Healthwatch Walsall's Report into Walsall Manor Hospital Discharge Process

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Healthwatch Walsall Healthwatch Walsall (HWW) is the independent consumer champion for health and social care in your local area, delivered by Engaging Communities Staffordshire.

Our job is to amplify the consumer interests of those using health and social care services across the borough and give local people an opportunity to speak out about their concerns and health care priorities.

Work such as this project reflects the patient experience and their views. It will be shared with commissioners of services, service providers

Background

For most people who are admitted to hospital there are no serious long-term implications from their admission and no need for ongoing social care support once discharged. However, for some people being admitted to hospital, this may lead to life changing conditions and ongoing support being needed.

For those, this may mean that they require support on their discharge from hospital and in the past, this has meant that some patients who are *medically fit for discharge have remained in hospital unnecessarily. This has been due to a number of factors such as waiting for social care assessments, care packages to be

arranged and or external and internal changes to properties to accommodate their support needs.
In order to prevent delays to discharge and to ensure that patients are assessed in a way to reflect the circumstances that they live in rather than assessing them in a hospital, processes have been put in place to reduce delays in discharge and to ensure patients leave with the most appropriate care package.

In reality, most patients will return to their own homes on discharge without any ongoing support needs. This project wanted to find out about the discharge of patients, those that were 'Medically for Fit for Discharge'* and patients discharged 'on the day*.

Whilst we are aware that there can be several issues affected a patient's discharge, this project aimed to understand the views from the patient being discharged from hospital including the planning of discharge and the involvement of patients and relatives in those plans.

This work area was identified at the end of 2018 based on intelligence we had gathered from patients, families and from information gathered from some of the meetings we attend.

Definitions

*Medically Fit For Discharge (MFFD). definition - care package and equipment, assessed as being needed and in place before their discharge can take place.
*Stranded definition – patients with a length of stay of 7 days or more.

Day to day discharge/ simple discharge – patients that are discharged from wards with lesser or no additional social care requirements.

We have inserted patient comments, highlighted in *"Italics"*

Aims and Objectives

- Understand the difficulties causing Delayed Transfers of Care of patients that were medically fit for discharge.
- Gather views on how the discharge process is communicated to patients and relatives.
- Understand the experiences of patients during day to day discharge and those using the discharge lounge.

The reports reflects the aspects of those patients who are 'Medically Fit for Discharge' and those patients who are discharged daily from the hospital.

Methodology

The work was carried out using a survey, in paper form, which was developed by our HWW team, based initially on what we heard from patients and relatives.

The work started mid December 2018 to March 2019. We undertook 9 visits to the discharge lounge, ward 3, ward 14 and ward 10.

In addition to undertaking patient experience surveys, during our visit's opportunities arose to chat with associated discharge department staff.

HWW staff and 11 volunteers were used to speak to patients directly about their experience(s) of discharge from the start of the discharge process on wards to the discharge lounge area and the completion of their discharge.

We collated 62 patient survey responses and 12 relative, carer or friend surveys/ comments. Not all the respondents to the surveys answered as patients received care, a Doctor came examine, patients were taken for scans etc.

Key findings

Delayed Transfers of Care of patients that were 'Medically Fit For Discharge'*

Most of the patients, 77% said, that they had received good to very good care during their admission. Though there was some less positive feedback around Doctor's not listening or discussing the discharge process.

Patients and relatives/carers were asked if they knew when they were going to be discharged. 58% were aware of the plan and when they were to be discharged. 39% of patients and relatives/carers were not aware.

We asked if they understood the discharge process. 55% did and 32% did not understand their discharge arrangements.

We also asked if they felt involved in the discharge process. 16% felt very involved, 44% felt fairly involved and 35% felt not involved at all.

Healthwatch met the 'Trusted Assessors' team and learnt how they are having a positive impact to support more efficient discharge arrangements.

Some patients have said there is a lack of access to interpreters to communicate with the diverse patient population/ languages.

One patient indicated that they could have been home a week ago but were waiting for a key safe to be fitted to their property.

Day to day Discharge/ Simple Discharge

There is currently no permanent, dedicated location for the discharge lounge. Moving into unused bays of hospital. Some patients felt that it can be cramped and have a makeshift feel.

We evidenced patients were not being informed or kept updated that they were being discharged that day.

One patient discharge letter had been available for over two hours but not given to them, so they remained until it was noticed.

Some patients were waiting in the discharge lounge in nightwear as they had none of their own clothes at the hospital or they were not aware they were being discharged that day.

We witnessed a patient being discharged without medication and was asked to return later that day to pick it up.

We were told that patients are discharged without their medication and a Taxi is arranged to deliver their medication later.

Hospital equipment, wheelchairs dedicated to being used in the transport of discharged patients was being used by other departments causing discharge staff to look for equipment or alternatives.

We were told that Doctors were promising transport (Taxis) to patients on discharge when it was not necessarily appropriate, or policy and was at the cost of the hospital.

A patient discharged was re-admitted to Walsall Manor Hospital less than 48hrs later with possibly the same condition originally admitted for.

Whilst we undertook our visits one patient was recalled from the discharge lounge and admitted back on to a ward.

Delayed Transfers of Care of patients that were 'medically fit for discharge'*

We visited patients' relatives, carers on ward 3, 10 and 14 to ask them about their involvement, understanding about their patient discharge and actual experience.

Themes

Waiting for social care

Some participants said that they were waiting for social care assessments and packages to be sorted out before they could be discharged from hospital.

One comment we received that they were 'just waiting for a care package. Not sure how long that will take' As a result they had no approximate time period as to when they will be leaving.

Patients and relatives stated that a Social Worker leaving, and the assignment of a new worker can mean a delay in the assessment and discharge process.

"Awaiting key safe and care package to be organised"

Waiting for beds

There was some feedback about discharge being delayed because of patients waiting for beds. This included palliative care beds, step down beds or care and nursing home beds.

The relative of one patient said that palliative care were 'looking for a bed in a nursing home' because there were not enough palliative care beds. They commented that an improvement to the discharge process would be an increase in 'hospices or nursing homes.'

Another participant said that they were delayed leaving hospital because they were 'looking for a nursing home out of area.' Somewhere in the Stoke area. Although their funding had been agreed

there was still a delay in being able to find a suitable home and that they had not been able to have their 'choice of home'.

Waiting for care and nursing home beds was a consistent theme.

"care home too far away"
"Great concern about discharge to care home in Stoke. Son main carer lives in Walsall and is on crutches following a stay in hospital. Daughter lives in Telford and does not drive".

Community Care

Some patients although returning home are not able to be fully independent and required the attendance of Community Nurses.
One patient required specialist medical equipment not only to be supplied but also a nurse to assist in the running and use of the equipment to meet their needs.

Other factors that may affect discharge were highlighted around community care and the need for staff to deliver specialist care.

"My discharge was planned for Monday, but now not known, told need to identify nurse in the community to deal with specialist equipment, someone may need to be trained?"
"Some discussion about today, but feels shouldn't with mental health support"
"Community nurse not available otherwise could have been discharged",

Communication

Communication between professionals or different departments was brought up by patients as something that could be improved.

Patients told us that communication form different professionals gave them different messages and were left not fully knowing what was happening.

Relatives also commented that improvements could be made around communication. Re-iterating the importance as they were in many cases the patients current and future carers.

"All hasn't been discussed I think I'm having a care package done"
"Gran is deaf and blind, so this makes conversations difficult"
"Nurses' good doctors stand offish"
"I felt night staff were not helpful on ward 3, overheard others complaining"

The role Integrated Care Services (ICS) – Trusted Assessors
Healthwatch Walsall met with two Trusted Assessors based in the Integrated Care Services at the hospital.

Their role as a Trusted Assessors Team is to assess patients' needs prior to the patients' discharge and to undertake discussions with care and nursing homes to ensure the patients' needs are met and to also support speeding up the discharge of patients safely.

In the past some care providers have felt that they have not received a reflective assessment of patient needs from the hospital, so they have sent out their own staff to assess patients. This may take days or weeks or weeks to be organised. Thus, the Trusted Assessor is pivotal to this role.

Bed availability is constantly changing in the borough. There has been I.T. issues in that some care or nursing homes have not been able to access assessments online, and teams have had to hand deliver assessments to care providers.

Two staff members we spoke to felt that they were making a positive impact through care on reducing the time a

patient has been in hospital to be transferred to care settings, therefore reducing the 'stranded*' patients.

The two ICS representatives felt that they were getting a positive response from external care providers and more providers were utilising their assessments rather than sending their own staff to undertake the assessment. Some care providers have also adopted the ICS assessment style and process when assessing possible residents to their homes.

Conclusions

There are many factors out of the control of the hospital which impacts on the discharge time and experience of the patient.
Patients generally felt that they had been involved with plans for their discharge, but for some this amounted to be the recipient of information rather than active players in their own discharge process.

Also, that the information they received could be different and contradictory from one professional to another or that information may not be passed on at all.

Relatives particularly felt that they were not involved or kept informed. As many relatives are carers it is important that they are involved in the pre and discharge process.

Trust and availability between professionals in the discharge process is still being built on and can be affected by staff leaving and staff holidays.

Recommendations

Families and relatives play a key role in supporting patients once they are discharged. It is recommended that both the hospital and social care services ensure that families are involved in the discharge planning process.

The communication between some patients and professionals, can lead to confusion on the part of the patient about their discharge. Therefore, it is recommended that patients are given a single point of contact to liaise with for their discharge.

Some patients told us about a lack of confidence on returning home in that for some there needed to be more preparation for being discharged. Therefore, it is recommended that patients concerns are considered when planning discharge and that suitable measures to alleviate their concerns are put in place.

The work undertaken by Trusted Assessors should continue to gain the confidence of care and nursing homes staff, to allow them to undertake patient assessments to reduce/ remove this admin time.

Devise a patient journey/ discharge log that contains information about the patient, their needs, their support requirements, where the patient is going, any additional after discharge contact details that may be needed. ALL in one place for ease of access and updating.

Day to Day/Simple Discharge

The numbers of patients discharged through the lounge varies daily and

depends on a number of factors. This takes place when Doctors or staff sign off patients and authorise discharge.

When speaking to staff on the discharge lounge, a 'Discharge lounge patient information leaflet' was available. But this is devoid of any timelines or deadlines around the discharge process.

Themes

The Discharge Lounge location(s)

We visited various locations where the discharge lounge was sited. Ward 10, complex discharge ward, bay of ward 9 and other locations.

The lounge(s) had a feel of make do, and some patients commented that they felt like being herded into a small space.

"Discharge lounge seems untidy cluttered with equipment"
"Discharge chaotic, admin poor, not enough space"
"Went to discharge lounge, fell, went back to ward"

We noted that discharge staff were helpful and offered drinks, water and food to patients and they were asked regularly.

Communication

Again, the quality of communication and information was raised by patients as an issue. The ward Doctor told some patients they could go, but without any indication of how long the discharge process may take or what is involved
Some thought they could go now! This initial lack of information leads to a false expectation for patients who may make arrangements or plans to go home.

"No one explained properly what's going on re: discharge"
" Told half hour ago, so a surprise"
"No communication about discharge, does not know what is happening, given no clear answers"

Getting Home

Whilst in the discharge lounge, we evidenced patients having issues getting home. This was due to the lack of information around the time of leaving the hospital and the demand on patient transport.
Many patients could not leave the lounge until transport was available. In many cases patients had to wait for relatives to pick them up.

It became apparent that relatives had spoken to staff and were under the impression they could attend and pick up the patient immediately. This was not the case as the discharge process was not complete. This meant non patients were in hospital unnecessarily.

"Delays with patient transport"
"Trying to contact relatives to get picked up"
"ambulance arrived, no meds but told 10minutes"

Administration

The completion and availability of 'Electronic Discharge Summary' (EDS) seems to be key. A Doctor writes this upon completion of their observations and assessment of discharging patients.

However, in many cases this was completed at the end of their overall ward round and further administrative tasks could be required such as booking patient transport, prescriptions for medication, pharmacy prescribing checks and issuing medication.

Many of the patients in the discharge lounge were not aware of the administrative requirements and tasks involved in their discharge process. They were only aware of a wait.

"Having to wait for doctor to sign paperwork to discharge me"
"Waiting for meds/discharge paperwork"
"discharge is make do, admin poor"
"3.30 came in at 11am, still awaiting discharge letter"

Conclusions

Some patients felt that they were being rushed out of hospital. Some patients only became aware of their discharge on the same day.
The movement and size of the temporary lounge does impact on the discharge process for patients. Making it feel a "make do" style of handling the discharge process.

The initial contact and information given by the discharging Doctor is key and sets the expectation of the patient regarding their discharge. The term 'you can go' is simply not enough information. The patient should receive information about the process and timelines.

Whilst patient care was stated as good to very good whilst admitted into hospital the general feeling about the discharge process was poor. Lack of information, communication and the time it takes were the key areas of poor experience for patients.

Recommendations

Designate a permanent discharge lounge/ area which does not re-locate. And is of adequate size to meet discharge numbers. Set timelines/ deadlines within the discharge process so that any failure in the process is picked up promptly and can be actioned by staff to get 'back on track'.

Assess the message a patient receives from the ward Doctor initially and ensure clear information regarding their individual discharge is given with timelines.

Adequate notice is given to patients on their discharge. To enable patients to make suitable arrangements for leaving hospital with family, friends or arrange any other support.

Ensure that patients and families are involved in the discharge planning process and informed and kept updated.

Patients and relatives are given a single point of contact to liaise with for their or relatives discharge.

Redesign 'The Discharge lounge Patient information Leaflet' to include clear process, timelines and deadlines and available in different languages (can be held electronically to print to meet language needs).

Consider patients dignity in the discharge lounge 0f wearing nightwear. Supply suitable attire or allocate more private areas in a discharge lounge.

Identify the extent of the use of taxis in the discharge process. Both as a potential safety/ security risk as well as a costing calculator. Any risk or cost may be eradicated if discharge process was more effective.

Consider colour coding and marking any required equipment used in the discharge process, so that it is only available to discharge staff. Or so that it may be recovered if taken off hospital premises.

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