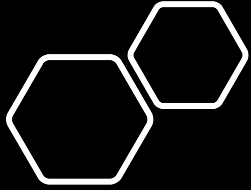
Sharing learning to support improvements in discharge planning at the end of life

Collaborative working across acute and community services:

Birmingham Community Healthcare NHS FT (BCHC) in partnership with

University Hospitals Birmingham FT (UHB)



Supporting improvements in discharge planning – Case Study

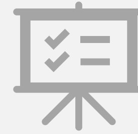
- Development of a ‘tool’ to support staff when planning discharges – the power of Twitter
- Background to development
- Launch and implementation
- What’s next and measuring improvement

Background

- University Hospitals Birmingham FT is one of the largest Trusts in England employing over 20,000 staff and treating over 2.2 million patients each year. It has more than 2,700 beds across its 4 sites plus community services
  - Approx 6500 deaths per year across the acute Trust
- Birmingham Community Healthcare NHS FT – provides a range of community and specialist services across Birmingham – serving a population of approx. 1.1 million
  - Palliative and end of life care is a core part of the care provided by our district nurse teams – approx. 1200 patients on DN caseloads at any one time
- Well established Birmingham and Solihull system wide End of Life Collaboration Group

Background to development

Initial review completed as part of preparation for divisional quality review of palliative and end of life care – community nursing



Incidents reported via datix highlighting the impact on end of life care

Feedback from teams as part of the quality review staff forum

Each incident had been followed up individually but this did not address the wider issues/themes that were identified as part of the review

Main themes

Insufficient information provided with referral to DN teams

No patient referral to DN team from hospital

Communication

Incorrect information given to families by ward staff

Miscommunication – medication and prescriptions

Working in partnership

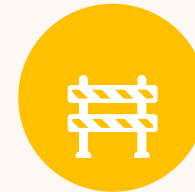
- Already established good working relationship with UHB – initial work prior to pandemic focused on EOL discharge planning and through CCG led system wide operational EOL group
- Approached UHB EOL and Bereavement Team – how could we support staff with discharge planning?
- Needed to be something that could make a real impact as a first step towards improvement – visual, simple messages, timely implementation – established approval routes
- Idea of an ‘aide memoire’ poster born – plan agreed to launch at UHB’s EOL Conference as part of dying matters week

Contents of poster

Incident themes

Work with DN team palliative care champions – what key messages would they want to give to support ward staff

+ input from UHB Community Team



Issues identified by UHB teams – what barriers had they identified when planning discharges

Discharge Planning for End of Life Care

D — DISTRICT NURSE TEAM

- Contact the district nurse team - fully involve in the discharge plan - call DN Team for initial discussion.
- Invite the DN team to complex discharge planning MDTs.

I — INCLUDE

- Include the patient and family in discharge planning conversations.
- Manage expectations of discharge and community service provision.

S — SYRINGE DRIVER AND ANTICIPATORY MEDICATION

Ensure syringe driver AND/OR anticipatory medication is prescribed on the 'Medicines Authorisation form' e.g. MASC and sufficient medication supplies on discharge. These MUST be sent home with the patient/family. If medication is not provided, families often need to travel to pharmacies meaning less time with their loved one.

C — CONTACT DETAILS

Birmingham DN service (BCHC)

Tel: 0300 555 1919 - option 1 for referral + call DN team mobile to discuss referral

BCHC Palliative Care Support line for patients and families - Tel: 0300 555 1919 - option 3 (24/7)

Solihull DN service
Tel: 0121 717 4333 - 24 hour phone line

Solihull Palliative Care Team:
0121 703 3780

H — HOME OXYGEN

- Does home oxygen need to be organised?
- Ensure oxygen can be in place for planned discharge date and time.

A — ADVISE OF REASON FOR ADMISSION AND TREATMENT GIVEN

Why was patient admitted? What treatment was given? Without this information community colleagues struggle to provide clinically safe care.

R — ReSPECT / DNACPR STATUS

Has Advance Care Plan (ACP) been reviewed considering discharge and community setting? INCLUDE ReSPECT form with the discharge documentation.

G — GENERAL PRACTITIONER

Contact GP prior to discharge, advise of the discharge plan.

E — EQUIPMENT

- Consider the need for bed frame, mattress, hoist etc.
- Has the patient been assessed?
- Have items been ordered?
- Have delivery times been discussed and agreed with the patient/family/carers?

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Launch

- UHB EOL conference included a focus on discharge planning – session presented by BCHC and UHB community teams
- Role of DN - end of life care a core component
- Learning shared from review of discharge incidents - emphasis on the impact this can have on patients and their families
- How we can work together to improve discharge planning
- Pocket sized leaflet version of the poster developed by UHB and included in the launch
- Posters well received by staff – helping to ensure the right people are informed to ensure seamless transfer

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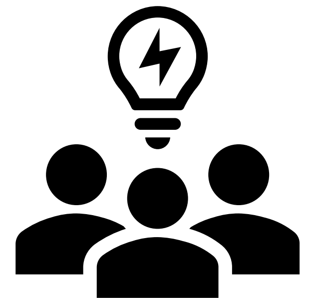
Some thoughts…

- We know its not perfect and that the actual flow of discharge isn't quite reflected but we wanted it to be visual and an aide memoire for staff
- List isn't exhaustive and acknowledge that some specialist areas are not mentioned - wanted to keep it simple with the main principles identified
- Great project to work on together - continue to build strong working relationship between acute and community teams
- We recognise that this poster alone won't address all the issues identified – one of a number of initiatives, but a step in the right direction



What’s next

Plans for ongoing collaboration - community services involvement in UHB EOL education programme

Develop stronger links – look at opportunities for ward staff to spend time with DN teams

Involve DN teams at an earlier stage of discharge planning – where complex needs, consider DNs visiting patients in hospital before discharge

Strengthen links with UHB Discharge Teams – avoid duplication

- Continue to review incidents and themes
- Patient experience – themes identified from concerns and complaints
- Staff experience – feedback from hospital and community teams
- Training and education – utilise as part of training

Any questions?

Thank you for your time