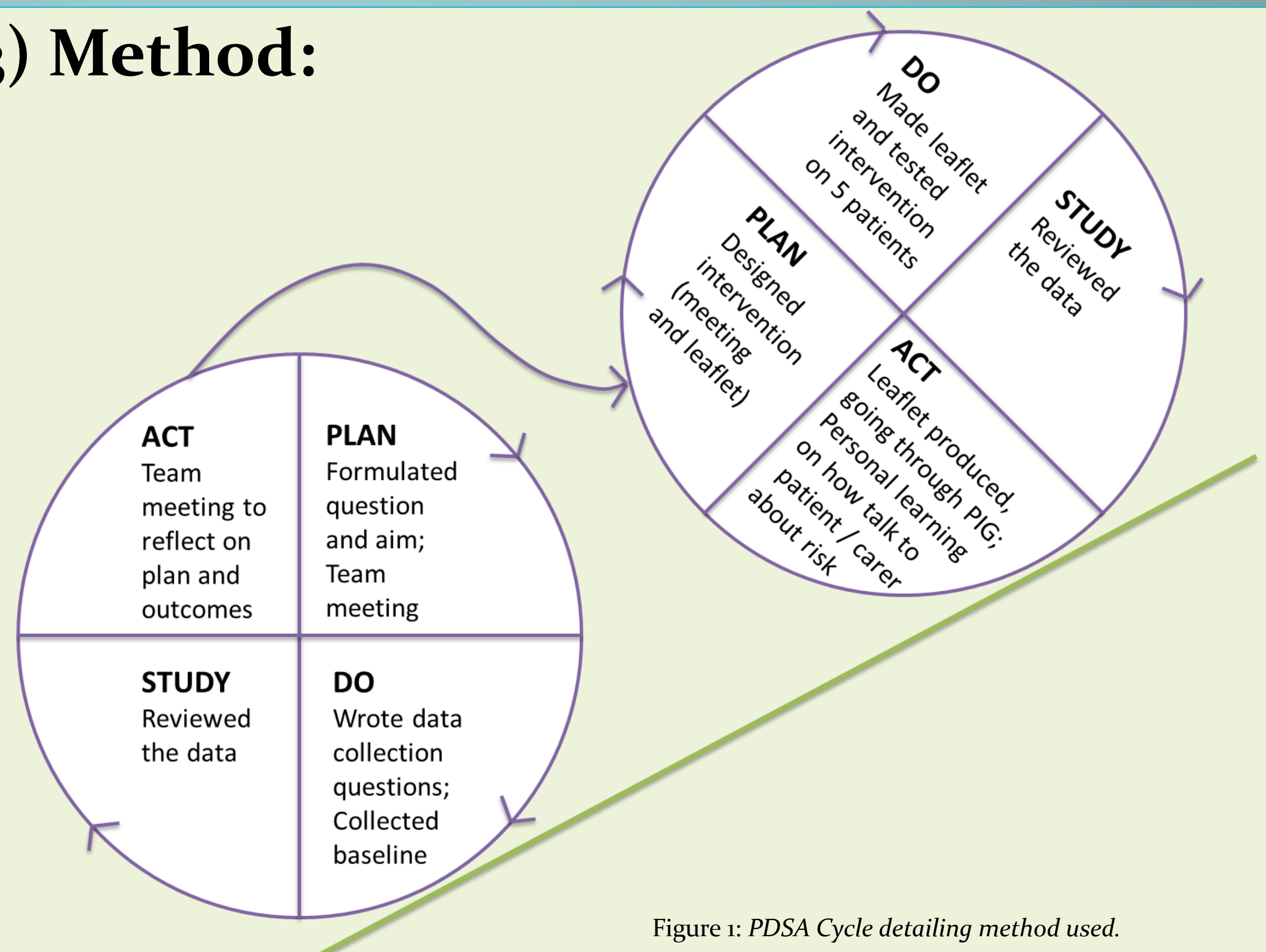# Contingency Planning: A Discharge Planning Pilot.

1) Aim:

To support people with Frailty and their families/carers to plan for and minimise risk of deterioration, increased care needs and readmission to unplanned care services.

2) Background:

- 16 Bed Inpatient Rehabilitation unit, predominantly Older People, all with some frailty.
- Staff reported anecdotal experiences of patients who we supported to go home but had concerns about how they would cope despite care in place.
- Current local discharge planning policies and standards advocate patient and carer involvement.
- No current mention of planning for potential future needs or risks as part of hospital discharge planning.

3) Method:

ACT Team meeting to reflect on plan and outcomes

PLAN Formulated question and aim; Team meeting

STUDY Reviewed the data

DO Wrote data collection questions; Collected baseline

DO Made leaflet and tested intervention on 5 patients

STUDY Reviewed the data

PLAN Designed intervention (meeting and leaflet)

ACT Leaflet produced going through PIG; Personal learning on how talk to patient / carer about risk

Figure 1: *PDSA Cycle detailing method used.*

4) Results:

Figure 2. *Chart detailing results of recall of discussions about risks.*

- 5 patients involved in pilot though unable to obtain data from one.
- **No patients recalled risk discussions, though their carers did and felt there was nothing else we could have added.**
- Patients reported feeling less involved than the pre pilot group reported, though all the carers reported feeling very involved.
- All received information, though none reported receiving written info, or not reading it if they did.
- Of those surveyed, one reported a need to increase their care and 2 reported some anxiety about managing.
- Self reported quality of life varied considerably, though majority didn't feel more socially isolated since discharge.

5) Discussion:

- Discharge planning was inclusive and effective.
- Few reported receiving written media, this may be because it was often amongst other discharge paperwork and not highlighted to people.
- Patients denied discussions surrounding risks, this may be due to their priority being on plans for discharge. Carers more able to retain risk discussions.
- No change in adverse outcomes, though outcomes likely due to different circumstances and individuals.
- After the intervention Carers were more forthcoming with suggestions for improvements.

6) What did I learn?

- It's never too late to improve a service
- Understand the Question!
- Generic information is of little use and relevance.

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