The effect social history taking mechanisms on discharge planning for adult patients admitted to the medical unit: A Service Evaluation.

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Background: With the escalating demands on the National Health Service (NHS) patient flow and early discharge planning are significant pressures. Studies suggest the medical profession leave discharge planning to nurses and rarely get involved (Burley, 2011; Graham et al. 2013) and social history is often reduced to three hurried questions limited to smoking, alcohol and drug use, usually attached on at the end of the medical interview (Anderson and Schiedermayer, 2010, Alex et al. 2013, Ingles and Burns,2015).

Aim: To explore how thoroughly the social history (SH) is completed and whether a detailed social history helps to expedite early discharge planning

Methodology and Methods: A quantitative methodological approach, using a service evaluation design that judged the quality of the current service by generating results to inform local decision-making (Twycross and Shorten, 2014; Thomas, 2009). Retrospective data collection eliminated the chances of bias. Social history documentation for patients who were admitted to an acute medical unit within the timeframes August- September 2015 (historical documentation framework) and August-September 2016 (current documentation framework) were included in the convenience sample. The sample size was calculated to represent a 95% confidence level with a +/- 5% confidence interval, one third of the population sample would be 217 rounded up to 220. The two timeframes compared two styles of SH documentation used in the Trust, tick box and free text. SH documentation was gathered from every 5th,7th, and 10th patient from the list of admissions over two months (n=220). Exclusion factors: Social history from independent young ambulatory patients aged 18-30 years

Social History Documentation

SOCIAL HISTORY Tick-Box (Year 2015)			
Is patient usually fully independent, mobile& self-caring? YES or NO			
Section A Admitted from: Own Home House Bungalow D/S flat U/S flat Sheltered Residential home Nursing home Community hospital	Home Support: Living alone With someone With carer Home care package Details of package	Usual Mobility: Able to do own shopping Able to get out of home but can't shop Housebound If so who helps? Driver Yes No	Walking Aids: None One aid Two aids Frame Wheelchair Bedbound Help to walk? Fall in 12 months Y/N If Yes, how many? Context of fall?
Smoking history: Never Ex-smoker Current What do you smoke? How many/ day? How long? Pack years? Advice given?	Alcohol Use: How many Units do you drink in a typical week? What do you drink? C A G E (circle) If >30 Units, complete 'AUDIT' and 'CIWA' assessments		
OCCUPATIONAL HISTORY (& Environmental Factors):			
FAMILY HISTORY: None relevant			

Fig.1 SH document used in 2015 (Tick-Box)

SOCIAL HISTORY Free- text (Year 2016)
Living arrangements:
Mobility:
Falls history:
Driver: YES NO
Smoking: Never Current Ex Pack years
Alcohol Intake Units per week?
FAMILY HISTORY

FIG.2 SH document used in 2016 (Free Text)

Fig. 1 & 2 demonstrate the format for taking SH and the extent of documentation required. Fig. 1 is 'Tick Box' style including occupational history. Fig. 2 is 'Free Text' style. SH has often been reduced to T.E.D. tobacco, ethanol and drugs status, but social history should have the same importance as disease history. Fig. 3 demonstrates a % of enquiry and lack of asking SH questions.

Results

SH	Year 2015		Year 2016	
Variable (n=220)	Yes (asked)	No (not asked)	Yes (asked)	No (not asked)
Accommodation	54 (24.5%)	166 (75.5%)	41 (18.7%)	179 (81.4%)
Accommodation	174 (79.1%)	46 (20.9%)		
Admitted From	20 (9.1%)	200 (90.9%)	74 (33.6%)	146 (66.4%)
Living circumstances	189 (85.9%)	31 (14.1%)	141 (64.1%)	79 (35.9%)
Home support	114 (51.8%)	106 (48.2%)	46 (20.9%)	174 (79.1%)
Social Skills	151 (68.6%)	69 (31.4%)	16 (7.3%)	204 (92.7%)
Driving history	62 (28.2%)	158 (71.8%)	103 (46.8%)	117 (53.2%)
Mobility	150 (68.2%)	70 (31.8%)	84 (38.2%)	136 (61.8%)
Aids	72 (32.7%)	148 (67.3%)	59 (26.8%)	161 (73.2%)
Wheelchair User	13 (5.9%)	207 (94.1%)	10 (4.5%)	210 (95.5%)
Falls History	65 (29.5%)	155 (70.5%)	82 (37.2%)	138 (62.7%)
Details of falls	11 (5.0%)	209 (95%)	17 (7.7%)	203 (92.3%)
Smoking status	183 (83.2%)	37 (16.8%)	156 (70.9%)	64 (29.1%)
Smoked/day?	189 (85.9%)	31 (14.1%)	103 (46.9%)	117 (53.2%)
Pack year History	164 (74.5%)	56 (25.5%)	120 (54.6%)	100 (45.5%)
Alcohol Use	163 (74%)	57 (26%)	138 (62.7%)	82 (37.3%)
Occupation History	91 (41.4%)	129 (58.6%)	16 (7.3%)	204 (92.7%)
Family history	131(59.5%)	89 (40.5%)	91 (41.3%)	129 (58.6%)

Fig.3 Analysis table of SH questions

Fig. 3 details the variables for SH documentation. All variables depict a list of SH questions taken from the medical clerking documentation for years 2015 and 2016. It identifies the SH questions that are asked or not asked on admission. The SH documentation for year 2015 contained 'tick box' questions and the documentation for year 2016 were headings only to allow for free text to be added, except for smoking history which were also tick boxes. Even with tick boxes to prompt clinicians, it does not guarantee that it will be asked or filled in on admission. Interestingly, enquiry about 'FALLS' and 'Driving' showed an increase in 2016 which emphasised the use of 'tick-box' documentation. Home support is important SH information, if a Package of care is to continue then details are required for the nursing staff to contact the agency and keep them informed of the patient's expected day of discharge so that carers can be reinstated. These details are important for PT/OT therapy assessments and ultimately for discharge planning. In 2015 family were the main home support, However in 2016, 174/220 were not asked about their support at home on admission.

Conclusion:

Clinicians are not exploring the SH at the time of admission, however a tick-box presentation was more likely to be used in comparison to a free-text section for SH. The data has not fully supported the implication that a detailed SH would impact on discharge planning , this requires further data to look at discharge documents and correlate SH and discharge planning, time lines from admission to discharge. More patients were seen in 2015 period and yet patients were staying in hospital longer in 2016 with less numbers clerked. Further data was required to identify the reasons for longer length of hospitalisation and this was not captured with the data collection tool. This was a limitation of the project and requires further research.

Implications of inadequate SH:

- Delayed discharge – re-instatement of POC
- Muscle wastage –reduced mobility- PJ Paralysis (10days in bed =10yr of muscle wastage)
- Extended recovery (7 day in bed, leads to 10% loss of strength in the elderly)(Yale University 2004)
- Prone to more infections- MRSA, HAP, CAIs
- Failed discharge- readmission within 30 days
- Delayed information for MDT decisions

Length of Stay: Gender distribution was fairly equal for both timescales, however data show an increase in length of stay during 2016, but it is not evident if this was due to poor discharge planning, secondary to lack of SH documentation on admission. Equally reasons for length of stay such as waiting on social services and for Nursing Home placements would need to be explored.

	2015		2016	
Length of stay	Female	Male	Female	Male
1-2 days	33	40	31	21
3-5 days	15	18	15	13
6-10 days	12	9	13	21
11-15 days	8	7	14	22
16-20 days	3	9	10	13
21- 50 days	10	10	12	17
More than 50 days	30	11	9	9
(n=220)	114	106	104	116

Fig.4 Length of stay

Recommendations:

- Focus on SH and reasons for length of stay either an Audit or Service Evaluation
- To review the current SH format and questions
- Use PT / OT questionnaire to aid SH taking
- Discuss with ED to start discharge planning in ED, e.g. POC contact Nos, Pre-empt transport arrangements with family, and fill in Nursing Front sheet in ED.
- Recommend having permanent PT / OT in ED to take SH for functional state with family members
- End PJ Paralysis (NHS England 2016) even in ED
- Finally, it is everyone's responsibility , to see, treat & discharge our patients in a SAFE and timely environment

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