their families, to recognise their own strengths
- Seeing the patient as a person and not just as the sum of their care needs
- Empowering staff to have the right conversations in challenging circumstances
- Embedded through long term culture change.

Wards who have used this approach say they benefit from:

- Better patient experience and outcomes
- Improved communication with patients, families and carers
- Decreased time patients spend waiting on wards
- Patients encouraged to become more independent
- An increased the number of people we send home in line with the Home First ethos.

How to adopt a strengths based approach - some simple steps

1. Priming and Framing

Priming and framing is an approach to conversations with patients and families/carers that **starts with strengths** and uses **active words** to promote action.

In the hospital we see patients at their most vulnerable so this is a useful tool to find out more about what the patient **can do** when they are at home.

It uses positive language (eg what will you be able to do yourself) to find out about and reinforce a person's assets and focus on benefits. It avoids the use of negative language (eg what do you need or struggle with).

For example - think about what we can find out by using the reframed options in green compared to some typical questions in red we might ask people around discharge:

What do you need? →	What's important to you?
What needs do you have? →	What do you think will help you achieve that?
What provision do you think you want? →	What will you be able to do yourself?
My job is to assess your eligibility for social care services →	My job is to understand what's important in helping you live independently
How can we help you with xxxx? →	What would help you to do xxxx by yourself?

2. Collecting key information about ability on admission

When the patient arrives on the ward, collect key information about the patient's functional ability **before** their medical episode to set a baseline. For example:

- Was the patient able to walk **independently** or did they do this with support?
- Was the patient able to go to the toilet **independently** or did they do this with support?
- Was the patient able to wash and dress **independently** or did they do this with support?
- If the patient needed support with any of these tasks: can you describe the support which they receive?

3. Testing the patient's abilities

Where possible, you should support the patient to get out of their bed, and observe them on ward. You should be able to answer the following question: *is the patient able to perform functional tasks at their pre-admission baseline, and if not, what has changed?* If you think the patient needs extra support to return to their baseline, consider input from your therapy team at an early stage.

4. Considering all options in a person's life

When engaging in a strength based conservation, consider all of the following elements and strengths in the person's life:

- Self - the patient's own abilities outside of hospital
- Network(s) (e.g. family, friends & wider support network)
- Community (e.g. community resources, voluntary organisations)
- Equipment, Technology & Resources
- Short term support (e.g. preventative support, reablement, respite)
- Longer term support (e.g. formal or informal).

Using these strengths can provide the support that a patient will need to go home independently without needing more formal packages of care or placements. **It helps identify and utilise what is available around the individual – default should not be intense care unless it is needed.**

Setting the scene

A real example is of a 74 year old with Alzheimer's who lives with her husband and had no existing package of care before coming in to hospital after a fall.

The patient was medically optimised and had initially been recommended by staff for intermediate care or Pathway 3 due to her Alzheimer's.

The patient did not want to go to a care home and wanted to return home if possible.

What we did

We worked with the ward on a strength-based assessment, looking at the fact that the patient had successfully lived at home prior to coming into hospital.

By using **reframing** we found out her strengths, what calmed her down, and what her and her husband could manage and where they perhaps needed a low level of help keep her living independently at home. We focused on her retaining as much independence as possible.

Outcome

The patient regained mobilisation quickly and was discharged home within a few days. She was able to be supported at home with a package of twice daily visits to give the bit of extra support that she needed to stay independent.

By using strength-based practice, ward staff reframed how the patient was seen. Discussing and identifying their strengths stopped the patient going to a care home. It also ensured they had the right level of care at home through identifying what they could do and finding out where some extra support was needed.

2 Effective Board Rounds using Hive

Board Rounds give the opportunity to make sure that the latest information on every patient on the ward is updated every day and all staff understand the status of each patient and actions needed to discharge the patient.

This is an essential part of preparing for discharge as it means that plans can be made in advance for a smooth discharge process.

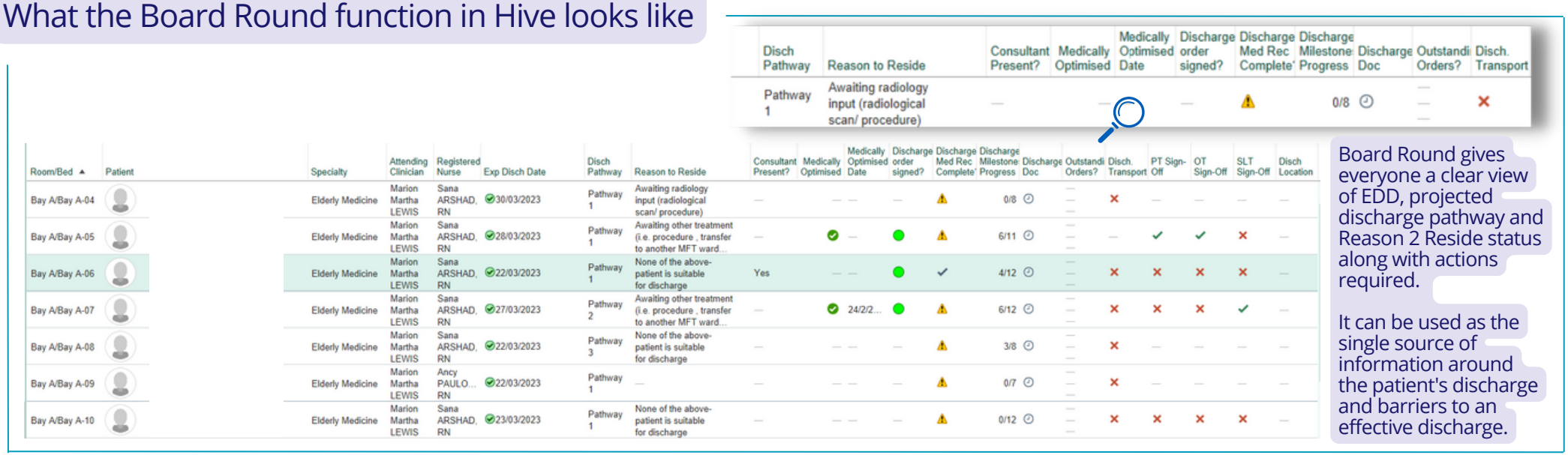
The Board Round functionality of the Hive EPR really supports this to happen in an effective way. It gives all staff a live overview of the current status of each patient and allows everyone to see the Estimated Date of Discharge (EDD), the discharge pathway they are planned to be on and other key information.

This in turn gives clarity to staff on what action needs to be taken and by whom to progress discharge.

Benefits of using the Hive Board Round function consistently as part of Board Rounds are

- It prompts action focused discussions to enable discharge planning from admission and reducing delays once declared medically fit as the wards Multi Disciplinary Team (MDT) have agreed and aligned plans
- It enables teams to plan work loads with accurate Estimated Dates of Discharges (EDDs)
- Individual members of the MDT are clear on what action they need to take next to progress patients discharge journey.
- TTO's/transport etc can be arranged in advanced rather than on day of discharge (where it often holds up the discharge)
- All ward staff are aware of likely discharge plan and pathway so consistent conversations can be had with patient, family and external system partners like community teams.

What the Board Round function in Hive looks like



Board Round gives everyone a clear view of EDD, projected discharge pathway and Reason 2 Reside status along with actions required.

It can be used as the single source of information around the patient's discharge and barriers to an effective discharge.

Ideas on how to use Board Rounds more effectively with Hive

1. Use the Hive Board Round function in every board round meeting

Hive gives a visual at a glance overview of every patient on the ward and their status. In Board Rounds make sure all staff can see this overview to help prompt conversations. It may be useful to have a single screen that all staff can gather round (see the in practice case study opposite) rather than printed sheets.

2. Ensure the information is updated on screen in the meeting

The Board Round meeting is the opportunity to make sure that all information is updated. Think:

- Is the EDD up to date?
- Is the patient on the right discharge pathway?
- Are there any issues that can be discussed with the MDT while everyone is present?
- Is Reason to Reside (R2R) information up to date?

Reason to reside is reported nationally on a daily basis. Updating Reason to Reside allows delayed patients to be escalated to reduce delay. Patients appear on the Patient Tracker List (PTL) used for discharge planning between community and acute teams once the reason to reside is set to 'no reason to reside' so this can be escalated as a delayed discharge and action can be taken to unblock this.

3. Ensure actions are recorded and followed up

Make sure that actions identified have a clear owner and are followed up by the afternoon huddle or for the next day's Board Round.

4. Are actions in place for patient's going home tomorrow?

Always double check that all actions are in place for patients due to leave the ward tomorrow - TTOs, transport or arrangements with the family for example. Leaving them until the day of discharge will lead to potential delays.

Setting the scene

Board rounds on a ward were not discussing EDDs, R2Rs or discharge pathways routinely. As the ward did not use a screen (all staff had printed out sheets), this made tracking actions and EDDs challenging.

This meant information was not up to date and was affecting how the ward prioritised discharges and actions. This affected overall flow as well as how wider system colleagues were able to prioritise work.

What we did

The ward used a **large screen** that all staff attending the meeting could see the Board Round to aid behaviour change. This simple change prompted discussion on areas that were not previously being discussed - with the Home First ethos at the heart of conversation - and actions updated on screen.

Having up to date information also allowed wider system teams (e.g. control rooms) to use the information to plan capacity and prioritise work to enable discharge.

Outcome

- **Consultants and ward staff used the Board Round in a much better way to predict blockers and put actions in place in advance to enable better flow.**
- **Having the information on screen and discussed by everyone meant accountability for actions was higher and solutions to challenges were talked about in the meeting and actioned.**
- **Recording actions on screen made it easier to predict what was next in the discharge planning process for each patient and delays on the ward reduced significantly.**

3 Understanding the community offer

Knowing what services are available in the community and the support that they offer patients is a key part of helping acute staff plan discharge.

Community services in the Local Care Organisations include a wide range of services. They range from traditional services like **District and Community Nursing** and **Intermediate Care** bedded services, through to social care services like **Reablement** and **Technology Enabled Care (TEC).** The LCOs also commission services from other providers of home care and care home support.

These services each provide tailored support for individuals and wrap-around services that can keep patients safe and independent at home or in the community. Understanding these offers helps staff to plan discharge with the right level of support. It also helps us to work with families so we can talk about the support and safeguards that are in place in the community.

The majority of these services are referred to via the Greater Manchester Supported Discharge form - or GMSD - which is the standard from for all discharge requirements on the Hive EPR

Here is a quick guide to some of these services, what they do and the Pathways they mainly support (the boxes by the side of each entry):

Discharge to Assess (D2A)

Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

Patients will be triaged for D2A through the standard Greater Manchester Supported Discharge form (GMSD).

PO

P1

District and Community Nursing and Therapy

The LCOs provide district and community nursing across Manchester and Trafford as well as community therapy and other support. A range of different services are offered to support people following discharge. These services are based on a neighbourhood level with patients treated in treatment rooms and community venues (and at home for housebound patients).

Referrals to Community Nursing and Therapy are through the GMSD Form.

PO

P1

Social Worker Support

The LCOs also provide adult social worker services across the neighbourhood teams.

These services can support patients and families with any change of circumstances that led to the admission to hospital or are a result of the admission.

Social work will follow up discharged patients as standard as part of discharge processes.

PO

P1

Voluntary Sector Support

There are a wide range of voluntary support offers that can be used to help P0 and P1 patients in particular with discharge. The offers include support with transport from hospital to home, check in calls, ensuring utilities and basic food stuffs are in place back at home and even some repair services.

The full range of services can be accessed on the MFT Intranet in the Home First Section. Click on the Home First icon at the top of any intranet page

PO

P1

Technology Enabled Care

Technology Enabled Care, known as TEC, is a range of technology especially designed to keep people safe at home and help reduce people's dependence on face to face care. The TEC offer includes falls alarms, GPS trackers, sensors in the home and medication reminder prompts.

TEC will be considered as part of the social care package after completing the GMSD form. A link with more information on TEC offers is shown on Page 12.

PO

P1

Community Care Navigators

Care Navigators are an LCO team who work with people to ensure they are connected with the right services available to them in their local neighbourhood. They work with people to signpost them to a services that can help with isolation, loneliness, advice, support and other non-clinical interventions across Manchester and Trafford.

You can refer direct to Care Navigators via the Single Point of Access - 0300 303 9650 or mft.spa-uhsm@nhs.net

PO

P1

Reablement (MLCO)

Reablement services are an in-house team in Manchester LCO who provide up to seven weeks support to individuals to help them remain independent at home. Reablement Support Workers provide a range of services from personal care to social support to help people adapt back in the community following discharge.

Reablement support will be considered through the information provided on the GMSD form.

PO

P1

Home Care Packages

The LCO contract with Home Care Providers to provide care packages in people's homes on discharge. There are different levels of support that can be commissioned depending on need. This can include between 1 and 4 daily visits or Twilight checks and other combinations to suit the needs of the person. Combining home care with TEC can also reduce the number of daily visits that are required.

Home Care packages will be considered through the information provided on the GMSD form.

PO

P1

Intermediate Care Units (LCO)

The LCOs run a number of Intermediate Care Units that provide short term bedded care. This is for people who are not safe between care visits in the community. Some people will go to a rehab community bed to recover, reable and rehabilitate. Others might go to an interim bed while home care is sourced, a social issue is resolved, or to assess whether they need a long-term bed.

Intermediate Care packages will be considered through the information provided on the GMSD form.

P2

Care Home and Nursing Home Placements

The LCOs work as part of local authorities to commission care home and nursing home capacity in the system. Long-term bed-based care should be seen as the last option where possible if other offers will not meet the patient's need. P3 is often for people who have had a life changing event, have been through other pathways multiple times or are likely to quickly decline.

Care Home packages will be considered through the information provided on the GMSD form.

P3

More on Technology Enabled Care (TEC)

Working with the LCO's Community Alarm and Technology Enabled Care (CATEC) teams has allowed people being discharged to access a wide range of technology enabled care equipment that can help them to remain independent. The team also provide a response service to attend to calls from people in distress using equipment.

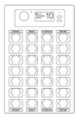
In the Back to Basics pilots on wards we've found that ward staff having knowledge of this kind of support can help facilitate a strengths based discharge - and also helps to provide reassurance to patients and families about the monitoring and support available outside hospital.

Specific items that may be useful to consider include:

Community Alarms - a small wrist or neck worn alarm where the user can send an alert or call carers, family or the CATEC team if they need help. Often used by people at risk of falls in the home

GPS devices - gives real-time location information. This means that if someone gets lost, they can be found by carers, family or the CATEC team. Often used by people with memory issues.

Household Sensors - can detect a variety of things, including movement, epileptic seizures, incontinence, floods, carbon monoxide, open doors and use of household appliances. Support people who are wanting to stay independent while providing peace of mind to users and families.



YOURmeds - portable medication dispenser that provides timed visual and audible reminders to take medication. If a medication dose is missed, an alert is sent so the person can be supported.

You can find more about all the TEC offers by speaking to the Control Room or you can view them in our brochure on the MLCO website at www.manchesterlco.org/technology-enabled-care [click link to visit].

Setting the scene

A dementia patient was admitted who was fully independent before coming to hospital. She had had carers at home before but had cancelled them.

When discussing discharge, the family wanted the patient to go into 24hr care as they were concerned about falls. The patient did not want this to happen so it looked like discahrge would be delayed.

What we did

With knowledge about the community offer and TEC we could suggest sending the patient home instead,

We held a best interests meeting and explained that Home First was the best option rather than staying in hospital or going to to Pathway 3 24 hour care. Together they looked at what could be put in place for the patient to remain independent at home and using technology so the family could monitor activities as well.

Outcome

Patient has gone home with a twice daily home visit package of care, a twilight call and is using the 'just checking' household sensor system. This is part of the TEC offer and allows families to check activities in the house such as which appliances are used and which rooms are being visited.

With the package of care and using TEC, the patient's family had confidence that she could manage at home and were reassured that they would be able to monitor any issues.

The patient wanted to go home and live independently. We listened and worked with the patient, family and community services to look at how we could make that happen safely.

4. Useful contacts and further information

We hope that this booklet is a useful guide to some of the things that can be done to ensure a Home First approach to discharge.

There are a range of other resources available to further support effective discharge processes.

On the MFT intranet

The Home First pages of the MFT intranet provide all the information you need at the click of a button. On the pages you will find:

- this guide
- useful contacts
- case studies
- updated contacts for discharge teams and community teams

Just click the **Home First** icon from the top of any intranet page -

You can also find the pages under the Hospitals/MCS menu in the Local Care organisation section.

Home First video induction

We've also produced an induction video for all members of ward staff to view to give a quick overview of Home First, effective discharge and some case studies of strengths based discharge.

The video can be found in the Home First intranet section or on Vimeo at https://vimeo.com/820451586.

Useful contacts

Here are some useful contacts to support you with Home First approaches and queries about discharge:

Control Rooms

Control Rooms are the coordinating point for all discharges. They are manned by health and social care teams. Daily hospital Patient Tracker List (PTL) calls which take place to discuss discharges should be the first point of contact for ward staff, but you can contact the Control Room directly about a P1, P2 or P3 discharge if there are further issues.

- **Manchester CR** - 0161 234 5629
- **Trafford CR -** via Tlcopathway1@trafford.gov.uk

Integrated Discharge Teams

IDTs are the hospital based teams on each main hospital site. You can contact them for advice and guidance regarding discharge planning for complex discharges.

- **Wythenshawe IDT** - 0161 291 3900 / 3901 / 2902
- **Trafford General IDT** - 0161 934 8237
- **MRI IDT** - 0161 701 6430
- **NMGH IDT** - 0161 720 2533

Keep this guide handy and use this page for any notes or other useful discharge contacts.

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