Healthwatch Richmond

Discharge from Hospital

Executive Summary

April 2016

Discharge Project Executive Summary

Between July 2015 and January 2016, Healthwatch Richmond carried out an extensive project to look at patient experiences of being discharged from hospital. We spoke to 120 people through outreach sessions to community organisations, visits to inpatient units at local hospitals and an online and paper survey. The aim of this work was to highlight patient views and experiences of being discharged from hospitals throughout Richmond.

The process of hospital discharge is complex. There are several different pathways out of hospital, differing between the acute and mental health trusts, and there are many stakeholders involved. This provided us with a significant challenge in gaining access to patients who have experienced the discharge process. Due to these complexities it was necessary to place limitations on the scope of the project to ensure that it remained manageable.

It became clear in the initial stages of the project that discharge from the mental health trust was a very different process to that of an acute trust. We therefore limited our focus to the challenges of discharge from the acute trusts into the borough, recognising that an area of future work may be to focus on discharge from the mental health trust. We were, however, keen to engage with mental health service users to find out their experiences of being discharged from acute settings.

Information about, and support following, Discharge

An overarching theme throughout the data is the lack of information provided to patients; for example "*I couldn't understand why I couldn't be on antibiotics at Teddington*". Additionally, throughout the report we have provided examples of patients who have experienced challenges with communication, transfers between services and care following discharge.

Poor communication between services and the patient can also lead to delays in discharge, as highlighted by the patient who told us that:

> *"…it also transpired that my next of kin had been told about my discharge the previous day but the information hadn't trickled through, and I didn't want to be in an empty house with no milk."*

This shows that there is a need for extra, non-clinical, support for discharge into the community. Patients and staff across organisations mentioned the "*need for an advocate*" and there is a clear gap in support where people require assistance to transition from hospital home, who may not have that support through their family.

Recommendation 1

We recommend to West Middlesex and Kingston hospitals that they ensure that patients are kept informed about their discharge as this can reduce the stress and anxiety often felt by patients who feel left in the dark, even when there is no new information to share.

In December 2015 Healthwatch Kingston recommended that Kingston Hospital "***inform/reassure elderly, vulnerable patients as early as possible about carers/help at home schemes upon discharge***".

West Middlesex University Hospital told us that they are *"developing an information leaflet explaining the discharge process to patients. There is also a daily Discharge Meeting which looks at patients who are due for discharge over the following three days.*

This helps to provide a focus for the nurse in charge of the ward to ensure that discharge dates are effectively communicated to patients and families." We were also told that work was underway to ensure that *"appropriate Estimated Dates of Discharge are set at the point of admission and these are communicated to the patient and family... led by the Medicine Bed Management Steering Group.*

Kingston Hospital told us that *"a programme of improvements will be incorporated into the refresh of the annual inpatient experience plan due in spring 2016".* We look forward to seeing this plan and the greater clarity it will provide on how Kingston Hospital will improve communication with patients around discharge.

Recommendation 2

We recommend that information about Teddington Memorial Hospital is given to patients being transferred there; as this was a source of concern for patients at West Mid.

West Middlesex Hospital told us that *"Since October 2015 the RRRT have been providing in-reach to West Middlesex Hospital to support the smooth transfer of patients to Richmond services in a timely manner [and] that patients being transferred to other establishments such as Teddington Memorial Hospital are fully informed about the experience they can expect."*

Both Kingston Hospital and West Middlesex Hospital told us that they are producing written information that is given to patients regarding Teddington Memorial Hospital.

The hospitals should note the crossover around producing information for patients and avoid duplication by ensuring that only one leaflet is produced.

Recommendation 3

We recommended to the hospitals that they provide patients who live alone with additional support to transition more successfully from hospital to the home.

Both Hospitals told us that they already had some provision for ensuring that there are basic amenities in the home, such as a pint of milk, including making referrals to the Nightingale Service. In addition Kingston Hospital have a *"hospital to home scheme"* delivered through its volunteering strategy – something that they are seeking funding to continue into 2016/17. **West Middlesex Hospital** report that they have *"approached Waitrose social responsibility programme to provide provision packs for patients on discharge."*

Poor coordination between services

Communication with professionals

A significant challenge highlighted throughout this report has been the clear gap in effective communication between services, predominantly from the hospitals, to care provided in the community (Nurses, GPs and occasionally care homes).

The nursing teams spoke of not having enough detail about the treatments that are being provided, finding that a patient has been kept in hospital after their expected discharge date, or has been discharged without their knowledge.

The RRRT spoke of the challenges in communication between providers when transferring patients with cognitive behavioural issues, or information on rehabilitation treatment provided in the acute settings.

Patients spoke of poor communication between services leading to problems, including care plans not being in place in time for their discharge, community care not turning up, and GPs not having information about changes to prescription medications following a stay in hospital.

Whilst we acknowledge that patients care is complex and things don't always go to plan, it is particularly important in these situations for good communication to keep those involved aware of any changes that have been made.

Recommendation 4

We recommended to hospitals that they will improve the communication between services, particularly with GP practices and community care staff and asked them to explain any actions that they are already taking in this area.

West Middlesex Hospital told us that their Discharge Governance Group has been a positive step towards improving communication methods between providers and this is something that will be extended across their other sites. We recognise that this has contributed to creating an open forum for connections to be made across organisations and an environment where concerns can be raised and resolved and see this as a positive process.

Kingston Hospital referred us to their "*Faster Flow, Safer Care*" programme as their process for improving communication which included the implementation of a structure for managing delayed transfers of care involving hospital and staff working in health and social care in the community. Whilst this is a very positive programme we note that Kingston Hospital's programme predates this report. The patient experiences collected in this report demonstrate that further improvements still need to be made.

Equipment

The comments received regarding equipment and the installation of equipment suggest that this area is a cause for concern. We acknowledge the challenges in the provision of equipment and understand that, at West Middlesex, there is work being undertaken to review this.

Equally, effective timing of services is also important when, for example, equipment has to be installed. This is particularly true for patients whose family members have had to make special arrangements to enable the equipment to be installed.

Conversations with the community nurses also stressed the importance of being provided with more warning and information when equipment, such as a hospital bed, is required

because of the higher cost of ordering equipment within 24 hours of discharge. This view was reflected in conversations at the West Middlesex Discharge Governance Group meeting.

Recommendation 5

We recommend that providers review the provision of equipment for patients in the home. Additionally, we recommend that the acute settings provide more than 24 hours' notice to community nurses on equipment that they need to order for patients due to be discharged.

Kingston Hospital reported that they endeavour to provide sufficient notice when patients need equipment, but that patients are sometimes in hospitals for less than the time it takes to order equipment.

West Middlesex Hospital told us that providing patients with smaller items of equipment from an on-site store can minimise delays and that the discharge governance group has also developed a checklist to ensure that equipment is ordered in time to reduce late notice costs.

The Nightingale service was also cited as having *"proved extremely beneficial in reducing delays in terms of equipment provision through their willingness to accept equipment on a patient's behalf"*.

Medication

We note that there is a significant delay on the day of discharge for patients waiting for medications to come through from the pharmacy.

The West Middlesex Discharge Governance Group acknowledged this as a problem and identified an action to enable pharmacy to have a patient's dosette box ready 48 hours before, where possible. The work in improving the delivery of medications for discharge is ongoing.

Recommendation 6

We recommend that providers review the length of time it takes for pharmacy to deliver medications to patients being sent home, identify the underlying the main causes and improve the process.

Kingston Hospital told us that they have expanded the pharmacy service in the Acute Assessment Unit, including at weekends, which has improved dispensing. They also note the importance of doctors completing prescriptions promptly, and have implemented a patient tracker to identify the expected date of discharge.

West Middlesex Hospital told us that improving the delivery of medication for discharge was raised by the CQC following their recent inspection of the site. As a result of this, there are several specific actions taking place:

- A working group established to review the process for medications to take home
- Involvement of Pharmacy within the Discharge Governance Meeting to discuss medication administration and assessment.

Non-emergency patient transport

We received a number of comments regarding non-emergency patient transport from all providers, with the most concerning comment collected being a safeguarding concern. Non-emergency patient transport is an important part of discharge, supporting patients to

return home safely. Flexibility around patient circumstances is important, particularly for older patients.

Recommendation 7

We recommend that the hospital reviews the provision of non-emergency patient transport and provides us with assurance that transport is being delivered appropriately.

Kingston Hospital told us that *"The Trust has recently undertaken an extensive review and retendering of non-emergency transport provision. A new supplier of non-emergency patient transport commences on 29th February 2016. We will continue to monitor the performance of this provision going forward."*

West Middlesex Hospital told us that *"with improved discharge planning a more co-ordinated approach should be possible with transport. This would also enable, where possible, relatives and carers to be involved in supporting transport home. This may include patients being taken home by relatives where possible."*

Outpatients

A few patients provided us with comments and concerns about outpatient appointments. Whilst this falls outside the scope of this project, when looked at alongside other comments collected it is clear that there are some significant concerns around outpatient appointments. This may be an area of future work for Healthwatch Richmond to explore.

Further information

Further information on the findings from this project can be accessed in the full report, available on our website. If you would like any further information about this project and to get involved with future Healthwatch Richmond projects, please contact info@healthwatchrichmond.co.uk or call 020 8099 5335.