# Discharge to Recover and Assess: *Home First*

## SUMMARY

### Key messages

Queensland's public hospitals are facing significant capacity pressures, with reduced acute bed availability and discharge delays for patients who no longer require acute hospital care. These discharge delays are a complex, multifactorial issue, making timely transition out of hospital challenging.

Discharge to Recover and Assess (D2RA) is a patient-centred model that supports safe discharge home as soon as a patient is clinically ready, with recovery and longer-term care needs assessed in the community.

Evidence shows patients prefer to recover at home, achieve better outcomes and independence and have fewer complications.[1-4] When supported with high-quality home-based care, patients have a shorter hospital length of stay, reduced unnecessary re-admissions and this frees up critical bed capacity for incoming acute patients.[4,7-9]

This guide aims to introduce D2RA and a culture of "Home First", challenging organisations to reframe the language and default settings of care, placing home as the preferred and expected destination for recovery wherever safe and appropriate.

# What is Discharge to Recover and Assess (D2RA)?

For more information on D2RA, including the principles, foundations, pathways and discharge coordination hubs, please see the long-form document. A brief summary can be found in Figure 1.

This model provides guiding principles and practical operational foundational components to enable a "Home First" approach. It also provides the language to describe different pathways of care and a reframing of how we manage discharge coordination in Queensland.

## What are the benefits of D2RA?

A core component of D2RA is the "Home First" approach. This approach prioritises discharging patients to their own home – wherever safe and appropriate – as the default pathway.

Evidence shows:

- people not only prefer to recover at home, but also achieve better outcomes in familiar, supportive environments[1-4]
- assessments for ongoing care needs are more accurate when done at home rather than in hospital[5-7]
- high-quality home-based care services can not only improve patient outcomes and independence but also shorten length of stay, prevent unnecessary readmissions, lower the risk of hospital-acquired complications such as infections, falls and loss of physical and cognitive function.[4,7-9]

It also frees up critical bed capacity for incoming patients requiring acute medical care and can reduce costs to the HHSs.[4,8-9]

## D2RA core components

### Patients should only stay in hospital while they are requiring acute care

Patients should only remain in an acute hospital whilst they are receiving treatment that cannot be delivered in any other setting.

To stay longer than this may have a detrimental effect on the patient and deny others access to care.

### Assessments of long-term needs should not be made in acute hospital

Assessments of long-term or ongoing care and support needs should not be made in an acute hospital.

Such assessments will not fully reflect the abilities of patients and may well lead to the overprescription of care and support.

### Home as default discharge location

Home (or usual residence) should always be the first option on discharge.

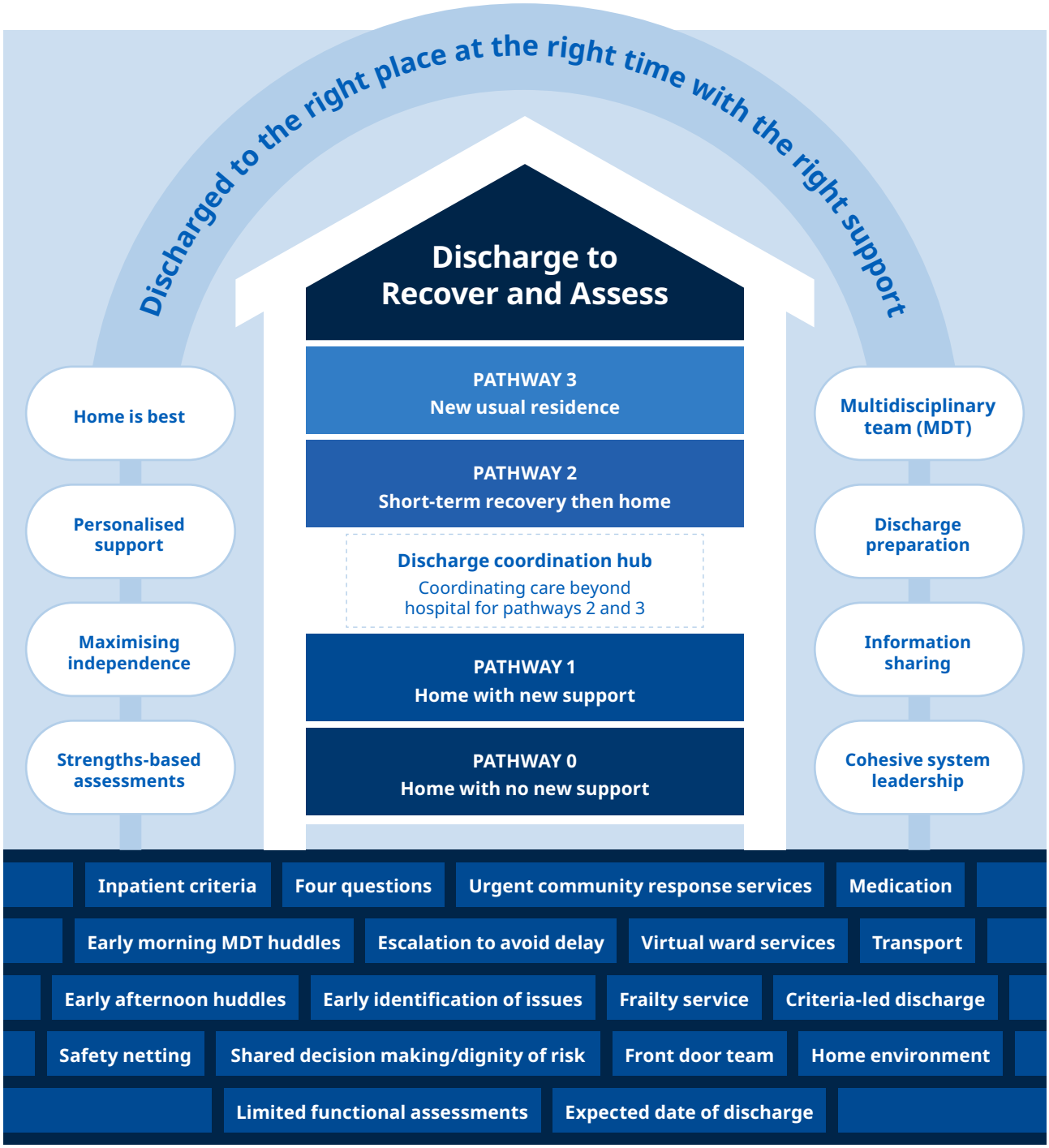
### Post-discharge support

A time-limited period of therapy, care and support, should be provided to those who need it on discharge.

This should help patients maximise their independence and meet their personal goals.

# Overview of guiding principles and foundations

**Figure 1:** Discharge to Recover and Assess



# Foundations

The foundational building blocks in Figure 1 support a practical approach to D2RA and form a framework that enhances patient flow and improves the patient experience.

## Inpatient criteria

Every acute patient should ideally be reviewed on a twice-daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made.

| |
|---|
| Requiring Intensive Care Unit or High Dependency Unit care? ✓ |
| Requiring oxygen therapy/non-invasive ventilation (that cannot be provided at home)? ✓ |
| Requiring intravenous fluid? ✓ |
| QADDS >2 (Queensland Adult Deterioration Detection System) ✓ |
| Diminished level of consciousness where recovery is realistic? ✓ |
| Acute functional impairment in excess of home or community care provision? ✓ |
| Last hours of life? ✓ |
| Requiring intravenous medication (including analgesia) > twice daily or that cannot be delivered through an infusion device? ✓ |
| Within 24 hours of an invasive procedure (where there is risk of acute life-threatening deterioration)? ✓ |
| Clinical exception? Must be warranted and justified. Recording of the rational will assist meaningful, time-efficient review. ✓ |

Consider the following questions to guide the clinical team's review and support effective decision making.

- Is the patient medically optimised? Avoid phrases like 'back to baseline' or 'medically fit'.
- What management can be continued as ambulatory or outside the hospital? I.e. heart failure treatment or Hospital in the Home (HITH) for IV antibiotics.
- For persons with low QADDS scores – can they be discharged with suitable follow-up?
  - Can their oxygen needs be met at home?
  - They are stable and don't need frequent observations (i.e. every 4 hours).
  - They don't require any medical or nursing care after 8pm.

## Look for alternatives

- If they are waiting for results, can they come back, or can you call them?
- Can any repeat bloods be done after discharge in an alternative setting?
- Can patients awaiting investigations go home and come back as an outpatient (with the same wait time as inpatients)?

# Pathways and discharge coordination hubs

## Pathways

HHSs may consider adopting the 4 discharge pathways as a consistent way to categorise patients and to guide how they are identified, planned for, and supported as they transition from hospital.

HHSs may consider implementing a discharge coordination hub that assists the flow of patients on pathways 2 and 3. Please see the long-form document for more information.