

Doncaster LINK

Discharge from Hospitals and After Care Survey Report

Report, findings and recommendations

Doncaster Local Involvement Network

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Survey Report

Discharge from Hospitals and After Care

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Appendix 1 and 2

- 1 Survey Questionnaire
(Included with the report)
- 2 Diary of Carer of 70+ Year Old Female
- patient of Doncaster Royal Infirmary
appertaining to discharge and after care
(Included with the report)

Acknowledgments

Data analysed by DJS Research Ltd

Introduction

On 1st April 2008 the Carers Federation were appointed by Doncaster Metropolitan Borough Council to be the Host for Doncaster Local Involvement Network (LINK). During the previous 18 months following the demise of the Patient and Public Involvement in Health Forums, a steering group had been active in Doncaster as one of 7 earlier adopter sites in the country to look at how the LINK could work locally.

Initially a Core Group (later to develop into the elected Executive Board) of local voluntary individuals and organisations formed the independent body of Doncaster LINK.

In August 2008 the LINK began its active work in engaging with the people of Doncaster Metropolitan Borough in order to seek their views in relation to the services provided in Doncaster.

The purpose of this work is to identify positive factors, unmet needs and concerns in relation to current service provision, then to liaise with service providers in order to influence positive improvements for the benefit of the general public.

In order to fulfil its remit of public engagement Doncaster LINK held a number of events where those who attended were able to express their opinions about the provision of health and social care services in the area.

One of the main concerns expressed repeatedly was discharge from hospitals and after care. The LINK Executive Board members agreed that further investigation was necessary in order to establish the facts around this issue, therefore a working group was set up to address the topic.

Target Group

The Target Group was to be patients discharged from Doncaster Hospitals during 2009 who needed after care in the community.

Research Process

- 1 The perusal of discharge and after care procedures.
- 2 In order to obtain background information about these issues the LINK sought opinions, suggestions and assistance from health and social care managers and practitioners which included the following:
 - Adult Service Director
 - Assessment Project Officer
 - Brokerage Service Managers
 - Cardiac Rehabilitation Service
 - Community Matrons
 - Danum Cardio Club
 - Discharge Co-ordinator Doncaster Royal Infirmary
 - Doncaster Stroke Support Group
 - Managers of the Primary Care Trust Community Intervention Team
 - Patient Advice and Liaison Services
 - Physiotherapy Outpatient Department Doncaster Royal Infirmary
 - Rapid Response Team Manager
 - Reablement Team Manager
 - Social Care Co-ordinator for Social Support and Reablement Centre
 - St James' Court Respite and Social Rehabilitation Centre
 - St Mary's Rehabilitation Unit
 - Stroke Unit (Outpatients Doncaster Royal Infirmary)
 - Take Heart Support Group
 - Tickhill Road Day Hospital
- 3 The sub-group devised a questionnaire with reference to communication, medication, transport and after care (both medical and social). The questionnaire was placed on the Doncaster LINK website and circulated to service user groups. In addition, patients were interviewed personally by sub-group members. **Appendix 1**

Questionnaire Topics

Ascertaining the requirement and availability of domestic aids and/or adaptations upon discharge.

In reference to communication determining whether:

- Patients were provided with an 'After Care Package'
- Everything was explained in an understandable manner
- The patient was given a copy of the discharge letter to their GP

In reference to medication, finding whether:

- Waiting for medication delayed their discharge
- The purpose, any changes and dosage instructions were explained in an understandable way
- Written information was given to the respondent
- They had been sent home with old medication

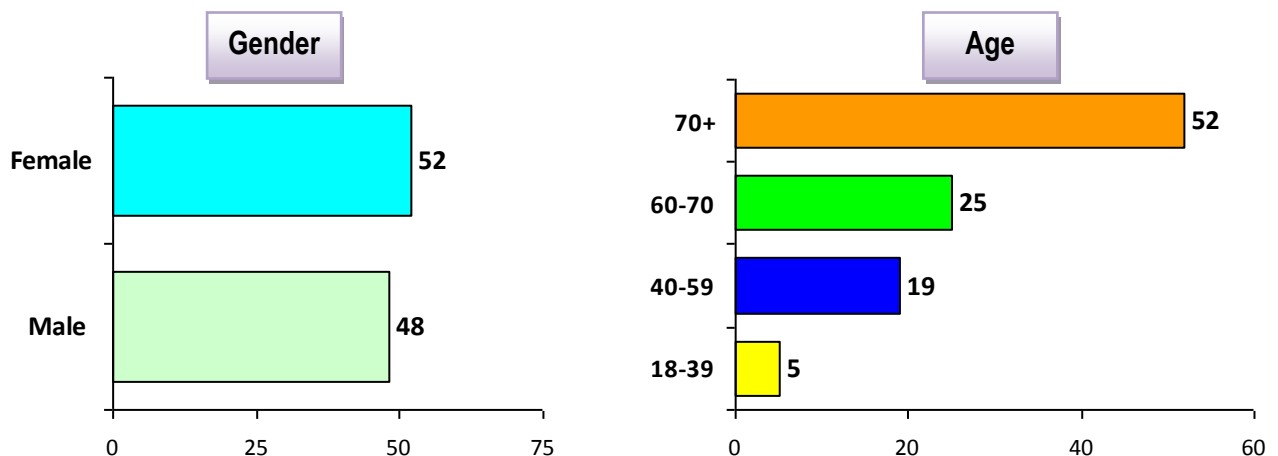
Finding out how patients travelled home and their requirement of assistance once home:

- How long for
- Who had visited
- Who had telephoned
- How often needs for assistance had been reviewed

Who did we speak to?

Status: 95 percent of respondents had been inpatients

Age and gender of patients - half aged 70+.



Data Analysis

Quantitative: 108 questionnaires were completed and data was statistically analysed.

Qualitative: A section for general comments was included in the questionnaire. These comments were analysed and the most common themes included.

Aids and Adaptations

57% required aids or adaptations in the home.

Q3 Did you need any aids or adaptations at home?

In 84% of cases these were available on discharge. Significantly more females required aids/adaptations than males (73% vs. 38%). Of the 70+ age group 61% required aids/adaptations. Patients (16%) complained that waiting for aids/adaptations had delayed their discharge.

Communication

Q6 Did you receive a copy of your After Care Package?

42% answered positively, however a similar number (39%) said they had not. Of those saying no, 25% were aged 40-59 years old, 40% were aged 18-39 years old and 44% were 70+ years old.

Q7 Was everything explained to you in a way you/your carer could understand?

A significantly higher proportion of 70+ year olds (27%) and 18-39 years olds (20%) said no. In contrast only 5% of all aged 40-59 year olds and 11% aged 60-70 year olds said no.

Some patients complained of insufficient information on discharge. *“I was appalled at the lack of information and guidance given on discharge. I had to do a lot of chasing up. I feel the Ward was very disorganised”* (Male 18-39 year old Doncaster Royal Infirmary).

Q8 Were you given a copy of the letter from your hospital to your GP?

68% stated they were not given a copy. 70+ year olds were least likely to receive this letter.

Medication

Q9 Did waiting for medication delay your discharge?

26% of patients had been delayed by waiting for medication. In 23% of cases the delay was longer than 4 hours. There were no significant differences between age or gender groups.

Patients stated that *“In order to be discharged to fit in with arranged transport, missing medication was delivered by taxi hours later”* (Female 60-70 Doncaster Royal Infirmary).

Q10a Upon discharge was the purpose of your medication explained in a way you could understand?

Across all age groups 20% did not understand. Statistically a significantly higher proportion were female.

Q10b Upon discharge were any changes about your medication explained in a way you could understand?

Across all age groups 36% indicated that the changes had not been explained.

Q10c Upon discharge were side effects of your medication explained in a way you could understand?

More than half indicated the side effects had not been explained in a way they could understand. Of these a significantly higher proportion were females (70%).

Q10d Upon discharge were instructions on how to take your medication explained in a way you could understand?

The majority (84%) had been given understandable instructions. Of those experiencing difficulty 21% were 70+ year olds and 25% were 18-19 year olds. In the age group 40-59 year olds no difficulties in understanding were experienced. A significantly higher proportion of females (24%) than males (9%) said they did not understand.

Q10e Upon discharge were you given written information about your medication?

45% said they had not received written information. Once again there was a higher percentage in the age groups 18-39 and 70+ year olds but no significant difference in gender.

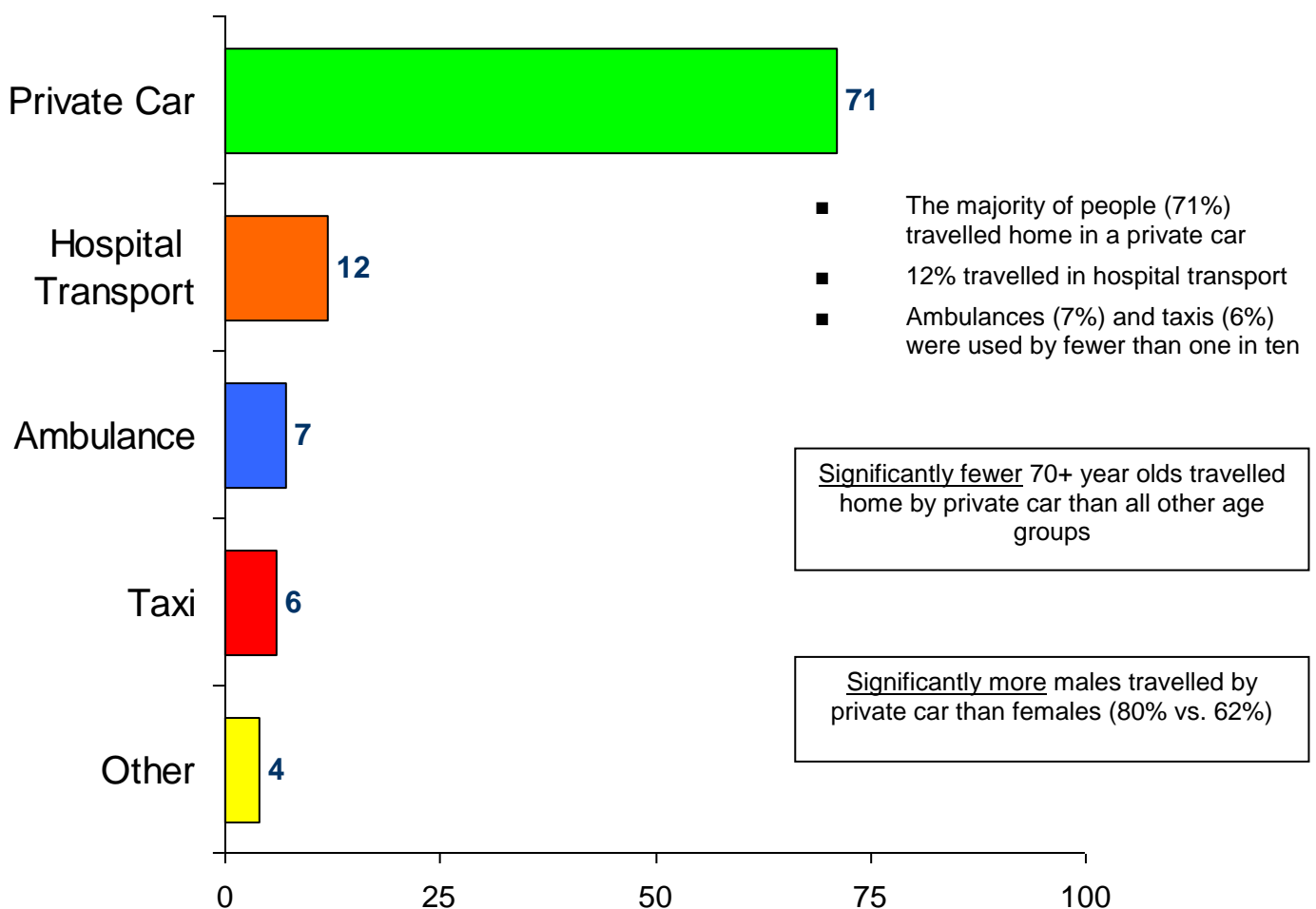
Q10f Upon discharge were you sent home with old medication?

A quarter (28%) had been sent home with old medication.

Concerns have been raised regarding patients being discharged from hospital with their old medication which is no longer prescribed, together with new medication, which they are instructed to take.

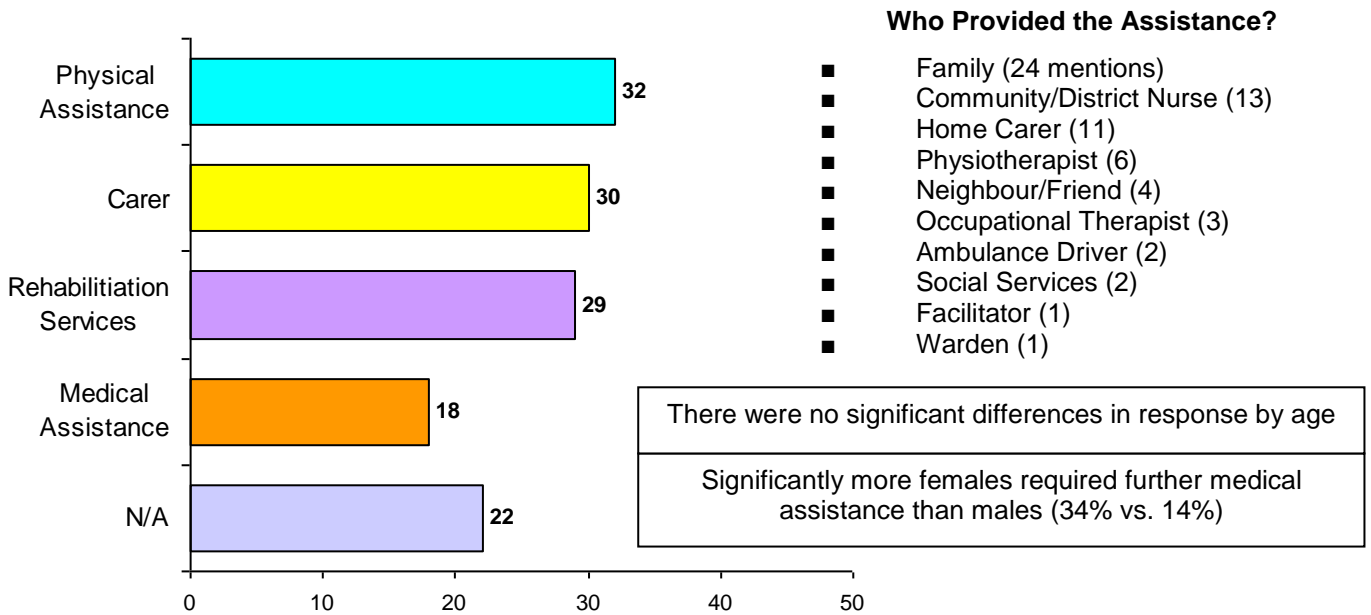
Q11 How did you get home?

The majority of patients travelled by private car.



Aftercare

Q12 When you arrived home did you require any of the following?

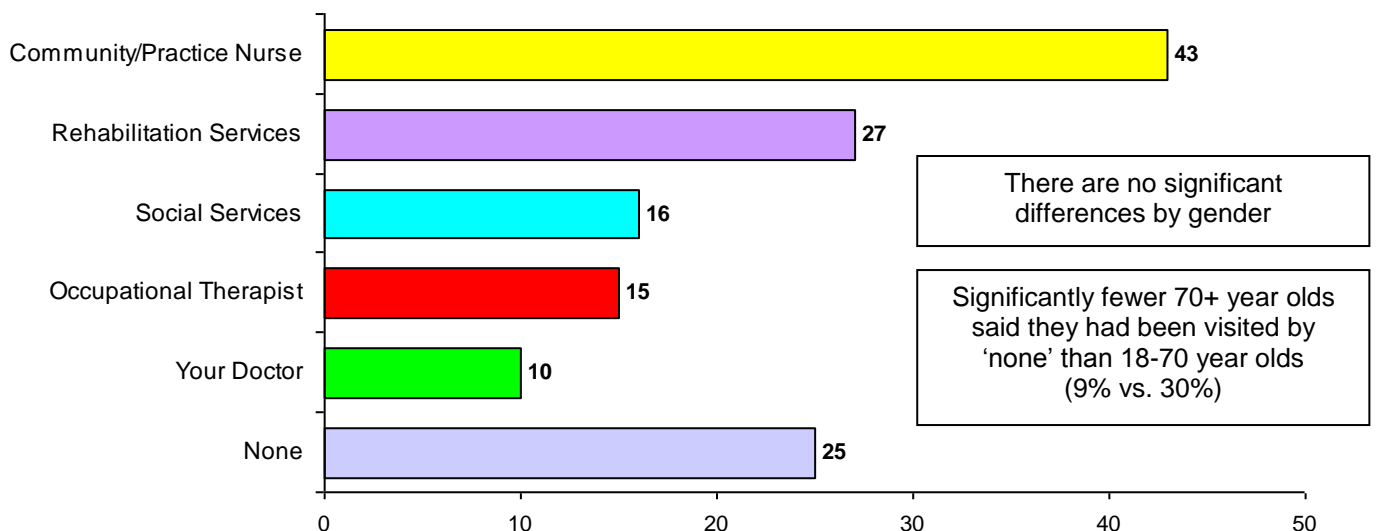


Q13 How long did you require assistance?

3 in every 5 patients required assistance for longer than a month after discharge. Of these over half were aged 70+, with females comprising the larger percentage. There was a greater percentage of the over 60 year olds requiring assistance for up to a month, however, there were no significant differences in gender in this group.

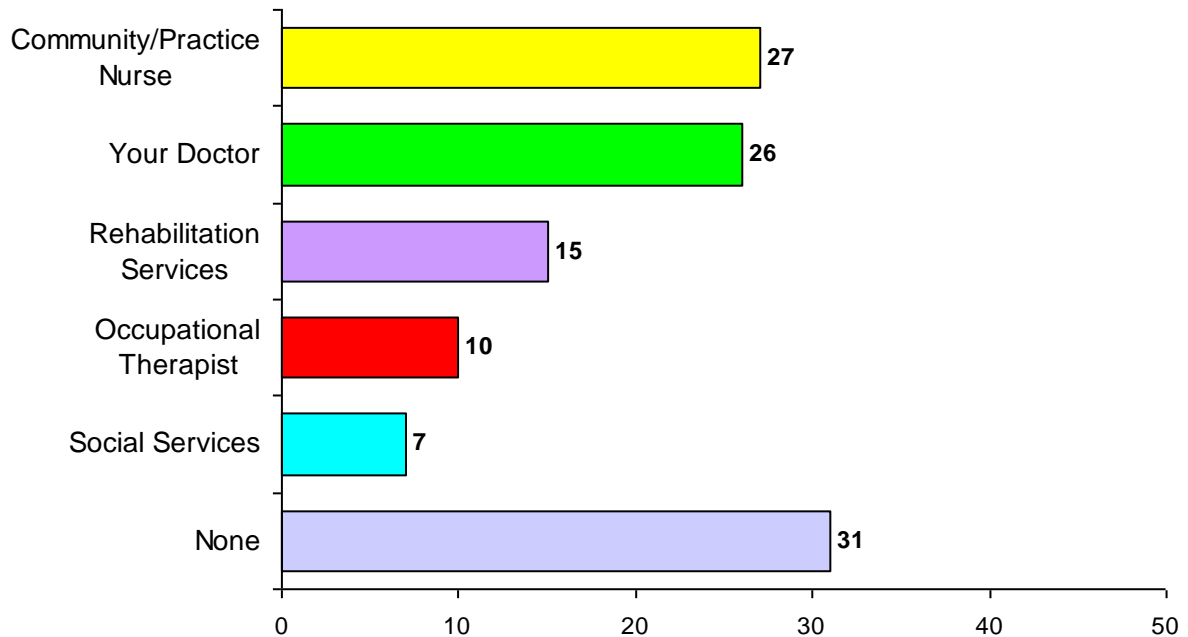
Q14 Since discharge have you been visited by or spoken to service providers?

Home Visits – Two fifths visited by Community/Practice Nurse



Q15 **Since your discharge have you spoken over the phone to any of the following?**

Telephone Contact - Doctors/Nurses found to be the most frequently contacted.



Patient's expressed concerns that GP's do not seem to be actively involved in patient's discharge home. *"It made all the difference having my husband to help me my GP did not even know that I had a fracture. Do they actually see the letter?"* (Female 60-70 year old). *"No contact from the GP whatsoever"* (Male 60-70 year old).

Q16 **How often has your changing needs for assistance been reviewed?**

Over half of those requiring assistance following discharge said they had not had their needs reviewed. Of those, 76% are over 60 years old. There were no significant differences in gender.

Reviews and after care were of concern to many patients. This is supported by the following examples:

- *"After care should be reviewed after discharge as it seems to be non-existent. You feel out on a limb after major surgery"* (Female 70+ Doncaster Royal Infirmary).

- *“It is important to have progress monitored by an Outreach Team to see if further assistance is required. If there is a lack of progress on the patient’s behalf, it would be good if they could ask for a referral”* (Female 40-59 Doncaster Royal Infirmary).
- *“After care physiotherapy sessions need to be longer and given over a longer period of time”* (Female 60-70 Park Hill).
- *“The physiotherapy service was good but a leaflet to show the exercises would have been nice”* (Female 60-70 Doncaster Royal Infirmary).

Conclusions

On the whole, experiences of patients were positive however, concerns were highlighted in relation to communication, medication and after care.

Communication

A quarter of respondents felt they had not been communicated with in an understandable manner. A significantly higher proportion of 18-39 and 70+ year olds repeatedly said that everything had not been explained in a way they could understand. This indicates there is a need to target the way in which information is communicated to meet the needs of the young and old. Poor communication between hospital departments, hospital staff, rehabilitation units, community teams, patients and their carers have been highlighted.

Insufficient information is given on discharge with vulnerable patients in particular being in need of more information. Respondents did not know how to make contact with service providers. Only 42% surveyed received a copy of their ‘After Care Package’. Two thirds of patients surveyed did not receive a copy of the letter from the hospital to their GP. Good provision of information is crucial for patients to receive on-going care. Lack of immediate access to the letter to the GP can delay administration of patients’ medication by Community Nurses.

Medication

26% of respondents' discharge had been delayed by waiting for medication. In 23% of cases the delay was longer than 4 hours. The LINK was informed of patients being discharged without all their medication and the missing medication being delivered by taxi hours later.

More attention needs to be given to explaining the purpose, changes and side effects of medication. Vulnerable patients need more assistance with their medication whilst in hospital in order for them to be able to manage their medication by themselves on discharge home.

Patients are being discharged with their old medication, which is no longer prescribed, together with new medication. This is a potential danger and confusing for the patient concerned.

The LINK has received positive feedback about the Nomad system where the name and dosage of each tablet is identified.

Aftercare

On discharge 71% travelled home in a private car. Other transport did not always meet the needs of individual patients. Nearly a third required assistance at home, a quarter for up to 3 weeks and 59% for more than a month. Most felt this assistance could not be improved although suggestions were offered in relation to information, appliances and support provision.

Concerns were expressed regarding reviews of after care with over half saying they had not had their needs for assistance reviewed.

LINK supports the proposed introduction in 2010 of the Short Term Enablement Programme (STEPS) which provides a short term service to help regain or enhance the ability to live as independently as possible in the home.

Recommendations

- 1 All patients needing after care in the community to be given a written 'After Care Package' containing the following:
 - Telephone numbers of relevant contacts
 - A copy of letter from hospital to their GP
- 2 Patients to be asked to show their copy of the hospital letter to the GP to the Community Nurses and other service providers attending.
- 3 All medication for patients awaiting discharge from hospital to be available within the Government guidelines of 4 hours.
- 4 Training to be given to hospital staff to develop communication skills in explaining the purpose, changes and side effects of medication, especially aimed towards the 18-39 and 70+ year olds.
- 5 Medication which is no longer prescribed to be withdrawn.
- 6 Relevant patients and carers to be informed of the Nomad system.
- 7 All patients needing continuing care in the community to have the following:
 - An on-going review of their after care
 - A formal review within 3 months of discharge
 - Thereafter review every 6 months
 - Reviews to be provided on request of patients

Doncaster Local Involvement Network (LINK) Discharge Procedure Survey Doncaster Hospitals' Patients

Doncaster LINK is your official independent Local Involvement Network. Our aim is to improve the links between your health and social care services.

We wish to give you the opportunity to say what you think about these services – what is working well and what is not so good.

Doncaster LINK is currently looking at what happens when patients are discharged from hospital.

If you have been an inpatient since January 2009 in any of the Doncaster hospitals it would be most appreciated if you could please spend a few minutes to complete the attached survey. This could help make a difference to future patient care.

Please return the completed form as soon as possible in the freepost envelope provided or alternatively to the address shown at the bottom of page 2 of the survey.

If you need help completing this survey you may ask a relative or friend to help you.

Thank you for taking part in the survey. The results will be made available in due course.

Doncaster Local Involvement Network (LINK) Discharge Procedure Survey Doncaster Hospitals' Patients

For office purposes only, please insert the first part of your postcode

Section A

- Q1** Have you been an inpatient? Yes No
- Q2** Hospital Name and Ward No?
- Q3** Did you need any aids or adaptations at home? (e.g. crutches, walking stick, toilet seat etc) Yes No
- If Yes, were they available upon discharge? Yes No
- Q4** Gender? Male Female
- Q5** Age Group? Under 18 18 – 39 40 – 59 60 – 70 Over 70

Section B

Communication

- Q6** Were you given a copy of your 'After Care Package' and contact numbers of agencies involved?
Yes No Do Not Know
- Q7** Was everything explained in a way you/your carer could understand?
Yes No Do Not Know
- Q8** Were you given a copy of the letter from the hospital to your GP?
Yes No

Medication

- Q9** Did waiting for medication delay your discharge?
Yes No By how long?
- Q10** Upon discharge, were the following about your medication explained to you in a way you could understand?
- | | | |
|--|---|---|
| <p>10a Purpose Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>10b Any changes Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>10c Any side effects Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| <p>10d Instructions on how to take given Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>10e Written info given Yes <input type="checkbox"/> No <input type="checkbox"/></p> | |
| <p>10f Were you sent home with old medication? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | | |

Section B (continued)

Arrival Home

Q11 How did you get home?

Hospital Transport Ambulance Taxi Private Car Other

Q12 When you arrived home did you require any of the following?

Medical Assistance Physical Assistance Rehabilitation Services Carer N/A

If yes, who provided your assistance?

.....

Q13 How long did you require assistance?

1-3 Wks 1 Month Longer

How could this help have been improved?

.....

Q14 Since your discharge have you been VISITED by any of the following?

Your Doctor Social Services Rehabilitation Services Community Practice/Nurse
Occupational Therapist None

Q15 Since your discharge have you SPOKEN over the phone to any of the following?

Your Doctor Social Services Rehabilitation Services Community Practice/Nurse
Occupational Therapist None

Q16 How often have your changing needs for assistance been reviewed?

Frequently Infrequently Never

Q17 Any Other Comments? (If necessary please use a separate sheet)

.....
.....
.....

Please return completed survey to:

Doncaster LINK
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APPENDIX 2

Doncaster LINK

Diary of Carer of 70+ Year Old Female Patient of Doncaster Royal Infirmary

November to December 2009

During a 3 ½ week stay in hospital the 91 year old female patient was in A & E, CDU and MAU during her first 24 hours. Thereafter, over the following 24 days she was moved another 5 times around the MAU and Ward 17 in addition to 2 visits to X-ray and one for a scan. She therefore was dealt with by a multiplicity of strangers with fleeting contact in an unfamiliar situation full of strange noises, sights, smells and confusion, all very alien to her normal quiet existence.

All these movements and experiences, coupled with drugs causing horrendous and terrifying hallucinations resulted in her complete confusion, very little recall and limited short term memory. This meant that any conversation with her was not necessarily accurate in its content, and, any information she received was either forgotten, misinterpreted or became garbled in her memory.

Disruption in her normal way of taking her medication meant she no longer had any idea of what she was taking or why.

She has no memory of anyone explaining about her medication and it was not discussed with her carer. The only thing discussed in the presence of both patient and carer was the use of a Nomad system. This method of medication delivery is excellent with the name and dosage of each tablet being on the Nomad.

After 14 days in hospital, an information pamphlet was left with the patient and a phone call made to the carer indicating a home visit accompanied by the hospital social care team was planned for 3 days later.

Home Visit

The patient arrived on time in a hospital taxi with wheelchair facility accompanied by 2 hospital staff who were excellent in their manner when dealing with the patient, eliciting information from her as well as guiding her into accepting the appropriate assistance available for her permanent return home. The carer was able to quietly express her particular concerns about the patient's safety with one of the hospital staff while the other was being shown around her home by the patient.

Day 21

8am A telephone call was received by the carer informing a bed arm was to be installed at the patient's home between 9 and 9.30am.

NOTE: Without prior notification the carer faced difficulties in attending the appointment.

10am The hospital Social Worker phoned to make arrangements to meet with the carer and patient on the ward between 11am and midday.

NOTE: This could have created difficulties for anyone without their own transport.

During this visit agreement was made to use the Nomad system. The carer was informed a key safe and door key would have to be installed at the patient's home prior to any social care arrangements. The patient was advised to arrange for the installation to be carried out by an independent installer, as it may take up to 3 weeks to be installed by the council.

NOTE: Delays in installation of the key safe would result in the patient being unable to return home resulting in 'bed blocking'.

Using the key safe and its contents would enable the STEPS (Short Term Enablement Programme) team to enter the patient's home morning and evening to give personal assistance for up to 6 weeks.

It was agreed the Reablement Team would also visit each lunch time for a short period to ensure the patients capability and safety to organise her cooking.

Day 23

3pm The carer was able to confirm with the Social Worker that the key safe was ready but there was a problem with the Nomad until the following week. Arrangements were made for suitable hospital transport home as the carer's car was deemed inappropriate.

The Ward Sister agreed she would telephone the carer as the patient was about to leave the ward allowing sufficient time for the carer to travel to the patient's home.

The carer was shown the list of medication which would be sent home with the patient and informed a copy would accompany the patient. Sadly, there was no time for discussion or clarification about the changes/ side effects/purpose of the patient's medication.

Day 25

2.10pm The carer received a telephone call from the ward informing her that the patient was about to be taken to the arranged vehicle for transport home. The carer was also informed that some of the medication would not be with the patient as there was a delay in all of it arriving on the ward. In order not to miss the arranged transport, the carer was informed the remaining medication, together with a copy of the discharge note would be sent as soon as possible by taxi.

Arrival Home

The hospital transport had a rear lift but the patient was not in a wheelchair as on her previous visit. There was no walking frame which she had been using to assist her movement in hospital. As she had been doing very limited supported walking for 4 weeks her knees were very wobbly and movement extremely difficult. Without the help of **both** the driver and carer supporting the patient to walk (very slowly) along a (very long) slippery drive which was a greater distance than she had been covering in hospital with the aid of a frame, it would have been impossible to get the patient into her home.

The remaining tablets and medication list arrived later that day by taxi.

The STEPS team commenced their support the same evening.

The Following 6 Weeks

Throughout the first 4 weeks at home the patient continued to have short term memory problems, didn't appreciate there was a difference between the STEPS and Reablement Team, didn't follow the Nomad correctly no matter how often these things were explained to her. She had a nasty fall at 3am in week 2 and was assisted by the Council Alarm System Team. She was then visited by a member of the Emergency Care Practitioner team to assess her injuries.

The twice daily visits by the STEPS Team for the first 6 weeks at home proved invaluable to both patient and carer, enabling the patient to regain her confidence, ability to converse, concentrate and improve her recall. At the same time this gave her carer time and opportunity to recover and recoup her energy.

Comments

- 1 There is very little stimulation in the wards to encourage a speedy recovery particularly in long term vulnerable patients. A radio at the nurse's station simply provides an additional confusing noise not a soothing or encouraging sound. Many patients have no idea there is a separate television or day room. Offers to take the patient there would encourage them to walk further and more frequently thus encouraging a speedier recovery.

NOTE: Could a Buddy System utilising volunteers able to visit specific patients on a regular basis possibly out of visiting hours be instigated to encourage conversation, concentration and stimulate interest?

- 2 The STEPS system is an excellent way of reintroducing the patient into their home, as well as giving an exhausted carer some opportunity to recover their energies. This service may need expansion to be more readily available to patients needing assistance after discharge as well as speeding up the discharge process.

- 3 There appears to be a problem with medication delivery from Pharmacy to the ward prior to patient discharge.

NOTE: If the ward is aware of the likelihood of discharge within the following 24 hours, would it not be helpful for all concerned if the prescription was sent through to Pharmacy at that time? This could reduce issues which arise when waiting for medication.

- 4 In many cases it is apparent at least 24 hours prior to discharge which patients are about to be discharged. Why can't the prescriptions be sent to Pharmacy at this point? This should result in the delivery of prescriptions to the ward in anticipation of discharge preventing any delay or possible bed blocking, thus ensuring the patient is ready for their transport home and there is no additional cost in delivering medication to the patient's home. It could also help ease the pressure put on Pharmacy at certain times of the day and give them a greater length of time to dispense a prescription (somebody needs to see what it is like to work in Pharmacy and observe the pressure they may be experiencing.)

- 5 There is obviously a problem around delivering a patient **into** their own home. If there is no carer, relative or friend to greet the patient upon arrival home then **who** is authorised to assist the patient into their home?