healthwatch Staffordshire

Hospital Discharge Report

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Acknowledgements

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- Patients and relatives who spoke to us as part of this study
- Nurses, pharmacists and other staff from Royal Stoke Hospital, County Hospital Stafford and Queens Hospital Burton
- Authorised Representatives, Caroline Goodfellow, Gwyneth McLaughlin, Ann Langdale and Harry Ferguson.

Introduction

Healthwatch Staffordshire decided to undertake a study to look at the experience of patients being discharged from hospital via discharge lounges. The background to the study stems from local intelligence received from patients, their relatives and care home providers and also from national research reports which indicates that hospital discharge particularly for physically and mentally frail and unwell patients often leads to poor experience if not planned and managed well. Feedback received by Healthwatch Staffordshire from patients discharged through this method indicated that the use of hospital discharge lounges as a means of discharging patients often resulted in long delays in discharge with a number of reasons cited, but mainly waiting for medications, and/or transport.

The special inquiry report 'Safely Home' published by Healthwatch England highlighted 5 core reasons why patients had reported poor discharge.

- People experiencing delays through a lack of coordination of different services
- People are feeling left without services and support they need after discharge
- People feeling stigmatized and discriminated against and are not treated with respect because of their condition or circumstances
- People feeling they are not involved in decisions about their care or given the information they need
- People feeling that their full range of needs are not considered.

These findings, in addition to Healthwatch Staffordshire's own feedback about hospital discharge prompted this work to find out in more detail the experience from patients and staff and to gain an organisational perspective across Staffordshire's 3 acute hospitals.

The purpose of this report is to give an overview of our findings of the discharge process at the 3 hospitals and highlight some of the common issues we identified and how these might be overcome to improve the patient experience. Each of the hospitals involved in this study were sent individual reports and these are published on our website www.healthwatchstaffordshire.org.uk

Individual action plans were produced by each hospital to address the issues we raised and recommendations we suggested. We were mindful in undertaking this study that the 3 hospital discharge lounges evolved differently and have their own unique issues to deal with. However, we hope that the feedback and findings from this study will enable us to highlight elements of best practice that can be incorporated into any future reviews and development of the discharge service.

Methodology used

The methodology used to undertake this study was:

- To examine the literature to see if there are any best practice models of hospital discharge and reports of research findings related to patients' experience of using a discharge lounge.

- To visit the hospital discharge lounges at the 3 acute hospitals in Staffordshire (Queens Hospital in Burton, County Hospital Stafford, Royal Stoke Hospital, Stoke-on-Trent) to observe the process of discharge and talk to patients about their experience of the discharge lounge using a questionnaire as a guide.

- Talk to staff who work on the discharge lounge to establish how these operate on a day to day basis, how decisions are made as to which patients are suitable for discharge via a lounge and identify what if any written criteria there are for choosing patients.

- As a result of identifying particular issues around waits for medication, we also visited the pharmacy service at Royal Stoke Hospital to observe the pharmacy process to try to understand where the potential delays can occur.

- Following our initial report and recommendations to the 3 hospitals, we carried out a further visit to Royal Stoke Hospital at their invitation to gain a better understanding of the decision making related to the discharge process, in particular who would be discharged from the discharge lounge and who would be discharged from the ward.

The outcome this study sought to achieve was to:

- Gain an understanding of the patient experience of discharge via a discharge lounge as opposed to a ward
- Highlight areas of good practice from the perspective of the patient and their family
- Identify and share areas of the discharge process that could be improved
- Identify models of best practice for hospital discharge
- Report our findings to each Hospital Trust and make recommendations that could lead to improvements in the patient experience of discharge based upon feedback received from patients, their families and staff working on the discharge lounge.

Results

Research

We found very little literature or previous studies on the use of discharge lounges as an effective means of people leaving hospital. The little literature we did find was focused upon discharge from hospital wards. There are reports published by Healthwatch England, The National Audit Office and the Parliamentary and Health Service Ombudsman which each look in detail at patient experiences of hospital discharge overall, particularly in relation to patients being appropriately supported on discharge. None, however, specifically look at hospital discharge lounges other than one mention we found in one report which mentioned patients reporting long waits on them.

The objectives of having a Discharge Lounge that we found in the literature published online were: -

- To free up beds in a timely way on the wards, when patients are medically fit for discharge but are waiting for medication or transport
- To assist with the flow of patients through the hospital. (Outpatients and day patients can benefit from the Discharge Lounge also, following assessment or treatment, while they wait for transport)
- To provide positive experience for patients who are transferred to a Discharge Lounge, and make them as comfortable as possible.

This quote from St George's Hospital Discharge Lounge operational guidelines sums up these objectives: -

> *"To enhance the quality of the patient journey by providing a safe and comfortable environment for patients to wait for medication, transport or family members, and to free up in-patient beds as soon as possible, as early as possible"*

Although hospital discharge lounges seem to have been established in hospitals across the country for many years we were unable to find any national policies, standards or guidelines relating to the operation of them. Only a few hospitals publish operational guidelines online e.g. Nottingham University Hospital and Dudley Hospital.

Data Collection

Data was collected through observation of the service and talking to patients using set questions. It was gathered over a period of 3 months during 2016 and included 3 observation visits and 2 further visits to look in more detail at the pharmacy service and meet with staff to look at the process of managing medication and look at the discharge process from wards in Royal Stoke Hospital.

Findings

Location and Accommodation

The location of the discharge lounge on all 3 sites was not very easy to find with poor signposting and no drop off / pick up points. We were told by staff on all three sites that over the years the location of the discharge lounges had changed, some on more than one occasion. This can be unsettling for the staff, some of whom felt that the lack of a permanent site undervalued the role they played. At the time of the visits we were informed that 2 of the lounges were on permanent sites and there were plans to move to a permanent site in the 3rd. Parking was a significant problem at all sites, and for relatives who want to collect patients from the lounge, this sometimes added significant delay whilst they drove around trying to find somewhere to park.

All three hospitals used their discharge lounges in slightly different ways with different opening times, between 8.00 am and 8.00 pm. Only one hospital opened their discharge lounge on a Saturday. Essentially however, all have the aim of freeing up beds more quickly.

The quality of the accommodation varied but all had limited facilities and were based in quite cramped conditions. One of the sites did not offer any real privacy and dignity to patients particularly those who were unwell or experienced an incidence of incontinence. This was because the discharge lounge was located in one room with male and female sides of the room and chairs placed down opposite sides of the room. The accommodation at another site was not fit for purpose with inadequate heating and air-conditioning and it was very spread out.

Staffing

Staffing on the lounges was made up of Ward Sisters, Staff Nurses and Healthcare Support Workers and on one lounge Volunteers were used. There were no assigned doctors, but cover would be provided if necessary from A&E or the ward where the patient came from. All staff on each of the discharge lounges presented as committed, enthusiastic and dedicated to making the patient experience as comfortable as possible and shared lots of ideas as to how to achieve this including improving the environment in which people were waiting. One nurse spoke very enthusiastically about her work and was keen to make the experience for her patients as relaxed as possible.

There were several issues however that were raised that impacted upon their perceived ability to offer an excellent service. One was the feeling of impermanence of the location. It was mentioned on several occasions that staff would like a permanent base but we were told by senior staff that there was a permanent base on two of the sites. Whether this had been communicated to staff was unclear. It was also mentioned on a few occasions that staff had little say on who came to the discharge lounge and despite sometimes feeling that some patients were inappropriately sent to the lounge they were sometimes overruled and patients came anyway.

Criteria for Admission to the Discharge Lounge

Although discharge policies were in place, the use of discharge lounges did not feature in either of them. Across all three sites, it was difficult to ascertain any criteria for how patients were selected to be discharged via the discharge lounges as opposed to discharge from the ward. There were no clear written criteria to establish patient's suitability to go to the discharge lounge and no information is given to patients about what would be happening in the discharge process once a patient was admitted to the lounge. The Authorised Representatives found that at two sites visited over two occasions there were 4 patients who appeared to be unsuitable for discharge via the discharge lounge. A gentleman had been incontinent. The lounge offered no privacy or dignity and he was clearly embarrassed that nurses were cleaning the area where he was sitting. At another site, a terminally ill lady, with a syringe driver in situ, was waiting to go to a hospice, she was confused and didn't know why she was there. She had been on the lounge since 9.15 and was still there at 12.15pm. Staff also expressed concern about her being there. Another gentleman had to be transferred back to the ward after 3 hours in a very breathless state. He had become anxious about being discharged home when he still felt unwell (he lived alone and required oxygen therapy). The ARs felt that there was a need for some clear criteria about the type of patient deemed suitable for admission to the discharge lounge and that there should be some two-way negotiation between the ward and the discharge lounge staff when suitability is questionable to ensure the lounge has capacity to manage the patient without compromising the patient's dignity, safety or comfort. The view of the visiting ARs was that there should be some clear exclusions for people whose needs could not be adequately met.

A further visit was carried out to one hospital to observe the whole process of hospital discharge in order to better understand how the discharge process works. It was evident from this visit that the pressure to discharge patients from wards so that other patients needing admission to those beds is at times intense. At a discharge meeting attended by the ARs there was a need to find 12 beds for patients awaiting admission and staff were being heavily pressed to move patients to the discharge lounge and had to explain if not, why not. There was no mention of patients' welfare or suitability and at this point it felt like the patient was a number going through a 'bed-freeing' process with no reference to any discharge criteria.

Patient Experience

As outlined above there were some patients who seemed unsuitable for placement on the discharge lounge as they were clearly too ill to be cared for properly in this environment. Most patients that were asked however, were quite happy to be on the discharge lounge and found it quite a comfortable place to sit to wait for medication or transport to go home. There were a number who had been transferred there from outpatients or other areas of the hospital who were waiting for transport. There were a few patients however who were not happy about being there. Two patients reported that they only knew they were going to the discharge lounge having gone to the bathroom and returned to find their beds stripped. Two other patients could not understand why they had been chosen to go to the lounge and would have preferred to wait on the ward though they had no complaints about the care given by staff on the lounge, who they felt were attentive and tried to make them comfortable.

There were a small number of patients who appeared to be unsuitable for waiting on the discharge lounge as outlined above and were not really able to give a view about their experience as they were too unwell or confused. One relative reported that they had received a phone call at 11.00 am which informed them that their relative was waiting on the discharge lounge for medication. It was suggested that they collect the patient at 1pm when the medication should have arrived. In fact, the medication did not arrive until 5pm. Had the patient also been waiting for transport this could have been another 2 hours as transport is not arranged until medication is delivered. This could have meant a possible 10 hours in transit which is not seen as acceptable to either staff or patients and their relatives.

Issues Highlighted

Pharmacy

Our biggest area of concern identified at all three hospitals was the delay in obtaining take home medication for patients on the discharge lounges which can be very detrimental to a patient's 'wellbeing'. All 3 sites operated differently but on all sites both patients and staff reported delays in the process leading to delays in discharge. One issue identified was that sometimes patients were waiting in the discharge lounge without their prescriptions being previously written up on the ward or sometimes the wrong medication was prescribed. On these occasions either the Doctor has to be chased up to go to the Discharge Lounge or the nurses have to go up to the wards to get the write-ups done or amended. This was one reason for delay along with a wait for a discharge summary (where these are issued).

On one site, the pharmacy department had previously received good feedback about the service and we were told that the pharmacy turnaround time was well above 80%. We were invited back to take a closer look at how the pharmacy operated. It was clear that the 80% figure reflected the time that the pharmacy received the prescription to the time it dispensed it. These figures did not appear however to take account of the time it took for the pharmacy to receive the prescription from the ward or the time it took to collect the medication once dispensed and deliver to the patient. Two of the three hospitals used medication tracking systems and one has direct access to the pharmacy but the result appears to be that awaiting medication is the biggest cause of delay in patients discharge and this therefore was an area in which recommendations were made for improvements.

At all three hospitals, recommendations were made to review pharmacy cover to see if there was a better way of deploying pharmacy staff and organizing the dispensing and delivery of medication more promptly.

Transport

The terms of the contract with the non-emergency ambulance service means that patients awaiting transport can often experience further delays as transport cannot be ordered until medication is delivered. This could result in a further delay of 2 hours before transport arrives and then there is potentially some considerable time taken sitting on transport waiting for other patients on board to be dropped off first. One driver who wished to remain anonymous spoke of his concern about the length of time some patients had to wait to get home and the detrimental effect on a Patient's wellbeing this could have.

Discharge Summaries and Take-Home Medication

One issue that was drawn to our attention was that Ward Doctors were not always available to write up take home medication on the ward and have to be called to the discharge lounge to do this. This can lead to a further delay before medication can be ordered from the Pharmacy. Ward Doctors according to NICE guidelines should ensure that the patient receives a copy of the discharge summary (in addition to the one electronically sent to the GP). This does not happen consistently but can lead to further delays when it does.

Best Practice in Hospital Discharge

In undertaking this study of hospital discharge from a discharge lounge, we have looked at the limited research available and observed the discharge process. We have also had discussions with patients, staff, relatives and managers and from this we have attempted to develop a best practice model. The areas outlined below are suggestions that we have identified as potentially enhancing the patient experience as well as providing more job satisfaction for staff working in this environment.

Operational Guidelines

Clear operational guidelines would assist all staff involved in the successful discharge of patients to the Discharge Lounge. These should include clear criteria of patients unsuitable for transfer to the lounge. From our observations, we feel the following should be excluded: -

- Patients needing end of life care
- Patients who are anxious and cannot readily cope with sudden changes. e.g.people with dementia, learning disabilities, mental health problems, autism etc.
- Patients who are very frail and need close monitoring and ongoing care
- Patients who have continence issues that are difficult to manage
- Patients with complex medical needs

All relevant staff should be briefed about the operational guidelines at induction to include an awareness of working to the criteria and responding to the need of Discharge Lounge patients in a timely way.

Pharmacy

This was an area that caused concern amongst both patients, staff and relatives. It was a common view that patients should not have to wait more than 3 hours for medication particularly as transport cannot be booked until medication is received. As part of induction training staff should be made aware of the negative aspects of keeping patients on the discharge lounge for long periods.

It is important to look at the whole pathway involved in the dispensing and delivery of medication. We saw some good practice in parts of the system (eg: dispensing medication) but this fell down in other parts (eg: delivery to the patient). Having a clear care pathway for medication with timescales would greatly improve the patient experience in this area. Consideration should be given to a patients' medication needs whilst on the ward to ensure that those who need regular medication will have access to it.

Location and Accommodation

Ideally the Discharge Lounge should be on a permanent site, and should be fit for purpose, with appropriate heating and air-conditioning, taking account of privacy and dignity of patients. The accommodation should be homely, and inviting, light and airy with comfortable armchairs, foot stools, reclining chairs, hoists and possibly beds. Bariatric chairs should be available if required along with standing aids. It should have resources such as TVs, magazines to keep people occupied if they are on the lounge for a period of time. It should be easily accessible with clear signposting, near suitable parking preferably with a pick-up point for relatives to have easy access.

Patient Information Leaflet

It would be helpful if patients were given a leaflet to explain about the Discharge Lounge and what they can expect during their time there. It would useful to provide this at the point that the decision is made to transfer the patient to the lounge so that they can understand what is happening to them. Patient information leaflets need to be jargon-free, and designed to be read by the patient at the point of being transferred to the lounge. The leaflets we have seen are more suitable for professionals or other people enquiring about the purpose of the lounge and what can be expected to patients when they go there, rather than being patient-friendly.

Use of Volunteers

One of the hospitals we visited made use of volunteers when possible to sit and talk to patients whilst they were waiting. This seemed to work well and patients valued it. It also takes the pressure off permanent staff and could enhance the quality of the service to patients.