



LINK Report: Hospital Discharge Event



April 2009

Hospital Discharge

1 Introduction

The Health and Wellbeing Sub Committee of North Tyneside Council's Overview and Scrutiny Committee approached LINK to ask for support in gathering patient and carer's experiences of hospital discharge to be used as evidence in their study on the hospital discharge process.

On 19th March we invited LINK members and members of the Community Network to an event in Wallsend where participants were:

- Encouraged to share their own hospital discharge stories including experiences of good and bad practice, and
- Asked to make suggestions for improving the discharge process.

This report summaries the information and discussions that took place on the day, using case studies as evidence (Section 2). Also included in this part of the report are patients' experiences captured by The Alzheimer's Society, who asked LINK to include their findings in our report. We go on (Section 3) to summarise a wide range of areas for improvement suggested by the LINK. Finally (Section 4) we set out the next steps for this part of our work.

2 Summary of findings

Both positive and negative hospital discharge experiences have been shared with LINK. However, several themes are apparent across the experiences. These are;

- lack of family/carer input
- problems caused by delayed discharge
- problems and confusion over follow up
- lack of involvement of the carers in the assessment of patient's ability to cope at home.
- poor coordination of services and communication between professionals and from professionals to carers and patients
- concerns about vulnerable patients

2.1 Family and carer input

Summary

Hospital staff and patients can make assumptions about the caring roles of relatives, who may have family/caring responsibilities elsewhere as well as employment commitments. Therefore families and carers need to be asked if support is needed and to be involved in discharge planning. There is also an expectation on carers and families to be able to administer medication without any support or information, or asking whether they are available at the necessary times.

It appears that many carers are unsure of their rights: What can you ask for? What can you not do? One LINK member commented;

“Very important for family/carer to have a voice, they are given all the responsibility, but none of the rights.”

Case Studies:

Several experiences have been shared with LINK that highlight the problems that can occur when a patient’s family or carers are not involved in the hospital discharge plan, or are not given adequate information by professionals at the hospital.

- Elderly patient taken in emergency, carer was herself unwell, but this was not taken into consideration. It was only good fortune that a neighbour was available to assist her discharge.

- Miss A was admitted to hospital with severe dehydration; both she and her mother have dementia. The family were initially told there was no hurry to discharge Miss A and therefore no hurry for the family to find a placement in a care home for her. They were then informed that she would be moved the following day to Stanton Lodge, giving the family little opportunity to visit. The family didn’t know anything about the place and whether it would meet their daughter’s needs. Miss A’s family had the following concerns;
 - No preparation/visits etc. for their daughter
 - The family did not have time to visit
 - Level of Supervision – would it be adequate? (she had been admitted to hospital with severe dehydration)
 - Could she take her belongings? etc
 - Can social workers and medical staff make these decisions without consultation?

Miss A was in fact subsequently moved from this placement as it did not meet her needs. This could have been avoided if her family had been consulted and involved in the discharge plan and given the opportunity to consider which care home would best meet her needs. (This information was provided by The Alzheimer’s Society).

- Mrs B was informed of her husband’s discharge to Princes Court by a member of staff passing her in the corridor. She thought her husband would be returning home. She rang The Alzheimer’s Society and was very upset; asking what Princes Court was, where it was and why her husband was going there. She felt this had been handled very insensitively and that little consideration had been

given to 55 years of marriage and that she had anticipated his return home. No-one had involved her in the decision making process or discussed with her whether or not her husband could return home. (This information was provided by The Alzheimer's Society).

- Miss C was very distressed regarding lack of consultation of her mother's transfer of care to Princes Court. She asked the Consultant if she could speak to a social worker, she was informed by the Consultant that she didn't need this. Miss C arrived one afternoon at the hospital to discover her mother waiting with her bags packed ready to go to Princes Court. Miss C hadn't been given the information about Princes Court nor had the opportunity to visit. Her mum's transfer of care did not happen that day. Both Miss C and her mother very upset about the situation. (This information was provided by The Alzheimer's Society).
- Miss D found out that her father was to be discharged from hospital, she was not informed of this directly and was not included in any discussions about the discharge procedure. She felt she could have provided vital information about her father which would have influenced his care package had she been consulted. (This information was provided by The Alzheimer's Society).

2.2 Delayed discharge

Summary

From our findings there appears to be two main reasons for delays in hospital discharge. These are to do with late arrival of medication from the hospital pharmacy and the coordination of patient transport services. This seems to result from a lack of forward planning and a lack of communication between the services involved (ward staff, pharmacy and the patient transport service). Delayed discharge can cause the patient and their carer further distress. LINK member's experiences included;

"Waiting for transport. No lunch, no meals if you're officially discharged but waiting around."

"Waiting hours of day for discharge with no meals/sat up on chair etc, people feel like a burden/a number. "

Case Studies

- Mrs E shared the experience of her knee replacement operation. With the first knee operation she experienced a speedy discharge. When she had her second knee operated on she was told that she could go home the next day by the Consultant. She had therefore arranged for her daughter to pick her up at 1pm. However, she was

not allowed to leave until 5 pm as she had to wait for her medicines to be ready from the pharmacy. This was also inconvenient for her daughter, who was caring for her young baby at the time.

“Why was this not organised to coincide with 1pm? Is this due to a lack of communication and disorganisation? Surely a speedy discharge is better for the hospital as it will free up the bed, so why the long wait? When you go in they take all your medications and re issue new ones before you leave. Why? This is time consuming and unnecessary.”

- Other patients had experience of waiting long hours for an ambulance to take them home. Another patient pointed out the problem of coordinating transport for follow up appointments.

“When admitted the lady in the bed before me was still waiting to go home, sat in the chair next to the bed.”

“Once discharged patients may have to attend physio 3 or 4 times a week. It is very hard to arrange transport for this.”

“Medication and ambulance transport biggest delays in discharge process.”

2.3 Follow up

Summary

One major concern for patients and their carers is the lack of information and support once the patient leaves hospital. It appears that when leaving hospital, patients and carers assume that there will be some form of follow up to ensure that the patient is recovering and coping, either from their GP or other community based PCT/NHS or social services. However, this does not appear to happen in every case.

This experience highlights a plethora of concerns surrounding hospital discharge and lack information regarding follow up follow up procedures.

Case Studies

- An 88 year old had a fall in her home. Accident and Emergency tried to discharge her after 5 hours, but the family fought for her to be admitted. She was, and was kept in for three weeks. Once discharged the hospital said a letter would be sent to her GP, however when the family arranged a follow up appointment, the GP had no information about the stay in hospital. Family constantly had to ask for information. No professionals visited the patient at home once she had been discharged. They were told by the hospital that it was the responsibility of the community care team to

follow up, but family were unable to contact anyone from this team. The family were then told that it was the responsibility of the GP because as well as the fall, the patient has Alzheimer's. However the GP did not offer any help and the district nurse would not come out to see her either. Because of the dual issues (fall and Alzheimer's) the patient was passed around different teams with no one taking responsibility.

- Questions have also been raised around discharge letters. Many patients and their carers assume that once discharged, information on the patient's hospital stay is sent their GP. However, several LINK members recounted experiences where the GP had been unaware of the fact that they, or the person that they care for, had been in hospital. The following questions were asked;

“What happens to discharge letters when they reach the GP? Is it filed? Put on a computer by clerical staff? Does the GP actually read it or even know that its there? Does the GP decide if follow up is necessary?”

- One LINK member also commented that there had been a plan in place before their hospital discharge for adaptations and social help that they would need once back at home. These things can take some time to organise and could be in place for the patients arrival home had there been coordinated forward planning.

2.4 Assessment of patient's ability to cope at home

Summary

Several carers described their surprise that the person they care for had been offered a social assessment in hospital, but had refused it. They felt that, as a family member or carer, they should be able to request a social assessment as they have a good understanding of the patient's needs, as well as the impact that it has on them in their caring role.

Case Study

One family shared the following experience;

- In hospital the patient was offered a social worker, but the family had not been present and patient said no. They felt that the patient refused the social assessment through fear of the stigma attached to having a social worker. However, a social worker could have helped coordinate the discharge from hospital and the patient's care once at home. Because the patient proved to hospital staff that she could make a cup of tea, she was sent home with no support. There was no consideration given for the fact that she suffers from Alzheimer's disease. The family was not invited to any

meetings between professionals about the patient's care. If the patient does not agree to a social assessment, then a social worker does not get involved and no family care planning is organised.

In this case the family were able to help, but what happens to people without families, who live alone and need follow up home visits and social support? If the patient refuses to go into nursing home and needs more care, but family can only offer so much or patient won't accept family's help, what will happen to that individual?

"Patients go from 24 hour care to none."

2.5 Information, communication and coordination

Summary

The lack of information for the patient and carer and the lack of communication, between professionals and from the professional to the patient and carers was also widely discussed by LINK members.

Many patients and carers felt that there was a need for one lead professional to coordinate care and discharge (would need to be in contact with carer, GP and community teams as well as working closely with the patient to make sure their needs are met). This would also improve communication between hospital and GP/community.

Comments included;

"There is a lack of consistency between professionals."

"Need to find your way through the system, you aren't always guided, sometimes need to make choices for yourself, but what if you can't?"

Patient pathways, once they reach the hospital discharge stage, are unclear. Patients are unsure of which professionals are making decisions about their care and how decisions are being made. In one case none of the professionals knew who was meant to be referring patient or to what service. This leaves carers struggling to follow up and find out where to go.

"It would have been good to have copy of discharge letter and contact number in case of worries."

Patients can be left feeling that communication is too time consuming for staff. Patients also commented that they didn't think that there was enough staff to receive communication from the patient, carer or other

professionals. Some patients felt that their wishes, concerns and preferences were ignored by hospital staff.

“Some cultures and staff don’t always understand patient’s needs and preferences. Communication on an individual basis. Some doctors/nurses can speak English but can’t write very well so difficult to communicate to other staff.”

There is a feeling that if you don’t ask for information you won’t get it. However, many patients and their carers do not know what information to ask for and they do not know what their rights are. Vulnerable patients and carers are less likely to ask/demand information and support through fear of being a burden to already busy hospital staff. This information should be readily available and offered by staff rather than patients and carers having to ask for it.

There has also been a problem with patient notes identified by some carers.

Case Study

- One experience was shared where a patient who had a mini stroke was admitted to cardio ward for low pulse rate. However a low pulse rate was normal for him, he should have been on the stroke ward for specialist treatment. Why did staff not see his notes and know this?

2.6 Vulnerable patients

Summary

- Patients don’t want to upset staff and are afraid to speak up for their rights.
- Is there a policy for elderly/vulnerable people to assess if they are safe to go home? (socially fit as well as healthy?). What procedures are in place to safeguard vulnerable people?
- Good and bad experiences, often bad for elderly

3 Suggestions for improvement

3.1 Carer involvement

The majority of people that shared their experiences with us concluded that involving patients and, very importantly, their carers in the discharge plan was vital. This would solve many of the problems that occur during the discharge process as patients and carers concerns could be addressed and any follow up procedures explained. It is important that these things are explained to the carer or family as well as the patient as the patient may vulnerable and not in the right frame of mind to absorb this

information or may not be capable of passing the information on to their carers.

3.2 Early Planning

It was also thought that the discharge process should be planned either at the point of admission, or where possible before admission. This would give patients and carers piece of mind and would allow them to pre plan any discharge arrangements including transport and home care (such as carer making sure there is food in the house/heating turned on, etc).

3.3 Social Assessments

There is an issue around the social assessment offered to patients in hospital. Most people refuse the social assessment because of the negative connotations of having a social worker. This assessment needs to be renamed to be less threatening. Personal Support Assessment was suggested. Many people don't know what the social assessment actually is. They shouldn't be asked if they want one, it should be standard. It was also suggested that these assessments should take place before a patient is admitted to hospital. Carefully asked questions (e.g. 'how do you normally get your shopping in' as opposed to 'do you need social services involved to get your shopping?') may make these assessments more accessible and less daunting for patients.

3.4 Lead Professional/nurse

In order to coordinate the hospital discharge, LINK members thought that having one responsible professional would be very useful. Their role would include contacting all relevant parties (Carer, GP, District Nurse, Social Services etc) and keeping the patient and their carer up to date. They would also ensure that the pharmaceutical service and the patient's transport home are in place for not just the day of discharge, but the right time of day. This individual should also be available to answer queries that the patient or their carer may have.

3.5 Learn from best practice

Best practice models currently exist in Stroke and Diabetes care. Could similar models be adopted across the board? Patients and carers with experience of services should be involved in helping to improve and shape discharge procedures.

3.6 Information

An issue surrounding information has been identified during this evidence gathering exercise and in other LINK activities. It has been suggested that LINK could look into information packs, what is available, is it up to dates and accurate. LINK is aware that Stroke North produces patient information packs and is interested in how this good practice could be

rolled out into other hospital departments and how other voluntary organisations or patient groups could be involved in improving hospital discharge procedures. Information on support available in the community from non NHS/PCT organisations should also be available. There were also suggestions that a booklet should be given to all patients or their carers on discharge. This would need to be user friendly and available in different formats.

Information relating to medications that patients are taking home also needs to be provided, both explained by a member of staff and written guidance to take away. Furthermore, staff should ensure that patients are able to take their medication (e.g. can they take the lid of the bottle?), before discharging the patient.

3.7 Coordination

Coordination of patient transport and pharmacy services with the discharging ward would hugely improve the patient discharge experience and reduce discharge delays. This would help to free up hospital beds in a more timely manner and would prevent distress and disruption caused to patients and carers when a planned discharge is delayed. Communication between these services and having the discharge plan in place much earlier on in the process would dramatically improve this.

3.8 Patient discharge areas

The comfort of patients awaiting discharge could greatly be improved if a comfortable area was provided. This area should provide drink facilities and meals when the waiting time coincides with meal times. This area should be staffed by a nurse as patients may still have care needs or be distressed. One patient experienced this sort of discharge at a hospital in Ealing and found that it was a much more positive experience.

3.9 Community Pathways and Facilitated Discharge

Hospital discharge procedures that place the patient at the centre of planning are favoured.

- Community pathways involve having a file on the bed that all professionals can write on, including carers. This is really good for stroke patients with memory loss and keeps carer and patient up to date (Dr, OT, Physio etc). LINK members who have experienced community pathways found it a very empowering process. In what circumstances are community pathways used? Can a patient or carer request one?

“It is essential that a care plan is in place before a patient is discharged.”

- One LINK member shared an experience of Facilitated Discharge (this lies within the Early Supported Stroke Discharge Team). She felt that this was

a very positive process, however this experience was 10 years ago and subsequent experiences have not been so successful. The facilitated discharge process seems to overcome many problems encountered by patients and their carers by fully involving them in the process and planning of their care along with the professionals involved in delivering care.

- The facilitated discharge was in its infancy at the time and was the procedure used after her husband had been discharged from hospital following a stroke. There were weekly team meetings at the patient's home to discuss his care, which included a physiotherapist (who came twice a day), district nurse and GP. There was wrap around care in place, which the patient and carer were involved planning. The patient had discharged themselves as care in the hospital from nurses was bad. Once the family proved to the professionals that they were able to cope, the professionals were very supportive. There were weekly care plans, worked out with all professionals involved at the patient's homes. This was an excellent service, but only lasted for 10 weeks. Facilitated discharge is normally only 6 weeks.

"This was a well supported and an empowering experience."

3.10 Emergency Packages

Several LINK members made the suggestion that the hospital should have emergency food packages that could be issued to patients being discharged. These packs might be given to patients who have no family or carer involvement and in other cases where staff are not certain that the patient will have sufficient provisions at home. The packs would include basics such as bread and milk. These packs could be incredibly useful as many patients, although fit to go home, may not be fit to shop for themselves straight away.

4 Next Steps

This report will be submitted to the Health and Wellbeing Sub Committee. However, the LINK Board may decide to do further investigation into some of the issues that have been raised in the report. In particular, LINK may choose to look into increasing the role of families and carers in hospital discharge and the discharge of vulnerable older people. These two issues have been identified by LINK members and partner organisations as significant concerns.

There was an overwhelming sense that patients and carers do not want to complain, but would rather support or be involved in improving hospital discharge procedures. This has been done in the case of stroke services, with the help of Stroke North.

Age Concern North Tyneside, The Alzheimer's Society and North Tyneside Carers Centre have all expressed an interest in being involved in any further work that LINK undertakes on this issue.

Produced by



North Tyneside Local Involvement Network

The Shiremoor Centre, Earsdon Road

Shiremoor NE27 0HJ

Telephone: 0191 200 1429

Email: link@voda.org.uk

www.linknorthtyneside.org.uk