TRANSITIONING A PATIENT FROM HOSPITAL TO HOME

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It is vital to have a good transition from hospital to home to prevent prolonged hospital stays and to prevent hospital readmission, which will save both money and discomfort for patients. This article discusses what's involved in the process of transition and provides best practice solutions, along with two example scenarios.

The two overarching principles to facilitate an effective transition from hospital to home are person-centred care and communication (including information sharing).[1] Decisions should always be in the patient's best interests and with the most efficient use of NHS resources, and when they are discharged, patients (who have capacity) should be involved in the discussions about their care. Families/carers should also be included in discussions about the future discharge home.

Good communication between the acute team, the community team and within the multidisciplinary team (MDT) is vital for successful and safe hospital discharges. This process begins with coordination by the MDT from the start of the admission. This is probably likely to be a virtual MDT meeting and all the professionals along with the patient should come up with an agreed plan. If social care is needed following discharge from hospital, this should be applied for as soon as possible, eg, a package of care at home or a care home placement (see Figure 1 overleaf).

Dietitians are involved for various reasons, mainly for those who need nutritional support following surgery or treatment for cancer or other diseases that put patients at risk of malnutrition. Dietitians are involved with patients who are newly diagnosed with diabetes, those who have started on insulin and those who have had a myocardial infarction. The patients who need the dietitian most are those who cannot meet their nutritional needs without artificial feeding via total parenteral nutrition (TPN) or tube feeding. The dietitian's next priority is the patient who needs supplements or food fortification advice and who has never been assessed for malnutrition. This group needs to be referred to the dietitian while in hospital, and those who are already known before admission can continue to be reviewed by the community dietitian.

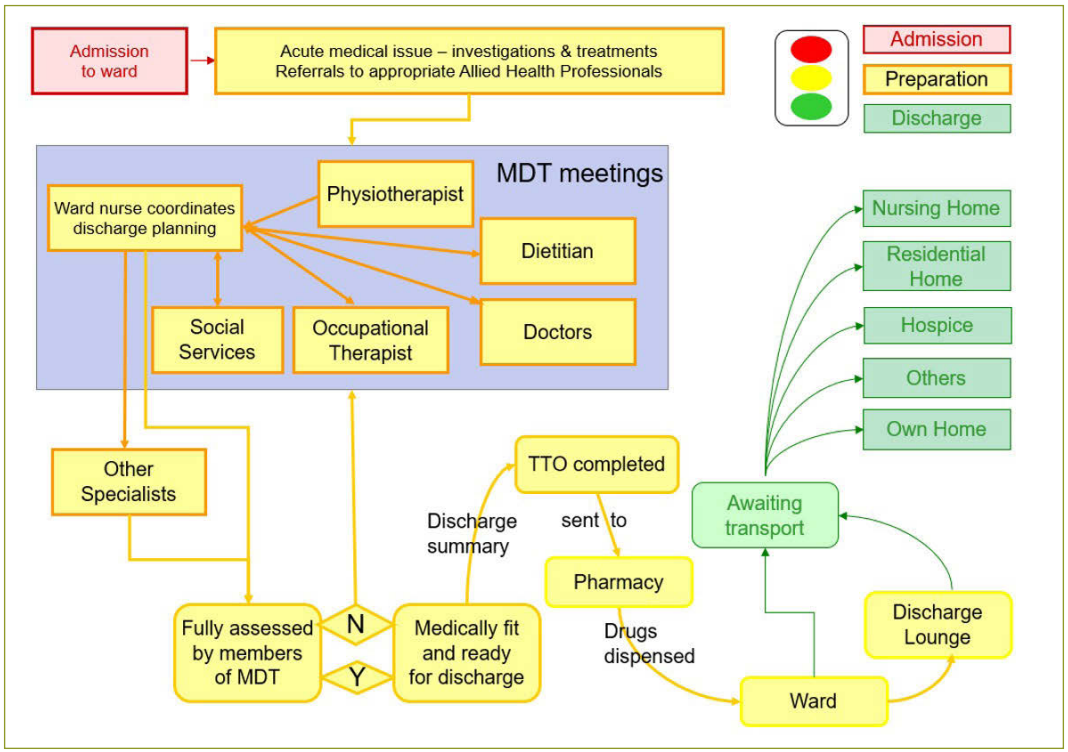
The MDT (see Figure 1 overleaf) should be involved early on in the discharge planning. Having a system that all healthcare professionals can have access to, so they can read and write notes, is the ideal. Unfortunately, such a system is not available throughout the UK. Having one would keep all stakeholders on the same page.

The medications also need to be prepared for discharge and the patient and GP should be clear about the short-term and long-term medication (on repeat prescription). Supplements sometimes prescribed by ward doctors should be short-term

REFERENCES

Please visit: www.NHDmag.co.uk/article-references.html

Figure 1: The hospital discharge process (courtesy of Dr Liang-Kim Ong)



and should not be on repeat prescription. However, if prescribed, it should be reviewed within a few weeks after discharge, ideally by the dietitian. Although dietitians write to GPs asking them to review supplements, this is rarely done in practice by the GPs. If there is no dietitian involvement in hospital, a first-line dietary advice sheet (with the dietitian department's contact details) should be given to arrange an opt-in appointment some weeks after discharge.

It is important to identify and support those who may be less able to access services and a telephone or video call may be better than a face-to-face community clinic or hospital outpatients. Sometimes a home visit may be needed initially too, particularly for those with poor mobility or who don't have their own transport.

If there is no dietitian review protocol, some patients end up being on supplements unnecessarily for months or years (a few become overweight and then need to lose weight) and some have supplements left unused. In both cases, this is a waste of NHS money. If they are not seen and need nutrition support, patients will deteriorate physically and mentally, leading to worse outcomes in terms of quality and quantity of life.

SOLUTIONS

A protocol should be agreed upon by all stakeholders locally regarding the transfer from the hospital dietitian to the community dietitian. This is particularly important if the patient was prescribed supplements or if they were referred whilst in hospital but not assessed by the ward dietitian.

Another possible solution is to have a section on dietary assessment in the discharge form or a letter so that the GP knows if a dietitian referral has been done or needs to be done. There is a shortage of dietitians, so it is fine for nursing staff to fill this in with the most recent weight and height measurements or nutritional screening assessment (oral intake).

CASE SCENARIOS

I would like to discuss two scenarios of patients who dietitians would likely be involved with. I talk about adults here, but both scenarios could equally be applied to paediatric patients.

1 A home enteral feeding patient – a tube-fed patient who has had a stroke and has dysphagia

The feeding regimen needs to be tailored to where and who will be looking after this patient in the community. If it is in their own home with an able and willing partner, then the carer needs to be trained to set up the feed confidently and look after the feeding tube. They need to know where they can get support if things go wrong and be introduced to the home enteral feeding nurse or at least given their contact details and the nutrition company's helpline. The acute dietitian also needs to order the feed and feeding ancillaries (enough for at least one to two weeks) for home as soon as a feeding regimen for home has been decided upon.

It would be helpful if the hospital dietitian sends a feeding regimen suited for home, discussing it with the carer and the patient and offering the options of pump or bolus feeding. Pump feeding doesn't always work as well at home when there are no nurses, so it is a good idea to propose bolus feeding if appropriate. Where possible, volumes of feed should be rounded to the nearest bag of feed to prevent wastage.

It's good to explain that it can always be altered (and there is flexibility regarding timings within 24 hours), reviewed and followed up with a community dietitian within two weeks. Details about the regimen and written instructions about the feed, including timings of water flushes and care of the tube, need to be given.

A discharge checklist for the discharging dietitian can be given to the nurse/patient on the ward, so they know what they are to take home from the hospital, what they will get from the community nursing team and what will be sent by the nutrition company to their home after discharge.

The patient needs to have contact details for both the dietitian who will be following up and the nutrition nurse, plus the number for the 24-hour helpline. They need to know who to contact for issues with the tube and issues with the feed and when they will be reviewed.

2 Oral nutrition support patient

If a patient is eating orally, dietary advice and written information for home must be given to the patient and carers before they go home. If they had oral nutritional supplements in hospital, it should be explained that they are neither meal replacements nor a long-term solution, but that they should be taken in between meals or after food.

The patient will ideally have a dietitian review three to four weeks after discharge, as this is when patients get used to being at home and usually start to eat better if their health is improving. If they have a condition that is not likely to get better, like a chronic disease, cancer or a neurological condition, then they need the right advice and, ideally, written information. If they have not seen a dietitian, they could be given first-line advice for home, a leaflet about the 'role of the dietitian', and then asked to opt in to a telephone/video clinic in case they no longer need or want it once discharged. The dietitian must always take into account the social situation of the patient at home (before and after discharge) and address the barriers to good nutrition from the first assessment.

CONCLUSION

All the staff caring for the patient taking the long view together makes for a successful discharge. This can be helped by understanding the process in both the acute and community settings (all students and qualified staff should have the chance to work in both settings) to truly understand it or, if not, they should familiarise themselves with the systems. Constructive feedback following discharge could help both sides too. Having both acute and community dietitians in the same NHS trust helps, but the key to success is good communication between the acute and community teams.