healthwatch Coventry

Effective discharge from hospital: the role of communication of home circumstances

February 2017

1. Introduction

1.1 Healthwatch Coventry is the independent champion for health and social care in Coventry, providing information and advocacy services and arguing for the interests of local people in how services are run and planned.

1.2 As a result of intelligence gathered through outreach and links with local voluntary sector organisations the Healthwatch Coventry Steering Group added this piece of work to the Healthwatch Coventry work programme for 2016-17.

1.3 Effective hospital discharge has been a topic of concern locally for some time in order to ensure a better flow of patients into and out of University Hospital Coventry. New initiatives have been tried including 'perfect weeks' amended processes, and development of interagency working.

2. Aims of this piece of work

2.1 To draw upon the experience of front-line voluntary sector workers about the issues they experience related to hospital discharge not working well for individuals and on the role that accurate communication of home circumstances plays in successful discharge so as to:

- enable dialogue and share learning with and from UHCW around what works
- feed into other Healthwatch work within UHCW through visits to wards looking at communication and person-centred care

3. Background

3.1 Healthwatch Coventry is delivered by Voluntary Action Coventry (VAC), Citizens Advice Bureau Coventry (CAB), Coventry Law Centre and Age UK Coventry as a partnership for the Here 2 Help (H2H) Voluntary Sector Consortium.

3.2 Carers Trust Heart of England hosts a Healthwatch Contact Point, is a founding member of H2H and also attends the Healthwatch Steering Group and Contract Management Group.

3.3 This piece of work has enabled Healthwatch to benefit from the knowledge and insight of other non-Healthwatch staff working for those agencies – senior caseworkers, occupational therapists, navigators and care managers.

3.4 Some of these staff are directly involved in making discharge work better, others indirectly through assisting clients when systems and communication have broken down resulting in poor outcomes for patients. When brought together as a focus group by VAC, this enabled a more rounded picture of discharge to be discussed, and learning to be shared between agencies.

3.5 This short paper is not a systematic analysis of discharge arrangements based on extensive surveys, data analysis or patient observation. It is simply a discussion based on the daily experiences of front-line voluntary sector workers. On that basis it should provide some value in stimulating dialogue with colleagues at UHCW and in informing more detailed work by Healthwatch on communication and patient-centred care on selected UHCW wards.

3.6 A focus group of front-line voluntary sector workers was held in May 2016, following by a series of follow-up conversations with those workers. The draft report was approved by the Healthwatch Steering Group in December and an initial meeting was held to discuss the report with Kerrie Manning, Integrated Discharge Team Leader. Further conversations were held in January 2017 with Kerrie and Tracy Siddons, Therapy Manager, particularly to clarify the situation around home visits by UHCW Occupational Therapists, and this has been incorporated into section 5.

4. Summary of the May 2016 focus group discussion - what works well and does not work well in the discharge process?

4.1 Breakdowns in the system are regular rather than rare, and a key issue is that **the home environment is not known on the ward** unless:

- someone has seen it through a pre-discharge home visit or
- ward staff ask the right questions to anticipate common problem situations and are given accurate information by the patient or their family.

4.2 Potential problem areas for frail people include quick access to a toilet, long flights of stairs, buildings without lifts, rooms with inadequate heating, beds upstairs that could have been brought downstairs prior to discharge, and lack of key locks for care assistants to enter.

A simple measure such as Whitefriars Housing installing a heater in the room the person is going to use can make all the difference to whether that person is safe to remain at home.

Sometimes ambulance crews will bring patients back to hospital because they have judged their home environment as unsafe to leave that patient in.

4.3 Ward staff may struggle to ask the right questions due to lack of time when under pressure (including pressure to free up that bed), or might be asking the right questions but receive inaccurate information from patients and carers. Patients are often keen to get home and will not necessarily give an accurate picture of what they do and don't have at home, nor will know or

anticipate what the common problem areas could be. Patients with dementia will often present a very inaccurate picture.

4.4 Some wards restrict daytime visiting, and families often visit in the evenings when there can be fewer staff. Consequently staff have less opportunity to build an accurate picture of their patients' home situation by talking to relatives.

4.5 Families will sometimes present an inaccurate or completely unrealistic picture if they feel they can or should cope without help, or again do not know what the common problem areas are in order to anticipate what help might be needed.

Navigating the NHS and care system is challenging at the best of times, and for many people who are particularly vulnerable (e.g. due to learning disabilities, dementia or the impact of their illness), articulating their needs can be difficult so families play a key role in this.

4.6 If patients or their family don't highlight that there is a problem at home, or don't anticipate what could be a problem, then discharge is often not successful because the home environment is not sustainable.The suitability of the home environment prior to discharge is key to the first few critical days following discharge as to whether the person has to be re-admitted, during which time they may have deteriorated further.

4.7 Discharge is too often being based on one question – can you climb stairs or based on observing on 4 stairs only. The situation is generally better in Frailty due to co-ordination within the Multi-Disciplinary Team, covering Wards 2, 12 and the Emergency Department. Being under the care of the Frailty Team provides some reassurance to staff that there will be more follow-up, and referral routes cover more practicalities, such as sorting out proper heating with the Housing provider.

4.8 The problem is exacerbated by a lack of a home visit before discharge to anticipate potential issues and order equipment, e.g. a commode, whilst the person is still in hospital. There are some home OT visits and some enablement beds in the city through 6 week placements, but there is still an issue regarding assessments in people's homes to assess whether they can cope in home.

4.9 Other problem areas for discharge include:

- transport - discharges often work better when family members collect as four hour waits for hospital transport are a problem
- patients coming home without medication

4.10 Re-admission impacts significantly on the patient, their carers, the ward, and other services. The cost of a re-admission lasting five nights is far in excess of the cost of a home visit with an OT pre-discharge.

4.11 The information gained on home environment is also critical for accurate assessments of care needs, so that the right package of support can be put in place. Again, speaking to the family about circumstances about what they need is key. The standard four-calls-a-day package may be more than the patient or family wants and as well as wasting money, these can break down in a few days if the patient or family is resistant to that level of intrusion. The lack of a pre-discharge home visit can mean that decisions taken on wards are not always based on an objective situation of a patient's home environment.

4.12 Time away from a busy ward to talk families through the situation, gain a full, accurate and realistic assessment of the patient's home environment, and then supporting the family through the transition from ward to home to a care package is valuable. The Carers Trust dementia reablement service assesses people in hospital for the service, liaises with family members before the patient goes home, then meets the person at home when they're discharged and does the risk assessment. They provide six weeks of interim care whilst their care package is being set up.

4.13 What was clear from the focus group was the positive direction of travel around inter-agency and inter-team working to try and reduce and prevent these problems, for example, the benefit of Age UK's involvement in daily Multi-Disciplinary Team (MDT) meetings to discuss each patient's medical needs, functionality (mobility, muscle strength, ability to climb stairs, etc) and readiness for discharge, and then linking this to a Community Matron or GP Liaison Nurse.

4.14 The number and roles of different teams can be confusing in terms of who does what, when, and why - there does not seem to one common flowchart or clear pathway showing how discharge processes (and teams) work across different wards and the patient's journey from pre-discharge to home to agreement of ongoing care packages. The overall impression can sometimes feel like "everyone is doing their own thing" and a common set of procedures would be helpful. *[The new initiative – "Why Not Home, Why Not Today?" has been introduced since the focus group met in May]*

4.15 It would also be helpful for Age UK Coventry and the Carers Trust to be able to meet different discharge teams to explain their role and help maximise appropriate referrals.

4.16 Focus group members were of the view that the initial decision from a staff nurse on whether to refer to the Integrated Discharge Team was crucial, as this is where additional support and coordination then kicks in. If accurate information is gained on the home environment which then leads to an appropriate referral, far more can be done to co-ordinate a successful discharge process, leading to a better outcome for that patient and greatly reducing the pressure on both health and social care through patient deterioration and re-admission.

4.17 Finally, the importance of being able to follow up with the patient at home following discharge was also key, including the 30 days follow-up provided through the Frailty Team. This can help ensure that agreed support has been actioned, give practical support on common problems (e.g. arranging for an automatic medication dispenser) and helping with other practicalities that can otherwise leave a frail person vulnerable to deterioration and re-admission, e.g. sorting out a personal alarm, accessing food vouchers for the Food Bank, sorting out registration with a GP, getting a new electric fire. Age UK Coventry provides this type of support for vulnerable older people.

5. Initial response from UHCW Discharge and Therapy team managers

5.1 Initial discussions of the draft of this report with Kerrie Manning and Tracy Siddons in December / January have been positive and constructive and there is an appetite to work together to provide feedback and make improvements to patient care, particularly where the experience of patients differs from UHCW procedures.

5.2 Tracy clarified the position of home visits by UHCW Occupational Therapists, noting that referrals come from the multi-disciplinary ward discussions which include Occupational Therapists, and the decision to make a home visit is based on the assessment of the patient and information from conversations with next of kin using standard assessment proformas, which are regularly audited. Some information is obtained by relatives taking measurements of the home environment or supplying photos. The latest guidance for procedures for home visits are about to be placed on the staff intranet for all staff to access. 120 home visits were conducted between April and November 2016.

5.3 Tracy noted that the decision on whether to assess on a small flight of stairs or full flight of stairs was based on clinical reasoning with progression to a full flight of stairs where there are confidence or exercise tolerance concerns.

5.4 Whilst multi-disciplinary ward rounds are not new, Tracy noted the positive direction of travel since the Healthwatch focus group met in May, with greater reach of ward rounds, greater integrated working between the Discharge and Therapy teams, and the allocation of case managers to each patient to reduce duplication and provide more consistent communication with patients.

5.5 Kerrie added the following additional information in relation to points in the draft report:

- 4.8 -some enablement beds for 6 weeks in sheltered accommodation - there are a variety of enablement beds ranging from housing with care up to enhanced residential care for up to 6 weeks.

- 4:11 - as in 4:12 where concerns are identified, enablement packages of up to 4 times a day are arranged by the hospital, liaising with families prior to discharge. The enablement agency will then undertake a risk assessment of the person in their home environment prior to assessing for any long term care needs. This enablement package can also include therapy where required. It is not purely for dementia patients.

- 4:14 - the Why Not Home concept has addressed some of the issues raised in this paragraph, by identifying case managers to reduce duplication and several services being involved to make it clearer for people.

- 4:15 - within UHCW Age UK work directly with IDT and receive updates on any new services.

- 4:16 - IDT now screen all new admissions 75 years and over to identify people who will require support, any changes are highlighted during the daily board rounds.

5.6 One of the purposes of this report was to "enable dialogue and share learning with and from UHCW around what works", and this is reflected in this initial dialogue and in the recommendations.

6. Recommendations

6.1 UHCW to promote greater awareness and clarity for all front-line staff on discharge pathways including the role and referral criteria of the Integrated Discharge Team (IDT) including through "Why Not Home, Why Not Today?" so that existing resources are used appropriately and the right patients receive specialist support.

6.2 UHCW to work to improve information and awareness for all front-line staff involved in discharge processes of:

- the common situations which lead to failed discharge, including issues with the home environments such as quick access to a toilet, long flights of stairs, buildings without lifts, rooms with inadequate heating, beds upstairs that could have been brought downstairs prior to discharge, and lack of key locks for care assistants to enter
- the importance of getting accurate information from patients and their families on these issues if they are to avoid re-admission
- the need to get information from a second source if they suspect that the patient or their family is not giving an accurate picture
- the importance of getting this information so that the decisions on whether to refer to Therapy and the IDT or not is based on an accurate assessment

6.3 STP co-design processes around proactive prevention to include greater emphasis on prevention through pre-discharge home visits including through community-based services collecting and communicating this information to hospital-based discharge teams, the resource commitment being offset by the reduction in time spent dealing with re-admissions and crisis management

6.4 UHCW, CWPT, Age UK Coventry, Carers Trust and other voluntary sector partners to continue and increase joint working to align and join up information and resources so that:

- a more accurate picture of home circumstances can be given more of the time
- respective skills, roles and resources can pooled and used in the most effective way

This will enable clinical needs to be met through a holistic approach which addresses **non-clinical issues** which impact on a person's health and the likelihood that they will need to be re-admitted.

6.5 Through Healthwatch Coventry, front-line workers from Age UK Coventry, Carers Trust, Citizens Advice Coventry and the Law Centre meet with the Discharge and Therapy Leads from UHCW later in 2017 to review the direction of travel and provide constructive feedback on the patient experience and how this can be improved.

7. Acknowledgements

Thanks to UHCW, Age UK Coventry, Carers Trust - Heart of England, Citizens Advice Coventry, and Central England Law Centre for their assistance in this work, which has been facilitated by Voluntary Action Coventry for Healthwatch Coventry.

8. Appendix

A report of investigations into unsafe discharge from hospital The Parliamentary Ombudsman (May 2016)[1] highlighted:

- patients being discharged before they are clinically ready
- patients not being assessed or consulted properly before their discharge
- relatives and carers not told that their loved one has been discharged
- patients being discharged with no home care plan in place or being kept in hospital due to poor co-ordination across services
- failures to check mental capacity and offer legal protections for those who lack capacity
- carers were not being treated as partners in discharge planning
- poor coordination within and between services

[1] https://www.ombudsman.org.uk/publications/report-investigations-unsafe-discharge-hospital-0

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