HOSPITAL DISCHARGE AND BLAYLOCK RISK ASSESSMENT SCREENING SCORE, OPERATIONAL MODEL FOR CONTINUITY OF CARE

OBSERVATIONAL STUDY

Stefania Tinti[1], Rosalia Spatola[2], Marina Verga[3], Annalisa Alberti[4], Anne Lucia Leona Destrebecq[5]

1. 1. PhD student Department of Biomedicine and Prevention, University of Rome Tor Vergata, Rome, Italy - University of Milan, Milan, Italy - ASST-Rhodense, Garbagnate Milanese, Milan, Italy; 2. RN University of Milan, Milan, Italy - ASST-Rhodense, Garbagnate Milanese, Milan, Italy; 3. MSc University of Milan, Milan, Italy - ASST-Rhodense, Garbagnate Milanese, Milan, Italy; 4. MSc University of Milan, Milan, Italy - ASST-Rhodense, Garbagnate Milanese, Milan, Italy; 5. Associate Professor of Nursing, Department of Biomedical Sciences for Health, University of Milan, Milan, Italy.
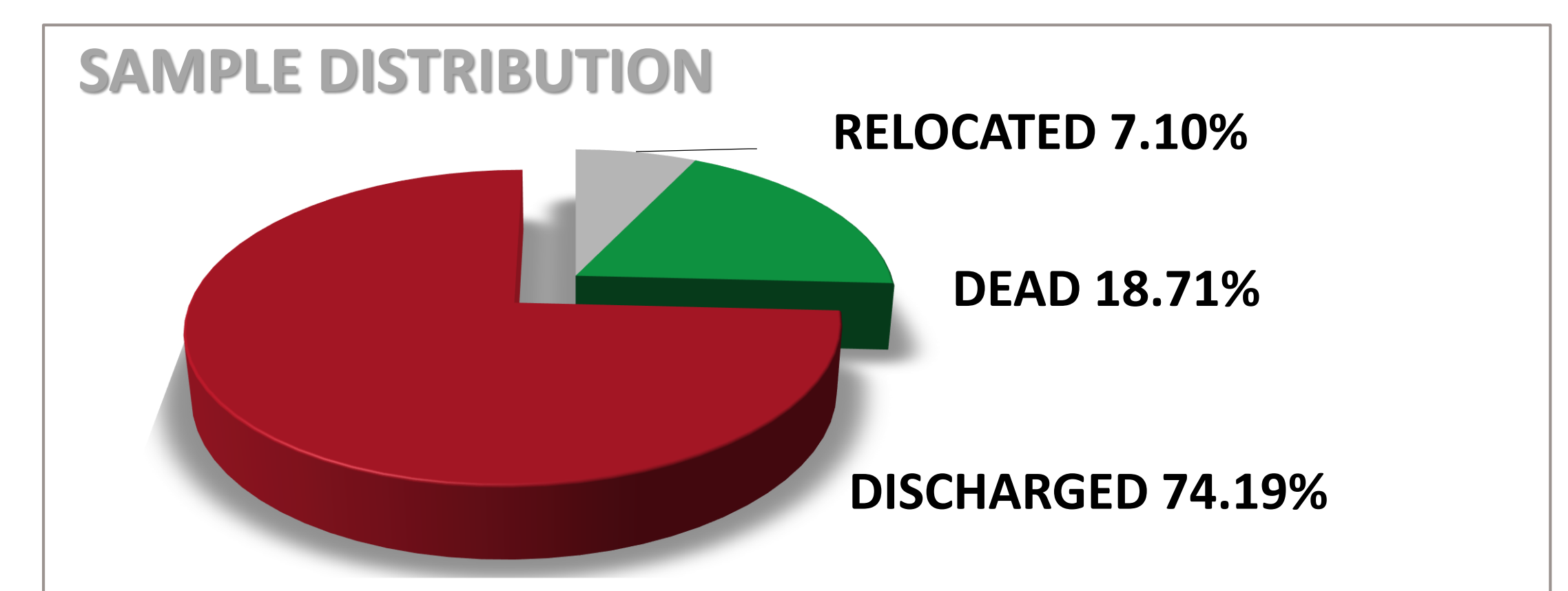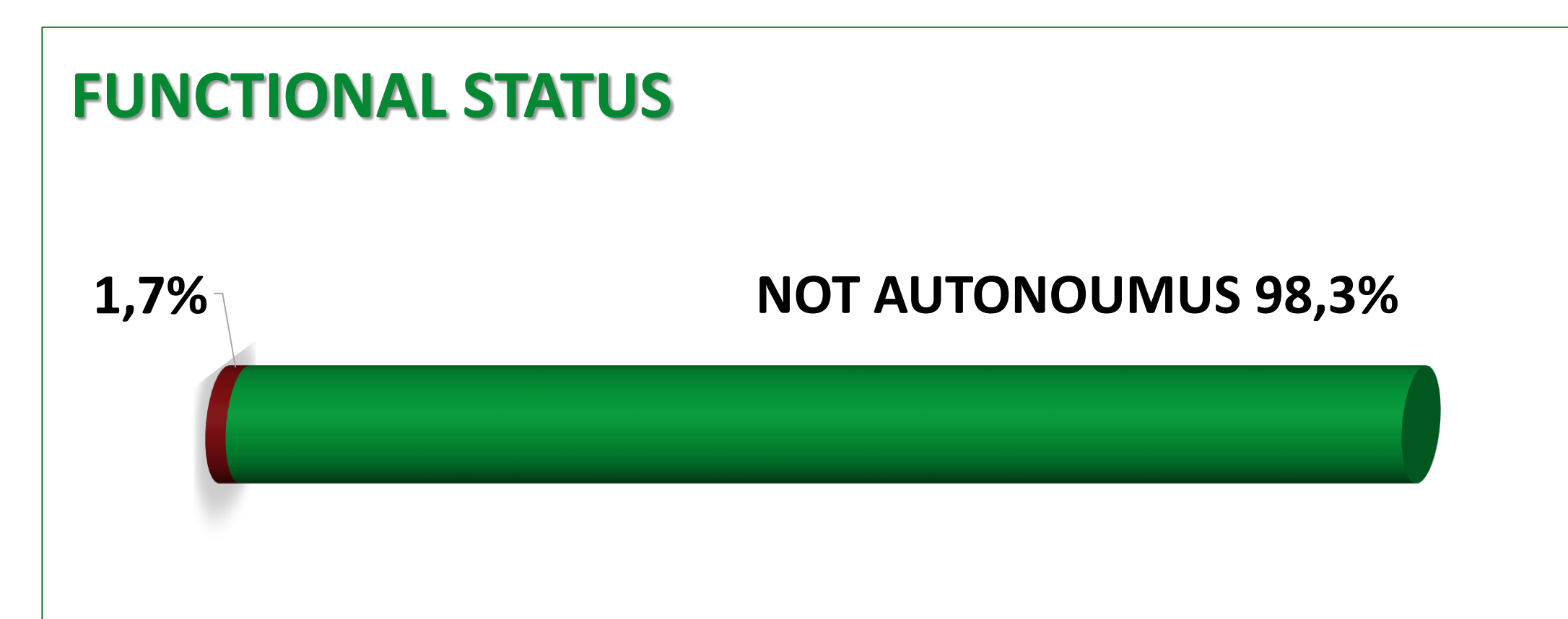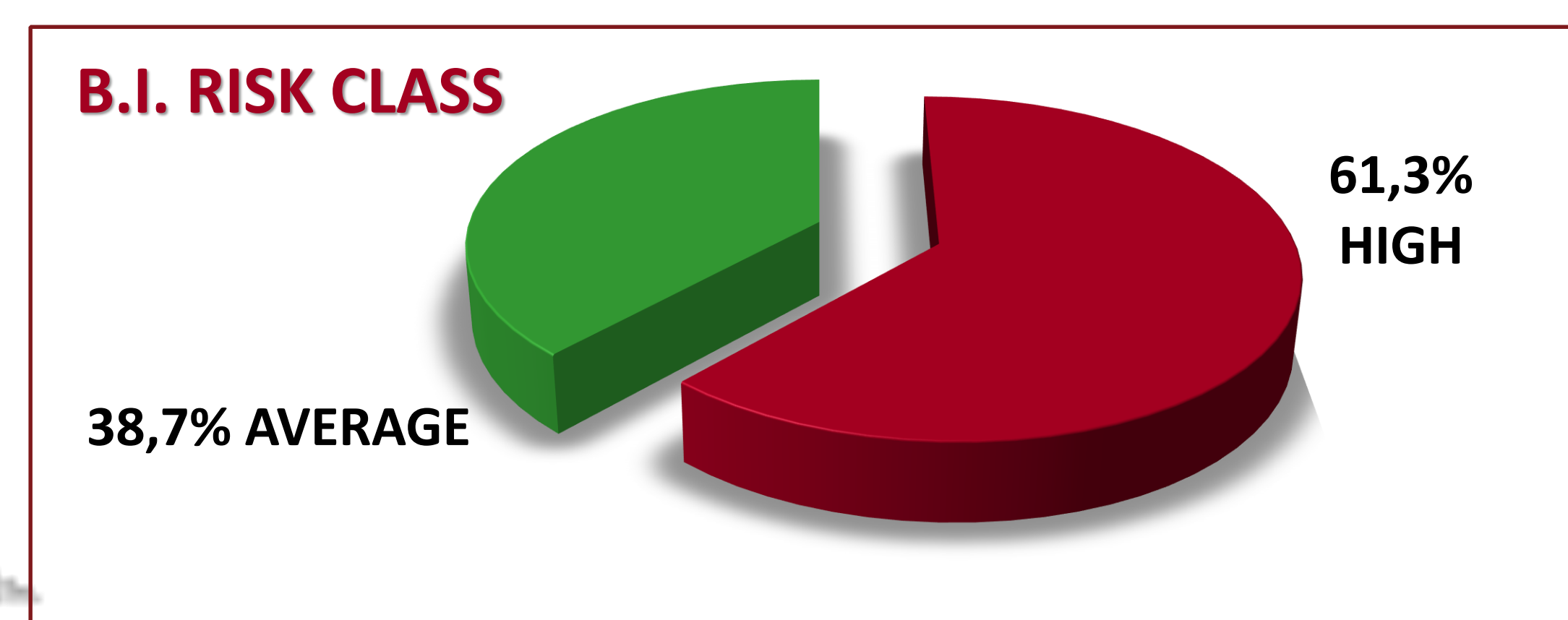
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Introduction: Chronic diseases are the main cause of morbidity and mortality in developed countries. In the last 10 years, the population aged over 85 has doubled and chronic diseases have a clear social impact in terms of severity, prevalence and cost. In Europe, chronic diseases are estimated to be responsible for 86% of all deaths. The average life expectancy of men is estimated to reach 83.6 by years; for women, to 88.8 years. This increase, places Italy at the top of the list of countries of the European Union. People hospitalised with complex discharge pathways due to clinical and/or social criticality may be affected by neoplasms, strokes, heart failure, COPD, diabetes, dementia, terminally ill. Difficult discharge is understood as continuity of care, together with the need for economic, human and organizational resources that go beyond the possibilities of the patient and his family. It involves professionals and services. Discharge must be planned and should begin immediately after hospitalisation or as soon as the patient has passed the critical or acute phase. A structured and individualized program for the discharge of the patient is associated with a reduction of the average stay, the number of re-hospitalisations and a greater satisfaction of the patient himself (discharge planning).[1] The BRASS (Blaylock Risk Assessment Screening Score) index (B.I.) predicts the risk of prolonged hospitalisation and difficult discharge.

Purpose: To assess the effectiveness of B.I. in screening patients at risk of difficult discharge, with particular reference to age, length of stay, compliance with corporate application criteria, activation of protected discharge.

Methods: **Observational Study. Setting:** Medicine. **Data collection**: consultation of health documentation. **Tools**: B.I. and "*corporate procedure for planning protected hospital discharge*". **Inclusion criteria**: males and females (age > 18). **Brass score**: 11-19 (average risk), > 20 (high risk). **Exclusion criteria**: ongoing hospital stay at the end of data collection. The BRASS index is measured within 48 hours of admission and 72 hours before discharge and assesses ten dimensions (*Age, Living conditions, Functional and Cognitive status, Behavioural model, Mobility, Presence of sensory deficits, Number of previous admissions and/or accesses to the emergency room, Number of active clinical problems, Number of medications taken*). **Score**: 0-40; **Three risk classes**: 0-10 - Ordinary discharge for low-risk; 11-19 - Protected discharge at home for medium risk that require discharge planning; ≥ 20 - Protected discharge for high risk, requiring continuity of care in rehabilitation facilities or institutions or through home care. Descriptive statistical processing with Microsoft Excel 2016.

Results: **Sample**: 155 patients: 87 (56.13%) women, 68 (43.87 %) men. **Main diagnoses on admission**: respiratory conditions (16.8%), sepsis (16,14%), heart conditions (15.50%), neurological conditions (14.88%), haematological conditions (12.27%). The high BRASS index shows a higher number of days of hospitalisation (14.7 DS 6.88). The average age of the sample is 81.8 (median 84, DS 9.7). **Emphasis B.I. Items**: Cognitive status 53,9% disoriented; Mobility impairments 88,7%; Auditory and visual impairment 53,9%; Previous admissions and accesses to emergency rooms 49,6%; Active clinical problems > 3 (74,8%); drugs taken 92,1%. Full compliance with corporate procedures is achieved in 38.71% of cases.

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B.I. RISK CLASS
61,3% HIGH
38,7% AVERAGE

FUNCTIONAL STATUS
1,7%
NOT AUTONOUMUS 98,3%

SAMPLE DISTRIBUTION
RELOCATED 7.10%
DEAD 18.71%
DISCHARGED 74.19%

Conclusions: The study highlighted the consistency between the BRASS index score and the specific characteristics of the sample. The population considered is part of the fragility therefore it is necessary to prepare a discharge plan in order to ensure continuity of patient care. The highest percentage of the sample is in the highest age groups reported by the B.I. Within 48 hours of hospitalisation, more than half of the sample presents a "high" risk of difficult discharge. The patients with "high" risk of difficult discharge reported a higher hospital stay [2] and "high" risk patients presented 10 days of hospitalisation. The probability of difficult discharge and hospital mortality increases in proportion to the B.I. The "functional status" and mobility configures a dependent population for one or more activities of daily living therefore a serious framework of non-self-sufficiency and the need for continuous care. The company procedure is not fully adhered to; the 72-hour deadline for completion is on the day of resignation; this discrepancy is due to organisational procedures that have not yet been consolidated. **Limitations**: the short period of data collection, the recent introduction of the tool, the lack of comparison with homogeneous groups, the mortality of the sample.
Operational proposals: an observational study following the consolidation of organisational arrangements in the context considered; carry out a survey on the experience of nurses following the introduction of the tool and their role in the planning of discharge and health education.

Key references
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2-Dal Molin A, Gatta C, Derossi V, Guazzini A, Cocchieri A, Vellone E, Rasero L. (2014). Hospital discharge: Results from an Italian multicenter prospective study using blaylock risk assessment screening score. International Journal of Nursing Knowledge, 25(1), 14–21.