

From Hospital Admission to Discharge:

Admitted Pathways (Models of Care) for adult patients who are to undergo planned orthopaedic operations.

This paper presents the expectations of Orthopaedic Patients regarding the admission to discharge pathway during their hospitalisation for surgery.

This Patient Pathway should provide a smooth transition from admission through to discharge. Hospital admissions may often be a distressing experience and have a detrimental impact on someone's quality of life, especially for vulnerable patients, those in care homes or users of social care services. Returning people from hospital back into the community as soon as possible is a key object of the Government's health and social care reforms.ⁱ

Ideally there are four steps in a Patient Pathway:

1. Attendance at a pre-admission assessment clinic: that includes surgical, medical and social concerns covering the full patient pathway.
2. Arrival at hospital: when assessment, tests, diagnoses, a treatment plan and a bed is organised in accordance with pre-admission assessment.
3. Admission to the ward: - where treatment is carried out in accordance with the agreed plan, the expected date of discharge confirmed, and any required discharge support identified and an active discharge plan put in place.
4. Managed discharge: to home or place of care when medically/socially ready to go home. This should include a clinical contact point details for use during the immediate post-discharge period. The Discharge Summary should be sent to the patient's GP within 24 hours and a copy made available to the patient and their carer.

Key points for admission:

A patient should have an agreed treatment plan within 24 hours of arrival.

An expected date of discharge should be discussed and agreed with the patient and the multi-disciplinary team staff caring for the patient before admission and definitely within 24 hours of admission. Any Social Care assessment must take into account the expected needs of the patient following discharge.

In the instance where a patient is not able to fully understand the agreed treatment/discharge plan the Hospital should make every effort to communicate with the patient's main carer – whether that be a family member or a representative of the patient's Care Home.

The planned date of discharge should be pro-actively managed on a daily basis by the responsible named member of staff and changes discussed with the patient, and their family, carers or advocate.

The responsible named member of staff should keep all hospital healthcare staff in the multi-disciplinary team, and those who are community based, informed of any changes to the discharge date to ensure the patient can leave hospital at an appropriate and agreed time on the day of discharge. This includes the management of take out medicines and equipment necessary at the time the patient is ready to leave the hospital.

Adult Social Care & Community Services should be kept informed, the better to co-ordinate the discharge.

Ward rounds should be scheduled in a way that allows, at least daily, a senior clinical review of patients.

Under The NHS and Community Care Act 1990 local authorities have a duty to assess vulnerable and disabled people who may be in need of social care support.

Discharge is only meant to happen when:

- a. Key decisions have been made about eligibility for services, the provision of any care needed and the source of that care agreed.
- b. Funding of all eligible resources or accommodation after discharge has been established. National guidance states that patients should not remain in hospital because of any funding disputes. This means that a patient who is eligible for care has a care package that is designed to meet their needs, and that they are supported when they leave hospital.

The patient may be offered intermediate care by an integrated nursing and social care team. This service may be provided at home, in a community hospital, or in a registered Independent Care Home. Intermediate care is provided for a time-limited period and is free of charge whilst the patient has potential to benefit from the rehabilitation (for a maximum period of six weeks). If the patient needs further help after this they will be referred back to community care services and reassessed for more long term support.

Discharge from hospital should be planned and arranged by a team that includes, or has links with, Adult Social Services and Community Doctors, Nurses, Therapists and Pharmacists. There should be a named member of the hospital staff who co-ordinates this process.

A toolkitⁱⁱ for the multi-disciplinary team focuses on the practical steps that health and social care professionals should take to ensure that the patient is discharged with full support. The vast majority (80%) of patients discharged from hospital are classified as “simple discharge”^{iii,iv} they are discharged to their own home and have simple ongoing health care needs which can be met without complex planning.

The patient pathway should provide for a smooth transition from pre-admission through to discharge and post discharge arrangements, the following steps should be followed:

The Discharge Plan should be considered as part of the Hospital pre-admission process. The discharge plan will consider and include:

1. Transfer, if necessary, from the Surgical Unit to the appropriate Orthogeriatric, Medical or Rehabilitation Unit in the hospital.
2. The expected date of discharge.
3. An assessment of expected needs, community health and social care.
4. Family/carer/friend (or Residential Care Home Manager) so that they are kept informed of likely support and kept up-to-date with any changes to the Discharge Plan to ensure there will be someone at home (so that the patient is not left in a cold house with no provisions)
5. Arrangements with the appropriate Transport Service (if the Family/Carer cannot arrange transport) so that they are kept informed of any changes to the schedule. Each should provide a contact telephone number to the other.

6. Ensuring that the patient, or an appropriate family/carer/advocate, fully understands the whole process and where possible, has agreed.
7. Having an assessment carried out to ensure continued necessary care in the community.
8. That if there is a need temporary care in a Home the Family/Carer is given full support to identify the most appropriate place, and that the Home is fully briefed to receive the patient.
9. That any changes to the expected discharge date are discussed and with the family/carer/advocate and that the Community Team is informed.
10. Assurance that on discharge all prior arrangements will be fully carried out and the patient's GP and Community Team have confirmed they have the necessary facilities prior to the patient's return home.
11. Any 'take home' medicines, dressings, walking aids, orthotics, physiotherapy etc are planned for, sourced local to the patient's residence when possible and provided in good time. Resolving cross-boundary issues must be the responsibility of the care team.
12. That all necessary equipment is delivered and installed prior to the patient's arrival.
13. That the patient is allowed home on an agreed day and at an appropriate time, and is properly dressed in their own clothes, with all their personal belongings, so that dignity and safety are maintained.
14. If the patient is going to a Care Home the Manager is fully briefed with discharge assessment and in full agreement with the details.
15. Appropriate national guidelines for follow-up care are discussed and included in the discharge notes. This includes future assessment and monitoring by the specialist surgeon with x-rays at specified intervals, if appropriate. It is also important that the patient is discharged with a contact number for reassurance and help during the first two weeks of leaving the hospital.

Good discharge planning offers certain benefits to the patient and the care team because the patient:

- a) Will know what is needed to do to help recovery.
- b) Is able to make plans with relatives/carers/friends about discharge.
- c) Might get home sooner and reduce the risk of hospital acquired infection.
- d) Adult Social Services and Community Health Care teams will know immediately of the discharge, if necessary, and be able to offer appropriate support.
- e) Is less likely to be readmitted.

i: *An Atlas of variations in social care, page 31, Hospital Discharge (June 2012)*

ii: *NHS – DH - Achieving timely 'simple' discharge from hospital (August 2004)*

iii: *Department of Health (DH) Discharge from hospital: pathway process and practice (January 2003).*

iv: DH “Our health, our care, our say’ better integrated health and social care (January 2006)

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