Orthopaedic Supported Discharge (OSD)

KSS AHSN #NOF Collaborative Event
24 June 2015

Michal Krasuski – Team Leader & Senior Physiotherapist
Radcliffe Lisk – Consultant Orthogeriatrician
“Consider early supportive discharge as part of the Hip Fracture Programme, provided

- the Hip Fracture Programme multidisciplinary team remains involved
- the patient is medically stable
- has the mental ability to participate in continued rehabilitation
- is able to transfer and mobilise short distances and, has not yet achieved their full rehabilitation potential, as discussed with the patient, carer and family.”
We set up a 6 month pilot looking at the effectiveness of an OSD team using £90,000 from the Trust’s Innovation Fund starting 1st March 2014.

The OSD team work within the hip fracture unit and there is a virtual board round led by the Orthogeriatrician 4 days a week.
Pathway prior to OSD in 2013

Current Pathway
“Fix”
Surgery Recovery
St. Peter’s Ward

“Discrete Rehab”
Rehabilitation
Ashford Ward

Pilot Pathway
“Fix”
Surgery Recovery
St. Peter’s Ward

“Discrete Rehab”
Rehabilitation Rehabilitation
Ashford Ward Normal Place of Residence

Early Supported Discharge

Patients first • Personal responsibility • Passion for excellence • Pride in our team
The key benefits for the patient outcomes are:

- Allowing patients to return to their usual place of residence earlier than usual.
- Reduction of patient institutionalisation.
- Contextualisation of rehabilitation.
- Reduction in LOS and costs
Team includes:

- Physio Band 7 Team Leader
- Occupational Therapist Band 6
- Nurse Band 6
- Two Therapy Assistants Band 3

Clinical Leadership from the Orthogeriatricians
WHAT THE SERVICE OFFERS

• A visit on the day of discharge whilst still in hospital to assess needs and make plans with the patient.
• Specialist therapy for the patient at home for up to 14 visits.
• Advice and emotional support to for patient, carer and family.
• Support to the patient to make their own decisions and set their own goals.
• Close working with the Orthopaedic Department and Geriatricians at Ashford & St Peters Hospital.
• Regular reviews of progress and plans during rehabilitation with the OSD Team.
• Onward therapy referral if required.
Multi-disciplinary Team Working

- Exercises
- Rehab

- Home visit
- Equipment

- wound care
- medication

PATIENT
On 10/03/2015 OSD celebrated its 1st birthday. We have now been operating for over 12 months.

- Total number of patients treated by OSD: 217
- Total number of completed home visits: 2261
- Average 11 visits per patient.
OSD - into its second year

- Employ 2nd nurse and to increase team capacity from 8 to 12 patients.
- Providing BD personal care visits as a part of rehab.
- Upskilling team to provide more complex care
Pts to Fielding

- 2013-14: 216
- 2014-15: 126
The Challenges of setting up a brand new service.

Was there even a demand for the service? Our statistics and patient satisfaction suggests there is.

Starting from scratch with formulating the necessary documentation and policies.

Having the correct skill mix – The team comprises of some with hospital experience, others with community experience. Being a small team it is important that each team member is able to support one another. This means our roles sometimes can overlap. This has involved learning new skills for all team members.
Knowing where to direct patients who need urgent medical assistance. As the patients are still under the umbrella of the hospital we have good links to the orthopaedic surgeons and the Orthogeriatrician consultants if we have any orthopaedic or post-operative concerns. We can usually bring a patient into the Fracture clinic on the next working day if they are 'in trouble.'

We communicate closely with the GPs to keep them updated on any changes made and for any other concerns. Also have access to the Rapid Access Centre through the consultant Ortho-Geriatricians.
We have identified, following a study of a small sample of patients, that 53% of patients with a fractured Neck Of Femur struggle to cope with their medication following discharge. This is significantly higher than other orthopaedic patient groups.

Solution

OSD are now trialling the Patient Medication Record (available on the Pharmacy Clininet page) with all our fractured NOF patients. Patients who continue to struggle with their medication are set up with a Nomad / dosette box.

As the OSD nursing staff visit on average 3 times whilst the patient is under OSDs care we can give ongoing advice and support. We can also seek the advice of the doctors at SPH or the GPs.
Earlier discharge means that some patients analgesic requirements are greater. They are also receiving an intensive rehabilitation programme which they may find painful.

**Solution:**
Ensuring the ward doctors prescribe sufficient analgesia on discharge.

To reduce poor understanding of how to manage their analgesia – OSD have devised an analgesic planner chart for non NOF patients.
Orthopaedic Supported Discharge (OSD)

PLEASE NOTE THIS IS NOT A

PRESCRIPTION

Pain relieving advice

You have been discharged from hospital with the following recommended medication for pain relief.

After an acute injury or surgery, pain is best controlled by preventing pain from building up. To do this we recommend that you take regular pain relieving drugs evenly spaced throughout the day.

<table>
<thead>
<tr>
<th>Medication</th>
<th>When you wake up / Breakfast</th>
<th>Lunchtime</th>
<th>Teatime</th>
<th>Bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You may have been prescribed another pain killer. This pain killer is for ‘breakthrough pain’. Please take this pain killer with the above pain killer/s if your pain is not controlled.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>When to take this medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As your pain reduces, please reduce the pain killer for the breakthrough pain first, before reducing the regular pain killer. Be aware that all pain killers are constipating and have side effects. If you have any concerns that you may be experiencing any side effects please discuss this with members of the OSD team or your GP.
We have found that the first 24-48 hours following discharge the most challenging:

**Solution:**
The home situation may not be quite as we have been led to believe. Our aim is that the patient is seen within **24-48 hours by both the OT and nurse** to ensure that they are safe and any initial problems are dealt with swiftly. **Then their physiotherapy programme will begin.**

Patients actually not be able to manage them at home.

Patients underestimate how tired they are going to get.

Information overload at the time of their discharge from hospita means the patient often retains very little information.
Working with other teams in the community

E.g. Community nurses, Carers, re-ablement team, Age UK, Red Cross. Our difficulty here was that we were unknown initially.

Solution:
• We have written to all the community nurses explaining our service.
• GPs are also getting to know us as we often liaise with them during the time the patient is receiving treatment from OSD.
• The GPs also receive a discharge summary when OSD discharge the patient.

Good communication is imperative
Orthopaedic Supported Discharge

Referral letter to A&E staff

Patients Name: [Name]
Address: [Address]
Hospital No: [Hospital No]
D.O.B: [Date]

Dear A&E Staff,

Thank you for your involvement with the above patient.

This patient has recently been discharged from ASPH following:

[space for details]

She has been under the care of the Orthopaedic Supported Discharge Team since discharge which is a community rehabilitation team based at SPH. We would be grateful if you would review this patient because:

[space for details]

This patient has already been discussed with:

[space for details]

Their recommendation:

[space for details]

Thank you

Signed: [Signature]
Designation: [Designation]
Date: [Date]

Orthopaedic Supported Discharge

Discharge letter to Community Nurse for patients under joint care

Patients Name: [Name]
Address: [Address]
Hospital No: [Hospital No]
D.O.B: [Date]

Dear Community Nursing Team

Thank you for your involvement with the above patient.

The Orthopaedic Supported Discharge Team (OSD) have now discharged this patient from their rehabilitation programme. We would be grateful if you could take over the following care along with the care from previous referral.

- Please check wound on ___/___/___
- Please remove clips / sutures / skin sutures on ___/___/___

Any other issues

Signed: [Signature]
Print: [Print]
Designation: [Designation]
Date: [Date]
Although there are similar teams we are unique because we provide an intensive rehabilitation programme with patients who have just undergone major orthopaedic surgery that would normally still be in hospital. This has been a steep learning curve!

We have come across many issues along the way which has required good problem solving skills and courage!
Patients quality of recovery is much improved and quicker within their own environment.

Being at home patients:
- feel more relaxed
- have a better nights sleep
- able to eat homemade food
- be around family or loving pets
- having peace of mind due to regular therapy and medical support
- reduced risk of hospital acquired infection
• 12 months period, 217 patients (105 hip fractures) were taken;
• 423 hip fractures presented.
• These patients are taken on average 7 days post surgery.
• This has reduced our Trust Length of Stay (LOS) for hip fracture patients from 21.5 days (March-Feb 2014) to 18.2 days (March –Feb 2015) without a change in readmission (7.89% to 7.57% respectively).
• Patients sent to the rehabilitation hospital (part of the Trust) have reduced from 44.2% to 23.6%;
• Home to Home within 30 days has increased from 53.99% to 61.22%. Mortality remains unchanged 4.83% to 4.96%.
• 99.3% patients said they were extremely likely/likely to recommend the service to friends and family.
The total cost for the year was £186,777 due to extra staffing that was required.

Our Trust received 423 hips for the period March 2014 to Feb 2015, with bed day costing £275, the possible savings are £383,873.

This shows that the model is cost-effective with savings of £197,095.
<table>
<thead>
<tr>
<th>Options</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely likely</td>
<td>123</td>
</tr>
<tr>
<td>Likely</td>
<td>15</td>
</tr>
<tr>
<td>Neither likely nor unlikely</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely</td>
<td>0</td>
</tr>
<tr>
<td>Extremely unlikely</td>
<td>0</td>
</tr>
<tr>
<td>Don't know (left blank)</td>
<td>2</td>
</tr>
</tbody>
</table>
• “Treated like a Queen”
• “First class after-care”
• “Weekend home care is good. They know about their patients’ condition and treat accordingly”
• “I couldn’t have coped without their help”
• “The team were always well informed, friendly and encouraging”
• “Very good that there is people to come out to help you, and take an interest in you rather than just fulfilling the system quotation.”
• “I want great care and I got it!”
• “Consider myself very fortunate, as a visitor to the area, to have had my accident here and not elsewhere”
Video!!
The impact of an Orthopaedic Early Supportive Discharge (OSD) Team in our Hip Fracture Service

R. Link, M. Krasowski, H. Walters, C. Parsons, K. Edens, K. Yeang
Department of Orthopaedics, Ashford & St. Peter’s NHS Foundation Trust (ASPHT)

Introduction:
There is evidence to suggest that OSD achieve outcomes that are at least as good as or better and more cost effective than those achieved in an in-patient setting.

NICE guidelines say “Consider early supportive discharge as part of the Hip Fracture Programme, provided the Hip Fracture Programme multidisciplinary team remains involved, the patient is medically stable and, has the mental ability to participate in continued rehabilitation and, is able to transfer and mobilise short distances and, has not yet achieved their full rehabilitation potential, as discussed with the patient, carer and family.”

Method:
We set up a 6 month pilot looking at the effectiveness of an OSD team using £90000 from the Trust’s Innovation Fund starting 1st March. The OSD team is made up of a physiotherapist (band 7), an occupational therapist (band 4), a nurse (band 5) and 2 therapy assistants (band 3). They may take up to 8 patients (NOF and non NOF patients) at any given time. The team work within the hip fracture unit and there is a virtual board round led by an Orthopaedic/cranian 4 days a week.

Results:
Over the 3 month period, there were 114 hip fractures, of which 32 met the criteria for OSD. In 6 months, 56 hip fracture patients were taken home by OSD. These patients are taken on average 7 days post surgery. If there was capacity, non NOF patients were included. Total number discharged with OSD = 103 at 6 months.

COMPILATIONS

<table>
<thead>
<tr>
<th>Problem</th>
<th>OSD Patients</th>
<th>Ward care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>5.0%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Fractures</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mortality</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Average number of visits
Physiotherapist: 3.3
Nurse: 3.5
Therapy Assistants: 4.4

Average LOS with OSD 11.4 days
Based on 400 hips a year with bed day of £260, possible savings of £351,200.

Conclusions:
OSD should be part of all hip fracture services as it reduces LOS and readmissions which leads to significant cost savings.

References:
Our successes:

• British Geriatric Society Autumn meeting Brighton 2014
• Poster presentation – “Eva Huggins Prize”
• It has been published as an abstract in Age & Ageing Journal April 2015 44 (supp 1)
The OSD service was received well by the recent CQC inspection in Dec 2014.

It was published in the CQC website report for our Trust under areas with outstanding practice.

The CQC said “the trauma and orthopaedic unit had set up an early discharge team to reduce the length of stay for patients with hip fractures. Patients had continuity of care from hospital into their own home as they had the same staff. This had reduced their length of stay in hospital”
KSS AHSN Awards 2015 Clinical Leadership Award
KSS AHSN Awards 2015 Clinical Leadership Award

Kent Surrey Sussex Service Improvement and Innovation Awards 2015

Winner

Clinical Leadership Award

awarded to

Orthopaedic Early Supportive Discharge (OSD) Team

David Clayton-Smith
Chairman
Kent Surrey Sussex Academic Health Science Network

Guy Boersma
Managing Director
Kent Surrey Sussex Academic Health Science Network
Conclusion