WANDSWORTH LOCAL INVOLVEMENT NETWORK (LINK)

IMPROVING THE PRACTICE OF HOSPITAL DISCHARGE AND THE PROVISON OF AFTER CARE IN WANDSWORTH

1. EXECUTIVE SUMMARY

Wandsworth LINK has carried out a study of hospital discharge and found that, despite noticeable efforts in some hospitals, there remain a number of recurring problems. These problems are mainly to do with delay, lack of communication with the patient and their carer or between staff and a lack of coordination between the hospital, community health services, and the providers of social care services whose services are critical for the patientôs recovery in the post-discharge period. Our main recommendations include the following:

- hospital discharge must be given greater attention as a priority in improving the work of hospitals and community services
- the role of the Discharge Coordinator must be extended to cover weekends and strengthened to include the task of ensuring that important after care arrangements are in place
- there must be better communication between hospital staff community services staff and the patient and their family and/or carer of the plan for the patientôs discharge
- there needs to be greater coordination between hospitals, social care providers, and community health services.
- GPs should take greater responsibility for patients of theirs who are discharged from hospital.

Our recommendations appear in full in **sections 5 and 6** below.

2. WHY HOSPITAL DISCHARGE MERITS ATTENTION

2.1 Discharge from hospital is a key issue at the interface between health and social care. It is also an important bridge in the continuation of the patientôs recovery after hospitalisation. As a óproblemô it has been known and documented over the past two decades. Successive governments have tried to tackle it with policies that have attempted to óntegrateôhealth care and social care. The last government, concerned about older people and other vulnerable people staying longer than necessary in hospital beds (`bed blocking`) introduced ófinesôon Local Authorities in 2003/4 where the óoverstayôperiod resulted from delay in arranging a suitable care package. A number of difficulties in the process remain, including the different funding and governance arrangements - local government is responsible for Social Care and the NHS for Health; NHS services are free at the point of delivery while most adult social care is subject to a variety of ómeans testedôcharges. Moreover, the agencies and professional disciplines involved in the process of discharge are many - hospital staff, community health staff, GPs, occupational therapists, care provider agencies, care managers/social workers, housing support staff, the patientôs next of kin and the patient himself - and this makes effective case planning and coordination particularly challenging.

2.2 The hospital discharge process can be a critical time for the patient and his carer. After a period of illness he may be suffering from temporary or permanent impairment and may need

assistance not previously required (including physical adaptations to his home and support services) in order to resume living at home. Alternatively, he may need to move to a care or nursing home. Discharge can thus be point of a ólife crisisô and, as such, needs also to be handled with the full involvement of the patient and his close relatives.

2.3 There has been much academic research and government guidance on óbest practiceô ó The Patients Charterô provides for patients and carers to be consulted at all stages regarding any arrangement made for them. The 2010 government guidance óReady to goô[1] lays out detailed guidance on how health and social care systems should be proactive in supporting individuals, their families and their carers in returning home or in moving to another setting. The Cochrane review of the academic research[2] concluded that óThe evidence suggests that a structured discharge plan tailored to the individual patient probably brings about small reductions in hospital length of stay and readmission rates for older people admitted to hospital with a medical condition.ô

2.4 Other LINk organisations in London have examined this issue. Islington LINk[3] interviewed hospital patients and found the need for better information and communication throughout their hospital stay. Sutton and Merton LINk have also recently reported a study of hospital discharge at St Helier Hospital.[4]

2.5. In view of the importance of getting hospital discharge right, in late 2008 and early 2009 the Wandsworth LINk made the improvement of the practice and services involved in hospital discharge one of its priorities. We did not expect to be able to address the subject comprehensively. In keeping with our mandate as a LINk, we have focussed on users', patients' and carersô experiences.

2.6 This report contains the finding of several activities which we undertook as outlined in section 3 below. Our approach in this work is summarised in the project plan in Appendix1.

3. WHAT WE DID

3.1 The Secondary Health and Social Care Sub-Group of the LINk held two fact finding days (25th June and 24th September 2009) during which staff from key health and social care agencies gave presentations and informed WL of hospital discharge from their experience and from their agencyôs policies.

3.2 The Wandsworth Enter and View team undertook two visits (17th February and 30th June 2010) to St Georgeôs Hospital wards focused on patients who were expecting to be discharged that day. The summary report of these visits is attached as Appendix 2.

3.3 We also arranged for 31 borough residents to be interviewed - most of them were vulnerable people who had recently experienced hospital discharge or were the carer of such a person.[5] We tried to interview a cross section of patients (with a spread of age groups, different client grouping, and residence in different parts of the borough or using different hospitals) but, in the event, this goal proved difficult to achieve. Of the 31 interviews, more than two thirds were interviews where

---

1 *Ready to Go – Planning the discharge and the transfer of patients from hospital and intermediate care* (Department of Health, March 2010)

2 Shepperd S., McClaran J, Phillips CO, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL., *Discharge planning from hospital to home*, Cochrane database of systematic reviews 2010, Issue 1 Art No:CD000313. DOI 10.1002/14651858. CD000313.

3 *Influencing change – A research report by Islington Local Involvement Network on the experiences of patients leaving hospital*, February 2010.

4 Sutton and Merton LINK, Service Review of Discharge from St Helier Hospital, Oct 2010. A full report and a summary of their findings has been published.

5 11 of the interviews were conducted by a WL Executive member and a HOST staff member; the remaining 20 interviews were conducted by trained researchers from the South West London Academic Network (SWAN).

the patient was a woman. One third of the interviews concerned a patient under the age of 60, 7 between 60 and 79, and 14 over 80 years of age. We interviewed at least 5 patients who were from an ethnic minority. Three of the interviews concerned patients with mental health problems; one concerned a patient with learning disabilities. The patients had been hospitalised in St Georgeôs, Chelsea and Westminster, St Anthonyôs, Kingston and Queen Mary's Roehampton. We do not think that the sample limitations detract from the need to ensure that patients, especially the most vulnerable, are discharged from hospital satisfactorily. Semi-structured interviews were conducted with the aim of finding out usersô experiences and any recommendations they might have to improve the ôhospital discharge experienceô for the future. We looked for both their experience of discharge and how they felt about what they had gone through.

3.4 We talked with the senior managers from the main health and care agencies about what their agency had done or continuing to do to ensure effective hospital discharge arrangements.

3.5 We held an open meeting with LINk members and interested borough residents in November 2009. We also solicited views from members at many other meetings and advertised our project widely.

4 WHAT WE FOUND

Our findings and recommendations, organised under the activity undertaken, are reported below. Where the same issue arose in multiple activities, we have taken care to mention the issue at least once.

4.1 The fact finding days resulted in the following information:

4.1.1 **St. George's Hospital** makes safe discharge an absolute priority and has comprehensive policies on discharge. We were told that these are regularly updated and scrutinised. Related policies include abuse, child abuse, liaison psychiatry, palliative and end of life care ï the range serves to affirm the complexity of the discharge process. 30-45 patients are discharged from St George's Hospital per day, of which ten would be considered by the hospital to be complex cases. Discharges which involve a referral to Social Services, which include some of the complex cases, are between 110-120 a month.

The discharge of elderly patients was identified as being more complex as elderly patients usually required community care and/or nursing home accommodation and it was often difficult to put in place arrangements for these. Multi-disciplinary teams are involved in the process and these include Discharge Co-ordinators on the wards.

We heard of the enormous pressures on hospitals and social services alike, with the need to liaise between so many services, with capacity often stretched, and no discharge being exactly the same as the next one. There was a realisation that good communication is key but that, all too often, this was not achieved.

Intermediate Care, we were told, works extremely well and the patient is happier when recovering at home but such care needs proper management; it was acknowledged that improvements could be made.

One of the biggest challenges is the ability to support elderly patients who do not need hospital care but who nevertheless require a high level support in continuing to live in their own homes. Extra Care housing is seen as an ideal option and can support a safe discharge process.

We were told that many patients who have a care package when they are admitted will require a more intensive package when they leave hospital and this can take time to put in place.

4.1.2 We heard that **Chelsea and Westminster Hospital** has similarly robust policies in place, but, in their view, Wandsworth did not have the nursing home capacity it claimed to have, and delays were often caused when trying to discharge someone in need of that care.

4.1.3 We also heard from the Wandsworth **Community Health Services Team**, comprising Community Matrons, nursing staff, specialist nurses, and healthcare assistants. As more care that was previously provided in hospital is now being provided within the community, the scope of work for this team has grown considerably. These teams support safe discharge, help to prevent re-admission, manage palliative and end of life care, rehabilitation programmes, observations and tests. They work with social services, pharmacists, and other agencies such as Age UK and the Red Cross.

4.1.4 The presentation from the **South West London and St George's Mental Health Trust** highlighted the possibility of planning for the discharge of mental health patients over a longer period of time using the Care Plan Approach, and often involving a wider range of healthcare professionals. This structured Care Plan Approach takes into consideration and addresses a number of factors that affect a patientôs ability to be discharged safely. Risk assessments may be carried out, carers may be involved, and discharge may be a staggered process. The timeliness of discharge for mental health patients may also be affected by availability of housing stock, specialised housing units, and lack of good day centres.

4.1.5 It was acknowledged, throughout the two days, that, while strenuous efforts are made to ensure hospital discharge is safe, timely and efficient, many factors can contribute to a breakdown in these efforts. The majority of discharges go well but, for the minority that do not, we were assured that improvements are continually being sought. Most of the problems we learnt of are mentioned elsewhere in this report. Those that are not include unrealistic expectations or demands made by family members of the patient, shortage of places in care homes, lack of training on the arrangements or instructions carers are likely to need to implement after discharge and delays in a patientôs notes being sent to the GP.

4.2 The Enter and View team found that, in many of the St Georgeôs wards they visited there were a number of caring and committed staff dealing with discharge. Many have staff in the role of Discharge Co-ordinator. The team noted that St Georgeôs had been working to improve the hospital discharge process. They also observed that discharge issues varied from ward to ward.

The main issues with relevance to St Georgeôs and other hospitals were:

4.2.1 Discharge Co-ordinators do not work at weekends and there is no formal cover for them when they are away from work. This can result in the discharge process being halted at the weekends.

4.2.2 Contrary to current policy at St Georgeôs, not all patients were discharged with medical discharge summaries.

4.2.3 Delays in several aspects such as take-home medication, transport and paper work were experienced on the day of discharge. Although some wards prepare these the day before, there are long waits for the pharmacy to provide the medication in wards such as in orthopaedic where there is rapid throughput.

4.2.4 It was unclear to patients who had the final authority on discharge. Patients and carers were confused by conflicting messages from different members of the staff team. ñMedically fit for dischargeòdid not necessarily mean that the patient was ready for discharge because, often, transport arrangements, medication, and therapy assessments were still to be completed. As to the actual time of discharge, some patients and their carers also said that they preferred to be discharged after 11 am.

4.2.5. Carers were not always consulted as early as they should have been about discharge plans and did not always have a chance to discuss medical issues with medical staff. The current discharge check list does not separate patient and their carer/family when, in some cases, it would be sensible to ensure both had been contacted.

4.2.6. There were reports of some delays in providing post-discharge community physiotherapy.

4.2.7. Discharge Co-ordinators did not routinely hear how discharge and after-care worked unless the arrangements broke down and thus could not learn from experience or rectify the situation for the discharged patient. There did not appear to be a system for routine checks on whether discharge arrangements had proceeded smoothly and that the discharged patient was coping adequately. There is thus no prospect of problems being identified unless the patient contacts the hospital or the hospital is otherwise informed by a third party.

4.2.8 The Enter and View team found that most Discharge Co-ordinators had little experience of community services outside the hospital setting and were therefore not able to recommend relevant services to patients and their carers.

4.3 From the interviews we found that of 17[6] patients (out of 29)[7] had a very unsatisfactory experience of being discharged from hospital.

4.3.1 Common causes of dissatisfaction were: delays between being told of their discharge and transportation becoming available or getting their take-home medicines; failure to inform the patientôs family or carer; failure to make the patient feel involved in the decisions taken on her discharge from hospital.

4.3.2 Of the more serious problem cases were those where after-care which was important for the patientôs recovery was not arranged until well after the critical phase had passed or where the patient was given insufficient information about how to care for their wounds, what symptoms to look out for and whom to call if they had any post-hospitalisation questions as well as where no attempt was made to assess if the patient would be able to cope once discharged from hospital. The very worst cases were those where elderly patients were returned to their home where they lived alone without proper arrangements for after-care and without the patient being contacted by any health or social care provider in the days after being discharged.

4.3.3 Five patients were very satisfied with their hospital discharge process. Of these, one patient waited all day before being allowed to leave the hospital and another patientôs satisfaction was in part coloured by comparisons she was making to hospital discharge in the 1940s! A factor common to almost all the cases where the patient experienced a smooth discharge process was the presence of a family member or carer at the hospital throughout the patientôs stay in hospital. As all 5 patients were over 80 years of age, age does not appear to be a determinant. Instead, the fact of having a family member or carer visiting the patient regularly in hospital appears to be critical; those without are more vulnerable and are, these interviews show, most at risk to an unsatisfactory discharge process.

4.3.4 Responses which mentioned the involvement of GPs in after care were few and were only evident in interviews with two voluntary mental health patients.

4.4 From the discussions with senior staff members in health and social care agencies and in reply to particular questions, we found that there was little, if any, internal órearchôor monitoring focused on *hospital discharge performance or practice* within Wandsworth. Much as we commend the work at St Georgeôs on their Urgent Care Review project in 2008 and 2009[8], the focus of this work is the patient éxperienceôand éjourneyôwithin St Georges, including discharge; excluded from its purview is what happens to patients after discharge.

---

6 This includes an extra instance of hospital discharge of a respondentôs neighbour.

7 This figure is less than the 31 interviews carried out because some interview responses had to be disregarded.

8

4.4.1. We note, that when the local Primary Care Trust commissioned an Urgent Care review[9] which included one work-stream dealing with discharge planning and intermediate care and another stream dealing with developing and streamlining community services, care services did not feature significantly.

4.4.2 On the positive side, we were told that the level of 'fines' for Wandsworth patients overstaying in hospital when they were ready for discharge is currently below the average for London boroughs and local authority money that accrues from these 'fines' is reinvested in the local NHS (at St George's and Kingston Hospitals) to fund staff posts that facilitate patient discharge. This we see as an example of good use of resources to tackle this issue.

5. WHAT CAN BE IMPROVED?

5.1 Recommendations arising from our fact finding days:

The recommendations arising from the fact-finding days are made under at least one of the subparagraphs below. In response to the point made that patients and their families or carers often have unrealistic expectations of the discharge process, we are of the view that this problem can be overcome through our recommendations regarding better communication with the patient, their family and/or carer.

5.2 Recommendations from Enter and View visits:

5.2.1 The role of Discharge Co-ordinator should be extended and strengthened so that there is cover at weekends and when she is away. Also, Discharge Co-ordinators should be given the authority to confirm the time of discharge only when both medical, therapy assessments, medication and paperwork are complete. Patients should be informed that it is only when the Discharge Co-ordinator has done this that they will be discharged.

5.2.2 On leaving hospital, all patients should have a medical discharge summary and information about after-care to take with them. Copies should be sent to their GP that day, preferably electronically. The full care and medical plan should be copied to the patient (or carer) and sent promptly.

5.2.3 Delays (on the day of discharge) in discharging the patient home due to writing notes up, dispensing medication, or awaiting transport should be reduced. More preparation might be made before the day of discharge.

5.2.4. Where a patient is ready to be discharged home safely and they prefer not to stay in hospital an extra night, the patient should be discharged, if necessary, after 11 am; the 11 am target for discharge should not result in the patient having to spend an extra night in hospital.

5.2.5 Significant carers should always be included in the consultations made by hospital staff prior to discharge. The discharge check list should have spaces where separate carer/family contacts can be recorded and the contacts used to check discharge plans before discharge goes ahead.

5.2.6 We would like discussion between the agencies as to whether those being discharged from hospital should be prioritised in the provision of community physiotherapy.

5.2.7 Unless other arrangements are agreed, Discharge Co-ordinators should telephone the patient or their carer 2-3 days after discharge to ascertain if all is going well. Where there are

---

[9] Closing Report – Urgent Care Review Project – 16th July 2009 – Wandsworth, St George's, Sutton and Merton and Lambeth NHS Trusts.

problems, they should give or facilitate advice from a healthcare professional within the hospital and, if necessary, help to make appropriate referrals.

5.2.8 Discharge Co-ordinators would benefit from a training/induction programme of visits to local community services to enable them to understand better the way community services function and what resources exist.

5.3 Recommendations arising from the interviews:

5.3.1 There needs to be consideration given as to how to reduce delay in getting the patientôs medicines. Though hospital pharmacies are busy, it may be that they can be given earlier notice of the patientôs intended discharge day and medication requirements.

5.3.2 Hospitals must give patients clear information on who has the responsibility for arranging transport. General information should be given but also information relating to the specific condition and situation of the patient should also be taken into account and instructions or information given as appropriate.

5.3.3 Patients must be given reasonable notice of when their discharge is to take place and what the hospitalôs procedures are for making the final ôready to leaveô decision so that they know what to expect. Patients should not be discharged within a short time after being notified without the full consent of the patient and without checks being made on the situation at home or elsewhere where the patient is to go after discharge.

5.3.4. Particular attention must be given to patients who are returning to homes where they had been living independently and where, subsequent to hospital discharge, they may be unable to cope without first putting in place social care.

5.3.5 The patientôs GP must be given prompt notice of the plan to discharge the patient and there needs to be greater clarity as to who has responsibility for the patientôs wellbeing and continued recovery after leaving hospital. We recommend that the issue of GP involvement post-discharge receive more attention.

5.4 Recommendations flowing from our discussions with Senior staff in Health and Social Care agencies:

5.4.1 We did not find an easy way to review hospital discharge practice in hospitals other than St Georgeôs Hospitals. We think these hospitals (including Kingston Hospital, Queen Maryôs, Chelsea and Westminster, Guys and St Thomasôs, the South West London and St George's Mental Health Trust) should work together with Wandsworth Council's Adult Services Department and Wandsworth Community Services Trust to review their performance and work to improve hospital discharge practice. We have anecdotal evidence that hospital discharge planning for patients from these hospitals can be problematic and there is much scope for improvement here.

5.4.2 Our discussions with the South West London and St Georgeôs Mental Health Trust informed us about the positive approach of planning for discharge from the time of hospital admission. We understand that they are moving to provide a single in-patient multidisciplinary team. We think this means that the transfer of care to the multidisciplinary community mental team will need to be handled carefully and sensitively. We were concerned to hear about some delays in discharge due to housing/appropriate supportive care settings becoming available and we suggest that the Trust and Wandsworth Council's Adult Services Department monitor all delays and systematically record any apparent shortfall in resources.

5.5 Recommendations from our open meetings and wider consultations:

Most of the recommendations from these echo those found through our other activities.

6. CONCLUSIONS AND KEY RECOMMENDATIONS

We found that the Wandsworth Health and Care system is working in a climate where all concerned are trying to improve their practice and do their best within tight resource constraints. We think that there are at least two dominant and rather separate cultures; the world within the hospital and the world of support services provided to support people at home or living in a community setting. There needs to be much more appreciation and continuity throughout the whole patient experience - throughout both the in-patient and community after-care phases. We think all agencies have a responsibility to improve discharge practice and achieve a broader understanding of patients' needs.

We are of the view that the lack of coordination and ownership of the responsibility for the patient are the biggest challenges. Wandsworth LINk will aim to bring together key managers from all the health and care agencies in order to discuss the ownership of action on each of its recommendations. We hope to facilitate an inter-agencyô process that delivers practical improvements. At the same time, it is clear from our investigations that the role of the Discharge Co-ordinator is at the heart of many of our recommendations and we feel it is vital that this role is strengthened.

Specific Recommendations

1. Wherever the patientôs medical condition allows it, forward planning of discharge should take place to ensure that there are no delays in discharge, in providing medication, transport or writing discharge summaries.
2. Discharge should not be postponed overnight if everything is in place for discharge.
3. The patient, his family and/or carer should be informed about discharge plans well in advance to enable them to make preparations accordingly. The communication of the discharge plan to the patient and family or carer should be recorded.
4. Hospital staff should consider the patientôs home situation and the housing situation when planning each hospital discharge.
5. At discharge, all patients should be given a discharge summary which is copied to their GP. The information given to the patient should include written guidance on how best to recover as quickly as possible, what to expect and whom to contact if the patient is in doubt about their recovery.
6. More attention needs to be given to communication between hospital staff and the co-ordination of services by all health and social care staff.
7. Community services, including physiotherapy, should respond quickly and within a week at most if needed by someone discharged from hospital.
8. Discharge Co-ordinators should receive more training on the role of social care assessment staff (care managers) and community support services.
9. The Discharge Co-ordinator should routinely make telephone contact with the discharged patient 2-3 days after discharge to check if the discharge arrangements are working out well. The Discharge Coordinator must ensure that the patientôs GP is informed.
10. GPs must take more responsibility for their registered patients post-discharge. Especially where the patient was hospitalised as a result of a referral by the GP, the GP should contact the patient within 2-3 days of discharge.
11. It is imperative that the work of the Discharge Coordinator needs to be extended to cover weekends as well as week days.
12. The focus given to hospital discharge at St George's is something we would like to see in all hospitals. Such focus should be given bearing in mind the need to work in conjunction with Community Services.
13. Processes should be put in place for periodic review and monitoring of hospital discharge processes and practice.

14. Inpatient mental health staff should ensure patients are introduced to staff from community mental health services to ensure a seamless hand over.
15. A record should be kept of any shortfall in resources (community support services) that delay discharge of mental health patients. This information should be used by all the agencies to make the case for resources and so ensure the availability of the full range of community support services.

7. NEXT STEPS

Aside from that already mentioned at para 6 (CONCLUSIONS etc) above, Wandsworth LINk plans to carry out some follow-up activity to ascertain what improvements have actually been made.

Jeremy Ambache and Carol Tan
Date

APPENDICES:

1. Project plan
2. Summary of Enter and View visits

APPENDIX 1

Hospital Discharge Project Plan

Action	Original Time Frame	Revised dates	Comment/Actioned	Further work planned
First Discharge Fact Finding Day	25/06/09		Action day held	
Second Discharge Fact Finding Day	24/09/09		Action Day held	
Secondary Group to consolidate all info gathered from discharge days one and two into one format	By 4/10/09		The notes have been written up	
Secondary Group to meet to discuss the main issues from fact finding days.			Done	
Design a questionnaire to be distributed to user groups ï carers, Age Concern etc.			On further reflection it is now suggested to increase the number of interviews (see below) rather than send out questionnaires. This may achieve a higher response	
Send out 100 questionnaires and aim to get at least 15 returned. Obtain advice from Dawn Warwick re distribution of questionnaire and use existing available social services resources	19/10/09		-See above amendment	
Closing date for questionnaire	19/11/09		-see above	
Questionnaires		15/9/2010	Advertise via twitter, facebook and the web site so that all who wish can complete a questionnaire.	
Secondary Group to liaise with local groups to gather further info on discharge policy and practices	-	July 2010	Visits to Day Centres to identify and talk to service users who have been discharged from hospital recently (CB)	
Secondary Group to meet to review all findings, prioritise issues and decide which one or two to pursue. Agree plan to take priorities forward	9/11/09		2 priorities suggested ï communication and publicity. But not followed through with key agencies.	None

Action	Original Time Frame	Revised dates	Comment/Actioned	Further work planned
Interview at least 10 service users, eg LINk members, (4 older people, 3 people with mental health issues, 3 disabled people) to find out their experiences of hospital discharge and after care. To seek any views and suggestions from them	30/11/09	?	Revised to expand to 25 interviews (rather than questionnaires see above (to aim for - 9 older people, 6 mental health, 6 physically disabled and 4 learning disabled service users, 4 Carers) (JA and SKW)	
Interview and seek evidence from users and carers who raised concerns with LINk about hospital discharge	30/11/09	September 2010	(JA and SKW	
Meet with Springfield (Tom Clarke/Stuart Thompson), Tooting Walk in Centre, Queen Elizabeth Hospital Roehampton	30/11/09	September 2010	Meet with Mental Health Trust and Queen Maryõs Hosp (JA and SKW)	
Review research and development work on hospital discharge by the agencies working in Wandsworth. Check if they have implemented any planned improvements.	31/12/09	September 2010	(JA)	
Consolidation and presentation of findings to LINk Executive	March 2010	24 Nov 2010	(JA)	
Present report with recommendations to all the key agencies responsible for hospital discharge services		Jan 2011	This is a new item suggested to get the buy in from agencies to our recommendations. We should get them to commit to improvement actions. (JA and SKW)	
Post audit report to review how recommendations and findings have been implemented	June 2010	June 2011	(JA and SKW)	

The initials shown in brackets indicate the person(s) responsible for each task

Jeremy Ambache
3.7.2010

APPENDIX 2

SUMMARY OF THE ENTER AND VIEW VISITS

With hospital discharge as one of Wandsworth LINkôs four priorities, the Enter and View Team wished to discover more about how patients and their carers experience the discharge process. We intend later to follow the patients into the community to assess the quality and appropriateness of their care and support at home which will help to inform our opinions about the Transformation Agenda - another of the LINkôs priorities. We twice visited St Georgeôs Hospital to seek the opinions and views of the patients who were being discharged and their carers.

We wanted to find out how the policies work on the ground on the day of discharge. In particular, we sought to establish whether the discharge process was safe and how the patients and their carers felt about the process.

Methodology

Our two visits were prearranged. We used a prepared prompt list of questions to find out the relevant facts that might influence each patientôs discharge planning. These included the reason for admission, whether it was planned or emergency, and the length of stay. We asked about mobility, the care needed at home and at what point the patient and carer were involved in discharge planning and made aware of treatment and follow-up.

The patients interviewed were identified by the staff as those likely to be discharged on the day of our visit. In order to understand the discharge process better we also talked to Discharge Co-ordinators, ward staff and Managers. We also followed up by telephone some of the patients and their carers after discharge to enquire if things had gone as planned and whether any further issues had arisen.

The team interviewed or discussed eight patients in all on the first occasion and five on the second. This limited number only gave a flavour of issues that arise during discharge but there was a consistency in their evidence. The selection included patients from four boroughs. None were planned admissions for surgery. Only two patients were assessed as needing a package of domiciliary social care. Of the others for whom plans had been made, one had the involvement of the Early Discharge Team, two returned to existing nursing home placements, and one was waiting for a Residential or Nursing home placement.

Wards Visited

The wards we visited on the first visit were Allingham, Rodney Smith and Holdsworth Wards. Allingham and Rodney Smith are medical wards where many patients who have long-term conditions and often longer-stay admissions are treated. Holdsworth, in contrast, is for patients recovering from trauma and planned orthopaedic surgery who are generally fitter and, more frequently, experience short hospital stays. Our second visit was to the geriatric wards of Thomas Young and Heberden, and the neurological ward of William Drummond.

Discussions with Discharge Co-ordinators

Our discussions with Discharge Co-ordinators revealed that their working hours were only from 8-4pm Monday to Friday, with no formal cover for weekends or when they were away from work. With unclear authority, no administrative help and often little experience of community services, they were responsible for coordinating input from other disciplines to achieve safe discharges. Unless things went seriously wrong, they received no feed back after the discharge.

The Ward Discharge Routines

We discovered that discharge routines varied from ward to ward according to the type of patient and treatment. On the orthopaedic wards, the Consultants usually do their rounds between 8 and 9am when patients are informed whether they can definitely go home that day. A member of the

medical team returns to the ward at about 11am to write out the prescriptions for the patients who are to be discharged and only then can patients go to the Discharge Lounge. The Hospital Pharmacy dispenses around four to five hundred prescriptions each hour and so there can be a delay of two to three hours before the drugs for the discharged patients arrive.

In other wards with less rapid patient turnover, there are different routines. In one ward, a ñurse-led dischargeòenables medication and reports to be prepared the day before so that, subject to a last medical check on the day of discharge, these delays can be avoided. The geriatric wards hold regular multidisciplinary meetings which take responsibility for deciding discharge in the light of assessments from the Medical team, Physios, OTs and Social Workers.

Patients due for discharge and significant carers are seen by the Discharge Co-ordinator before they leave the ward and some patients and carers are included in earlier discharge planning. Patients are each given appropriate leaflets and other relevant information that they need which should include a medical summary, a copy of which is also sent to their GP.

Follow up

The follow up telephone calls with carers were very informative and useful. Some patients had stayed in hospital a few more days. Carers who had had them appreciated discussions with ward staff; others felt they had not received enough information or had had to push to talk with medical staff. Some had experienced confusion about the timing for collection of the patient from the ward. One highlighted the lack of an OT assessment and equipment, and another was not aware of community services that might be appropriate for her father. Not all had been discharged with a medical summary.

RECOMMENDATIONS

1. Discharge Co-ordinators were commended as a crucial element in ensuring safe discharge. Where appropriate, every ward should have one. We wonder if consideration has been given to extending their capacity, for instance, giving them both more hours so that discharge planning can continue during the weekends and administrative assistance to follow up details whilst the co-ordinator is dealing with other patients.
2. Seek ways to rectify the time lags on the day of a patientôs discharge, particularly those caused by delays in writing up and dispensing medication. Aspects of the nurse-led discharge pilot might be applicable in other wards.
3. We felt that the importance of Medical Discharge summaries could not be over-emphasised, particularly when the patients are elderly or otherwise vulnerable. If such patients need the help of their GP or an emergency service following discharge, the presence or absence of the discharge summary could prove crucial in receiving/not receiving appropriate treatment or readmission.
4. Patients, even with unplanned admissions, appreciated being kept informed of progress and given as much prior warning of their estimated discharge date as possible in order to make home arrangements. When last minute arrangements were possible, the 11am discharge goal was less important to them than an additional night away from home.
5. We agreed with the Discharge Co-ordinators that they could benefit from learning from practice. In the first few days after discharge, communication from patients could be encouraged in order to give feed back about the success of their after-care arrangements. Also more targeted training and visits to community services could increase their skill set and authority.
6. More priority should be given to including significant carers in plans and medical explanations. They deserve a separate and distinct section in the Discharge Check List so that their involvement/lack of involvement is recorded.
7. In spite of pressure on beds, there should be no doubt that proper checks are completed before a patient is discharged.
8. It is important that patients and staff understand the role of the Discharge Co-ordinator so that there is no confusion in the patientsôminds about who determines final readiness for discharge. Frustration over delay and confusion can be caused if patients, after being declared medically fit,

are not aware of the discharge coordinatorôs responsibility to ensure a safe discharge with all paperwork completed and transport arranged.

Jenny Purkis

August 2010