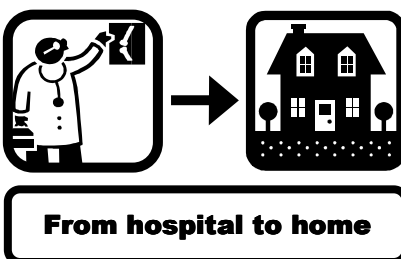


Gloucestershire Local Involvement Network (LINK)

Hospital Discharge Pathway Task Group Report

December 2009 – July 2010



*“Gloucestershire LINK will help influence,
Improve or change the way local health and
Social Care services are planned and delivered”*

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1. INTRODUCTION

Local Involvement Networks (LiNK) were set up in April 2008 as part of the legislation in the Local Government and Public Involvement in Health Act 2007. One of the main functions of LiNKs is to collect views from patients, carers and the public about health and social care services in their local authority area. These views are given to the Commissioners, Providers and Regulators of the services, to help improve these services.

The Discharge Pathway Task Group was set up by the Gloucestershire LiNK Stewardship Board following a prioritisation of the issues raised at public events. A discussion group at a subsequent LiNK members' event in September 2009 confirmed the multiplicity of problems relating to discharge. The Terms of Reference were agreed by the Gloucestershire LiNK Stewardship Board. See Appendix 1.

(N.B. As issues had only been identified from within the acute and community hospitals, the Discharge Pathway from the 2gether Trust was not included in the scope of the task group.)

2. BACKGROUND

An analysis of all the comments received at public events together with the experiences of members of the task group suggested that the main problems relating to hospital discharge were:

- Lack of information for patients and carers
- Poor communication between staff and patients with no identified person accountable for what is happening
- Lack of support available/arranged at home
- Long wait for occupational therapist assessment at home
- Information not being sent to GP who often does not know the patient has left hospital
- More difficulties with discharge following emergency admissions than planned ones
- Discharge at or shortly before the weekend cause difficulties as no services until Monday
- Poor communication and information about services available on discharge from hospital (this includes voluntary agencies and private care)
- Carers often not listened to or consulted
- Patients discharged to community hospitals and back to care homes without their relatives being informed
- Patients not always given instructions about treatment at home e.g. self administered injections

- It is often not clear who the patient should contact after discharge if problems arise and what symptoms they should look out for
- Home conditions are not always considered and elderly partners are expected to support rehabilitation even though they may not be fit to do so

A number of case studies illustrating these concerns can be found in Appendix 2.

For patients with extremely complex needs involving a multiplicity of professional staff from health and social care, there was evidence of a system that worked quite well with a lot of co-operation between the Acute Trust, Primary Care and Social Care.

3. PROCESS

3.1. MEMBERSHIP

The membership of the task group can be found in Appendix 3.

Members came from a wide range of locations across Gloucestershire and represented a variety of backgrounds and organisations. The original lead member of the group was Maureen Dore, Vice Chair of Gloucestershire LINK. Maureen left the area in April 2010 and was replaced by the LINK Chair, Barbara Marshall.

The group held a total of six meetings between December 2009 and July 2010. Discussions concentrated on the initial part of the discharge pathway with particular reference to “simple” discharge, which applies to approximately 70% of patients. THE remaining 30% are “complex” discharges and this was not an area of particular concern raised at our public events.

3.2. INFORMATION REQUESTED

A request was made for the most up-to-date policies in relation to discharge from Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire NHS Care Services Board and Community and Adult Care Directorate (CACD).

A formal request was also made for the number of concerns and complaints raised about discharge in GHNHSFT, NHS Gloucestershire and CACD for the period 1st April 2009 and 30th November 2009.

3.3. POLICIES

The task group looked at all the relevant local policies (see 3.2) as well as looking at national policy documents available on the Department of Health website. See Appendix 4.

Comments raised by members of the group regarding some of the policy documents are summarised below.

The Gloucestershire Hospitals NHS Foundation Trust Clinical Policy “Patient Discharge – Adult, August 2009”

- The document is not user friendly
- There should be a checklist that nurses can follow easily
- Inadequate information on discharge medication procedures
- No mention of signposting for rehabilitation/social care packages
- Little reference to carers’ involvement
- No clear process for providing instructions to patients about future treatment at home e.g. self administration of injections

The Community Hospital Discharge policy

This document was thought to be excellent with a clear flowchart that was easily understood. (This policy was developed in consultation with members of the Carers Forum which is reflected in the content.)

The Gloucestershire County Council Policy “Protocol for Hospital to Area Transfer of Cases, Planning and Policy, Social Services Directorate, Gloucestershire County Council December 2004”

In the group’s opinion this document needs to be updated. In practice, there was clear evidence of a much closer working relationship between health and social care professionals than is indicated in this policy.

The Domiciliary Care Policy and Procedures, Gloucestershire Community Steps Service, Gloucestershire County Council Revised June 2009 and the Intimate Personal Care and Clinical Tasks, Planning and Policy, Social Services Directorate, Gloucestershire County Council December 2009

These documents show that once the patient is discharged there are clear procedures in place for patient care.

3.4. EVIDENCE FROM ORGANISATIONS

The task group invited representatives of three local organisations to a meeting in order to hear evidence relating to hospital discharge from the perspective of each organisation. The information provided at this meeting is summarised below.

a) **Age UK (formerly known as Age Concern) Gloucestershire** (represented by Annie Somervell)

- Age UK Gloucestershire has a Hospital 'After Care Scheme' provided under contract with Gloucestershire County Council.
- This is a free scheme and can follow on from intermediate care. The scheme is only available to people who do not have a care package.
- Referrals are received from hospitals, GPs, social workers, relatives and patients themselves. A high percentage of referrals come from the Gloucester, Cheltenham and Stroud areas.
- Following an assessment, the patients have a visit lasting one to two hours a week for approximately six weeks.
- The scheme has three co-ordinators covering the county with over 200 volunteers. (Volunteers do not undertake personal care or heavy domestic work.)
- The scheme is welcomed by the Acute Trust although some of the Community Hospitals rarely make referrals.

Three case studies from Age UK Gloucestershire can be found in Appendix 2

b) **Carers Gloucestershire** (represented by Tim Poole, Chief Executive)

- Needs are different between rural and urban areas.
- Discharge from the Acute Trust is one of the top issues for carers.
- The lack of recognition and respect for carers needs addressing.
- Carers are often frustrated about the situation they are in. Better communication would relieve that frustration.
- Carers' views and opinions are not sought until shortly before patients are due to be discharged.
- There is an ethos of "this is how it is done round here".
- The treatment the patient is having and the potential side effects are not communicated to the carers.
- Carers have to pick up the pieces when the patient gets home.
- Carers need training to be able to give medicines effectively.
- Carers need to be seen as partners in the provision of care for patients. This will benefit medical and nursing staff.

- There is a case for carers to provide training to nurses to assist them in understanding the carers' needs as well as the needs of the patient.
- Carers may need an assessment to see if their own needs are being met and their capability to care for the patient if they are discharged e.g. can they lift or turn the patient, can they cope with providing some nursing care?
- All the services that can support the patient and the carer should be arranged prior to the patient's discharge, so that they are activated as soon as the patient gets home.
- Patients will get better much more quickly if the carers are supported adequately.
- People do not know what services are available to them.
- There is a good relationship with Community Hospitals resulting in a good practice agreement. Community Hospitals already talk to carers early on so that they are involved in the discharge process/care package.

c) Gloucestershire Care Providers Association (represented by Susie Oakley)

Susie Oakley arranged for a short questionnaire to be sent to a number of care homes in Gloucestershire prior to the meeting. She then provided feedback from these questionnaires to the task group.

- Where the patient is already known to the care home and is discharged back to that home, there are very few problems apart from medication. This appears to be due to the care home staff taking a proactive role to get information from the hospital staff.
- Where the patient is discharged from the hospital straight to a care home, problems have arisen with communication and information. Discharge from a community hospital to a care home is a much better process.
- Information given on discharge is patchy, some homes receiving no information and others just minimal information.
- Time of arrival of the patient to the home is variable. For example the patient may not arrive until late in the afternoon even though originally scheduled for midday.
- GP is not aware the patient has been returned to the home until around a week after discharge.
- Medications sent into hospital with the patient are returned unopened.
- One care home reported that in addition to a patient's original drugs being returned unopened, he was sent home with all his drugs in a "nomad" tray, with seven different tablets in one pot. As the care home staff could not identify which tablet was which, they could not use them.

3.5. PATIENTS WITH ADDITIONAL PROBLEMS

Discussion in the task group identified other concerns regarding patients who are discharged from the acute hospital but have the additional problem of dementia or a learning disability.

The Community Hospitals have set up a group discussing the Dementia Pathway for Discharge but there does not seem to be a similar process in the acute trust.

Liaison between the Gloucestershire Hospitals NHS Foundation Trust and 2gether Foundation Trust could be improved. This has been raised by the Carers Forum, as carers are not often consulted in these discussions. One carer reported that her husband had regular admissions to the Acute Trust. His mental capacity particularly his memory had diminished. His medical history including a suicide attempt had to be repeated each time, to the distress of the carer and the patient. The carer suggested that a brief history be included on the front of the notes to prevent this repetition.

3.6. MEETING WITH HEALTH AND SOCIAL CARE PROVIDERS

The task group arranged a “question and answer” session in April 2010 which was attended by representatives of the following providers:

- **Gloucestershire Hospitals NHS Foundation Trust** (Gill Brook, Head of Patient Experience)
- **NHS Gloucestershire** (Becky Parish, Assistant Director Patient and Community Involvement)
- **Gloucestershire Care Services** (Rosi Shepherd, General Manager Cheltenham Locality)
- **Community and Adult Care Directorate**

The main points discussed were:

- Appointment of key workers by multi-disciplinary team
- Use of discharge lounge
- Information sent to GPs and given to patients
- Liaison between health and social care professionals to look at care needs before discharge
- Use of community hospitals to assess patients' needs
- Delayed discharges (bed blocking)
- Communication with relatives/carers when patients are moved to community hospitals
- Delay in Occupational Therapy assessments in the community and equipment e.g. hoists
- Use of Hospital After Care Service provided by Age UK Gloucestershire

4. PRINCIPLES FOR DISCHARGE PATHWAY

Having taken into account the views of the public and the task group members, as well as the case studies, and having also examined the national and local working policies, the group sought to answer the following questions that should be asked whenever a patient is to be discharged:

WHEN will the patient be discharged?

WHICH type of discharge - simple or complex?

WHO should be involved in the decision to discharge?

WHAT needs to be done before patient is discharged and afterwards?

WHERE is the patient to be discharged to?

HOW will discharge policy be carried out, reviewed and audited?

WHY isn't discharge working?

4.1. WHEN will the patient be discharged?

A patient is considered fit for discharge when he/she no longer requires the services of acute or specialist health care staff within a secondary care setting. This will usually occur when:

1. The patient is medically/clinically stable and/or safe to transfer as assessed by the medical/surgical team.
2. Ongoing general nursing and rehabilitation needs can be met in a more suitable setting either at home or in a community/rehabilitation unit, a nursing/residential home or hospice.
3. Review and ongoing care of the patient's condition can be shared with his/her GP including adjustment to medication.
4. Additional tests and interventions can be carried out as an outpatient or in a home care setting.

The decision as to when to discharge the patient should:

1. Be identified early as part of the patient's initial assessment and certainly within 24 hours of admission (or pre-assessment) for elective patients
2. Be based on the anticipated time for tests and treatment to be carried out and for the patient to become clinically stable and fit for discharge

3. Ensure that both patient and carer are fully involved and informed about the clinical management plan and the expected date of discharge
4. Include a daily review of the patient's condition by doctors/nurses/ward staff and response to treatment to determine if the expected date of discharge needs to be revised
5. Ensure all the necessary arrangements are in place to optimise (simple) discharge including GP letter (or copy e-mail/fax), outpatient appointment, any medicines to take out and patient transport arrangement confirmed
6. Ensure the Multi-Disciplinary Team consisting of medical, nursing, occupation/physiotherapy/speech therapist and hospital Social Workers are involved within 48 hours of admission if an initial assessment using the "Blaylock" or other suitable assessment tool (see Appendix 5) suggests a more complex discharge plan is required

4.2. WHICH type of discharge - simple or complex?

Discharges can be either simple or complex.

Simple Discharge is where the individual

1. Is likely to be discharged to their own home or place of residence
2. Has ongoing care needs that are straightforward and do not require complex planning and delivery

These patients tend to have an easily predicted length of stay and their continuing care can be managed by their GP/primary care team, and they have no requirement for ongoing secondary care.

Complex Discharge is where the individual

1. Is likely to be discharged to their own home with support, or to a care home, to intermediate care or to residential / nursing home care
2. Has complex ongoing health and/or social care needs which require detailed assessment, planning and delivery by the Multi-Disciplinary Team (MDT)

Length of stay for these patients is often more difficult to predict and will require regular review by the medical/clinical team and the members of the MDT.

4.3. WHO should be involved in the decision to discharge?

The **Patient** should understand:

1. What their treatment involves
2. How long they will be in hospital
3. Where they will be going after discharge
4. Whether there will be further outpatient appointments/attendances for further treatment /therapy
5. What medications have been prescribed, when they should be taken and what the possible side effects are
6. When they should go to see their GP
7. If they have multiple health/social needs, who the Liaison/Key Care Worker is and how they can be contacted

The **Carer** needs all the above information as well as the following:

1. What they need to do, a) while the patient is in hospital, b) when the patient is close to the discharge date, and c) on discharge e.g. arrange for stair rails, grab rails, ramps etc.
2. How and when to contact the patient's GP/Social Worker/Key Liaison Care Worker
3. To ensure that hospital staff/ multi-disciplinary team members have all the information they need from the carer to facilitate clear decision making
4. To inform the Multi-Disciplinary Team of any change in domestic/social circumstances that might affect the discharge process

The **Multi-Disciplinary Team (MDT)** needs to:

1. Be convened within 48 hours of the patient's admission in line with national guidelines, especially if the initial assessment (using Blaycock or other tool, Appendix 5) suggests that complex discharge planning is required
2. Regularly re-assess the patient's progress
3. Decide who is to act as the Key Liaison Care Worker linking the hospital, community, primary care and Social Services, acting as first point of contact for the patient and the patient's carer for advice or if problems arise
4. Ensure that all agencies who are to be involved in the patient's continuing care are aware of their role, when and where they will see the patient, and how they will keep both patient and carer informed
5. Ensure all decisions taken and actions carried out are properly recorded and communicated to the patient/carers/primary care team
6. Review its own effectiveness quarterly

4.4. WHAT needs to be done before patient is discharged and afterwards?

Before discharge:

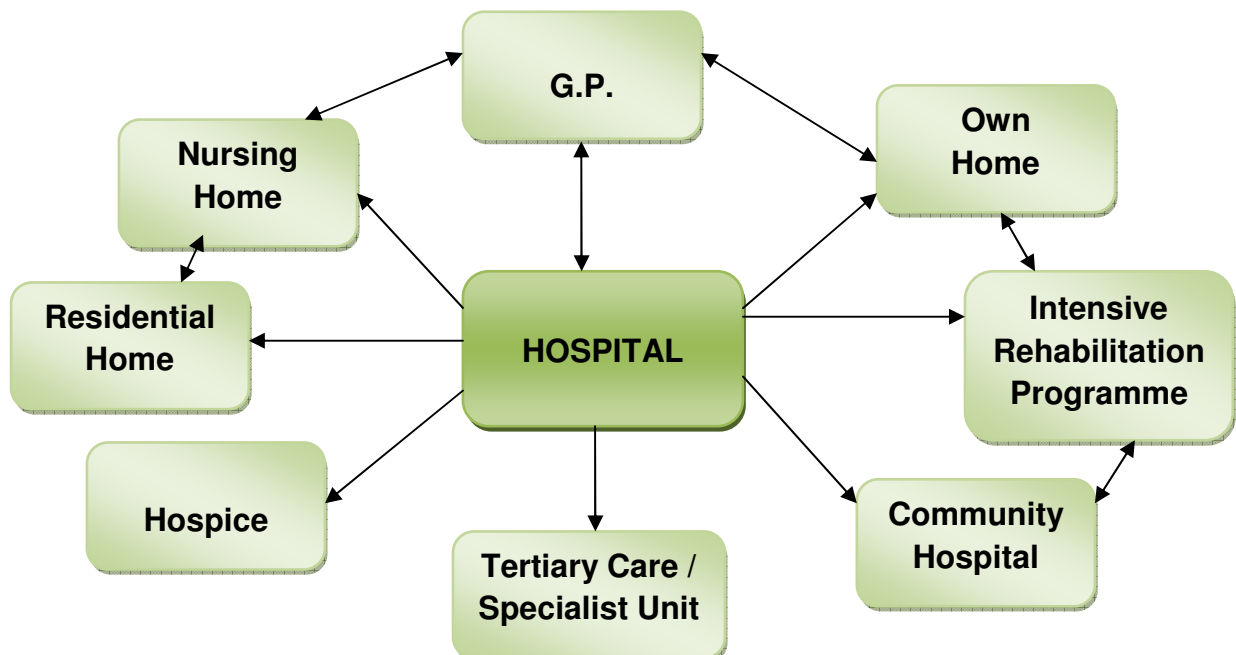
1. Once the decision as to the expected date of discharge (EDD) has been made, this should be recorded in the patient's notes/nursing record.
2. The board above each patient's bed should show the EDD, discharge checklist, the name of the consultant/senior doctor involved together with the ward and liaison care nurse.
3. A decision needs to be made as to whether the discharge requires medical clearance or can be facilitated by a trained nurse discharge co-ordinator.
4. 24 hours before their planned discharge, patients should be reviewed by the medical team/ward staff/Liaison Nurse or other member of MDT if involved.
5. Drugs to take out (TTO) should be prescribed by the Senior House Officer on Ward Round the day before discharge.
6. A checklist of questions/actions should be completed (Appendix 6).
7. The patient and their carer should be fully informed of the discharge plan.

After discharge:

Approximately 4 weeks after discharge, the hospital should check with patient/carer via the GP or key worker that discharge worked satisfactorily.

4.5. WHERE is the patient to be discharged to?

Early on in the patient's admission, an assessment should be made as to the most suitable place the patient can be discharged. This can be summarised as shown in the diagram below (The arrows indicate the links between the hospital and the ultimate place to which the patient will be discharged.)



The key individuals who MUST always be involved in the final decision as to where the patient will ultimately go are:

1. The patient
2. Relatives/Carers/staff in care homes
3. The Medical Team in charge
4. Liaison Nurse (working with the MDT)
5. Social Care (if involved)

The GP and primary team members are the essential link between all the agencies involved. They have a continuing care responsibility for the patient and MUST be kept fully informed of the decision on discharge and follow-up

4.6. HOW will discharge policy be carried out, reviewed and audited?

A hospital discharge policy will only work if:

1. There is a clear commitment by all involved from management through medical, nursing, paramedical and community health staff plus social services to make it work
2. An Officer (Modern Matron) takes the lead and ensures on a regular basis that:
 - The policy is being implemented properly
 - They are available to 'trouble shoot'
 - The policy is reviewed with users on a regular basis and revised in light of experience

To ensure that the hospital discharge policy is working, regular reviews by the Modern Matrons should include:

1. Quarterly meetings of Multi-Disciplinary Team key workers
2. Feedback from patients/carers as to how the system worked for them

4.7. WHY isn't discharge working?

Sometimes hospital discharges do not work as they should. Nationally, 5% of patients are re-admitted to hospital within a few weeks of discharge. In Gloucestershire, the equivalent figure is 6.4% (2008/09) and the 2009/10 figures show this has risen to 7%. This is usually because:

1. Patients and Carers are not fully involved in the decision making process
2. The GP/Primary Care/Community Team are not informed or are informed too late of what is happening on discharge
3. There has been a change in the patient's domestic/social circumstances
4. Medical complications arose in hospital necessitating a change of treatment, date of discharge and place of discharge

5. Too premature a discharge arising from pressure on acute hospital beds or because of the need to meet government waiting list targets, resulting in emergency re-admission with 28 days
6. There is poor communication or a breakdown in communication between the various agencies involved
7. Social Care may experience difficulties in finding appropriate accommodation for a patient with complex social/medical problems resulting in 'bed blocking'
8. Patients are transferred to Community Hospitals a distance from the patients'/relatives' home
9. Poor training/awareness of staff regarding discharge policy. These problems may be obviated by a review meeting of the key staff involved. The responsible officer (modern matron) should ensure that any changes to the policy arising as a result of these meetings are implemented as soon as possible.

5. CONCLUSIONS

- 5.1. It is clear from the reports of group members and detailed case studies that the discharge of patients from GHNHSFT has not been working satisfactorily, as at least 7% of patients are re-admitted to hospital within 14 days. In the period between 1st April 2009 and 30th November 2009, there were a total of 68 concerns/complaints received by the Trust about discharge (see Appendix 7). But in the same period, NHS Gloucestershire received only 3 complaints about discharge from the community hospitals. While these figures may not seem very great compared with national rates of 5.5% re-admissions within 28 days, the situation in Gloucestershire requires action if re-admission rates are to be reduced
- 5.2. On most of the wards in the GHNHSFT there is no identified person to whom the patients or their carers can take their concerns about discharge and how it will work
- 5.3. On discharge from GHNHSFT there is inadequate or delayed information regarding discharge given to the GP and members of the primary care team
- 5.4. Prior to discharge from GHNHSFT except in the more complex cases, there is often very little communication between the patients, their relatives/carers and the ward staff about their home conditions and ability to care for themselves
- 5.5. There is often a delay in the provision of minor home adaptations and long delays in assessments at home by the occupational therapist
- 5.6. Prior to and after discharge from GHNHSFT, there is poor communication between health care staff, social care staff and the voluntary and community sector. This leads to a lack of support arranged/available at home
- 5.7. Information about the range of services available in the local community is not easily available, particularly for elderly patients who do not use a computer
- 5.8. The discharge policy in the Community Hospitals appears to be working well. There is a much closer working relationship between health and social care staff
- 5.9. The actual transfer of patients from the acute hospitals to the community hospitals or to care homes could be improved. Adequate medication particularly for pain relief does not always accompany the patient. Relatives/carers are not informed in adequate time prior to the transfer
- 5.10. The task group is aware that GHNHSFT held a Rapid Improvement Event in August 2009 on discharge and that they have been working on a revision of the policy with a series of action cards. Unfortunately these documents have not been made available to the group.

6. RECOMMENDATIONS

Taking into account all the comments and concerns expressed to the LINK together with their discussions, the task group have agreed to make the following recommendations to the commissioners and providers below.

NHS Gloucestershire and Gloucestershire County Council (Commissioners)

- 6.1. Implementation of the national policies for discharge should be included in all contracts
- 6.2. Working in partnership with the patient, their relatives and carers should be included in all contracts
- 6.3. Every effort should be made to encourage joint working between health and social care professionals prior to discharge as happens in the arrangements for the more complex cases
- 6.4. The monitoring process should be made more transparent for the public to understand

Gloucestershire Hospitals NHS Foundation Trust (Provider)

- 6.5. The revised discharge policy should ensure that there is good communication in all stages with the patients, their relatives and carers
- 6.6. There should be closer working between health and social care staff as there is in the discharge of complex cases
- 6.7. Patients should receive information about their treatment and any possible complications prior to discharge. This should include an identified point of contact within the hospital
- 6.8. Improvements should continue to be made in the communications between the primary care team and the hospital prior to and on the day of discharge
- 6.9. When a transfer is made to a Community Hospital there should be a clear process for the transfer of medication with the patient, particularly for pain relief

Care Services Board (Provider)

- 6.10. All the community hospitals should make referrals, where appropriate, to the Hospital After Care Service (Age UK Gloucestershire)

Community and Adult Care Directorate (Provider)

- 6.11. An up-to-date policy should be produced to replace the Protocol for Hospital to Area Transfer of Cases (December 2004)
- 6.12. There is close working between health and social care staff in the discharge of complex cases. This should be replicated for all hospital discharges.

ACKNOWLEDGEMENTS

Gloucestershire LINK wishes to thank all members of the task group, including all those who contributed to this piece of work of the task group:

- Age UK (previously Age Concern) Gloucestershire
- Carers Gloucestershire
- NHS Gloucestershire
- Gloucestershire Hospitals NHS Foundation Trust
- Community and Adult Care Directorate, Gloucestershire County Council

APPENDICES

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Hospital Discharge Pathway Task Group Terms of Reference Gloucestershire LINK

Aim

- To review the patient experiences of the discharge pathway out of the acute and community hospitals in Gloucestershire
- To make recommendations to improve the patient experience to the providers and commissioners of health and social care services

Objectives

- To review the relevant policies and procedures of all the providers of the discharge pathway in Gloucestershire
- To review the literature for national policies on discharge
- To identify where problems have been encountered
- To obtain details of the number of concerns/complaints that have been received by the providers in the preceding twelve months
- To identify areas for change and improvement
- To submit a report to the LINK Stewardship Board for onward transmission to the commissioners, providers and regulators

Membership

- Any LINK member who has expressed an interest in the discharge pathway

Frequency of meetings

- This is a short term group and forms part of the LINK workplan for 2009/10
- Meetings will be arranged through the Host (GRCC); there should be no more than six weeks between each meeting

Case studies

The following are selected examples of typical cases referred to the Hospital After Care Service, Age UK Gloucestershire

Case studies 1-2

- Two cases of elderly people being discharged from Gloucestershire Royal Hospital with no follow up or anyone checking if they had food at home.

Case studies 3-5

- Two clients who felt they were discharged from Gloucestershire Royal Hospital on Christmas Eve with no support or any advice on where to get help if needed, one who should have been offered a care package, and one who could manage but went home to a cold house and no provisions

Case study 6

- Letter to Gloucestershire Royal Hospital, Ward Manager of Ward 4A:

Case study 1

“I am writing to express our concern regarding the discharge arrangements for Mrs X.

We received a referral for our Hospital Aftercare Service from Ward 4A, via the Ward clerk on the 23rd December 2009. We were informed that Mrs X would be discharged home later that day, to the care of her husband who was in receipt of a full care package. We understood that Mrs X had been admitted to hospital twice following falls and to stabilise her diabetes, she had also sustained injuries to her hands and face as a result of her fall.

Our Hospital Aftercare co-ordinator contacted Mrs X on the morning of 24th December to arrange an assessment visit. Mrs X informed her that she lived alone and that her husband had passed away two years previously. She had no relatives locally and no support available to her. Mrs X had no fresh food and she was not able to get out and do any shopping, her discharge medication had been sent home with her but she was unable to take it as she had very little feeling in her hands and was unable to remove it from the packets. She was also unable to manage her personal care needs. She confirmed that no care package had been put in place. Our co-ordinator contacted the Duty Social Worker to express concern that this lady was at risk during the forthcoming holiday period and they managed to arrange for the Village Agent to visit to do some emergency shopping and put her medication out for her so she was able to take it.

We have subsequently visited Mrs X and arranged for one of our volunteers to visit her twice per week for six weeks to help with practical tasks.

We feel that this lady was clearly vulnerable and did not receive a safe and effective discharge on this occasion and thought we should raise these issues with you. We also understand that Mrs X's daughter has visited from her home on the Isle of Wight; she has also expressed concern regarding her mother's discharge and is aware we will be raising this with you."

Response from Gloucestershire Royal Hospital:

"Thank you for your letter expressing your concerns. Mrs X was referred to Age UK by our ward clerk when Age UK came to the ward but your organisation was further contacted by the ward sister on the 23rd December to confirm discharge. Mrs X was very keen to go home and expressed no concerns about her discharge even though she lived alone and her family lived far away. She asked that the Village Agent and neighbour be contacted and was more than able to communicate any concerns she may have had, as she was fully involved in all the decisions with her discharge.

She was assessed as having no care needs on the ward, she was also assessed by the physiotherapist as being able to mobilise and be safe on the stairs and this is documented in her notes. The Village Agent was contacted and was aware of Mrs X's discharge and the contacts made on her behalf to yourselves and the district nurses who were to keep in contact with her. It was discussed with yourselves that Mrs X would probably benefit from an assessment for a life-link but that this could not take place until after the new year, when she would receive regular after hospital care.

Her medication was given and explained to her prior to discharge but she did not express any concerns over opening any medication. She had been on medication prior to her admission and had presumably managed with no problems.

Mrs X was asked whether she had enough food in the house and was insistent that there was plenty of food in the freezer and that she did not need anything. All this was discussed with the Village Agent and he was fully aware of arrangements made."

Case study 2

An elderly, very frail lady, with no telephone, no lifeline, lives alone, single, no next of kin, was in hospital for approximately three months. She had lived in her present council bungalow for three weeks prior to hospital admission. She was sent home with two slices of bread in clingfilm, and a few small cartons of milk.

Case study 3

Cheltenham General Hospital November 2009

“No approach was made to any member of my family, who visited my mother every afternoon and evening during the five weeks she was in Ryeworth Ward, to obtain information about her that she was unable to give.

We did not have a satisfactory answer to our enquiry about psychiatric input on Ryeworth Ward. We were told a psychiatric assessment could be done on my mother, but it wasn't.

We were told a bladder scan would be done but it wasn't.

It became apparent, while we were asking for information about contributory factors to my mother's confusional state, that no-one had sat down with her for even ten minutes to assess.

The only time nursing staff asked for information was related to discharge, and then it appeared other members of the team were not aware of this. I think we had five discharge dates altogether.

Discharge was planned while my mother still had a UTI, and despite our concerns about her ability to mobilise with the original home care package. It was the social worker who talked to us about these concerns and re-arranged the discharge dates, not medical or nursing staff.

Staff appeared to be very much under pressure, while caring for fragile older people. Information was often given to people too quickly who had sensory impairments; or from too far distant, or without facing the patient and making them aware they were about to be asked to make a choice, or be given information.

Ward cleanliness was an issue. Bed tables were wiped on the surface, but were sometimes sticky around the edge and underneath. Food leftovers were on the floor for five days in one instance. There were faeces on the floor of Ryeworth Ward for over an hour.

I am left wondering if as a family we were expecting too much to be considered to be involved in decisions about my mother's care. Considering her age and how vulnerable she was, I would have liked to know who her named nurse was, how her treatment was progressing, what investigations were planned, and what the desired outcomes were. Discharge and discussions about Residential Care seemed to be the main priority, while my mother had not recovered from her original illness.

We think that at 91 she has experienced age discrimination.

At all times, we have tried to keep an open mind about what we have observed, because there were many contributory factors. We are aware that a team has a lot to communicate while people are unwell. Staff appeared to miss many opportunities with my mother and us, to exchange information clearly.”

Case study 4

“The patient suffered a fall in Gloucester at the end of 2009. She was taken to GRH A&E Department where she was examined and x-rayed. The ambulance and A&E staff were very professional and considerate and efficient.

On admission, the patient was examined by a doctor who was informed by the patient that she had a blood disorder so he took a blood sample. When the Duty Sister came on in the afternoon, and did a ward round, she did not say a word to the patient. During the transfer to Ward B the two members of staff “escorting her” never said a word. This surely is not the way to treat an elderly person in severe pain.

The husband visited the patient. On returning later he found that that the patient had been transferred to Acute Ward B.

The husband approached the ward sister in Ward B that evening to get some idea of what was to happen only to be told that she was busy with her paperwork and to see the ward nurse. In the time it took to find the nurse, he could have been informed as to what would be happening, if of course the sister knew. Certainly the nurse did not seem to know much. The response was the same that next day with a different sister.

The next day, Monday, it was noticeable that the porter who took the patient to the next ward, Rehabilitation 1, was much more compassionate to the patient than the staff in Ward B. One of whom told the patient, who had great difficulty in standing, “Don’t rely on me”; another nurse said “Don’t lean on my back”. Staff clearly need reminding they have a duty of care.

The next day, the patient was told she would be going to a community hospital. This turned out to be “Rehabilitation Ward 1” in GRH which is in fact a Geriatric Ward, now called an over 70 Ward. This is probably illegal under the Age Discrimination Act where it refers to goods and services. Three wards in three days!

Since the patient was in full possession of all her mental faculties surely she should have been in an orthopaedic ward. It was not until she was in this ward that she had a proper wash.

It was one of the ward sisters who explained to the patient precisely what her injuries were. It has to be said that the standard of nursing was very variable, some excellent some not, the

biggest problem appearing to be a case of disorganised chaos. Whilst no one was unkind, kindness and compassion were also lacking.

Problems that arose were:

1. It was assumed for some reason that the patient was independent when she could barely stand. Supplying a walking frame would be been useful.
2. She was not seen by a Physiotherapist until day 4, whose diagnosis was that her lack of mobility was due to excessive pain, she was barely able to take a few steps at this stage. Consequently a booster pain relief was prescribed. One wonders if there was confusion as to why she was there.
3. One night the staff were excessively noisy. Subsequently the patient was moved away from opposite the nurses' station to a corner in Bay C.
4. On Sunday the lights were not extinguished until after midnight.
5. Drug round timings could be haphazard.
6. Sometimes the late drink was not served.
7. On some occasions requests for assistance were responded to with "in a minute" but not dealt with.
8. A major problem seems to be noise, often because of a time lag in responding to call signs. The level of sound appeared to be high and must cause stress for the calling patient and the staff. A system of flashing lights would be less intrusive for both patients and staff and reduce the general noise level.
9. The patient was told on Friday that she was medically fit and could be discharged on Monday or Tuesday. On Monday morning it was realised that she had not managed the stairs, this however was remedied, thus clearing the way for her discharge. This was agreed in the afternoon, but because she has to wait for a supply of medications it was agreed that her husband would collect her later if everything was clear. This was done but on arrival he had to hunt for a wheelchair. Fortunately a staff nurse was kind enough to assist. She was then taken home where she continues to make variable progress.

We know that our GP surgery was not informed of her admission to hospital, nor as far as we know her discharge.

No one ever asked the husband whether he would be able to care for the patient, fortunately he can.

No care plan was provided to give the patient any guidance as to what progress could be expected along the road to recovery. When for instance, would the booster pain relief no longer be needed? Was there a need for Physiotherapy follow up?

We know the hospital have said they want to see the patient in a month, but, what is the reference point for this month, the date of admission, discharge or some date in between."

Case study 5

1st April 2010

“My mother is 93. She was diagnosed with kidney cancer in 2004. No treatment or surgery was advised and she has, over the last six years, been very stable with little or no pain or symptoms. When she was originally discharged a care package was implemented initially with a visit at home in the morning to help her get washed etc. Community Nurses and District Nurses visited but both these services have withdrawn over the years.

She has been into hospital a couple of times since the original diagnosis (a broken hip and bladder infection).

She is now having care twice a day morning and evening. We had a social services assessment to allow for the extra care at night three years ago.

At the beginning of March she started to suffer with acute pain and bleeding. We called the GP who prescribed antibiotics.

The bleeding and pain got worse and the GP was called again on Thursday 11th March 2010. He called for an ambulance to take her into hospital.

She was admitted to A&E at 1.30 (my daughter was able to rush round to the hospital to be with her as I was in Hereford).

She was repeatedly asked by about four different doctors and nurses her history. This was extremely tiring and she became exhausted. All this history is in her notes, and I asked the question why they couldn't access these notes.

She was finally admitted to Montpelier Ward at about 7.00pm.

She had some blood tests, ultrasound, and had a catheter inserted to wash out the bladder. She was moved to Kemerton Ward on Saturday 13th March 2010.

She was moved to Knightsbridge Ward on Tuesday morning at 1.00am (in the middle of the night).

She was discharged on Tuesday in the morning. We were advised that she would be seen by the hospital palliative care team but were then told that they were too busy and would be seen by the community palliative care team. No review of her care plan was carried out by anyone.

My mother was very weak and muddled when she got home. I arranged with Cleeve Link who provides her care to come at lunchtime to prepare meals and to generally help her. This is an extra ½ hour visit.

On Friday 19th March I was very concerned about her as she was still in pain. I called the GP who came but had no knowledge that she had been discharged or indeed the results of the tests. I explained that the community palliative care had been asked to contact her and the GP said he would chase them up which he did.

I also phoned Social Services Adult Helpdesk to ask for a review of her care package and explained the reasons why. They agreed that this should be an urgent referral.

She called out the GP on Monday 22nd March as she had more bleeding and pain. A new GP arrived who did not know her, her history etc., and as she was not English, Mum could not understand her and therefore had no confidence in her.

My mother has recently been reassessed by Glos County Council for funding for her care. At present she pays approximately £18.00 per week for her care package. We have been advised that this will now be reduced to £5.00 per week (for whatever care is deemed to be needed).

The community palliative care team are now in place and are absolutely fantastic, giving Mum all the help and support that she needs.

I phoned the Adult Helpdesk again today and have been given the telephone number for the Cheltenham Office but am not hopeful of any visit soon.

In my opinion all this should have been sorted before my mother left hospital. However my concern is that if I was not around to act on Mum's behalf, she could easily be back in hospital although she has stated that she does not ever want to go back to hospital."

Case study 6

Received from Anchor Trust

"Mrs M is 91 and was admitted to GRH after a fall several weeks ago. She was later transferred to Lydney Hospital and is now anxious to return home. She told me she is "a fraud" being so well cared for in Lydney Hospital even though she has fully recovered. She is anxious that someone needier should be occupying the bed she is currently occupying. (Mrs

M cannot praise Lydney Hospital highly enough and wants everyone to know that it must never close. The nursing staff confirmed that they were just waiting for this lady's care package to be arranged and that she should have been discharged earlier.

The following day the family of this lady called me to see if I could suggest anything to help get their mum home more quickly.

I initially called Social Services (SS) in the Forest of Dean who confirmed that the finance for the care package had been agreed and that they were waiting for someone to take the package on. I was told that there is a shortage of carers. It was explained that once the finance of the package is agreed, the work is 'put out' and SS have to wait for someone to pick the case up. The lady I spoke with was aware of the delay and sounded really frustrated and said she was not allowed to chase this up or hassle others but that the case was with Community Steps. She also mentioned getting charged for bed blocking – I am not sure exactly to what department she was referring regarding the payment of the charge. This lady also said that the financial situation will get even worse.

I then called Community Steps. The lady I spoke to was really helpful and confirmed what I had been told by SS in the Forest of Dean. She asked me to call back later which I did. Later that day I was told that someone had just taken the package on but the carers would not be able to start until Monday (this was now Wednesday).

After speaking with the family again, it became evident that they had purchased a keysafe themselves; they did not know that this could have been provided and fitted by their local Home Improvement Agency as part of their mum's Care Package."

Members of the Gloucestershire Local Involvement Network (LINK) Task Group

- Maureen Dore, Chair from December 2010 until April 2010
- Barbara Marshall, Chair from April 2010
- Eileen Barnes
- Michael Bone
- Melanie Burgoyne
- Louise Duruty de Lloyd
- Val Dyer
- Don Espie
- Judy Gazzard
- Dr Gervase Hamilton
- Cynthia Laird
- Ruth Langley
- Maureen Law
- Bryan Love
- Peter Mannion
- Susie Oakley
- Sister Elly Maria Pantekoek
- Dave Peachey
- Annie Somervell
- Raymond Storey
- Fannie Storr
- Lynne Saunders
- Chris Tombs
- Jane Winstanley

Documents consulted

- *Achieving timely “simple” discharge from hospital* (a toolkit for the multi-disciplinary team). Dept of Health, August 2004
- *Patient Discharge – Adult. Trust Clinical Policy*. Gloucestershire Hospitals NHS Foundation Trust, August 2009
- *Policy on the Discharge and Transfer of Patients – Clinical Policies, Protocols, Guidelines and Procedures*. NHS Gloucestershire Care Services, December 2009
- *Protocol for Hospital to Area Transfer of Cases, Planning and Policy*. Social Services Directorate, Gloucestershire County Council, December 2004
- *Domiciliary Care Policy and Procedures*, Gloucestershire Community Steps Service, Gloucestershire County Council, Revised June 2009
- *Intimate Personal Care and Clinical Tasks, Planning and Policy*, Social Services Directorate, Gloucestershire County Council, December 2009
- *NHS Continuing Healthcare and NHS Funded Nursing Care*. Public Information Booklet. Dept of Health, 2009
- *Managing Patients’ Medicines after Discharge from Hospital*, Care Quality Commission, December 2009
- *Discharge from hospital: pathway, process and practice*, Department of Health Gateway Reference 1074
- *Hospital Aftercare: Help and support following a stay in hospital*, Leaflet, Age UK Gloucestershire

NHS Gloucestershire Blaylock Risk Assessment Tool

| Gloucestershire NHS | | | | Full Name: | | | |
|---|----|----|----|--|----|----|----|
| The Blaylock Risk Assessment Screen for Discharge Planning Support | | | | Date of Birth: DD/MM/YYYY | | | |
| Circle the appropriate score on admission (OA), on transfer (OT) and on discharge (OD) for each section, and record total | | | | NHS / Hospital Number: (or affix hospital label here) | | | |
| Age | OA | OT | OD | Cognition | OA | OT | OD |
| 55 years or less | 0 | 0 | 0 | Orientated | 0 | 0 | 0 |
| 56 to 64 years | 1 | 1 | 1 | Disorientated to some spheres* some of the time | 1 | 1 | 1 |
| 65 to 79 years | 2 | 2 | 2 | | | | |
| 80 + years | 3 | 3 | 3 | Disorientated to some spheres all of the time | 2 | 2 | 2 |
| Living situation / Social Support | | | | Disorientated to all spheres some of the time | 3 | 3 | 3 |
| Lives only with spouse | 0 | 0 | 0 | | | | |
| Lives with family | 1 | 1 | 1 | Disorientated to all spheres all of the time | 4 | 4 | 4 |
| Lives alone with support of family | 2 | 2 | 2 | | | | |
| Lives alone with support of friends | 3 | 3 | 3 | Comatose | 5 | 5 | 5 |
| Lives alone with no support | 4 | 4 | 4 | <i>*spheres = person, place, time, self</i> | | | |
| Care Home Resident | 5 | 5 | 5 | Behaviour Pattern | | | |
| Support with care package | 6 | 6 | 6 | Appropriate | 0 | 0 | 0 |
| Functional Status | | | | Wandering | 1 | 1 | 1 |
| | | | | Confused | 1 | 1 | 1 |
| Independent in A.D.L's | 0 | 0 | 0 | Depressed | 1 | 1 | 1 |
| or dependent in any of the following | | | | Sensory Deficits | | | |
| Eating / Feeding | 1 | 1 | 1 | None | 0 | 0 | 0 |
| Bathing / Grooming | 1 | 1 | 1 | Visual or Hearing deficits | 1 | 1 | 1 |
| Toileting | 1 | 1 | 1 | Visual and Hearing deficits | 2 | 2 | 2 |
| Transferring | 1 | 1 | 1 | Number of Drugs | | | |
| Incontinent of bowel function | 1 | 1 | 1 | Fewer than 3 drugs | 0 | 0 | 0 |
| | | | | Three to five drugs | 1 | 1 | 1 |
| Incontinent of bladder function | 1 | 1 | 1 | More than 5 drugs | 2 | 2 | 2 |
| | | | | Mobility | | | |
| Meal Preparation | 1 | 1 | 1 | Independent | 0 | 0 | 0 |
| Medication administration | 1 | 1 | 1 | Independent with walking aid | 1 | 1 | 1 |
| Handling own finances | 1 | 1 | 1 | Independent with human Assistance | 2 | 2 | 2 |
| Grocery Shopping | 1 | 1 | 1 | | | | |

| | | | | | | | |
|---|---|---|---|----------------------------------|---|---|---|
| Transportation | 1 | 1 | 1 | Non ambulatory | 3 | 3 | 3 |
| Number of active medical problems | | | | TOTAL SCORE | | | |
| Three medical problems | 0 | 0 | 0 | | | | |
| Three to five problems | 1 | 1 | 1 | | | | |
| More than five problems | 2 | 2 | 2 | | | | |
| Number of Admissions / A&E Visits | | | | Signature And Completion Date | | | |
| None in last 3 months | 0 | 0 | 0 | | | | |
| One in last 3 months | 1 | 1 | 1 | | | | |
| Two in last 3 months | 2 | 2 | 2 | | | | |
| More than 2 in the last 3 months | 3 | 3 | 3 | | | | |
| <p>Low scores (< than 10) suggest that the patient has few needs for discharge planning. A moderate score (10-19) suggests that the patients problems are more complicated and require extensive discharge planning, with rehabilitation but probably without long term institutionalisation. A high score (> than 19) suggests that the patients problems are complex, and require extensive discharge planning, with long term rehabilitation and / or long term care.</p> | | | | | | | |
| <p>Reference – Predictive validity of the BRASS index in screening patients with post discharge problems Blaylock-A et al. Journal of Advanced Nursing 1999, Nov, vol.30, no.5, p:1050-6</p> | | | | | | | |

Multi-Disciplinary Discharge Action Planning document

“Achieving timely ‘simple’ discharge from hospital: A toolkit for the multi-disciplinary team

Factsheet 2

Developmental ‘health check’ progress tool

Use this check list to establish how close you are to implementing timely patient discharge and to identify the steps you still need to take.

1. Willingness to try

| | | |
|---|-----|----|
| • Have you started to review the discharge process through process mapping? | Yes | No |
| • Have you started to discuss timely discharge within the multi-disciplinary team? | Yes | No |
| • Have you approached the information manager to look at current pattern of discharges? | Yes | No |

2. Support

| | | |
|---|-----|----|
| • Do you have support from the lead consultant, clinical director, and senior manager? | Yes | No |
| • Have you started to discuss timely discharge with the director of operations executive lead? | Yes | No |
| • Have you gained support and agreement with the director of nursing and medical director to begin nurse-initiated discharges earlier in day and at weekends? | Yes | No |
| • Have you identified your allies and champions who will support you? | Yes | No |
| • Have you referred to the DH workbook ‘Discharge Planning - pathway process and practice’? | Yes | No |

3. Discharge pathway

| | | |
|--|-----|----|
| Have you agreed the elective or emergency pathway and patient group? | Yes | No |
| Referral routes established (access to pathway) | Yes | No |
| Scope of pathway decided: | Yes | No |
| – Pre-operative or pre admission | Yes | No |
| – From point of admission | Yes | No |
| – At point of medical stability (clinical stability) | Yes | No |
| – On day of discharge | Yes | No |
| – Post discharge | Yes | No |
| – Exit route(s) established | Yes | No |

Checklists

| | | |
|--|-----|----|
| Discharge checklist developed? | Yes | No |
| Nurse or AHP led discharge checklist? | Yes | No |
| Decision when checklist is to be used (48hr/24hr/ON DAY) | Yes | No |
| Patient focus (involvement) considered? | Yes | No |

4. Clarify roles and responsibilities

| | | |
|--|-----|----|
| • Have you identified the members of the team who are involved in the discharge process? | Yes | No |
| • Have you mapped the discharge process with the roles and responsibilities of members of the clinical team? | Yes | No |
| • Could you clarify the roles and responsibilities? | Yes | No |
| • Could you change the roles and responsibilities so that it improves the discharge process? | Yes | No |

5. Estimated date of discharge (acute)

| | | |
|--|-----|----|
| Estimated date of discharge (EDD) process in place? | Yes | No |
| Endorsed by consultant teams and junior doctors? | Yes | No |
| Agreements with labs and X-ray for turn around times of tests etc? | Yes | No |
| Implemented consistently at post take ward rounds or MDT meetings? | Yes | No |

Estimated date of discharge (rehab)

| | | |
|---|-----|----|
| Supported by regular multi-disciplinary team input | Yes | No |
| Links from EDD and nurse initiated discharge established? | Yes | No |
| Wider consideration of 'number of contacts' required by AHP | Yes | No |

Estimated date of discharge (primary/Intermediate)

| | | |
|---|-----|----|
| Considers primary care perspectives (e.g. district nursing input) | Yes | No |
| Considers intermediate care service input/assessment/availability | Yes | No |

6. Training(knowledge, skills and competencies)

| | | |
|---|-----|----|
| Skills/competencies required, are clearly identified (matrix)? | Yes | No |
| Supporting nurse initiated assessments are developed? | Yes | No |
| Training and work-based learning needs identified | Yes | No |
| Supervision and assessment in carrying out nurse-initiated discharge in place | Yes | No |

7. Agree to pilot or run a PDSA

| | | |
|--|-----|----|
| Have you run a PDSA around timely discharge for a specific group of patients? | Yes | No |
| Have you identified the criteria you will use to monitor the impact of change on the patient pathway and timely discharge? | Yes | No |

8. Policy

| | | |
|--|-----|----|
| Have you reviewed your hospital discharge policy? | Yes | No |
| Nurse initiated discharge as part of policy? | Yes | No |
| Nurse initiated discharge policy links with Trust discharge policy? | Yes | No |
| Written in collaboration with multi-disciplinary team including social services? | Yes | No |
| Written in collaboration with primary and intermediate care services | Yes | No |
| Signed off by legal team / clinical governance approval? | Yes | No |
| <i>Policy indicates scope of nurse initiated discharge from secondary care, primary care, intermediate care and nursing / residential settings</i> | | |

9. Protocols/guidelines

| | | |
|--|-----|----|
| Individual condition based protocols developed with lead consultants? | Yes | No |
| Exclusion/Inclusion criteria decided (to assess suitability for NID)? | Yes | No |
| Screening tools written in conjunction with physician or surgeons? | Yes | No |
| Protocol clear about when transfer of care from medical profession to nurse or AHP protocols is to happen? | | |
| – Protocols signed off by relevant professionals with implementation and review date | | |
| – Clinical governance aspects of protocols are agreed by trust clinical risk departments, legal advisers | | |

10. Outcome measures

| | | |
|--|-----|----|
| Agreed measures before and after new process in place? | Yes | No |
| Audit mechanism in place? | Yes | No |
| Established as a pilot project? | Yes | No |
| Agreement about how to disseminate best practice or lessons learned? | Yes | No |

Achieving timely 'simple' discharge from hospital: A toolkit for the multi-disciplinary team

**GHNHSFT numbers of comments, complaints and concerns
re discharge, received between 01/04/09 to 30/11/09**

| | |
|----------------------|-------------|
| Number of comments | = 6 |
| Number of complaints | = 19 |
| Number of concerns | = 49 |
| TOTAL | = 74 |

Additional information

During the same period there were a total of 100,043 discharges across the Trust