

REASON WHY?

The current documentation and process for completion of the Transfer of care documents relies heavily on the Inpatient Therapy Team however the description of a patients needs after discharge should be a multidisciplinary process.



To significantly reduce the time taken from a patient being declared as having no criteria to reside to being discharged by June 2024.

PLAN

The initial plan was to review the content of the transfer of care documentation to ensure that all parts were relevant and fitted the DHSC Hospital Discharge and Community Support Guidance 2022.

Secondly the team were going to review the process of how the form was completed shifting the balance of work from the inpatient therapy team to the discharge team. It was envisaged that this would lead to less duplication of work, better communication with patients, and less time being spent on the process.

As an aside it would also free up therapy time to complete treatment with patients.

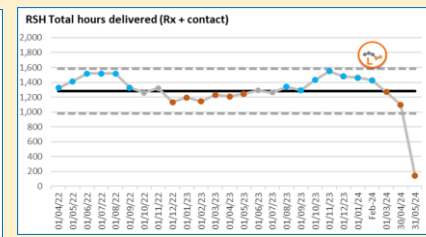
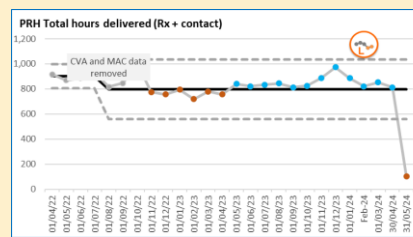
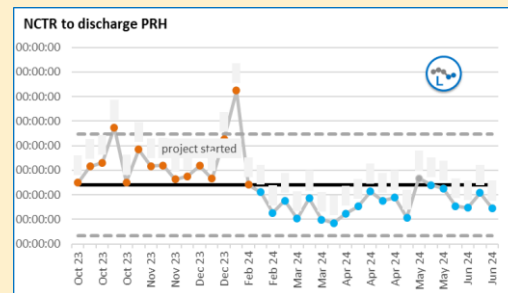
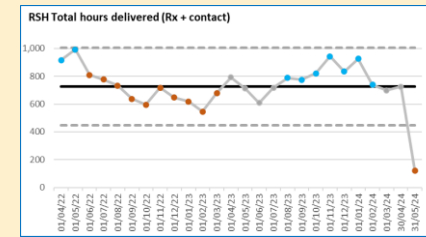
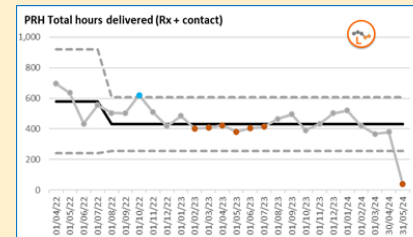
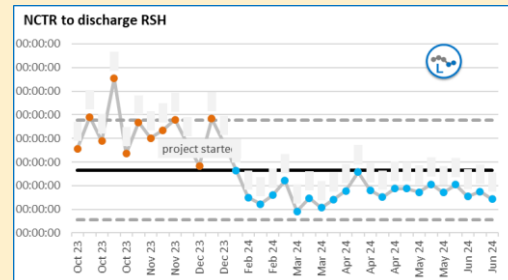
DO

The form went through several iterations with each being tested before being reviewed further.

Therapy staff and discharge staff worked together on the wards to ensure communication was clear. Some done in ward rounds and some written, so the therapy staff also changed where they wrote information to make it clearer for the discharge team to find.

STUDY

Integrated Discharge Team (IDT) data shows a clear reduction in time taken between patients being declared as no criteria to reside and discharge that has been sustained on both sites. Occupational Therapy (OT) and Physiotherapy (PT) data show an increase in time given to patients an both sites (OT top, PT bottom). (Please note the therapy data shows an anomaly as care flow interrupted data collection over the past two months.)



ACT

To ADOPT the new way of working.

Next Steps

Therapy staff have now been involved or are planning involvement in a number of projects that have been facilitated by being able to spend extra time with patients.

For example:

- groups being run on wards
- involvement in deconditioning work
- plans to re-introduce home visits for patients who would benefit.