healthwatch Leicester

healthwatch Leicestershire

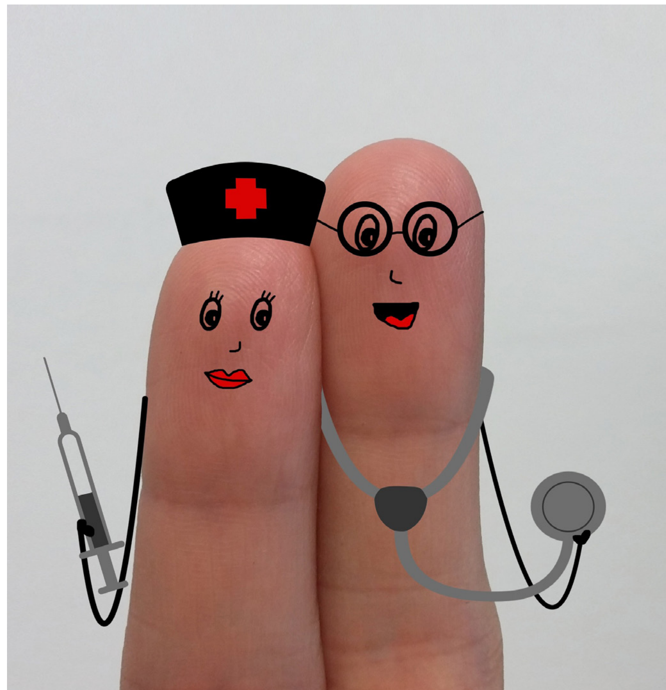
Hospital Discharge Report

July 2019

Introduction

Healthwatch Leicester and Healthwatch Leicestershire are the public champions for health and social care. We collect feedback from the residents of Leicester and Leicestershire who have used health and social care services about their experiences. The feedback is used to influence health and social care commissioners and providers to share good practice and develop service improvements.

On this occasion Healthwatch Leicester and Healthwatch Leicestershire decided to undertake a project to understand the experiences of patients being discharged from hospital. The project wanted to understand how involved patients were in planning their discharge, if they were happy with the process of being discharge, and how comfortable they were with what was decided for their discharge in terms of where they were discharged to. The project also sought to understand what staff were involved in discharge planning and how they communicated with the patients about what was going to happen at their discharge.



Methodology

This project used semi-structured interviews to collect feedback from people who were being discharged from hospital to understand their experience of the discharge process.

Interviews took place in the discharge lounge at The Royal Infirmary and Glenfield Hospital and all participants gave their signed consent to take part in the project.

The feedback has been analysed and organised into themes and these are presented in the findings below. There were a limited number of participants and the nature of data collection means that the findings are a snapshot of the experiences of those individuals that were willing to take part and are therefore, not necessarily representative of all people who are discharged from hospital in Leicester and Leicestershire.

There is no breakdown in the feedback between people who are normally resident in the City or the County. Although respondents were to be asked for the first part of their postcode in order to differentiate between localities, many failed to provide it and so no meaningful distinctions can be made.

Findings

There were ***18 interviews*** undertaken with patients who were waiting in the discharge lounge. In addition to this we received comments from one family member of a patient and comments from three members of staff.

The feedback from the participants has been collated and organised into themes in order to understand where there have been common experiences.

Themes

Urgent admissions

The way that the participant came to be admitted to hospital was discussed with them and how many times in the last twelve months they had been admitted.

From the feedback that was received it was apparent that most admissions were unplanned or emergency admissions. This would mean that their discharge planning would take place whilst they were in hospital and that no planning could take place prior to their admission as could happen with a planned admission.

Patient involvement

A recurring theme was that patients often did not feel that they had been involved in their discharge planning. This included simple receiving of information about what was happening with their discharge.

For others, they felt that the planning had been done without them and that they would have liked ***'to be more involved'*** in the plans for their discharge. One participant commented that their discharge plan had been ***'done without my involvement'*** whilst another said that they had 'talked over my head.' Another said that they had '***not spoken to anyone'*** about their discharge. The lack of involvement in their discharge planning meant that some of the participants had concerns about their return home with one saying that they had ***'no forward plan'*** and another saying that they ***didn't 'know what would happen'*** when they '***got home'.***

However, others felt that they had been involved with one commenting that they had been ***'totally involved'*** and another saying that they had been 'listened to' and the discharge had been done '***more his way'.***

On the day delays

A key theme was that patient were experiencing delays on the day of discharge. This made patients feel ***'annoyed'*** and ***'frustrated'*** with one participant telling us that they had been ***'waiting all bloody day'*** in the discharge lounge. Another said that ***'up until the discharge lounge'*** their discharge had ***'gone really well'*** whilst another participant described themselves as ***'absolutely livid'*** because they had been waiting for four hours to leave.

Communication about the causes of delays on the day were seen as an issue for some of the respondents. This was particularly the case in respect of having indicative timescales on when they might be able to leave the hospital.

Although it was observed by one of the Healthwatch Staff carrying out the interviews that one participant was given information about the reason for the delay in their discharge this was not the case for many. One patient said that they had been in the discharge lounge for ***'eight hours'*** and ***'no-one had come and said when' they 'were going home.'*** By this point the patient said they were ***'tired and fed up.***' Another commented that they did not ***'know what the hold up was.'*** Being kept informed of the reasons for delays and when they might expect to go home was suggested as an improvement with one participant saying ***'it's a plus to know what's happening.'***

Waiting for medication was a major cause of delays on the day and left participants in the discharge lounge for long periods of time. One respondent said that ***'waiting for medication was the cause of today's delay'*** whilst another said that they had been ***'waiting for medication 9am until 9pm. 12 hours'.***

A member of staff commented that *'if the only thing that is needed is a signature by the doctor, and then he has to deal with an emergency, there can be a long wait for the signature needed for medication. '*

Improving the process for obtaining medication for discharge was a key point made by participants when they were suggesting how the discharge process could be improved. Comments included general suggestions that they should *'speed up medication'* to more specific suggestions of having *'more pharmacists.'*

Waiting for hospital transport was also a cause of delay in the discharge lounge. One participant commented that they were *'waiting for an ambulance'* before going on to say '*I could get a taxi but why should I pay?'* Another said that they were *'going home in an ambulance'* but had been *'waiting for four hours.'*

One staff member commented on how medication delays and transport delays could be interconnected saying that '*sometimes medication has a hold up and the ambulance allocated to the patient is re-allocated to someone whose medication has been arranged.'*

Waiting for discharge paperwork could also be a cause of delays once discharge had been confirmed for that day. Some of the participants said that they were delayed because they were *'waiting for a discharge letter.'* Another said that they were 'waiting for a letter about my care.'

The long wait in the discharge lounge and lack of entertainment there was mentioned by two of the participants who both commented that there was no television available and having one could improve the discharge experience where there are delays.

Late notification of discharge

For some participants there was little awareness of when they were going to be discharged prior to being told it was that day. One participant was informed *'40 minutes prior'* to the interview taking place for this project. Another said that they were *'not told'* when they were going to be discharged and they were *'told on the morning'*. The last notification suggests that there was little patient involvement in the planning for their discharge.

For one of the participants their discharge had needed to be delayed by a day because they had had no prior notification that they may be discharged at that point and they had not got any clothes to leave hospital in.

Family support

Most participants were leaving hospital to return to their own homes. It was notable that many of those spoke about their family members supporting or caring for them. There were a range of different arrangements spoken about including family members '*caring'* for them, or family members *'popping in'* to check on them, as well as families where there are formal carers and families were also checking in. For some of the participants there was a reliance on spouses to care for them on their discharge from hospital.

It was also commented on that for one family, they were not involved or kept informed of discharge plans that were made for their relative. They commented that when they had arrived to visit their relative they were not on the ward but had been moved to the discharge lounge. The decision to discharge had not been discussed with any family members.

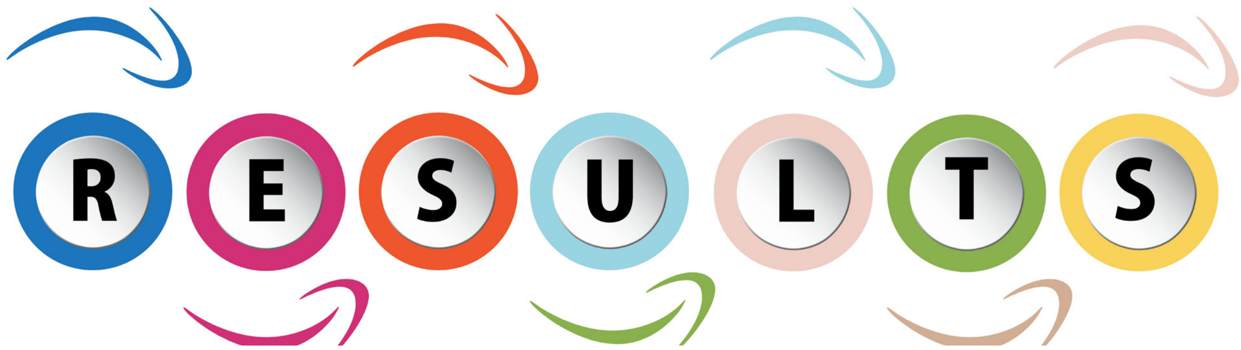
Staff involved in discharge planning

Nobody mentioned having had any discussions or involvement with social workers about their discharge or care following discharge.

Only one participant mentioned that they were going to go into residential care for a short while after they were discharged and they said that they had arranged this themselves. It was planned in advance and *'had always been the case.'*

Others said that they had spoken to the '*doctor on the ward'* and had had *'no discussions with nurses' or had discussed it with a 'surgeon'* but there were *'no nurses'* involved *'in discharge'*.

Others said that they had spoken to a range of medical professionals including *'physios'* and *'nurses'*. For one participant though, they had only spoken to *'the nurses on the discharge lounge. No others.'*



Conclusions

The number of participants in this project were small and the feedback they have given is a snapshot of their experience in a short time period. However, there were some common themes found within the feedback.

There was little patient involvement in planning for discharge. Most of the participants had not been consulted on their discharge and some would have welcomed more say in what happened around their discharge.

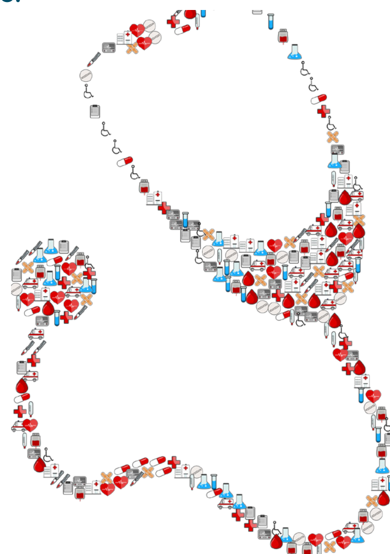
On the day delays were a key theme for the participants in the project. For some there were issues in relation to a lack of communication about the reasons for the delays. For others, the issues were in relation to the process of being discharged, including delays with paperwork and particularly waiting for medication. Waiting for transport home was also seen as a reason for delays and there was potentially a link between delays in medication and long waits for transport home.

As there were long reported delays waiting in the discharge lounge the lack of any entertainment, such as a television was an issue for some participants.

Last minute or on the day notification of discharge was common. This meant that participants had not necessarily been able to make arrangements for their return home and also points towards a lack of planning for the discharge of patients and their ongoing recovery at home.

All but one of the participants was being discharged back to their own homes. Most had commented that they were going to be receiving care or support from their family members. It became clear that the support of families was key to the ongoing care of participants. However, it was not clear how much involvement families had in the discharge process and making decisions on longer term care.

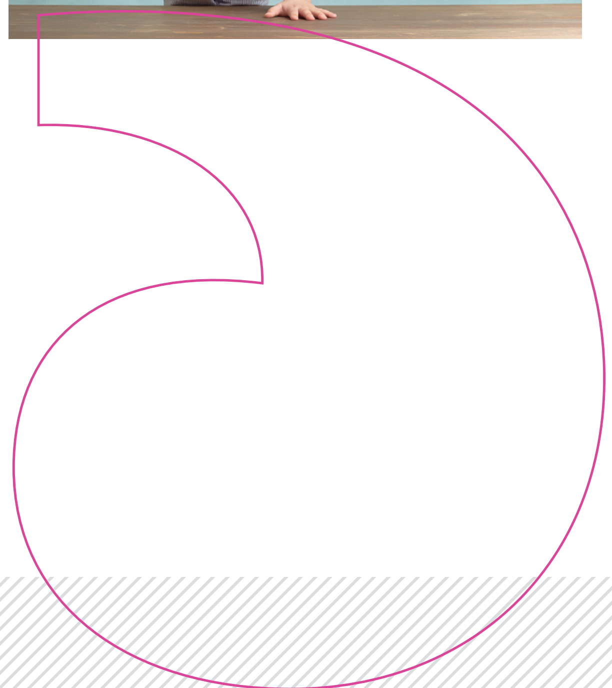
None of the participants indicated that they had spoken to anyone from social care in relation to their discharge. Those that had spoken to anybody about their discharge said that they had spoken to medical staff. For some of those the only staff they had spoken to were doctors or surgeons with no nursing involvement. Again this, suggests that there is a lack of planning and understanding of the circumstances that the patients are returning home to.



Recommendations

The following recommendations are made based on the report findings.

- In view of the key themes being concerned with on the day delays it is recommended that consideration is given to how to reduce the time spent in the discharge lounge, including a reduction in waits for medication.
- Participants felt that they would benefit from more information on the day timescales for leaving hospital. It is recommended that consideration should be given to providing information on timescales for leaving the hospital on the day of discharge.
- On the day notification was a common occurrence. Therefore, it is recommended that it is ensured that patients are kept involved and informed on plans for their discharge and likely dates for discharge in advance. This would reduce the instances of patient's being given little notice of their discharge and ensure that they can make suitable arrangements for returning home.
- Family support when returning home was a key theme for our participants. However, it was not always the case that families had been involved in plans for discharge. Therefore, it is recommended that when planning for discharge health and social care providers ensure that families are involved and consulted with.



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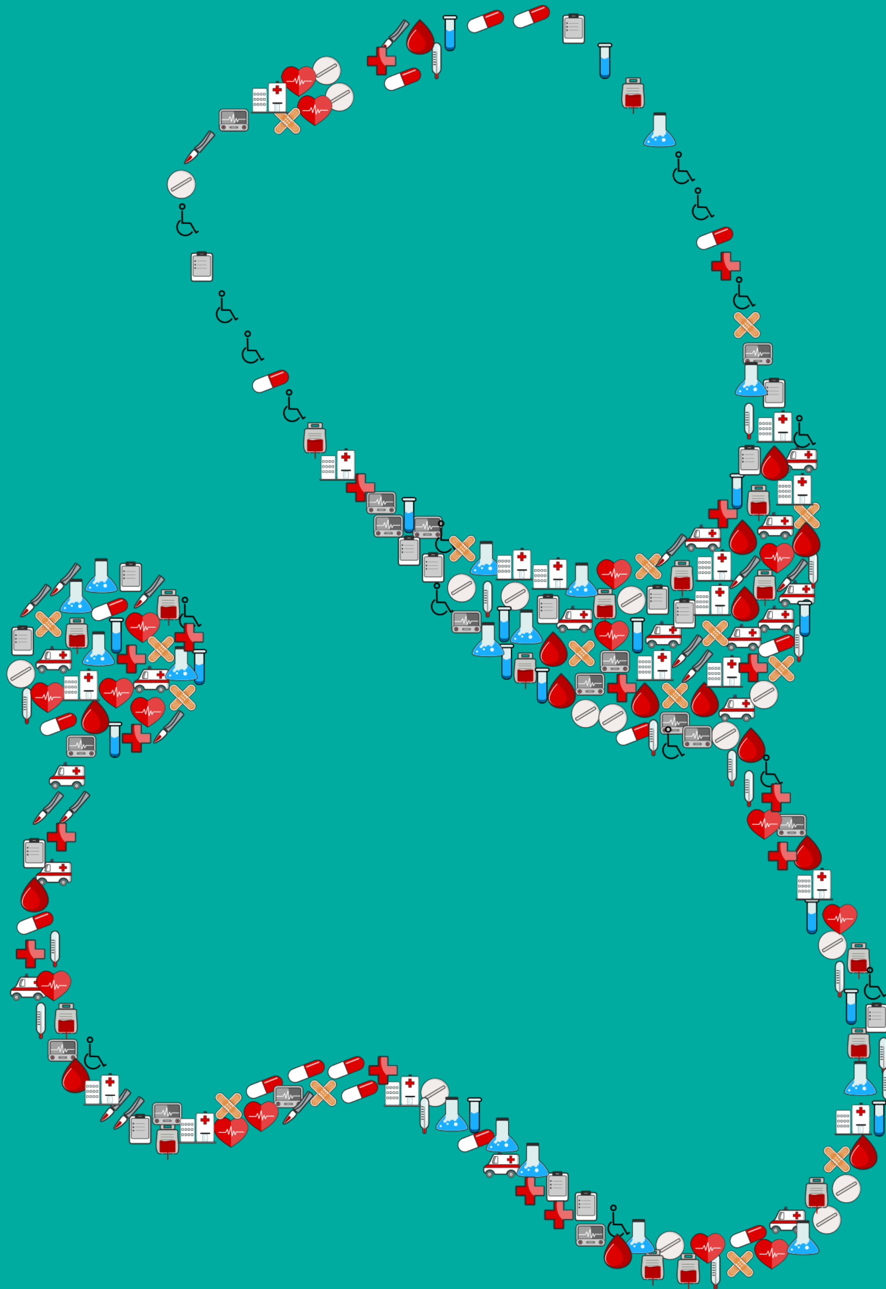

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