# Healthwatch Walsall

## Hospital Discharge Report

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# Forward

*"Tens of thousands of people are potentially being sent home without proper support when they leave hospital or a care home." (Healthwatch England)*

The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and Carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

Healthwatch Walsall (HWW) has a local mandate to report on and represent patient concerns and comments with regards to the service they receive from Health and Social Care providers throughout the Borough.

Healthwatch Walsall held a series of events, workshops and advisory groups to understand where concerns lie in Health and Social Care from across the borough. As a result of these meetings key priorities were identified by Assembly members.

One of the immediate priorities was to undertake research focusing on a patient's journey/discharge from the Manor Hospital. HWW formed a Hospital Discharge Task Group, its aim was to evaluate how well integrated the discharge system is at the Manor Hospital by looking at patient journey of hospital discharge and post discharge care. We wanted to hear about patient experiences, good or bad regarding their stay in the Manor Hospital.

Hospital Discharge Task Group were all members of Healthwatch Walsall Assembly.

The Task Group Members were:

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This report is designed to support the Manor Hospital in improving patient experiences by highlighting a number of areas for improvement based on the patient experiences.

# Executive Summary

Hospital discharge refers to when a person leaves hospital once they have recovered. People should not be discharged from hospital unless they are medically fit and signed off by a named doctor (DoH 2010; DoH 2003). Hospital discharge is a process that needs to be done timely and safely. If this process is done too early there is an increased risk of re-admission and unsafe discharge. Similarly, if the patient overstays (delayed discharge) it can increase the risk for infection, cause depression, frustration as well as lack of confidence and dependency (DoH, 2010). This is why we need effective discharge planning.

Every hospital has a discharge policy in place – the Manor Hospital complies with the Transfer of care policy and the DoH document called 'Ready to Go' (DoH 2010). The Department of Health has outlined 10 key principles to achieve a safe and timely discharge process listed in Table 1. These principles are based on a person-centred approach, treating individuals with dignity and respect. The patient and their carers are provided with information and are involved at all stages of the discharge process and make informed choices.

**Table 1**

**Ready to go? 10 Key practices and Principles**

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.

**DoH 2010, p6**

Problems arise when any one of the 10 steps are not implemented correctly. These key principles need to be in place for every patient to be discharged in an appropriate way.

Nationally hospitals have experienced a steadily increasing pressure on urgent and emergency care services. Since 2012 there has been an increase of 18% in emergency hospital admissions in Walsall (Walsall CCG, 2014). Patients have stated that they don't know where to go and often choose to go to A & E, which puts further pressure and demands on the Manor Hospital. Patients are waiting longer to be seen and treated (Health & Wellbeing Board, 2014). Effective planning for discharge with clear dates and times reduces:

- the patient's length of stay
- emergency readmissions
- pressure on hospital beds.

Hospital discharge has been raised as an issue by the national Healthwatch network, which has launched its first special inquiry 'Then what?' The Inquiry will reach out to communities right across the country through site visits, focus groups, public hearings, and the mobilisation of the 148 local Healthwatch groups to hear real life experiences of the discharge process and learn what can be done to improve outcomes

**The Manor Hospital Walsall NHS Hospitals Trust**

The National inpatient survey and the A&E Survey completed in 2013/14 shows improvements in inpatient survey results. The key areas for focus over the next year are:

- pain control
- out of hours or overnight care
- communication and information
- the discharge process or post discharge information
- the attitude of staff towards patients

(Walsall Healthcare NHS Trust, June 2014; Walsall Healthcare NHS Trust, 2013/2014).

Patient experience has improved since 2010 and there have been improvements in maternity services (Walsall Healthcare NHS Trust, 2013/2014).

The national inpatient survey results for the patients discharged during July 2013 showed a slow but sustained improvement with 12 questions now in the top 20%. The Trust was going to concentrate on improving communication and the discharge process at that point.

The Trust report on patient experience raised concerns about clinical care and treatment, communication and discharge planning (Walsall Healthcare NHS Trust, Feb 2014).

The report identified a number of key areas to focus on:

- Poor communication and lack of information, which included medical staff not answering questions, times of mealtimes not being clear, delays in getting test results and patients not understanding what the results mean, the availability of free prescriptions and the choice of treatments.

- Patients did not understand what is happening with the discharge process or post discharge.

- Lack of adequate pain control.

- Concerns about the standard of care received by patients out of hours or overnight.

- The attitude of staff within the organisation towards patients.

The Manor Hospital has 490 beds with a further 41 beds provided within local nursing homes delivering intermediate care services.

The Trust has listened to patients and is trying to learn from their bad experiences and using that feedback to improve patient care. The past few years the focus was on improving the national inpatient survey results and Family and Friends test results rather than some of the patient issues highlighted above.

The Trust does now recognise that they need to focus on these issues and are being discussed at the Patient Experience Group and the For One and All Group.

**Healthwatch Walsall**

Healthwatch Walsall has listened to patients in Walsall about their hospital experience. Gathering patient views and experiences of their stay in hospital is important so as to understand what the people of Walsall want.

Patient views and experiences have enabled Healthwatch Walsall to be able to establish what needs to be improved and also what is working for patients. This will ensure that the provision of health and social care services will help to reduce unnecessary readmission to hospital and timely discharge focusing on re-enablement and recovery.

In the summer of 2014 Healthwatch Walsall commenced a study of hospital discharge and aftercare. Through the use of patient surveys called 'My Story' we collated the patient experiences. Appendix 1 is the poster that used to advertise the survey.

114 questionnaires were completed on hospital discharge and 36 case studies were completed. The survey and case studies reveal both good and bad practice within the hospital. A copy of the questionnaire is attached in Appendix 2 and the consent form to take part in the case studies in Appendix 3.

## Good Practice

We have seen evidence of good practice and organisation. The system can work seamlessly and joint working can be achieved as demonstrated in the case studies (CS):

- CS 5 was transferred to a hospital closer to home and had received good care. Carers had notified her care provider before she went home and had the necessary equipment in place with carers coming every day and the district nurses came to dress her ulcers. She was reviewed again and new equipment was delivered and she has been receiving care in her home for the past decade. Effective joint working does exist and has shown to work seamlessly.
- CS 9 received good care and aftercare when he left hospital and his experience illustrates that there is good joint working between the hospital and the community.
- Stroke and Maternity services have evidence of good communication between multidisciplinary teams.
- CS 17 experience has had a positive impact on his health and welfare and helped him overcome his phobia of injections.

## Areas for Improvement

The survey and case studies identified a number of areas where improvement is required these are split between hospital services and social care:

### Areas for improvement in hospital services

**Communication**

- Consistency of provision of information
- Consistency of involvement in discharge decision
- Minimising short notice discharge
- Consistency in explaining procedures & tests
- Consistency of information on transfer to social care

**Care & compassion**

- A few staff fall below the generally high levels of compassion, empathy and kindness of most staff.

## Areas for improvement in hospital services

**Dignity and Respect**

- Some patients felt their needs were ignored
- A few concerns about lack of privacy when discussing personal issues, or receiving treatment
- Occasional delays in washing and getting clean clothes

**Early Discharge necessitated by**

- Impact of norovirus
- Pressure on beds

**Organisation & Coordination delaying discharge**

- Waiting for doctors
- Waiting for medication
- Waiting for ambulance
- Waiting for test results
- Occasional late night discharge / transfer to care
- Some medication errors reported
- Inconsistent arrangement of follow up appointments

## Areas for improvement in social care services

**Aftercare and co-ordination**

- Consistency in support after discharge
- Consistency of information and signposting to other services
- Delayed provision of care after discharge
- Consistency of information sharing with other teams
- Consistency in transfer & care packages

## Areas for improvement in social care services

**Staffing**

- Concern about levels over weekends & holidays
- Attitudes of some staff upset patients
- Call times do not always meet the needs of patients

A full list of key themes that was gathered from the case studies and questionnaires in in Appendix 4.

# Recommendations

## Integration

1. Establish an integrated Discharge Task Group involving all partners and Healthwatch Walsall to review the findings and recommendations.
2. Set up an ongoing multidisciplinary monitoring group.
3. Improve the consistency of handover process between wards, departments and other agencies, ensuring the patient and family/carers are kept informed.
4. Establish systems and monitoring procedures to ensure the discharge policy is adhered to at all times especially during festive holiday periods and at weekends.
5. The Trust and all partners are recommended to adopt the refreshed Discharge Pathway.

## **Hospital care**

Review the Discharge Pathway Process internally and with external partners to identify areas for improvement with a special on focus on:

1. ensuring minimum staffing levels
2. developing a Discharge Checklist to ensure consistency and sign off prior to discharge
3. developing a Medication Discharge Checklist to ensure consistency and accuracy and more timely receipt of medication
4. developing a Toolkit and checklist to ensure communications meet the needs of  patients with sensory impairments or conditions that affect capacity

5. developing a contingency / protocol to deal with outbreaks of Norovirus
6. involve patients and special needs groups to improve the quality and consistency of advice to patients
7. implement systems to ensure all follow up appointments and tests are booked prior to the patient being discharged
8. involve patients in ideas to improve the appearance and fabric of the Discharge Lounge to make it more welcoming and comfortable.

### Social care

1. Ensure care staff are trained in the need to treat all patients with dignity and respect.
2. Do more monitoring of the quality of care services and attitude of carers.
3. Improve the timing of care visits to better meet the times that patients normally eat meals or take medication.

# Methodology

**Aim**: To evaluate how well integrated the Manor Hospital discharge system is.

**Objectives:** Healthwatch Walsall (HWW) wanted to hear about patient experiences, good or bad regarding their stay in the Manor Hospital. To listen to peoples experiences who had stayed for three or more days and within the past six months at the Manor Hospital. This was extended to include views of people who had stayed in hospital over the past year.

## Part 1: "My Story" Patients Journey of Hospital Discharge

HWW collected case studies of patient experiences of their stay in hospital. To ensure we gathered as many views and experiences of Walsall people we planned six "My Story" events held across the libraries in Walsall (Central, Aldridge, Bloxwich, Brownhills, Darlaston and Willenhall) over a 4 week period. A trial run was conducted prior to the event.

Participants would contact HWW to book an appointment. At the time of booking they were asked a few screening questions to ensure they were eligible. The screening questions asked were:

1. Were you a Patient at the Manor Hospital for 3 or more days?
2. Was it in the Past 6 months?

Only once they met the criteria were patients booked in for their 20 min one-to-one interview to share their experience of their stay and complete the questionnaire on hospital discharge. Other options were available such as a phone interview or sharing their story by e-mail to HWW. All participants received a £5 gift voucher as a thank you for their time and for sharing their experience.

### Recruiting patients to share their experiences

Participants were recruited by advertising in the local Express and Star newspaper two weeks prior to the event. Posters were also distributed to all GP Practices in Walsall, the Manor Hospital, Pharmacies, and local libraries across Walsall as well as promotion on the HWW website.

## Part 2: Surgical Follow-up Clinics

HWW, with the permission of Manor Hospital, attended the surgical follow up clinics to complete the questionnaire on hospital discharge. Members of the Hospital Discharge Task Group visited the Manor Hospital surgical follow up clinics on June 30th and July 7th and collected data using the hospital discharge questionnaire.

## Part 3: Presentation on Hospital Discharge

Mark Pitcher, ex-lead for integrated discharge team at the Manor Hospital, was invited as a guest speaker to talk to the Hospital Discharge Task Group regarding the Manor Hospital Discharge Process and Practices in Walsall and current local issues.

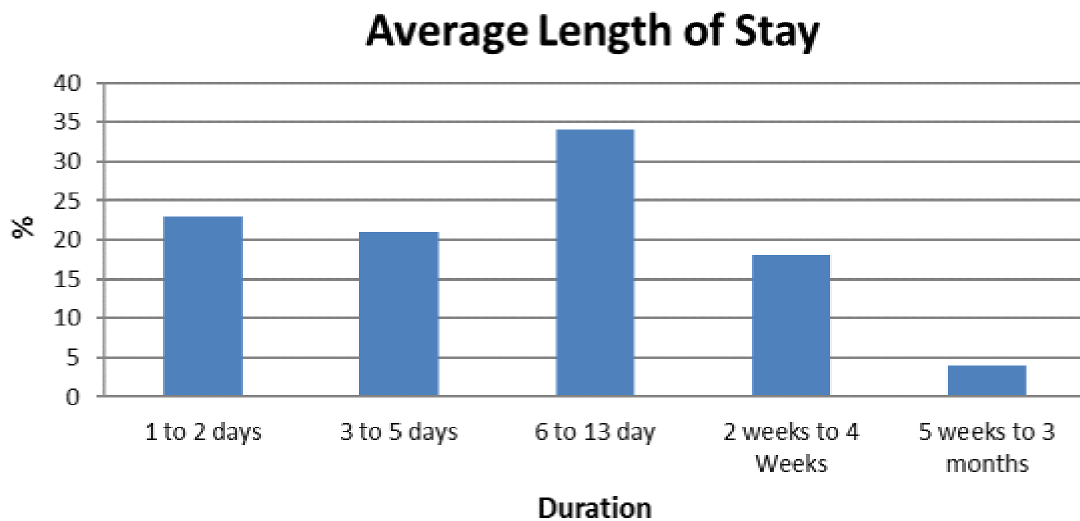
All the case study data was recorded and transcribed fully. All information collected was anonymised and stored safely in a locked cabinet. The data was analysed for key themes and to gather experiences of good practice and suggestions for improving the hospital discharge process for patients.

# Findings

## Average Length of Stay in Hospital

This ranged from 6 days to 13 days (34%) followed by 1-2 days (23%) and 3-5 days (21%) in hospital and 20 people (18%) stayed from 2-4 weeks and 5 people (4%) stayed 5 weeks to 3 months.

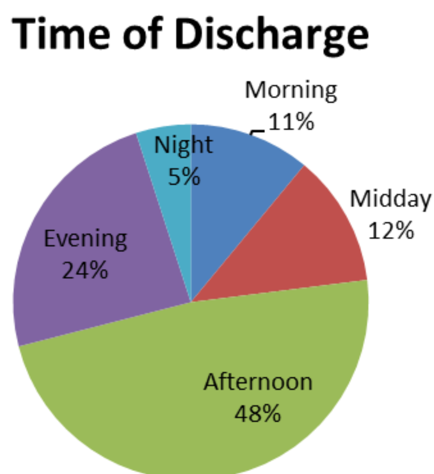
Figure 1




## Time of discharge

48% of respondents were discharged in the afternoon between 2pm-5pm. 24% were discharged in the evening between 5:30pm -8pm. 23% were discharged by midday. 5% were discharged at night after 8pm, as illustrated below.

Figure 2



## Readmission

17 people (15%) were readmitted to hospital out of total 114 people who completed the survey within a month of discharge. Different people coordinated discharge in 29 of the responses (25%) and 91 people (80%) had enough notice of discharge. 57 people (50%) had a delayed discharge. 36 peoples' (32%) discharge was delayed due to waiting for medication and 11 (10%) waiting for the doctor to discharge them.

28 (25%) of people they felt that they should have received care once discharged but didn't get any and for those where care was arranged 39 (44%) people said that it met their needs.

Of the 17 were readmitted, at the time of their initial discharge 14 (78%) people were happy to go home and 4 people (22%) were unhappy about the decision to discharge them.

The rate of readmissions at Walsall Manor Hospital between April 2013 - February 2014 report a total of 25,434 patients were discharged and 4004 patients were readmitted within 30 days of admission. This is a 15.7% readmission rate during this period.

The questionnaire results showed 15% were readmitted within 28 days of discharge for the same condition.

A summary of the remaining questionnaire results is attached at Appendix 5 and a demographic analysis is in Appendix 6.

## Comments and Suggestions Made by Responders

Appendix 4 highlights some of the key themes that were identified and comments made by those who completed the survey on hospital discharge.

**Walsall Manor Hospital Formal Complaints - Themes**

- A total of 266 complaints were received during the year (as at end January 2012), of which 241 related to hospital based care and 25 to community care provision (Walsall Healthcare NHS Trust, 2013/2014).

- In 2012/13 the team had 319 complaints, which included concerns raised about care and treatment, poor communication, and regarding appointments and services.

- The main theme emerging in April 2014 was clinical care, assessment and treatment. The second highest theme was discharge and communication (Walsall Healthcare NHS Trust, April 2014).

## Poor Communications

72% patients in our survey reported that they were fully informed about their discharge but 26% were not happy with the communications during their stay. 2% of patients were unsure.

The following case studies (CS) demonstrate that the patient would like information and advice from their doctor to simply explain procedures or results and what to expect in the coming days.

A précis of information relating to the discharge process for each case is attached at Appendix 7.

CS 21- his experience highlighted poor communication and the doctor did not explain anything to him nor provide any progress or updates at all.

CS 26 was also not informed about any test/scans

CS 2 highlighted there was no continuity of care and a lack of information, she was not told that she could bring her medicine from home. Nurses need to show empathy and compassion as they did not listen to her requests. The doctor confirmed that he thought she was discharged from hospital and there were further delays due to medication errors. Furthermore her physiotherapy appointment was not arranged and she was still waiting for physiotherapy. She commented: “My stay in the hospital was traumatic and scary as I could easily have been lost in the system”. She felt ignored and depressed, which reflects the findings of research into delayed discharge.

Doctors must provide good care and communicate effectively by listening to patients and answering their concerns. The Doctor is responsible for giving information the patients need to know in a clear way, as well as being considerate and sensitive when giving patient/family information and support. When they are on duty the Doctor must be “readily accessible to patients and colleagues seeking information, advice or support” (GMC, 2014)

Information is not always provided to the patient who is requesting progress updates or provided an opportunity to discuss or raise any concerns. The care needs to be more patient centred and holistic but this too falls short. There was poor communication between patients/family and staff about the ability to care for themselves and a lack of proper assessment for cognitive ability.

CS 32 “On Saturday they transferred me at night at 10pm to the discharge room. I wasn’t aware I was going to be discharged I thought I was going home on Monday morning.”

CS 34 “The discharge was totally out of the blue, giving my family no warning. There had been no heating on in my home and if the family had been warned it could have been turned on in advance.”

These three feature cases highlight a catalogue of errors, mainly due to a lack of communication and information, from the time the patient entered hospital to the

time they left home and post discharge. Their stories paint a concerning picture of poor care and has left a negative impact on their lives with some of the patients losing faith and confidence in NHS services.

## POOR CARE

### Hospital Standard of Care

Every hospital has a standard of care that you have a right to expect. All hospitals in England must ensure that the care and treatment they provide meet national standards. "You can expect to be respected, involved and told what's happening at every stage. Whereby staff will respect your privacy, dignity and independence. You can also expect to be safe such as being cared for in a clean environment, and maintain good staffing levels. Personal records will be accurate and kept confidential." (CQC, 2013)

CS 2 highlighted that the hospital environment was dark, left on her own in a room with no windows and very depressing atmosphere. This could be improved. There were also comments made about more staff on the wards and keeping accurate records

### Continuity of care and co-ordination

The General Medical Council, who regulate Doctors, state "share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers. Check, that a named clinician or team has taken over responsibility." (GMC, 2013).

There was a lack of clinical continuity in the cardiac ward, where a patient was waiting to be discharged by the Consultant. The Consultant had shown a lack of professionalism by not taking responsibility for their care. Although the patient felt treatment was good, the service or patient experience was weak due to poor handover or lack of communication and discussion with other members of staff resulting in failure to co-ordinate discharge. This is shocking and poor practice. Even if Doctors are facing huge pressures and demands this does not excuse their behaviour.

Unfortunately, the consultant did not check to see that a named doctor has taken over the responsibility. If the workload is unmanageable then they need to recruit more doctors to serve their patients and provide patients a good quality of care and not be left alone.

On average 54% stated that one person coordinated their care, 25% one person did not and 18% were unsure. It appears a large proportion of patients do not have clear information or even know who is in coordinating their care.

In CS 4 the consultant did not inform the family or listen to the families concerns. She had to be readmitted and had a fall in hospital and needed surgery, which was always rescheduled. She would be left waiting for surgery with nil by mouth and then be told that it was cancelled. She was already in a weak state and these

delays have impacted on her health. There is a lack of compassion and lack of information from Doctors on progress of care. The family would request for updates but were not updated quickly and this would cause distress to the family.

## Dignity and Respect

Some patients reported that they did not have the right to privacy and confidentiality, and felt ignored by staff. They felt that they were treated as invisible and stated that staff did not respond promptly to requests for help to go to the toilet.

CS 2 and CS 27's story both talk about what they had witnessed first-hand on the ward how poorly vulnerable elderly people were treated in hospital and state that nurses did not listen to them and did not treat them with respect and ignored their calls for help. Even PALS who visited CS 2 didn't respect her privacy and confidentiality.

One lady felt she would be a nuisance if she kept asking for the nurse and often was left alone upset and crying in hospital (CS 3). Both CS 2 and CS 27 have lost confidence in the Manor Hospital.

Our investigations revealed a number of negative experiences about sensory impairments (CS 12), CS 4 had lost her hearing aids on the ward and they were not replaced. The family made requests but no one did anything about it and nobody was allocated with the responsibility to ensure the hearing aids were found.

Another patient who is diabetic was nil by mouth and waiting all day for his surgery.

All of these are all examples were staff were not sensitive to patient's needs. "Ensure all staff are aware and respond sensitively if you have a hearing or visual difficulties or memory problems" (Age UK, 2012).

It is also important "not to discharge patients with the feeling that they have just been cast on one side as soon as their medical treatment is considered to be complete" (Age UK, 2011). This was felt by several people in this study (CS 15 and CS 25).

"If I am in severe pain and in a busy area I don't expect my medical information to be shared with everyone in the main reception. You need privacy to talk about your problem because they are my medical issues. I don't want to be overheard. They expected me to stand. There is no were to sit and communicate to reception. I found that very difficult to give my information. I had asked for a seat and they didn't have a seat. I believe that 12.5 hours wait in A and E and they don't come. I needed help and I was ignored. That is not right."(CS 26)

Even with the pressures on the ward, staff need to be aware of what needs to be done and implement best practice at all times. Patient should be treated with respect and dignity at all times. There needs to be more care and attention to support the patients care.

## Early Discharge

Patients have been discharged before they were clinically ready and clinically safe to be discharged.  This could be due to a variety of reasons as reported in the case studies: poor communication, norovirus, or if the patient is self-discharging, and discharge before holiday period.  The consequence is unplanned re-admission (CS 36 story).  There were 5 people (14%) of case studies were readmitted to hospital for the same condition within 28 days of being discharged from hospital.

Norovirus on the ward puts even more pressures on the ward and results in patient care not being a priority.  The patients expressed feeling rushed and ignored and without important support and aftercare in place

Norovirus on the ward puts pressures on staff and consequently affects the patient care.  The patients are rushed and discharged early and no after care arranged.  After care should be in place before you leave hospital.  In some cases there was no assessment done and the patient was not clinically fit to go home.  Not always the best interest of the patient.

On several occasions the patient was discharged early without the appropriate needs assessment or even aftercare in place (CS 34, CS 35 and CS 36).  The family is left to cope on their own without any support or aftercare being arranged.

### Discharge over the Weekend and Holiday

To avoid staying longer in hospital patients often choose to self-discharge home. However, some patients reported this was without any arrangements for aftercare or even a follow up call to see how they are coping at home. There needs to be better support and advice once they go home.  This finding is also reflected in other studies (Lynch, 2011; BMA, 2014; DoH,2010; DoH, 2003).

They should also take extra care when making plans to discharge someone on Friday, or during a weekend, as it may be difficult to contact home care workers and GPs on these days.  Hospital discharge policies should include details of what to do in such circumstances.

If patients are unhappy about their discharge they should be able to raise concerns with the hospital staff.  It is important to take extra care when planning to discharge patients on Friday or during the weekend and holiday periods.  This creates difficulties to contact home care workers and arranging for aftercare.  More needs to be done to ensure that patients can leave hospital and with the appropriate care in place.

Hospital policies should have protocols in place with details of what to do in such instances.  Even though it is acknowledged as part of the Hospital discharge policies should include details of what to do in such circumstances (DOH, 2010).

## Better organisation and coordination

80% of our survey stated that they had enough time to be discharged with 17% who did not have enough notice to make arrangements to go home.

76% of patients were happy go home and 22% where not happy to leave hospital or didn't feel ready to go. Factors in delayed discharge include: poor communication, long wait for medicine, long wait for transport, and time to arrange aftercare as documented in the case studies. However, long stays in hospital increase the risk of infection and depression as witnessed in CS 2 story (CS 27, CS 28, CS 2, CS 29).

As evidenced in the case studies we can see that additional test and appointments followed are not always through.

As we have seen the hospital discharge can be a slow process. Where the person is told in the morning that they can leave but are still waiting hours for medication or transport it can be frustrating. This requires better planning and organisation within hospital.

Sometimes even when the patient is ready to be discharged they are faced with further long delays of 3-6 hours waiting for family to arrive or waiting for hospital transport such as ambulance to take them home(CS 5). Long delays create anxiety and may harm the patient. The hospital staff should always try to minimise any delays.

Even before leaving the ward the nurses could have advised a patient that he was under another doctor's care and would be better to reschedule the outpatient appointment and avoided disappointment.

CS 5 experience, the uncertainty of waiting for 'transport' is not caring and should be managed. We have a duty not to harm our patients; however, making them wait many hours, without knowing when they are going to leave creates anxiety and may harm the patient (BMA, 2014).

In this case the patient stayed 8 hours in the discharge lounge after having a heart attack unable to go home. She was distressed and under the circumstances at risk.

**Long Delays for Hospital Beds**

CS 31, CS 12 and CS 26 had waited many hours; up to 15 hours before they are even admitted to a ward and have a bed

"There were no beds available. I had to wait too long for a bed on the ward nearly 15 hours. I was surprised they took me off the trolley in my condition and had to sit on a chair. This could be better." (CS 31).

**Departure Lounge**

Long waits in the discharge lounge was a common theme seen in both good and bad experiences of hospital discharge, as well as the wait for medicine, ambulance transport or waiting for a bed to be available. This illustrates that people accept and expect delays and although they may not like it they will overlook it as long as the overall care and treatment received in hospital was good ( i.e. informed, tests

done, when talking to the doctor were treated with dignity and respect, given enough notice and support once they left hospital). They are pleased with their treatment in general regardless of the long wait in discharge lounge or wait for medicine.

"On Saturday they transferred me at night at 10pm to the discharge room. I wasn't aware I was going to be discharged I thought I was going home on Monday morning" (CS 33).

**Medication Errors**

50% of people in our survey had a delayed discharge due to wait for medicine, seeing a doctor or arranging care. With patients stating "Hospital is struggling to cope, serious delays – the pharmacist holds up a lot of things".

CS 33 stated "I missed my hospital injections at night, I know on two occasions they did wake me up for my injections, they could have kept to a timetable without keeping it late at night".

## After care support and co-ordination with partners

Most patients (68%) were given a date and times of discharge. A quarter reported that they were given different dates and times of discharge. The Manor Hospital has a hospital discharge policy, which aims to ensure smooth and seamless care and effective joint working. The policy discusses the purpose of discharge lounges, intermediate care services, transfer of care and how joint working is to be achieved. 'Services you receive from the NHS (continence pads, visit by community nurse) are free but you may be charged for services you receive from your local council'. The policy states that patient transfer will not occur after 8pm without permission of the director on call (Walsall Healthcare NHS Trust, 2011).

A social worker will come to assess your needs and see what services are available to help meet your needs. They can provide equipment in your home below £1000 free of charge (Walsall Healthcare NHS Trust, 2011). Services are available but they are not always coordinated or managed well.

Intermediate care in the community helps support individuals to remain in their own homes. Especially for people who need ongoing support when they leave hospital. The transfer of care process is in place to ensure that patients receive the right care in the right place and at the right time. Unfortunately this is not always the case. Some patients had good care in hospital but had no support or aftercare in place once they went home.

Intermediate care is supposed to bridge services between primary and secondary care but they needs to be coordinated and managed better and need for good joint working between independent sector and community services to improve the quality of life and independence.

It has worked well for CS 16, CS 14, CS 6, and CS 5 who experienced good care and aftercare in place. However, a number of patient stories say their treatment was good but they had problems with aftercare not being in place (CS 8, CS 34, CS 35).

"I was assured that a care package was in place, which started on the night of my discharge. I felt as though I was rushed out of the Manor, with no proper care package put in place and no discussion with my family." (CS 34)

Health and social care systems need to support individuals and their families to return home or residential care/rehabilitation. We need to know how best to manage discharge of individuals and transfer of care between these different settings? How best to achieve good practice and how to improve the discharge and transfer process and practices?

Sometimes the care and treatment in hospital is good but care stops short. Once they arrive home they experience problems and have no support, help or advice from the hospital (CS 10).

The patient doesn't know who to contact and discuss their concerns and who to tell if they are not managing well at home. (CS 8) Often times it was felt that if someone in the hospital or GP could give a call and check on the patient, especially elderly patients, to see how they are coping and to advise them if they need further assistance and support. This would most certainly improve patient experience.

"A phone call from GP or somewhere to see you are ok. You are left to it and it is a big operation, especially if it's a big wound it is not easy to get over. Luckily I looked on webpage and saw it was normal to feel this way. I managed, I was self-sufficient and had the help of my husband." (CS 10).

It has been suggested to have 'what if leaflet?'. For instance, if the district nurse has not arrived the leaflet can explain who to contact and what to do in these situations.

CS 8 felt she had to say that she had someone to look after her but in fact she lived alone and had no option to say that, otherwise she was afraid that she would not have surgery. Surely this can't be right. No one should feel the need to lie in order to receive treatment. This makes the situation worse as they are not being assessed properly for appropriate aftercare in place.

For seamless and timely discharge it is essential there is good communication between health and social care agencies, patient and carer involvement in making decisions and accurate needs assessment. In addition agencies need to be aware of their roles and keep both the patient and carers informed passing vital information to multidisciplinary teams on.

Our findings are similar to other reports examining joint working with community care and how well the hospital, social care and community services work together (Walsall LINk, 2013; Lynch, 2011). The case studies also have reported similar findings with a lack of support after they leave hospital, poor communications to arrange social care and no follow up.

Patients also experienced long delays between notification of transfer and ambulance transport and long delays in medicine and patients being discharged with wrong tablets also found by nursing homes, and being discharged late at night.  These are common themes and continue to be problems in hospital in general.

## Staffing

Some respondents stated that they observed and experienced staff shortages, which impacted on support such as getting out of bed or requests for information or for going to the toilet (CS 34) she had asked for support to go to the loo but soiled herself before the nurse arrived who told her not to worry it happens all the time but CS 34 said she was not used to it, the experience of no one coming help her left her feeling helpless.

CS 25 felt the nurses did not want to know when she buzzed to ask for support as she had had an accident.  It was two hours later when they came to change the bedding.

# Conclusion

Effective Discharge is important so that there are enough hospital beds for people who are waiting for either planned operations or emergency admissions. The main theme identified at the Manor Hospital is poor communication and the need to share relevant information and improve collaborative working.

Discharge is a slow process and full of possible delays. This could be avoided with better planning and management and clear communication throughout the discharge process. Patients need to be kept aware of what is happening, why it is happening and what they can expect in their care. Patients need to be empowered with clear information, advice and support available to them when they leave hospital.

Hospitals are under pressure to cope with increased demand and bed shortages. To prevent unplanned re-admission and good continuity of care, patients need to be more involved in decisions and have necessary information and support available to them prior to going home.

Sharing patient case studies about good and bad experiences in hospital demonstrates how important it is to work in partnership with other organisations. Their case studies illustrate problems that occur when the process is not planned correctly in accordance with the discharge process and how it can be improved.

The Royal College of Physicians in response to the report 'Hospitals on the edge' in 2012 have set up a Future Hospital Commission (RCP, 2013). The report identifies how hospitals can improve and change to meet patients' needs and shares their vision on future hospitals and involving patients in their care. They report on how integration of social, primary and secondary care, when they work together, can benefit the patient. They also talk about a culture shift towards improving patient experience and care.

The Trust acknowledges that they want to improve patient experience and this has improved since 2010 but unfortunately hospital discharge remains a key theme along with poor communication and information. There needs to be more collaboration and partnership working to achieve positive outcomes. Even with all the efforts to reduce readmission rates it was nearly 16% and needs to be further reduced (Walsall Healthcare NHS Trust, 2014).

The Manor Hospital is sharing patient experience and closing the gap between the board and the patient experiences on the ward. The Walsall Healthcare NHS Trust only now acknowledges the need to focus on what matters most to patients. The Trust needs to continue with its progress made to sustain improvements in patient experiences and to focus on what matters most to patients, i.e. improve overall communication and the hospital discharge process.

# Acknowledgements

The Hospital Discharge Task Group would like to thank …

- All the people who shared their experiences "My Story" on hospital discharge.
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- Mark Pitcher, ex-Integrated Discharge Team Service Manager at the Manor Hospital, as a guest speaker at our task group meeting speaking about current issues on hospital discharge and providing local information on the Manor Hospital Discharge Process.
- The Walsall Libraries for allowing Healthwatch Walsall to use their venues for conducting interviews.

We are grateful to everyone who helped us to recruit patients and for supporting this study.

# Disclaimer

Please note that this report relates to findings as a result of the 36 case studies and 114 questionnaires carried out during October 2014. As such it will not be fully representative of all the patients that go through the Manor.

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# Strengthening the public and patient voice

## Ensuring local health care and care services are centred around what matters to the Walsall people

Sep 2015

healthwatch
Walsall

# Appendix 1 – Poster

**Have you been a patient at Walsall Manor Hospital for 3 or more days and within the past 6 months?**

We want to know about your experiences of discharge from hospital and any after care you needed when you returned home.

- Were there any difficulties with your discharge from hospital?
- Did you have appropriate support in place when you returned home?

Call us to book in for a chat about your story or e-mail your story to us. We would like to hear from you.

## Book your 20 minute session today

## Call us on 01922 614144

or e-mail your story to shazia.ahmed@healthwatchwalsall.co.uk

Our sessions will be from 10am-4pm on the following days:

| | | |
|---|---|---|
| Wednesday | 7th May | Brownhills Library |
| Thursday | 8th May | Bloxwich Library |
| Wednesday | 14th May | Darlaston Library |
| Friday | 16th May | Central Library |
| Tuesday | 20th May | Aldridge Community Centre |
| Thursday | 22nd May | Willenhall Library |

If these dates don't suit you and you would like to take part please call 01922 614144 and alternative arrangements can be made.

# Appendix 2 – Hospital Discharge Questionnaire

## Manor Hospital Discharge Questionnaire

1. **Gender:** Male ◯ Female ◯

2. **Age bracket:** 0-17 ◯ 18-24 ◯ 25-44 ◯ 45-59 ◯ 60-74 ◯ 75+ ◯

3. **Postcode:** ________________________________

4. **Disability:** Yes ◯ No ◯ If yes please state: ________________________

5. **Ethnicity:** British ◯ Irish ◯ Eastern European ◯ Other White Background ◯
   Indian ◯ Pakistani ◯ Bangladeshi ◯ Chinese ◯ Other Asian Background ◯
   Caribbean ◯ African ◯ Other Black Background ◯ Mixed Race ◯
   Other: _______________

6. **Length of stay in hospital (days):** _______________

7. **What time were you discharged?** am/pm __________________

8. **What ward(s) were you on?** _________________________________________

9. **Reason for hospital admission:**

10. **Were you re-admitted within one month of discharge for the same condition?**
    Yes ◯ No ◯ Don't Know ◯

11. **During your stay in hospital, were you given different dates and times for discharge by one person or different people?** Yes ◯ No ◯ Not sure ◯

12. **Did one person co-ordinate your discharge from admission to discharge?**
    Yes ◯ No ◯ Don't know ◯

13. **Did you feel fully informed on the decision to be discharged?** Yes ◯ No ◯

14. **Were you given enough notice to make the relevant arrangements for returning home?**
    Yes ◯ No ◯

15. **Were you unhappy about the decision to discharge you?** Yes ◯ No ◯

**16. Was your discharge delayed?** Yes ◯ No ◯

**a. If so, was this due to waiting...?** **Length of delay**

| | | | |
|---|---|---|---|
| i. | For medicine? | Yes ◯ No ◯ | ___________ |
| ii. | To see a doctor? | Yes ◯ No ◯ | ___________ |
| iii. | For hospital-organised transport? | Yes ◯ No ◯ | ___________ |
| iv. | For any other reason? | Yes ◯ No ◯ | ___________ |

(e.g. discharge to rehabilitation, re-enablement, residential / nursing home) If yes, please state: ___________

**17. Did you receive a copy of the letter sent from your hospital to your GP?**

Yes ◯ No ◯

**18. Did your GP change the medication prescribed by the hospital?**

Yes ◯ No ◯

i. If so, were you informed why? Yes ◯ No ◯

**19. Did someone check if you needed care after discharge?** Yes ◯ No ◯

**20. Do you think you should have received some care/support after discharge home, but didn't get any?** Yes ◯ No ◯ Don't Know ◯

**21. If you received care after discharge, did it meet your needs?**

Yes ◯ No ◯

**22. How do you think the discharge process could be improved?**

# Consent Form

Please complete if you are happy to take part in the study.

**Title of Study: Patient Discharge from the Manor Hospital.**
**Please tick**

1. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
2. I understand that any data or information used in any publications which arise from this study will be anonymous ☐
3. I understand that all data will be stored securely and is covered by the data protection act. ☐
4. I hereby consent to sharing my story on patient discharge and agree to have my story tape recorded. ☐
5. I agree to take part in the above study. ☐

| Name of Participant | Date | Signature |
|---|---|---|
| ______________________ | __________ | ______________ |
| ______________________ | __________ | ______________ |

# Appendix 4 Key themes

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| Poor Communication | • "Not informed about what happens next, no one tells you what is wrong more spoken at than to."<br>• "Everyone else on the ward saw the doctor and explained everything to them. Mine never said a word."<br>• "Sent to discharge lounge at 1pm not discharged until 5pm daughter unaware. GP didn't receive hospital discharge letter although ward sister said she had faxed it."<br>• "Poor communication - not receiving appointment and being discharged for not turning up and given wrong appointments. People don't know what is happening confusion."<br>• "More notification when you are going to be discharged" |
| Lack of Organisation and Coordination | • "Someone to take responsibility if doctor had to go off on an emergency. Someone should step in I would have thought so we were all getting distressed in ward 7 waiting for discharge letters and tablets."<br>• "Doctor was on holiday and did not discharge me. Need better communication between staff."<br>• "I was promised an appointment to see respiratory specialist within 8 weeks - still waiting. " |
| Lack of Follow up and Aftercare | • "Too long wait for district nurse to dress wounds. She had to contact district nurse office to arrange a visit. The District Nurses were not informed by Manor Hospital."<br>• "Make sure adequate provision is in place at home before discharging patient. No follow up by social worker"<br>• "After discharge received no appointment for follow up due to new computer system. Very unhappy with outpatient appointment and follow up care. No results from blood tests and biopsy." |
| Lack of Dignity & Respect. i.e. not Listen to the patient, Respecting Patient decision/choice | • "To listen to what you want instead of doing what they want".<br>• "They ignored me and did not listen to me"<br>• "I was not taken to the hospital of my choice and that was not right. " |

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| Lack of Personalised care | • "I felt once someone said you could go home. There was a rush to get you out of hospital."<br>• "Once you were discharged it was like you were dismissed. They didn't help me at the end felt a bit ignored."<br>• "They could have actually asked if somebody was picking you up or if I needed help to take my things down for you. (if the offer to help could have been there)"<br>• "Patients given more time -to make it more personal. More communication between staff and wards"<br>• "Felt pressure/rushed to take her home."<br>• "The nurses and doctor to sit with the patients and talk to them generally. They don't talk to patient and be spoken to as a human being. To be compassionate and not invisible- more personal care" |
| Lack of Support and advice when they leave hospital | • "There should have been a nurse to come out and support you and the hospital didn't do that you were disappointed."<br>• "Follow up phone call to ensure all was ok"<br>• "More support and advice for after care."<br>• "Not given enough information, not knowing what is going to happen it was a difficult time (thought he was dying). It is very hard to know where to go when you have cancer need more support for patient and family." |
| Lack of aftercare and lack of care arranged on Friday and Holiday period | • "Better after care things should have been in place when you came home. There was no care package in place."<br>• "I should have been discharged on weekend but after care was not arranged. I wanted care to be in place from Monday. No arrangements were made. They insisted that I stay 3-4 days then they might have arranged for after care. Especially if first operation went wrong and there was no after care. You would have expected it second time."<br>• "To make sure patient has items/everything they need to help with recovery e.g. equipment (toilet seat frame)" |
| No Contingency plan for Holiday Period | • "Medication should have been there on the first day because she did not have her yellow book to record medicine she couldn't give her medicine -during Easter everything is closed."<br>• "It would help if someone would pick up the phones on the holiday and nobody answers it there should be a better system in place. A better way to communicate. The intermediate care team had answered the phone and had listened to me and I told them what was happening to her."<br>• "Not good enough to send people home. No one open to help you during the holidays" |

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| Long Delays in Discharge Lounge | • "Less stressful /rush from ward to swift ward"<br>• "Patients to be kept on wards rather than discharge lounge because it was congested and not comfortable. I waited 3 hours in the discharge lounge, it could have been coordinated better "<br>• "When you get to the discharge lounge wait there it's a very slow process and too many patients to treat."<br>• "Improve discharge process and not have to wait all day in the discharge suite giving up your bed when you had an operation"<br>• "Experience in discharge room was stressful and long. Not waiting in the discharge lounge for an ambulance." |
| Lack of Compassion and Caring | • "Staff need to be more polite and caring when you ask them for help"<br>• "Taxi booked for discharge lounge but went to ward and Taxi sent away. Carer was arranged to put patient to bed but due to delay carer had left."<br>• "They should be more compassion and see if he is clean, they didn't clean up the mess that was made. Poor cleanliness" |
| Lack of Information from Carers &<br>Not sharing relevant<br>information | • "Didn't know who the care teams were and what time they come and what they do. Etc."<br>• "I don't know it is sad that we have to send people home and they have to fall to go back to hospital and then to a care home. We have to prove that we cannot manage in the home to fall over and then go."<br>• "Not sure what time the care assistant came and who is doing what etc. who is doing other chores if people are living independently. Not enough information is provided."<br>• "No communication among multi professional groups and not updating their system. The care is arranged by re-enablement team but they didn't know what had happened and that she had a fall. The district nurses also did not know she had a fall. Nobody knows anything there is no information being passed on from one team to another and it is not right time to discharge people when so close to the holidays. And no one explained about continence needs." |

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| **Medication Errors** | • "I missed my hospital injections at night I know on two occasions they did wake me up for my injections. They could have kept to a timetable without keeping it late at night" |
| **Norovirus** | • "Norovirus was on the ward. Medical staff needed to focus on the patient and their symptoms and listen to the patient. They lose focus on everything else when you have norovirus on the ward. Nurses were not polite on ward 12 need to be more caring and polite- could be due to the virus but that doesn't excuse their behaviour."<br>• "More communication with the family. To be notified sooner about elderly parent coming home. To make sure the house is warm and to make arrangements. The norovirus was on the ward and the hospital was closed to visitors during that time."<br>• "Came in by ambulance at 3pm to A& E and no beds available until 3am - 12 hours later partly because he needed a private room because of infection. The Nurses are under staffed. They rang on the day to say he could go home. We didn't think he was ready to go home at this time. He was sent home early because of norovirus on the ward- he was not ready too weak and couldn't walk. It was too late to be discharged. Family needs to be more informed about what will happen and why doing tests. More notice to come home to prepare house and move the bed downstairs. No communication between doctor and patient and family needs to be improved."<br>• "Better communications, left sitting on armchair for 7 hours. Rushed out for norovirus twice" |
| **Long wait for beds to be available**<br>**&**<br>**Not Enough Staff on duty** | • "There were no beds available. I had to wait too long for a bed on the ward nearly 15 hours. I was surprised they took me off the trolley in my condition and had to sit on a chair. This could be better."<br>• "More staff on the ward then the staff would not be rushing around and there is less chance of being held up."<br>• "More doctors to discharge"<br>• "The staff should be better organised and provide clear information. The ward was understaffed."<br>• "Staff on stoke ward were busy they had no time for a break. They give so much of themselves to the patient and patients don't realise how busy they are. The nurses rushing around. Need more staff to help people for example to get up out of bed." |

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| **Have social service assessment done before discharge and provide care that meets the needs of the individual.** | • "Before re-enablement team did their assessment a temporary agency provided care for the first weekend that fell very short. The service (Servacare) was inadequate. I would prefer to have social service assessment done before discharge. The care should link up better to meet her needs and expectations of the family straight away within the first week and not delayed." |
| **Deliver more patient centred care and being aware and sensitive of patient needs.** | • "Operation scheduled for morning I went to hospital for 7:30 am, I am a diabetic so had to fast. At 9am I was told no operation because not had a swab for MRSA on pre-op check. I could have last operation in the afternoon but still not sure until it happened at 6pm. Sent home 1 hour after surgery and was not given any information on what had been done during the operation and no aftercare information. I had to phone to ask when to have stitches out, told 2 weeks but appointments over 2 weeks. Not happy with the way I was treated. Nurses did not know I was a diabetic. I could not get a doctor to speak to me and I was just given paracetamol for my pain. I would have liked to speak to the doctor. I had an appointment at fracture clinic at 10 am and was seen late." |
| **After Discharge More Information & Support** | • "Would have liked more information on what to do if you have any problems. I was told to phone the ward but no one answers the phone. Need for Better communication." |
| **Need to create a quiet, clean, and comfortable hospital environment.** | • Treatment was ok. However, I was in the bay with 5 dementia patients and therefore could not get rest and had to sit outside the bay and sit in the office all night. My partner came and was adamant I was not staying so nurse brought paperwork for discharge. |
| **check patient records carefully to avoid making medication errors** | • "Had allergies and told them, when discharged gave patient medication she was allergic to. So had to get pain killers off the GP. Drs and medical staff should check patients notes carefully" |

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| Poor Care for Elderly.<br>&<br>Staff need to listen to the family concerns | • "Listen to family when there is a temporary loss of mental capacity (ref ward 9). Do not lie to the family, say patient is ok then family find she is prescribed major antipsychotics and anxiolytics (ward 9). Consider risk of falls due to cardiac conditions especially when there is a risk of falls (critical care unit). Consider she may actually need rehab and be reasonable with family (critical care unit/CCU)."<br>• "When registrar asks the family to contact the medical secretary and she then will not give blood results (due to patient confidentiality) the patient can't be treated for severe anaemia."<br>• "Unhappy with decision to discharge because given no availability of rehab beds it would have meant a move to Parklands then rehab. But failed discharge from CCU resulted in a fall and readmission for a femur."<br>• "Discharged on Sunday and had appointment at fracture clinic on Monday. Ridiculous to send her home and get her back in on the following day. On Monday ambulance turned up but didn't know keys outside of house so couldn't get in. She is unable to move to answer door. Next appointment is 2 weeks away- still couldn't have the plaster off. Ambulance never prepared for the patients lack of mobility nor were the fracture clinic expecting her to get on x-ray beds. Physiotherapy supposed to |
| Avoid delays in Medicine | • "Sorting out medication from pharmacy a little quicker"<br>• "Medications need to be prescribed day before discharge. Mine were sent to another ward which resulted in the delay."<br>• "Time to discharge a patient and receive prescriptions could be improved a lot"<br>• "Medication should be ready instead of waiting for hours"<br>• "They could sort medicines out quicker. So they are ready at the point of discharge and not to call back or delivered by taxi"<br>• "Everything ready for discharge but failure with medicine had to return"<br>• "Long wait for pharmacy. Far better if you have the prescription and you fill it up at a local chemist."<br>• "Never gave injections was sent home without medicine and went 4 days and they were not ready." |

| Key Themes | Comments made for Improving Hospital Discharge |
|---|---|
| Inaccurate medical notes | • "I should have had 2 blood transfusions but I only received 1 the second one was not done they said it didn't matter yet my medical notes recorded I had two." |
| Access to Medication | • "Information before didn't prepare you for what would happen in surgery. It was worse than I thought. In pre- op they said it was ok for me to go on holiday after the surgery but I found it to be struggle and had to have my follow up appointment earlier because of the pain. I also had pain killers and had trouble getting pain relief from out of hours doctor, phoned 111 and said to go to A and E for pain killers. Problem in access to medicine" |
| Care Staff Issues | • Not happy with care staff-time and attitudes.<br>• No social workers available.<br>• Not satisfied with the night carers came too late |
| Comments | • "District nurses are rushed see you once or twice a week too much to do not enough time to concentrate on the job"<br>• "Firstly they need to make sure you are fit and well to leave. I am sure this would make a difference with people being re-admitted. Make sure all medicine is ready for time of discharge and equipment is already at home."<br>• "Better communication required between hospitals to speed discharge and free up beds"<br>• "Quicker discharge and be more organised. Should happen evening before discharge and be able to leave in the morning"<br>• "Waiting time could be improved"<br>• "Hospital struggling to cope. Serious delay pharmacist holds up a lot of things."<br>• "Seems too many people involved in discharge. One person needs to make the decision" |

# Appendix 5

**Summary of Responses from Hospital Discharge Questionnaire**

| Question No. | Yes | No | Unsure | NA |
|---|---|---|---|---|
| 10. Were you re-admitted within a month of discharge for the same condition? | 17 (15%) | 95 (83.3%) | 2 (1.7%) | 0 |
| 11. Were you given different dates and times for discharge by one or different people? | 27 (24%) | 78 (68%) | 7 (6%) | 2 (2%) |
| 12.Did one person co-ordinate<br><br>Your discharge from admission to discharge? | 61 (54%) | 29 (25%) | 21 (18%) | 3 (3%) |
| 13. Did you feel fully informed<br><br>On the decision to be discharge? | 82 (72%) | 30 (26%) | 0 | 2 |
| 14. Were you given enough notice to make the relevant arrangements for returning home? | 91 (80%) | 20 (18%) | 0 | 3 (3%) |
| 15. Were you unhappy about the decision to discharge you? | 25 (22%) | 87 (76%) | Mixed 1(1%) | 1 (1%) |
| 16. Was your discharge delayed? | 57 (50%) | 54 (47%) | 0 | 3 (3%) |
| 17. Did you receive a copy of the letter sent from your hospital to your GP? | 67 (59%) | 35 (31%) | 9 (8%) | 3 (3%) |
| 18. Did your GP change the medication prescribed by the hospital? | 12 (11%) | 94 (82%) | 0 | 8 (7%) |
| 18.1<br><br>If so were you informed why? | 10 (9%) | 4 (3%) | 0 | 100 (88%) |
| 19. Did someone check if you needed care after discharge? | 57 (50%) | 48 (42%) | 0 | 9 (8%) |
| 20. Do you think you should have received some care/support after discharge, but didn't get any? | 28 (25%) | 74 (64%) | 3 (3%) | 9 (8%) |
| 21. If you received care after discharge, did it meet your needs? | 39 (34%) | 23 (20%) | 0 | 52 (46%) |

# Appendix 6

## Questionnaire on Hospital Discharge

### Gender

There were more women (55%) than men (45%) that had completed the survey as shown in chart 1.

### Age

People over the age of 45 made up 79% of the people who participated in this survey. The age group 25-44 year old made up 11% of those surveyed and 10% were people under the age of 24. As shown in chart 2.

### Disability

There were 58 (51%) people who had a disability and 56 (49%) able bodied people. There were a wide range of disabilities such as schizophrenia, spondylitis, COPD, Blind, learning disability, osteoporosis, arthritis, rheumatoid arthritis, can't walk, hard of hearing, macular degeneration.

### Ethnicity

Majority of the ethnic group were British (86%) followed by 6% Pakistani origin, 3% English, 2% Indian, and 1% Northern Irish, 1% Mixed race and 1% Eastern European

Appendix 7

# The Patients Experience of the Discharge System at the Walsall Manor Hospital

# Case studies

# Healthwatch Walsall

*NB. These case studies have been edited to exclude experiences as far as possible that are not directly related to the Hospital Discharge process, which is the focus of this study. The excluded extracts which include many examples of good or failed care can be seen in the full versions of the case studies.*

## Case Study One

***"the NHS is letting elderly people down, rather than working together in cooperation,."*** (Daughter-in law)

As far as we know, my mother's cognitive abilities have never been properly assessed, so people assume she is of sound mind and can make important decisions.

There were no incontinence pads in her home. No-one saw it necessary to inform us before her discharge, that she was not incontinent, therefore not eligible for them. This information was given to me by the care-coordinator after she returned to the nursing home. The paramedics and care assistant agreed that my mother should not have been discharged to be on her own. We were not given details of her care package or who was providing care, and the times they would call. Communication between the family and professionals has been the bare minimum. It was always up to us to ask people to find out any information, which was not made easy. Often it is unclear to visitors whom the people in charge are and whom they need to ask.

We were phoned late afternoon the day before the discharge, asking, if I would be responsible for administering my mother's medication for one day only, or they wouldn't be able to discharge my mother. This increased the pressure to agree, because she was really desperate to go home and would have been even more upset. I had expected some instructions for the medication and knew she was on 'Warfarin' so each dose had to be recorded in the yellow book but could not find it.

It had been an absolute nightmare, a waste of our time and a complete disgrace! A prime example of one department not knowing what the other one is doing is the hospital appointment, sent to my mother's address, while she had been in the nursing home for a week!

### Main issues highlighted by the case study

1. Difficult for patient's to know who is in charge on the ward.
2. Discharging patients on Bank Holiday/Easter means less support is available
3. Break down or absence of communication between multi disciplinary teams
4. Incomplete inadequate and untimely information about care packages and incontinence support
5. No assessment of mental capacity for safe discharge home with the right care in place.
6. Inadequate arrangements for medication including lack of instructions to family

## Case Study Two

My stay in the hospital was traumatic and scary as I could easily have been lost in the system. I was in A & E for about 5 hours and had various other tests and an x-ray. I was given the option of being admitted or going home. I was told apart from morphine nothing further could be done until I had an MRI. I decided to go home and was given crutches and a Zimmer frame.

I could not mobilise and out of desperation I rang the emergency services again and this time after being in A & E for 4 hours I was admitted due to the pain and weakness in my legs.

When Dr eventually came to see me I think I had been in hospital 9 days, and he apologised and said he did not know I was still in hospital as he thought I had been discharged and I could go home that day. The doctor said his understudy would write it up and send it to the pharmacist ready for me to take home but he did not complete the paperwork correctly, and the pharmacist would not release my medication. The Dr had to redo the prescription and the pharmacy had closed at 5pm. I was told I would have to stay another night as I needed my morphine that evening and the next morning.

My care plan stated it had been done in consultation with me, which is untrue. It also said I had refused to let the nurse examine the site of my injection. That conversation never took place. After leaving the hospital I tried to get my Physiotherapy appointment. No appointment to date. I have now taken out private health care because I am afraid to go back into Manor Hospital.

### Main issues highlighted by the case study

1. First hospital stay failed to address the medical problem resulting in re-admission.
2. Nurses not listening to patient requests.
3. Medication mix up wasting time and causing extra night stay.
4. Confusion regarding discharge (doctor thought she had been discharged) and delays due to prescription / medication errors.
5. No consultation / involvement in discharge
6. Follow up appointments not arranged.
7. Inaccurate record keeping.

## Case Study Three

I was next to an 86 year old woman who had broken her ankle and had been in hospital a month. The lady would cry a lot. I could tell she desperately wanted to go back home, so she could be with her husband. The main barrier to this appeared to be the capacity of the Physiotherapists. Elderly patients should be prioritised for physiotherapy assessments so that the patient can go into rehabilitation rather than have an extended stay in hospital all alone and missing her family.

### Main issues highlighted by the case study

1. Lack of effective co-ordination of care such as physiotherapy caused delays to discharge
2. Delayed discharge adversely affected the emotional well being of vulnerable patients

## Case Study Four

This is a very sad case raising many issues about the adequacy of care, but it does not specifically relate to the discharge process.

## Case Study Five

She fell and broke her left leg and had an operation in Wales before being transferred to Manor Hospital. She spent 8 days on the ward and was moved to the departure lounge waiting 3 hours for an ambulance to take her to a Nursing Home. She would have preferred to stay in the ward as the departure lounge was very congested. They kept saying ambulance was busy and we waited 3 hours for the ambulance. She came home and already had most of the necessary equipment and all care in place.

### Main issues highlighted by the case study

1. Exceptionally long delay (11 hours) waiting for ambulance

## Case Study Six

I was admitted to hospital for 2 weeks after having a fall at home. I stayed on the ward for 12 days**.** All arrangements were made for me to go home and my family picked me up. I had all the equipment I needed at home. Walsall council set up re-ablement care. The physiotherapist came out twice to my home to assess me. I have just been discharged from re-ablement services and I will be contacting my private care company to come visit 2-3 times a week.

### Main issues highlighted by the case study

1. This example shows that discharge can work well.

## Case Study Seven

I was taken by ambulance to A & E where the Manor Hospital saved my life. They were going to discharge me but I wasn't feeling good and I had a relapse while in hospital. The hospital had made all the arrangements for me to go home. Someone did discuss what care I would need and set up all the necessary care that I needed. I received 6 weeks after care at home.

The first 2 weeks when I was discharged the Carers came too early in the morning. I didn't like that and on 3 separate days a man came out for my personal care. "I refused the care and requested for a female Carer, but they never took any notice." But after that the new Carers came from the social services/care they were better

### Main issues highlighted by the case study

1. If the time of care delivery does not meet patient's needs significantly it may not be fit for purpose.
2. Failure to consult the patient about the appropriate gender for care provider can impact on patients dignity especially for personal care.

## Case Study Eight

I had a total hip replacement and was asked who would look after me if I had the operation? I live on my own but I said I have someone to look after me because if I didn't have someone to look after me they wouldn't do the operation. Its blackmail**.** There were complications with the operation but treatment was good and I have praise for the hospital.

The problem was discharge and access to aftercare. I was told that as soon as I was discharged they would arrange aftercare. But the nurse said we haven't got any information about the after-care so I won't be able to go home. I just insisted that I was going home and I was not going to stay 3-4 days unnecessarily. I said I'll sort that out (they backed me into a corner again) I didn't want to stay in. They said how am I going to manage? I said I would sort it out, but I wasn't able to even though I said I would cope but I wanted to go home and not stay in a bed unnecessarily.

I left the hospital with crutches. My daughter and son in law picked me up on the weekend because it would be more difficult during the week. I had a feeling that I wasn't going to get aftercare. But someone should have contacted me to find out how I was managing without after-care. There was no contact at all. If they had phoned me up and ask if I needed aftercare I would have accepted it. I needed somebody. I had all the information about what you should and should not do. I had no Carer and I didn't know what was on offer.

### Main issues highlighted by the case study

1. The process was rigid and inflexible and did not meet the patient's needs
2. The decision to self-discharge resulted in forfeit of aftercare and support, leaving her vulnerable and unprotected.
3. The patient was not involved with the decision and her wishes appeared secondary.
4. There was no follow up.
5. Weekend discharge is difficult resulting in longer stays than necessary
6. The lack of sensitivity to patient circumstances led to distress a longer stay in hospital and ultimately risky self discharge and forfeit of aftercare.

## Case Study Nine

I had my operation on 21st March. I was there for 7 days and physiotherapy came every day. I was discharged at 1:45pm after lunch. The nurse sorted out all the paperwork. The nurses came around every day. Everything I needed was provided and arranged by the hospital. I had a carer for a week to dress me and I found after 2-3 days we didn't really need it, someone asked why I had stopped care?

They installed another rail on the stairs and arranged a blue badge. I saw the physiotherapist at the hospital 6-week appointment as arranged. The nurses came out and gave injections every day for 6 weeks.

### Main issues highlighted by the case study

1. An example of good practice and comprehensive care, which illustrates that effective joint working benefits all concerned.

## Case Study Ten

I had a full hysterectomy and felt the care particularly from student nurses was very good and tended to most of my needs with the help of my family. The consultant saw me on Friday with a view of being discharged on Sunday. On Sunday the doctor on duty was happy for me to go home. My daughter came and picked me up which was planned. I think it was more because I wanted to go home as I just needed to rest. They gave me a leaving hospital letter, which basically said if you have a problem give us a call or speak to your GP. They did not ask if we need any care and no help was offered. It was up to me to sort myself out. Everything was a struggle, like climbing a mountain but I got up the stairs one step at a time. I managed it but if there was no backup at home it would be a different story. As it was my wound opened up in a couple of places. I had to bath it myself at home until my husband could take me up to the GP."

### Main issues highlighted by the case study

1. No assessment of ability to cope at home.
2. No follow up leaving the patient vulnerable.

## Case Study Eleven

Admitted with symptoms of DVT in arm (had previous DVT in right arm after giving birth 5 years ago). Still had severe chest pains but was discharged as no clot was found. I was not happy because they ruled out one thing but did nothing further to find out the cause of my pain. It was only when I made a fuss about this they agreed for me to talk to a doctor. After waiting another hour I was told it was probably acid-reflux (which I never had and no tests were done to prove this) and told they would send for me as an out-patient. To this day I'm still waiting as I never heard from them again.

### Main issues highlighted by the case study

1. No Follow up tests organised as an outpatient appointment.
2. Patient not involved with and unhappy about decision to discharge.

## Case Study Twelve

They don't take enough care of blind people and nobody knows when they come to your bed that you are blind. Tablets are left on the locker and you don't know they are there. Different people talk to you and you can't see their faces so you don't know who they are. I told a nurse and she put up a notice to say that I was blind. After this they treated me as if I was blind, except when I needed the toilet I didn't know if it was a male or female toilet. I was sent home and when I went to the toilet everything came out of me...blood all over the place. I had to ask my son what colour was coming from me. He said Mom it's blood and he phoned ambulance straight away. They took me to hospital and I was discharged 3 weeks after I was admitted. Nobody tells porters that you are blind, so you have to tell everybody why you can't see the trolley? When I came out of hospital I had a nurse come twice a day to do my insulin. I have good support

### Main issues highlighted by the case study

1. Lack of awareness (possibly training) about blindness.
2. Procedures for assessing disability on admission not effective or not followed.
3. Discharge without an accurate diagnosis with serious consequences and risk to patient.

## Case Study Thirteen

I went to the A and E and waited 1-2 hours to be seen by a doctor and admitted to ward 3. I was kept overnight just in case it would happen again. The doctor looked after me and ward nurse was helpful because she spoke my language and helped me with my needs. They said I had sprained my hand and to carry on with regular hand exercise and I could go home. I had to wait for my prescriptions - about 3 hours and then went home at 11am the next day and they told me if I had any other pain in my wrist to come back.

### Main issues highlighted by the case study

1. The need to have access to language support in all areas of the hospital
2. The need to have access to patient information in a variety of languages especially for high risk medication and care issues.

## Case Study Fourteen

Nurses on ward very helpful and cleared up any issues I may have had. I left hospital with relevant paperwork required for work and any medication. Appointment date given for nurse to come to home to remove staples from wound. No further help required when discharged as stayed with family.

### Main issues highlighted by the case study

1. An example of an effective discharge

## Case Study Fifteen

I had to attend a clinic and wait to be admitted to a ward for treatment. I sat around the ward and said can I go? I asked for a sick note, which was given to me, which was good as I didn't have to go to the GP. Generally my stay was good the only thing that could be improved i.e. to be asked if they need help to carry your bags etc. Once you were left you were ignored and dismissed. The day after my surgery I was visited by two volunteers from the 'Breast Cancer Awareness Group'. They didn't ask they just came and I thought that was lovely. They were talking to me which was reassuring and very nice. Having that arranged was helpful and useful.

### Main issues highlighted by the case study

1. Generally good experience just felt ignored at the end
2. Good communication and information from doctors and nurses.
3. The patient appreciated receiving a sick note showing staff to be "caring and kind".
4. Breast Cancer Awareness Volunteers made a very positive impact and reassured the patient.

## Case Study Sixteen

The wound on my foot was not healing and my Dr told me to go to hospital. I was admitted to hospital later that day. Everybody was golden at the Manor Hospital. I was just diagnosed as a diabetic and before I went into hospital I had a phobia of injections and I don't any more. They made you comfortable as possible and they staff treated me with kindness.

### Main issues highlighted by the case study

1. Good care and skillful painless treatment had huge impact on patients trust, confidence and phobia of injections.

## Case Study Seventeen

The first time I went into hospital I was shaking and not feeling well and the cardiac nurse and cardiologist saved me. I was having a mini stroke. My treatment was perfectly fine and I thank God I was at the right place at the right time. I had to be re-admitted and my treatment and care went like clockwork. They were aiming for discharge on an evening but it's just one of those things. I knew I was coming home the next day. Physiotherapy aftercare was arranged because I need help to walk about and getting up the stairs is not that easy. I had all the equipment that I needed and I could manage. There was the odd delay or two but you don't have a big enough pharmacy to cope because there are too many patients. Overall it was a good experience.

**Main issues highlighted by the case study**

1. Patients really appreciate the excellent performance by the majority of staff that keeps them alive.

## Case Study Eighteen

I have been in and out of hospital during my pregnancy because I have high blood pressure. The nurse told me that we could go home but then the new ward nurse came on shift and saw that my daughter was yellow. They did a few tests and found that she was jaundiced and put her under the light for 6 hours and then had another blood test to check that she was not jaundice. After 2 days she had no more jaundice and they said she was fine. On the last day the doctor had to check the baby to see that she was all right and that took 3 hours. We also had to wait for medication (3 hours). Someone had talked to me about what I should and should not do and gave me a leaflet while in hospital. The Midwife came to see me at home for the first 3-4 days to check the baby. Then it was once a week that the midwife would come to see how we were doing. The midwife had monitored blood pressure at home. I didn't have any problems. After being discharged by the midwife the health visitor came out to see the baby.

**Main issues highlighted by the case study**

1. Is the initial decision to discharge a cause for concern in light of the second diagnosis?
2. The potential impact of a 6 hour wait for the doctor and medication for mother and baby.

## Case Study Nineteen

I presented in labour on Saturday evening in the delivery suite. I stayed 2 days and my care from the moment I attended the delivery suite through to my discharge was second to none. They told me that I would be going home and waited maybe 30 min to 1 hour for the staff nurse to come around and do the paperwork to go home. At 11:30am I went home. The nurse gave me a baby pack and information on what to do. I felt the staff were very busy and could not come to you immediately but they were good. The next day the community midwife came out and saw the baby and me. She came on 3 visits over the course of the week. The Health Visitor then came for a week to do baby checks and gave support. Thank you for a great experience.

**Main issues highlighted by the case study**

1. An effective well run process and good patient experience

## Case Study Twenty

I had a stroke and was taken to A and E and admitted to the stroke unit. All the staff from the paramedics, A&E and the stroke ward were excellent. Physiotherapy and OT assessed me and said I could go home once I had received the medication from the pharmacist. The pharmacist was busy and you received your medicine 6 hours later**.** I rang my family at noon and told them I was waiting for my medicine. I sat by my bed and got dressed and just waited. The nurse gave you a letter and I picked up 2 stands to hold onto when you use the toilet. That was the only equipment I needed. I walked out of the hospital and went home. The district nurse came the next day to check on me and gave me leaflets on stroke. She said if I had any worries to come to the stroke ward or back to A and E. The district nurse visited a couple of times and then a stroke nurse came every 3 months and then once a year. I stayed in for a week and received excellent care from all the staff including the physiotherapy and occupational therapists. Thank you for a good experience in a horrible situation.

### Main issues highlighted by the case study

1. Long delay for medication
2. Good aftercare

## Case Study Twenty One

I went in for a routine operation and woke up early the next morning. The auxiliary told me to get out of bed she had to change the sheets. I was in absolute agony. The nurses didn't help you to the toilet and I could not get any real co-operation from anybody. I feel I have been really neglected. The doctor came the next morning and didn't even stop for 30sec. He never explained anything.
It was 1 o'clock and the nurse said I could go home. All the paper work was done and I was discharged. But, just before I was going to be discharged I felt a lump and because it didn't hurt. I thought it was natural from the operation and went home. The district nurses came out once a week to treat my wound. Every time I phoned up the hospital there was no follow-up or nothing. I never had a follow up appointment at the Manor. I was fed up with Walsall Manor I was getting nowhere. I went to my GP and told him I want to be referred to Wolverhampton and within a fortnight I had an appointment to see the consultant in Wolverhampton. That was the end of the Walsall Manor Hospital. I wouldn't have anything to do with them again.

### Main issues highlighted by the case study

1. Appeared to be a lack of compassion.
2. Poor Communications and lack of information resulted in loss of trust

## Case Study Twenty Two

I went to casualty and I told them about the medication and dosage for the patient, who was taken up to the ward. On Thursday, he was very lethargic, mumbling and falling asleep. I said, do you realise he is a paranoid schizophrenic and that is why he is having all these problems. A few days later he could hardly walk and the nurse said he can go home today. "I am not taking him home like that I said. How am I going to handle him? You created the problem you sort it out!" She agreed and they kept him for another week.. As long as he can walk I would be able to manage him better at home. All I wanted to do is get him home. I wasn't happy to leave him in hospital because of the

problems of splitting medicine. When he came home he was still very poorly and would take him 3-4 weeks to get back to normal. Physiotherapy went 2-3 times. While at home he was under constant care with him not walking and his paranoia. This experience illustrates how quickly things can go wrong if there is poor communications and result in a lack of patient care. Better communication from staff and passing patient information such as medication list to the next staff on the ward would have avoided the problems he experienced.

### Main issues highlighted by the case study

1. Not listening to carer about medication needs resulted in severe consequence
2. Lack of thoroughness in checking and administering medication
3. Poor Communication and handover of information.

## Case Study Twenty three

When he was discharged he had an 8cm wound on his stomach. I queried this and they said it would heal on its own and the district nurse would come out to dress it so we took him home. He came home at 3pm in the afternoon and when he went to the toilet he was bleeding twice within the hour. I phoned the ward and said you discharged him this afternoon and he's bleeding. Can I bring him in as you advised on discharge? When I phoned she said oh no, you can't bring him into the ward you have to take him to casualty? Does that mean I have to sit in casualty? He's had an operation and he's bleeding. She said we have no beds.

I went to casualty and they did an x-ray and couldn't find anything and the next day he could go home. We were told that he would be released in the morning- asked what time? They said it doesn't matter because he will be taken to the discharge room so you can come at any time. We went in the afternoon and he was sitting up in the discharge room since breakfast. That's a long time for somebody to wait sitting in a chair after having had surgery. So I was glad to bring him home.

He was home for a week and we still didn't have a district nurse. I was dressing his wound every other day. I phoned the District nurses up and they said they didn't have any notification of him. The hospital told me they will put it in place**.** Since then they have been coming regularly. Nice nurses, very good can't fault them. But he has a nasty infection and I do feel as though time was wasted when he came out of hospital. He had been out of hospital a month and had an infection for the past 10-12 days and it is bringing him down.

### Main issues highlighted by the case study

1. Was he fit to be discharged
2. Given misleading or conflicting information about going back to the ward
3. Failure to arrange after care as promised.
4. Long wait in the discharge lounge

## Case Study Twenty-Four

I went for surgery to the day unit. After the operation they did not tell me anything. Physiotherapist came and I was groggy from anaesthetic and I was told to get off the bed and on my feet and walked me around the ward and ready for discharge. In my eyes I weren't ready for discharge. I thought they would keep me overnight. I was sick from anaesthetic and when I came from theatre I had high blood pressure as well. The physiotherapist was trying to rush me and get me out of bed and get me walking. I nearly collapsed on the floor, I couldn't do it! When I did get home I went to bed and my bandage came off. My wife had phoned
111. A paramedic came out and he assessed me and said I can't touch the knee and called for the ambulance- who advised me to go to the Manor as I may have a blood clot. The consultant didn't even look at my knee he only looked in my file. I was on physiotherapy for a week that was set up by the hospital. After 2 appointments he said I don't need any more physiotherapy. I needed more physiotherapy. When I try to walk down the street I have a limp and I feel pain on my side and front of the knee. I can't even kneel down.

### Main issues highlighted by the case study

1. Poor communication, not listening to the patients concerns
2. No Continuity of Care
3. Rushed discharge and questionable patient fitness.
4. Medical problem not resolved for patient (potential re admission)

## Case Study Twenty-Five

My wife was admitted after an operation and they pulled her straight off the trolley. She was bleeding. I said "can you pack it in, be gentle". The nurses were nasty towards her. They should take more care of people who come out of operation. She had to stop in for 3 days and could then go home. On the last day the doctor came around 10:30 -11 am and said she could be discharged and took taxi home. She left hospital in a wheelchair and had a month of physiotherapy. Once the wound was better about 2-3 weeks later she was on crutches and physiotherapy showed her how to walk up and down stairs and everything was fine after physiotherapy. Physiotherapy was doing more for her and they were polite. There is no communication with staff you are left on your own. There should be more respect from nurse and be speak politely to patients**.**

### Main issues highlighted by the case study

1. Patient felt harshly treated by staff.

## Case Study Twenty-Six

I went to A and E with severe abdominal pain. On the morning the Dr came around and I asked if I could leave and go home and I was discharged later that day. There was a delay in getting paperwork organised it is only a letter and simple painkillers to be prescribed. Pharmacy took so long to get your medicine. I didn't need aftercare and my follow up outpatient appointment letter arrived and was on the Wednesday.

### Main issues highlighted by the case study

1. Pharmacy delays

2. Paperwork delays

## Case Study Twenty-Seven

I was admitted to Walsall Manor Hospital with pneumonia for 10-11 days. Someone had said I could go home but that member of staff left and the next staff hadn't heard that I was going home. Later she said that I wasn't going home because there was no paperwork completed**.** Then flurry of activity (I was not included in) then they started asking me questions about medication. The pharmacist had my medicines but still debate about seeing respiratory specialist**.** I don't know who or why they wanted me to have an appointment to see the respiratory team before I left. Then it was decided I could go home and that I would receive this letter to see the specialist within 8 weeks with the appointment. It is almost 10 weeks later I have still not had a letter**.** I checked my medication and there was a mistake. It said on the letter I had my previous inhaler and my new inhaler. I obviously had not had my old inhaler. They queried this with the pharmacist- who said I no longer needed my old inhaler and the letter was wrong. This caused a delay of 10-20 minutes. Nobody talked to me about my care plan. They talked at me not to me. They told you how to use medicine and changing my inhaler but not information on how I can manage myself.

### Main issues highlighted by the case study

1. Given different discharge information by different staff
2. Lack of communication and explanation about respiratory appointment.
3. Lack of involvement in discharge
4. Error in medication and delay

## Case Study Twenty-Eight

I arrived at A and E by ambulance. They rushed me in, I was on morphine and they took me to another department. I could have gone home straight away more or less or the next day, but the doctor went on holiday. The nurses kept coming around but no one told me that I could go home until one of them came back from holiday and said oh are you still here? You could have gone home. Then they arranged that morning for me to go home. The nurse came and told me they would send a district nurse to come and change my dressings. When I was discharged there was no communication with hospital about what is happening, there is no feedback. The district nurses are rushed they have that many people to deal with they have not got the time. They spend more time on administration than where it is needed.

### Main issues highlighted by the case study

1. Poor communication
2. Poor co-ordination

## Case Study Twenty-Nine

I was taken by ambulance to A and E after a heart attack. They had looked after me very well the care was very good. I just couldn't get discharged. I went to ward 7 and the consultant came the next morning at midday. He said I was alright and I could go home but I believe he had to go for an emergency call. The nurse told me to wait and someone would be up to take me to the discharge room. I was waiting for a wheelchair- they came an hour later and took me to the discharge room. I stayed 8 hrs in the discharge room. No one knew what to do with us. There were 4 of us. From what we were told the pharmacist couldn't give the medication out because there was no discharge letter and you had to wait. Later on they said nobody had admitted me even though I

stayed overnight. So they had to have someone admit me before I could be discharged. At 4 pm I couldn't believe it, you just sat and waited we couldn't do anything without a prescription and discharge letter. You had no choice. Then the nurse said Good News we have your discharge letters and medication. They had arranged everything by 9 pm and then you were free to go home. The treatment was good it was the wait to go home that was the problem.

### Main issues highlighted by the case study

1. Poor organization
2. Long delay
3. Missing paperwork (admission)

## Case Study Thirty

I was taken into A and E and was in the A and E for 12 hours before they moved me. A consultant came to see me about 4:30-5PM and he gave me a letter off and told me to book an appointment for my COPD. I had to wait two hours for my medication to come and then I was ready to go home on the Wednesday night after a 2 hours delay for in medication. The hospital had arranged for a respiratory nurse to come and see me twice a week. My treatment in hospital was very good. I couldn't fault the nurses at all!

### Main issues highlighted by the case study

1. Long delay for medicine

## Case Study Thirty-One

I was taken to A & E Manor Hospital and admitted to the cardiac ward then moved to the general ward for one night and then went home. I had raised concerns about coming home with the sister. I was on my own and they never asked me if I needed care or support. They filled a form and tried to arrange support but the office is closed on Friday afternoon. I stayed in hospital till Monday. I said will go home although it was difficult because my wife died in January and I am bereaved. I have disability allowance and my wife would assist me but now she is gone. The hospital arranged for someone to do an initial assessment (took 3-4 days) and I could get free support for 6 weeks but would have to pay for the service after that. It would be nice to have home care and domestic help around the house. This was ok when my wife was alive but now I need help. I have no family assistance, after the 6 weeks then what? I have financial concerns how to manage.

### Main issues highlighted by the case study

1. Delayed discharge due to no cover over the weekend.
2. Patient discharged without aftercare.

## Case Study Thirty-two

My daughter phoned the paramedic and took me to A&E. They took me to acute medical unit and then after an hour I went to the general ward. On Saturday they transferred me at night at 10pm to the discharge room. I wasn't aware I was going to be discharged I thought I was going home on Monday morning. On the Sunday morning a different doctor came around midday and told me I could be discharged. My Grandson had come to visit me. I don't think he was told I was going home. He took me home by 3pm. There was no one to look after me when I was discharged. We

are still waiting for CT scan appointment, which was arranged by the hospital. It has been 6 weeks (the waiting list is 6-8 weeks). I had my follow up appointment letter by post to see the urologist, but we are still waiting for the CT scan appointment arranged by hospital. It has already been 6-8 weeks.

### Main issues highlighted by the case study

1. No involvement in discharge decision
2. Poor communication with family about discharge
3. Poor arrangements for aftercare

## Case Study Thirty-Three

The paramedic brought me to the Manor. I was transferred to the angiogram ward in the night and in the morning after breakfast the doctor checked me and said I could go home. It was 4-5 hours before I was discharged home. My daughter came for me and I could go home. The district nurses came out the next day. The hospital had arranged for the district nurse to come out twice a day for a fortnight for my IV antibiotic injections. It put it right. After a fortnight the nurses told me to contact my GP and have the injection strength increased. Nobody followed it up. I had to get my own GP to increase the dose of the injections.

### Main issues highlighted by the case study

1. Co-ordination did not meet patient expectations

## Case Study Thirty Four

I was taken by the family to A and E and was admitted into a cubical. My discharge was a nightmare, the hospital rang my daughter and told her to fetch me, at the time she was at work so told them she could not come until evening. The discharge was totally out of the blue, giving my family no warning. There had been no heating on in my home and if the family had been warned it could have been turned on in advance. The ward also demanded that my daughter collected my equipment, which my daughter refused to do because her car is not big enough. In the end the equipment (2 walking frames, toilet seat, and a commode) came with me on the ambulance.

I was put on an ambulance and my daughter was told I would arrive home at about six o clock but I did not arrive until after eight o clock**.** I have no bed downstairs and could not by any means get upstairs by myself or with my daughters help. I was assured that a care package was in place, which started on the night of my discharge. At ten o clock my daughter rang the care providers and was told that they did not know anything about the call. Fortunately they sent someone out at 11 pm to help put me to bed. They said the hospital didn't tell them they had to come. But the hospital had told my daughter that a carer would be sent. I felt as though I was rushed out of the Manor, with no proper care package put in place and no discussion with my family. I am 86 years old and I needed the help, but it was very poor and took weeks before the carers got into a routine with me. I had 6 weeks of care package arranged by the hospital. I was having 4 visits a day and 4 different people every day. One day I was woken up at 7am, had my dinner at 12pm then they did my tea at 4pm and came round to put me to bed at 7.30pm. This is very poor service leaving me in bed for 12 hours at a time. I talked to the providers and there was nothing they could do I had care for 6 weeks but if I wanted any more care I would have to pay for it. It is so expensive I can't afford it. They don't want to know and there is pressure on the family. Both my daughters are the main Carers but I live alone and am on my own for long periods of time.

### Main issues highlighted by the case study

1. Poor co-ordination
2. Poor communication
3. Poor service received from carers.
4. Timing of aftercare visits did not suit the patient's needs.
5. Too little notice and rushed discharge

## Case Study Thirty-Five

On the day my wife was discharged they told me she was going to be discharged from the ICU because of the Norovirus on the wards. She would be better coming home. She was discharged at 4:30pm and by the time the ambulance came it was 9:30pm and arrived at home at 10:10pm on the Monday night. I had no aids whatsoever, it was over 2 weeks later that the OT came out to see me about help. In hindsight those things should have been in place when she left hospital and I needed help, which didn't arrive. I had aftercare for 3 weeks I thought I could cope better. They came in twice a day morning and night. The Carers met your needs. I can't fault the hospital care, it was the discharge, the way it was done, with no help and a very sick lady. The problem lies with aftercare, it should have been organised better. I was told a few days ago that she might not pull thru and that she might die. You can't imagine the state I was in. She was on life support for 9 days. You see if I could have stopped in intensive care I wouldn't have wanted to come home early. It was all rushed and I had no after-care. We complained about the after-care. They have apologised for the failings but also state that I agreed to take her home but not realising what I was taking on. I was in a traumatic state of mind. She was very poorly to come home, she was hallucinating, didn't know where she was because of the state she was in**.** Happy she was alive and to get her home. I thought I could cope. I didn't know, she was not assessed they said we won't release her until she manages the stairs. She never even tried the stairs but was still discharged early. When the ambulance men came they brought her home they had to support her from the wheelchair to the bed. No way could she climb the stairs at home.

### Main issues highlighted by the case study

1. Discharged with poor health
2. Agreed to self-discharge but did not have information about her needs.
3. Lack of information and advice
4. No aftercare in place before they were discharged
5. Discharged late at night due to long wait for ambulance

## Case Study Thirty-Six: Female patient's Story

My nephew made an emergency appointment with the GP. The GP gave me a letter and sent me straight to the hospital and the doctor checked me and said I would be admitted to the ward. I was on the ward for 3 days and I wanted to go home. I raised the issue to go home with the nurse who said she would discharge me in a bit and later that evening I was discharged at 6:30pm. No doctor came to examine or visit me during these days. I think it was because the Norovirus was on the ward. I felt the virus was the focus not me, I didn't feel any better in hospital and so I went home. I

was home for a day and I went back to my GP and he sent me back to Manor Hospital requesting a chest x-ray. which revealed that my lung had collapsed and I had pneumonia. He gave me antibiotics and sent me home. I felt even worse. I could not speak and whispered to her brother, "get me an ambulance". The ambulance came and the paramedic put an oxygen mask on me. I could finally breathe and took me to hospital. The paramedic said if I didn't ring when they did it could have been fatal. I went to A and E and the doctor admitted me. The doctor said that they have no record of me being in hospital a few days before. I was on the ward for about a week. Then the head nurse said that I have finished my course of antibiotics and now it is going to be a slow recovery and I could go home. The nurse gave me a discharge letter to give to my GP and gave me another 7 days course of antibiotic and anti-sickness tablets to take home and finish. My brother came and picked me up. I was happy to be discharged. I didn't feel rushed in my discharge.

## Main issues highlighted by the case study

1. Early discharge with no assessment
2. Re-admitted and had not updated records