St Mary’s Hospital
Isle of Wight
Bournemouth
18 April 2012
Planning Patient Care: Early Discharge Planning

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NHFD Progress

Introduction: October 2009
- Slow progress, blue book criteria
- Highlighted deficiency

April 2010: BPT criteria
- Time to theatre: Anaesthetic Cooperation
- Orthogeriatric involvement:
  - Medical review
  - Falls Assessment
- Osteoporosis referral
- Joint Protocol

April 2011 – April 2012
- Aim: Consultant Orthogeriatrician – Full Time
- Discharge Concerns
BPT Adherence April 2011

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<thead>
<tr>
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<th>St Mary’s Hospital</th>
<th>National</th>
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<tbody>
<tr>
<td>Time to Ward</td>
<td>5.44hrs</td>
<td>9.8</td>
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<tr>
<td>Time to Theatre</td>
<td>37.25hrs</td>
<td>37.6</td>
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<tr>
<td>Length of Stay</td>
<td>20.56days</td>
<td>20.56days</td>
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<tr>
<td>Orthogeriatric Assessm</td>
<td>98%</td>
<td>65%</td>
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<tr>
<td>Bone Protection</td>
<td>99%</td>
<td>68%</td>
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<tr>
<td>Falls Assessment</td>
<td>92%</td>
<td>75%</td>
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BPT Uplift 2011

[Bar chart showing quarterly uplift for St Mary's and National with specific numbers for each quarter: 22.5 for Q1, 40 for Q2, 68 for Q3, 75 for Q4.]

Legend:
- St Mary's
- National
Anaesthetic Involvement (2010/11)

Hours to Theatre

April, May, June, July, August, September, October, November, December
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<tbody>
<tr>
<td>Time to Ward</td>
<td>3.86hrs</td>
<td>9.23hrs</td>
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<tr>
<td>Time to Theatre</td>
<td>29.43hrs</td>
<td>34.25hrs</td>
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<tr>
<td>Length of Stay</td>
<td>20.15days</td>
<td>19.68days</td>
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<td>Orthogeriatric Assess</td>
<td>93.67%</td>
<td>70%</td>
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<td>Bone Protection</td>
<td>100%</td>
<td>89%</td>
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BPT Uplift 2012 (Provisional)

St Mary's

Q1: 80%
Q2: 81%
Q3: 63%
Q4: 54%
Island Characteristics

- Single Hospital, Contained Resident Population
- 250 hip fractures per year
- Elderly population
- Tourist influx
- Small Staff pool
  - Advantages and Disadvantages
Acute Length of Stay

- Year 2012
- Year 2011

Graph showing the comparison of acute length of stay between 2011 and 2012 from April to March.
‘But the Fracture is Fixed’

- Length of Stay Concerns
  - Acute Trust: Pressure on Trauma Beds
  - Overflow into elective ward
  - Difficulty in finding discharge beds

- Orthopaedic Surgeon doing ‘Medical’ Ward Round
- ‘SEP’
Discharge Problems

Discharge Possibilities:
- Home
- Residential Home
- Intermediate Nursing Care (24)
- Independent Living Resource Centre (ILRC) beds (8)
- Rehabilitation Ward (40)

Competition for above beds: Medical, Surgical, Orthopaedics

Long Stay = well patient waiting for bed elsewhere: Continuing care vs Social Services vs Rehabilitation Unit
Solution: Early Discharge Planning

- Simple Concept – Difficult in Practice
- Fits well with ‘Enhanced Recovery’
- Cooperation between Continuing Care Team and Ward Staff
- Every Patient has a Discharge Plan on admission to ward
Early Discharge Planning

- Hip Fractures Patients identified at Morning Trauma Meeting

- Trauma Meeting includes:
  - Nurse Practitioner
  - Senior Ward Nursing Staff
  - Physiotherapist

- Patients identified for early referral to Continuing Care – Day 1
Early Discharge Planning

- Continuing Care Team:
  - Community Based
  - Regular Ward Rounds
  - Control over all community beds
  - Prioritise Orthopaedics Patients:
    - Better prepared forms, appropriate referrals
Summary

- NHFD has allowed identification of problems
- BPT has created impetus
- Improvements
  - Orthogeriatrics
  - Anaesthetic cooperation
  - Early Discharge Planning
The Future at St Mary’s?

- Priority: Full Time Orthogeriatrician
- Maintenance of improvements
- Future BPT criteria
- Trust Discharge planning
- 30 Day follow up