Leaving Hospital – Response to recommendations made by Healthwatch following their visit April 2013

In April 2013 the Healthwatch Enter and View team visited St George's Hospital to undertake a follow up study to a visit in 2010 on the patient's experience of hospital discharge. This report responds to the recommendations that came from that report.

Since the visit and before the recommendations were received, the Trust has completed a service improvement project on the discharge process. The aims and objectives of this project were to:

- Improve discharge processes within medical and senior health wards
- Reduce the number of delayed discharges of medically fit patients
- Improve Patient experience, and to
- Improve the methods and mechanisms used to refer patients to Social Services
- Improve Staff satisfaction

Some of the benefits are captured below. There were also substantial anecdotal feedback from staff around the benefits of, for example, shadowing colleagues and having protected space to complete discharge paperwork and processes.

BENEFIT METRICS ACHIEVED		
	Originalfigures	**Achieved at 90 days**
Number of patient delays (DTOC)	26.3	18
Number of days delay (DTOC)	174	86
Complaints relating to discharge	1.2	1
% of discharge coordinators shadowing colleagues in community	0%	100%
% of patients leaving within 90 mins of their book ready time	75%	86%
Average response times to requests to move patients to QMH	124 mins	53 mins

Readmissions (plan to maintain)	20.2	20.6

Recommendations from the report

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.

The trust acknowledges the importance of informing patients and their carers' as early as possible about planning for discharge and will agree with the discharge coordinators and ward leaders the best way of encouraging the friends and carers of patients to become involved where appropriate. Good practice already exists in some of our wards and this needs to spread across the organisation.

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.

The trust fully recognises the importance of the discharge coordinator particularly in managing complex discharges. The service improvement project reviewed different aspects of their job and the way in which they work in order to help them be more effective.Some of the outputs of this work stream were:

- Identifying quiet office space away from the nurses' station to enable them to complete necessary paperwork for patients with complex discharge needs.
- Provision of dedicated cordless telephones, with a messaging service. This allows the discharge coordinators to carry the phones with them and allowsexternal agencies and patient relatives to leave messages.
- Virtual Desk Top computers which allow all staff to access their documents, emails etc. from most computers anywhere in the Trust.

The trust has also worked with the London Health and Social Care Information Centre and is due to join the Secure Information Programme that has been

rolled out to over 60 Health & Social care organisations, which will help with the speedier transfer of information to support admission and discharge.

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.

- Work is being done across the wards to standardise the information displayed on the white boards. Where appropriate this will include information about communication difficulties. Patient specific information e.g. problems with hearing is displayed above patient's beds so that all staff are aware.
- The Trust is currently looking at moving towards the use of electronic white boards. Once the information for standardised whiteboards is agreed, and tested, the trust will implement this into electronic whiteboards. This is envisaged to provide the trust with better and more real time patient information allowing for better planning of bed allocation, movement of patients from ED/AMU to the wards, and to enhance the focus on proactively managing the expected date of discharge (EDD) of patients. This project is part of a larger service improvement project which is aimed at improving flow and capacity across the organisation.

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 nowbe more easily accessed by other staff from the white boards.

- Within each medical & senior health wards, the Discharge Coordinators have identified 1/2 staff nurses who they are training to provide cover for them.
- The new telephones will assist with this as relative/carers can leave messages.

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.

- All the current discharge co-ordinators within the medical & senior health wards have been out to work with Wandsworth Community servicesand nurses from the community have also been in to the hospital to work with the discharge coordinators. All staff have found this to be a very valuable learning experience and therefore it will continue and include visits to other relevant agencies or service providers.

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.

- This was a key element of the discharge coordinator work stream. In recognition of the amount of time that is needed to understand and plan the discharge needs of older or more vulnerable patients it was decided that the management of more straight forward discharges should go back to be the responsibility of thenurse looking after the patient or the nurse in charge. This allows the discharge co-ordinators more time to use their skills on preparing the complex discharges for a safe transfer or discharge.
- The staff on the senior health wards are very experienced at assessing and understanding the needs of their patients and the process of discharge planning has always been a very important aspect of the care pathway involving the full multidisciplinary team who meet regularly to discuss their patient's progress.

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.

- The Trust continues to work hard on improving the patient's experience of hospital transport services. The Transport group meets fortnightly to ensure any transport issues are addressed.
- Ward teaching has occurred to ensure all staff can book transport so this can be booked when discharge decisions are made out of hours.Updated information is also available on each of the wards to support staff in booking transport appropriately.
- As much as possible, planned discharges are booked the day before, allowing for transport to pre-plan more journeys therefore have more capacity for on the day bookings. This is monitored so that we can see which wards need extra help and support to comply with trust policy and processes.
- As a result of the focus on transport in the Discharge Management Project, bookings are now being made earlier in the day, ensuring that beds are being freed up sooner and that patients are getting back to their place of care earlier.
- A service improvement project on transport is also part of our overall programme.

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.

- The trust is committed to completing a discharge summary of a patient's hospital stay before they leave the ward and certainly within 48hours of their discharge.
- The lead nurse for discharges will look into producing pre-printed labels to put on the envelopes to remind patients of the contents.
- Part of a recent improvement project has looked at how we can improve this process.

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.

- This point has been raised previously and information leaflets are available for patients with specific conditions (e.g. diabetes, rheumatoid

arthritis, angina etc.) or for patients following surgery or other interventions (e.g. cardiac surgery and endoscopy procedures).

- As part of general care and in preparing a patient to go home both nursing and medical staff will talk to patients about their recovery and advise them on what to do if symptoms arise or become worse. This will be patient specific and depend on individual patients' needs and follow up arrangements. This advice might include contacting a clinical nurse specialist (e.g. heart failure) or community nursing / social support or a GP.
- A discharge advice leaflet "Now you are leaving hospital" was designed following the previous visit from Wandsworth LinK. This leaflet is given to patients discharged from the medical and senior health wards. It details services that have been set up for the patient and provides them with the name and number of a person to contact for each service if needed. The discharge coordinators have been reminded to make sure patients are given this information.

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.

- The trust acknowledges that best practice might be for the acute services to follow up more patients once they are discharged but with an integrated service and good referral processes once the patient has left hospital they become the responsibility of our community staff. Patients are given details of who to contact if they have concerns as described above.
- Within Wandsworth some patients are referred to the Community Ward if there are on-going concerns. The Community Ward has health and social care professionals and will provide a follow up service.
- A staff satisfaction questionnaire of acute and community staff is currently in use to identify where improvements can be made in the discharge processes.

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.

- The decision that a patient and their family make about whether they can no longer cope in their own home is often a difficult one that takes time and can result in a number of failed discharges before they accept that they are no longer coping. When a patient is insistent on going home but the MDT feel a 24hr setting would we a safer option the trust will always inform our community staff. This is to help ensure that a rapid transfer can occur if/when necessary.
- The trust is about to start some work with the Emergency Care Intensive Support Team (ECIST) on the pathway for the frail elderly. This will review the whole pathway and recommendations from your report on the need for a fast track assessment will be fed into this process.
- At the time of discharge some patients refuse the input of social services. Staff will offer these patients the contact details of AGE UK and give advice on contacting their GP if they change their minds.

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