

Discharge Report

Executive Summary

A *Deep Dive* into patients' and carers' experience of being discharged from acute hospitals in West Sussex

August 2015





Our report, *Well Enough to Go Home?* highlighted some of the issues local patients faced when they were discharged from hospital.

For this report, we spoke to 71 patients in the Discharge Lounges and wards at Worthing and St. Richard’s Hospitals (June to July), and followed the story of 18 of these patients through in-depth interviews to explore in detail patients’ and carers’ experience of the discharge process.

This work was commissioned by West Sussex County Council, but was carried out independently by Healthwatch West Sussex, with the agreement of Western Sussex Hospitals NHS Foundation Trust.

Care was taken to conduct the research ethically and our work has undergone a quality assurance process. In order to protect their identities, some names and genders have been changed in the report.

Summary of findings

Overall, patients were pleased with the treatment they had received. Even when patients had a bad experience or things had not gone smoothly, most participants told us how grateful they were for their treatment, paying tribute to the staff who had cared for them.

For some, problems after discharge stemmed from a failure to diagnose and treat the condition for which they had come to hospital. This led to patients being readmitted or making little progress with their recovery in the weeks since leaving hospital.

We recommend

Trusts should consider including follow-up checks in the discharge plans of patients whose primary cause of admission has not been identified, to reduce the risk of readmission.

We recommend

Trusts should support physiotherapy and occupational therapist teams to adopt a consistent approach to post-discharge planning in line with the principles of the Care Act (e.g. promotes wellbeing, is person-centred, help prevents, reduces or delays the risk of readmission and reflects the person’s assets).

Therapy Support

Therapy was often most effective when it combined the therapist’s expertise and knowledge of the condition with the patient’s understanding of their own needs.

A few patients felt that assumptions about their capabilities had been made on the basis of something written in their medical notes. Although participants valued a holistic approach, they felt it was important to have the opportunity to talk through their own needs fully; this did not always happen.



Patients shared how there could be gaps in the physio and occupational therapy support. Some participants had been readmitted to hospital, and had stayed on a different ward. People were aware that the types of support differed between the wards, meaning it was possible to miss out on the support needed.

We recommend

Trusts should review the delivery of a therapy services in non-specialist wards to ensure patients are able to receive the appropriate advice and care both whilst in hospital and after discharge.

We recommend

Western Sussex Hospitals NHS Foundation Trust should carry out a root cause analysis of a sample of patients who acquire urinary or kidney problems as secondary conditions during their stay in hospital, and to examine whether the proportion of patients developing these issues is within the expected range.

Urinary and renal conditions

Four patients said they developed urinary or kidney problems as secondary conditions during their stay in hospital. We didn't look at any medical records during the study or determine whether the proportion of patients developing these issues was within the expected range. However, this issue does highlight some of the challenges which secondary conditions can create. Patients didn't feel these complications were always made clear to them promptly.

Supporting carers

From what relatives shared, it was clear some felt uncomfortable dealing with some of the caring tasks needed when the patients came home. Others had to carry out specific procedures but without receiving sufficient advice or training. Given the sensitive nature of the topic, some felt unable to ask for advice, and found it difficult to discuss this with the patient.

We recommend

Trusts should ensure that all carers receive appropriate training and support to enable them to provide the care required by the patient after discharge.

For some patients, the process of planning their discharge went smoothly. This appears to have been more likely where the admissions themselves were planned. Not every patient received such a careful assessment.

We recommend

Trusts should ensure that patients and carers are involved at all stages of discharge planning, and understand that this is a formal process.

Being involved in discharge planning

There is evidence that what patients perceived as mere conversation may actually have been staff asking questions to inform the discharge planning. Overall, people didn't have a sense that they felt they had engaged in a formal process of planning for their discharge.

On at least one day, it was not possible for a certain number of patients to be discharged from one ward, because packages of care could not be arranged.



Reliance on relatives

Some patients were highly reliant on a relative to make decisions about their discharge. Many were perfectly content to let this happen.

“Well... I haven’t had a lot to say with the doctors, because a lot of the time my son’s been with me ...because he is my carer... and so he usually explains to me...”
(Michael, Broken shoulder, Worthing)

Where family members are responsible for providing caring, it is important they are consulted and kept informed during the discharge planning. One relative had not been informed that the person they cared for was being discharged, and so was not present when they arrived home.

We recommend

Trusts should review their discharge processes to ensure carers’ situations are taken into consideration, to reduce the risk of patients being discharged without the appropriate support at home.

We recommend

Trusts should ensure that their discharge processes ensure a coordinated response for patients who are being treated for multiple conditions.

Where decisions about discharge involve information from several sources, the potential is introduced for delays to occur in sharing important details or for it to be unclear who the decision rests with.

Discharge planning could be especially complicated for patients with more than one condition, as a change or delay in any one of their treatments could affect the timescale.

Voluntary sector support

Several people mentioned they had used voluntary sector organisations: all were satisfied with the service they received. Only one person mentioned receiving help to resettle back at home on the day they were discharged. Although leaflets about this type of service were available on the wards, it usually required the ward staff to decide whether this would be useful for the patient or family. One member of staff felt more needed to be done to plug these services.

We recommend

Trusts and voluntary organisations offering support services should ensure that patients and carers consistently receive information which allows potential users of the services to understand their benefits. This could form part of the discharge checklist.

The day of discharge

Although some patients were discharged directly from the ward, many spent some time waiting in the Discharge Lounge. Patients who did not have to wait too long found these to be pleasant locations but many experienced a wait of at least several hours.

We recommend

Trusts should ensure that, wherever possible, patients being discharged alone have access to appropriate food (preferably a hot meal) before leaving the hospital.

Most patients were offered food in the Discharge Lounge, or had eaten lunch on the ward before moving on. While the need for food is obvious, patients who were returning to an empty house were especially concerned to have eaten well.



“I was worried I was going to have a hypo before I got home and the fact that I hadn’t even got a biscuit ... I did ask if anybody had got a biscuit, one of the other ladies said, ‘I’ve got some.’ [The staff] just seemed to be busy all the time, seeing people in, seeing people out...”

(Josephine, Ulcerative Colitis, Worthing)

We recommend

Trusts should ensure that patients who wait for longer than a few hours in Discharge Lounges can access food. This should include patients with specific dietary needs.

We recommend

Trusts should aim to ensure that drugs to be taken home are made available at the time of discharge, reducing the need for patients to wait for hours in the Discharge Lounge.

The most common cause of delay was patients having to wait for their medication. It was not uncommon for patients to wait around four hours to receive this. Some patients found they needed to ‘make a fuss’, threatening to leave without their medication or offering to come back the next day. Several participants reported that other patients had actually become fed up of waiting and left without their medication.

Dorothy waited in the Discharge Lounge from 11am but was told to arrange for her husband not to collect her until 3pm. When he came to pick her up, she still didn’t have her medication. She told the staff that if she couldn’t have her medication immediately, she’d like to be discharged without it. This made the staff rush around, someone went to collect her medications and she got it straight away.

(Dorothy, Suspected kidney stone, St. Richard’s)

Staff in the Discharge Lounges are active in fetching medication from the pharmacy, and talking through what was required to be taken when. Patients are issued with paperwork which details this, but it seemed that people could find this confusing; it appeared that some may not have remembered and understood everything they were told by the time they got home.

We recommend

Trusts should review the information provided about medications on discharge, to ensure it is as clear as possible for patients and their carers. This should include being able to identify each medication, as well as understanding what each one is for, when and how they should be taken, and any potential side-effects.

We recommend

Trusts should ensure that, wherever possible, patients are informed of any complications arising from their stay in hospital, such as allergic reactions to drugs.

Drug allergies

Several people had been allergic to a particular drug. One person hadn’t been informed she had suffered an allergic reaction to that drug.



Transport

Many patients had long waits for their transport to arrive. Others were forced to make alternative arrangements. Discussions with staff indicated that transport arrangements do not always appear to work as well as they could.

Some patients are surprised that they can only take one bag on patient transport, as they often have more than one with them.

Transport organisations are given a two-hour window ... but these are not always adhered to. This can cause difficulties if a patient has a package of care booked, such as a carer due at their home. In certain rural locations, bookings get pushed backwards because crews don't want to travel out to those locations in late evening so it gets reallocated. It gives a bad impression if the estimated arrival time keeps changing, and forces staff to stay beyond the end of their shift.

Worthing only has one Transport Coordinator while St. Richard's has two, although Worthing has more patients.

(Discussions with staff)

We recommend

Clinical Commissioning Groups should note and consider what patients and staff have shared about transport when commissioning transport services.

We recommend

Western Sussex Hospitals NHS Foundation Trust should review the transport co-ordinator arrangements and ensure there are appropriate arrangements for both Worthing Hospital and St. Richard's Hospital.

We recommend

Health and Social Care providers and stakeholders should examine how they can deliver a seamless transition of care between hospital and home, involving the patient, carers and family at all stages. Written information should be given to the patient detailing their expected care requirements and how these are to be met, with contact details should problems arise.

After discharge

Around half the participants received some form of care after leaving hospital, providing assistance with either medical or personal needs. This is in addition to care given by relatives.

The range of organisations and individuals can make it difficult to understand what role each should play, and to keep track of appointments and visits. Speaking to one patient and their carer, it was clear how easy it was to become confused and exacerbated by the similarity of some of the names of the services.

One person showed us a collection of paperwork and leaflets. Some of these were of faded photocopies of poor appearance. Others were several years' old, predating recent changes to the NHS, and therefore gave incorrect, out-of-date information.

We recommend

Providers should review their paperwork and leaflets to check legibility, accuracy and currency of the information being provided to patients. Where possible vague standard information should be replaced with information tailored to each patient.



The quality of information on some was also poor. Some leaflets were rather vague about what service the patient would actually receive. For this reason, a number of participants were more than a little unclear about what support they should be receiving.

We recommend

Providers should ensure that information giving details of ongoing treatment or appointments explains clearly what has been arranged and why.

We recommend

As part of their information, advice and guidance commissioning and legal requirements under the Care Act, West Sussex County Council should undertake to look at how people living alone (e.g. without informal carers support) can access and use information and advice to prevent, reduce or delay the need for additional admissions or support.

Our observations suggest that merely asking patients what support they need might not be sufficient to identify what is actually needed. Some patients would have benefited from help in understanding what equipment and assistance might be useful when they leave hospital. Other patients needed a persistent relative to persuade them to accept some extra help. This begs the question of who would perform this task for individuals who do not have someone to do this for them.

Funding and eligibility

Only a few participants made specific mention of funding. One person had considered putting in a claim for Attendance Allowance. She had been given the relevant contact information to make a claim while she was still in hospital. However, even several weeks later, she had not got round to arranging this. She appeared a little daunted by the prospect of applying.

“I think probably I have been entitled to it for a ... long time. But I don’t know how to go about getting it... I have never lived in a state like it is now all my life because things have gradually gone downhill and I just can’t keep up with [the housework] you know.”

(Mary, Knee replacement, St. Richard’s)

We recommend

Both Health and Social Care providers should ensure patients are informed that additional funding may be available to support them at home. They can be advised to seek support from Citizens Advice or Age UK to make an application.

We recommend

Western Sussex Hospitals NHS Foundation Trust should consider whether it can extend its programme of follow-up call to include as many patients as possible, checking patients’ progress and where necessary, taking steps to reduce the risk of readmissions.

Some patients received a follow-up phone call a few days after discharge, to check on their progress. This may have benefitted other patients who did not have any other form of follow-up arranged.



Delay in obtaining services

Several patients experienced delays in receiving their follow-up treatment, expressing concern that this may have affected their recovery.

Warren was referred to Bognor War Memorial Hospital for speech and language ...and was told it would be between 4-6 weeks following discharge. After this time had elapsed, he phoned to chase the referral and was told the speech therapist was going on holiday and his therapy would start when they returned... more than two months after his stroke.

(Warren, Stroke, St. Richard's)

We recommend

The West Sussex Clinical Commissioning Groups should review the commissioned pathways for patients accessing speech and language therapy as part of their stroke review.

We recommend

Local general practices should ensure their patients have access to up-to-date information about community transport options. Staff should assist patients to understand what support is available to help them get to/from the surgery.

Diane required her leg to be dressed each week ... A hospital doctor had tried to arrange a nurse to visit her to do this after discharge but was told by the GP surgery that they do not send nurses out to the house anymore. As it was too far to walk to the surgery, Diane paid for a taxi. This has ended up costing £40 per month, and has persisted for a number of months. She did raise this ... at the surgery but was told there was nothing they could do.

(Diane, Heart failure, St. Richard's)

Equipment

Numerous patients had been given items of equipment to support them once they left hospital. A few suggested that they were not using all the items but some did not seem to know how they could return them. Others had to wait for equipment to be installed in their homes, such as hand rails. This led to them remaining in hospital for longer than would otherwise have been required. Information about when this would happen did not always appear to be clearly communicated to the patient and hospital in advance.

Housing and accommodation

Several participants raised concerns that a housing association had been slow to make adaptations to their home. A common feature of these conversations was the person 'not wanting to make a fuss'. However, they had been left for many months without adaptations which were clearly necessary.

We recommend

Trusts should ensure that, where appropriate, a home assessment is undertaken to identify the steps necessary to make the home safe for the patient to be discharged.

Housing Associations and other organisations need to be aware of this tendency, and need to be more proactive in following up on requests of this type, particularly for residents who have serious health conditions.

One person was homeless at the time they were discharged from hospital. The hospital appeared to be aware of this fact, but was unable to do anything. However, it is surprising that it was not possible for something to have been put in place.



Evelyn's story

Evelyn was in a difficult situation regarding her care and housing, because her relationship with her husband appears to have broken down. She had multiple health conditions which led to her being severely restricted in a number of respects. Evelyn has received good support from Social Services and the Police, who have put precautions in place in case the husband becomes violent.

We recommend

The Safeguarding Adults Board should review 'Evelyn's case' to see what lessons can be learnt from this example.

However, the housing association does not seem to have taken into account the potential risk which Evelyn believes she faces, because the husband's condition has not been officially diagnosed.

Full details of the patients' and carers' discharge experience can be found on our website: www.healthwatchwestsussex.co.uk/what-were-doing under the Report tab.