**Discharge to Assess – “Challenges and Benefits”**

This model of discharge for frail older people was referenced as ‘best practice’ in the recent NHS England Guide for Commissioners (March, 2014) and by Philp (2012, Health Service Journal) It is now routine practice on an elderly medicine ward at Sheffield Teaching Hospital with plans to expand the approach Trust wide.

This ward has access to Active Recovery (AR), who are a community team consisting of nurses, Occupational Therapists (OT’s), Physiotherapists (PT’s) and rehabilitation assistants who assess the patients ongoing care and therapy needs at home. This means patients no longer wait in hospital for these assessments, which reduces delayed discharges and improves patient flow. This challenges the current model of OT and PT assessment within the acute hospital, which has traditionally been based around the ‘Assess to Discharge’ model.

Challenges experienced as part of the test phase:

- Admin (phoning, faxing, photocopying)
- Delays in Medication for discharge (TTOs)
- Capacity in community
- Patient/carers concerns
- Access to property
- Time constraints
- Establishing roles and responsibilities
- Quick assessment but lengthy referral process
- Change in our role and assessment process

How we overcame the challenges:

- Flow nurses now co-ordinate the discharge, OT’s and PT’s complete their assessments and paperwork and move on to the next patient.
- Doctors are now encouraged to complete TTO’s as soon as patient no longer requires acute medical care.
- Community services are employing more rehabilitation assistants and are continuing to review their capacity.
- All team members on the ward have an increased knowledge of AR and patients/carers are informed about AR at the point of admission.
- The location of patient’s house keys is discussed as soon as possible on admission to the ward.
- As the Therapy part in the process has been reduced to assessment only our time has been freed to allow us more intervention with patients.
- Although our assessment process has been shortened, we still rely heavily on our clinical knowledge and reasoning to work towards a safe discharge for our patients.
Working with this model our assessment has been condensed to include: initial interview, transfers and mobility assessment, which is often done jointly between OT’s and PT’s, and recommendations for discharge. This approach still requires therapy skills in the hospital to identify immediate needs on transfer but it moves further OT and PT assessments and timely provision of services into the community setting.

Some benefits of this model have been:

- Assessment now takes place within an environment familiar to the patient, it is ‘context specific’ and the patient’s immediate and longer term needs can be more appropriately evaluated in their own home
- Issues which may have been developing for some time which precipitated an acute admission will be assessed and plans put in place while the patient is still able to be at home.
- Patients and their relatives report increased satisfaction. AR work until 8pm and are happy to accept evening discharges.
- Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient.
- A reduction in length of stay.
- A reduction in the risk associated with vulnerable patients remaining in a hospital environment.
- Increased discharge rates on the ward where this process is now fully implemented.
- Freeing up hospital beds reducing medical outliers.
- Increasing patient flow through the hospital.

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