Supportive Discharge Service
Stephanie Robinson
Occupational Therapist
Mr Admitted Patient-
a real case study

- Pt anxiety about ability to cope
- Family anxiety – lots of anxiety about falls
- Family concerns about ability to cope
- Expected large POC required on discharge
- Poor transfers
- Long term catheter – being managed by nursing staff
- Reduced confidence
- Readmission following failed discharge
- Poor mobility unsteady gait – lean backwards – constant supervision
- Medication changes not independent on the ward
- High risk of falls – mobilising with supervision
- Poor transfers
Service Aims

- 20.7% of population over 65 in Harrogate District
- 16.7% National average over 65
- AHPs into action
- D2A model
- SDS
- OT, Physio, Nurses and Multi-disciplinary assistants
What does our service offer?

• Reduced Complication
  • Early referrals
• Avoid lengthy admission
  • Community ready
  • Shared risk taking
• Home environment
  • Patient the expert
• Joined up assessment
  • Communication
The difference our service made for Mr Admitted Patient ..... 

- Still at home months later  
- No more significant falls  
- No readmissions onto base wards  
- Functioning confidently
From July 2017 – September 2018

- 908 referrals
- 724 of those were appropriate for the service
- Saved 2.2 bed days per patient
- 1751 bed days overall
How did we do it?

• Therapy led service
• National guidelines and local initiatives
• PDSA
• Crossing boundaries
• Data collection
• Outcome measures
The service going forwards

• Substantive team
• Strengthening partnerships
• SDS plus-Virtual ward
Any Questions?
Further Reading

• South Warwickshire Discharge to Assess model

• Discharge to Assess- Quick Guide Department of Health and NHS England

• AHPs into Action

• #AHPsintoaction on Social Media

• David Oliver: Fighting pyjama paralysis in hospital wards
  BMJ 2017;357:j2096  https://doi.org/10.1136/bmj.j2096