healthwatch
Blackburn with Darwen

‘Discharge experiences of vulnerable adults to a residential care setting’

April to June 2019

Disclaimer:

This report is not representative of all service users with a dementia who have been discharged from Royal Blackburn Hospital to a care home setting. It is an account of those service users who chose to share their experiences with Healthwatch Blackburn with Darwen either through direct engagement, completing questionnaires or by electronic means.

This additional engagement is an appendage to the report ‘A Dementia Friendly Discharge from Hospital’.

Contents

Rationale

Healthwatch BwD have undertaken these engagements as an extension of a previous project **'A Dementia Friendly Discharge from Hospital'.** It was identified in one case study that communication in the transition from secondary to residential care could have been improved.

Healthwatch BwD wanted to gather the discharge experiences of vulnerable adults and their family members to two residential care settings to ensure that their views are also represented in the transition from secondary to primary care.

Methodology

Enter and View visits were arranged to two care homes in Blackburn to look at the service and speak to residents and care home providers about their experiences of the hospital discharge process.

Healthwatch Representatives also made a second visit to meet with family members, over a 'cake and coffee', to discuss how they experienced the discharge process of their loved one.

Three separate questionnaires were used to support conversation from each perspective.

A third provider was also invited to provide feedback on their experiences but were experiencing a very busy period and therefore were unable to provide feedback.

Two providers engaged and responded with Healthwatch BwD representatives, as did five family members and ten residents in total.

Acknowledgements Thank you to the care home providers and family members who supported us to gather the experiences of vulnerable adults who were discharged back to a care home setting, providing valuable insight into the transition from acute to regulated care.

Summary of hospital discharge experiences:

From the perspectives of the patient/resident, family and care home provider

On the whole residents, family members and providers indicated that they were mostly satisfied with the discharge process and that the time of discharge was usually appropriate.

The main themes for improvement across all perspectives were that residents, family members and providers wanted adequate and more timely notice prior to discharge from hospital. They also wanted improved communication at the point of discharge.

The main issues raised have been highlighted below.

- More notice about discharge to allow for better communication with family members. i.e. not at 'short notice' and 'rushed'.
- Discharge meetings taking place when told that they would happen.
- Keeping patients informed about their discharge and when it is happening.
- Taking care of patients' personal possessions in the transfer process, especially teeth and spectacles.
- Ensure that the hospital contacts the home prior to discharge and with some notice.
- Avoid delays in discharge summaries and information, to ensure continuity of care from the hospital setting to the home.
- Professionals working more closely together.

Discharge experiences:

Feedback from Residents

Most of the respondents (8/10) said that their wishes were considered in discharge planning and that they felt involved. This was also reflected in the report 'A dementia friendly discharge from hospital' report.

Five respondents (half) said they were kept informed about their discharge and what was happening. Four said they were not kept informed, being told at short notice that they were being transferred to the home for further rehabilitation. One person said they had not been kept informed about continuing medical treatment on discharge to the home by either the hospital or the care home staff.

"I was given short notice that I was being discharged due to a shortage of beds".

"I was not informed when my discharge was going to take place".

Almost all (8/10) respondents said that they were discharged to the home at a suitable time, mostly before 6pm.

Almost all (8/10) respondents said that their personal belongings arrived at the home with them but one person said that they arrived six days later.

One respondent felt that discharge information was delayed to the extent that it had an impact on their wellbeing. Continuing treatment decisions could not be made by the GP or care home staff without the information.

Another resident discussed their concerns about treatment they were still having following their discharge from hospital. They said that they were unsure about the treatment and had been told by hospital staff that it would discontinue once at the home. Unfortunately, this had not happened due to a delay in discharge information. We were informed by the care home that they are this 'chasing up' this information.

There is an apparent delay in the GP also receiving the resident's discharge notes following her hospital stay which is said to be hindering the GP and care home staff from making decisions about the post discharge treatment. The resident told a Healthwatch Representative how this was impacting on her overall mood and wellbeing. "It's making me feel really fed up and upset".

"The hospital-based doctor responsible for the person's care should ensure that the discharge summary is made available to the person's GP within 24 hours of their discharge. Also ensure that a copy is given to the person on the day they are discharged." (NICE Guidelines).

Summary of patient/resident feedback

On the whole most respondents expressed that they were satisfied with their discharge experience but felt that it could be improved by: -

- Keeping the patient informed about their discharge, giving adequate notice so that it is not rushed and keeping the patient informed when it is actually going to happen.
- Avoiding delays in forwarding treatment discharge information from the hospital.
- Looking after personal belongings in transfer to the home.
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"All went smoothly. My care and physiotherapy were arranged on discharge to the home".

"I was given a few days' notice that I was being discharged due to a shortage of beds".

Discharge experiences from family members:

Summary

Most of the five family members who spoke to us said that they were generally satisfied with the discharge experience from the hospital to the care homes with discharge times being appropriate. However, some family members expressed that some things could have been better, such as,

- More notice about discharge to allow for better communication with family members. i.e. not done at 'short notice' and 'rushed', and 'discharge meetings taking place when staff have indicated that they would happen'.
- Agencies working more closely together.
- One family member said that the long wait for the ambulance to transfer her husband back to the care home was stressful for both of them due to his advanced dementia.
- Taking care of patients' personal possessions such as teeth and spectacles, the loss of which is costly to the patient and family but can also have a negative impact on the person's wellbeing.

"It was a positive experience at the hospital and the discharge except that the hospital lost his dentures. I would have to take him to a dentist outside the care home which would be very unsettling and I don't think he would allow the dentist to fit him for new ones due to his advanced dementia. He now cannot chew which is disappointing as he really used to enjoy his food".

"Overall it was a positive experience but some things could have been better".

"Overall it was a positive experience, it went smoothly and my mum's discharge notes came with her from the hospital".

Discharge experiences for Care Home Providers:

Three care home providers were asked the following five questions regarding their experiences of patient/resident discharges from Royal Blackburn Teaching Hospital to their services. Two providers gave the following feedback. A third care home was not able to provide feedback to the questionnaire due to time constraints.

1. Do the hospital staff managing the discharge of a resident/patient to the home involve the home in the discharge arrangements?

One care home provider said that they were sometimes involved in the hospital discharge arrangements of a patient/resident to the home but not always. Occasionally they can get a call saying that the resident has been discharged and on route to the home without any prior notice. The second provider said that they were mostly involved with the discharge arrangements but that the hospital sometimes try to discharge back to the home before the patient is ready.

"Sometimes you ring the ward to enquire about a resident to be told that they have already been discharged".

"The hospital sometimes tries to discharge people early before they are back to baseline."

2. Are you contacted by the hospital prior to the resident being discharged from the ward to the home?

Both providers said that they were only 'sometimes' contacted by the ward informing them that the patient/resident was being discharged and, were on their way, back to the home.

3. Do residents/patients usually arrive at the home at an appropriate time?

Both care home providers said that they were mostly satisfied with the time that patients/residents arrived back at the home following discharge from hospital, normally before 6pm.

"If I explain to the ward staff to try not to send the patient/resident too late they tend to arrive before 6pm".

"The hospital now knows that we will not accept discharges after 8pm".

4. How satisfied are you with the level of information you are given in the discharge summary about the resident?

e.g. Medication, mobility, escalation plans, managing conditions etc.

One provider felt that the information given on the discharge summary including medication, mobility, escalation of plans and managing any conditions, was not as informative as it should be.

For example, the patient's mobility is not always as good as stated, which is not helpful in terms of organising staffing levels. The second provider said that they were mostly satisfied with the information they received from the hospital discharge summary was said to be 'usually very thorough.'

"Medications are fine when they are all sent".

"A patient/resident's mobility is sometimes on the discharge summary but not always".

"Managing the patient/resident's condition is not on the discharge summary".

"Sometimes residents come back without a discharge summary but when contacted a discharge summary will be faxed over".

5. How satisfied are you with timeliness of the discharge summary once you have received the resident to the home?

One care home provider said that the discharge summary mostly came with the patient/resident to the home, however from talking to a resident this would not appear to always be consistent. The second provider did not respond to this question.

In a discussion with a care home manger and relative for the report 'A Dementia Friendly Discharge from Hospital', information was said to sometimes be delayed or inadequate.

"The discharge summary mostly comes with the patient/resident to the home".

Summary

No significant issues were raised by the care home providers who said that they were mostly satisfied but some things could be better such as: -

- Ensure that the hospital contacts the home **prior** to discharge and with some notice.
- Be realistic about the patient's abilities so that appropriate levels of staffing can be organised at the home.
- Discharge summaries and information should to be sent with the patient to the home and within 24 hours of discharge.

Healthwatch Blackburn with Darwen Recommendations:

1. The hospital should give adequate notice about a patient pending discharge to allow time for effective communication with family members and the care home receiving the patient. i.e. not done at 'short notice' and 'rushed' and should not be determined by 'bed shortages'.
2. Discharge meetings should take place when relatives have been told that they would happen.
3. Keep patients informed about their discharge and when it is happening.
4. Ensure patients' personal possessions are with the patient on transfer especially teeth and spectacles. The introduction of the Red Bag scheme is an excellent initiative to keep peronal possessions and information with the patient throughout their hospital to care home journey.
5. Improve communication with care home managers receiving patients from hospital such as: -

- Ensure that the hospital ward contacts the home as soon as they know what time the patient is due to be discharged and not when they are in transit.
- Avoid delays in discharge summaries and information, to ensure continuity of care from the hospital setting to the home.

References:

Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline. Published: 1 December 2015. nice.org.uk/guidance/ng27

Beyond Barriers: 'How older people move between health and social care in England'. Care Quality Commission July 2018.

A Dementia Friendly Discharge from Hospital. 2018-19 Healthwatch Blackburn with Darwen