

## CONFERENCE ABSTRACT

### Using an integrated model of care between an acute hospital and primary care in a transitional care unit to support patient flow and discharge home

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**Introduction:** Hospitals have increasing numbers of emergency department attendances each year. We need to treat these patients more quickly and avoid emergency over-crowding thus allowing patients to flow freely through the acute hospital. Hospitals require timely and efficient discharge processes to achieve adequate patient flow. In a previous quality improvement project to reduce readmissions, we had highlighted the importance of supporting patients with complex discharge needs at the time of discharge. Achieving safe, timely and person-centred discharge from hospital to home is an important indicator of quality and a measure of effective integrated care. At a time when building new acute beds is not feasible innovative new ideas are required to attain this goal.

**Practice change:** We planned and commissioned a new off-site 18-bedded transitional care unit (TCU). The nursing and therapy team of the TCU are part of our acute hospital nursing service. The medical model is a unique hybrid with a local general practice providing day-to-day medical input supported by the consultant geriatricians from the acute hospital. Active daily discharge planning and creating links with community is a primary goal of the TCU. There is a weekly multidisciplinary meeting including the GPs and geriatricians with the unit team.

**Aim:** Our TCU was developed to support the smooth flow of patients with complex discharge needs from the acute hospital back to home in a safe and timely manner. The goal of the TCU is to reduce the patients' stay in acute care and provide effective discharge planning.

**Targeted population:** The TCU is designed to care for patients who no longer require active acute hospital facilities but are not yet ready to discharge directly home. Patients requiring multidisciplinary assessment, a short reablement programme or social care set-up before discharge are suitable. All patients come directly from our acute hospital.

**Highlights:** The TCU opened in September 2016 after nine-months of planning and refurbishment. The TCU is now admitting about 50 patients per month with an average length

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of stay of 9.1 days. The identification of appropriate patients for the TCU is sustained by a daily "discharge support meeting" and senior staff assessment in the acute hospital. The TCU has developed increasingly close links with other community discharge support services

**Discussion & Conclusions:** Our TCU has been successfully opened and is achieving its goals. Successful discharge involves far more than a move from hospital to home. Appropriate discharge planning emphasises patient support and communication. Success and sustainability of the TCU is possible with a dynamic nursing and therapy team. Acute hospital identification and assessment of appropriate patients is vital for the TCU. The hybrid model of medical care has been a positive innovation that could be replicated elsewhere.

**Lessons learned:**

Social & non-clinical problems are often involved in complex discharges

Discharge planning is not started early enough in acute hospitals

Communication and information transfer between acute wards and TCU is critical

Complex operational issues emerge in organising and running an off-site unit

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**Keywords:** discharge planning; transitional care; frailty; reablement; multidisciplinary team

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