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Case study: Improving the return to original residence

St Thomas' Hospital London

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Background
Our local NHFD data demonstrated an increase in the length of hospital stay (LOS) for our hip fracture population from 2016 to 2019 and a high rate of discharge to settings other than the original residence (27.6%). This is in comparison to a median LOS of 15.2 days in the UK with the top quartile of trusts achieving a LOS of <13.5 days and rate of discharge to original residence of >77%.

Aim
Using a quality improvement programme we aimed to reduce length of stay and increase rate of discharge to original residence.

Process
We established a multidisciplinary and cross specialty focus group including physiotherapists, occupational therapists (OT), nursing staff, orthopaedic surgeons, orthogeriatricians and a transfer care navigator. The focus group met regularly to develop, implement and evaluate the impact of four key interventions:

First, we identified a tool to protocolise the setting of an estimated discharge date (EDD). We undertook a literature review and identified the New Mobility Score (NMS) as the most clinically feasible, valid tool to sue to predict post-operative function. This tool supported a stratification of EDD; high level 4 days, medium level 9 days and low level 15 days. In August 2018 the pre-operative NMS score was implemented as a means of setting a reliable EDD for all hip fracture patients.

Second, we implemented a systematic approach to pre-operative OT screening and assessment, Preoperative OT intervention provided an early opportunity to discuss expectations including discharge destination, to address areas of patient and family concerns, to establish early and goal setting and to assess baseline cognition. *This is currently achieved in 95% of patients.*

Third, through discussion at the focus group, the need for a transfer of care navigator (TCN), to help streamline and coordinate the discharge process, became apparent. We established a daily communication tool between all members of the MDT using email to ensure early identification and proactive management of potential delays to care and discharge.

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Finally, we ensured senior orthogeriatrician presence at the daily board round on the ward, with a consultant or senior registrar present four days a week.

Simultaneously, our two main local boroughs (Southwark and Lambeth) integrated strategic leadership and operational management of community intermediate care pathways, further supporting streamlining of services.

Outcomes

	2018	2019	Percentage change
Acute length of stay days	18.0	15.1	-16.11%
Overall hospital stay days	19.6	18.3	-6.64%
Discharge to original residence within 120 days	70.9%	86.4	+21.86%

By utilising NMS, the team were able to work towards an early, yet attainable discharge date and supported the concurrent delivery of medical care, rehabilitation and discharge planning. Furthermore, combining NMS and pre-operative OT assessment allowed the team to manage expectations of patients and relatives regarding likely functional status on discharge and ongoing community functional needs. These needs could be communicated to community rehabilitation providers to ensure continuity of care and reduction in duplication of work, with benefits for the patients and the providers. Senior orthogeriatrician daily leadership through presence at board rounds facilitated interdisciplinary communication of expected EDD, and was further supported through timely email updates to ensure prompt identification and effective management of potential delays to discharge.

We believe this multidisciplinary quality improvement programme reduced length of hospital stay for our patients with hip fracture and improved discharge to original residence as well as quality of care.