healthwatch Isle of Wight

No Place Like Home

A Healthwatch report on the discharge of patients from the IOW NHS Trust to residential care, nursing homes and people`s own homes on the Isle of Wight – December 2017

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The IOW NHS Trust and the IOW Clinical Commissioning Group for supporting Healthwatch Isle of Wight with this piece of work.

Summary - Getting it right first time

Effective discharge can not only reduce the chance of a readmission to hospital, but can make a huge difference to the health and wellbeing of the person concerned. Hospital discharge has been the subject of media attention for several years now and Healthwatch England conducted a special enquiry on the subject in 2015.

Healthwatch Isle of Wight`s predecessor (the Isle of Wight LINk) completed a piece of work around hospital discharge in 2012 and Healthwatch Isle of Wight decided to revisit this work, following concerns raised by care and nursing home managers and from domiciliary care providers in 2017.

Between the 14th May and the 21st June 2017, our authorised representatives contacted 77 residential care homes, 12 nursing homes and 23 care at home providers on the Isle of Wight. The representatives all asked to speak to the registered manager or, if they were unavailable, to the person in charge. Each person was then asked a number of questions relating to their residents experience of hospital discharge within the previous six months. We felt it important that the focus of the work looked specifically at recent discharges from the IOW NHS Trust to ensure the information we obtained was up to date.

The findings of this report are based around the discharge of 71 people who required social care support and who were discharged between November 2016 and May 2017. All of the discharges at night were from the A&E department, with no late night discharges from hospital wards. Mental health wards were praised for the comprehensive planning and quality of discharges

The majority of people discharged from hospital were dressed appropriately and with their dignity maintained, however, 13 managers and staff who answered the question felt that this was not the case.

"communication could improve between hospital and care agencies"

As in 2012, a significant proportion of the care/nursing homes and domiciliary care providers expressed the belief that the concerns highlighted in this report, the media and the community, stem from the hospital's rush to get the patient discharged. This seems to be reflected when we see that 19 people (30%) of managers reported that following the discharge, the person was readmitted to hospital with the same issue.

Delays in discharge were mainly attributable to people having to wait for medication from the pharmacy or having to wait for hospital transport to take them home.

The vast majority of care providers reported that they send written information in with the person they care for, including information about their general care needs, medication and other important information, however, a significant number of people who responded to the survey stated that hospital staff rang them frequently asking questions about the persons care. Several people stated that the information they sent in with the person had been `lost` in hospital.

Background

Healthwatch Isle of Wight is the local "consumer champion" for health and social care services. It was created in April 2013 through legislation bringing in a Healthwatch organisation in each local authority area of England. Feedback from the public is used to identify and share good practice and to highlight improvements that need to be made to health and social care services. Healthwatch Isle of Wight is supported by a team of paid staff and an enthusiastic and proficient group of volunteers.

Healthwatch Isle of Wight relates to all health and social care services funded for Isle of Wight residents. The principal focus of this report is `the discharge of people who were in receipt of social care support, primarily, those who live in residential care or nursing homes and those who are receiving care at home services.

The discharge of people from hospital has been the subject of media attention for several years, with the Times newspaper reporting in 2012 that hospitals are `throwing patients out of hospitals` late at night to free up beds. The newspaper estimated that each year, more than 400,000 patients are discharged between 11pm and 6am: many of whom could be elderly or vulnerable patients with inadequate care and support. Although the report included case studies of several patients who had been discharged

inappropriately, it failed to determine the reasons why people were discharged, what they experienced or how many of the discharges were in fact inappropriate.

In 2012, shortly after the publication of the Times report into hospital discharges, the Isle of Wight LINk (Local Involvement Network) completed a piece of work about the discharge of elderly patients to residential care homes, also focusing on late night discharges. This was in response to feedback from the public highlighting late night discharges and discharges where the person was not treated with dignity and respect. A report by the IOW LINk was subsequently published in 2013 and one of the themes identified from feedback received, was that that care homes were not always given sufficient notice by the IOW NHS Trust that the person was being discharged to their care. Issues were raised regarding the dignity of people being discharged particularly in regards to their clothing and poor communication between the hospitals and care homes was experienced by some care homes who took part in the survey.

In 2015 Healthwatch England conducted a special enquiry relating to hospital discharge, focusing on the experiences of older people, homeless people and people with mental health conditions. [1]With the help of 101 local Healthwatch, over 3000 people shared their experience of discharge. The enquiry recognised that when discharge goes wrong, it comes at significant cost, both to individuals and to the system.

In January this year, The IOW Local Safeguarding Adults Board identified hospital discharge as a priority, with the aim of developing a more co-ordinated multi-agency approach to discharge from hospital, both to improve outcomes for people and to promote continuous quality improvement in health and social care services.

There are many reasons why it is important for people to be discharged as quickly as possible from hospital. An Isle of Wight Health and Social Care System Discharge Policy was developed jointly by the Isle of Wight NHS Trust, the IOW Clinical Commissioning Group and the IOW Council in Sept 2016[2] It clearly states the potential consequences of a patient who is ready for discharge, remaining in hospital and this includes the following:

- Exposure to unnecessary risk of hospital acquired infection
- Physical decline and loss of mobility/muscle use
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available
- Increased patient dependence as the hospital environment is not designed to meet the needs of people who are medically fit for discharge

Studies have shown that For every 10 days of bed-rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80-years old, and reconditioning takes twice as long as this de-conditioning. One week of bedrest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence;

However, despite the wealth of facts and figures around the risks to people if they stay in hospital for too long, we are also fully aware of the risks of unsafe or poorly planned discharges. In May 2016, the Parliamentary Health Services Ombudsman (PHSO) wrote a report into unsafe discharge from hospital, highlighting nine cases where things went wrong, causing suffering and distress for patients, their carers and families.[3] This report makes it clear that poorly planned and executed discharges can be just as problematic for people as unnecessary delays and can cause significant and irreparable suffering to people. As the report stated; `Failures in these areas severely undermine peoples trust and confidence in the NHS`. The report tells the stories of 9 people who were not treated with dignity and respect and there was a failure to meet their basic human rights.

With this in mind, In Dec 2016, the National Institute for Clinical Excellence (NICE) produced a Quality Standard: `Transition between inpatient hospital settings and community or care home settings for adults with social care needs`.[4]

This set out to improve the process of hospital discharge by setting out some quality statements, which are the standards that health providers are expected to reach.

List of quality statements

NICE guidance and quality standards are aspirational but achievable standards that health and social care providers are expected to meet to improve people`s care and to ensure that standards are maintained in all parts of the country.

Statement 1. Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.

Statement 2. Older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.

Statement 3. Adults with social care needs who are in hospital have a named discharge coordinator.

Statement 4. Adults with social care needs are given a copy of their agreed discharge plan before leaving hospital.

Statement 5. Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

What Healthwatch Isle of Wight Did

Earlier this year, Healthwatch Isle of Wight decided to revisit the piece of work previously completed by the Isle of Wight LINk to identify whether improvements have been made to the IOW NHS Trust discharge process and to see whether people's experience of discharge is better. We had previously received mixed feedback from a number of care providers about the quality of the discharge process, so decided to look at the subject in more depth.

In May 2017 Healthwatch Isle of Wight held a series of planning meetings to review feedback we had received relating to hospital discharge, and this enabled us to determine the focus of the work.

Healthwatch Isle of Wight authorised representatives reviewed the questionnaire used by the IOW LINK in June – October 2012. It was decided that it would be useful for the same questionnaire to be used, to enable a direct comparison between the results obtained from care providers in 2012 and those obtained in 2017. One additional question was added: Care providers were asked if they routinely sent staff in with their residents when they were admitted to hospital

The authorised representatives then telephoned all residential care homes, nursing homes and domiciliary care organisations that are registered with the Care Quality Commission.

The questionnaires were anonymised and the results then analysed to identify themes relating to both good practice and areas needing improvement.

What Healthwatch found

Discharge Questionnaire

Between the 14th May and the 21st June 2017, our authorised representatives contacted 77 residential care homes, 12 nursing homes and 23 care at home providers on the Isle of Wight. The representatives all asked to speak to the registered manager or, if they were unavailable, to the person in charge. Each person was then asked a number of questions relating to their residents experience of hospital discharge within the previous six months. We felt it important that the focus of the work looked specifically at recent discharges from the IOW NHS Trust to ensure the information we obtained was up to date.

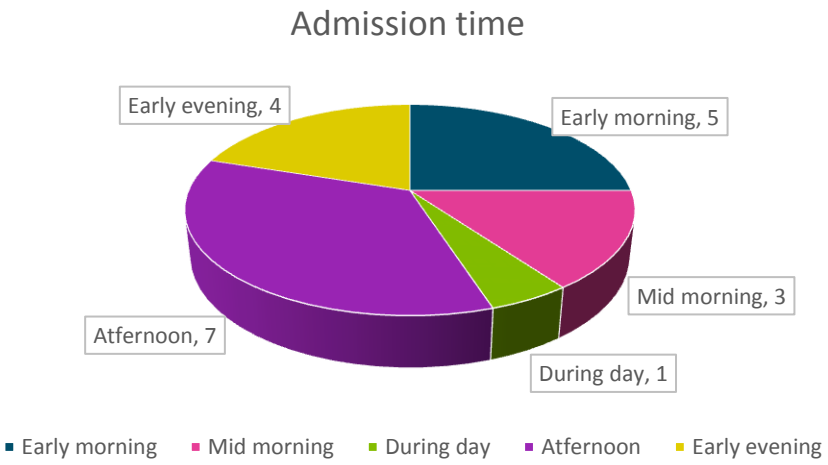
- Of the 12 Nursing homes, all 12 responded and had had discharges within the last 6 months. 5 nursing homes concentrated on 1 discharge and 7 mentioned multiple discharges.

- Of the 23 care at home care agencies we contacted, 15 responded to the survey. 4 had had no experience of discharge, 5 concentrated on 1 discharge and 6 discussed multiple discharges.

- Of the 77 residential care homes, 67 responded and of these, 18 had not had experience of discharge within 6 months, 1 item of feedback was not included in this report as it related to a mainland hospital, 36 related to 1 discharge, 4 gave two examples of discharge and 8 related to multiple discharges.

The findings of this report are based around the discharge of 71 people who required social care support and who were discharged between November 2016 and May 2017.

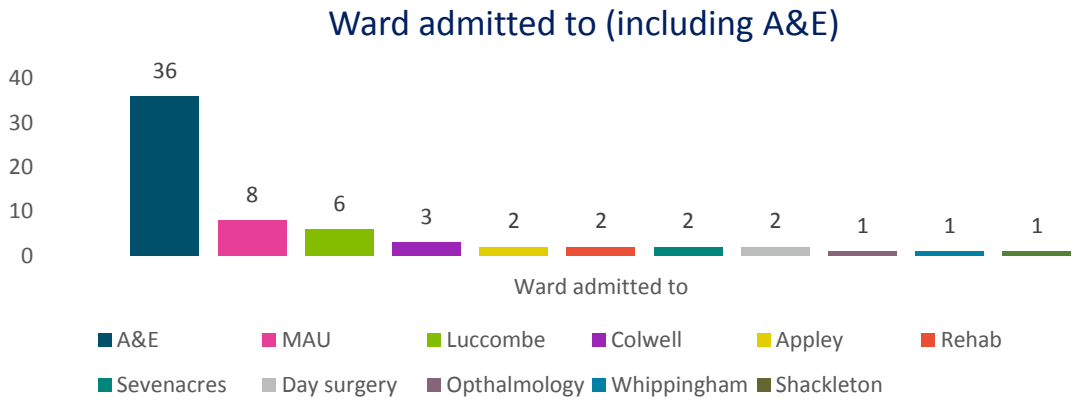
Question 1: What time and date was the person admitted to hospital?



The majority of admissions had taken place in May 17 (20), with one admission taking place in Dec 16 and one in Jan 17.

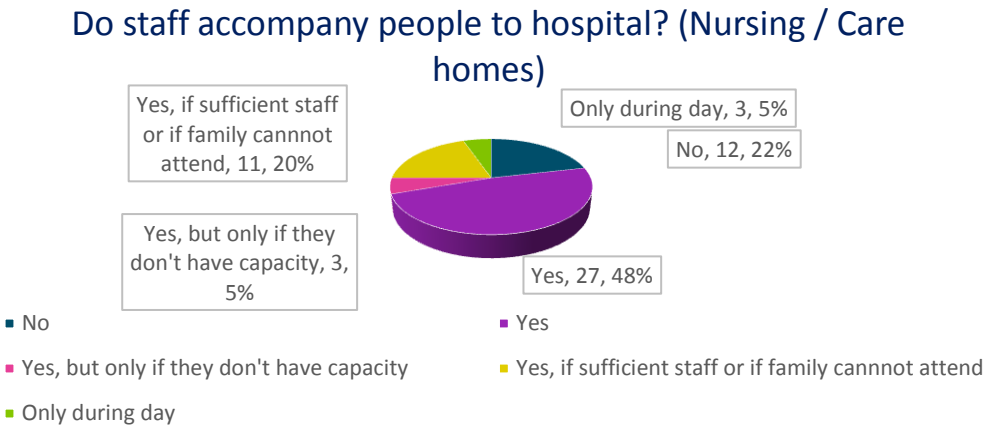
The most popular time of admission was during early afternoon and no one was admitted to a ward during the night (10.00pm – 8.00am). It is important to note that when people are assessed and /or treated at A&E, they are not seen as having been `admitted` to St Marys hospital, until they have been formally admitted to a ward ie MAU or Coronary Care Unit, therefore this question relates only to the time and date that people were formally admitted to a hospital ward, rather than A&E.

Question 2: What ward was the person admitted to?



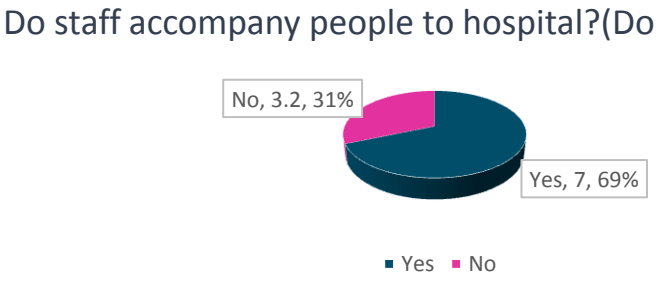
The vast majority of the people we surveyed who attended the IOW NHS Trust, went only to the A&E department (36) and 28 people were admitted to wards as specified above.

Question 3: Does a member of staff accompany the person to hospital?



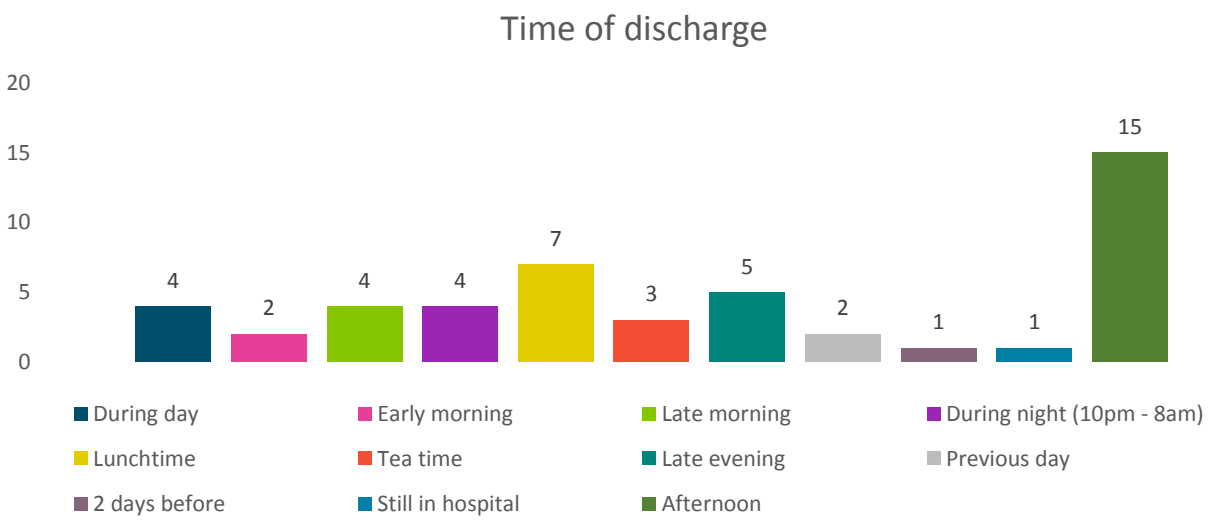
Most registered managers or senior staff member within the care and nursing homes who answered this question, said that they would always try to send staff to accompany residents to hospital, although 12 homes confirmed that they would not routinely send staff with people. 3 providers said that they would only send staff if the person lacked capacity. A significant number of homes described the difficulty they face in releasing staff when a resident is admitted to hospital at night due to lower staffing levels and difficulties in releasing staff, and we found that most homes will with liaise with residents family and friends to ensure they have the opportunity to accompany the person to hospital if this is their wish.

`Yes if the resident isn't reliably able to give a history a member of staff always goes with them. If it is in the night the manager is called and meets the resident at the hospital`.



Of the care at home managers or senior staff who answered this question, 7 providers stated that they would accompany service users to hospital, while 4 stated that they would not. Several agencies reported that family members usually accompany their relative to hospital.

Question 4: What time was the person discharged?



This question relates to the time that people were informed that they were ready to be discharged, not the time they left the hospital.

It should be noted that 2 people had been ready to be discharged the day before they returned home and one person had been ready to be discharged two days prior to returning home. At the time of our survey, one person was still in hospital, having been readmitted.

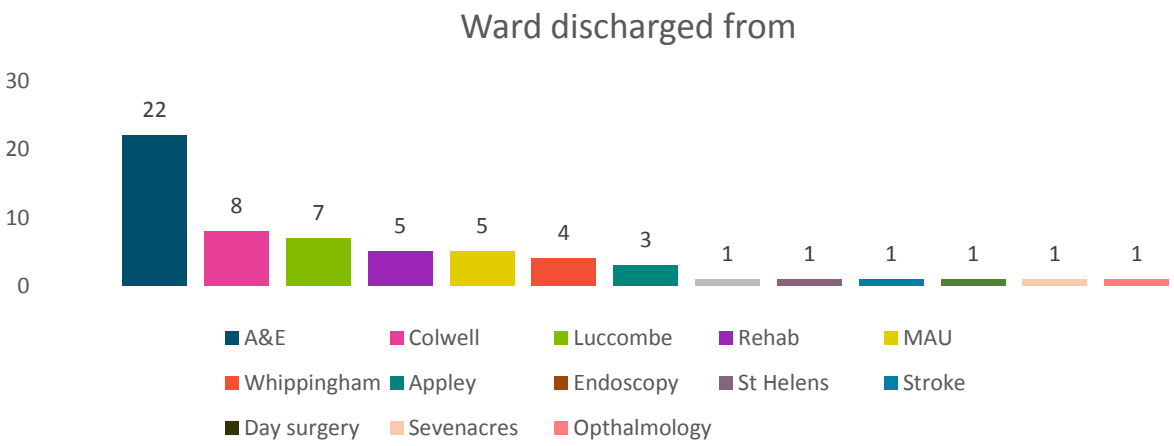
All of the discharges at night occurred from the A&E department, with no late night discharges from hospital wards. Mental health wards were praised for the comprehensive planning and quality of discharge.

Several people commented that it was usual for people they support to be discharged at night.

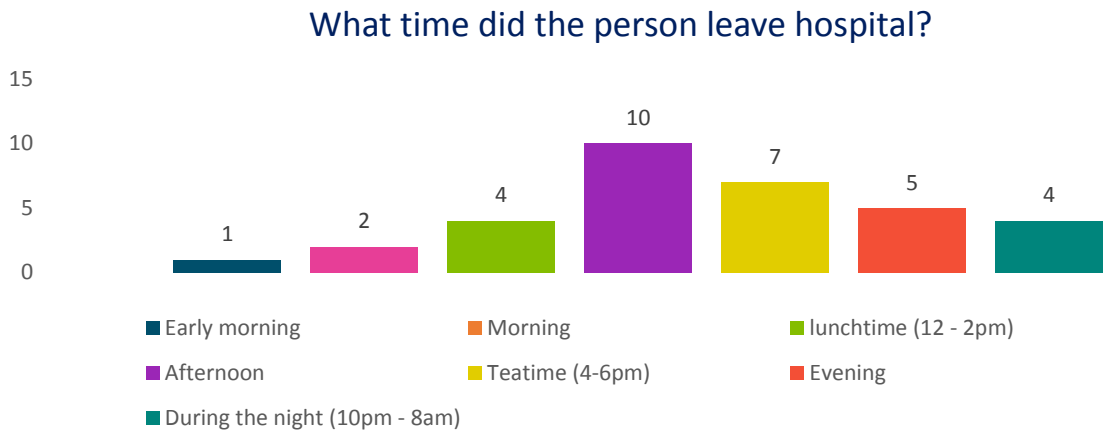
`If they are discharged from A&E, then this can be any time, day or night`

However, the two examples which related to discharges from mental health services received very positive feedback, with good planning and communication with care providers seen as good practice. Several homes said that they would not accept discharges after 6.00pm due to the fact that they often need time to arrange for specialist equipment (such as a pressure relieving mattress) and sufficient staffing levels, to ensure they can safely meet the person's needs.

Question 5: What ward/department was the person discharged/sent home from?

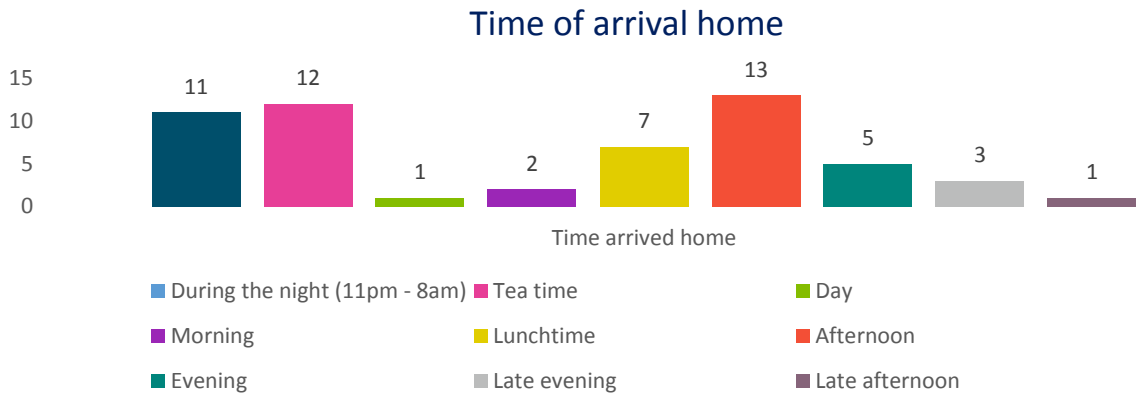


Question 6: What time did the person leave hospital?

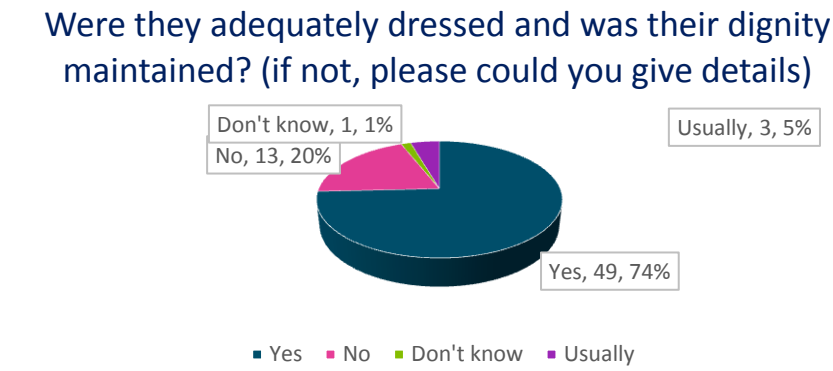


The majority of people left hospital during the afternoon.

Question 7: What time did the person arrive home?



Question 8: Was the person adequately dressed and their dignity maintained? (if not, please could you give details)



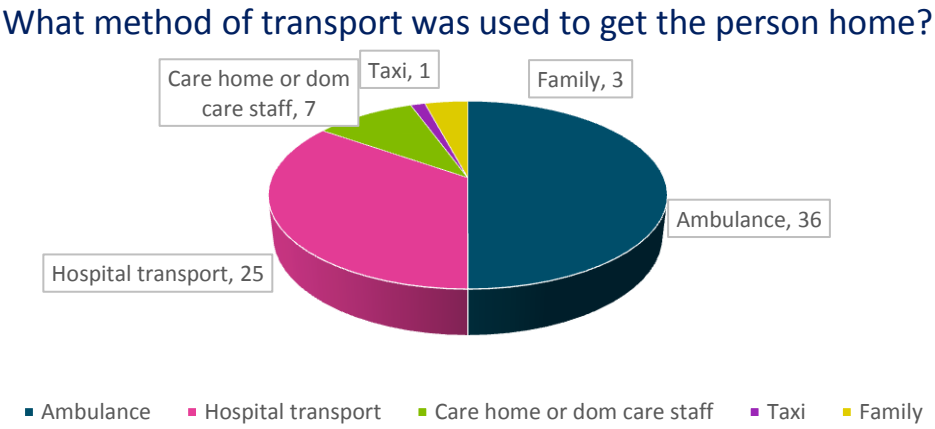
`Very cold, not adequately dressed`

`usually discharged in nightwear`

`Not appropriately dressed - discharged in night clothes. No incontinence pads, no underwear`

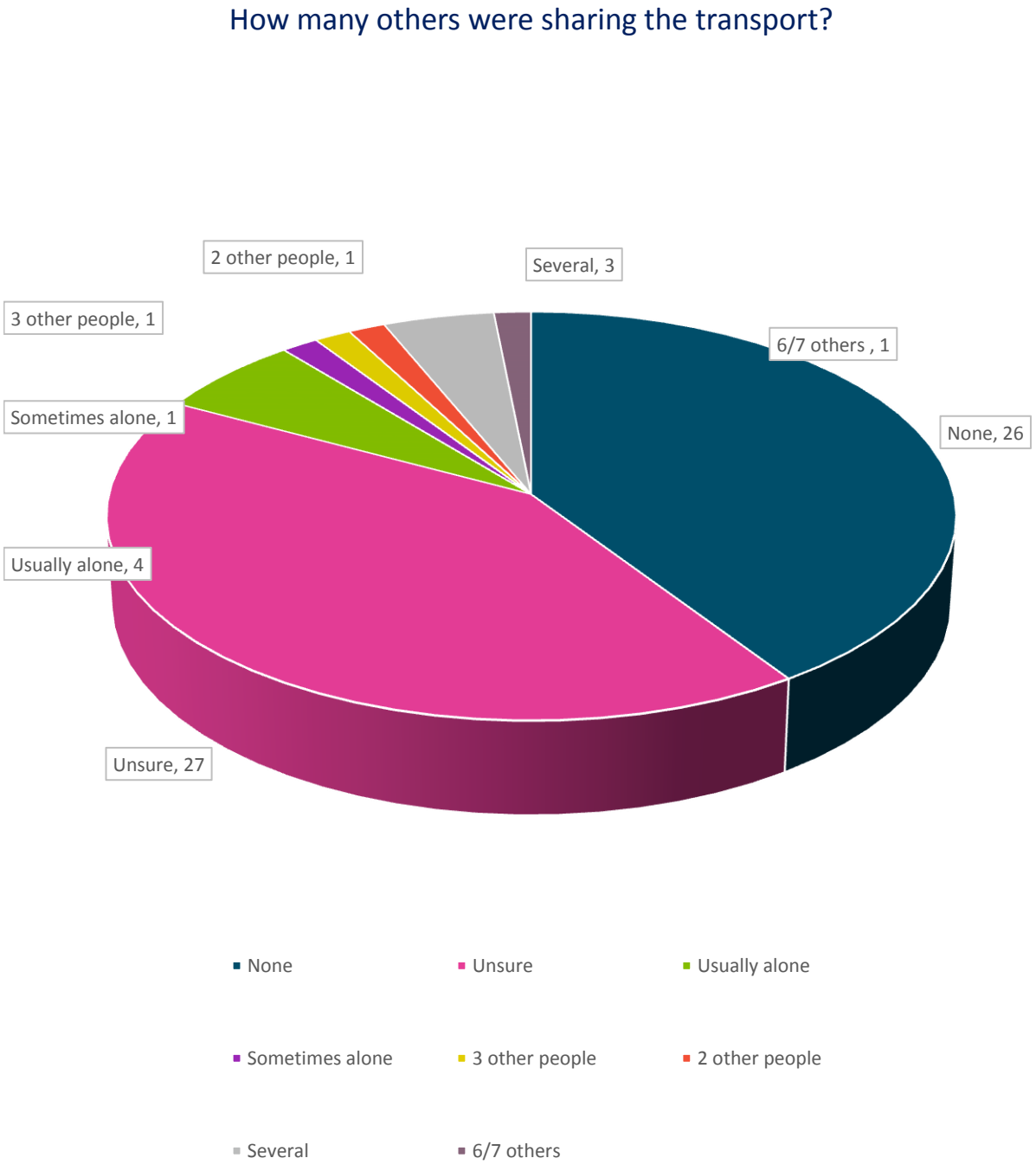
The majority of people discharged from hospital were dressed appropriately and with their dignity maintained, however, 13 managers and staff who answered the question felt that this was not the case.

Question 9: What method of transport was used to get the person home?



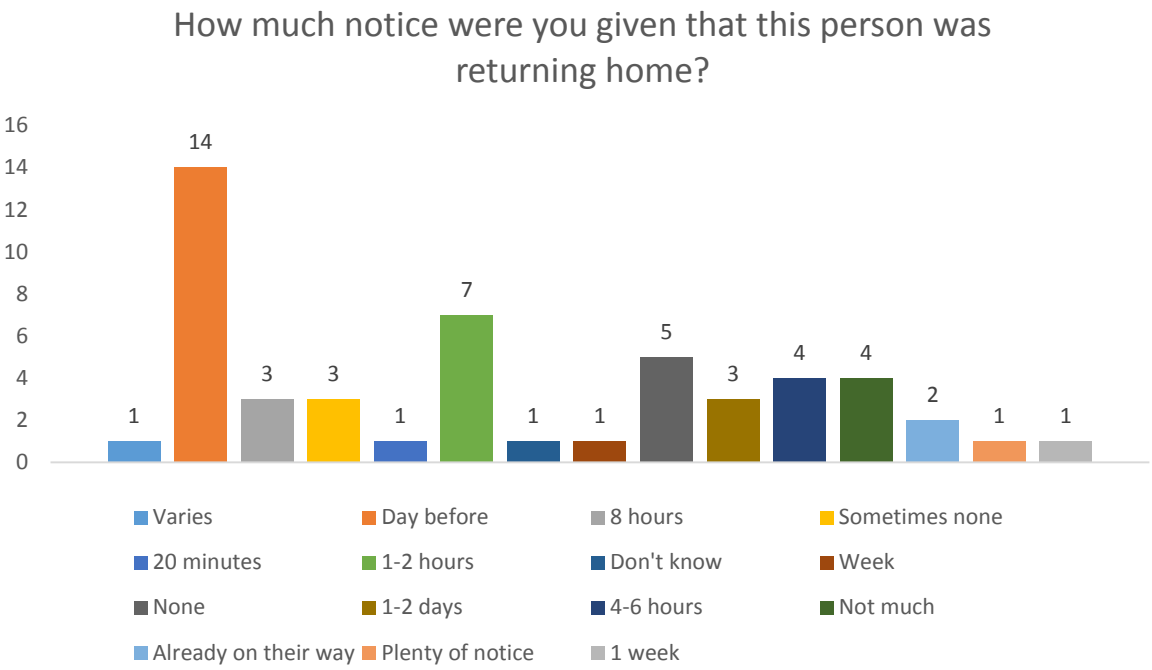
The majority of people were taken home via hospital transport. One person reported that the person with dementia was sent home in a taxi. The care home paid the taxi fare.

Question 10: How many others were sharing the transport?



`Sometime in day time (they are) with a patient going to a different home. At night normally one patient alone`.

Question 11: How much notice were you given that the person was returning home?



`We have to ring every morning to find out who will be home`

`None when being discharged form A&E. When being discharged from the ward can be a few hours`

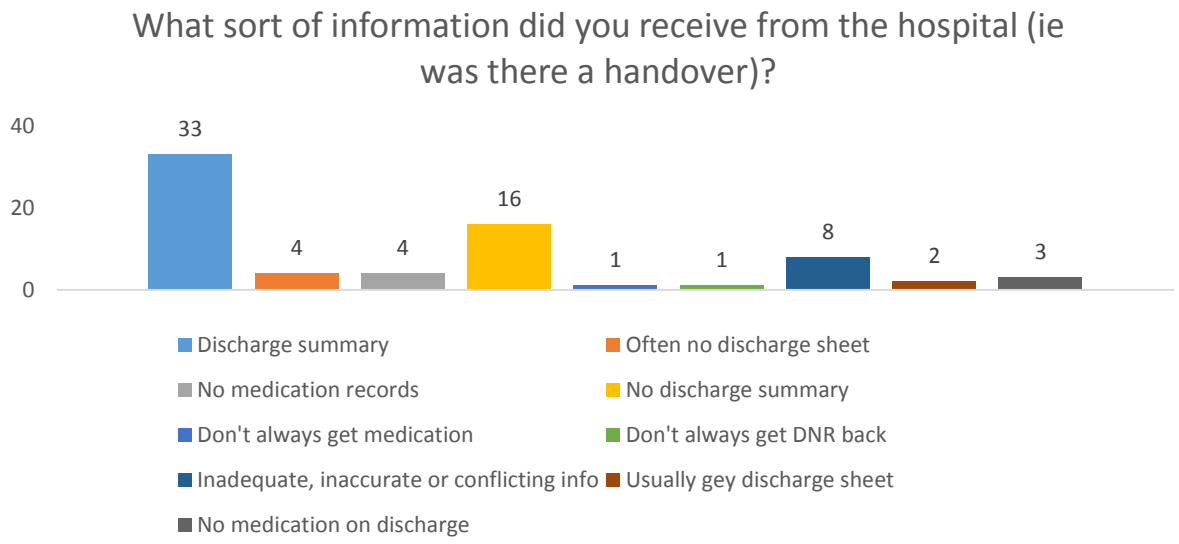
`Hospital calls in morning - more delays due to hospital not guaranteed a transport time and there are frequent delays with medication `.

Several care at home providers noted the difficulty they face in organising staff with just a few hours notice.

`Often just hours notice, so no carers in place.

Question 12: What sort of information did you receive from the hospital (i.e. was there a handover)?

`Received notes but could not read them/ discussed with nurse. Had discharge summary and medication list`

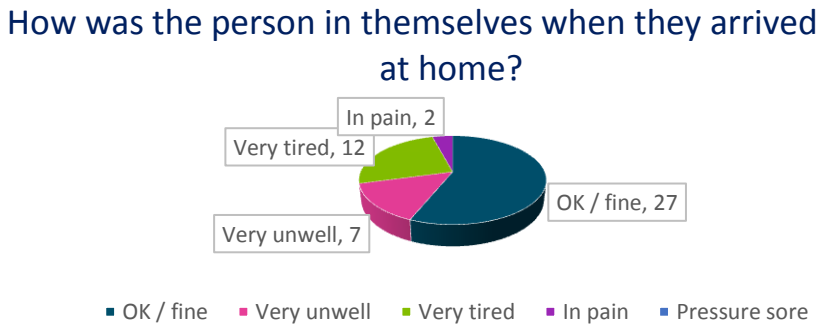


Less than half the people who answered this question said that they received a discharge summary sheet. A discharge summary sheet contains important information relating to a persons stay in hospital and may include information about what they were admitted to hospital for, the results of any tests they had, any treatment they received, any changes to medication and what follow up treatment if any is required. Within the Isle of Wight Health and Social Care System Discharge Policy Dec 2016, it states that: A copy of the discharge summary should be made available to the person`s GP within 24 hours of their discharge and a copy should be given to the person on the day they are discharged.

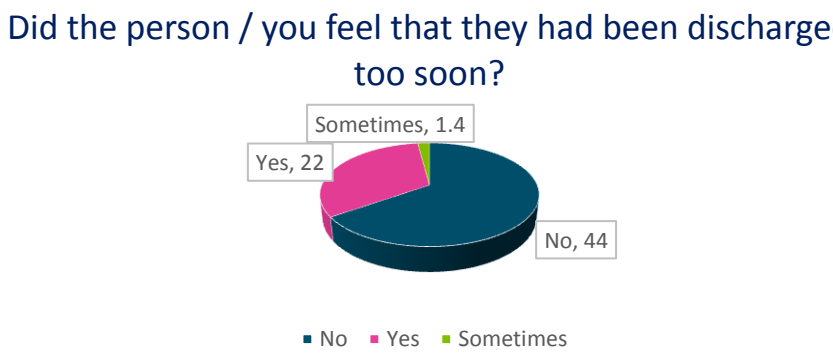
`No information received either written or verbal`

One person who has diabetes, was discharged from hospital without any insulin. Another care or nursing home manager explained the problems encountered when people are discharged late in Friday evening, particularly if they have not previously been a resident of the home. If the person becomes unwell and needs medical attention they are 'out of area' for their own GP, the care/nursing homes' only recourse is to contact 111 for advice which is problematic if they do not know the person well.

Question 10: How was the person in themselves when they arrived back home?



Question 14: Did the person/you feel that they had been discharged too soon?

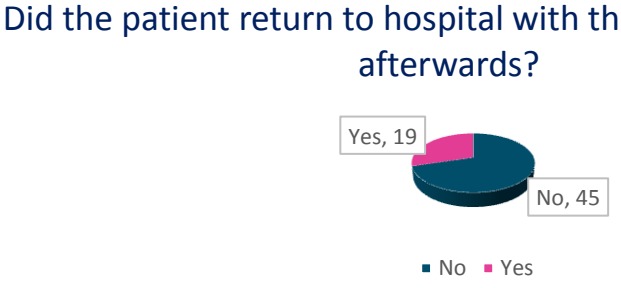


'They are putting people's lives at risk.

"Discharge can be rushed and they sometimes want to discharge them before they are medically fit".

"We send their medication in with them, but sometimes when they are discharged, we notice that there are missed doses.

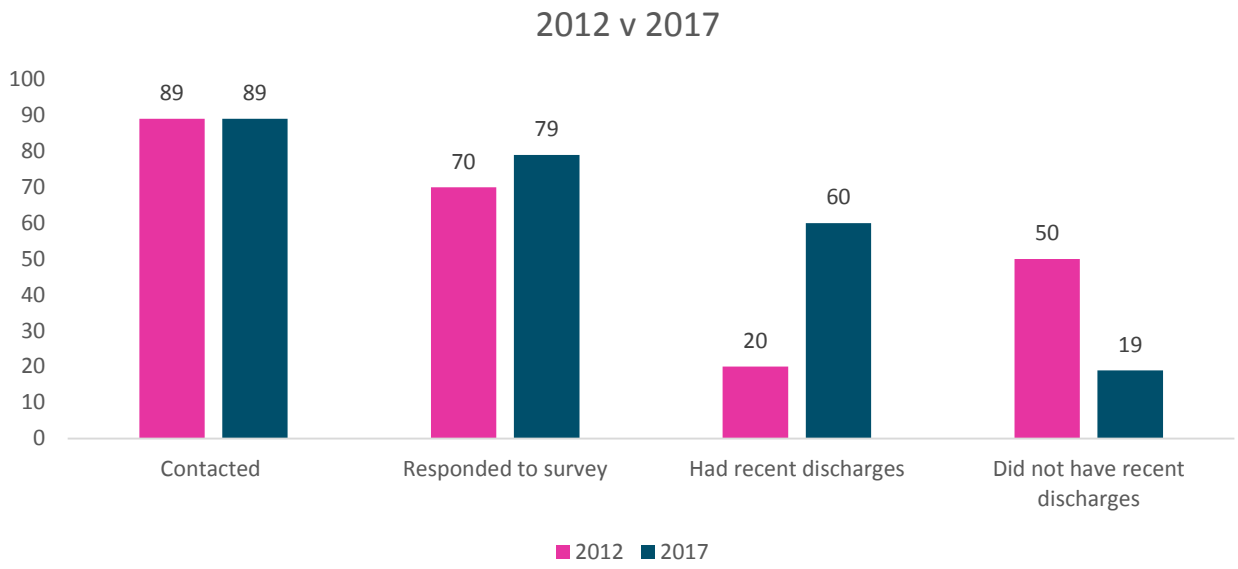
Question 15: Did the person return to hospital with the same issue soon afterwards? (please provide details)



Comparison with LINk 2012 survey results

In 2012, the IOW LINk representatives contacted 89 care and nursing homes. Of those, 70 (78%) responded to the questionnaire.

- Of the 70 that responded, 50 (71%) had not recently had any of their residents admitted to hospital.
- This left 20 care homes (29% of those that responded) who had recently had residents discharged from hospital late at night, and who answered all or part of the questionnaire.



In 2017, Healthwatch Isle of Wight representatives contacted 89 residential care and nursing homes and 23 care at home providers. For the purpose of this comparison, we will be looking only at the results obtained from care and nursing homes

- Of the 89 care and nursing homes, 79 responded (89%) and of these, 61 had had discharges within the last 6 months, although one was not included in this report as the feedback related to another hospital.
- This left 60 care or nursing homes (76% of those who responded) who had recently had residents discharged from hospital and who answered all or part of the questionnaire.

Main Findings in 2012 and 2017

- In 2012, 20 care homes (29% of those who responded) had recently had residents discharged from hospital late at night, the times of early evening/late night discharges ranged from 6pm – 4.30am.

  In 2017, 11 (14% of those who responded had recently had residents discharged from hospital late at night and the times of early evening/late night discharges ranged from 9.45pm – 3am.

- In 2012, of the 10 care homes who provided the time of their residents' discharge from hospital and the time of their return to residential care, the average waiting time between the two was 74 minutes. Though the range of times was very large, the quickest time from discharge to care home was just 15 minutes, whilst the slowest time was 210 minutes (three and a half hours).

  In 2017, of the 20 care or nursing homes who provided the time of their residents discharge, the average waiting time between the time of discharge and their arrival home, was 119 minutes (almost two hours). The quickest time was 30 minutes and the slowest time was 9 hours. The main causes of delay were cited as people having to wait for transport to take them home and having to wait for medication to be dispensed from the hospital pharmacy.

- In 2012 of the 15 responses to the question as to whether the residents' dignity was maintained when they were discharged, 9 (60%) stated dignity was maintained and 6 (40%) stated that dignity was not maintained.

  In 2017, of the 50 responses, 39 (78%) stated dignity was maintained and 11 (22%) stated that dignity was not maintained.

- In 2012 an ambulance or hospital transport was used to return residents in all but one case, though this one case involved an off-duty care home nurse having to use her own car to pick up a resident from hospital.

  In 2017, 48 residents were taken home by hospital transport (usually by ambulance), 5 were collected by staff, 1 was taken home by a family member and 2 took a taxi back home.

- In 2012 of the 8 responses to the question, how much notice was the care home given that their resident was being discharged from hospital, the average time was 77 minutes. Two care homes reported that they had no notice whatsoever and the greatest amount of notice was 4 hours.

In 2017, of the 43 responses to the question, 15 care or nursing homes said that they had been notified the day before, 14 had been given a few hours notice and 6 had been given no notice. The greatest amount of notice was 1 week.

- In 2012, Of the 20 responses to whether a handover took place between the hospital and the care home and what form it took, 3 (15%) stated no handover had occurred at all, whilst 17 (85%) stated that some sort of handover had occurred. Of these 17, the main form of handover was the receiving of discharge papers or Doctor's notes.

  In 2017, of the 55 responses to this question, 42 (76%) had received some form of handover, with the vast majority having received a discharge summary sheet. 13 (24%) received no handover.

- In 2012 Of the 19 responses to the question whether the care home thought that their resident had been discharged too soon, 6 (32%) responded Yes and 13 (68%) responded No.

  In 2017, 15 said yes, 36 said no.

What has changed since 2012?

- The number of people being discharged at night has reduced from 29% to 14% and this is more significant given the fact more people responded to the survey in 2017.
- More people are being treated with dignity, with numbers rising from 60% - 78%.
- In 2017, more people were taken home by a variety of means other than hospital transport, including paid care staff, taxi and family members.
- The number of people given no notice of discharge was reduced from 25% in 2012 to 14% in 2017.
- Slightly less care and nursing home managers/staff thought that the person had been discharged from hospital too soon, with percentages reducing from 32% to 29%.

Conclusion

The IOW NHS Trust, the IOW CCG and the IOW Council have worked tirelessly to reduce delayed transfer of care numbers on the Isle of Wight and latest figures from NHS England show the Isle of Wight is one of the top five areas for hitting targets and improving their delayed transfer of care (DTOC) targets.

We have many reasons to celebrate, with more people being treated with dignity and respect and with more notice being given of discharge. However simply transferring people to a more appropriate environment is not enough. It is essential that all people discharged from hospital are done so in an ordered and safe way and at an appropriate time. There are still vulnerable people who are arriving home in the middle of the night with no support.

Several care and nursing homes reported that although they had sent medication in with the person they support, the hospital staff had not sent any back home with them. This meant that there may have been a delay in giving someone their medication because many care and nursing homes do not keep additional stocks of medication. Two care or nursing home managers also reported that they were not given any information about when the person they support had last been given medication in hospital. This meant that they had to delay in administering pain relief due to the risk of overdose and this is not acceptable.

Care and nursing home and domiciliary care managers indicated that in order for them to provide a consistently good quality of care, they must be provided with enough information about treatment and medication provided to the person in hospital. Discharge notes should be clear and information such as anticipatory care plans and DNACPR forms should be returned with the person.

When discharges did go well, they were always well planned in advance, with effective communication between the hospital ward staff and care home or domiciliary care staff. Discharges from mental health wards were particularly noted as positive examples.

Recommendations

Healthwatch Isle of Wight recommends the following for the Isle of Wight NHS Trust:

1. All people with care and support needs should be discharged with a comprehensive discharge summary, with a copy given to the person and to the care provider at the point of discharge.
2. Sufficient medication should be given to the person to take home on discharge and care providers should receive an up to date record of the time and date of the most recent administration of medication at the IOW NHS Trust. This is essential to ensure people receive the right medication at the right time and to ensure that no one is left in pain.
3. People should be dressed appropriately on discharge and able to wear day clothing if this is their wish.
4. Care providers should be given appropriate notice of discharge to enable them to be able to meet the needs of the person and acquire the necessary equipment etc.
5. All necessary paperwork should be discharged with the individual, including any advance care plans, DNACPR forms etc.
6. Information sent in to the hospital by care providers must go with the person if they move from one department of the hospital to another to ensure continuity of care
7. The discharge procedure should be reviewed to ensure that vulnerable patients are checked regularly when waiting for transport or medication. Sufficient food and drink should be made available to them and medication given as prescribed

Healthwatch Isle of Wight look forward to working closely with the IOW NHS Trust to monitor performance against recommendations.

References

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http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/final_report_healthwatch_special_inquiry_2015_1.pdf

[2] The Isle of Wight Health 7Social Care System Discharge Policy

http://www.iow.nhs.uk/Downloads/Policies/Isle%20of%20Wight%20Health%20and%20Social%20Care%20System%20Discharge%20policy.pdf

[3] A report of Investigations into unsafe discharge from hospital by the PHSO

https://www.ombudsman.org.uk/sites/default/files/page/A%20report%20of%20investigations%20into%20unsafe%20discharge%20from%20hospital.pdf

[4] NICE Guidance Dec 2015 `Transition between inpatient hospital settings and community or care home settings for adults with social care needs`

https://www.nice.org.uk/guidance/ng27/chapter/Recommendations#discharge-from-hospital