healthwatch
Stockton-on-Tees

University Hospital of North Tees Delays to Patient Discharge Report

April 2016

Introduction

Healthwatch Stockton-on-Tees

Local Healthwatches have been set up across England to create a strong, independent consumer champion with the aim to:

- Strengthen the collective voice of citizens and communities in influencing local health and social care services to better meet their needs.
- Support people to find the right health and social care services for them by providing appropriate information, advice and signposting.

Healthwatch Stockton-on-Tees works with local people, patients, service users, carers, community groups, organisations, service providers and commissioners to get the best out of local health and social care services. This doesn't just mean improving services today but influencing and shaping services to meet the needs of the local communities tomorrow.

Healthwatch Stockton-on-Tees is steered by a Board of volunteers, commissioned by the Local Authority and accountable to the public. Healthwatch Stockton-on-Tees are the only non-statutory body whose sole purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak-out on their behalf.

Healthwatch has:

- The statutory right to be listened to; Providers and Commissioners must respond to Healthwatch within 20 days of submission of requests for information or reports.
- The statutory power to Enter & View publicly funded health and social care services.
- A statutory seat on the Health and Wellbeing Board.

Rationale and Purpose of the Visit

Following the work completed by Healthwatch Stockton in 2014 on 'Arrangements for Discharge' from the University Hospital of North Tees, the report stated that further work would be carried out investigating transport arrangements following patient discharge. The report explained that this work was a confirmed project on the 2015/16 work programme.

For reference please follow the link and see Executive Summary:
http://www.healthwatchstocktonontees.co.uk/sites/default/files/final_report_discharge_from_hospital_0.pdf

Aim:

- **To establish and determine to what extent, transport arrangements are causing delays in patients going home following discharge.**

Objectives:

- **Research and gain an understanding of the hospitals transport arrangements including what policies and procedures must be followed, expected waiting times and when staff can notify the patient about their transport.**
- **Healthwatch staff planned to have conversations with patients / relatives / carers etc. to gather intelligence regarding patient experience and waiting times for patient transport following discharge.**
- **Analyse feedback and determine what, if any recommendations can be made to improve patient experience and reduce waiting times for patient transport.**

Methodology

Healthwatch staff arranged a meeting with University Hospital of North Tees Trust staff to discuss conducting the proposed work. An agreement was made to carry out this work in the discharge lounge for one week to gather evidence of patient experience.

Healthwatch staff designed prompt questions to instigate conversations with staff, ambulance drivers, patients, family members and carers in the discharge lounge. Healthwatch staff and volunteers also observed the environment, processes and times scales in the lounge throughout the week.

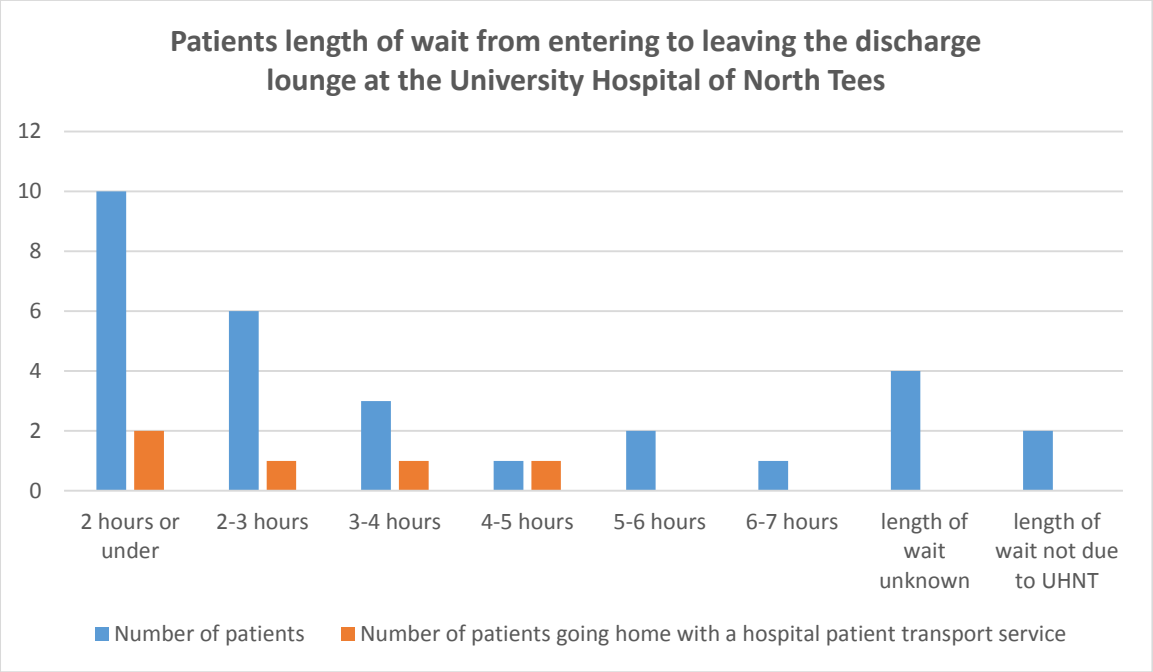
Following analysis of the feedback gathered, Healthwatch will provide recommendations to the Trust to improve patient experience throughout the discharge process.

Results

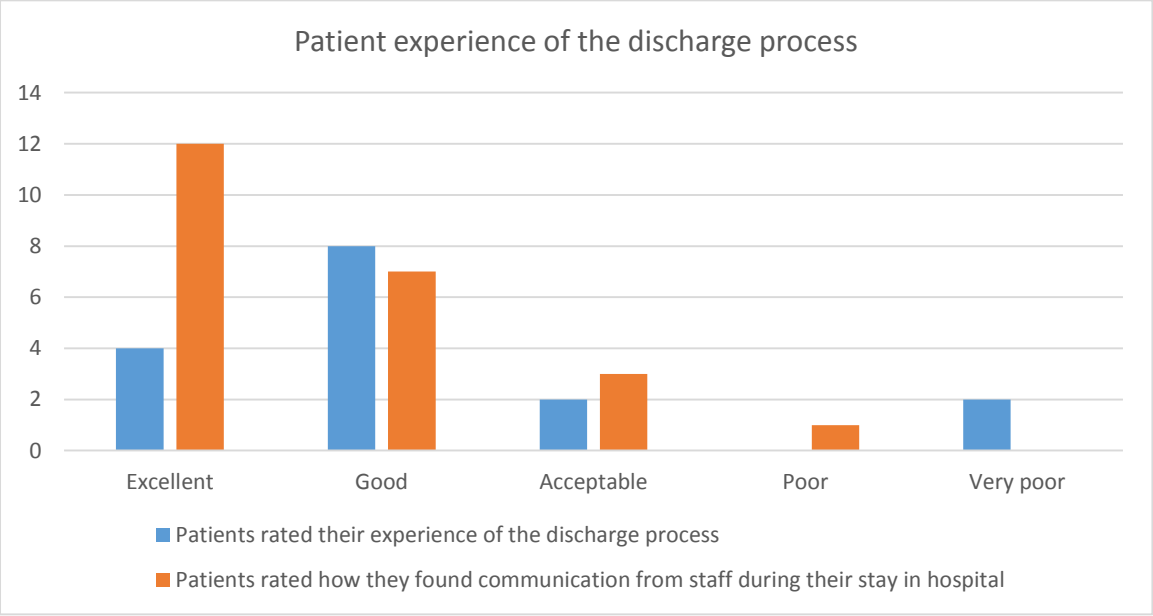
Patient Feedback

Healthwatch staff had conversations with 29 patients waiting in the discharge lounge. ** Text in pink are actual quotes from patients and staff.*

The graph shows the length of wait from entering the discharge lounge to the patient leaving the lounge.



The graph below shows the responses from 23 patients who were asked how they rated their overall experience of being discharged and how they rated communication from staff during their stay.



One lady who had been transferred to the discharge lounge from A&E where she described it as 'busy' telling us they needed the room and said 'It's been a long time to wait to go home'

Other quotes from patients:
'Every hospital I've been in I've had to wait for meds, on the ward mainly'

'Could have communicated more and don't seem to have that personal touch anymore'

'Would rather have been given prescription to get own meds'

'If there was a TV it would make it better especially with the long wait'

'They want you out and want the beds but it's not working is it?' The same patient told us 'Never been looked after so well then they do this to you' referring to the wait for medication.

'Came in this morning through (11.20am) Rapid Assessment Unit, then told to go to Discharge (3.15pm) Lounge as would get meds quicker. Now 4.30pm and I'm tired and still waiting'

'Excellent service but a long delay'

'Didn't know I was coming out until half an hour ago' 'Lots of rushing upsets me'

'TIRED: JUST WAITING TO GO HOME' This patient arrived at 10.30am to wait for a prescription and then go home. Between 2.00pm and 3.00pm she was informed they were now looking for a bed for her and she would need to stay in. At 4.20pm a bed was found, the discharge lounge staff member on duty asked if she could help with a gown 'or anything else' as the patient wasn't prepared to stay in.

The ambulance service brought a patient in who told us that they did consider coming in the car but parking was not appropriate due to the fees.

One patient informed us she could have gone home on Sunday if they had known discharge was going to be Monday, as no action had been taken with the consultant informing her on the Sunday that they couldn't operate and she was to be referred to the pain clinic. The patient explained to Healthwatch that she was sent to the day ward and slept there where they were 'very good' and tried to hang on to her but they needed the beds.
After being moved from A & E due to lack of space another patient said 'felt process could have been speeded up'

A patient who was transferred from Ambulatory care who waited 1 hour 15 minutes for his medication in the discharge lounge told us he had received his discharge information from the ward and rated his overall experience of the discharge process and communication as 'good'

One gentleman who had previous experience of stays in the hospital told us it was his first experience of the discharge lounge and commented 'They have looked after me well'
Another patient said 'It's a good thing being able to get off the ward'

A limited number of patients used the transport service from the discharge lounge during the week Healthwatch conducted this piece of work. Comments from patients who had been brought in to the hospital by ambulance praised the crew.
Patients who had used the patient transport services before when asked 'How did you find the service?' replied
'Yes, good, I've waited about an hour previously'
'Ambulance, good service, well looked after by the staff'
'Yes, it's usually good'

Staff Feedback

Staff were very happy to give feedback to Healthwatch on the transport and discharge process and how the lounge is managed. When asked how the discharge lounge was staffed one staff member said 'not enough sometimes'
Healthwatch were informed that ward staff are responsible for ordering transport as they know the patients capabilities, they ring bed managers and service desk to order an ambulance. Discharge lounge staff will assess patients as they arrive in the lounge and sometimes after speaking to the patient will order or cancel ambulances or cars according to health and mobility.
Discharge lounge staff informed Healthwatch that approximately 100 – 125 patients leave the hospital from the lounge each week.

Staff felt when colleagues were on annual leave, staff shortage created a problem and highlighted that for 2 days the previous week there had been no Health Care Assistants (HCA's) at all working in the lounge.
Healthwatch observed the lounge was quiet in the mornings and staff commented, only 1 patient was present until 12.15pm that day.
Discharge lounge staff felt that porters or ward staff could support by helping to bring patients to the lounge as they are sometimes too busy to do this which results in patients remaining on the wards.

Healthwatch asked staff what they felt were the benefits of the discharge lounge, they responded with the quotes below;

'Priority of receiving scripts quickly'
'Free the ward up for beds'
'Getting patients home quicker'
'Last week 2 patients waited 5 hours for prescriptions'
'Need to have nurse led discharge'
'Often waiting around for GP letters'
'Main issue - getting letters/prescriptions written'

2 members of staff commented that prescriptions should be written the night before. If no changes are expected nurse led discharges should be allowed.

Healthwatch asked what they thought could be changed to improve the transport service?

'Wards booking patient transport as well as Discharge lounge for patient transport to get out quicker'

'Patients sometimes miss transport if they are waiting for doctor's letters, medication'

'I also think a good idea would be a drop off service to deliver medicines rather than patients waiting several hours'

'We did have a system for 1 winter when we delivered prescriptions, this worked well as older people, especially going to nursing homes were not waiting too long in the lounge and ambulances could get them to their destination and the script followed by car later in the day. Maybe this could be looked at again.'

Staff also commented that the Trust could consider 2 Trust ambulances instead of 1, and not pay for the private crew, also to recruit more volunteer drivers to reduce taxi costs.

'Spend a fortune on taxi's'

'Patients expect if they are brought in by ambulance they should go home by ambulance'

Feedback included the Trust looking at the way staff question patients about getting home, so they don't expect an ambulance.

Discharge lounge staff commented on the environment and health and safety:

'Lock the lounge at night – things taken / dumped / rubbish / mattress'

'Need better furniture / magazines / TV / radio? / recliners, need matching furniture to make it more homely'

'Need a toilet for patients in the discharge lounge'

' Having certain rules about patients conditions eg; not sending dementia patients or immobilised patients as it's dangerous for the patients as discharge lounge do not have the staff to look after them & keep them & other patients safe'

Volunteer drivers transport patients home in the afternoons, they work from 1.00pm – 4.00pm. Healthwatch spoke to 2 volunteer drivers who said the most complaints they receive from patients is regarding the long wait for medication and letters. They told us they are often waiting around for people to transport home with this being the cause of the delayed discharge.

Healthwatch Observations

15/02/16 – 19/02/2016

On the first day of Healthwatch's investigation, conversations were held with the discharge lounge staff with regards to the numbers and roles of those who supervise the discharge lounge. It was highlighted that there was issues regarding staffing levels. The usual number of staff in the discharge lounge each day varied considerably throughout Healthwatch's visit. Staff informed us the lounge has 3 trained part time staff and 2 Health Care Assistants (HCA's) allocated to work in this area.

On one particular day, a Healthcare Assistant from ITU was working in the discharge lounge with no previous experience of working in this area of the hospital due to staff shortages. On another occasion, the Healthcare Assistant regularly allocated to the discharge lounge was removed to work on a ward due to the hospital reaching NEEP level 5. During the week of Healthwatch's visit, the NEEP level escalated from 4 to 5 and then returned to a safe level.

Healthwatch were informed by staff that the guidelines state the total time for patients waiting to go home in the discharge lounge should be no more than 2 hours. During the week, Healthwatch observed that the majority of patients waiting to go home, were in the discharge lounge for more than 2 hours. One particular patient waited a total of 6 hours 25 minutes and stated that their experience at the hospital had been 'spoilt' by the delayed discharge.

The long delays observed during the week Healthwatch visited the discharge lounge were found not to be caused by the patient transport service but were actually due to delays in supply of medication and obtaining the discharge letter, which the patient is required to take home with them. The discharge lounge staff were observed constantly phoning the wards and relevant staff members to try and chase up the prescriptions and letters and on one particular occasion a member of staff from the lounge visited the ward to try and speed up the process. Healthwatch were informed that the pharmacy had a cut-off point for discharge prescriptions and on one occasion at approximately 4:40pm, the discharge lounge staff had to contact the ward to arrange for medication to be dispensed.

The current system allows Doctors to complete all of their ward rounds before they then write the required prescriptions and letters, due to this patients are left waiting for an excessive period of time before receiving these and enabling them to go home. This causes a knock-on effect for the ambulance drivers who are often stood waiting for patients to receive their medication and letters before they can transport them home. Furthermore, staff felt that the wards were under pressure from the bed managers to discharge the patients inappropriately causing ambulance crews to be arranged unnecessarily.

Staff felt increased pressures due to the closure of a number of services at Hartlepool hospital resulting in an increased number of patients being transferred to University Hospital of North Tees, further impacting on the discharge lounge.

On a regular occurrence, Health Care Assistants often leave the discharge lounge to go and collect patients from the wards, collect prescriptions from the pharmacy and taking patients to the toilet (which are not located in close proximity to the lounge) reducing resources in the lounge during these times.

Healthwatch staff observed that although a family and friends comment box was present in the discharge lounge, there was no information leaflets, feedback forms or antibacterial hand gel to be seen. There used to be a TV on the wall for patients to watch whilst waiting to go home, one member of staff commented ‘It was a nice option for patients waiting to go home’. In addition to this, the furniture did not appear to be fit for purpose with seating which appeared to be too low for the elderly or frail. It was observed that there was not enough seating available for patients present and their family members in the afternoons when the volume of patients waiting for medication and letters increased. On one occasion 2 inpatients were observed being treated in the discharge lounge due to lack of available beds on wards.

Lunch bags arrive between 11:30am and 1pm, staff were observed regularly offering food and drinks to patients and relatives during lengthy stays. On one

occasion, a patient with diabetes was encouraged to have some food after staff overheard her explaining her condition to a patient nearby. Staff then highlighted to Healthwatch that patients are transferred to the discharge lounge without medical information provided such as; allergies, diabetes etc.

Throughout Healthwatch's observations staff were observed ensuring the health, safety and rehydration of patients.

One patient was observed waiting for over 6 hours after confusion over if he did or did not need medication and a letter. The junior doctor came in to the lounge to apologise and explain she had been on her own due to a doctor being off ill so had to prioritise patients and had not had time to write the letter. This confusion continued as the doctor informed the patients it 'should be ok' for him to go home without the letter, however, discharge lounge staff confirmed that they would need to see both before he left to ensure the medication matched the letter's content. A Staff Nurse also came in to the lounge, sent by the doctor, to check his medication and inform the patient it should be with him in half an hour. The patient was able to go home when the medication and letter arrived two and a half hours after this conversation.
A family member came in to collect a patient who was waiting for medication and the discharge letter. He was not prepared to wait and left the discharge lounge without informing staff, who had not seen this as they were making and handing out tea and coffee for patients waiting in the lounge.
Healthwatch asked what the process was for this situation and were told that the letter would need to be posted out to the patient.

Healthwatch staff observed 2 gentlemen who were brought to the discharge lounge by ward staff at 3.20pm, both were patients with dementia and were wearing hospital pyjamas. The HCA asked the ward staff before she left if they wandered, to which she replied 'the first one doesn't wander'. He was observed getting off his chair numerous times and on one occasion attempted to wake up a patient who was using one of the two beds located in the lounge. The same patient climbed into the available bed and was behaving inappropriately with his hand down his trousers, this caused distress to a family member waiting to take her mum home who repositioned herself so he was out of her line of vision. Discharge staff at this time were managing a full lounge with patients waiting for medication and letters before they could go home. Once staff noticed his behaviour they immediately covered him with a blanket.

At 5pm there was 1 staff nurse and 1 HCA on duty in the discharge lounge. Both patients with dementia were observed wandering at this time, 1 with increased resistance to stay seated. The patient waiting for transfer to a care home who was in the bed was still in the lounge. The HCA due to finish at 5pm made the decision to stay at work and cancel her evening arrangements as she felt the

risk to leave 1 Staff Nurse on duty alone with the 3 patients was not safe. This member of staff confirmed to Healthwatch that she escorted one of the gentleman home in a taxi at 5.45pm as the wait for the ambulance was going to be too long. She arrived home at 7.20pm.

Healthwatch were informed that staff often had to stay back, past their usual working hours, to ensure health and safety of patients and colleagues.

On one occasion the discharge lounge staff member rang 5 times to aid the speed of medication arriving and insisted on arranging transport for the patient if his son didn't arrive to take him home. He was escorted by the staff member to main reception to meet his son. He was understanding that it was busy and said 'Everyone's got to wait their turn'

Conclusion

Healthwatch Stockton-on-Tees gathered a range of feedback from patients, staff, family members, carers and drivers who support patients going home from the discharge lounge. Most patients who Healthwatch spoke to praised the staff and hospital about the care they received. However it was brought to Healthwatch's attention that some improvements could be made to improve the environment for patients waiting to go home and patient experience with regards to the discharge of patients from lounge, particularly the length of wait for medication and discharge letters.

References

- University Hospital of North Tees website: http://www.nth.nhs.uk/hospitals/north-tees/

Recommendations

1. Environment recommendations:
    - Healthwatch would recommend that the discharge lounge has suitable seating which is appropriate for the frail and elderly, some of the current seating is too low.
    - The location of the lounge would benefit from being near a toilet to avoid staff being taken away for long periods of time to escort patients who have mobility problems.
    - The lounge would benefit from a TV being reinstated and suitable leaflets displayed in the trays which are available. These leaflets need to include the friend and family test leaflets to enable patients to feedback their experiences in the comment box which is provided in the lounge.
    - Antibacterial dispensing liquid should be available and visible to patients, family and carers in the lounge environment. Healthwatch suggest this is located at the exit points.

2. Healthwatch recommends the Trust evaluate the procedures used when doctors and consultants complete ward rounds. The delays for medication, discharge letters and transport appear to be caused by the current system which is having a negative impact on patient experience at the point of discharge.

3. Recommendations to reduce risk:
    - Following raised concerns regarding patients with dementia, additional needs and patients who have specific dietary requirements, for example diabetes or allergies, Healthwatch would like to recommend that staff on the wards communicate with the discharge lounge staff to make them aware of these patients who may need additional support and identify additional risks to them waiting in the discharge lounge.
    - It is also recommended that patients with such specific requirements as above are dealt with as high priority to ensure already overextended staff resources are not stretched further and that they are discharged in a timely manner to prevent any potential distress or upset for the patients and family members.
    - Healthwatch recommend that the staffing in the lounge is reassessed. The delays due to medication and discharge letters put a huge strain on staff in the late afternoon.

- It is recommended that discharge lounge staff do not leave the lounge to collect patients from wards compromising the safety of patients waiting in the lounge.

4. Some frustrations patients faced whilst waiting for their medication and discharge letters, was wondering why they could not go and collect the medication themselves. Healthwatch recommend that the hospital staff explain to the patients reasons for this.
   Healthwatch recommend trailing the introduction of dispensing carts on the wards. This would help to speed up the delivery of discharge medication.

5. Healthwatch would also like to recommend that patients are kept well informed at every point of the discharge process. By giving each patient an expected time of discharge, keeping them regularly informed about transport arrangements, and any medication delays with reasons, will help to improve patients trust in the hospitals procedures. Ensuring patients feel involved in the planning of their discharge and also preventing any unrealistic expectations arising, will be beneficial.

6. It is recommended that the Trust trial a system that was successfully used over a winter period whereby volunteer drivers delivered medication and discharge letters later in the day to patients. This could be adopted for patients who are ready to leave the hospital in the morning or early afternoon who are likely to have a lengthy wait in the discharge lounge, and those going to nursing homes.

Acknowledgements

Healthwatch Stockton-on-Tees would like to thank all staff at the University Hospital of North Tees and in particular those who work in the discharge lounge. Healthwatch were met with a friendly and professional team who were extremely accommodating and cooperative during our visits. Healthwatch would also like to thank the patients, their family, friends or carers who gave their time to provide information about their experiences of their discharge from the University Hospital of North Tees.