

**Nurse Led Discharge  
and  
In Reach  
Report**

**10th April 2006**

# **Nurse Led Discharge and In Reach**

## **Introduction**

This report will summarise the findings of the Enhancing Primary and Secondary Care subgroup in relation to Nurse Led Discharge and In reach. The brief of this group was to produce an evidence-based paper which included the following information:

- Definition of the concept, what is the initiative is trying to achieve, what outcomes could be measured and evaluated.
- Current and proposed position in GB
- The current position in Northern Ireland
- Evidence of effectiveness and cost, impediments, any constraints and associated risks
- Recommendations on how this initiative could be introduced and taken forward in NI

## **Nurse led discharge - Definition**

Nurse led discharge is reported as a process that involves nurses assessing the patient, liaising with the multi-disciplinary team and planning timely discharge based on an agreed clinical management plan. It may also involve the writing of discharge letters, making follow up calls and giving advice to patients and carer and other health and social care professionals involved in the person's care. Lees L ( 2004)

Currently there is a lot of debate about the definition of nurse led discharge and possible derivatives. Several terms are used for example:

- nurse coordinated discharge,
- nurse facilitated discharge,
- nurse directed discharge,
- nurse initiated discharge,
- practitioner led discharge,
- criteria led discharge,
- patient led discharge .

The general conclusion is that nurse led discharge is:

- Providing ongoing patient assessments to assist timely discharges
- Promoting the relevant discharge decisions in collaboration with the multidisciplinary team, patient and family
- Taking calculated risks

And that nurse led discharge is not:

- Carrying out a series of instructions by a medical team
- Deciding a patient is fit for discharge without consultation with relevant professionals
- Discharging patients according to different roles depending on who is on duty.

It is important that in all discharge processes risk management and the legal implications should be considered, with consideration of the following questions:

- What could possibly go wrong?
- What is negligence?
- Duty of care towards the patient
- Vicarious liability

#### **In reach is defined as**

- An individual or a team who actively case manage a patient out of hospital or the service they are receiving to their end point destination. In reach may be used to provide specialist advice prior to decisions to transfer or discharge patients.

#### **Current position in Great Britain, Nurse Led Discharge and In Reach.**

Nurse led admissions and discharges is one of the ten key roles shaping the future of nursing as set out in the NHS Plan Department of Health 2000. The importance of Nurse Led discharge has also been highlighted by Liz Lees Consultant Nurse Acute Medicine Birmingham, Heartlands and Solihull Hospitals NHS Trust (2004) who described this process as nurses requiring:

- a thorough understanding of the process called discharge planning
- educational support, training and achievement of discharge competencies

and that without this nurse led discharge is at risk of becoming a quick fix remedy for creating bed capacity.

This is supported by a number of DOH documents for example; Achieving timely 'simple' discharge from hospital, launched by Sarah Mullally previous Chief Nursing Officer and Professor Sir George Alberti National Director Emergency Care DOH 2004. This document presents as a toolkit that focuses on the practical steps for effective discharge planning. The 10 Step Guide is central to improving hospital discharge processes and can be used to make sure that staff cover the essential steps.

The fact sheets provide practical tools to check how they are doing and to identify what else needs to be done. Another document is also available: DOH workbook Discharge from Hospital pathways process and practice: Health & Social Care Joint Unit and Change Agent Team DOH 2003. The Healthcare Commission National Patient Survey (2004) also identifies patient delays in discharge home from hospital as a key area where standards can be improved.

Evidence in England suggests that Nurse led discharge is being interpreted as the transference of responsibility for discharge from doctors to nurses. It has also been suggested that doctors never actually discharged patients but expedited and confirmed the patient's medical stability for discharge through appropriate diagnosis and investigations. The term nurse led discharge could also imply that discharging patients is a uni disciplinary process which it is not suggesting that the key to successful nurse led discharge is to ensure that nurses have the knowledge, skills and competencies to undertake this role.

### **Current position in Northern Ireland**

The aim of this work is to identify examples of nurse led and in reach activity that could be replicated across Northern Ireland to improve patient flows by reducing delays in the patient journey and facilitate early discharge back to home and or into the community.

These themes are reinforced in the regional strategy A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland (DHSSPS, 2004). and the Primary Care Strategy Framework Caring for People Beyond Tomorrow (DHSSPS 2005).

Both strategies place emphasis on the development of new roles and ways of working, reduction of reliance on the hospital sector, seamless service integration, improved accessibility, patient choice, and the provision of high quality services with improved outcomes.

4:18 Objective 3 in the Primary Care Strategy Framework Caring for People: Beyond Tomorrow (DHSSPS 2005) aims to enhance and streamline home care and treatment processes to facilitate effective hospital discharge planning.

The DHSSPS Priorities for Action 2006/08 provides targets to improve health and wellbeing and develop primary and community services and improve patient flows within the hospital system. This includes of avoiding unnecessary hospital admission, streamlining the patient journey through the health and social care system, facilitating earlier discharge from hospital, and maximising the potential of primary care professionals in contributing to the management of patients in the community.

A scoping study was undertaken across all HPPSS Trusts in Northern Ireland. As a result of the scoping study there is evidence of varying levels of activity in the areas of nurse led discharge and in reach across Northern Ireland.

The process of nurse led discharge is active within the hospital setting with examples of in reach activity from community staff into hospital. Some of the initiatives has included a mix of outreach and in reach activity. A full report with examples of nurse led and in reach activity across Northern Ireland is available at Annex 1.

### **Evidence of effectiveness and cost**

Information provided under the individual Trust headings will provide the reader with examples of this activity and associated information on outcomes achieved.

Evidence is available on costings and bed days saved. Others have yet to audit or evaluate their schemes as these are still in their infancy or have yet to be implemented.

Future proposed outcomes should include:

- Reduction in length of hospital stay
- Reduction in delayed discharges
- Number of patients discharged
- Readmission rates
- Bed days saved
- Improved provision of consistent and integrated care, transfer of care process, and discharge letters
- Medication management and patient concordance
- Empowered and informed patients through patient satisfaction surveys
- Provision of more effective use of healthcare resources
- Improved patient experience care pathways./ evidence of use of patient care pathways
- Barriers to implementation
- Cost benefits / VFM

### **Benefits of Nurse Led Discharge**

The benefits of nurse led discharge and in reach can be described as

- Contributing to the reform and modernisation agenda
- Improving the quality of discharge planning
- Improving the patient experience by involving patients in their discharge planning, achieving a more timely discharge.
- Reducing the volume of delayed discharges
- Appropriate utilisation of nursing and other professional skills
- Achievement of increased value for money and effective patient care

### **Discussion**

Nurse led discharge is about nurses taking responsibility for initiating, driving and following through on the decision to discharge which may be carried out in partnership with medical colleagues and within clear protocols. This culture change of nurses taking ownership of driving patient discharge has real potential to make far reaching changes in future reform and modernisation of service delivery.

Nurse led discharge and in reach have the potential to facilitate the strategic objective of creation of more integrated working arrangements between hospital, community and primary care. Services should have consumer focus and be needs led with redirection of investment to primary and community care. Future services developed must be realistic, financially resourced, sustainable and provided by a competent and educated workforce to ensure good governance and public protection. A number of these components could be enhanced if developed through a framework of Managed Clinical Networks.

Nurse led discharge and in reach are proving to be valuable service redesign initiatives. Use of advanced nursing skills with independent and supplementary prescribing to enable completed episodes of patient care is critical. Skilled care, case management and risk management coupled with decision making skills are essential. Any new developments must fully address the clinical standards agenda clinical and social care governance and audit with unified budgets and equity.

Different cultures, working practices, professional and geographical boundaries and roles challenge the concept of partnership working. A new cultural context and organisational arrangements need to be in place to address the different cultures that exist within and between professions which can create resistance to innovation and hinder the achievement of strategic priorities. Issues around team and professional differences need to be resolved.

A consistent approach is required to support the implementation of Nurse Led Discharges across hospital, primary and community care. Collaboration and co-operation between health and social care professions is essential. With this is the recognition for negotiation between the multidisciplinary team regarding the parameters of their practice and the relative 'role adjustments' required to function in an interdisciplinary manner within the multi/interdisciplinary team. This recognised negotiation will enhance crucial partnerships in care between professionals for the benefit of patients and assist in meeting organisational targets for discharge.

In hospitals there is a need to review and redesign the purpose and timings of ward rounds to facilitate timely patient discharge. All discharge should take place early in the working day and operate on a 7 day a week basis to include bank holidays.

Examples provided within this report could be transferred to other HPSS Trust areas. Organisational and local arrangements need to be in place to ensure this transfer of learning and implementation to promote consistency of service provision for patients.

## **Recommendations**

To implement nurse led discharge and in reach on a regional basis the following recommendations are suggested:

- Review the current cultural context and organisational arrangements to create systems to support innovation and new ways of working
- Review and redesign the purpose and timings of ward rounds to facilitate timely patient discharge
- Provision of twenty four hour community nursing services
- Facilitation of treatment of acute episodes outside of hospital
- Provision of clear budget streams with pooling of resources to meet patient need
- Implementation of clinical management systems to include governance and audit to evidence outcomes, performance and benefits for patients
- Access to clear discharge policy with protocols for discharge on a 7 day week basis to include bank holidays
- Provision of nurse education to ensure competency based approaches to care delivery
- Ensure that future developments in community and primary care infrastructure are fit for purpose and facilitate provision of effective treatment and care.
- Development of care pathway approaches to promote effective patient care, assist cross boundary working and continuity of care
- Promote effective inter, intra and multidisciplinary working through integration and engagement of the wider team for example GP, Social Work, Allied Health Professionals, Pharmacy and Voluntary and Statutory Agencies.
- Use of information technology to beget seamless working arrangements and ensure the transfer of patient information to inform continuity of care in the community and primary care
- Implementation of case management, intermediate care and appropriate rehabilitation schemes to enable early patient discharge
- Strategies and information to enable patients to manage their conditions with provision of care plans and care pathways

**Exemplars of Nurse Led Discharge and In Reach Activity**  
**( information provided by each HSS Trust)**

**WHSSB**

<p><b>Altnagelvin HSS Trust</b></p> <p><b>Nurse led Discharge</b></p>	<p>Commencing some pilots in Nurse Led Discharge in the following areas:</p> <ul style="list-style-type: none"> <li>• ENT</li> <li>• Cardiology</li> <li>• Dermatology</li> </ul> <p>Nurse Led Discharge also exists on a less formal basis across specialties</p>
<p><b>Sperrin Lakeland HSS Trust</b></p> <p><b>Nurse led Discharge</b></p>	<p>Emergency Nurse Practitioners assess and discharge their own patients from A&amp;E.</p> <p>Within Tyrone County Hospital this includes the Community Rehabilitation Team which is multi-disciplinary. Patients are referred to the team whilst in hospital. Assessment is carried to decide if patients meet the criteria for follow up rehabilitation / care for 6-8 weeks in their own homes.</p> <p>The Discharge Co-ordinator also visits the wards on a daily basis to plan for patients who need district nursing input after they go home.</p> <p>The Cardiac Rehabilitation Liaison Nurse will collect the information from the cardiac ward in relation to patients who have had a myocardial infarction and will visit them at home approximately 2 weeks after discharge.</p>
<p><b>Sperrin Lakeland HSS Trust</b></p> <p><b>In Reach Services</b></p>	<p>Nurse Specialists including Stoma Care, Stroke, Palliative Care and Respiratory Care nurses will visit patients whilst in hospital and will follow them up when back at home</p>
<p><b>Foyle HSST</b></p> <p><b>In Reach Services</b></p>	<p>Parkinson's Disease Nurse</p> <p>Trusts involved: Foyle and Altnagelvin Trusts</p> <p>Service delivered: Each Thursday on a weekly basis this nurse works with the Consultant Neurologist at Altnagelvin Hospital. At this review clinic the nurse sees all patients first to review all aspects of care and she provides specialist advice on: Symptom control, Medication Management and coping strategies in living with their illness.</p> <p>This service commenced in 2003. Outcomes achieved include:</p> <ul style="list-style-type: none"> <li>- Continuity of care for patients across primary and secondary care</li> <li>- Close working relationship between medical and specialist nurse</li> <li>- Close involvement with Parkinson's Disease Society</li> </ul> <p>Effectiveness / costs</p> <p>The University of Ulster are currently undertaking a piece of research to measure the effectiveness of this service. This includes user participation.</p>

<p><b>Foyle HSST</b></p> <p><b>Nurse facilitated discharge planning</b></p>	<p>Early Supported Discharge for COPD Patients Altnagelvin Hospital and Foyle Trust Londonderry working in partnership.</p> <p><u>Staff involved</u></p> <ul style="list-style-type: none"> <li>• Consultant is the principal contact at Ward 3 Altnagelvin Hospital.</li> <li>• Respiratory Nurses and all other nursing and medical staff of Ward 3 Altnagelvin Hospital.</li> <li>• Foyle Trust Staff: One Full time G Grade and one Part-time G Grade who provide a service from 9am to 5pm seven days per week.</li> <li>• Recently secured funding for 1 Full Time G Grade and 2 Part-time Grade G.</li> </ul> <p>Usually these patients would stay in hospital for 10 days, providing they meet the agreed criteria for discharge they can go home on the 6<sup>th</sup> day. This process involves Foyle Trust nurses taking home early, patients who have been admitted with an exacerbation of COPD. The Consultant at Altnagelvin Hospital is responsible for these patients not their GP.</p> <p>This service has been in place since 2003; To date 240 clients have benefited from the project. 1131 bed days have been saved. 11 admissions have been prevented.</p>
<p><b>Nurse facilitated planning / Geriatric liaison meeting</b></p>	<p>Trusts involved.: Altnagelvin Hospital and Foyle Trust.</p> <p>Staff involved: Weekly multidisciplinary meeting involving medical, nursing and social work staff from hospital and one of the nurses from the Foyle Trust Older Peoples programme of care.</p> <p>Process involved: Discussion using the discharge and admission lists for the Geriatric unit. Arranging for co- ordination of discharge of elderly patients to home. Alerting community staff to hospital admissions and deaths of patients.</p> <p>Length of Service: Approx 13 yrs.</p> <p>Benefit to patients: Enables information to be delivered to all professions involved in patient care and aims to provide a smooth transition from hospital to home.</p> <p>Benefits to the organisation: Holistic assessment of a given individual can be made and home circumstances are discussed thus assisting in a safe discharge home and aiming to prevent re admission.</p>
<p><b>Early discharge &amp; Rehabilitation at Home Service</b></p>	<p>Reablement scheme – Early discharge &amp; Rehabilitation at Home Service. This scheme is an intermediate care scheme, which aims to facilitate early discharge from hospital or prevent admission to hospital, for older people, by providing a comprehensive reablement assessment and rehabilitation programme up to a maximum of 6 weeks.</p> <p>The Rehabilitation Team work closely with the Acute and Community Teams in selecting suitable referrals for the scheme and onward referral of clients who need longer-term services, given that the team’s involvement is time limited.</p> <p>The service is staffed by a Coordinator, an Assistant Coordinator (Nurse), Physiotherapists, Occupational Therapists and Support Workers.</p>

<p><b>Foyle HSST</b></p> <p><b>Intermediate Care Team</b></p>	<p>Trusts involved : Foyle and Altnagelvin Trusts</p> <p>The Intermediate care Team include the Foyle Trust Intermediate Care Co-Ordinator Team Leader , 5.02 WTE and 2 Grade B Nursing Auxiliaries and work in partnership with General Practitioners and the multidisciplinary team at Altnagelvin. The service operates from 8.30am – 11pm daily.</p> <p>This service provides acute care to patient's in their own home and therefore prevents hospital admission and enhances early discharge. This team of specially trained community nurses provide a Trust wide service to people with acute health care needs who require nursing intervention for up to 6 weeks.</p> <p><b>Types of treatments:</b> Manage Infections / pneumonias / infected wounds  Provide intravenous fluids or sub-cutaneous fluids  Administer intravenous antibiotics  Administer intravenous blood transfusions  Manage palliative care patients after 5pm  Insert or re- site Peg (feeding tubes) when blocked or dislodged  Provide acute nursing care for emergency bowel conditions  Administer blood transfusions  Manage acute wound conditions</p> <p>This service was established in March 2005.</p> <p>Benefits to patients:      Early discharge from hospital  Remain at home in familiar surroundings  Prevent admission to hospital  Reduce risk from hospital acquired infection  Minimise disruption to family life  Receive complete palliative care at home</p> <p>Benefits to organisation: 98 patients treated in 2005  74 new referrals in 2006  1068 hospital bed days saved  Joint working between 2 Trusts  Agreed criteria for readmission</p>
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NHSSB

<p><b>United Hospital</b></p> <p><b>Nurse Led Discharge</b></p>	<p>A three month pilot study of Nurse Led discharge was completed at the end of October 2005. An evaluation paper is currently being compiled.</p> <p>Early indications are favourable with over 40 nurse led discharges the process included staff and patient / service user views</p>
<p><b>United Hospital</b></p> <p><b>In reach</b></p>	<p>The Community Rehabilitation Team screens patients in hospital to determine the suitability of patients for community rehabilitation.</p> <p>Hospital Staff have led the development of a COPD pathway that has discharge as an integral component. The community Trust have expressed an interest in further developing the community component with the view to early discharge (plan to include, home nebulising).</p> <p>Joint Community and United Hospitals Service Improvement Projects 2005/2006 that includes in reach activity -Contenance Service –Cardiac Rehabilitation and Heart Failure</p>
<p><b>Home First HSS Trust</b></p> <p><b>In reach</b></p>	<p>Acute care at home team (ACAHT) - this scheme prevents admission through close working with Antrim Area A &amp; E dept. and facilitates early discharges from the wards by providing intensive nursing interventions within the patients home environment e.g. IV antibiotics, Blood transfusions. An example of the innovative in-reach role undertaken by this team is the COPD Early Discharge scheme. This will allow for the identification of patients in hospital, who may be discharged earlier, with the help of the ACAHT working within the community.</p> <p>Cardiac Rehabilitation-The Cardiac Rehabilitation Service provides a service to clients who have had a myocardial infarction, stent insertion, and postoperative bypass or valve surgery. The team will complete a holistic assessment of the client while in hospital including reassurance, information, risk factor assessment, risk stratification, education, mobilisation and involvement and support of the partner/family followed by a home visit within one week of discharge.</p> <p>Orthogeriatric coordinator - The Orthogeriatric Co-ordinator identifies and assesses patients over the age of 65yrs that require in-patient treatment for their Orthopaedic injury or fracture. At present the regional fracture service is based in Royal Victoria Hospital Belfast and NHSSB patients are identified through in-reaching into the hospital by the co-ordinator, assessment undertaken and appropriate onward referrals are made.</p> <p>Diabetic nurse specialist - It is the role of the Diabetes Specialist Nursing Service to empower patients to successfully manage their condition; ultimately minimising the risk of complications and potentially living a near-to-normal lifestyle. This involves the in reach to United Hospital, both outpatient clinics and wards, following diagnosis of Diabetes to facilitate education provision and to facilitate discharge. Specialist areas of care are renal patients, young people and ante-natal patients and pump patients.</p> <p>Learning Disability Nurse role- The Learning Disability nurse provides an intensive in reach role for patients undergoing Dental treatment under General Anaesthetic services. The Learning Disability nurse case manages the patient from referral through admission and follows the patient up on discharge from hospital.</p>

<p><b>Home First HSS Trust</b></p> <p><b>In reach (contd)</b></p>	<p>Chronic Disease Management specialists; Heart Failure nurse, Community Respiratory nurse. These newly created posts within Homefirst Community Trust will provide seamless care for these specific conditions across primary and secondary boundaries. Through in-reach patients will be identified for follow-up within their own environment and care will be transferred from the corresponding secondary care professional.</p> <p>Case Management coordinator role- this role will enable the active case finding of patient at risk of rehospitalisation through an in reach role. The case finder will identify people at risk of unplanned hospital admission through the use of the. Patients At Risk of Re-hospitalisation (PARR) Case Finding Tool. Patient's consent will be obtained and information will forwarded to appropriate members of the Health &amp; Social Care teams.</p> <p>Continuing Care Nurses- The Continuing Care Nurse will case manage patients with Chronic conditions- Heart Failure, COPD, Asthma and diabetes within their own home/ care home environment. This will be facilitated through in reach as the first step in the process.</p> <p>Continence promotion service- An ongoing service improvement project identified the capacity to increase efficiency across the existing continence services by establishing an in reach role by the existing Continence Promotion services into United Hospitals through the creation of a multidisciplinary continence care pathway. Four months following implementation a 28 week maximum waiting time has been reduced to 12 weeks.</p> <p>The Community Rehabilitation Team screens patients in hospital to determine the suitability of patients for community rehabilitation and facilitates earlier discharge for patients by proving a multidisciplinary rehabilitation service within the patients own home.</p>
<p><b>Causeway HSST</b></p> <p><b>In reach</b></p>	<p>Rapid Response</p> <p>This initiative was set up to prevent admission or facilitate early discharge of patients. The majority of referrals to this service come from the Acute sector however, there are increasing referrals now being generated by Primary Care.</p> <p>Bed days saved have been used to calculate the cost effectiveness of the service whilst questionnaires completed by users and referrers have been used to evaluate the service.</p> <p>The Rapid Response team has worked in conjunction with existing core services to deliver a range of managed complex healthcare solutions to patients in their preferred setting and in doing so has increased capacity within the Acute to treat those who require in patient care. The main constraint at present is that we currently do not have a 24 hour service at this time the service ceases at 10.30pm.</p> <p>Continence</p> <p>A fortnightly urodynamic clinic is facilitated by the Continence advisor. Previously this service was not being provided locally with patients having to travel to Antrim/Belfast for this procedure to be facilitated. The waiting list was approximately 18 months to 2 years prior to commencement of the clinic. Within 3 years the waiting list has been reduced to 12 months.</p>

<p><b>Causeway HSST</b></p> <p><b>In reach</b></p>	<p>Tissue Viability</p> <p>The role of the Tissue Viability Nurse within Causeway HSST is to provide specialist wound management advice to staff and care to patients in both the Acute and Primary care settings. Advice and care given enables patients' complex wound problems to be effectively managed with regard to healing rates, patient comfort, dressings/medication costs, nursing time and bed days.</p>
<p><b>Causeway HSST</b></p> <p><b>Nurse Led Discharge</b></p>	<p>Causeway Early Supported Discharge starting May 06</p> <p>(CREDS) project is commencing with a nurse and physiotherapist jointly working to facilitate discharge to community for patients with COPD due to start May 06</p> <p>Discharge Liaison nurse to commence May 06</p> <p>A community nurse is being currently recruited by the Trust to work within the current hospital discharge team to expedite discharge to community in a timely and sustainable fashion</p> <p>Orthogeriatric liaison nursing service implemented March 06</p> <p>An orthogeriatric liaison nurse is based within the Hospital at Home team to undertake hospital assessment of orthogeriatric patients as part of a care pathway to facilitate early safe discharge</p> <p>Macmillan Nursing one post holder in place for last 4 years</p> <p>A Macmillan Specialist nurse is in post to support discharge of palliative care patients diagnosed with lung cancer while a second Macmillan Nurse to be appointed in May 2006 will assist in the discharge of patients with generic palliative care needs</p>

<p><b>BCH HSS Trust</b></p> <p><b>In Reach activities</b></p>	<p>To date there have been three main In Reach projects which have sought to render care provision between hospital and community as seamless as possible through close partnership with primary care Trusts.</p> <p>In the year 2003-2004, we had a member of nursing staff, employed by the South and East Belfast Social Care Trust, based within the BCH A&amp;E Department. This individual identified patients, who with the assistance of the Rapid Response Team, could be safely discharged home.</p> <p>The Heart Failure Service also has an initiative with the South and East Belfast Health Community, where joint evidence based protocols have been agreed by Cardiologists and GPs, for the pharmacological and non pharmacological management of heart failure within the hospital and community. This has allowed many hospitals admissions to be aborted, where previously the patient would have been admitted.</p> <p>There is also a similar initiative in planning stage presently for the management of COPD patients within the community. This will allow for the identification of patients in hospital, who may be discharged earlier, with the help of a specialist respiratory nurse working within the community. Whilst currently at planning stage, there is scope to greatly reduce the length of hospital stay of many patients with chronic respiratory disease.</p>
<p><b>BCH HSS Trust</b></p> <p><b>Nurse Led Discharge</b></p>	<p>A baseline assessment across all Directorates was undertaken in May 2005, when clinical areas outlined their current activity with regard to Nurse-Led discharge and feasibility for future development.</p> <p>Since then, several areas (Oncology / Haematology, Cardiology and Dermatology) have developed protocols which enable nurses to discharge patients. Surgical areas are in the process of educating nursing staff with a view to subsequently developing protocols for Nurse-led discharge. In other areas such as Day Care and Outpatients, there are nurses with higher level specialist training, who discharge patients.</p> <p>The Trust is also hoping to employ a Care Pathway Co-ordinator, who will assist clinical areas in developing pathways, which will enable nursing staff to discharge patients following specific surgery and treatments.</p>
<p><b>South &amp; East Belfast HSS Trust</b></p> <p><b>Heart Failure In Reach to BCH</b></p>	<p>Patients with Heart Failure from BCH both Cardiology and Acute General Medicine</p> <p>The process involves identifying patients with Heart Failure from BCH both cardiology and acute general medicine. The assessment of patients at home and within the hospital outpatient clinics, involves a full clinical heart failure examination, optimisation of medication, clinical investigation (i.e. ECG's and biochemical markers) depending on clinical indication/ judgement.</p> <p>A holistic approach is used and referral is made to other members of the multidisciplinary team as appropriate.</p> <p>The aim is to create an 'expert patient' who can recognise the signs of deterioration in their condition and contact the heart failure service accordingly.</p> <p>This process is led by two Heart Failure Nurses who commenced in April 2004.</p>

<p><b>South &amp; East</b> <b>Belfast</b> <b>HSS Trust</b>  <b>Heart</b> <b>Failure In</b> <b>Reach to</b> <b>BCH</b> <b>(Contd)</b></p>	<p>Outcomes/ benefits achieved - patient</p> <ul style="list-style-type: none"> <li>• Reduction in length of hospital stay</li> <li>• Continuity of care post discharge, providing specialised advice and support.</li> <li>• Optimisation of medication at more timely intervals.</li> <li>• Number of clinic attendances is reduced.</li> <li>• Hospital admissions are avoided.</li> <li>• Improved quality of life.</li> </ul> <p>Outcomes/ benefits achieved – organisation</p> <ul style="list-style-type: none"> <li>• Established a service/ resource, which facilitates the management of a chronic disease within the community.</li> <li>• Reduction of clinic waiting times.</li> <li>• Reduction in hospital admissions and therefore and increase in bed days saved.</li> </ul> <p>Difficulties/ issues/ constraints have arisen /need addressed. The main constraint of the service is that patients are drawn from only BCH following a hospital admission/ clinic visit..</p> <p>A fundamental role of the Heart Failure Nurse is the optimisation of gold standard therapy thus it is beneficial that the nurse is an Independent and Supplementary nurse prescriber. The heart failure nurses are currently undertaking the Independent and supplementary nurse prescribing course however this has led to a reduced number of days available to cover the heart failure clinics and home visit. This is a temporary situation and will be addressed once the course is completed in May 06.</p> <p>Costs / Bed days saved / Effectiveness</p> <p>According to the NI Database of Healthcare Resource Group costs, a patient admitted to cardiology in BCH with heart failure is likely to spend between 7-10 days (mean 7.88) in hospital, at a cost of £427 per day or approximately £3362 per patient stay.</p> <p><u>April 04 – April 05</u></p> <p>112 home visits / 198 patients seen by the community heart failure nurses at BCH. (not all S&amp;EBT). 31 clinic visits saved. 24 hospital admissions saved. 189 bed days saved 24x £3362 = £80,688 cost saving</p> <p><u>April 05 – April 06</u></p> <p>273 home visits 243 patients seen at clinic 143 clinic visits saved 64 hospital admissions saved 504 bed days saved.                      64x £3362 = £215,168 cost saving</p> <p>There has recently been a heart failure nurse appointment to the Ulster Hospital and it is anticipated that there will be soon be referrals from this source.</p>
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<p><b>South &amp; East Belfast HSS Trust</b></p>	<p>Active in Reach Team (ANR Team)</p> <p>To prevent admission the Active In-Reach Team will work closely with the A&amp;E Departments, GPs and the 24 hour District Nursing Service. To achieve early discharge, the ANR Team will work with the hospital team to make the necessary pre-discharge arrangements to facilitate a Consultant-led Treatment Plan.</p> <p>The 24 hour District Nursing Team, led by the District Nursing Sister, will provide this level of intensive nursing care at home supported by the Active In Reach Team. The Team will provide technical and staff support during the first hours of care and will work closely with the District Nursing Sister and staff.</p> <p>The Trust has also focused on the further development of the nurse led case finding model, developed in 2004/05 with Belfast City Hospital.</p>
<p><b>South &amp; East Belfast HSS Trust &amp; BCH HSS Trust &amp; UCHT</b></p> <p><b>In Reach</b></p>	<p>COPD Enhanced Discharge Scheme</p> <p>This Scheme, which is due to commence May/June '06, identifies patients who have frequent admissions to hospital. These patients will be discharged home earlier with an enhanced package of care for up to 7-10 days. The Team will also provide visits during an acute exacerbation to reduce admissions to hospital. Patients can have, if required, access to Home from Hospital Services in relation to personal/social care for a time limited period.</p> <p>Hospital expeditors (BCH) and Discharge facilitators UCHT will screen admissions for patients with an exacerbation of COPD. Each patient will be assessed daily by a member of the Community Respiratory Team according to inclusion/exclusion criteria for suitability for enhanced discharge. Medical and Physiotherapy staff to confirm eligibility and need for Community Physiotherapist A plan of Care will be formulated which should include recommendations for care should the patient's condition deteriorate.</p> <p>Once accepted for Enhanced Discharge the patient will be transferred home with follow up visits by the Community Respiratory Team. Patients will have their own hand held notes and may remain on the scheme for up to 10 days.</p> <p>Patients will be provided with an information leaflet with contact numbers. They will be asked to contact the Community Respiratory Team (C.R.T) should they experience any new symptoms or if there is deterioration in their condition. Further support out of hours can be accessed through the on-call hospital medical team.</p> <p>When patients recover from their exacerbations, responsibility for care will return to the GP. Patients who deteriorate or who fail to improve may be re-admitted to hospital via A &amp; E. Patients will be reviewed 6 weeks post discharge.</p> <p>The process for Enhanced Supported Discharge falls into 5 components:</p> <ol style="list-style-type: none"> <li>1. Case finding and assessment</li> <li>2. Discharge arrangements</li> <li>3. Care in the community</li> <li>4. Discharge from supported follow-up</li> <li>5. Review</li> </ol> <p>The Service has not commenced yet and is in the planning and recruitment stages. Staff involved will include and two nurses and one physiotherapist.</p>

<p><b>South &amp; East Belfast HSS Trust &amp; BCH HSS Trust &amp; UCHT</b></p> <p><b>In Reach</b></p>	<p>Community Nursing In-Reach Schemes (CNIR)</p> <p>Eligible patients are identified in hospital wards and/or A &amp; E Departments.</p> <p>Patient Expeditors and Discharge Co-ordinators meet on a daily basis to discuss cases suitable for earlier discharge. Patient Treatment Plan is drawn up in conjunction with hospital staff</p> <p>CNIR Nurses will access various drugs/equipment. They will set up and deliver care and will hand over to core District Nursing teams.</p> <p>The CNIR Nurses will provide training and support for any procedures the District Nurse is not familiar with and will continue to provide care until the District Nurse feels competent to continue the care.</p> <p>This service is very much in its infancy. Staff are in the process of induction in both hospitals and are networking with the various directorates to promote their services. It is expected that the service will begin to operate May '06.</p> <p>Referrals to the scheme will be made to named nurses, clients must be SEBT residents only. Data sets have been agreed to monitor outcomes of service in relation to bed days saved and benefits for patients on service</p> <p>Staff involved will include 2 nurses</p>
<p><b>Green Park Health Care Trust</b></p> <p><b>Nurse led Discharge</b></p>	<p>Withers Orthopaedic unit - Nursing staff Discharge as per protocols</p> <p>Fracture Review Nurse - Outreach services to Fracture Rehabilitation wards in hospitals throughout EHSSB Area.</p> <p>Fracture Discharge Co-coordinator facilitates discharge to rehabilitation settings</p> <p>No in reach activity reported</p>
<p><b>UCHT</b></p>	<p>Community in reach services being developed. (See also SEBT )</p>
<p><b>Mater Hospital HSS Trust</b></p> <p><b>Nurse Facilitated Discharge</b></p>	<p>Patients discharged from the Elective Surgical Unit receive a courtesy telephone call from nursing staff 2 days after their discharge. Following a protocol, a significant cohort of patients are selected for 4 week phone review rather than surgical outpatient follow up. The 4 week phone review results in a further significant number of patients being discharged from the hospital system and back to the care of their general practitioner.</p> <p>The Trust has also recently developed a draft Nurse Discharge Policy which, in the first instance has been piloted by the Respiratory Nurse Consultant. However, the policy is sufficiently generic to support nurse discharge by appropriately trained and supported staff working in other specialities. Early findings would suggest that Nurse facilitated discharge can bring forward the time of day at which patients are discharged.</p>

<b>Royal Group of Hospitals</b>	<p>A 24-hour bed manager service facilitates the discharge process across the Royal Hospitals site. New bed management software, which will in the future enable nurse led discharge and the provision of an expected discharge date, is currently being reviewed for efficacy.</p>
<b>Nurse &amp; Midwifery-Led Discharge</b>	<p>In Medicine and Surgery directorates a Discharge Coordinator facilitates discharge to the patient's home, rehabilitation services and nursing homes. There are also good examples of nurse-led discharge within the ambulatory specialties:</p> <ul style="list-style-type: none"> <li>i) Within the emergency department the minor injuries unit is run by emergency nurse practitioners who see, treat and discharge patients home;</li> <li>ii) In the outpatient department the nurse-led Rapid Access to Vascular Examinations (RAVE) clinic promotes earlier diagnosis and rule-out of vascular disease allowing discharge from the vascular outpatient service.</li> </ul> <p>The Tissue Viability Nurse Service within The Royal Hospitals models how rapid access to a complex wound clinic post-discharge facilitates earlier discharge of patients from hospital. Advice and care given enables patients' complex wound problems to be effectively managed with regard to healing rates, patient comfort, dressings/medication costs, nursing time and bed days.</p> <p>Cardiac Rehabilitation is a further example of this: multidisciplinary input into the pre-discharge phase, followed up by home visits by the Cardiac Liaison Nurse within 2 weeks of discharge and access to an 8-week programme of advice and exercise ensures safe and timely discharge of patients. The patients are further monitored at the 6-month point following their cardiac incident and on an ongoing basis by the secondary prevention nursing team.</p> <p>Within the Burns Unit the multi disciplinary team work with the patient and family on the development of a discharge plan, which for the major burn-injured patient is some weeks prior to actual discharge. Nursing staff co-ordinate input from other agencies / disciplines where applicable to ensure effective and timely discharge.</p> <p>Other special interest nursing roles provide specialist advice, treatment and follow up at home when necessary. Areas in which these roles have developed include: Nutrition, Continence, Epilepsy, Head and Neck cancer and Palliative care.</p>
<b>In-reach Services</b>	<p><u>Midwifery</u></p> <p>Midwives work within a Wellness model with the woman as the focus of care. The entire pregnancy journey is focused on mother and baby going home well, with some confidence in their parenting skills, to be further supported by community midwifery care. Women are home on average within 3 days and initiatives are attempting to reduce the length of stay further. Midwives make discharge decision in partnership with women, only involving medical staff when there are clinical problems.</p> <p>Staff are currently proposing the establishment of a model of working in which the Mater Hospital, North and West Belfast Trust and the Royal Hospitals work collaboratively in the provision of services for heart failure patients. Heart failure affects population in the UK (that is about 30,000 people in Northern Ireland). At least 5% of hospital beds are occupied by patients with heart failure, but in addition, heart failure may complicate other surgical conditions. The introduction of the RGH/Mater/N&amp;W Heart failure model could save over 1,453 bed days per year.</p> <p>The respiratory service has links to in reach working with N&amp; W and the A/E department in facilitating early discharge of patients from hospital.</p>

<p><b>N&amp;W HSST</b></p> <p><b>In Reach Services</b></p>	<p>North and West Belfast Trust provide a wide range of in reach services to both the Mater Hospital Trust and the Royal Group of Hospitals. A number of these services are long established whilst others have been recently developed to meet identified emerging needs.</p> <p><b>District Nursing</b></p> <p>District Nurses regularly attend hospital case conferences and visit hospital wards prior to the discharge of complex patients to ensure a seamless transfer to community. Nurse managers and link community nurses attend regular meetings at the Mater and Royal Hospital to discuss the discharge process and resolve clinical issues and to jointly plan patient care across the acute/community interface.</p> <p><b>24 Hour Nursing Service</b></p> <p>The staff for the 24 hour nursing service in reach into both the Mater and the Royal Hospitals A&amp;E Departments and Wards. This service facilitates earlier discharge of inpatients, prevents admission of some patients attending A&amp;E Departments and prevents some A&amp;E attendances.</p> <p><b>Condition Specific Services</b></p> <p>The community diabetes specialist nurses provide an in reach joint clinic in the Mater Hospital to facilitate patients commencing on insulin at home. These nurses also attend clinics in the Royal Hospital run by the hospital staff to ensure a seamless service for Royal patients commencing on insulin at home.</p> <p>The newly appointed Heart Failure Nurse will work closely with their peers in the Royal and the Mater.</p> <p><b>Children Specific Services</b></p> <p><b>Childrens Asthma Service</b></p> <p>Asthma Nurses from the School Nursing Team carry out a nurse led clinic linking with a hospital/community paediatrician. These nurses in reach into hospital when children are being discharged.</p> <p><b>Community Children's Nursing</b></p> <p>The community children's nursing team are involved in the discharge planning of children with complex needs through formal multidisciplinary discharge planning meetings and informally by regular visits to the child and family in hospital. Building up a relationship with the child and family prior to discharge and identifying any difficulties, training needs or additional equipment required.</p> <p><b>Health Visiting</b></p> <p>The Health Visiting Service in reaches to both the Mater and RBHSC, in particular to A&amp;E departments as a Liaison service. The aim is to provide an effective communication system between the A&amp;E departments and community Health Visitors to ensure the needs of clients, children and their families living in the North and West Belfast area are met. The system is for all children aged 0-6 years and all children up to 18 years where there is cause for concern. Where there are child protection issues these are automatically referred to Social Services. An agreed protocol has been developed to facilitate this process.</p>
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<p><b>N&amp;W HSST</b></p> <p><b>In Reach Services</b></p>	<p>Diabetes Service</p> <p>Community Diabetes Specialist Nurses provide an In Reach, joint clinic in the Mater Hospital to facilitate patients commencing on insulin at home. These nurses also attend clinics in the Royal Hospital run by the hospital staff, to ensure a seamless service for Royal patients commencing on insulin at home.</p> <p>Diabetes Nurse specialists in reach into the Mater and Royal Hospitals to outpatient clinics and wards to facilitate discharge and treatments in the community and carry out a joint clinic with the Mater hospital.</p> <p>MacMillan Oncology Joint Appointment</p> <p>This Joint appointment between the Belfast City Hospital and North &amp; West Belfast Health &amp; Social Services Trust has been developed to work across boundaries and create a seamless service. The role aims to improve communication, increase quality and continuity of care, provide education and support, acting as a resource to staff in both Trusts.</p> <p>Specialist Palliative Care Nurse</p> <p>This joint appointment between the Northern Ireland Hospice and North &amp; West Belfast Health &amp; Social Services Trust is similar to the oncology post, working across the boundaries of community, the hospice and local Acute Hospitals, to ensure a seamless service for patients and carers. The role aims to improve communication, increase quality and continuity of care, provide education and support, acting as a resource to both community and Hospice staff.</p> <p>Working Women Service</p> <p>The nursing staff working in this service do not in reach to the hospital but do regularly arrange for the GUM service and Breast and Cervical screening services to outreach to their clients supported by nursing staff for the Working Womens service</p> <p>Homeless project developments</p> <p>A community nurse practitioner with extended and supplementary nurse prescribing is working with the homeless in North and West Belfast. This nurse has a top sliced budget for EHSSB and in reaches into the Mater and Royal Group of Hospitals</p>
<p><b>DLT</b></p> <p><b>In-reach activity in Down &amp; Lisburn Trust which facilitates discharge</b></p>	<p>Hospital At Home</p> <p>Three teams  1 Downpatrick Area  1 Lisburn Area  1 Saintfield Area</p> <p>Facilitates early discharge to patients with on-going medical, nursing or rehabilitation needs e.g., fracture rehabilitation, IV antibiotic therapy, palliative care, wound care, short term IV fluids. Service is available across the Trust. The service has been running for 10 years and has been subject to external and internal audit.</p>

<p><b>DLT</b></p> <p><b>In-reach activity in Down &amp; Lisburn Trust which facilitates discharge</b></p> <p><b>(contd)</b></p>	<p>Psychiatric Liaison Service</p> <p>Psychiatric liaison out-of-hours CPN is available to both A&amp;E Departments in the Acute Hospitals (LVH &amp; Downe). This service has been running for 2 years. This is a triage service which facilitates patient management of clients with mental health problems. The CPN, on contact by either A&amp;E Departments, carries out an assessment and based on this assessment either;</p> <ul style="list-style-type: none"> <li>◆ Facilitates discharge, or</li> <li>◆ Seeks further assessment by the on-call psychiatrist.</li> </ul> <p>This service has been evaluated and is reported by A&amp;E staff to be very valuable in terms of facilitation referral or discharge but also in terms of expert advice.</p> <p>Addiction Liaison</p> <p>An addictions liaison service is available currently Mon – Fri, only to the Downe Hospital A&amp;E Dept. This has been running for nearly 2 years. On request the addictions nurse visits the department or makes telephone contact and can facilitate discharge or optimal management. The service has not been formally evaluated but is reported by A&amp;E, Downe Hospital as being a very valuable service.</p> <p>Community Equipment Co-ordinator</p> <p>The Trust has a community equipment co-ordinator in place since 2003. The post holder is contacted by wards and departments in hospitals within the Trust (Downe Hospital, LVH, Thompson House) and ensures patients who have complex needs for equipment, have this in place. The current post-holder is called Norma Glen, previously a district nurse. The post has not been evaluated as yet.</p> <p>Palliative Care Team</p> <p>The hospital Palliative Care Team in LVH and Downe Hospitals work closely with the Community Team to facilitate discharge of patients with palliative care needs.</p> <p>District Nursing Teams</p> <p>Both A&amp;E Departments (LVH &amp; Downe Hospital) liaise with district nursing to facilitate early discharge, particularly for patients with deep venous thrombosis.</p> <p>Other Services</p> <p>The community are currently setting up a stroke, heart failure and COPD service. The aims of these services are to avoid admission or facilitate early discharge.</p>
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## SHSSB

<p><b>Craigavon &amp; Banbridge HSST In Reach</b></p>	<p>Nurse Led Discharge and In reach Activity includes the Intermediate Care Scheme and discharge of patients with complex needs and extended District Nursing service to include intravenous therapies and sub cut fluids.</p> <p>The Complex Needs Project commenced in November 2004, and is designed to facilitate early discharge through an Enhanced Intermediate Care Scheme for those people formerly Care Managed from hospital setting. This scheme has built on the existing Intermediate Care Infrastructure.</p> <p>The Core Intermediate Care Scheme, targets patients with rehabilitation potential and was commenced in 1999 with continued development and expansion year on year. The scheme is comprised of a step down and step up element with up to 6 weeks rehabilitation and an extended rehabilitation therapy period for fractures. Full annual statistics are available year on year up to 31<sup>st</sup> March 2005.</p> <p>The service is provided at both CAHGT and Daisy Hill Hospital. Staff involved in this scheme include</p> <ul style="list-style-type: none"> <li>- Intermediate Care District Nurse Sister Co-ordinators, Hospital Nursing and Social Workers, Community District Nursing, Social Work, Trust Home Care NVQ 3 staff, Allied Health Professions, Clerical, Information and IT Staff.</li> </ul> <p>This process involves partnership working to facilitate person centred discharge from hospital through liaison with hospital/community staff and families. The outcomes to date have demonstrated a reduction in hospital stay and a more person-centred approach to long-term decision making. There have been significantly different outcomes, over a 12month period for those people formerly care managed, benchmarked against those patients discharged through Enhanced Intermediate Care the estimated average bed days saved per patient, from the date of referral for discharge assessment, to the date of discharge.</p> <p>In terms of outcomes/benefits achieved for both the patient and the organisation</p> <ul style="list-style-type: none"> <li>• 3465 bed days saved from 1/11/04 to 31/10/05 benchmarked against Care Managed discharges for the period 1/11/03 to 31/10/04. with 231 patients discharged through the scheme with an average 15 bed days saved per patient.</li> <li>• At the regionally agreed figure of £150 bed cost for each delayed discharge day, this equates to £520,000 for that year.</li> <li>• The 2005/6 Price Waterhouse Cooper “Value For Money Audit” stated the following: “In most areas the Trust scores higher than NI average and University of Leicester benchmark. 100% of carers felt that staff treated them with dignity and kindness” (NI average 96.7% University of Leicester 95.5%).</li> </ul>
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<p><b>Craigavon &amp; Banbridge HSST</b></p> <p><b>In Reach (contd)</b></p>	<ul style="list-style-type: none"> <li>• 20% less people were discharged through the Enhanced Intermediate Care Scheme compared to the previous year, for patients who were discharged through care management.</li> <li>• 35% increase to the Core Intermediate Care Scheme which targets those people with potential for rehabilitation.</li> <li>• a reduced number of people being care managed into Nursing/Residential Homes and their own homes, with 15 people returning to core services compared to 3 people the previous year.</li> <li>• 3 people, at the end of the 6 week period required no services.</li> </ul> <p>The SHSSB commenced commissioning Enhanced Intermediate Care from NMHSST and ADHSST from 1/12/05 as their preferred method of discharge for patients who would formerly have been Care Managed to those Trusts from CAHGT and DHH.</p>
<p><b>Armagh &amp; Dungannon HSS Trust</b></p> <p><b>Nurse Led Discharge</b></p>	<p>This has not yet commenced in the Trust, but is being considered.</p>
<p><b>Armagh &amp; Dungannon HSS Trust</b></p> <p><b>In Reach</b></p>	<p>Implementation of nurse led discharge for terminally ill patients Implementation of the nurse led. Complex Needs Enhanced Intermediate Care Scheme project previously piloted in C&amp; B HSS Trust.</p> <p><u>Intermediate Care Co-ordinators</u></p> <p>ADHSST has 2 intermediate care coordinators (nurses) who provide an in reach service to the acute hospital, (CAH) The nurses visit the wards and screen patients for suitability for early discharge from hospital through the intermediate care service. From 1<sup>st</sup> Dec 2005, there will be an enhanced Intermediate care service, which has extended referral criteria to include older patients with complex needs who would previously have been referred via care management; these patients will no longer be delayed in hospital due to the care management process.</p> <p><u>DN Key worker end stage Terminally ill patients ; facilitate early / timely discharge</u> District Nurses from 1<sup>st</sup> Nov 2005; undertake a key worker role in regard to all end stage terminally ill patients in hospital, within ADHSST area. This will involve in reach, to the hospital by the District Nurse, who will facilitate the early discharge of these patients, thereby ensuring that patients whose choice is to die at home are discharged home, with identified nursing equipment and services.</p>
<p><b>Newry &amp; Mourne HSS Trust</b></p>	<p>Community in reach services would include specialist nurse carrying out consultation visits into hospital with a view to facilitating discharge.</p> <p>In the early stages of exploring the role of the intermediate care sister in expediting early discharge to primary care and intermediate care settings.</p>

<p><b>CAHGT</b> <b>Nurse Led Discharge</b></p>	<p>The concept of Nurse Facilitated Discharge in a more proactive way is in the early stage of implementation with particularly emphasis placed on appropriate discharging at week ends and bank holidays. The next stage in this process is to move towards Nurse Led Discharge. This will equip Nurses with the competence and confidence necessary to move to Nurse Led Discharge.</p>
<p><b>SHSSB</b> <b>Mental Health Services In Reach</b></p>	<p>Each trust within the board area has appointed a facilitator for the introduction of home treatments and crisis response which in the developmental phase for the past six months</p> <p>The facilitators in reach into hospital settings, day hospitals and community teams to promote cross boundary working and support the increasing shift of services for patients with mental health issues to community settings</p>

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