Walsall Manor Hospital Discharge Process March 2023

healthwatch Walsall

Engaging Communities Solutions

Contents

Abbreviations that may appear in this report.

WMH = Walsall Manor Hospital

PALS = Patient Advice & Liaison Service

DL = Discharge Lounge

A&E = Accident & Emergency

CQC = Care Quality Commission

DNS = Deviated Nasal Septum

AMU = Assessment Medical Unit

ITU = Intensive Treatment Unit

Introduction

Healthwatch Walsall are the independent voice of the public in health and social care services in Walsall. We gather feedback from members of the public about their experiences of using health and social care services. We use that feedback to work with service providers and commissioners to find ways of improving services for the public.

One of the ways that we collect feedback is through carrying out a focused project around particular services, conditions, or groups within the community. Each year the intelligence we receive through a number of ways is collated to identify priority projects. Based on this feedback one of the themes identified for 2022/2023 was the discharge process from Walsall Manor Hospital. This project aimed to understand the current experiences and views from the patient being discharged from hospital including the planning of discharge and the involvement of patients and relatives in those plans.

Methodology

We developed a survey that was available online and in hard copy format. The survey also allowed participants to share more specific experiences and to give feedback on any social care support that may have been required for when they were discharged into their domicile. We were seeking views from the commencement of the project up to 18 months previously. The survey was carried out from July 2022 - February 2023. The survey was made up of 32 multiple-choice questions, 1 date question, and 6 open text questions that enabled respondents to expand on their responses.

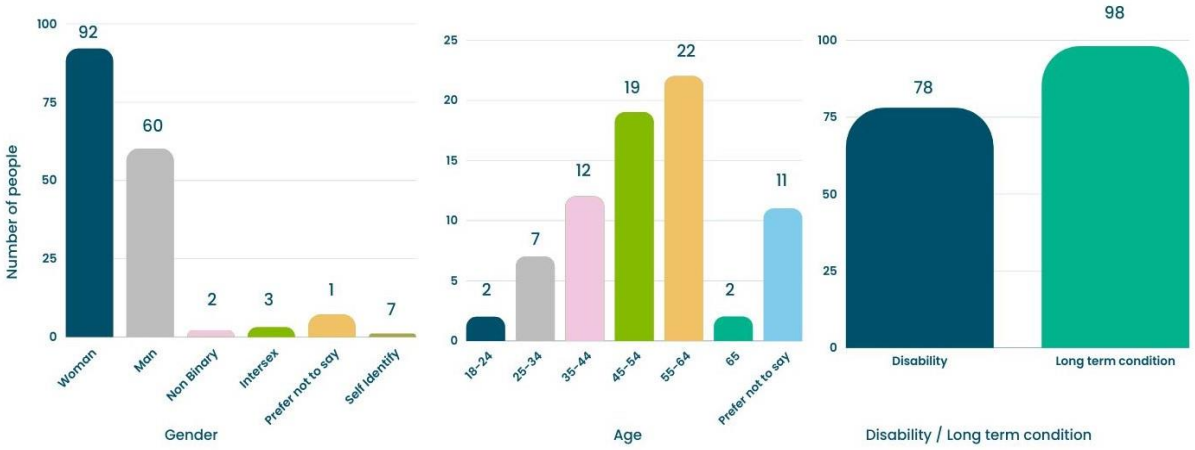
Healthwatch Walsall ran the survey for the period noted above in order to see if there were any seasonal variations in patient experience and to see if the winter pressures impacted on the discharge process. As noted previously, a paper copy was also made available and was used to

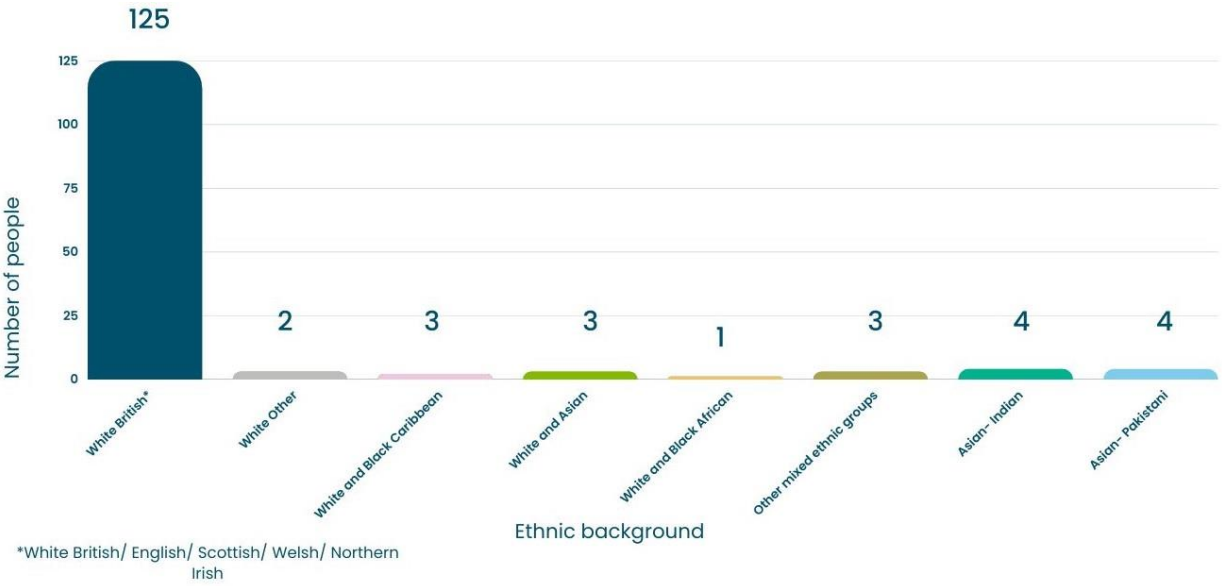
collect feedback from patients/relatives and carers at face-to-face interviews in the discharge lounge, Elderly and Frailty Unit and during public outreach opportunities at venues such as Walsall Manor Hospital and community events. Pre-paid envelopes were made available to minimise the cost of completing the survey and to allow surveys to be completed at a time most convenient for the participant.

Healthwatch Walsall would like to thank the Red Cross, patient experience team at Walsall Manor Hospital and the Local Authority social care department for their support in distributing the hard copy surveys and promotion of the links to the online survey.

Who took part

Participants were: patients, relatives or carers who had recently or were currently being discharged from Walsall Manor Hopital to various locations including back to their own home or nursing or care settings. Some patients or relatives may or may not have needed additional care support needs.





Data from our survey

The survey received a total of 171 responses some of which were multiple choice questions, open text questions were analysed thematically and examples of feedback we received are included in the reporting of each theme. Below are the participants responses to the questions we asked. The questions were not mandatory giving participants the choice to answer or not. Therefore, the figures for each data set are different but represent the answers given.

We asked if the participant was the patient, relative, carer or friend.

Patient - 153

Relative, carer or friend - 18

We asked if the participant was currently in the hospital

Still in the hospital - 95

Not in hospital - 74

We asked respondents if they were involved in the discharge plan

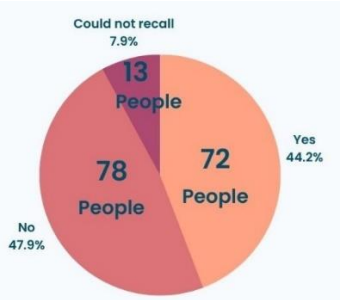
Yes – 78 **No - 84**

We asked participants about their most recent discharge from Walsall Manor Hospital (WMH)

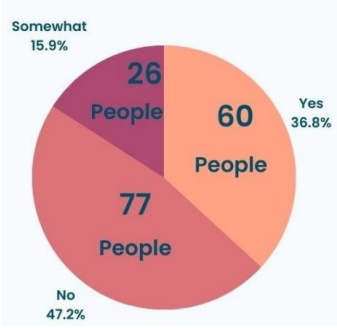
Past 3 months – 87 **3-6 months ago - 22**

6-12 months ago – 32 **Not previously discharged - 22**

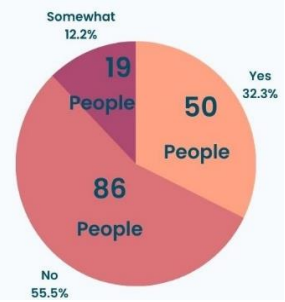
Was the discharge plan discussed and explained?



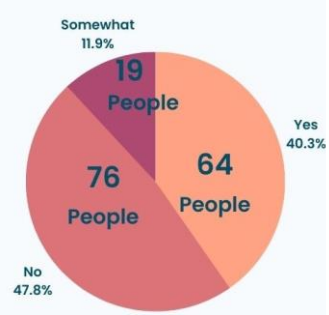
Were the discharge arrangements explained or given in a format that the respondent could understand?



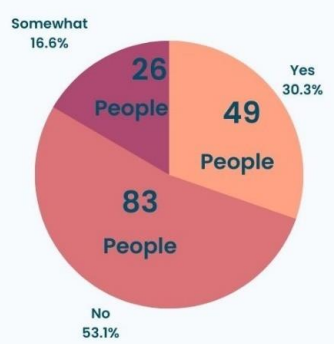
We asked if they felt involved in the discharge planning



We asked if they fully understood the discharge arrangements



We asked participants if they were kept updated about the discharge planning



We asked participants to indicate all of the services that communicated with them about the discharge arrangements

Social Worker -18

Occupational Therapist -10

Physiotherapist - 19

Integrated Care Services - 5

Rehabilitation Services - 1

Patient Transport -16

Local Authority Care Assessment team – 4

CPN - 1

None - 58

Other - 33

We asked what other services were involved in discharge

Physiotherapist – 1

Dentist – 1

Ward Staff - 12

Community Nurse -2

Chiropodist - 1

Doctor/Consultant - 9

Wheelchair Service - 1

Discharge Team - 2

The remaining responses were analysed thematically, and 6 themes emerged, **Discharge planning, Patient sentiment, Medication, Communication, Discharge delays, Patient and family involvement in discharge planning**.

Discharge planning

'I had no idea I was going home'
'Only found out when nurses came to collect me on the morning of discharge'
'No discharge planning'
'Confusion over discharge date'
'Did not seem to plan appropriately'

'I didn't experience any planning to be discharged, I was discharged despite the doctor saying I would be in hospital for the next 3 days'
'Last thing I was told was that I was going to have an MRI scan and then I was told I was going home. I did not have my MRI scan'
'It is like the doctor tells you one thing and they do another'

Patient sentiment

'I came home, went to another hospital for a second opinion, they are treating me now'
'I don't ever want to go back to this hospital'
'This hospital is rubbish'
'I am proud of the NHS'

Medication

'Arguments between staff about medication'
'My medication came in a taxi the next day'
'Mom should have had anticoagulant drugs after her op'
'They sent it in a taxi 5 days later'
'Waited for medication for 3 hours'

Communication

'Sent home not fully understanding why and what to do next'
'The staff did not communicate with each other on the ward, I kept having to tell them what was happening'
'The doctor was too busy to see me, the nurse said the follow up was hard to explain but I should receive an outpatient appointment in 8 months'
'Total lack of communication'
'Discharge was unexplained, I was just told to sit and wait'
'They tell you nothing here'

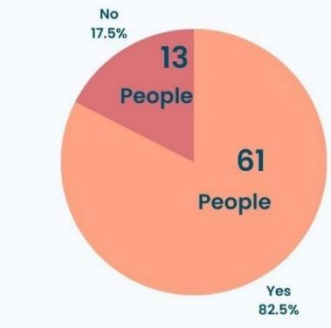
Discharge Delays

'I keep being told I was going home, and I was not sent home'
'Discharge lounge can be a little frustrating'
'I was in the discharge lounge for hours, I felt ill and just wanted to lie down'
'I sat in the discharge lounge for 7 hours'
'Patient transport were turned away twice'

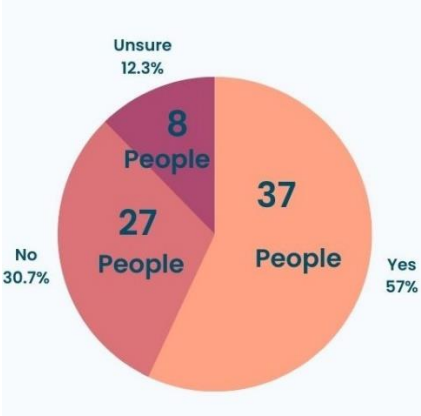
Patient and Family Involvement in Discharge Planning

'Not fully consulted about what is needed on discharge'
'My parent had surgery and the hospital thought it was ok for her partner who is XXX years old, deaf, visually impaired and has Alzheimer's to be her main carer, despite the fact that we had raised this as a concern early in their stay but weren't listened to'
'Biggest concern is not being involved, I was just moved by ambulance and not told where I was going to'

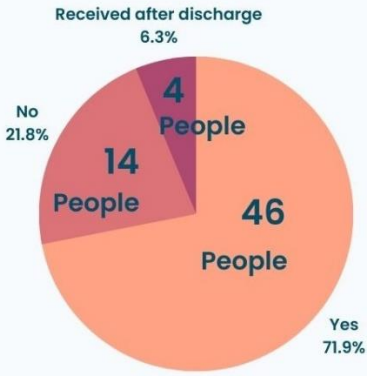
We asked if the patient felt safe and well enough to be discharged at the point that, the discharge took place



We asked about medication and if it was available upon discharge



We asked if a discharge letter had been included in the discharge information that was received by the patient/relative/carer



We asked how long the discharge process took to be completed on the date of discharge

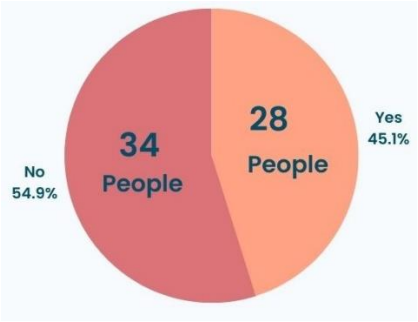
Less than an hour - 13

2 to 5 hours -33

6 to 10 hours - 15

Longer than 10 hours - 5

We asked if they felt the discharge was delayed



We asked about the type of transport used to take the patient to their discharge destination

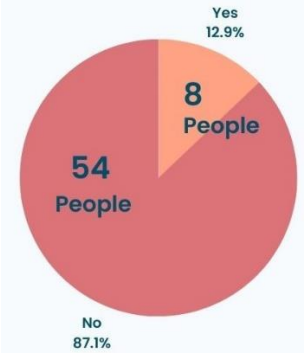
Ambulance - 25

Family or friend - 34

Taxi - 5

Other - 3

We asked service users if they felt the discharge was delayed due to transport issues



We asked participants to rate their discharge from WMH

Very good	Good	Mixed feelings	Poor	Very poor
13	20	20	4	8

We then asked an open text question asking respondents to tell us anything else they wanted us to know about the discharge process at WMH. 3 themes emerged, **Pharmacy and Medication, Discharge Delays** and **Discharge Plan.**

Pharmacy and Medication

This was the most common theme that was discussed, and comments made noted below:

'Discharge was delayed by one day due to medication not being ready'

'Delayed by 24 hours due to medications being sent to the ward instead of the discharge lounge'

'Discharge was delayed as I waited for 6 hours for tablets that never turned up'

Discharge Delays

This was another theme that was raised in the feedback and comments made noted below:

'There was a lot of hanging around waiting for full discharge process to take place'

'Thought I was going home until 8pm but was then told no carer at that time'

'Although the staff were pleasant and helpful, it seemed very disorganised, and patients everywhere were obviously not comfortable'

'Waiting for transport'

Discharge Plan

Participants made the following comments:

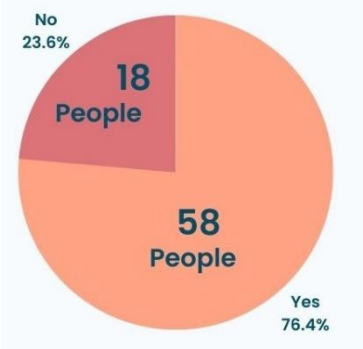
'District nurses did not keep appointments'

'Would have felt more comfortable and happier waiting on the ward instead of waiting in the discharge lounge'

'When I arrived in the discharge lounge staff very efficient and helpful'

'I feel the staff on the discharge lounge were amazing, caring, and really interested in my circumstances'

We asked if the discharge destination was clearly communicated



We asked when the information about the discharge destination was given to them

Soon after admission - 7

Sometime during admission - 13

On the date of discharge - 47

We asked where the patient was discharge to

Discharged to own home -63

New care/nursing home - 2

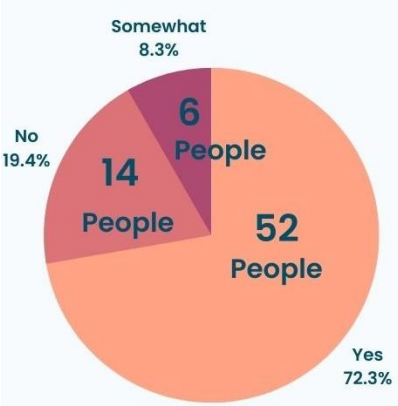
Stepdown bed care/nursing home - 2

Current care/nursing home - 1

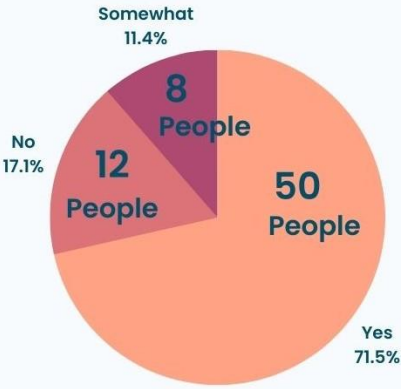
Family or friends' homes - 2

Other - 4

We asked if respondents felt involved in the choice of where they were discharged to



We asked participants if they felt fully informed about the discharge destination



We asked how long the discharge arrangements took to commence following discharge

42 - Immediately following discharge

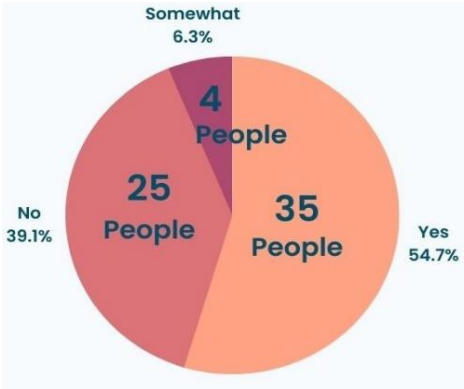
11 – Within a week

3 - 2 to 4 weeks

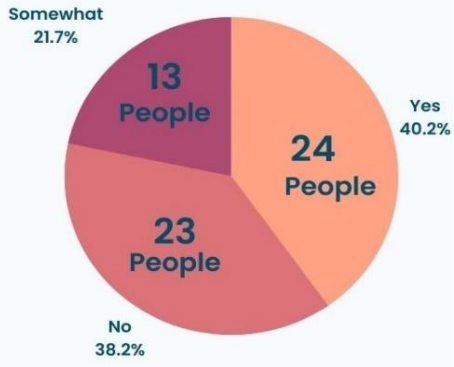
2 - 1 to 3 months

7 - Not commenced

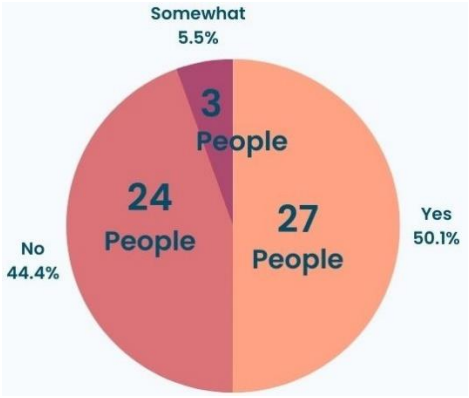
We asked if the patent's support or care needs have changed since their admission to WMH



We asked if post-discharge care was explained



We asked if care packages, aids and equipment were available at discharge



The next question was an open text question asking participants to add any further comments they wanted to make about their discharge destination or care. The themes identified are as noted below:

Care Package

This was the most common theme discussed and the comments received are as noted below:

'Some care was put into place, some wasn't'

'Support or care after discharge was never discussed'

'Carers will be coming to my home 4 times daily when I go home', someone else told us that the process was time consuming'

'The discharge destination or care had been put into place in 'quite a smooth and organised way'

Communication

This was another theme raised in the feedback and the comments received are as noted below:

'It would have been good to know when my leg was due to be dressed and that the district nurse had been arranged'

'Not really had much info about discharge'

'They discharged me and everything wasn't done'

'None of my patient notes were transferred from Good Hope Hospital, and that I had to repeat everything to the staff at WMH'

Aids and Equipment

This was the final theme that was raised by the feedback and the comments received are as noted below:

'My dad is unable to walk without assistance and needs a wheelchair, we've had to get a referral via our GP and pay to hire one'

'Created additional stress'

'Had to wear ECG monitor for five days, but it wasn't clearly explained to me how to use it, and when I phoned WMH to ask why the monitor was beeping the Doctor didn't know as it was a new device'

A further open text question asked participants if they have any ideas or suggestions as to how the discharge process could be improved. The feedback we received was analysed thematically and 3 themes arose from the data.

Pharmacy and Medication

This was another theme discussed, and the comments received are as noted below:

'Waiting for medication takes a while'

'Issue electronic prescriptions to patients so they can go to their own pharmacy'

'Ensure the patients have the appropriate medication on discharge'

'Medication waiting times are too long'

Discharge Delays

This was the final theme discussed, and the comments received are as noted below:

'Patient transport is an issue'

'Like it to be a little quicker if possible'

'A quicker turn around'

'Patients can go home'

'There should be less waiting around'

Communication

This was the most common theme that was discussed, and the comments received are as noted below:

'No discharge plans were discussed with me as the nurses did not seem to know and said the doctor had not made any entry in my notes'

'Information about medications prescribed at the point of discharge would be helpful'

'Give patients adequate notice of discharge'

'Doctors would explain clearly about the plan of action'

'To have things explained more'

'Don't know what is happening at what time'

ADDITIONAL SUPPORTING INFORMATION

Findings from observations and staff comments

As well as chatting with waiting patients/relatives in the discharge lounge we also made notes and recorded observations. Below is the recorded responses and notes of a visiting Healthwatch Walsall staff. Please note that all identifiers have been removed.

Staff member comment:

'I am mopping up other people's work in the Discharge Lounge. If the correct paperwork is not completed by the ward before the patient comes to us, I can't discharge the patient. For instance, controlled drugs must be signed off by the Doctor on the ward before the Pharmacy can prescribe them. If this is not done, I am chasing the ward trying to get a doctor to sign the forms. Today fortunately, a Doctor from a Ward had to come to the DL to see a patient, whilst they were here, I got them to sign other patients' paperwork'

Care/Nursing home related feedback

We also sent a call out to care/nursing homes regarding patients who are discharged to their care settings.

Listed below are the comments we received:

- Trusted assessments are not always up to date, change in needs not always documented i.e. catheter in situ but not on documentation when patient/resident arrived
- Discharges do not always come with all items required i.e. incontinence pads, catheter passports or medication

When asked how the discharge and referral to their setting could be improved, we were told:

- Ensure up-to-date information (any changes since assessment took place)
- Ensure all items needed are sent with resident
- Ensure any referrals to other professionals are done prior to discharge

What this may suggest

- There are tasks not carried out such as medical equipment being removed from patient prior to transit
- Information may not be up to date or complete on patient handover
- Patient items sometimes go missing when a patient is discharged to a care setting
- Some checks are not being made/effective at point of discharge to care/nursing setting
- Trusted assessments are hit and miss regarding being complete or up to date

Patient/relative/carer case studies

We collect patient experiences daily across various Walsall health and social care services. One of our collection portals was our Service Feedback centre (now called Have Your Say), an online service experience review opportunity for service users or relatives to leave compliments, concerns or potential complaints.

The below relative experiences have been agreed to be used as case studies with any identifying characteristics removed.

Case Study 1

'My relative (patient) was taken in by ambulance with suspected sepsis and kept for 6 hrs and sent home at midnight. When I collected them, they were wrapped in 5 blankets and literally shaking. I was told they had a severe UTI however they didn't have the antibiotics to give to them until the next day. They were then taken in a day later as their symptoms were still the same and taken straight to a ward as they looked so poorly with the instruction of intravenous antibiotics by the doctor. This was at 1pm still at 6.30pm when I left, they were in the same place with no treatment. On leaving I informed the nurse that they hadn't had their medication as she said she would be back to give it to them. At 11pm they still hadn't had it however it had been logged that they had it at 5pm which was not accurate as I was with them. I was also told that they were being discharged and I argued this as they hadn't had any medication. They were moved from pillar to post through the night with still no medication. I was called at 2pm the next day to say they could come home. I further challenged the medication and they basically called both me and the patient a liar as it was recorded that they had it.
I ask for it to be documented on their file that we disputed the medication administration. To further add to this later that evening around 10pm a discharge letter was pushed through their door! We are absolutely disgusted with the medics and the patient care that we received. My relative (patient) is still unwell but I refuse to bring them back to this hospital at this point. They were offered 1 drink and a dry dinner and felt they were left alone. There was no compassion or empathy by any of the staff.'

Case Study 2

'Tried over 2 days and estimated 60 calls to three wards, only got through once to be told to call back. Tried to call back to wards and just keeps ringing, called PALS for support, guess what just keeps. ringing. Patient is subject to a Safeguarding issue caused by an unacceptable unsafe discharge by the Manor Hospital, staff such as doctors and ward sisters not aware of this when patient was returned.'

FROM DISCUSSIONS WITH RELATIVES

After a discussion with the relative the following points were communicated to Healthwatch Walsall

- Patient had at least two discharges
- No relative visits due to covid, has dementia so not able to communicate with people
- 47 calls to wards on one occasion until called PALS
- Patients stay in hospital for 3 weeks, lots of chronic conditions and needed a bed to be discharged. Patient had a needs assessment, but relative kept calling to find out, bed had not been ordered. It took up to 10 days to get in place for the patient to return to relatives' home
- Discharged on one occasion, late at night, catheter bag still attached, no resource in place to change, no information of what to do
- Care package not set up, so family intervened/delivered
- Patient discharged, emaciated, dirty and delirious. Family called hospital spoke to hospital doctor who suggested to readmit patient
- No medication on one discharge occasion, later sent by taxi
- No discharge letter on one occasion
- Ambulance transport crew raised safeguarding concern around discharge of patient
- Patient walked into hospital but can't walk now and has further issues
- Patient had someone else's mobile phone brought back home with them, handbag and jewellery were missing but later found and returned
- Also request to pick up and clean return clothing but not patients clothing

After a discussion with the relative the following points were communicated to Healthwatch Walsall

- Felt initial discharge unsafe and had to call GP and take patient back to A&E
- Patient felt kept in corridor, moved around bit not knowing where they were or had been
- Communication between staff contradictory 'patient staying in' and then 'going to be discharged'
- Medication paperwork may be incorrect/signed but no medication administered
- Patient had no dignity when trying to go to toilet, area open to passers by
- Left in same clothes overnight when apparently admitted
- No medication available due to pharmacy being closed so sent home
- Discharge letter posted/hand delivered to home not given at time of discharge

Key Findings

- Discharge process inconsistent
- Patients and relatives not always involved
- Ward staff, doctors and consultants appear to be mostly involved with a patient(s) discharge with others brought in when a decision is made around discharge
- Many participants were not aware they were being discharged until minutes or hours before being discharged
- Poor patient information checking around medication and patient ID on wards by staff
- Patient information provided can be contradictory
- Patient records are incomplete/incorrect
- Discharge letters are sometimes not available at the time of discharge
- Patient dignity can be compromised
- Patients may become immobile after periods of time in a hospital bed
- There were some delays on medication by the pharmacy at the hospital, medication followed the discharged patient(s) by taxi later or even days later
- Discharge was delayed in DL due to recheck(s) of patient records including medication and transport of patients
- Care packages are not always in place on date of discharge
- Relative/carer involvement and communication within the discharge of patient(s) is mixed at best and can show a lack of understanding, patient safety and compassion by staff, one person told us the following:

  'My parent had surgery and the hospital thought it was OK for their partner who is almost 100 years old, deaf, visually impaired and has Alzheimer's to be their main carer, despite the fact that we had raised this as a concern early in their stay but weren't listened to'

Conclusion

There are wide ranging comments in this report, and it is pleasing to note the positive sentiments told to us. The negative feedback are areas that can be addressed and the findings can offer opportunities for learning and improvement.

The discharge experience is mixed for patients. When it has gone well there has been minimum or no disruption to the patient discharge and aftercare. However, this has not been consistent and in many cases, Issues around patient involvement and communication has been highlighted as poor or not happening.

The work that is now being carried out by the discharge lounge staff is important and represents a 'check back' of patient discharge and their records. Whilst this is a safety net, it often chases up missing or incomplete patient information which in turn holds up discharge. The staff in the discharge lounge are trying to engage with ward staff to redress this and get ward staff to ensure information is current and valid.

Not only is it key that information is current and valid it is important that all parties involved in the patient discharge should be involved, informed and kept up to date.

The addition of a permanently sited discharge lounge has improved in part the patients discharge experience from Walsall Manor Hospital. It offers a safe, warm environment whilst waiting and staff are attentive and caring. Patients can be offered food parcels or clothing if they are discharged and do not have items readily available. Nursing care can still be administered to the point of discharge to such a venue as a Nursing Home.

The staff work hard to check all required discharge information is current and are often required to check for information that should have been completed at ward level. This contributes significantly to discharge waiting times.

In many cases the patient discharge happens without prior knowledge of the patient. They do not feel informed or involved. Communication at ward level seems to be the key point of poor communication with patients/relatives/carers.

Patient information is available in the discharge lounge in the form of leaflets, posters and bed hangers. It is however unclear if the ward staff present the information to patients.

There may be delays in care provision including availability of equipment and aids. It is important these are in place to ensure a smooth transition for the patient.

Recommendations

- Conversations around discharge should commence on admission.
- Ensure that any communication from staff is clearly understood by patients/relatives/carers
- Patients/relatives/carers should feel they are able to ask questions and receive answers
- Improve inter departmental communications
- Ensure discharge destinations are identified and communicated to all parties
- A discharge letter should be issued at the point of discharge for all patients
- Patient records are kept up to date and valid at the point of discharge.
- Address negative patient experiences around discharge process.
- Ensure a consistent empathetic and person-centred approach to discharge process
- Dietary needs are met in the discharge lounge
- Seek to ensure aids and equipment are in place at the earliest possible stage of discharge
- Patient information, medical treatment/needs information and belongings are transported with the patient on their discharge
- Give patients/relatives/carers adequate notice of patient discharge
- Patients/relatives/carers need more detailed information around the discharge plan/process
- Improve medication process from pharmacy to reduce waiting times in the discharge lounge
- Consider if medication can be dispensed by community pharmacies to reduce waiting times of patients to be discharged
- Minimise use of taxis to transport patient medication, reducing potential for error
- Consider ward staff work in the discharge lounge to understand the impact of delays that arise from ward level.

Acknowledgements

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Useful Links

'Delivery plan for recovering urgent and emergency care service' published January 2023. Page 27.
Link: https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf

CQC Inspection Report published January 2023
Link to report: https://api.cqc.org.uk/public/v1/reports/ee5c2289-3c99-4f7e-b194-94988dc24744?20230125080313

NHS choices reviews
Link: https://www.nhs.uk/services/hospital/manor-hospital/RBK02/ratings-and-reviews

Comments left on Facebook reviews
Link: https://www.facebook.com/WalsallHcareNHS/reviews

Comments left on Google reviews
Link: https://www.facebook.com/WalsallHcareNHS/reviews

Quick Guide Discharge to Assess
Link to document:
https://www.nhs.uk/nhsengland/keoghreview/documents/quickguides/quick-guide-discharge-to-access.pdf

NICE Transition between inpatient hospital settings and community or care home settings
Link: https://www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877

Healthwatch Walsall previous reports on discharge from Walsall Manor Hospital are available on our website.
Link: https://www.healthwatchwalsall.co.uk/sites/healthwatchwalsall.co.uk/files/Hospital-Discharge-Report-Sep-2015-1.pdf
Link: https://www.healthwatchwalsall.co.uk/sites/healthwatchwalsall.co.uk/files/Walsall-Manor-Hopsital-Discharge-Report-2019-2.pdf
Link: https://www.healthwatchwalsall.co.uk/sites/healthwatchwalsall.co.uk/files/PDF-Supplementary-evidence-for-discharge-report-1-1.pdf

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Social Media Platforms
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