NHS Highland

Essential Action 3:
Daily Dynamic Discharge
Case Study – NHS Highland

Testing the Daily Dynamic Discharge Approach in the Community: Part One of the Highland Improvement Story

6 ESSENTIAL ACTIONS
Unscheduled Care

Healthier Scotland
Scottish Government

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When it comes to healthcare improvement, someone with a vision and passion for making things better for patients can kickstart a process of change. A committed change agent who can clearly articulate their vision can help to initiate much-needed improvement. However, for the change to be sustained, it needs to be embraced and embodied by the whole team. This story from the Highland Health and Social Care Partnership shows how one nurse helped to inspire an entire team. This, in turn, has led to a bigger piece of work which has the potential to transform discharge planning across the Highlands. This is part one of the Highland improvement story…

Proactive Discharge Planning in a Community Setting

Acute hospitals are increasingly aware of the importance of patient flow in managing unscheduled care pressures. The correlation between discharging patients in a timely way and meeting the four-hour Emergency Access target has prompted many acute hospitals to adopt proactive approaches to discharge planning.

It is more unusual for community hospitals to take such an approach to discharging patients, as they are not subject to the same patient flow pressures as their colleagues in acute. However, community hospitals in NHS Highland have adopted the Daily Dynamic Discharge model, developed by the Scottish Government's 6 Essential Actions to Improve Unscheduled Care programme, as a way of improving the flow of patients into the community and supporting their colleagues in the acute setting. It is early days but teams are already noticing some important efficiency improvements…

6 Essential Actions to Improve Unscheduled Care

Daily Dynamic Discharge is a key part of the 6 Essential Actions to Improve Unscheduled Care programme. These are the six actions regarded as fundamental for improving the experience, safety and care of patients during episodes of unscheduled care[1].

Some of the components of Daily Dynamic Discharge are:

- Dynamic multidisciplinary team planning – the team meets within 12 hours of a patient's admission to discuss their discharge plan
- Setting an Estimated Discharge Date (EDD) within 24 hours of the patient's admission to the ward – assessing and documenting the date of predicted medical fitness within the care management plan
- Effective ward rounds – using a set of questions to prompt the right discharge discussions for each patient
- Daily whiteboard meetings – brief morning meeting to prioritise the day's tasks, which will be owned by members of the multidisciplinary team, to prevent any delays in discharging patients
- Golden Hour ward rounds – a way of ordering which patients are seen first during the ward round, determined by clinical need and proximity to discharge
- Non-slip task management – a daily task sheet created by the facilitator of the morning meeting, and which is reviewed at the afternoon meeting
- Check, Chase, Challenge – a senior member of the hospital is invited to challenge estimated discharge dates or tasks that do not contribute to timely discharge
- Ward access targets – ensuring wards understand what capacity they should be aiming for
- Pre-noon discharge – discharge earlier in the day to align capacity with demand

1 www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care

There are six community hospitals across the Inner Moray Firth area, linked closely to Raigmore Hospital in Inverness. These community hospitals mostly care for older patients with complex health and social care needs. Lead Nurse for the Highland Health and Social Care Partnership, Kate Patience Quate believes passionately that the standard of care in community hospitals should equal that provided by the acute hospital. She heard about the Daily Dynamic Discharge model, developed by the 6 Essential Actions for Unscheduled Care National Programme team, and was keen to explore whether it could be used to standardise discharge planning practice in the community hospitals and improve flow across all the hospitals in the Inner Moray Firth area.

"We recognised that we needed to be more dynamic and move towards a seven-day approach to transferring and discharging patients."

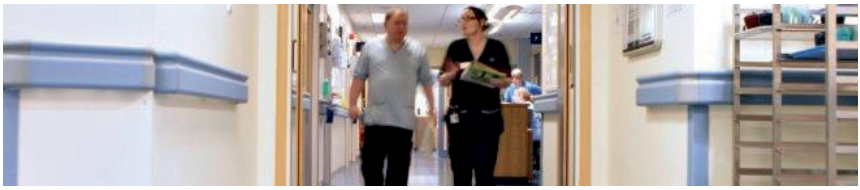
Kate Patience Quate,
Lead Nurse, Highland Health
and Social Care Partnership

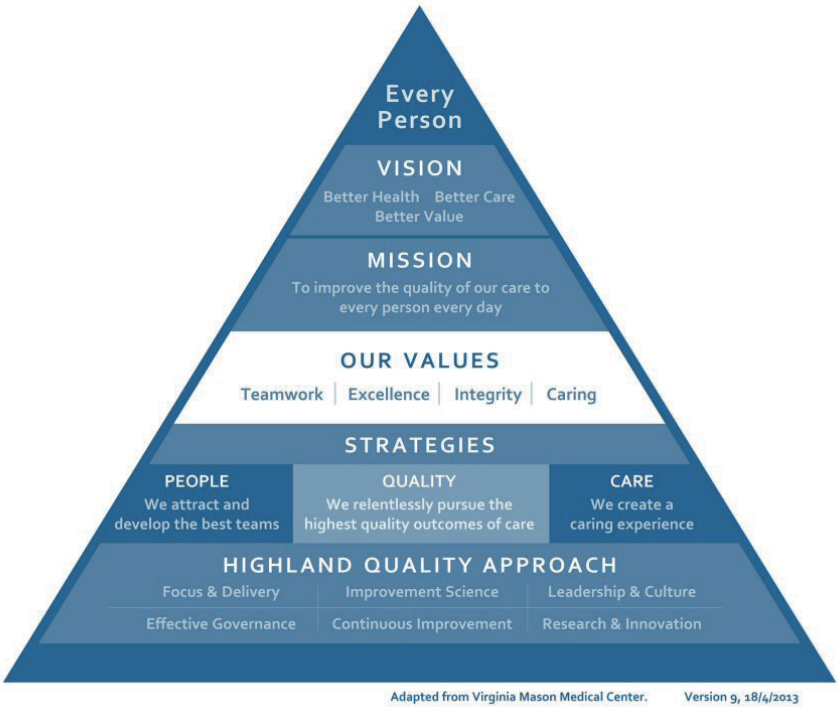
Patient Discharge Patterns

Kate began by collaborating with her colleagues, Iona Mcgauran, Lead Nurse in Raigmore Hospital, Mark Smith, Associate South and Mid Operational Unit and Amanda Trafford, Lead Allied Health Professional. They examined the available data to determine if there were any patterns in discharging patients from the community hospitals. Kate explained:

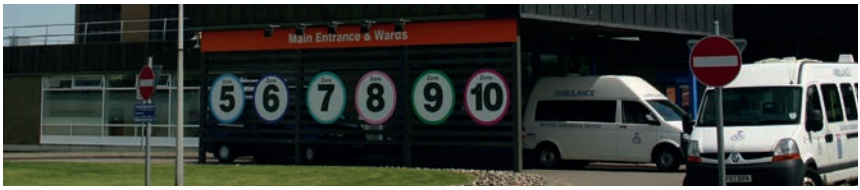
"We identified three peaks in discharging patients from community hospitals: two days after transfer from the acute hospital; 9-11 days after transfer and 28-30 days after transfer. From this, we drew a number of conclusions. We concluded that patients discharged after two days probably didn't need to be admitted in the first place and could have gone straight home; we deduced that patients discharged after 9-11 days were probably discharged as a result of our weekly multidisciplinary team meeting and we concluded that patients discharged after 28 days were the ones who really needed to be in hospital and who required a coordinated multidisciplinary team approach to enable them to be discharged safely."

6 Essential Actions to Improve Unscheduled Care





The principles of Daily Dynamic Discharge fitted in well with The Highland Quality Approach

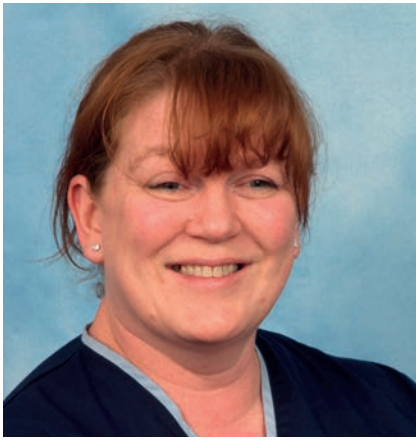


Daily Dynamic Discharge

The Highland Health and Social Care Partnership decided to implement the Daily Dynamic Discharge model across its community hospitals. Kate said:

"Most of the focus on patient flow improvement takes place in the acute setting, so community hospitals are often excluded. We believed that we could improve the efficiency of patient discharge from community hospitals by becoming more proactive in identifying suitable patients at an earlier stage. In NHS Highland, we have pioneered an approach to continuous improvement called The Highland Quality Approach, based on lean methodologies. It places the person that we are caring for firmly at the centre of everything we do and has three main aims: 1. To reduce harm 2. To reduce variation and 3. To manage variation."

"The principles of Daily Dynamic Discharge fitted in well with The Highland Quality Approach and provided a framework for us to improve proactive discharge planning in a community setting. We recognised that we needed to be more dynamic and move towards a seven-day approach to transferring and discharging patients. We were also keen to be much more proactive in pulling patients from the main hospital, ideally back to their own home but often back to their local community hospital as they required ongoing sub-acute hospital care. The Daily Dynamic Discharge toolkit has been part of a suite of different approaches which have supported us to do this. To date, it has been really helpful in establishing a standard approach to running our local huddles in each of our Community Hospitals."

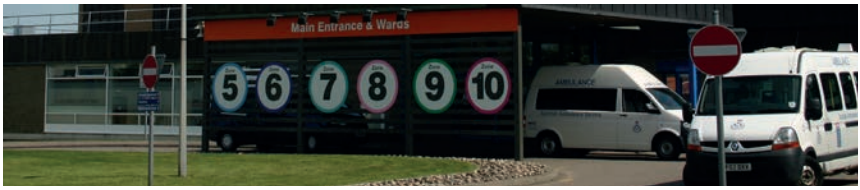


“Staff take the initiative in making calls and in setting things in place to facilitate earlier discharge. We are also more proactive in pulling patients out of Raigmore so we can free up beds there and speed their return to the community.”

Julie Ransome,
Senior Charge Nurse,
Invergordon Community Hospital

Involving Teams

The work began in November 2016. At the outset, Kate and Mark held a workshop to introduce community teams to the Daily Dynamic Discharge model. Mark explained: “We weren’t prescriptive about what they had to do, instead we asked them to identify what might help them to improve discharge planning and invited them to make pledges. We held a follow-up meeting six weeks later so people could report on their progress and request further support.”



Multidisciplinary Team Huddle

One of the pledges was for each of the community hospitals to establish a regular huddle, bringing together the multidisciplinary team to review the status of patients and discuss what needs to happen to facilitate timely discharge. The senior charge nurse from each of the six community hospitals then links in, by video conference or jabber, to a daily virtual huddle. The virtual huddle is coordinated by a manager from the Highland Health and Social Care Partnership and links in turn into the Raigmore Hospital daily huddle. The virtual huddle lasts for a maximum of 15 minutes each morning to review patient flow, quality and safety issues and resolve any problems, wherever possible.

The Experience at Invergordon

The community hospitals are at different stages in implementing the morning huddle. Invergordon Community Hospital is a 28-bedded hospital that has recently introduced it and is already seeing improvements, as Senior Charge Nurse, Julie Ransome explained:

"Before this we were finding that patient discharge dates could slip, sometimes by weeks, because of a lack of communication and coordinated whole team approach. Now, we have a short, focused meeting where we talk about which patients are being discharged and when. We look at any discharge delays and discuss what we can do to move the process forward. Staff take

the initiative in making calls and in setting things in place to facilitate earlier discharge. We are also more proactive in pulling patients out of Raigmore so we can free up beds there and speed their return to the community. Bed management is not an exact science, things change all the time, but we are communicating better now with our colleagues in the acute hospital and we let them know when beds become available."

Lead Allied Health Professional, Amanda Trafford added:

"Each of our Community Teams now receives an automatically generated daily report which notifies them of people from their local area who have been admitted to hospital in the last 24 hours. Some of these people will already be known to the health and social care teams but they may not be aware that the person has been admitted to hospital. This report prompts the teams to make contact with the hospital ward, share relevant information and initiate the conversation about early discharge planning. We have developed a standard operating procedure for this work and it is referred to as Community Pull."

"We weren't prescriptive about what they had to do, instead we asked them to identify what might help them to improve discharge planning and invited them to make pledges."

Mark Smith,
Associate South and
Mid Operational Unit

Challenges

As with any change in procedure, the introduction of the new daily huddle was not without its challenges, as the team at Invergordon found. The huddle takes place at 8.30am, which is one of the busiest times of day on the wards, coinciding with the drugs round, patients getting up and breakfast. The hospital decided to treat the huddle as a priority, which means that other tasks might get moved back to accommodate it. To assist with the process and free up time it chose to dispense with the morning handover meeting for auxiliary nurses. Instead, they now receive electronic printed sheets prepared by staff on the previous shift. Julie said:

"This was not a popular change when we proposed it but we explained to staff why we needed to do it and now they can see that it gives them extra time to spend with patients, they prefer it."

"We are focusing on putting patients at the heart of everything we do, avoiding duplication and eliminating waste. The Daily Dynamic Discharge model is helping us to achieve this across the community and encouraging us to become more proactive in our discharge planning."

Kate Patience Quate, Lead Nurse, Highland Health and Social Care Partnership

Afternoon Board Round

Invergordon Community Hospital also recently introduced a twice-weekly multidisciplinary board round at 3pm. The team meets to discuss all patients on the ward and highlight any safety and discharge planning issues. Meetings are attended by GPs, pharmacists, Occupational Therapists and members of the wider team to facilitate joined-up discussion and planning. Julie is considering asking different members of the team to lead the meeting on different days:

"At the moment the meetings are nurse-led. We would like there to be a greater sense of ownership amongst the wider multidisciplinary team so I am considering inviting different members of the team to lead the meetings on different days. We receive regular support from Kate Patience Quate who is leading the process and she helps us to resolve any problems that we experience."

Avoiding Duplication

Another way that the Highland Health and Social Care Partnership is improving discharge planning is by avoiding duplication. The discharge planning process begins when the patient is in the acute setting but, previously, when a patient was transferred to the community hospital, the whole process began again – patients were readmitted and reassessed. Now, the discharge plan follows the patient from the acute to the community setting, providing continuity and avoiding duplication of effort.

Community hospitals have also implemented the concept of whiteboards from the Daily Dynamic Discharge toolkit, showing all of the relevant information relating to patients and their discharge plan for all staff to refer to. The Health and Social Care Partnership is also considering other elements of the toolkit, such as the Golden Hour ward round, to determine whether they can be adapted for a community setting.

Working Across Organisational Boundaries

Kate concluded: “Through the Highland Approach we are focusing on putting patients at the heart of everything we do, avoiding duplication and eliminating waste. The Daily Dynamic Discharge model is helping us to achieve this across the community and encouraging us to become more proactive in our discharge planning and to work more efficiently across organisational boundaries.”

Following from the initial success of this project, NHS Highland has embarked on a bigger piece of work involving Raigmore Hospital and partner organisations across the community. Watch this space for more details…

Key Learning Points

- Identifying peaks in patient discharge to determine patients who could benefit from earlier discharge or from avoiding admission altogether
- Asking community teams to identify what might help them with more effective discharge planning rather than imposing a solution on them
- Key lead with a strong vision
- Engaging staff in the initiative though use of pledges to support local ownership
- Better communication between teams at the acute hospital and community hospitals via the morning huddle
- Dispensing with the morning shift handover to free up auxiliary nurses' time
- A discharge plan that follows the patient from the acute to the community hospital
- Discharge planning across organisational boundaries
- Clear identification of tasks that support the delivery of the estimated date of discharge, and ownership of those tasks by members of the multidisciplinary team

Deliver: safe, person-centred, effective care to every patient, every time, without waits, delays and duplication

In order to: improve the experience of patients and staff

The 6 Essential Actions:

Clinically Focused and Empowered Management

The operation of basic hospital and facilities management, visible leadership and ownership through managerial, nursing and medical triumvirate team, creation of clear escalation policies and improved communication supported by safety and flow huddles.

Capacity and Patient Flow Realignment

Establishing and then utilising appropriate performance management and trend data to ensure that the correct resources are applied at the right time, right place and in the right format. This will include Basic Building Blocks, Bed Management Toolkit, Workforce Capacity Toolkit and alignment with Guided Patient Flow Analysis.

Patient Rather Than Bed Management

Managing the patient journey requires a coordinated multi-disciplinary approach to care management, dynamic discharge processes: access to diagnostics, appropriate assessment, alignment of medical and therapeutic care; home when ready with appropriate medication and transport arrangements, discharge in the morning, criteria led discharge, transfers of care to GP.

Medical and Surgical Processes Arranged for Optimal Care

Designed to pull patients from ED through assessment/receiving units , provide access to assessment and clinical intervention, prompt transfer to specialist care in appropriate place designed to give care without delay, move to downstream specialty wards without delay and discharge when ready, utilising criteria-led discharge where appropriate.

7 Day Services

The priority is to reduce evening, weekday and weekend variation in access to assessment, diagnostics and support services focussed on where and when this is required to: avoid admission where possible, optimise in-patient care pathway, reduce length of stay and improve weekend and early in the day discharges safely.

Ensuring Patients are Cared for in Their Own Homes

Considers pathways to support avoiding attendance, and how someone who has an unscheduled care episode can be optimally assessed without need for full admission, if required they will be cared for and discharged to their own home as soon as ready. Anticipatory Care Plans, redirection to appropriate health care practitioner and shift from emergency to urgent care is the focus for sustainability.

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Acknowledgments

We would like to thank everyone who has contributed to this case study. By openly sharing your experiences, your challenges and your learning, you are helping to spread best practice and drive system-wide improvement.

These stories serve to inspire others and celebrate the hard work of individuals who are committed to making things better for patients. In particular, we would like to acknowledge:

- Kate Patience Quate, Lead Nurse, Highland Health and Social Care Partnership;
- Julie Ransome, Senior Charge Nurse, Invergordon Community Hospital;
- Mark Smith, Associate South and Mid Operational Unit;
- Amanda Trafford, Lead Allied Health Professional;
- All staff at NHS Highland and all staff at Health and Social Care Partnership;
- Case study writer, Kate Philbin and the National Unscheduled Care Team.

If you are inspired to share your improvement story, we would love to hear from you. Please get in touch at UnscheduledCareTeam@gov.scot

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