Aberdeen Adaptations Demonstration Site

Delayed Discharge Project Evaluation Report

Introduction

As part of the Adapting for Change (Joint Improvement Team, 2014) Demonstration site, in Aberdeen, a small group was drawn together to gather information regarding the delays in hospital discharge from Aberdeen's acute hospital, Aberdeen Royal Infirmary (ARI) and the Health and Social Care Partnership at Woodend Hospital. The group involved Occupational Therapy leads from across the two NHS sites and Bon Accord Care, who provide the Community Occupational Therapy Service on behalf of Aberdeen City Council. Members of Senior OT staff from both sites were also included. Representation was also given by the Disabled Persons Housing Service (DPHS). DPHS Aberdeen is a local charity offering housing advice, information and advocacy to disabled people, their families and carers.

The purpose of the group was to develop an effective way of gathering information about delayed discharges, specifically due to re-housing, adaptation or equipment need. The group would then feedback the findings of this project to the wider Demonstration site group in Aberdeen. It was agreed that this would be done by using only patients recorded as delayed discharge on the EDISON (Electronic Discharge Information System Online Nationally) recording system. Discussion was held as to whether those patients delayed by only a couple of days, and therefore not always routinely recorded on EDISON, were to be included in the information gathering. It was decided to exclude these (see Limitations). A form was developed (Appendix 1) and distribute around OT staff in both ARI and Woodend sites for use over a 3month period, from May 2015 until July 2015. The group met following the end of this period and discuss the themes which arose from the returns.

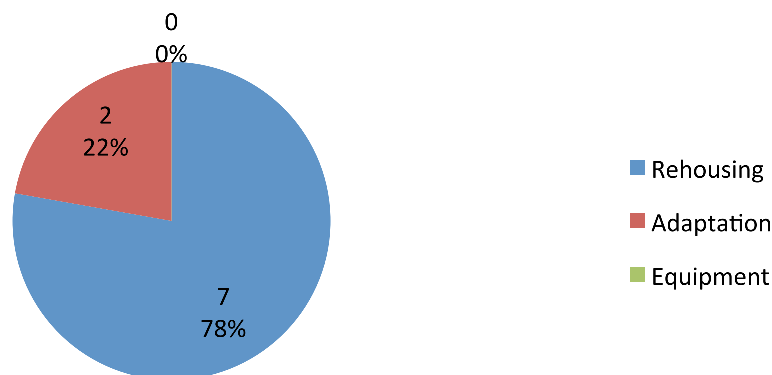
Findings

From the 3month project, there were a total of 14 responses across both sites (7 from ARI and 7 from Woodend). This constituted 6.4% of the total Delayed Discharges recorded on EDISON for patients resident in Aberdeen City for this period (8.4% at ARI and 5.2% at Woodend). Although this figure is relatively low delayed discharges due to re-housing alone accounted for 32% of the delayed discharge days.

Reasons for Delayed Discharges on Returns

The number of returns where rehousing, equipment or adaptation were listed as reasons for delayed discharge were as follows:

Figure 1: Aberdeen Royal Infirmary – Reasons for Delayed Discharge (Re-housing/Adaptation/Equipment)



* *Note* – 2 returns listed Rehousing and Adaptations as the reason for delayed discharge.

Figure 2: Woodend Hospital – Reason for Delayed Discharge (Re-housing/Adaptation/Equipment)

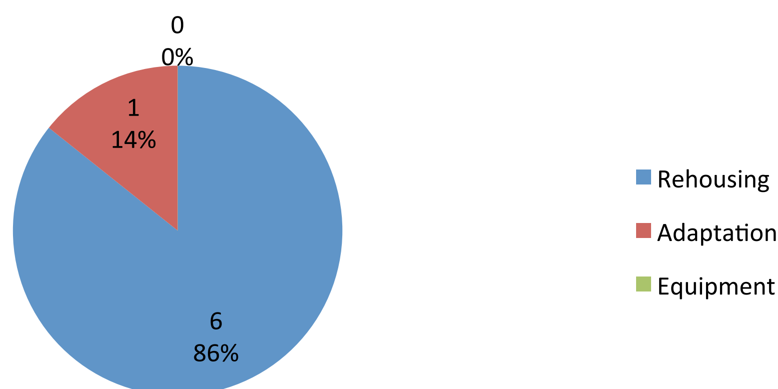
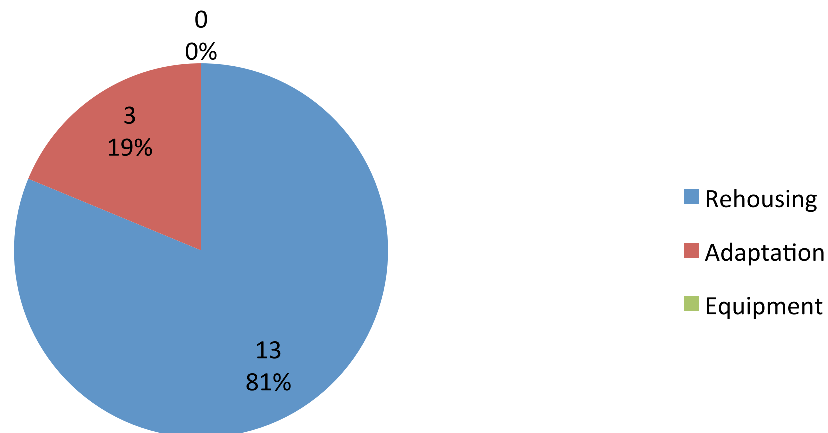


Figure 3. Total Reasons for Delayed Discharges on Returns across all returns



* *Note* – 2 returns listed Rehousing and Adaptations as the reason for delayed discharge.

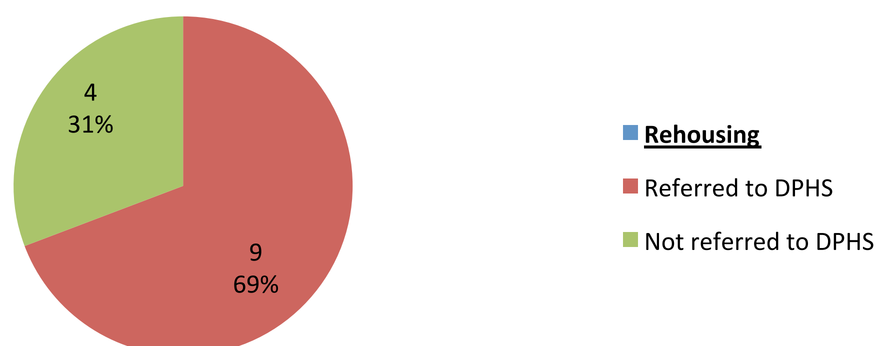
** No returns given stated that equipment was a reason for the delay.

Involvement with Bon Accord Care Community Occupational Therapy Service

All 14 returns were known to Bon Accord Care Occupational Therapy Service, whether it be via the GP attached Occupational Therapist or the Housing Occupational Therapist.

Disabled Persons Housing Service (DPHS)

Figure 4. Percentage of those delayed due to re-housing across both sites referred to DPHS



* of the 4 returns not referred to DPHS each had allocated staff actively seeking re-housing (3 with Social Work staff allocated either for Sheltered or Very Sheltered Accommodation and one Social Worker actioned the rehousing application, and 1 was on the re-housing register prior to admission and had an allocated Housing Officer who was kept up to date with the circumstances of this patient).

Use of EDISON

Figure 5. Date re-housing/adaptation identified vs. date patient added to EDISON

Patient	Day Count between date need identified and date added to EDISON	On EDISON prior to Hospital intervention being complete?
1	+79days	Yes
2	+17days	Yes
3	+7days	Yes
4	+10days	Yes
5	N/A	No
6	+17days	Yes
7	+2days	Yes
A	+50days	No
B	+2days	No
C	+20days	No
D	+24days	No
E	N/A	N/A
F	+33days	Yes
G	N/A	N/A Re-housing already identified as being required prior to admission

Adaptations to current property

3 returns identified Adaptation work as being a reason for delay

Patient	Type of Adaptation	Tenure/Responsibility of Adaptation	Reason patient could not return home awaiting adaptation
1	Ramped access Level access shower	Owner Occupier responsible via Scheme of Assistance grant funding with support of BAC OT	Went home awaiting adaptation
2	Lowered kitchen units and removal of unit to accommodate fridge freezer. Higher toilet Automatic door opener Adapted path	Aberdeen City Council	New property not furnished prior to adaptation work being completed
B	Level access shower	Owner Occupier private install	Patient discharge awaiting completion of adaptation

Rehousing needs

A total of 13 returns identified that re-housing was the reason for delay.

Patient	Type of housing required	Referred onwards	Reasons why patient could not be discharged awaiting re-housing
1	Ground Floor wheelchair accessible property	DPHS	Major restrictions in current property – access to property, access to toilet facilities, door width restrictions and shower access.
2	Ground floor wheelchair accessible property	DPHS	Existing property was not wheelchair accessible internally or externally
3	Nursing Home	Social Worker	Level of care required exceeds what can be provided in community.
4	Ground floor wheelchair accessible property	DPHS	Property not wheelchair accessible
5	Ground floor wheelchair accessible property	DPHS	Property internally not fully accessible for wheelchair. Living room on entry level

Patient	Type of housing required	Referred onwards	Reasons why patient could not be discharged awaiting re-housing
6	Ground floor wheelchair accessible property (with 2nd bedroom for medical need)	Social Worker (involved prior to admission)	Internal and external access difficulties. Could not access kitchen, bedroom or bathroom
7	Ground floor wheelchair accessible sheltered housing property	DPHS, Houseability	Door widths in existing property not wide enough to accommodate wheelchair
A	Very Sheltered Housing	DPHS	Difficulty with access to property and need for care at home.
C	Ground floor wheelchair accessible sheltered housing property	DPHS	Current property not wheelchair accessible.
D	Ground floor wheelchair accessible very sheltered housing property	DPHS	Current property not wheelchair accessible.
E	Sheltered Housing	None given	Current property not wheelchair accessible.
F	Ground floor wheelchair accessible very sheltered housing property	Social Work	Current property not wheelchair accessible
G	Wheelchair accessible flat	Housing Officer	Current property restrictive for wheelchair accessibility.

Technology Enabled Care

In the returns, staff were asked to identify if Technology Enabled Care (TEC) had been considered as an alternative in any of the incidents of delays – no returns entered that this had been given consideration. The project did not gather information on the delays purely due to care restrictions (see limitations).

Limitations

There are a few limitations to this project which should be identified. This was only a 3month collection of data from the period of May 2015 until end of July 2015. Further projects for longer periods at alternative times of the year, may identify different themes. The project was not inclusive of all delayed discharges across the two NHS Grampian sites, and only concentrated on those resident in Aberdeen City who were delayed with their discharge by reason of re-housing, adaptation or equipment needs alone. It was recognised by the group that often care provision is

a combined reason for delay and that often once re-housing is identified, there is further delay sourcing care for the individual. The group agreed to only capture delayed discharges as recorded on the EDISON system. This project did not capture those delayed by only a few days (and therefore not added to EDISON) due to equipment or adaptation needs. It was acknowledged by the group that the OTA in a Van service operated by Bon Accord Care has been especially helpful in reducing the number of these, however future data collections could capture these patients and identify when “minor” delays occur.

Discussion

Following the collection of data, the group met collectively to discuss the individual cases and agree common themes.

The group identified an issue with the local authority Housing Priority system, where applicants in hospital who required re-housing were not seen as priority until they were placed on the EDISON system. As a result, and to prevent delay, patients are routinely added to EDISON, once re-housing is identified. This is often prior to their medical or rehabilitative interventions being complete and subsequently not ready for discharge. This not only skews the data but is a misleading representation of the true picture of delays within the two NHS Grampian sites. It was also highlighted by one case that a change of circumstances does not “re-set” housing applications. Prior to admission the patient had declined a property. Their needs had changed as a result of the admission, but because they had declined a previous property this was taken into account when looking for re-housing, further delaying the patients stay in hospital. Another example referenced a Pre-Allocation home visit carried out jointly by the NHS and Housing OT to a ground floor property. Once there, the OT’s discovered that although the property was ground floor, it was completely inaccessible to a wheelchair user. There was discussion around simple information that could be collated about the property which would allow the Housing Officer to exclude any ground floor properties with certain accesses issues i.e. internal steps.

Managing expectations for the patient and their family was also raised as a theme. It was agreed that early discussions about discharge planning were essential, however the use of a “neutral” person, external to the person’s on-going intervention on the Ward, have been particularly useful, especially where family have placed barriers in the way. The “neutral” person has been able to clearly explain the reasons why the patient cannot remain in hospital indefinitely, protecting breakdown of relationships between the ward staff and the patient/family. Around the management of expectations there was also discussion about agreeing collectively as hospital and community staff what is an acceptable discharge protocol. Is it acceptable for a person to be discharged to be house-bound in their own house awaiting re-housing? Is it acceptable for a person to only be able to access the living room of their home with a hospital bed and commode? Glasgow was referenced within the group as having agreed protocol. It was further acknowledged that this is perhaps easier to

accommodate in Glasgow where care packages are more readily available. Joint work with Care Management, Community Alarm and the Fire Brigade would be especially helpful in agreeing this, as well as with Housing providers to agree that if someone returns home to “make do” this will not reduce the priority of their application. There was also discussion about the cost of keeping someone is hospital and whether funds could be used creatively to reduce lengths of stay. For example, one patient was delayed with their discharge awaiting re-housing, however could have been discharged to live downstairs in their home, with the disconnection of a gas fire and the replacement of the carpet while they awaited re-housing. This was not acceptable to family and the patient remained in hospital. Creative use of funding could have improved this situation.

“Step down” facilities are especially valued as a resource to discharge patients to when unable to return home. These include Rosewell House Rehabilitation Unit, Clashieknowe Intermediate Care Unit and Craig Court Neuro Rehabilitation Unit. There is a need for these types of facilities both within and outwith the City in Aberdeenshire.

It was acknowledged that there is currently a care shortage in Aberdeen, with particular pressures on out lying areas of the city. There were examples given where patients, who had already been delayed by awaiting re-housing, who were further delayed once housing was identified due to lack of care provision in that area.

The group acknowledge positive developments and relationships which are to be acknowledged as helping to alleviate delays. These included the OTA in a Van service and the wider Bon Accord Care Occupational Therapy team being quick to respond with allocated workers to discuss the situation with and promote early discharge planning. The Disabled Persons Housing Service was acknowledged as providing a huge support to patients. DPHS and Aberdeen City Housing Department were praised for allocating applications in a timely manner. The role of the Housing Liaison Officer was praised as a positive development.

Suggested recommendations from findings to go forward to the Adapting for Change, Aberdeen Demonstration site

Based on the discussion of the group the following is suggested based on the themes raised;

- Pathways – These need to be streamlined which may include a team/person having a specific role to link clinical and social needs. Helpful if a budget could be released to support this.
- Resources – e.g. Commissioning interim/step down opportunities for patients, especially those who are younger, both within the shire and the city
- Systems – e.g. Smarter patient/client management systems to be explored where housing priority needs can be included
- Team working – e.g. discharge arrangements need to be communicated earlier within the patients' pathway to community services/care management

References

Joint Improvement Team (2014) - Adapting for Change
http://www.ccpscotland.org/hseu/wp-content/uploads/sites/2/2015/03/Adapting-for-Change_Margaret-Moore-JIT.pdf

Contact

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Appendix 1 – Information collection form

Adapting for Change – Inpatient Survey

ABERDEEN CITY COUNCIL RESIDENTS ONLY

Patient Name		**CHI:**	
Post Code		**OT:**	
OT Area	ARI ☐ Ward:………….. Woodend ☐ Ward:…………..		
Diagnosis/Condition			
Tenure Type	Owner Occupier ☐ ACC ☐ Private Rental ☐ Housing Association ☐ Please specify: ……………………. Other ☐ Please specify: ……………………….		
Date defined as "Delayed discharge" on EDISON List			
Reason for Delayed Discharge – tick all which apply	Equipment ☐ (Go to Equipment Section) Adaptation ☐ (Go to Adaptation Section) Re-housing ☐ (Go to Re-housing section)		

Equipment

Detail of equipment defined as essential for discharge	
Date assessed as being required	
Equipment requested from	Liaison Nurse ☐ Bon Accord Care OT Service via Duty OT ☐ Hospital Direct Order via BAC-KUS ☐

	Family advised to purchase ☐ Other ☐
Date request for equipment made	
Alternatives considered to facilitate discharge (if known)	Family/Informal carer support ☐ Intermediate Care placement ☐ Technology Enabled Care ☐ Self Directed Support ☐ Other ☐ Please specify ………………………………
Why alternative not suitable (if known)	

Adaptation

Date OT Identified need for Adaptation	
Type of Adaptation	Please specify:
Layout of Property	Bathroom on access level ☐ Room for bedroom/bed on access level in short term ☐ Any other relevant details:
Date of Referral	
Who referred to	Bon Accord Care OT via Duty OT ☐ Family/Friend ☐ Other ☐ Please specify ………………
Alternatives considered	
Why alternative not suitable (if known)?	

Re-housing Needs

Type of current property	
Reasons current property not suitable to be discharged to	
Date rehousing need identified	
Date Service User consent given to investigate options for onward referral	
Type of housing identified as being required (tick all which apply)	Access to facilities on ground floor ☐ Wheelchair accessible property ☐ Sheltered Housing ☐ Very Sheltered Housing ☐ On-site care required ☐ Other ☐ Please specify:
Date of onward referral	
Who referred to	Disabled Persons Housing Service (Aberdeen) ☐ Houseability (Aberdeenshire) ☐ Other ☐ Please specify: