

## **LEAVING HOSPITAL**

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### **THE EXPERIENCE OF PATIENTS BEING DISCHARGED FROM ST GEORGE'S ,TOOTING**

#### **EXECUTIVE SUMMARY**

##### **Why we did this study**

In 2010, Wandsworth LINK carried out an Enter and View study into how patients were experiencing being discharged from hospital.

Three years later we wanted to check on what has changed. We have focussed on talking to patients leaving St George's, the main hospital serving people in Wandsworth.

##### **What we looked at**

We have focused on issues identified in the 2010 report:

- Is discharge being planned effectively and sufficiently in advance?
- Are carers and families being adequately involved in discharge planning?
- Is discharge hindered by gaps in cover by Discharge Co-ordinators?
- Are Co coordinators sufficiently knowledgeable about social care resources?
- Are delays due to medication and transport being avoided?
- Are discharge summaries and post discharge guidance being given to patients?

##### **What we did?**

To get a comprehensive picture, we:

- arranged visits to four wards on two days in July 2013 and spoke to patients and staff. Talked to patients, or their carers, once they had got home to find out how the discharge had worked in practice;
- approached local voluntary organisations to ask for evidence of good and bad patient experiences of leaving hospital;
- spoke to nursing managers at St George's about current practice and policy;
- obtained analysis of patient concerns and complaints about discharges reported to St George's and summarised an internal audit report;
- analysed official data on delayed discharges and emergency re admissions;
- spoke to a member of the Intermediate Care Team and attended a meeting of Discharge Co-ordinators;
- spoke with a consultant leading a change management project on discharge procedures at St George's;

## What we found

Our main conclusions from all the evidence we collected are:

- **There are welcome signs of successful efforts to improve discharge procedures:**
  - Improved tools for sharing information have been introduced
  - Better written information is available for patients
  - Significant improvements in timely ordering of medication and providing patients with medical summaries
  - A greater focus on monitoring discharge performance
- **But we encountered evidence of problems apparently yet to be resolved:**
  - Most patients and families are confused about responsibilities for discharge arrangements and do not understand the role of the Discharge Co-ordinator
  - Transport delays continue
  - There continues to be a lack of training and not enough cover for Discharge Co-ordinators with too much reliance on informal and ad hoc learning
  - Few patients are aware of who to contact post discharge if things go wrong and how to manage recovery from their illness
  - A weakness in monitoring and review arrangements when patients get home and evidence that some older people in particular are left to struggle and then find it difficult to get services

The detail of these conclusions is set out in the main report along with our recommendations, suggesting additional steps the hospital might take to improve further the experience that patients have when leaving St George's.

## **LEAVING HOSPITAL**

### **DISCHARGE FROM ST GEORGE'S HOSPITAL:**

#### **FOLLOW UP STUDY REPORT BY ENTER AND VIEW TEAM**

#### **PLANNING AND CONDUCT OF THE STUDY**

##### **Why we did the visits**

In April 2013 the Healthwatch Enter and View team decided to undertake a follow up study to the LINK report on Hospital Discharge completed in 2010. The 2010 report was a substantial piece of work based on a range of enquiries including ward visits by the Enter and View Team. It had been followed by discussions with the responsible health and social care agencies including St George's Hospital. At that time some of the recommendations had been accepted, some not. In the past year we became aware of various further grumbles about the discharge process. We wanted to find out how much had changed since 2010? Some action had been taken in response so had the LINK report made a difference? Were any of the recommendations still relevant? We chose St George's since it is the major hospital serving the Wandsworth area and had been the main focus of the previous study.

##### **What we looked at**

The main questions we agreed to focus on were based on the recommendations that had been made in the LINK 2010 report on Hospital Discharge and the subsequent discussions.

##### **We wanted to find out whether:**

- discharge is being planned effectively and sufficiently in advance
- carers and families are being adequately involved in discharge planning
- discharge or discharge planning is hindered by gaps in cover by Discharge Co-ordinators eg at weekends or at holiday times
- Discharge Co-ordinators are sufficiently knowledgeable about social care assessment and the availability of community services
- delays in discharge on the day such as waits for medication and transport are being avoided

- discharge summaries, including guidance on recovery and contact details for use in case of concern, are being given to patients, if appropriate their carers, and copied to their GPs
- there is a clear procedure to ensure Discharge Co-ordinators identify and follow up within a few days of discharge those patients for whom such follow up is appropriate
- arrangements are in place to monitor and review the discharge process.

### **What we did**

We approached a number of local voluntary organisations to ask for evidence of good and bad discharge experiences, initially by letter and followed up some by telephone.

Contacted and spoke to the Nursing Managers at St George's about current discharge practice and policies.

Analysed a copy of the discharge process internal audit report, based on information from patient records, which was kindly supplied to us by the Trust. Collected evidence about the number of informal and formal complaints recorded by the Trust regarding discharge.

Arranged visits to four wards on two days in July and spoke to staff and patients. We followed up the inpatient interviews in a number of cases by, with their permission, telephoning or visiting the patient after discharge and speaking to either them or their carer to find out how the discharge had worked in practice.

Spoke to a member of the Intermediate Care team at St George's

Attended a Discharge Coordinators meeting to discuss our findings and try out our suggestions.

Communicated with the external consultant leading a St George's commissioned Discharge Management Project which was taking place whilst we were doing our study. The goal of the 13 week Kaizen Rapid Change Project 4, Discharge Management (Acute Medicine & Senior Health) was to identify ways of speeding up discharge by using working groups to identify and trial changes that might improve the discharge process.

## **THE WARD VISITS**

We visited four wards on two separate days: one elderly care ward, two medical and one surgical ward. We interviewed a total of 21 patients using a prompt/ question format similar to that used in the previous Enter and View investigation. There were more patients from Wandsworth than other boroughs and of varied ethnicity. All except one had been emergency admissions. Just under a quarter were under 50 years old and these younger surgical patients were mainly those who had the shorter inpatient stays. Just over half of the patients over 66 years were receiving or needed some form of social care – one was awaiting residential placement. Two had been readmitted after a recent discharge.

<b>Boroughs</b>	Wandsworth	11	Merton	4	Lambeth & Sutton	2 each	Richmond & Croydon	1 each
<b>Time since admission</b>	Under a week	7	Under 3 weeks	10	4-6weeks	2	Readmission after recent discharge	2
<b>Ethnicity</b>	White British	14	Afro Caribbean	4	Asian	1	Other	2
<b>Age</b>	Over 80	4	66-80	8	51-65	4	35-50 plus one under 35	5
<b>Ward</b>	Older persons	3	Medical	11	Surgical	7		

We followed up 16 of these patients after discharge or, in the case of two patients who were still in hospital, with their families. The interviewer either telephoned the patient or in three cases visited after discharge and spoke to either the patient or their carer. We also discussed and observed the discharge process with ward staff, especially the Discharge Coordinators where there was one. Only the surgical ward did not have a Discharge Coordinator in post at the time and the responsibilities were shared by the nursing staff.

### **The sort of evidence we looked for on the ward visits and follow up telephone calls and what we found:-**

For each question we identified indicators that we thought would demonstrate whether the expected discharge activity was happening systematically

#### **1. Discharge being planned effectively and sufficiently in advance?**

- Was information about home circumstances recorded?

For the majority of patients there was evidence that planning had started early. One patient reported enquires into his home circumstances “started when he came in”. In another case we noted that a message about a cluttered home needing possible clearance had been conveyed on admission via the ambulance staff who brought the patient in. We accept the limitation that seriously ill patients might not be able to talk about their home circumstances when first admitted but it appeared that they had in most cases been approached as soon as appropriate. Only one patient, whose circumstances were apparently straight forward, had not yet been seen by the busy Discharge Coordinator despite being on the ward for a day or two. This meant that staff were unaware of her carer responsibilities, which could have caused problems.

Evidence from both the Intermediate Care Team and one Discharge Coordinator emphasised that as well as home circumstances information on the patient’s “preadmission baseline abilities” (mobility etc before admission) were necessary in order properly to manage discharge and rehabilitation for frail older people. This required considerable research and they both felt it was not always done thoroughly enough.

We observed that the way information was recorded varied from ward to ward. The detailed “Discharge Check List” did not serve to record preadmission information and was not used universally by all wards. We understand this check list is being reviewed prior to the introduction of the electronic patient record system.

- **Recorded where all the ward multidisciplinary team (MDT) could see?**

The recently introduced whiteboards and daily “whiteboard rounds “ appeared to offer a valuable daily opportunity for home circumstances and estimated discharge dates to be shared with all the MDT-doctors, nurses, physiotherapists, occupational therapists and other professional groups involved in the patients’ care. We observed it enabled members of the team to answer simple questions from patients quickly and directly. However, we were concerned that a number of the whiteboard records were not up to date, particularly the anticipated discharge date and dementia monitoring, so we felt they could be misleading. Also we thought that it is important that information on communication problems such as sight and hearing loss and language is always added to the whiteboards so all staff involved were aware of them. (We came across at least two patients who had sight problems that not all staff seemed to take into account).

One Discharge Coordinator recorded the home and social circumstances in the shared patient notes in a way that they were more easily seen by all the multidisciplinary team who accessed notes. Rather than separate sheets for each professional input the notes were continuous in date order and identified the profession by a coloured sticker. The introduction of electronic records may enable social information in bulky patient notes to be more usefully accessible.

We came across one piece of evidence of unshared information- the fact that a patient’s wife was away from home had led to one wasted OT technician’s home visit.

- **Patient did not have ability to plan and to be fully aware of discharge issues?**

At least 7 out of the 21 patients interviewed were for various reasons vague or apparently unrealistic about their home circumstances and how they would cope at home. This high proportion emphasised to us the necessity for staff to verify facts and arrangements with families and carers to achieve safe discharge.

- **Had facts given by patient been verified with family/carers?**

We felt it was important that when patients are in any way confused and vulnerable the facts about how they cope at home should be verified whenever possible with family and carers-or even a home visit if no information is available. In the elderly ward the Discharge Coordinator made a point of checking the accuracy of facts that had been obtained in other wards and settings. She emphasised that experience had taught her the importance of checking various family sources rather than assuming that one relative spoke for all.

- **Was the discharge process explained to the patient and did the patient understand it?**

A “Leaving Hospital-Planning for Discharge” sheet had been distributed to patients in some wards. Some patients were aware of the content but others, because of sight, language or mental capacity problems, could not read or understand it. Moreover, if left on the bed table or locker, the sheet of paper could be easily lost and not seen by significant friends and family visitors. In view of this we hope our recommendations about changes to this sheet will be given serious consideration and they will be displayed in a more permanent and easily seen position.

One patient who spoke no English relied on information from bilingual family members who visited frequently and spoke to staff. When we visited, the patient was worried because she did not know whether she would have to pay for ICT.

In spite of staff attempts to explain the discharge process, in our interviews some of the patients’ answers demonstrated confusion as to who determined and confirmed the day of discharge (see below section 3).

- **Can patient identify the Discharge Coordinator?**

Not all patients were asked but at least eleven of the 21 patients could not identify the Discharge Coordinator or Sister taking responsibility for discharge. On the other hand one referred to the Discharge Coordinator by her first name.

- **OT and physiotherapy assessments**

About half the patients had problems with mobility and self-care. Therapy input was mentioned by at least 6 patients and Physiotherapists and Occupational Therapists were observed to be an integral part of the ward team. Aids for daily living had been provided prior to discharge for at least 2 patients.

## **2. Carers and families adequately involved in discharge planning?**

- **Discharge process shared with carers?**

Our information is not complete because we did not interview the family and carers directly, so depended on the patients' impressions (some were very vague and we could only assume others must have been involved) and on the feedback we obtained after discharge. At least ten patients' relatives had definitely been involved to some degree and there was evidence that for some there had been substantial contact about measuring and fitting aids to daily living and a well organised case conference about future residential placement.

- **Conversations with carers and family?**

A wife would have liked to speak to staff but could only visit in the evenings when no one was available. Another found it very difficult to find out precise medical information.

- **Family and friends know who to talk to about discharge?**

Three carers knew the Discharge Coordinator by name and one spoke very highly about the support she had received negotiating the complicated application process for residential care. One however reported a bad experience in another ward where arrangements for discharge were shared between the MDT team.

## **3. Discharge or discharge planning being hindered by gaps in cover by Discharge Coordinators eg at weekends or at holiday times? Cover arrangements?**

This was an issue raised in the 2010 report which recommended that Discharge Coordinator cover should be provided on a 7 day a week basis to ensure contact with families and carers who might only visit at weekends. The Trust had however made clear at the time that they did not accept this recommendation which they considered unnecessary and impractical.

The current position accordingly is that when Discharge Coordinators are absent e.g. at weekends, sick or on leave no dedicated substitute Discharge Coordinator cover is provided. -with the exception of annual leave cover in Senior Health. Discharge Coordinators work 7.5 hours Monday to Friday and when they are off duty, cover is provided by the available nursing staff. In the surgical ward where no Discharge Coordinator was in post the sister and senior nurses were carrying out the discharge planning. Discharge Coordinators told us they mostly communicated with relatives and carers by telephone or email and left messages with other staff to talk to visitors who came when the Discharge Coordinators were off duty.

- **Evidence of confusion /omission when Discharge Coordinator not around?**

A number of negative incidents which we identified through our post-discharge follow up **may** have been related to the absence of a Discharge Coordinator:

- two discharge summaries which had not arrived 6 days after the patient had left hospital coincided with the Discharge Coordinator being away;
- on the ward with no Discharge Coordinator, transport went to the wrong ward and caused a 6 hour delay in the patient returning home;
- two last minute cancellations of discharge pick up arrangements happened on a ward where discharge responsibilities were being shared by non -Discharge Coordinator staff.
- one patient, was discharged to ICT at a weekend and arrived a day earlier than expected by the ICT unit. She spoke no English and family members were not informed. We were told later by a member of staff 'it was chaos'.

A member of an ICT team to whom we spoke valued the role Discharge Coordinators play saying "Discharge Coordinators have more relevant experience and have an important role in aiding smooth discharge planning; this is preferable to nurse rotation in the role."

We were told by Discharge Coordinators that some discharges require a substantial amount of time to complete paperwork, which conflicts with other clinical work if no Discharge Coordinator is on duty.

- **Is it clear how or by whom discharge arrangements are finalised?**

During telephone follow up after discharge, some patients had acquired on the ward the misleading expectation that the doctor would finalise discharge and were surprised to find it was a nurse or Discharge Coordinator that did so. Some patients had to wait beyond an initial estimated date for symptoms to clear even when most discharge arrangements were in place, as happened in two cases, but they accepted this was necessary and understood.

In general there was vagueness about the phrase "ready for discharge". Was it medically fit as determined by the Doctors or MDT fit when all professionals involved had completed their assessment and treatment? Given this imprecision it can be difficult to determine what constitutes a delay.

#### **4. Are Discharge Co-ordinators sufficiently knowledgeable about social care assessment and the availability of community services?**

- **Evidence of training and knowledge**

The 2010 LINK report suggested a need for more training for Discharge Coordinators on the role of social care assessment staff (care managers) and other community support services. The Discharge Coordinators we met reported that they "learned on the job" from OTs, ICT coordinators and social workers but had not visited community services. We were told that

sometimes outside agencies were invited to the monthly hospital Discharge Coordinator meetings to explain some aspects of community care but the coverage appeared far from comprehensive.

However, warm recognition of one aspect of their expertise came from one family member interviewed who was immensely grateful for the help from the Discharge Coordinator with the complicated “Capacity” issues and application for residential care which had been progressing so slowly.

- **Awareness of community alternatives**

In our interviews Discharge Coordinator’s demonstrated their knowledge of the following community services in a range of Boroughs;

The Virtual Ward, Mascot alarms, Supported Discharge, Mental Capacity issues, District and Stoma Care Nurses and setting up various services provided through Social Services including house clearance.

Discharge Coordinators reported using information websites. But they expressed difficulties in about communicating with all the Community Health and Social Services which vary from Borough to Borough some of whom rely on indirect messaging services.

One aspect of the recent Kaizen Discharge Review (see below) addressed the need for hospital staff to be more aware of and able to access what was on offer in the community.

#### **5. Are delays on the day of discharge such as waits for medication and transport being avoided?**

The most significant delays concerned transport. Delays to an anticipated discharge date because of medical, therapy or social necessities were understood by all concerned but people sometimes (rightly or wrongly) found it harder to understand why they had to wait for hospital transport once they had been declared fit for discharge. In a number of cases the hospital transport delays had been of up to 6 hours with the patient, and in one case his paid carer, sitting by the bed all this time. Where the transport had been ordered the day before, there seemed to have been only one delay due to confusion regarding the ward, but transport ordered on the day of discharge resulted in very long waits for 3 of the patients we interviewed.

Discharge Coordinators said they are attempting to book transport earlier and the Kaizen Discharge Review proposed improving the ease of communication between the ward and transport and to facilitate bookings. Meanwhile patients and their relatives did not understand about the likelihood of long waits and late arrivals of hospital transport if it is ordered on the day.

We did not come across significant delays due to waiting for medication, as identified in our previous (LINK) report. Discharge Coordinators told us that they now normally get medication prescribed 24 hours before discharge and blister packs that take 48 hours to make up, even earlier.

6. **Are discharge summaries, including guidance on recovery and contact details for use in case of concern, given to patients, if appropriate their carers, and copied to their GPs?**

- **Medical summaries?**

All but two of the patients followed up after discharge had received a medical summary. This is an improvement since the LINK report but falls short of the 100% target aimed for. Of the two that had not received a summary, one who was concerned 6 days after discharge had to be advised of the ward number to ring for help.

One patient 4 days after discharge had not opened the envelope he had been given containing the summary because he was not sure what was in it and whether it was for him. A label explaining the contents might have helped.

- **Services provided and contact details?**

On follow up after discharge patients for whom this was relevant reported they had found the list of services useful. One used it to re-contact the OT. Others welcomed the reassurance it gave them that Community nurses, outpatient appointments had been arranged and they could contact them if necessary.

- **Who to contact if concerned?**

People expressed a variety of ideas about who to contact if they had concerns after discharge, varying from ringing the ward and going to A&E, to being confident that their GP would have received the Discharge Summary and be able to help. Only two were really clear about what they had been advised to do. The Kaizen Discharge Review referred to a leaflet "What to do if something happens" but we did not come across these.

- **Recovery and condition management information?**

Some patients expressed the need for more information about how to manage their recovery. "No advice or instructions just a bag of medicine" one complained. Others hoped that this would come via their GP or were receiving such support from a Community nurse specialist. Some Discharge Coordinators in specialist wards said they gave out condition specific recovery leaflet but we did not come across any. Discharge Coordinators aspired to talking through and providing a medication printout and two patients referred to this but one patient told us he was "very confused" by the changes in his heart medication.

**7. Is there a clear procedure to ensure Discharge Co-ordinators identify and follow up within a few days of discharge those patients for whom such follow up is appropriate?**

- **Reported practice**

The 2010 LINK report recommended that Discharge Coordinators should routinely follow up all patients after discharge to check that discharge arrangements were working well but the Trust made clear at the time that they did not consider this appropriate in all cases. When we asked about current procedure one Discharge Coordinator said she did usually follow up after discharge with a telephone call to check all was well. Others said that out of personal concern they sometimes asked Social workers or OTs how a discharged patient was getting on but no record was kept of such contacts and there was no regular system for obtaining feedback on how discharge arrangements worked out in practice. The existing audit, being based on the hospital paperwork, did not cover this.

- **Actual practice**

When we followed up after discharge no significant planning problems were revealed except the patient who arrived unexpectedly at ICT residential care when no one was there to admit her. All other services appeared to have arrived as expected. One patient once home appeared to have unmet care needs: he was unable to manage his washing and cleaning and get out of his flat and “will have to see how it goes.” It appeared in this case Discharge Coordinator follow up might have indicated he was taking time to accept his need for home care or rehab services. Fortunately he had a niece who lived nearby who was involved organising a Mascot Alarm and could take the initiative to help him ask for services.

Without follow up Discharge Coordinators are not always aware of transport delays unless the patient has waited in the ward or someone contacts them with concerns.

**8. Are arrangements in place to monitor and review the discharge process?**

- Kaizen Rapid Change Project 4, Discharge Management (Acute Medicine & Senior Health)

A review of discharge processes was actually happening at the time of our visits. Our team were contacted by Danny Gregory an external consultant from GE Healthcare, contracted by St George’s to review the discharge process in the Medical and Older people’s wards. The Kaizen Discharge Review involved 13 weeks of investigating issues, identifying problems and achievable solutions culminating in a “Process Improvement Week”.

- **Discharge Coordinators' meetings**

Regular meetings of the Discharge Coordinators provided a forum where improvements were discussed but it was not clear how suggestions would be taken forward beyond group. For example better ways to contact the Merton Community Nursing team. And how ideas from outside the group could be fed in and integrated into practice. For example the feedback from the ICT team regarding patients' "preadmission baseline abilities"

## **OTHER EVIDENCE**

This part of the report summarises other evidence we have gathered that sheds light on how patients experience the process of going home after a stay at St George's. This has come from:

- The Home from Hospital service provided by Age UK Wandsworth
- A patient reporting her experience to the Pocklington Trust
- The Patient Advice and Liaison Service (PALS) and Complaints Service at St George's
- St George's internal file audit of the discharge process
- Government statistics on hospital and social services performance

Some of these sources are more likely to pick up dissatisfaction with the discharge process, which needs to be taken into account.

## **Home from Hospital Service**

Age UK Wandsworth offers a wide range of services that aim to improve the quality of life for people aged 60+ living in the Borough.

Using trained volunteers, the **Home from Hospital Service** offers free practical support and assistance to people aged 60+ living alone in Wandsworth. The support is for up to 6 weeks after they have left hospital and is funded by the Reablement service. The service is provided to people being discharged from any hospital, not just St George's.

The service receives approximately 10 referrals a month, roughly a third of which lead to a service being provided. 61 people have been helped since the service started 18 months ago.

Common circumstances of people helped are that :

- They have been quite confused or disoriented immediately after treatment, often still under the influence of medication.
- They have not always understood what has been offered to them and the different roles of various professionals/teams.
- They have sometimes refused offers of help before returning home, partly because of their innate sense of independence and partly because they just want to get home following the trauma they have experienced.
- They manage for a while at home but later realise they cannot really cope and contact Age UK for help. In some cases they have run out of food.
- Because they have been signed off from services at discharge, they effectively have to start again to get help from the statutory agencies.
- They are highly appreciative of volunteers who can spend time with them and help in ways that address their needs differently from task focused professional carers. They also value someone with the time to explain the complexity of the services on offer.

***Our thanks to Pamela Hatton from Age UK Wandsworth for providing this information***

## **Thomas Pocklington Trust**

Pocklington is a charity providing housing, care and support services for people with sight loss. It provides a 52 dwelling supported housing scheme in Roehampton and passed on the story of a female tenant who had been a recent inpatient at St George's hospital.

### **An account of leaving hospital from a person with sight loss :**

After contacting the Watch Alarm Service because of chest pains, I was taken by emergency ambulance to A&E in the early hours of the morning. I was not in a state to collect up a bag or change into outdoor clothes.

From A&E I was admitted to a ward for observation and to await blood results. I was finally discharged home at about 6.50pm in the evening of the same day.

Contradicting the doctor, the nurse, backed up by the sister, told me it was not possible to provide transport home because the hospital policy is that if patient can walk 4 steps they have to find their own way. I pointed out I was in my night clothes, registered blind and used a guide dog and had no money or bus pass. If staff could arrange a taxi I offered to pay on arrival at my home but they refused to do so.

I had to be very tenacious until I was finally provided with hospital transport. I feel that the staff, or the policy, do not take account of sight loss, only checking for physical mobility.

## **The PALS and Complaints services at St George's**

Every hospital has a PALS service, offering patients or their relatives information and the opportunity to report concerns with the care they are receiving. Patients and relatives may also lodge a formal complaint directly or after talking to PALS.

The **PALS service at St George's** received 1180 referrals in the 6 months October 2012 to the end of March 2013.

39 of these referrals (3.3%) were concerns with the discharge process:

- The Surgery Directorate (9 concerns), the Senior Health wards (7) and Neurosciences and Acute Medicine Directorates (6 each) accounted for most of them.
- Common issues related to the lack of communication, information and forward planning.
- In the vast majority of cases the PALS service was able to resolve the shortcomings by direct intervention.

**St George's dealt with 19 complaints relating to the discharge of patients** during the six months October 2012 to March 2013.

The largest group (6) were from people discharged from Surgical wards (including Trauma and Orthopaedics) followed by 4 that related to discharges from A&E. The main issues raised and the responses from St George's were:

Subject of complaint: poor care arrangements after discharge (6 complaints)

*St George's response: The nursing team is now utilising a discharge checklist to ensure both clinical and social care plans are recorded clearly. This will be checked daily by the Senior Staff Nurse, the Discharge Coordinator and will be monitored by the matron on her rounds. Staff who are not clear about the discharge process will be supported with further training by the Discharge Coordinator and their practice monitored by the Senior Charge Nurse and the Matron. It has also been emphasized to doctors the importance of providing clear advice to patients regarding the aftercare of their injuries.*

Complaint: next of kin not being informed of a patient's discharge (3 complaints)

*St George's response: Apologies were given and staff reminded of the importance of keeping next of kin and carers informed of discharge.*

One complaint – on behalf of a relative who did not arrive back at her care home until 0200h – has led to a change in policy. No patient is to be discharged after 2200h unless the patient themselves or their next of kin express a desire to be discharged after this time.

***Our thanks to staff at St Georges at for providing this analysis for us***

**St George's internal audit of the discharge process**

The hospital's clinical audit team has developed a methodology to log the efficiency and effectiveness of discharge practices across all wards, both elective and emergency. Discharge Co-ordinators examine case notes and assess them on key criteria, using an online data collection tool.

Between October 2012 and April 2013, **St George's internal audit of discharge processes** showed:

- The results from 296 file audits – three quarters from emergency wards, 20% from elective wards.
- There was evidence of discharge planning for 85% of patients. But in only two thirds of cases had this started on admission as expected in the discharge policy.
- For around 70% of patients the discharge planning included assessment of

continuing health and/or social care needs.

- Patients were most commonly referred to Physios (55% of cases), followed by OTs (40%), Social Services (33%), Intermediate Care (30%) and District Nursing (25%).
- Only 55% of medication was prescribed at least 24 hours before discharge, an area identified for significant improvement.
- 45% of patients need transport home but in only just under half of these cases is the transport booked 24hours before discharge.
- Nearly all patients had, according to the documentation, been given the reason for admission and treatment.
- For 90%, general information was given to them on discharge, but this fell to around 70-75% when it came to information on post discharge concerns and who to contact if there is a query.
- Over three quarters of patients went home on discharge, around 10% to care homes and 7% to other hospitals or intermediate care.
- The average time between a patient being declared medically fit to being discharged was 28 hours. This meant that two thirds were discharged the same day and a third at a later date.
- Over 80% of patient records included full or partial details about discharge arrangements. This fell to just over two thirds where a Discharge Checklist and Plan had been completed.

### **National statistics**

Two sets of national statistics about NHS and Social Services performance shed light on the process of people being discharged from hospital :

- a) Delayed transfers of care
- b) Emergency re admissions

#### **Delayed transfers of care**

The NHS and social care agencies in Wandsworth responsible for prompt transfers of care from hospital to other, mostly community, settings have a very good track record in this area.

To trigger a delay that counts for the measure, a patient must be in hospital for over a day despite being declared fit to leave by a doctor and multi-disciplinary team.

In May 2013 St George's ranked 53rd out of 244 Trusts nationally for the fewest number of delays.

An analysis of the 4 delays recorded in June 2013 shows that:

- 3 were from acute services, 1 from non acute.
- the NHS was responsible for 116 days of delay, mostly down to awaiting non acute NHS care. Social Services was responsible for 36 days, mostly relating to finding a residential home placement.

For the whole of 2012-13, delays for all reasons accounted for less than 5 days per 100,000 population putting Wandsworth into the lowest band along with 29 other areas nationally.

### Emergency re-admissions

This measure can shed light, in part, on the effectiveness of hospital discharges and the transfer to health and social care services that support people in the community.

It counts the % of emergency admissions of people who have been discharged from the same hospital in the previous 28 days.

Over the last 8 years, the figure for St George's has averaged just under 11%. The figures for the last three years were:

2010-11: 12.2%

2011-12: 10.4%

2012-13: 11.8%

So, at just over 11%, slightly above the 8 year average.

In 2012/13, the national figure for all hospitals was 11.6% so St George's is an average performer. (Because of the hospital's regional catchment for some high risk admissions, it argues that is in fact a better than average performer).

St George's, according to its 2012/13 Quality Account, is still aiming to improve its performance – for example by expanding its use of telehealth technology – facilitating remote monitoring of patients with heart failure or respiratory illness, and community virtual wards – highly responsive multi-disciplinary management of patients with chronic long term conditions.

## **CONCLUSIONS ON DISCHARGE PROCEDURES**

In general we saw welcome signs of successful efforts to improve discharge procedures at St George's since the 2010 LINK report, but we encountered some evidence of problems apparently yet to be resolved.

In particular there was evidence of early discharge planning and improved tools for sharing the information such as the "white board rounds" as well as attempts to improve patient records so relevant information is more accessible. We welcomed the new "Planning for discharge" sheets but felt they could be improved and better displayed.

Despite these improvements, we still found patients and families were mostly confused about who determined final discharge arrangements. While a number of patients and family members were very appreciative of the Discharge Co-ordinator's efforts and knowledge, the majority of people we spoke to did not know of the DC or their role. The high proportion of patients we interviewed who were not aware or realistic in their thinking about their future care at home brought home to us the importance of recognising that family and carers must be involved at an early stage where possible. We were concerned that there did not appear to be a reliable system for ensuring a patient who did not speak English understood the plans for their discharge.

As listed above, we came across evidence of a number of serious lapses which might be partly attributed to the absence of a DC for significant periods or at significant points in the discharge process. We recognised that at weekends and in the evening tasks could apparently be delegated effectively to senior nursing staff but even so we found that evening visitors did sometimes complain that they did not know who to approach for information. The issue of cover does not therefore seem to have been fully resolved.

We asked about training for DCs and found little evidence of formal training, most learned on the job and had not visited the community services they were putting in place. They were dependent on learning from other professionals, information websites and indirect referral procedures. This did not seem to us sufficient for this important function.

At the discharge stage itself we identified a small number of patients who experienced significant transport delays. With regard to medication, DCs we spoke to were aware of the need to order in advance and we found only one patient who spoke of waiting for medication, which was far less than in our previous study. The majority of our interviewees were discharged with Medical Summaries, but not all and a small number failed to receive them within a few days of discharge. While not satisfactory this was a significant improvement on our previous study. However, still only a few of the patients discharged were clear about who to contact if things went wrong or how to manage their recovery.

We were told there is no formal system of follow up post discharge. So the DCs were not necessarily aware that of the patients we identified who struggled when they got home or

had a bad transport experience. This seems a weakness in the monitoring and review arrangements although we welcomed the system of monthly DCs meetings where processes were discussed and were made aware of the Kaizen Rapid Change project that was taking place to develop further improvements in the discharge system.

Finally, we were made aware by Age UK of their concern that a number of elderly patients in declining health leave hospital in the belief that they will be able to manage independently at home as well as they did before admission. This can prove not to be the case and after a short period at home patients can experience difficulty. Under existing arrangements as we understand that such people have to take their place in the queue for assessment for re-ablement or other support, which can be a lengthy process. It seems to us that there should be a fast track process for such cases for a window of perhaps six weeks after discharge.

We make a number of recommendations below designed to help tackle the problems we encountered in discharge arrangements.

## **RECOMMENDATIONS**

**In the light of our findings we wish to recommend that St George's Hospital take the following further actions in the context of their ongoing work to improve discharge arrangements:**

- 1. The "Leaving Hospital-planning for discharge sheet" should be displayed in a place that is conspicuous to friends and carers as well as patients. It should identify the Discharge Coordinator (or other staff responsible) by name and encourage patients and their friends and carers to make contact to enable early planning.**
- 2. Endorse the importance of the Discharge Coordinator role and review how their time is prioritised, in particular to allow sufficient time for completing papers, researching base line preadmission abilities and starting early discharge planning for all patients.**

- 3. Continue and improve the white board system. Particularly keep boards up to date and include important communication issues- such as sight, hearing, language and learning disabilities where special care is needed.**
- 4. Provide floating cover for Discharge Coordinators so wards are not without cover during holidays and sickness. We accept, however, that weekends and evenings can be covered satisfactorily by clear delegation to other nursing staff provided that clear information is available to relatives and carers about how to contact the Discharge Coordinator(as above), and given that basic information can now be more easily accessed by other staff from the white boards.**
- 5. Provide more training for Discharge Coordinators to include shadowing of more experienced staff and regular visits to community services to improve communication and knowledge.**
- 6. Acknowledge that many patients, particularly in the older persons' wards, are unable to plan and anticipate their future needs without help. Planning requires time and skill to consult all parties, the patient, family/carers in order to make decisions in the patient's best interest.**
- 7. Continue efforts to minimise delays by booking transport as early as possible and if possible making communication between ward and transport office easier. We recognise that the provision of hospital transport cannot always be immediate and if patients are to be transported home on the same day as the discharge decision all concerned must be prepared for a period of waiting.**
- 8. A greater effort is needed to ensure completion of discharge summaries on time for the patient to take a copy with them in all but exceptional circumstances. A label on the envelope would remind the patient and carers of the contents.**

9. We believe patients being discharged from hospital, and their carers if appropriate, should be given written guidance about how to manage their condition, what to watch out for and who to contact if something goes wrong. Accordingly we recommend that where this is not already being done consideration should be given to how it might be done in future.
10. Follow up more patients both to check their health and social care post discharge and as a form of audit of the discharge process. Work to develop channels of communication with outside agencies to improve the feedback of information to make the discharge process smoother and check what has worked well.
11. The Hospital should review with the joint commissioners how arrangements might be developed to provide a fast track assessment process for recently discharged patients, particularly but not exclusively the frail elderly, who may find after a short period at home that they cannot manage as they had anticipated.

### **Healthwatch Enter and View Team**

**Andriy Drypen**

**Martin Haddon**

**Jenny Purkis**

**Alison Tomlin**

**Peter West**

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