Experiences of inpatient general rehabilitation

Norfolk Community Health and Care NHS Trust (NCHC)

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Contents

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Who we are and what we do

Healthwatch Norfolk is the independent voice for patients and service users in the county. We gather people's views of health and social care services in the county and make sure they are heard by the people in charge.
The people who fund and provide services have to listen to you, through us. So, whether you share a good or bad experience with us, your views can help make changes to how services are designed and delivered in Norfolk.
Our work covers all areas of health and social care. This includes GP surgeries, hospitals, dentists, care homes, pharmacies, opticians and more.
We also give out information about the health and care services available in Norfolk and direct people to someone who can help.

At Healthwatch Norfolk we have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We make sure we have lots of ways to collect feedback from people who use Norfolk's health and social care services. This means that everyone has the same chance to be heard.

Summary

The project aimed to engage patients, their relatives, and staff to gather insights into the inpatient general rehabilitation service provided by Norfolk Community Health and Care NHS Trust (NCHC). Using interviews and a survey, the study explored the full patient rehabilitation journey - from transfer from acute care, through inpatient rehabilitation unit stay, to post-discharge experiences - identifying strengths and areas for improvement.

The summary is structured around the key areas of focus identified in the methodology: acute hospital communication about rehabilitation, the ward environment, the quality of care and therapy, discharge and post-discharge care.

In addition to the main project objectives, the *Guide for Unpaid Carers – Hospital Stays*, designed to provide practical information and support to Carers and the people they care for throughout the hospital journey, was also evaluated as a separate project outcome.

Acute hospital communication about rehabilitation

Patients were commonly transferred from acute hospitals following falls, orthopaedic procedures, or a medical condition, often with reduced mobility, balance difficulties, or declining strength. Rehabilitation units provided a structured environment to support recovery, regain daily function, and meet care needs when returning home was not immediately possible. Communication from acute settings about rehabilitation was often limited. Stress, pain, or fatigue sometimes hindered patient understanding. Placement decisions were frequently influenced by bed availability rather than patient preference. While staff tried to balance patient-centred care with operational pressures, the process was often perceived as unclear or inflexible. Clearer and more timely

communication could improve patient understanding, engagement, and satisfaction.

The ward environment

First impressions of rehabilitation wards were generally positive. Staff were praised for warmth, attentiveness, and professionalism, helping to reduce admission anxiety. The physical environment was clean, comfortable, and supportive of therapeutic needs, with adequate safety or assistive equipment. Noise was generally manageable, though call bells and disturbances from other patients disrupted rest. Mealtimes were the area of lowest satisfaction. While patients were generally satisfied with the food, consistent staff support was needed to help patients access communal dining areas and assist those requiring meal adaptations or help to eat or drink. This underscores the importance of adequate staffing to ensure patients' safety, comfort, and wellbeing during mealtimes.

Emotional wellbeing was influenced by anxiety about recovery and discharge, fatigue, and periods of isolation. Social interaction and recreational activities supported mental health, providing cognitive stimulation, companionship, and routine. Staff support, alongside visits from family and friends, was highly valued. Opportunities for leisure were sometimes limited by low awareness, insufficient encouragement or assistance, and cognitive or physical constraints. While structured communal or volunteer-led activities were appreciated, patients often relied on self-directed activities, personal devices, or television. Low-pressure, socially oriented, and adaptable activities could enhance engagement, emotional resilience, and overall wellbeing.

The quality of the care and therapy

Experiences of clinical care were largely positive. Attentive nursing, professional competence, and empathetic communication fostered trust in clinical decision-making. However, workload pressures, standardised ward norms and routines, and occasional gaps in communication or follow-up limited responsiveness, continuity, and personalisation. Rare safety incidents and systemic pressures highlighted the need for

sufficient staffing, greater flexibility to accommodate individual preferences, and a sustained focus on communication and coordination.

Therapy experiences were mixed. Supervised sessions were generally skilled and patient-centred, promoting functional independence and gradual progression. However, many patients expected more frequent and intensive therapy than they received, leading to disappointment with perceived progress. Self-directed exercises were valuable, but effectiveness depended on clear guidance, staff support, and patients' ability to manage fatigue and pain. Opportunities for everyday mobilisation varied, often limited by staffing pressures or uncertainty over whose role it was to assist. Communication about rehabilitation goals, plans, and progress was sometimes reactive, unclear or fragmented, leaving patients and families uncertain about outcomes and timelines. Improving experiences requires a better understanding between patients and clinicians of each other's expectations, adequate staffing to support therapy and mobilisation, and proactive, transparent communication that fosters partnership with patients and families.

Personal care was generally reported positively, respecting privacy, dignity, and independence. Staff maintained privacy with physical barriers and encouraged patients to do what they could for themselves. Empathetic interactions and reassurance during vulnerable moments were widely appreciated. Challenges included delayed responses to call bells, particularly for toileting needs, resulting in discomfort, embarrassment, and increased reliance on continence products. These issues were more evident during night shifts, when staffing levels were lower or care was delivered by temporary staff who may have been less aware of individual needs. Inconsistent hygiene routines and occasional lapses in communication, particularly for patients with cognitive difficulties, also affected dignity. Adequate staffing, responsive care, and effective supervision are key to upholding consistently high standards.

Discharge and post-discharge care

Experiences of discharge planning varied widely. Some patients met discharge coordinators early, while others only received guidance shortly before returning home. Explanations of the discharge planning process were often limited, and understanding was influenced by intermittent contact with staff, stress, fatigue, illness and cognitive

impairment. Communication and shared decision-making primarily focused on home adaptations and equipment, while decisions about discharge timing or care packages were often presented as predetermined. Family involvement ranged from minimal to active, with some families experiencing directive communication and pressure to take on additional caregiving responsibilities. Clear, timely, coordinated communication, along with practical support for carers are central to improving understanding and satisfaction with discharge decisions.

On discharge, many patients felt ready, safe, and supported to return home, reflecting improved mobility, growing confidence, or trust in staff judgement. Others felt less prepared due to ongoing health and mobility challenges, or perceived organisational pressures. Discharge timing often depended on equipment delivery and care package finalisation. While most patients received sufficient notice, last-minute notifications occasionally caused upset. Verbal instructions and discharge summaries were valued, though many patients received paperwork without staff talking them through it, leading to variable understanding. Confusion about medication and transport delays were common issues. Returning home was emotionally charged for patients. These findings emphasise the need for more thorough assessment of readiness, clear and proactive communication about discharge day plans and paperwork, safe handover of medications and supplies, and emotional support to ensure a smooth return home.

Following discharge, patients accessed a range of community health and social care services, including equipment and home adaptations with follow-up occupational therapy, community physiotherapy, consultant care and district nursing, short-term reablement or ongoing domiciliary support, social services input, voluntary sector assistance, and specialist services such as emergency response and falls prevention programmes. Experiences of these services were mixed. For some, effective interagency working – with clear communication, proactive coordination and timely follow-up - supported safe transitions home and recovery. However, perceived communications gaps, bureaucratic inefficiencies and unclear responsibilities sometimes caused stress, delays in care provision or declines in functional ability. Improved communication and coordination across health and care services, and a single point of contact to guide patients and relatives could enhance the navigation of post-discharge services.

Evaluation of the Guide for Carers

The *Guide for Unpaid Carers – Hospital Stays* was valued for helping Carers understand what to expect during hospital stays and discharge, and to advocate for the person they care for. Its professional appearance and logical structure enhanced engagement, though small font size, dense layout, complex language, and reliance on hyperlinks or QR codes limited accessibility. Recommendations include simplifying language, clearer section breaks, adding practical checklists, and consolidating key contacts on a single page. Implementing these changes will enable Carers to support patients effectively while reducing stress and confusion.

Based on these findings, Healthwatch Norfolk made four key recommendations:

- Enhance communication about rehabilitation to support meaningful patient understanding and manage expectations,
- Improve patient awareness of rehabilitation activities to encourage engagement and better support therapy delivery,
- Strengthen patient-centred care through workforce capacity, training, and support,
- Improve discharge planning and day-of-discharge experiences.

Why we looked at this

Project rationale and objectives

Evidence from Healthwatch across other regions shows that patient experiences of community beds, rehabilitation and discharge are consistently shaped by the support provided, the quality of communication, and involvement in care and discharge decisions (Healthwatch Staffordshire, 2019; Healthwatch Warwickshire, 2021; Healthwatch Leeds, 2022).

While Norfolk Community Health and Care NHS Trust (NCHC) routinely collects feedback about their inpatient general rehabilitation service through surveys such as the Friends and Family Test, its Patient, Carer & Partner Advisory Group, and patient stories shared in *The Voice* newsletter (Norfolk Community Health and Care NHS Trust, 2025), there is limited independent insight into the lived experiences of service users. This is particularly relevant given the likely increase in demand for inpatient rehabilitation in the coming years due to Norfolk's ageing population (Norfolk Insight, 2025).

This project was commissioned by NCHC to complement existing feedback and provide detailed, rich insight into the experiences of patients, families, and staff across rehabilitation, discharge, and post-discharge care. By hearing directly from those using and delivering the service, the project aimed to identify strengths and areas for improvement and to develop recommendations that help ensure the service meets the needs of patients, improves their experiences, and supports better outcomes.

Background information

The inpatient general rehabilitation service explored in this report operates within the Discharge to Assess (D2A) model, which is designed to support timely discharge from acute hospitals and reduce deconditioning associated with prolonged hospital stays, while ensuring patients' long-term care and support

needs are assessed at an optimised point of recovery or stability(BNSSG Healthier Together, 2023). Patients arriving in an inpatient general rehabilitation service will have been discharged on Pathway 2. Nationally, it is estimated that approximately 4–5 % of patients are discharged from acute care on Pathway 2, with around 50 % discharged on Pathway 0 (simple discharge home) and 45 % on Pathway 1 (home with additional support). A small minority of patients require long-term residential or nursing care on Pathway 3 (Department of Health & Social Care, 2020). Pathway 2 applies to patients who are medically stable and no longer need acute hospital care but are not yet ready to return home safely. These individuals spend a short period of additional recovery and rehabilitation in a community setting, where they receive multidisciplinary support to promote recovery and prepare for a safe discharge.

Inpatient rehabilitation provides a structured, supportive environment where patients can rebuild strength, mobility, and daily function following illness, injury, or surgery (British Geriatrics Society, 2024). Rehabilitation should be active and goal-oriented, personalised to each patient's needs, and focused on restoring independence rather than simply providing rest. Evidence shows that effective rehabilitation improves people's ability to carry out everyday tasks, reduces the risk of hospital readmissions, and is highly valued by patients and their families as a supportive pathway from hospital to home (NICE, 2017). Community and rehabilitation services operate within the context of ongoing workforce pressures. National reports highlight challenges in recruiting and retaining staff across nursing, therapy, and support roles, alongside increasing patient complexity and demand for services (NHS England, 2023). While staff continue to provide compassionate and high-quality care, system constraints can limit their ability to personalise care (CQC, 2023).

Clear, timely, and accessible communication is central to positive patient experience and effective engagement with rehabilitation (Healthwatch England, 2022). This is particularly important for older patients, those with cognitive or sensory impairments, and individuals experiencing pain, fatigue, or emotional stress, who may find it challenging to absorb and retain information. Repeated explanations and clear written materials are therefore essential to support understanding and engagement.

Early, coordinated discharge planning is essential to ensure patients feel safe, prepared, and supported to return home following their rehabilitation stay (NHS England, 2022). Poorly coordinated discharge can result in patients returning home unprepared, increase the likelihood of hospital readmissions, and place significant strain on unpaid carers, who often play a central role in supporting recovery after discharge (Carers UK, 2021). Legal and policy frameworks, including the Health and Care Act 2022 and the Hospital discharge and community support guidance, set statutory expectations for safe discharge processes and emphasise the importance of involving patients and carers throughout (Department of Health & Social Care, 2022). However, national research consistently highlights gaps in communication, coordination between services, and support for Carers, with many reporting that they are under-informed, involved too late, or unclear about what support will be available once the person they care for returns home (Healthwatch England, 2023).

How we did this

The aim of the project was to review the inpatient general rehabilitation service provided by Norfolk Community Health and Care NHS Trust (NCHC). We had a particular focus on acute hospital communication about rehabilitation, the ward environment, the quality of care and therapy, discharge and post-discharge care.

We conducted interviews with patients and relatives who were admitted to bedded general rehabilitation following discharge on Pathway 2 from Norfolk NHS acute hospitals. We also interviewed staff working across the following five participating rehabilitation facilities:

- Alder Ward – Norwich Community Hospital
- Willow Therapy Unit – Norwich Community Hospital
- Dereham Community Hospital
- Pineheath Ward – Kelling Hospital
- Swaffham Community Hospital

Interviews allowed us to explore research questions in depth, while also allowing interviewees to raise issues that were important to them that we hadn't thought of.

Qualitative insights from the interviews informed the design of a survey for patients and relatives with lived experiences of inpatient general rehabilitation. The survey was distributed across the units listed above, as well as the two remaining community hospitals managed by NCHC: North Walsham and District War Memorial Hospital, and Ogden Court Community Hospital (Wymondham). Survey questions were grounded in interviewees' experiences and were written in language people could understand and relate to. The aim of the patient survey was to test whether the themes identified through qualitative feedback were reflected more broadly across all inpatient general rehabilitation facilities in Norfolk.

As part of this work, we also conducted a focus group with Carers to evaluate a new guide coproduced by Carers, Carers Voice Norfolk and Waveney, and staff working

across health and social care in the region. The guide is designed to provide Carers, and the people they look after, with practical information and guidance to support them from hospital admission through to discharge. As the material was unlikely to raise confidential patient information, the focus group offered a safe space for Carers to share their views on the guide and collaboratively generate ideas for improvement.

Methodology

Demographic information for all participants is provided in Appendix 1.

Patient and relative interviews

Twenty-five patients and ten relatives were recruited for interviews during Healthwatch Norfolk's visits to the five participating rehabilitation facilities.

Interviews were conducted in two stages: first, face-to-face from approximately two weeks after the patient's admission, and then by telephone two to three weeks after discharge.

Two semi-structured interview guides were developed based on a desk review of best practice guidance for the rehabilitation and recovery of patients on Pathway 2, the researcher's participation in Patient-Led-Assessments of the Care Environment (PLACE) and observations from preliminary visits to inpatient general rehabilitation wards.

The first round of interviews explored:

- Reasons for acute hospital admission and transfer to inpatient rehabilitation
- Acute hospital communication about rehabilitation destination, purpose, and what to expect
- The physical environment of rehabilitation wards
- Clinical care and experiences of therapy
- Respect for privacy, dignity and independence
- Mental health and emotional wellbeing

The second stage of interviews focused on:

- Patient and family engagement with discharge planning
- Feeling ready, safe and supported to return home
- Experiences on the day of discharge
- Provision and coordination of post-discharge care and support.

Each interview lasted approximately one hour and was recorded for later analysis. Recordings were transcribed using an artificial intelligence service from rev.com and thematically coded manually in NVivo.

Patient and relative survey

Themes identified through the patient and relative interviews informed the development of a survey questionnaire, which included a combination of multiple-choice, closed-ended, and open-ended questions.

To ensure accessibility for people with varying levels of digital confidence, the survey was distributed online as well as in paper form. The online version of the survey was hosted on SmartSurvey. An Easy Read version was available on request. Respondents also had the option to complete the survey by telephone with support from Healthwatch Norfolk staff. The paper version of the survey is included in Appendix 2.

The survey ran from early July to the end of September 2025. It was promoted via GP websites, NCHC, the Healthwatch Norfolk website, social media platforms, newsletter, and voluntary and community-based organisations. A small number of paper copies were also handed to patients on the day of discharge.

Survey data from 31 participants were downloaded and analysed using Microsoft Excel. Percentages were rounded to the nearest whole number. Any comments included as direct quotes are presented as people wrote them, to preserve their authenticity.

Rehabilitation staff interviews

Twenty-five staff members working in various capacities across the five participating rehabilitation facilities were recruited. Interviews explored:

- Challenges in maintaining high standards of care and therapy
- Barriers to patient engagement with rehabilitation activities
- Communication and collaboration within multidisciplinary teams
- Barriers and facilitators to a smooth discharge

Staff interviews were recorded, transcribed using an AI service from rev.com and thematically coded manually in NVivo.

Carers focus group

Unpaid Carers (or relatives) of patients who had recently received, or were receiving, inpatient rehabilitation in June 2025 at Swaffham Community Hospital - where the Carers' guide was being piloted - were invited to take part in a focus group. Four people volunteered to participate.

The aim of the focus group was to explore how useful and effective the guide is in supporting Carers and the people they care for during the rehabilitation journey.

The discussion explored whether:

- The presentation and content of the guide met Carers' needs.
- The information provided helped reduce confusion and anxiety around hospital stays and discharge.
- The guide helped Carers advocate more confidently for the person they care for and supported clearer communication with hospital staff.

The focus group discussion was recorded, transcribed and thematically coded in NVivo.

Participants' involvement and consent

In line with General Data Protection Regulation (GDPR) requirements and research ethics requirements, informed consent was obtained from all people involved in this research. Participants were clearly informed about the purpose of the data collection, how their information would be used, how long it would be retained, and their right to withdraw consent at any point prior to the publication of the report.

They were assured that all responses would be anonymised, and any identifying details would be removed before being referenced in the report. Digital data was stored on password-protected drives, while paper survey responses were securely stored in a locked drawer at the Healthwatch Norfolk office. All data collected will be deleted at the end of the project.

Limitations

There are several limitations to this project that should be acknowledged.

Participation in interviews, the survey and focus group was voluntary and based on self-selection. Participants were not randomly sampled so experiences cannot be generalised to all patients, relatives, or staff across the inpatient general rehabilitation service provided by NCHC in Norfolk.

Not all patients were willing or able to complete the second stage of interviews due to fatigue, ill health, hospital readmission, or transfer to care homes. This may have limited the capture of post-discharge experiences.

We received survey responses from a limited number of participants. Engagement was particularly challenging, as patients with lived experiences of inpatient rehabilitation are often elderly, have complex health needs, may experience cognitive difficulties or have limited access to online platforms. In addition, workload pressures on ward staff restricted the distribution of paper surveys to current or discharged patients. The same workload pressures also made it difficult to recruit participants for the focus group.

Nevertheless, the project's findings offer valuable insights into the experiences of patients, relatives, and staff. Detailed findings can be found in the "What We Found Out" section of this report.

What we found out

From acute hospital to inpatient rehabilitation

This section explores the journey from acute hospital admission to transfer into inpatient rehabilitation, drawing on the perspectives of patients, relatives, and staff. It examines why patients are admitted to acute hospitals, the reasons for their subsequent transfer to rehabilitation units, and how communication around rehabilitation is experienced by both patients and staff.

Reasons for acute hospital admission

The people interviewed in our study were admitted to the Norfolk and Norwich University Hospital (N&N) or the Queen Elizabeth Hospital, King's Lynn (QEH) for a range of acute medical or surgical reasons before transfer to inpatient general rehabilitation wards in community hospitals. None of the participants were transferred from the John Paget University Hospital (JPUH).

Most (around two-thirds) required acute hospital care following falls, often linked to reduced mobility, balance problems, or declining strength, with injuries ranging from soft-tissue damage to fractures sometimes requiring surgery. As one participant described, *"I slipped on a pavement, broke my hip and was transferred to the QEH where I had surgery."* **A smaller number of interviewees were admitted for planned orthopaedic procedures**, such as hip or knee replacements, or after serious trauma caused complex injuries. For instance, one participant recalled a car crash which *"fractured both shoulders and wrists, a knee, and cracked two ribs."* **Others were hospitalised due to age-related frailty, worsening chronic conditions, acute illnesses, or sudden medical complications.** For example, one man described how his relative *"had been very unwell and unsteady on his legs before being taken by ambulance with suspected sepsis caused by an infected pressure sore".*

While each story was unique, hospitalisation often marked a turning point in physical strength, mobility, and capacity for self-care, highlighting the need for further recovery in an inpatient rehabilitation unit before returning home or moving to long-term care.

Reasons for transfer to inpatient rehabilitation

Transfers to inpatient rehabilitation served three overlapping purposes: **regaining strength and daily function after illness or prolonged hospital stay; receiving structured therapy to improve mobility; and, providing support when discharge home was impractical.** In effect, rehabilitation units act as a bridge between acute hospital care and home, offering a safe and supportive environment for ongoing recovery.

Regaining strength and function

Patients were often transferred because they were extremely **weak following illness, surgery or prolonged bed rest**. Deconditioning, a gradual loss of muscle mass and strength, balance difficulties, fatigue and a reduced ability to manage everyday tasks, was commonly caused by these health events as well as by extended periods of limited mobilisation during hospital stays.

One relative described his mother as *"completely bedbound after being treated for a severe chest infection — she couldn't stand or do anything for herself"*. In another case, a patient recovering from surgery explained:

> *"It got to the point where I couldn't get out of bed.*
> *My muscles were so wasted I couldn't move my legs.*
> *I was exceptionally weak.*
> *[We] tried to do a bit of standing and walking in the hospital,*
> *but I needed more time, shall we say…"*
> *[That's why] they told me they would move me to rehab."*

In these situations, the purpose of rehabilitation was to help patients regain strength, rebuild independence, and restore the ability to cope at home.

Structured therapy and support to regain mobility

Other patients were transferred to rehabilitation facilities after falls, fractures, or surgery limited their ability to walk, balance, or bear weight on affected limbs. They **required supervised physiotherapy and tailored exercises to regain safe mobility**. One patient explained:

> *"I had a routine knee replacement.*
> *When the surgeon went to put the very last screws in,*
> *I [suffered] a hairline fracture in the tibia [due to] brittle bones.*
> *Hence why I have got a brace and [I am not] weight bearing.*
> *But if I'm good and I do as I'm told in rehab, I'll be walking again."*

Even successful surgeries left some patients feeling insecure about using a new joint or limb, making rehabilitation crucial for safe independent living:

> *"The physio [at the hospital] came round and got me out of bed.*
> *He wanted me to be on a walking frame and to hop.*
> *I found it totally impossible... I mean, I'm 81 for goodness sake!!*
> *And so, he said [I couldn't] go home, [I would] have to go into rehab."*

Recovery in a safe and supported environment

Some transfers were motivated less by therapy needs and more by social or practical factors such as living alone, limited family support, or temporarily unavailable Carers. For example, one patient explained that she had to be transferred to rehabilitation because her *"Carer had just had a hip replacement and couldn't look after [her while] she needed quite a lot of assistance"*.

For others, rehabilitation provided a **supported environment during periods of adjustment or emotional vulnerability**. Patients who were recently bereaved, socially isolated, or anxious about returning to an empty home described this need clearly:

"I live [alone].
My wife died six months ago, and I am grieving.
And my sons live far away.
I have mobility issues so it [was] going to be quite difficult with the arm in a sling to care for myself."

"I knew I weren't well enough to go home because I gradually went downhill since I first fell about eighteen months ago. This really upset me."

Others required supervised support due to cognitive difficulties and the hazards of homes that were no longer adapted to their needs:

"The problem was that [my mother] has got dementia and she was trying to weight bear [when she shouldn't because of her fracture]. The hospital told us that they'd be sending her to a rehab unit to rest and recuperate. They would [provide supervision] there and assess her [home environment] needs."

Bridging the gap from hospital to home

Acute hospitals primarily focus on medical stability and immediate recovery so, **once patients are stable, the emphasis shifts to preparing them for discharge**. As two participants observed:

> *"[The hospital] sent me to rehab because they [could] only do so much so me. And they've got to have beds, haven't they?"*

I was in hospital for two weeks [and] then was no longer acute. In other words, I was bed blocking. I live on my own so there was no option but to go to a [rehabilitation unit]."

However, some people told us that **therapy in acute hospitals was often limited** by staffing pressures and competing demands, leaving physiotherapy *"very sporadic because obviously they've got a lot of people to take care [of]".*

Together these constraints can leave patients unsafe to manage basic self-care at home. As one patient explained, he would have *"liked to go home, but physio [at the hospital] was limited, and [he] couldn't feed [himself] or walk to the toilet. It was better for [him]"* to move to a rehabilitation unit. **Rehabilitation units therefore bridge the gap between acute care and home, offering a supportive environment where patients can continue their recovery.** These settings play a crucial role in helping people rebuild confidence, independence, and quality of life after hospitalisation.

Communication around rehabilitation purpose and what to expect

Patient and family perspectives

Patients generally understood the reason for transfer: they were not yet ready to return home safely and needed more time and support to rebuild their strength, mobility, and ability to manage everyday activities. **Many accepted this rationale, particularly when recognising their own limitations**. For example, one patient explained she *"had to go to rehab because [she was] not able to walk or do anything for [herself]. It [was] quite simple".*

However, **communication about what the rehabilitation journey would entail was often minimal:** *"Nothing was really explained. No, they didn't communicate what would happen in rehabilitation."* ***Frequently,*** **only generic or functional explanations were given**, typically focusing on mobility and readiness for discharge home rather than the process of rehabilitation or specific therapeutic goals:

"She wasn't ready to come home.
The idea was to get her on her feet, walking again and all that sort of thing."

"Getting back to moving again. They didn't really go into the specifics of It."

Some patients and relatives described the purpose of rehabilitation simply as being *"well-looked after in a ward where it's a little quieter"* or a chance *"to rest and recover". This suggests* that **rehabilitation was sometimes framed, or at least understood, as a step-down or convalescent phase rather than an active process to restore function and independence**.

Where patients or relatives received **explanations about the therapeutic intent, these tended to be vague and limited in scope**. Very little was conveyed about the wider multidisciplinary support available in rehabilitation facilities, such as occupational therapy - which helps patients relearn daily activities, adapt their home environment, and use assistive equipment - and clinical care for managing medication and ongoing health needs. Instead, discussions **typically focused narrowly on physiotherapy** and exercises to restore strength and mobility:

"They told me I would be getting physio to get my leg mobilised and get on my feet again."

"[They explained it was] just a case of doing exercise and testing me how much I can stand up, and walk up a step to get into the house."

Patients reported **wide variation in expectations about the intensity of rehabilitation**. While some anticipated only occasional interventions, others were led to expect *"intensive, daily therapy",* with hospital staff often positioning rehabilitation as a resource-rich environment offering greater therapist availability and more focused attention than was possible on acute wards. Staff likely intended to reassure patients

about continued recovery opportunities, but **some developed inflated expectations, which could lead to disappointment** when the actual intensity of therapy did not match the description:

> *"They said that there was a good team there, that they would do rehab, and that I would be able to get it more focused than what they could actually give me in the hospital."*

> *"I was sent there on the understanding it would be hard rehabilitation, intensive and daily. That is not actually the case."*

Information about the duration of rehabilitation was rarely given clearly. While some were given rough estimates, ranging from two to four weeks, many patients described their stay as open-ended and dependent on clinical progress. As one patient explained, *"I think that I will need to stay until I get my balance back, but it will be up to physiotherapy to say when I can go."* Others recalled being told simply that *"there was no timescale,"* or that "*it was two weeks rehabilitation, but it might take longer."* This uncertainty left patients and relatives without a clear expectation of how long their rehabilitation journey would last.

Communication in acute hospitals seemed to have often been constrained by the pace and pressures of care with sometimes rapid transfers leaving little opportunity for discussion. One patient explained, *"I didn't get to the hospital until about four in the afternoon then I was only there for one night before they sent me to rehab the next morning."* People told us that explanations were frequently minimal or rushed with **practical priorities taking precedence over patient education and dialogue**: *"I was told I was going for rehabilitation. I wasn't quite sure what it meant but it sounded good. There wasn't time [for explanations] as there was a bit of a rush to get me there. Bang, bang, bang and out again."* Patients also described **fragmented communication from different staff**. As one interviewee recalled, there was *"no time for questions about rehabilitation. I was seeing different physios every two days, and they were literally with me for five minutes."* Some patients recognised that **staff may have limited familiarity with the rehabilitation process, which could contribute to inconsistent explanations and confusion**: *"Different staff in hospital are going to have different views of what's going*

to happen when you go to a rehabilitation centre… If they've never been there to see what's going on, they might not know."

Consequently, communication about rehabilitation was often **procedural rather than collaborative, leaving patients uncertain yet compliant**, trusting professionals to *"get them there"* without fully understanding what rehabilitation would entail.

Many patients told us that they were not fully able to absorb or retain explanations about rehabilitation. **Understanding was often partial or delayed**, only becoming clear once patients arrived at the rehabilitation unit. **Stress, pain, medication, and fatigue frequently limited people's ability to process information**. As one patient reflected:

> *"I'm sure they did [explain] but I probably wasn't in a receptive mood after having just had a big operation. It [was] all a bit overwhelming… It [took] a while to catch up with what [was] going on."*

A relative explained, "*I don't think my mother understood anything at the time. [It wasn't] their fault, she was given a lot of morphine."* **Emotional fatigue also reduced engagement with explanations,** particularly when disappointment about transfer dominated attention: *"I don't think they explained but I was a bit upset. I was disappointed I was being sent [to rehab]."* Some described **additional barriers such as cognitive difficulties and sensory impairments**: "*It's hard to say if they spoke to my mum about rehab. Because she can't hear properly, she doesn't always take everything in properly."* These experiences highlight the need for clear, repeated communication at several points in the transfer process, at times when patients and families can best understand and retain it.

Overall satisfaction with communication about rehabilitation varied depending on prior knowledge, personal expectations, and trust in professionals. Patients already familiar with rehabilitation were content with minimal information: *"I was satisfied with what they were saying because I had been up to this rehabilitation hospital before for my husband, so I knew a little bit about it. I was happy."* Others were satisfied with basic reassurance, for example: *"I was told I would get physiotherapy. That was good enough*

for me." Trust in staff could also compensate for incomplete or rushed communication. As one patient reflected, *"You soon learn to trust those who know what's going on. You know what I mean? You just go along with the flow…"*

Conversely, **dissatisfaction arose when communication lacked sufficient detail or opportunities, frequently leading to misunderstanding or uncertainty**. Two patients described the confusion and anxiety this caused:

> *"They just told me I was going to rehab.*
> *Well, my nephew said it was a drug rehabilitation centre.*
> *They just said [I was] going and that was it.*
> *What could I do about that? Nothing at all."*

> *"It would have been nice to know a bit more about rehabilitation,*
> *one of them saying that [they would] not send [me] home before [I could] walk*
> *when I was worrying. They let me down on that one…"*

These accounts highlight the **importance of clear and timely information.** As one patient recommended *"If staff have time, a little bit more information about where you are going, why, and what's going to happen next would be helpful",* emphasising the value of giving patients sufficient information to engage meaningfully in their rehabilitation journey. Insights from patients and relatives provide a clear picture of the strengths and limitations of communication, which can be further understood alongside staff perspective.

Staff perspective on communication around rehabilitation

According to acute hospital staff Healthwatch Norfolk spoke to, **discussions about a patient's discharge usually begin upon admission.** The Community Access Team (CAT) at the N&N, and the Complex Discharge Planning Team at the QEH are multidisciplinary (therapists, nurses, assistant practitioners discharge coordinators, etc…) and assess patients' needs to determine appropriate discharge pathway. When patients would benefit from an additional period of recovery in an inpatient facility (Pathway 2 discharge), they are referred to the Home First Hub, which then arranges short-term

rehabilitation placements in community hospitals or other intermediate care settings. We asked staff from these teams about their approach to communication with patients and families.

Staff described differences in how and when they communicate about rehabilitation, often influenced by time pressures, individual practices, or the patient's condition. Communication appears largely variable, with no standard approach, which can lead to inconsistent information sharing and affect person-centred care. One staff member explained:

> *"[We are asked] to try and see the [patient] if [we] can or if not, to do a telephone call. I'm on the ward pretty much every day. My first point of call is to see the [patient] in person. I normally get their consent at that point to talk to family and anyone that they want me to discuss their plans with."*

However, patient involvement is not always consistent. If a patient is too unwell or lacks the capacity to process information, **communication often defaults to families**. As one practitioner noted, "*There are plenty of cases from what I've seen where the person hasn't been spoken to, sometimes it's just the family".* While this can sometimes be appropriate, it risks sidelining patients, leaving them uncertain and anxious about the next phase of their recovery and rehabilitation journey.

Partly compounding these communication challenges, **staff reported a knowledge gap about what rehabilitation in community settings involves**. As one practitioner explained, *"We don't know what people get in the community hospitals… I have no idea,"* while another admitted, *"I can explain what [rehabilitation is] but I've never been to any community short-term bed".* Without first-hand experience or understanding, explanations given to patients are often generic and may lack credibility or reassurance. Staff also described giving patients and relatives only a *"generic overview… because we don't know where they're going," noting that "It could be anywhere in Norfolk… a rehab facility or a care home with rehab staff visiting."* This ambiguity can lead to uncertainty and anxiety for patients about what the rehabilitation process will entail, potentially resulting in unmet expectations.

Communication and choice about rehabilitation destination

Patient and family perspectives

People in our study reported that communication about rehabilitation destination was often minimal and reactive. **Patients commonly described being told rather than consulted, with little opportunity to express preferences or ask questions**. As one person recalled, *"Well, I didn't know [about rehabilitation destinations]. Nobody really explained anything to me. They just said, we're going to send you to Dereham."*

Several people described the **process as sudden, with transfers announced with little notice or explanation.** *"A woman appeared and said, 'you are going to rehab, it's imminent,' just like that. That was the first I heard about going to the Willow,"* one patient explained. Another added, "*I was just told that I was on the list for three places… Suddenly one day they said I was coming here."* These accounts illustrate how patients often experienced rehabilitation placement as system-driven and opaque, with little opportunity to understand and influence the rehabilitation destination.

Many patients felt powerless and resigned to decisions made on their behalf. *"No choice at all,"* said one participant. *"I had to wait for a space to become available and then I was just told I was coming here and that was that."* Others echoed this, explaining that they were transferred to *"whichever facility a bed came available"*. In practice, **placement decisions seemed mostly driven by system pressures, including the need to move patients out of acute hospitals quickly, and the availability of rehabilitation beds rather than by patient preference**.

Patients and relatives consistently reported that choice of rehabilitation destination was limited. Although **some expressed preferences** - often based on previous experience, reputation, or convenience for visiting - these **rarely influenced the final outcome.** One participant hoped to go *"to Dereham or the community hospital in Norwich where[she] had been before as [she] quite liked them"* while another requested Kelling Hospital because she *"knew people who had been there and recommended it",* but, in both cases, they were sent elsewhere *because "a bed became available[in another facility] first."*

Distance from home emerged as a major concern, often creating emotional and practical difficulties. Patients described **fewer visits from family and friends**: *"It's a long way from where I live, I don't get many visitors", and "I had never heard of Swaffham before. We had to look it up on the map. They didn't have anywhere nearer. This was the only vacancy… That's why I don't get many visitors; it's too far from home."* Relatives also highlighted the **strain of long journeys** and frustration when nearby facilities were unavailable. *"What I found a bit annoying is that [my mother] had to go all the way to Swaffham, which is like 28 miles [from where we live] when there is a rehabilitation ward down the road."*

Although some participants were frustrated or upset about limited choice or distance, they felt resigned to outcomes: *"I was quite upset they were going to send [me] to Dereham because it's quite a long way from where I live. But you just accept it. You can't do nothing about it."* Others accepted their placement gratefully, focusing on the opportunity for recovery. *"I didn't have any say,"* one patient said, *"but if this is the place to get me better, that's good to me".*

In summary, communication about rehabilitation destination was largely procedural and reactive, shaped by system pressures and bed availability rather than person-centred dialogue. Patients had little choice or understanding of the process, and distance from home created for many emotional and practical challenges.

Staff perspective

Staff acknowledged that while they aim to consider patient preferences when arranging rehabilitation placements, **operational constraints often limit the choices** available. A common approach is to explain to patients and families upfront that **placements are allocated based on availability rather than personal preference**:

> *"We have those conversations and explain we can't choose where a patient is going to go for [rehabilitation]. We have to make [it] very clear that [there is] a list that [patients get] added to. When the next available bed becomes free, they will be offered it."*

Staff noted that **postcode and proximity to home are sometimes considered, but there is no guarantee** that a patient will be transferred to their preferred location:

"I believe they take your postcode into consideration, but it's not guaranteed that you are going to be [transferred to a rehabilitation unit] close to your address. [Patients] can't pick and choose community beds. Literally, [they will be] allocated one. We have no control over that."

Patients often have a short window to accept placements, and can only refuse a bed a limited number of times before the next available must be accepted:

"We can't guarantee how long the beds are going to be [available]. So, we're not trying to rush you into a decision, but these are the options we've been given, right?"

"They can decline [a placement] if they're not happy and then after that they have to accept the next option."

Staff also recognised the impact of placement distance on families, particularly where travel difficulties could limit visits or support. They described attempting to find closer options when genuinely necessary, while emphasising that priority was to ensure the patient's timely transfer and recovery:

"We do get disgruntled families. [If they would] desperately struggle, I think [the HFH] would look at closer options. But if it's just a family member being a bit put out with a half an hour car journey, [we explain that taking the first available bed] is in the best interest of their loved-one."

In short, staff reported striving to balance patient-centred care with the realities of limited rehabilitation capacity. **Communication is framed around setting expectations about allocation procedures and supporting patients and families to understand and accept placements.** This perspective helps explain why, from the patient viewpoint, the process can feel opaque or lacking in choice, even when staff are actively trying to manage expectations and offer reassurance.

From acute hospital to inpatient rehabilitation - Summary

Overall, transfers from acute hospitals to inpatient rehabilitation are driven by a combination of medical, functional, and social needs, with rehabilitation units providing a bridge to support recovery in a safe environment. Patients generally understand the purpose of rehabilitation, but communication about what it involves, and the likely duration is often limited or inconsistent. Similarly, choice of rehabilitation destination is constrained by operational pressures and bed availability, leaving patients and families with little influence over placement. From the staff perspective, efforts are made to manage expectations, explain allocation procedures, and balance patient-centred care with practical realities, yet these constraints help explain why the process can feel opaque or inflexible from the patient viewpoint.

Experiences of patients, relatives and staff in inpatient rehabilitation

First impressions

Patients frequently described **positive first impressions of staff** on arrival at rehabilitation units: *"I felt very welcomed, you know what I mean?"* **Gestures of welcome and personal introductions made a strong impact:** *"It was lovely because one of the healthcare assistants came to the ambulance to greet me. Then the nurse was there as well, very welcoming,"* and *"Immediately [after I arrived], a member of staff came to me, introduced herself and the two other people in the bay. I thought, that [was] nice."* Many also appreciated the **warmth and attentiveness shown by staff from the outset**: *"The two members of staff on duty when I arrived were fabulous, very reassuring. We had a laugh and then I was fine."* These first encounters set a supportive tone, helping patients feel comfortable, safe, and valued.

However, some **patients described feeling anxious and unsettled during evening or weekend admissions**. One recalled: *"I was brought in on a Friday night. It was dark but [staff] didn't put too many lights on. I was a bit disorientated. The first impression was a bit strange,"* while another said: *"I came into this big and quiet space and thought, I don't know whether I'm going to like this."* Wards are typically quieter at weekends due to reduced therapy provision and staffing, which can intensify these feelings. One patient noted: "*That weekend [when I was admitted] was really quiet. I suddenly realised I wasn't allowed to be mobile for six weeks and I felt a bit, not depressed exactly, but mopey."* These feelings were usually temporary: *"Monday, the full staff were back, everything livened up, and I settled in fine."* This suggests that during evening or weekend admissions, extra orientation, reassurance, and support are important to help patients feel less isolated until normal routines resume.

Patients' experiences of admission procedures highlighted both thoroughness and the potential for anxiety. The inventory of personal belongings and initial physical examinations could feel intimidating and intrusive, particularly when patients were fatigued and emotionally vulnerable after transfer from acute care. Although these checks are standard safeguarding and nursing procedures, patients' reflections

suggest emotional discomfort: *"They count[ed] everything I had and checked [me] head to toe like [I was going] through airport security,"* and *"A nurse went through my bag, taking everything out. It made [me] feel like a criminal. I wasn't happy, feeling sorry for myself."* At the same time, patients valued the care and orientation provided by staff: *"They wheeled me in, did observations, asked questions, and a lovely nurse told me what to expect. [By the next morning], the physio team arrived."* Such accounts suggest **that while admission procedures can be stressful, the attentiveness and professionalism of staff help patients feel reassured and supported from the start.**

Patients and relatives frequently reported **positive initial impressions of the physical environment** on arrival at rehabilitation units. Many highlighted the **welcoming nature of the wards:** *"Plenty of staff, plenty of space. Absolutely great,"* and *"bright, clean and welcoming."* Practical touches and thoughtful gestures also contributed, reinforcing comfort: *"Have you had anything to eat? They brought me some food, sat me near the window and I thought, lovely,"* and *"Do you want a duvet on the bed? And do you want two pillows? In the N&N, you're lucky to have [one]. I thought, well, this is very nice."* The **calm, relaxed atmosphere was particularly valued,** free from the constant noise and activity of acute hospitals: *"It's not machines beeping everywhere all the time or people running around. It's a lot more relaxed", and "I think it's quite a quieter environment really, [fewer] beds on a ward."* Overall, these accounts suggest that **the ward environments reassured patients, helping them feel comfortable and supported from the outset**.

The physical environment of rehabilitation wards

Figure 1 summarises patient and relative ratings of different aspects of the ward environment. Overall, the data indicate **generally high satisfaction with cleanliness, layout, and equipment, while ratings for temperature, noise and mealtime experiences were more mixed.** These patterns suggest that, although **core standards of hygiene and day-to-day operations appear to be met, personal preferences, comfort and rest may be more variable across wards.** It is important to note that the number of survey respondents was small (n=31), meaning these findings should be interpreted as indicative rather than representative. Nevertheless, the trends provide useful context for understanding patient and relative experiences, which are explored in more detail in the following sections through qualitative feedback. These qualitative insights capture

the nuances of individual experiences, highlighting the factors that shaped satisfaction with daily life on the wards, as well as areas where experiences varied or improvements could be made.

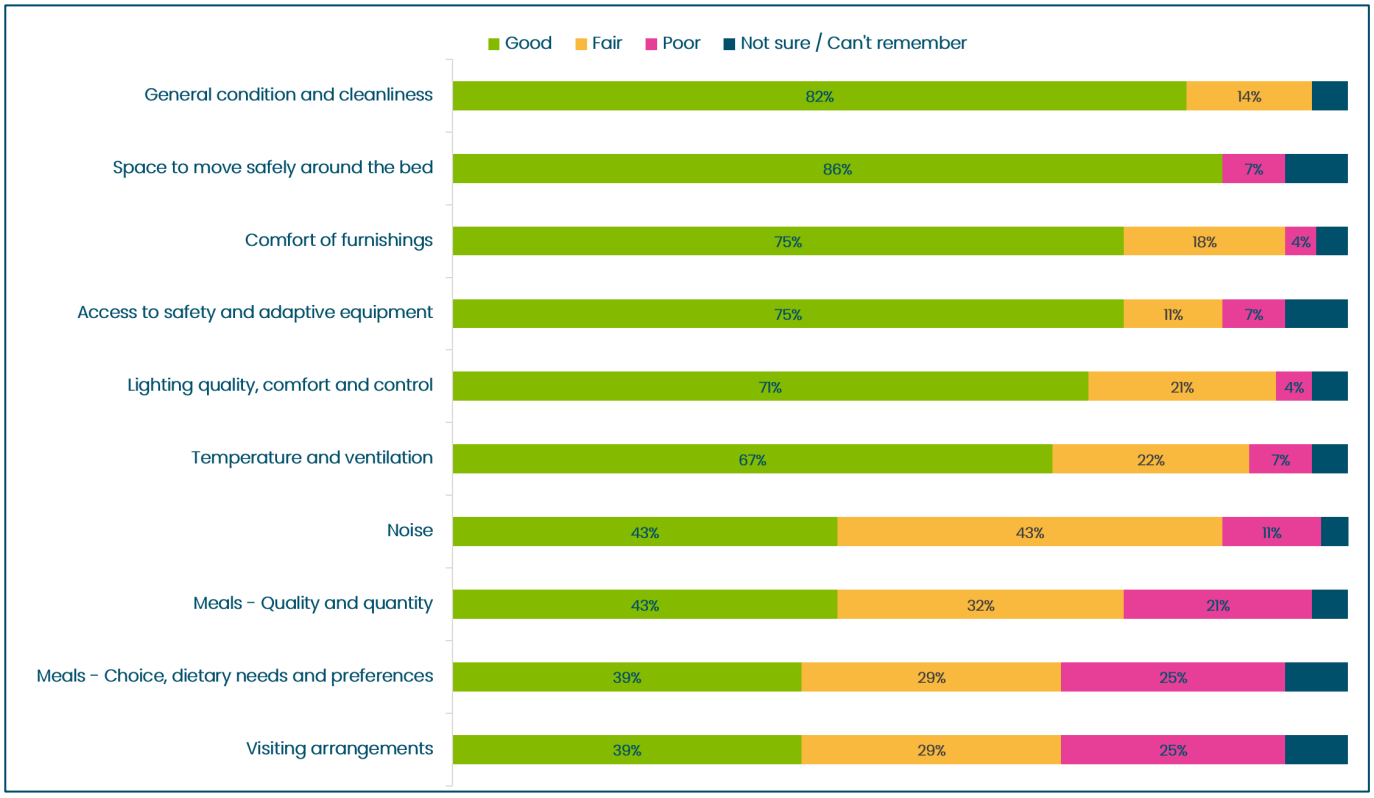


Figure 1. Percentage responses to the question: Overall, how satisfied were you with the physical environment of the ward? Please rate each aspect.

General condition and cleanliness

Patients and relatives generally described the wards as welcoming, clean and functional, though perceptions varied between older and newer units.

The Willow Therapy Unit, a state-of-the-art rehabilitation facility, opened in March 2025. **Patients praised the new unit for its comfort and modern design**. One said: *"I've felt terribly comfortable all the time I've been here,"* and another described it as *"wonderful… beautiful… amazing. Partly because it's new, isn't it?"*

Older wards had some dated features, including worn whiteboards above beds, slightly tired-looking cupboards, doors and walls that needed attention. A relative at Foxley Ward (Dereham Community Hospital) observed: *"It does make you smile when you walk in, but it sort of reminds me of an old-fashioned hospital and it could do with a*

lick of paint. But then, it's all perfectly functional and full of modern high-tech equipment, which is the main thing at the end of the day." At Pineheath Ward (Kelling Community Hospital), redecoration was in progress, and one patient noted: *"I've moved into three different rooms because they're decorating."*

Consistent with the high survey ratings for cleanliness, **wards were always described as spotlessly clean and orderly**. People frequently commented that *"the floors are always clean," "beds are neatly made,"* and *"nothing is left unturned."* **Cleaning routines were visible and regular**, carried out by staff described as *"very thorough"* and *"efficient,"* with attention to detail around furniture, corners, and immediate responses to used surfaces.

High standards of hygiene and infection control were evident during patient changeovers. One patient shared that *"[staff] strip everything, even take the curtains down and put new ones up, wash the walls, sterilise the bed. It is so incredible. There are no germs over there."*

For many patients, the **daily presence of cleaners** provided a sense of normality and reassurance. Their friendliness **contributed positively to the atmosphere, helping patients feel cared for beyond their medical needs**. One patient remarked on the effort and cost involved in maintaining such high standards, saying it *"must cost a bomb just for the washing of the bedding alone."*

Space and layout

Overall, **ward layouts balanced comfort, accessibility, and therapeutic needs, though experiences of space varied across facilities**. Older bays were generally comfortable and airy, though some felt cramped: *"It's a bit tight around the beds with the chair and the personal effects unit. A little bit of a problem."* Another patient remarked: *"It is set up four to a bay. I can manage to get out of bed but there's not much room [to manoeuvre]."*

At the newer Willow Therapy Unit, bays were very spacious. The purpose-built layout supported rehabilitation and mobility, allowing patients to practice walking and other exercises safely: *"When you are learning to walk, it's good to have a bit of distance between the bed and the bathroom."* However, some patients felt the larger spaces reduced opportunities for social interaction: *"People that like chatting say […] you can't hear each other and have to shout."*

Comfort and accessibility of equipment

Patients generally acknowledged that hospitals are not luxurious, *"You're in the hospital, it's not a five-star hotel"*, setting a baseline of realistic expectations. Overall, ward furnishings, including beds and seating, were mostly considered comfortable, though experiences varied with individual needs.

Some chairs caused discomfort: *"The chairs are all right. But after a while, they make you bum go numb."* Adjustments or alternative seating were usually provided: *"[My dad] did have one of those reclining chairs, but he said he wasn't comfortable in that… a couple of days later the physios provided one of those high seat chairs."* Beds were generally praised as *"lovely, cosy and snuggly too"*, though better staff training on bed controls could enhance comfort.

Positive interventions to meet individual comfort needs were highly valued. Staff responsiveness was appreciated when adjustments were made quickly: *"They found [y petite [husband] a smaller chair,"* and *"I asked for a pressure cushion, which they fetched for him."* Adaptations to improve accessibility were also described: *"They measured how far my feet were off the floor and gave me a cushion. They also moved [all the furnishings] on wheels so I could have easy access to everything. They were brilliant, really catering for my needs.* However, not all patients experienced this level of support. A relative described unmet needs due to equipment shortages: *"My mum was in heart failure, and her legs were swelling up like balloons. I [asked] the nurse [for] a foot stool, and she said she couldn't find one. In fact, they didn't bring one for the duration of mum's [stay]."*

Accessibility of assistive and safety equipment was generally good, but a few challenges were reported. Call bells could be difficult for patients with limited strength or dexterity: *"One night I couldn't find [my call bell] and I panicked a bit… [it] had fallen behind the bed,"* and *"[My mother] does have trouble pressing the [call bell]. She literally hasn't got strength [because of] her arthritis."* **At the Willow Therapy Unit, toilet safety and accessibility could be problematic.** One patient explained that she *"once fell because they hadn't put [the grab rails] down."* Layouts and fixtures sometimes complicated use for patients with limited mobility: *"When you sit on the toilet and the toilet paper is right behind you, you can't reach it"* and "the wash basin is right in a corner and the staff can't really get near you to help", prompting a patient to say that *"whoever designed [these toilets] has never actually limped into a hospital."*

Lighting comfort and control

Patients reported that some bays are naturally brighter or darker depending on wall colour, orientation, and surrounding trees. However, **lighting was generally flexible, combining natural and artificial sources.**

Some patients found the lights overly bright at times: *"It's on all day; it is a bit silly"* but accepted that *"nurses needed them on to see properly."*

At night, lighting was dimmed from around 7 p.m. and turned off by 10–11 p.m., with staff using torches for patient checks. **Some minor light disturbances were reported**, such as broken blind slats letting in early morning light or low-level ceiling lights occasionally shining into patients' eyes. **Different preferences for lights at night occasionally caused frustrations.** One patient said: *"All four of us [in the bay] like going to bed quite early [but] the lights don't go out until sometimes 11 o'clock at night, which is a bit annoying,* while another noted: *"Some people want the light off early. That is a bit of a nuisance. I like to read as I don't sleep much."*

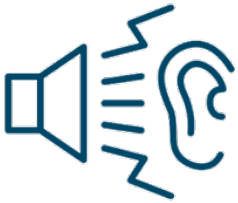
A few patients found bedside light controls difficult to use, particularly those with limited hand strength or movement. One explained: *"I can't reach the light switch. I need to use the call bell if I need the light changing,"* while another said: *"Apparently with this [remote] you can turn your light up and down. You have to press quite firmly, but I can't do it."*

Temperature and ventilation

Interviews were conducted in a warm summer and patients and relatives reported **mixed experiences with temperature and ventilation**. **Most wards felt comfortable, with open windows providing a light breeze**, though partially opening windows sometimes made bays feel warm and stuffy: *"I wouldn't say it lacks ventilation in there, but it is very stuffy…"* and *"It would be nice if you had fans or air conditioning, wouldn't it?"* Fans were generally available when needed and one relative appreciated: *"[My father] wasn't even complaining he was hot, but* they provided a fan. I*t was just a nice thing for them to do."*

At the newer Willow Therapy Unit, sealed windows and a filtered air system are designed to keep a constant temperature. However, **patients reported noticeable day-to-day variations**: *"I thought that it was more chilly yesterday, but I'm not actually cold today."* Some needed extra layers: *"One day, I had to put my dressing gown around my arms. Some of the other ladies complained that they [were] not warm enough and the staff all felt cold too."*

Noise



Patients and relatives generally found rehabilitation facilities much quieter than acute hospitals: *"It is not so noisy compared to the N&N. It was terrible there," and "It's almost eerily quiet here compared to the QEH."*

Routine ward noises – trolleys, moving beds and equipment, fire doors closing, footsteps; conversations - were considered manageable, part of the *"normal run of the place"*, *and often* blended into the background as a form of 'white noise.' As one patient remarked, *"What noise? The worst thing is the magpies out there in that tree."* Noise was more noticeable at certain times of day during ward activities such as morning rounds, patient mobilisation, washing, dressing and mealtimes: *"It's very busy but it's not very noisy, except at certain times of the day [like] first thing in the morning when they're getting people out of bed."*

Call bells were the most frequent source of disturbance. One patient said: *"Call bells are the only bit of noise that we get that's regular,"* while another humorously remarked: *"Patients all start ringing the call bells together to go to the loo. It's like a church service, my own little private concert."* Others acknowledged their own contribution: *"You're aware of other people's call bells… but that can't be helped. I probably disturb others in my bay ringing mine four or five times a night."* Most patients said they grew *"used to that buzz."*

People also expressed understanding and tolerance **for noise from other patients with cognitive or neurological conditions, especially at night.** Two patients recalled: *"The lady in the bed next to me had Parkinson's, she saw things that weren't there and used to call out. She couldn't help it, but I'm a very light sleeper, and it kept me awake,"* and *"The two ladies in my bay can't help it but I get no sleep whatsoever. Sleep helps me recover and I'm not getting it."* Others acknowledged shouting due to pain or inability to use call bells, adding this was an **unavoidable part of hospital life**: *"We're in a hospital, you expect that,"* and *"That's nobody's fault, just the fall of the dice."*

Although patients generally tolerated routine ward noises, even moderate disturbances can affect sleep, rest, and concentration. In turn, fatigue may reduce their engagement with rehabilitation activities, highlighting the importance of managing noise to support recovery and overall wellbeing - a point reflected in the survey, where satisfaction with noise levels received more mixed ratings than other aspects of the ward environment.

Food and mealtime experiences

Food is more than nutrition in a rehabilitation setting: it is essential for recovery, safety, dignity, and wellbeing. Meals affect strength and healing, while the way food is prepared, served, and eaten can influence comfort, independence, and social interaction. In our survey, **food and mealtime experiences emerged as an area of lower satisfaction.** This topic also generated strong feelings among patients and relatives, who were particularly keen to discuss it in interviews, offering detailed accounts of what worked well and where improvements could be made to ensure meals are safe, enjoyable, and responsive to individual needs.

Patients were generally satisfied with the taste and quality of their meals. Positive feedback included: *"The food is really of a very good level for a hospital. It is all nicely cooked. The fruit crumbles and pies [are] excellent, really good,"* and *"On the whole, I think the food is pretty good. [There is] only one meal which I did not enjoy. Everything else I've eaten; I've got no complaints."*

However, **some patients found hospital meals less appealing.** For some, **sensory changes made food difficult to enjoy**: *"I don't like it very much, but maybe I'm fussy [because] I have lost my sense of smell and taste. Everything tastes terrible."* Others **missed the flavours of home-cooking,** commenting that *"food in hospitals is never very good, very hit and miss, especially if you're a good cook,"* and that they were *"more old-fashioned in the food that [they] like*d." Including more traditional dishes on the menu was suggested as a potential improvement: *"Maybe the older generation would prefer more traditional food. That's something [the rehabilitation facilities] could look at."*

Several patients also commented that meals were largely prepared off-site, delivered frozen, then reheated on the ward. Some held **preconceptions that frozen food might be less tasty or less healthy**:

> *"They haven't got a kitchen here. They don't do any cooking.*
> *Apart from toast, everything else [comes] frozen.*
> *Not very appetising, I'm not going to say they're fantastic.*
> *Last night, I had indigestion like never before [after dinner]*
> *so today I had a sandwich for lunch.*
> *That was the safest thing to eat on the menu."*

The range of food options was generally described as generous and accommodating: *"Would you like this? Would you like that?", "The choice is amazing. It's like a hotel menu,"* and *"They always give you a soup if you want it [and then] three choices for your main course, one of them vegetarian. Three desserts and a good [selection] of sandwiches. Yeah, very good."* Patients valued **the ability to request adjustments or substitutions for personal preferences or dietary restrictions**:

"If [I'm] not happy with the menu, [I] ask for a jacket potato or a salad. And they [do] adapt for me. So that's really kind."

"I am not used to eating pork because my husband was Jewish. They always try to find an alternative."

"I have celiac disease, so food choice is a bit limited for me. The housekeeper is very understanding and attentive. She's been trying to order [gluten-free] snacks for me."

While some patients were happy with portion sizes, most felt the **meals were too large**. **Reduced appetite** was often attributed to limited physical activity, age-related lower energy needs, or the emotional effects of being unwell and in hospital:

"You have your breakfast at eight o'clock. Lunchtime is at twelve and your [evening] meal at five o'clock. That's perfect if you're doing something but when you just lay [in bed], you're not burning it off."

"They give you too much food for old people. I've lost my appetite in here. I don't know, it must be that sitting around doing nothing all day."

Some patients said they had asked for smaller meal sizes, but their requests were not always acted on: *"I have asked again and again for small portions, but they all come up the same. I don't want to eat that much, it's off-putting."*

Most patients reported that **meals were served hot and well-presented**: *"They bring [food] individually to each patient, it's hot and it's got a cover over the plate."* Some appreciated that *"they don't bring the second course until you've finished your first", which helps* keep food warm. However, a few patients noted that **meals could sometimes arrive lukewarm** but acknowledged the **challenge for staff tending to many patients**: *"It's not their fault it's cold, they have got a lot of people to get around. It's just not very appetising."*

NCHC NHS Trust uses a recognised colour tray system to help staff identify patients who may need additional support with eating or drinking. This system generally **supports appropriate assistance, with patients with dexterity challenges** reporting help such as having their food cut up or being fed.

However, **some patients experienced more limited support, suggesting there may be opportunities to ensure consistency of care at mealtimes**.

A couple of patients with swallowing difficulties described adapting their food choices to manage meals: *"[When I look at the menu], I think, Am I going to be able to get that down? I can't seem to be able to swallow pieces of meat. When I can't eat, I have soup at the next meal, which I know I can."* This emphasises the **importance of ensuring all patients can safely consume their food and routinely offering meal modifications, such as softening or pureeing**. Without these adaptations, patients may avoid certain foods, skip meals, or rely on limited options, potentially compromising their recovery and wellbeing.

Some relatives described **instances where food or drinks had been left out of reach**. One recalled: *"I assisted patients who couldn't access their food or drink as it was put too far away from them, and they had been calling the bell for a while..."* A more concerning example involved a patient with dementia. Her relative reported repeated occasions when she was left without her drinks:

> *"A few times I noticed that the teas [my wife] had been given*
> *were cold on the table at the end of the bed.*
> *She couldn't reach and she needs help: someone has to hold her drink for her.*
> *I reckon half of the time, she [hadn't] had anything to drink.*
> *I asked her, 'why aren't you drinking your tea?' And she said, I haven't had any tea.*
> *[She's got dementia], whether that confused her or [not], I don't know.*
> *But I assumed the girl that came in with the tea would know*
> *[of my wife's condition and support needs]".*

These accounts suggest that, at times, **staffing pressures and lack of awareness of patients' needs can put them at risk of unintended neglect**. They highlight the importance of routine checks, careful monitoring of food and fluid intake, and attentive support at mealtimes - particularly for patients with limited mobility, cognitive impairments, or other vulnerabilities.

Patients were generally offered flexibility in where they ate, including in bed, in a chair at their bedside, or in communal day rooms. Many valued this choice, which allowed them to align with personal preferences, comfort, and physical abilities: *"I sit in my chair and eat at my table. I have an apron because I drop things... I feel embarrassed"*, or *"Maybe when I feel a bit stronger, [I will go to the day room for meals]. For now, I feel more comfortable sitting in my chair."* Other patients preferred to eat privately, citing independence or personal habits: *"I stay in bed or in the chair because I'm very private and like to keep myself to myself,"* or *"Breakfast I [like to] have in bed and [other meals] in my chair. I always stay in [my room]."*

Although **most patients stayed in their bays for meals, some appreciated communal dining, noting the social interaction it offered**: *"I enjoy having community meals because you've got other people to talk to."*
However, barriers such as sensory impairments could limit participation:
"The day room is lovely but the acoustics aren't good for me. Because [I'm] deaf, I can hardly hear [others], which is a bit sad."

Staff play a key role in supporting patients' choices around where and how to eat. A relative suggested **that limited staffing may explain why patients were not always taken to the day room for meals**, noting: *'There's not enough staff so patients are not moving as much as they should. Anybody that can go to the dining room should. It help[s] with things like your bowels and get[s] you to socialise with other people. That's lacking here."* Some patients reported that **staff had stopped offering certain options**, possibly due to **workload pressures or assumptions about their likely preferences**: *"I [usually] eat in my chair but sometimes I go to the day room. [Staff] used to offer to take me first, but they don't now, they've given up..."* **Consistent, proactive offers of dining locations, combined with appropriate assistance, are important to ensure all patients can exercise genuine choice.**

Visiting arrangements

At the time of our interviews, visiting hours across NCH&C rehabilitation facilities were limited. Since August 2025, they have been extended (10am to 8pm) to align with acute hospital standards, offering greater flexibility for families and friends to visit at times that better support both patients and visitors. The following accounts therefore reflect experiences under the earlier, more restricted arrangement.

Visiting was perceived as a vital source of emotional support for patients, yet **restricted hours often created challenges for relatives who worked or lived far away,** particularly since patients are often placed in the first available rehabilitation bed rather than close to home. Some described relatives rushing after work or making long journeys for short visits: *"My husband works in the day, so only [comes] in the evening. [We] might only get half an hour before [he needs to] travel back home again."* Others felt the hours simply didn't fit around everyday life: *"It's [nearly] an hour for my niece to drive on her days off and she has to go back to pick up her son from school."*

Despite these challenges, **patients valued staff flexibility and support**. **Staff often made informal exceptions or provided private spaces for visits**: *"Nothing's ever been said but they just let him stay a bit longer,"* and *"My brother came at lunchtime. The staff arranged for me to meet him in one of the quiet rooms, which was very nice."* Visitors were therefore recognised as important for emotional support, social connection, and overall wellbeing.

Most visitors found parking manageable, including those with mobility needs: *"My wife [drives a car] with a disabled badge. No problem at all [with parking],"* and *"My [relative] is a big lady and not very mobile… but it's been very easy."* On rare occasions, peak-time congestion created challenges at the Norwich Community Hospital site: *"Car parking is a nightmare at the Willow, you get stressed out before you go in to visit [your loved one]."* A few people also noted **minor access issues at the entrance**: *"I pressed the buzzer [several] times but there was no one at the desk… Eventually, an ambulance arrived and I followed them in,"* and *"It's bit difficult to get through those doors and you have to wait sometimes for someone to see you."*

Access to food and drink for visitors appeared inconsistent across facilities. Most sites have vending machines, though Foxley Ward does not, and some visitors brought their own refreshments: *"[My son] always brings drinks. He always comes prepared."* Others reported restrictions on consuming food or drink on the wards: *"You couldn't buy [snacks] and I would've happily bought a cup of coffee from the kitchen, but you couldn't… Apparently, visitors cannot be given anything [to eat or drink]."* Some were unsure where to access water: "*There isn't anywhere I can get some drinking water that I have seen other than the jug of water on mum's table."* Clear guidance and consistent practice across all sites would reduce confusion and better support visitor comfort during their time on the wards.

Experiences of the ward physical environment – Summary

Overall, rehabilitation wards were described as welcoming, clean, and supportive of recovery. While older units showed some dated features, these did not appear to compromise the quality of care. Patients and relatives were generally satisfied with hygiene and comfort, and staff efforts to adapt furnishings for individual needs were highly valued. Safety or assistive equipment were largely adequate, though call bells could be difficult for some patients. Noise was generally manageable but call bells and disturbances from other patients occasionally disrupted rest and restorative sleep. Experiences of meals were more mixed: while patients were generally satisfied with the food, support with eating and drinking was inconsistent, and staff did not always facilitate access to communal dining areas. Visiting arrangements, previously restrictive for many families, have since been extended, providing greater flexibility.

Staff pressures were frequently mentioned in accounts and appear to underpin many of the remaining challenges, underscoring the importance of adequate staffing to sustain patient-centred safety, comfort, and wellbeing.

Clinical care

Patient and family accounts of clinical care within rehabilitation settings reveal a broadly positive picture of **attentive nursing practice, effective communication with patients, and overall confidence in clinical competence**, alongside some concerns about **consistency, coordination, and the personalisation of care**. Taken together, these experiences highlight both the dedication of staff and the systemic challenges that can affect the delivery of timely, patient-centred care.

Attentive and proactive nursing care

Attentive nursing was consistently highly valued, with continuous monitoring, consistent record-keeping and preventive care clearly visible. Across multiple accounts, nurses were described as caring, responsive, and committed to patient recovery and wellbeing. A patient rated the standard of care as *"nine out of ten,"* with another emphasising that nurses were *"very vigilant, putting [a healing] cream and a barrier cream on a moisture wound, and keeping notes. Now it has cleared up."* A relative similarly observed that nurses were *"watching a wound [on his wife's heel], could see that the bandage had been changed regularly, and that [his wife] had one of them booties put on […] to stop her foot touching anything."* These examples highlight how **clinical awareness and attentive care practices enhance patients' sense of safety while fostering confidence and reassurance** for both patients and their families.

Competence and trust in medical oversight

Patients generally expressed **trust in the clinical care provided by advanced clinical practitioners and visiting consultants**, particularly regarding medication management and clinical decision-making. One patient said, *"I feel the medical care is good. [When clinicians] come in, the medication we're on is written down, they refer to their sheets and seem to know what they're doing."* Another explained: *"One of the things which I think is invaluable is the fact that the doctor comes in on a Thursday to see us. When he came to me, I [asked] about medication [for an overactive bladder]. I explained [my] situation, and he prescribed the medication; I've been on it four nights now. I think that this service, and the clinical practitioner, are really very good."*

Although doctor visits were often infrequent, clear communication and continuity between services maintained patient confidence: *"The doctor comes around once a week [but] he's referring something back to my surgery from a blood reading. So, that's all okay."* These accounts suggest that **well-maintained record-keeping and follow-up support continuity of care, even in models of care where medical staff are not always on site.**

Effective two-way communication and relational care

Patients emphasised the **importance of two-way communication with clinicians**, particularly when they **felt listened to and well-informed**. Staff responsiveness and clear explanations helped patients understand their care and supported autonomy. One patient said, *"They explained my treatment to me. When I got an extra tablet, I asked and they said that was for [my] bowels."* Another noted, "*They come and have a chat with you to discuss how you're feeling and your medicine, that's nice."* A third reflected, *"I don't need to ask questions because I know exactly what I'm taking, for what and when,"* demonstrating how effective communication fosters understanding and independence.

Patients also valued approachable, non-hierarchical interactions with doctors and nurses. One observed, *"[The doctor] was a charming man. I liked [that] he was at my level rather than towering over me [and] being intimidating [while] I was sitting in my chair."* Another reflected on broader cultural change: *"Back then, doctors didn't really mix, they did their job [but] kep[t] patients at arm's length. [Here], nurses and doctors are very approachable. It's not me and them anymore, they come and talk to you."* This shows a shift from traditional hierarchical care towards a more **respectful and empathetic approach, where relational qualities such as listening, empathy, and respect are valued alongside clinical competence.**

Hospital routines and patient preferences: areas for improvement

While most patients described clinical care positively, some pointed out how **systemic pressures and standardised routines could limit personalised care and affect comfort and autonomy.**

Several patients **described tensions between hospital routines and individual needs, suggesting that they often prioritise efficiency over patients' own knowledge of their health and daily habits.** One patient illustrated how rigid medication schedules could disrupt established personal routines:

> *"For years, I have been taking medication to stop me [going to the toilet at] night.*
> *My body was used to that.*
> *[In the ward], they insisted on giving it to me first thing in the morning.*
> *I did find that horrendous; [it] totally mucked up my body.*
> *I couldn't pass water during the day at all,*
> *but I was calling for a bed pan four or five times every night."*

Another patient commented on how **hospital norms and clinicians' authority can unintentionally undermine comfort and dignity** by disregarding natural differences and lived experience:

> *"When you're in hospital, they expect you to do a number two every day.*
> *I don't know anybody [my age] that goes every day.*
> *But, because of the way they work,*
> *I was forever having suppositories, enemas and laxatives.*
> *I [spoke to the doctors] but they know better than you."*

Patients also described how the **regimented rhythm of hospital life could be intrusive, disrupting rest.** One explained early morning rounds:

> *"I didn't like being woken up to do a blood pressure test and things like that.*
> *But that was standard: six o'clock, you [could] nearly set your clock by it.*
> *And then [staff] would say, 'How did you sleep?' Fine until I got woken up!*
> *I'm a light sleeper [and] it [was] hard to get back to sleep again [afterwards]."*

Many expressed resignation, perceiving that **personal preferences carried little weight within institutional routines:** *"That's the way they do it. You're in hospital, you can't change rules for people."* This sense of acceptance suggests that **hospital culture may**

discourage patients from asserting their own needs, reinforcing professional authority and limiting autonomy. While routines provide structure and predictability, **greater flexibility and responsiveness to individual preferences could enhance comfort, dignity, and patient-centred care.**

Pain management also generated varied experiences. Several patients described that **paracetamol was often offered as a first-line treatment, even when it had previously been ineffective or unsuitable** for them. One participant stated: *"They always offer paracetamol. That doesn't work. They don't say you've got to take it; it's up to you."* Another reflected: *"Because of a personal bad experience of overusing paracetamol in the past, I haven't accepted all the paracetamol they wanted me to take. I haven't felt it enforced on me. It's [my] choice in the end."* These perspectives illustrate a complex experience of patient empowerment: patients felt respected through shared decision-making, yet the default reliance on paracetamol exposed gaps in personalised care. This underscores the importance of **approaches that combine patient choice with clinical protocols to ensure pain relief is both effective and individually tailored.**

Task-driven care and patient safety risks

A few patients highlighted **experiences where clinical care felt task-oriented rather than centred on individual needs**. While recognising that clinical staff were *"working hard,"* these accounts suggest that **systemic pressures and task-focused routines can sometimes reduce opportunities for personalised engagement and create safety risks.**

One relative offered an isolated observation about **care feeling procedural rather than relational**, suggesting that efficiency sometimes overtook empathy. She explained:

> *"I know time is of the essence, [but] everything is [about] ticking box[es]. Does [the patient] seem okay? Tick. Is he in pain? No, tick. I'm not saying they're not caring; they're all working hard. But, sometimes, it feels [like] some [staff] forget there's a patient at the centre of everything."*

Another relative emphasised that careful conversation and observation are essential for detecting problems, noting that **assumptions or incomplete assessment can have serious implications for safety or recovery**. She recalled how her mother was discharged with chronic diarrhoea and later required re-admission: *"Obviously, [Mum] wanted to get home [so] I assume [she didn't tell] the truth. Perhaps [staff] should have discussed [bowel habits] a bit more thoroughly with her. Maybe they need [ed] to be a little bit more observant."*

A patient reported a near medication error with potentially serious consequences, highlighting the **risks of distraction and multitasking during care delivery**. A nurse almost administered the wrong medication after being interrupted during the drug round:

> *"One of the ladies [in the bay] would keep calling when the nurses [did] the drug round. [One day], a nurse got distracted [and] ended up coming to me with the medication of the person in the next bed. I heard her say insulin [but] I knew it wasn't my injection. I don't take insulin. That could have been a very serious mistake! 'I'm being disturbed,' she said."*

A relative also shared an incident where a nurse gave all tablets to her mother at once, creating a physically unsafe situation and causing emotional distress: *"A nurse put all the tablets in [my mother's] mouth in one go and [she] nearly choked. I thought that was unkind. A lot of nurses think that all 90-year-olds are gaga and don't know what's going on, but that's not the case, is it?"* While this account may reflect pressures on staff to complete medication rounds efficiently, it also shows that some patients have **concerns about the potential for dismissive or overly standardised treatment of older and vulnerable patients.**

Challenges in communication and continuity of care

While most patients and relatives described clinical oversight positively, a few raised concerns about **gaps in communication and continuity of care - both within the**

rehabilitation settings and between the units and other healthcare providers. Their accounts underline how infrequent medical visits, incomplete documentation, and delayed information-sharing between clinicians can create uncertainty and anxiety.

One person recalled a worrying episode when her relative appeared to have a stroke, and **clinical observations were not fully documented or acted upon**:

> *"I thought [my relative] was having a stroke, his speech just went completely.*
> *The nurse took obs straight away; that was good.*
> *But then, this allegedly didn't get documented,*
> *[and] the doctor only saw him on the Sunday or Monday.*
> *He said that can sometimes happen when you get tired.*
> *No way that was tiredness! That needs investigating. Things like that worry me."*

A patient reported **delays in communication between visiting clinicians and specialist hospital services**, as well as **difficulties in securing timely specialist follow-up**:

> *"I was saying to the visiting doctor from the N&N that I needed an appointment with the surgeon because [a] fistula next to my stoma is [leaking] waste.*
> *The visiting doctor emailed the surgeon last week,*
> *and this week [he informed me that] the surgeon didn't know [about it].*
> *I would've thought that the visiting stoma nurse would've said [something].*
> *I find that particularly strange.*
> *Anyway, he's going to see me within four to six weeks.*
> *That's a long time, that concerns me a bit."*

Another patient noted that **infrequent doctor visits and restrictions on nurses' prescribing authority could leave patients waiting for essential care**:

> *"The lady opposite me was told she needed antibiotic for cellulitis.*
> *They left it four days before she got her antibiotics.*
> *Doctors do visit quite irregularly, and nurses can't prescribe."*

While these experiences were not widespread, they point to **vulnerabilities in communication between clinicians and follow-up processes.** Strengthening coordination between clinical teams - alongside timely documentation, information-sharing, and escalation - would help to ensure that emerging concerns are recognised and addressed without delay.

Clinical care - Summary

Overall, patient and relative experiences of clinical care in rehabilitation facilities underscore the high levels of professional commitment, compassion, and attentiveness with **nursing vigilance and relational care emerging as particular strengths.** At the same time, the findings show that **workload pressures, hospital routines, documentation practices, and communication between clinicians can occasionally limit personalisation, responsiveness and continuity of care.** Addressing these challenges calls for adequate staffing and sustained focus on communication and coordination, ensuring that clinical care remains safe, effective, and firmly centred on the individual.

Experiences of therapy

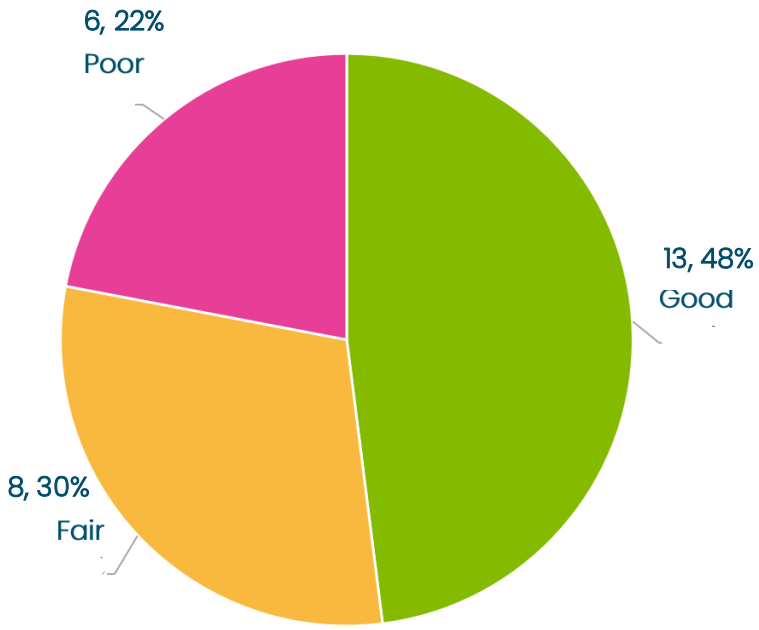


Figure 2. Percentage responses to the question: How would you rate the overall quality of the therapy provided in the ward?

Figure 2 presents satisfaction ratings from twenty-seven patients and relatives for the quality of the therapy on rehabilitation wards. **Thirteen respondents (48%) rated the therapy as good, eight (30%) as fair, and six (20%) as poor.** Given the modest number of survey respondents, these findings are illustrative rather than representative. However, they suggest that **while many patients and families recognised positive aspects of therapy, a notable proportion reported mixed or less satisfactory experiences.** The following sections draw on qualitative feedback to add depth and context, capturing the nuances of individual experiences and exploring factors that influenced satisfaction, as well as areas for potential improvement.

Expectations and impact on satisfaction with progress

As described earlier in this report, **many patients had limited understanding of rehabilitation before admission**. Many anticipated **physical recovery and a return to normal life, with less awareness of the broader therapeutic support beyond supervised physiotherapy.** One patient summarised this perspective simply: *"I knew [there] would be physios and they'd get me walking."* Others appreciated the broader **restorative and enabling role of therapy:** *"Therapy is [about] getting someone to a mobile position and*

improving [enough] to go back home to normal life, [or a] new normal." Most placed trust in professional guidance: *"I left it with health professionals to do what they thought was best."*

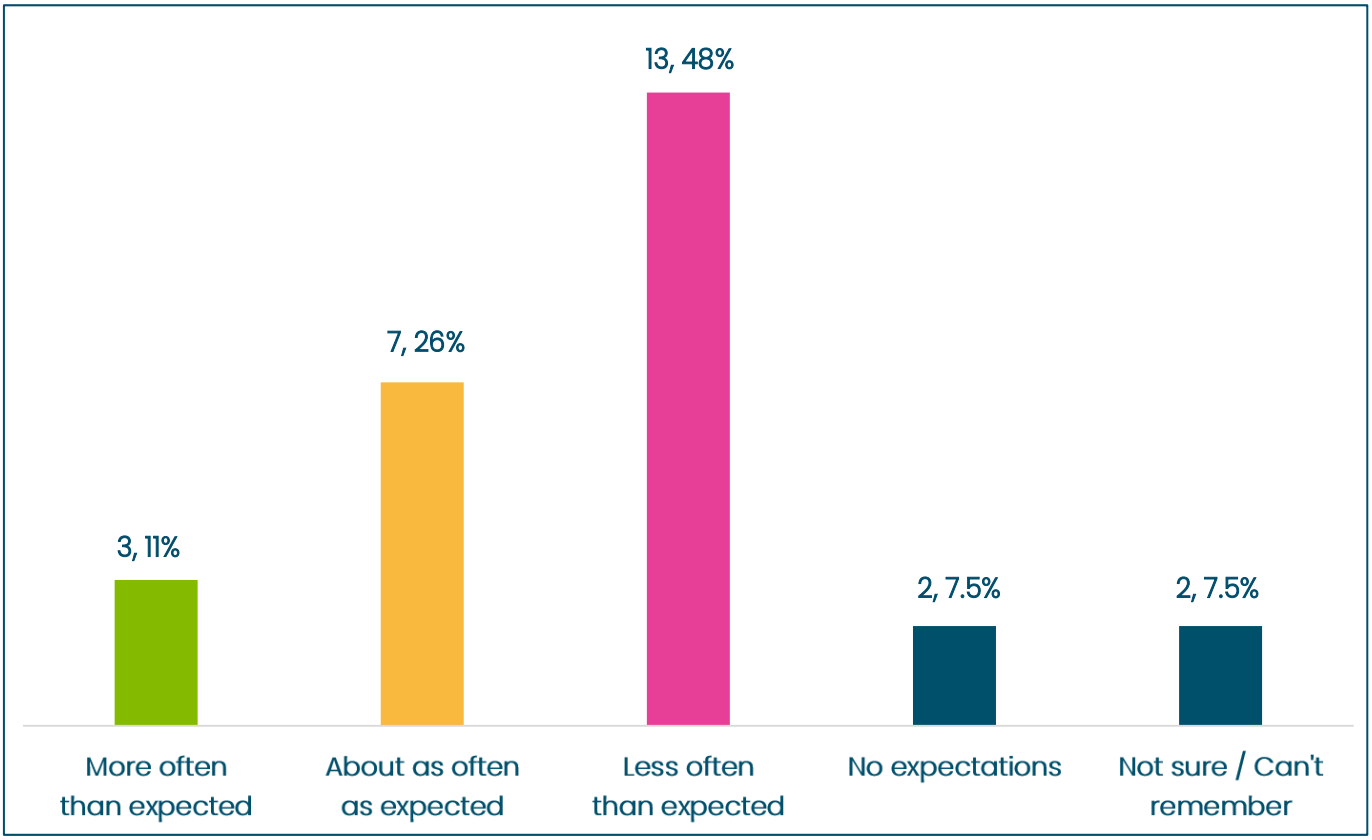


Figure 3. Percentage responses to the question: How often did you receive rehabilitation therapy from physiotherapists and occupational therapists?

Upon arrival in rehabilitation wards, **many patients and relatives expected frequent, structured, and intensive therapy**. These expectations were often shaped by information received during acute care or general assumptions about rehabilitation. Figure 3 illustrates the gap between expectation and experience: only seven (26%) of survey respondents received therapy as often as hoped, while thirteen (nearly half) perceived a notable shortfall. Several accounts explain this discrepancy. One relative commented:

> *"I was told [my father] was leaving the QEH for some intensive physiotherapy, but I don't think [what he received] could be described as [such]. I don't think he was looked at [by the therapy team] in the first week he was there. And then, unfortunately, it was very patchy, and there was no cover at [weekends] and [for] bank holidays."*

Patients echoed similar sentiments. **Many expected daily therapy sessions but often experienced far less frequent contact, usually two to three times per week**: *"I thought I would've been seen by a physio every day to get me moving. It's not happened [and] I think that's a bit poor,"* and *"I was sent here on the understanding it would be hard rehabilitation… it would be quite intense. That is not the case."* **The brevity of therapy sessions further compounded disappointment**: *"This week, I think I've seen them once to go on an exercise machine for 15 minutes, and once to try some stairs. It's not what I was advised and expected. It's not enough to get me home soon,"* and *"When the physio came, [it was] for 10 minutes and that's it."*

The **mismatch between expectations and reality appeared to affect patients' perceptions of progress.** One patient observed: *"I've been here for about two weeks, and I don't think I am progressing well. I said to the physios [that] I really want to get moving, but they're not pushing basically. I think that's a bit poor."* Another reflected: *"Progress is not as good as I was hoping. [I am] probably not as active and mobile as I'd like after the time I've been here."* Others expressed similar concerns: *"I was expecting [my mother] would be walking better than she actually is; it's been a waste of time,"* and *"If I could have had [more] physio, maybe I could have come out earlier."* These accounts suggest that **unmet expectations contributed to dissatisfaction** and, in some cases, **undermined confidence in rehabilitation outcomes.**

Staff interviews strongly reinforce this theme and help explain why this mismatch persists. Staff consistently described rehabilitation as a finite, time-limited intervention, requiring active engagement, but noted that many patients arrive with unrealistic expectations, **limited understanding of what rehabilitation involves, or a belief that improvement will simply happen once they return home**.

Staff highlighted how **cognitive impairment, fatigue, pain, anxiety, and deconditioning make it difficult for some patients to grasp the purpose of rehabilitation or link present effort with future outcomes**. Several staff explicitly described a *"sick role"* mindset, where patients see themselves as temporarily unwell in hospital but assume they will automatically recover at home.

Staff also acknowledged that although expectations are explained on admission, these conversations may happen when patients are fatigued, overwhelmed, or unable to

retain information, and goals are not always revisited. This helps explain why patients later reported confusion or frustration about what they were *"working towards"*, despite staff believing goal setting had occurred.

Despite frustrations, **many patients and relatives tempered their criticism by acknowledging the constraints faced by staff**. Interviewees expressed empathy for therapists, recognising that **staffing levels, workload, and organisational pressures could limit therapy delivery**. One Carer explained: *"I'm not blaming [the therapists], they're lovely [but they're] quite short-staffed. What they can do with their patients has got to be a bit of a concern."* Similarly, two patients observed: *"They're short staffed, they're busy, […] run off their feet and I don't know what else,"* and *"[I am not getting] as much [therapy] as I would like but as much as they can give. I'm not the only person here [and] they only work so many hours a day."*

Some staff interviewees corroborated patient perceptions of limited therapy sessions, admitting that they often have to **prioritise patients based on their *"likelihood of progression"*** due to small team sizes. However, they also emphasised that **shorter sessions are often a clinical necessity rather than just a resource issue**. They noted that many patients arrive from acute care *"completely exhausted"* and *"deconditioned,"* meaning **they physically cannot tolerate more than 10-15 minutes of exercise at a time** without needing to recover.

Some relatives **questioned whether available staff were being used to their full potential**. One remarked that, despite seeing *"three, four, five, six therapists walking about,"* little therapy seemed to be taking place, likening it to *"a pub with no bar staff."* He speculated **that excessive paperwork and administrative demands could be diverting therapists' time away from direct patient care**: *"There's too much red tape, everything has to be signed and crossed and dotted; you can't blow your nose without having to write three pages of report."* Together, these perspectives emphasise that **dissatisfaction with therapy provision was directed at systemic limitations rather than individual staff.**

Overall, these reflections highlight a shortfall between expectations and provision. While staff dedication was recognised, perceived insufficient therapy frequency and intensity were seen to diminish patient motivation and morale, hinder recovery and discharge

readiness. **They point to the need for clearer communication and approaches that more effectively manage and align patient expectations with what rehabilitation services can realistically provide.**

In interviews, staff confirmed that there were staffing pressures, particularly highlighting how **short staffing, prioritisation of basic care, discharge coordination, and documentation** reduce the time available for therapeutic activity. Staff also noted that rehabilitation delivered *"in a reablement way"* takes longer, and **when staffing is tight, care necessarily becomes more task focused**. This mirrors patient accounts describing care as sometimes *"tick-box"* or procedural, even while recognising staff goodwill.

Importantly, **staff accounts also complicate the patient narrative** by showing that **therapy is not confined to formal sessions**. Nursing staff, healthcare assistants, and others described how encouragement, mobilisation, conversation, reassurance, and pain management are all part of rehabilitation, though patients may not always recognise these as "therapy". This helps explain why **patients can perceive inactivity even when staff feel rehabilitation is happening continuously in small, informal ways**.

Supervised therapy sessions

Patient and family members portrayed **an overall picture of skilled, patient-centred rehabilitation delivered with care and encouragement**. Experiences emphasised the importance of gradual progression through personalised pacing and emotional reassurance, alongside a strong focus on functional independence and safety.

Patients described a **diverse and engaging range of therapy activities, encompassing both structured exercises and functional practice**. Sessions made use of therapy rooms equipped with walking frames, parallel bars, mock-up stairs, and even video-based exercise machines (Figure 4).

This variety helped **maintain interest while developing strength and coordination in practical contexts**. One patient explained, *"I've been to the physio room where they've got the mock-up steps and, I don't know what you call it, like a video game thing where you cycle. And then they've got me walking by holding parallel bars."* Another said, *"I*

went to the gym once to do some work on the bike. I thought this is great. I enjoyed that." Such diversity reflects a **holistic approach to rehabilitation, where therapy is both functional and motivating, incorporating everyday movements as well as enjoyable, confidence-building tasks.**

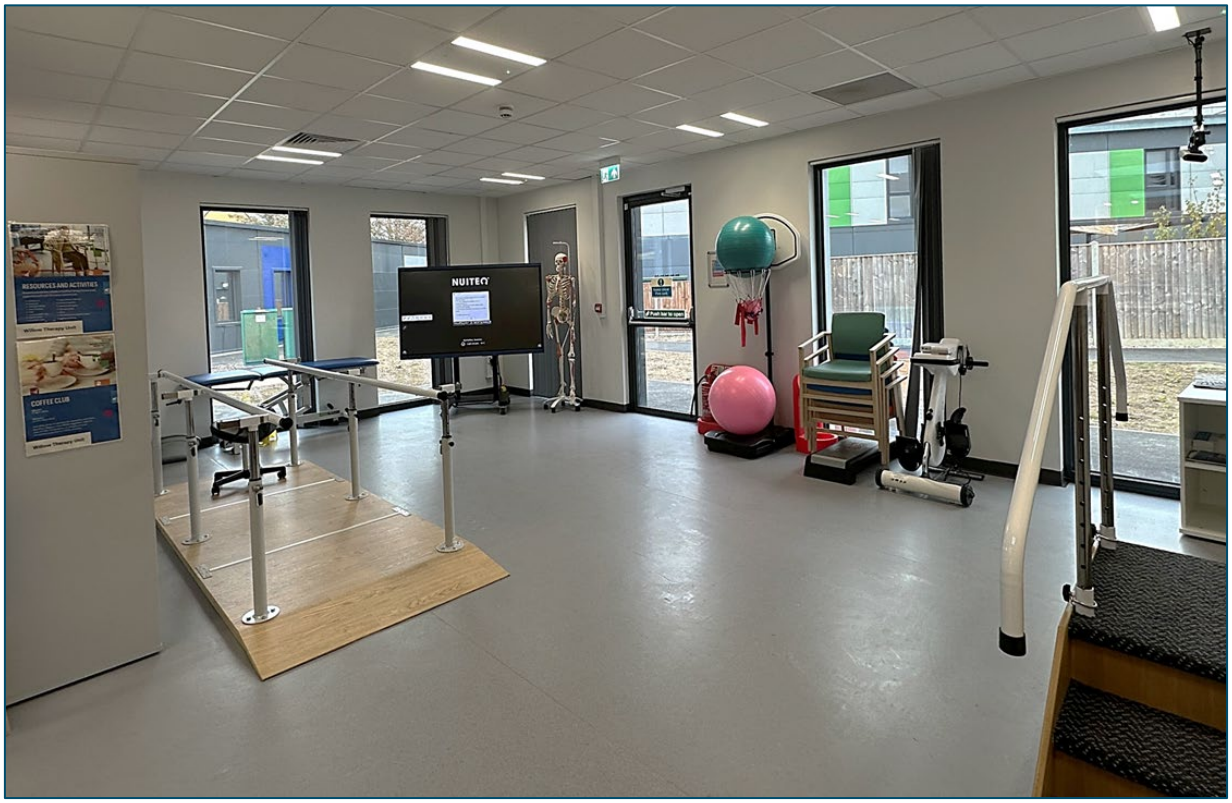


Figure 4. A photo of the therapy room at the Willow Therapy Unit.

Therapy strongly focused on re-learning practical independence, with the goal of supporting a safe and confident return home. Exercises replicated everyday movements – including walking, transferring between bed and chair or climbing stairs - and were tailored to each person's living environment. As one patient explained, *"They are showing me exercises which are good for my knee, and the safe way to get in and out of bed."* Another said: *"I had to climb steps in the therapy room to see if I could get up the ones into the house."*

Patients also described reablement activities as a positive and purposeful part of their rehabilitation, focused on rebuilding functional independence, developing confidence in managing daily routines, and preparing for life at home. Reablement addressed activities of daily living, helping patients to regain self-care skills such as washing, getting dressed, or using the toilet. One patient reflected: *"Sorting myself out for [when I*

need] the toilet, that's what we are practising now. [And] I do know that I will have a commode that can be converted to a wheelchair by the time I go." Another added: *"[The occupational therapists] are organising a commode to go outside of the bed and one of those horrible things to put on the toilet to raise it."*

Patients were also encouraged to take part in everyday domestic tasks, using adaptive equipment and practicing the preparation of light meals in the therapy kitchen (Figure 5). One relative shared: *"[My relative] has started going [to the therapy kitchen] to practise making a cup of tea, then putting his cup in the dishwasher and things like that."* A patient explained: *"You are encouraged to prepare your own breakfast. That's part of your rehabilitation. Opening a butter or a margarine with only one hand, it's quite difficult [but] you have to learn how to look after yourself again."*

Figure 5. A photo of the therapy kitchen and dayroom at the Willow Therapy Unit.

Staff repeatedly emphasised that **patients engage better when they understand the purpose of rehabilitation tasks**. Staff gave examples of how everyday activities (such as making a cup of tea or getting out of bed for meals) are therapeutic, but acknowledged that **without explanation, patients may perceive these tasks as pointless, patronising, or even time-wasting.** This mirrors patient accounts where engagement improved when therapy was clearly linked to independence at home.

Patients consistently described therapy as a step-by-step process that evolved in line with their recovery. Sessions typically began with simple movements and progressed to more challenging work as strength, mobility and confidence improved. This **individualised progression reflected thoughtful clinical assessment and sensitivity to each person's readiness.** One participant recalled: *"The first few weeks it was just arm stretches. Last week they brought this machine where you had to put your arms up and it helped you stand up. And then today [we tried] a walking frame [to support transfers between] bed and chair."* Another explained, *"[The physio] gets me to walk with a frame to one of the lines on the floor one day, and the day after, the next line."*

Patients valued sensitive pacing and reassurance for confidence-building, with therapists seen as attuned to physical limits and emotional readiness: *"When I first came here, they said the stand they use in hospital was too much for [me]. So, I had an electric one that pulled me up and then progressed to a different stand aid and eventually to a frame. It was done in stages."* **Patients felt encouraged to challenge themselves with activities which promoted safe and achievable progress**. One commented, *"The physios never ask me to do something that they aren't confident I can do."* Another echoed this, saying, *"They let me do it at my pace. We see each day as it comes."* This approach helped to reduce fear of falling or re-injury: *"It's done in little steps. Would you like to try this today? [They tested me with] a tripod stick but I wobbled. So now I've just been given a Zimmer frame, which is I feel more confident with. The last thing I want is to fall over and break the arm again."*

Staff also highlighted how **fear, anxiety, and uncertainty about the future reduce engagement**, reinforcing patient reports that **emotional reassurance and trust are as important as physical therapy**. Several staff described deliberately taking time to listen, build rapport, and offer reassurance — even though this work is not formally recognised as "therapy". This may help explain why patients often rated relational aspects of care highly, even when therapy intensity fell short of expectations.

Several patients contrasted this carefully graded progression with acute hospital experiences where they had felt pushed too quickly: *"[In hospital], they said the only way to get better [was] to bend that knee. Here, [they're] listening to what I'm saying. They're not pushing when I've had enough [so I won't] relapse [or] do more damage in the long run."* A relative observed, *"[Here], everything's been taken slowly to help build*

[Mum's] confidence. There's no point in rushing her to get her up on the feet. At the QEH, they did it two days after the operation. She started shaking within seconds; she was terrified she would be falling over again." Together, these perspectives highlight the therapeutic value of patience, reassurance, and shared decision-making, supporting both physical and emotional recovery.

A strong thread of **positive relationships with therapy staff ran through much of the feedback.** Patients valued therapists who **combined technical skill with warmth and empathy,** describing them as approachable and reassuring. *"The physiotherapists are brilliant, they really are. They're lovely,"* said one participant. Another commented: *"They're always there ready if they think you're going to tumble so you feel safe."* Such trusting relationships fostered a **collaborative dynamic**, in which patients felt respected, listened to, and supported through the challenges of rehabilitation.

Finally, **patients' accounts revealed a deep sense of personal effort and determination, with many expressing pride in their own progress**. Even when exercises were painful or demanding, individuals described persevering for the sake of recovery and independence. *"They've said that I'm doing really well with the exercises and I can feel myself getting stronger. I'm really pleased about that,"* said one. Another remarked, *"It's like a knife stabbing you… but I do it."* This commitment was often linked to the desire to return home: *"It's all tied up with being able to go home. And being able to cope in my own home."* The accounts illustrate how motivation and professional support work together with patients striving to do their part, and therapists providing the expertise and encouragement to help them succeed.

Self-directed therapy activities

In addition to supervised sessions, many patients engaged in self-directed therapy, **practising skills and building confidence outside formal therapy times.** These activities, tailored to individual goals, and abilities, supported independence and self-management.

Self-directed therapy often involved self-guided exercises, helping patients to stay active when therapists were busy. One patient explained: "*The physios were only there for about 10-15 minutes, but they taught me some exercises to do [by myself]."* Most

patients received printed handouts: *"I've got two pages of exercises that I can do on my own,"* while a few described verbal instructions and notes left on whiteboards: *"No handout. Just verbally and what they've written on the board."*

Guidance was generally clear and responsive, enabling patients to practise safely: *"[Some exercises] I knew already because of having the other knee done, but there are a few that are slightly different, but they were explained well."* **Therapists remained approachable and willing to assist despite limited time:** *"They're busy with other people but they do come and see if you need anything. I've got a bit confused doing a couple and [the therapist] came and explained them all to me again."*

A few patients, however, found it challenging to follow or remember instructions, leading to uncertainty. One patient reflected: *"I don't know if I am overdoing it, or not. I don't know."* Another added: *"There are two different sheets, so I thought, do I do it whole in one go, or half of one and later half of the other?"* Delays in receiving written guidance occasionally added to this uncertainty: *"I saw the physio who said I'll bring a printout. Well, I'm waiting for that printout… I should nag more really because I've been here a while."*

Patients were generally diligent and self-motivated in following their exercises, although **engagement varied**. Some practised frequently and proactively: *"I've been doing [self-directed exercises] every morning, lunch and evening. [Whenever the physios] have offered something, I've said let's have a go,"* and *"I am always moving, I stretch my legs and do exercises when I sit [on my chair]."* Others faced **limitations due to pain or fatigue**: *"I try but I don't always do that many on my own because the pain is dreadful. I only do things that suit me."* Another commented: *"The physio has given me exercises to do in my chair. I don't want to push myself because I feel tired and want to go to sleep."* A few patients **resisted engagement due to personal preferences or emotional barriers:** *"[Mum] is difficult and not interested. They [went] through some exercises with her, but she's not bothered; everything is her own way."*

Several staff members described how **poor sleep, night-time disturbance, pain, medication effects, and general frailty** can significantly reduce patients' capacity to engage in therapy. These accounts help explain why some patients may appear *"unmotivated"* or *"resistant"*: Many are physically exhausted, fearful of falling, or managing multiple conditions that limit tolerance for activity. This aligns closely with

patient accounts of wanting more therapy while simultaneously feeling too tired, sore, or anxious to participate, revealing **a tension between the desire for progress and the capacity to engage**. Staff also described **practical constraints**, such as the need for multiple staff to assist with transfers, the competing priorities of personal care and safety, and the challenge of mobilising patients in unfamiliar, open ward environments that feel unsafe.

Overall, these accounts indicate that **while self-directed exercises support patient autonomy and continuity of therapy, their effectiveness depends not only on patient initiative but also on clear and timely guidance, as well as ongoing support** such as regular check-ins and reminders, to help patients practise safely and consistently.

Opportunities to get up and mobilise

Figure 6 shows that **patients' experiences of getting up and moving around varied considerably during their time in rehabilitation**. Thirteen respondents (50%) felt they had received sufficient opportunities to mobilise, whereas a substantial minority (10, 38%) reported that this occurred less frequently than they wanted or needed. These findings align with qualitative feedback from patients and relatives.

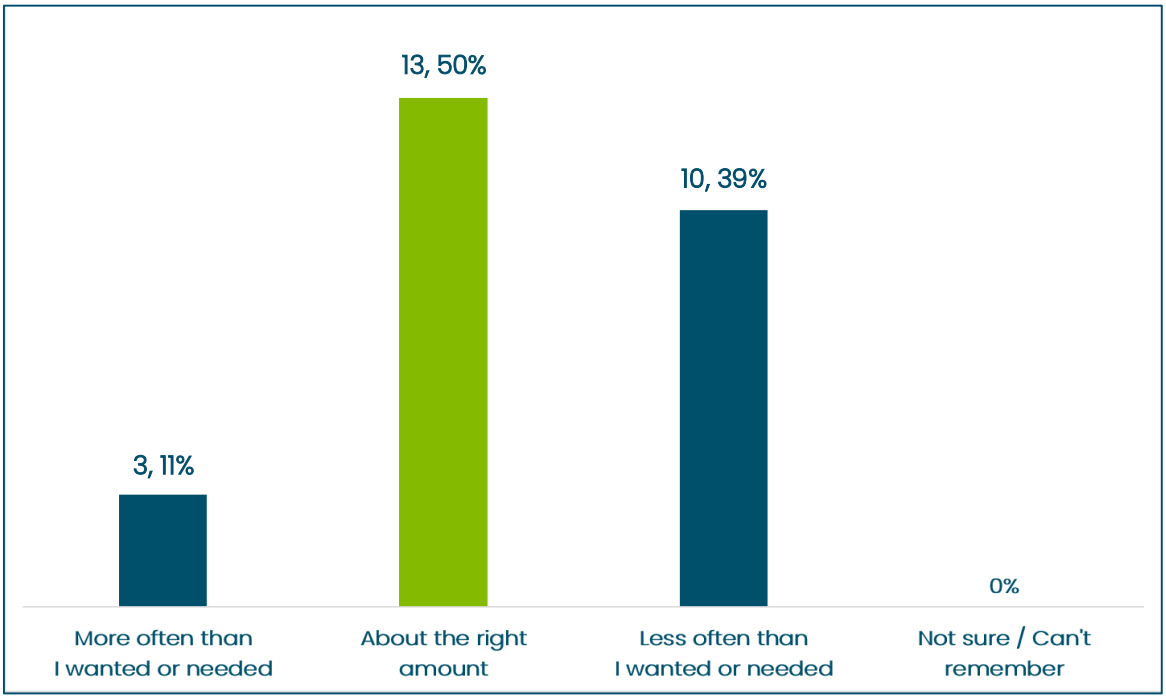
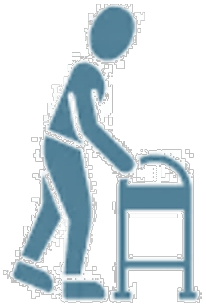


Figure 6. Percentage responses to the question: How often were you encouraged and supported to sit out of bed/chair to move around?



Some interviewees described active encouragement from staff. One relative said: *"[My mother] was walking the corridors by the end of the third week. And others were as well on a regular basis."* **Staff were seen as proactive in offering walking opportunities and supporting the use of equipment**. One patient noted: *"Staff always ask, would you like to go for a walk? And [they] encourage you to use different equipment." Another added: "It's offered. They say, should we go and have a little walkabout in the corridor?"*

Patients took pride in small milestones, highlighting the motivational value of regular support: *"The other day they walked me around three quarters of the building. I was tired when I finished it, but I could do it,"* and *"They are brilliant getting [my mother] up. The other day, she managed to walk 20 metres. She was proud."*

At the same time, **other patients and relatives described largely sedentary wards, where opportunities to mobilise beyond essential movements - such as transferring to and from bed and chair, or going to bathrooms – were limited:** *"There wasn't much in the way of going for a walk with staff, only to the toilet and back," and "I literally have not seen [my relative] move since I've been visiting, only when they've helped her up to take her through to the bathroom."*

Many of the patients we interviewed were **not yet safe to walk independently** and **required one or two staff to assist:** *"I'm not allowed to walk [without] an escort, like the King and the Queen,"* and *"I'm not in a position where I can go for a little walk around the room. They want two people following [me]."* This reflects a **balance between promoting mobility and managing risk**. However, in some situations, caution **inadvertently restricted progress:** *"They say I have to have somebody [with me] but, last night, nobody came so I walked myself with the Zimmer [frame] into the bathroom, which was okay. I'm past [needing one-to-one assistance] now, I want to do as much mobility as I can."*

One relative, who had previously worked in rehabilitation, described what they felt were **missed opportunities for mobilisation**:

*"I saw loads of [patients] sitting in chairs [or] stuck in bed.
The only time I saw anyone [mobilising] is when the physio came and that's it.
[Staff] didn't give [opportunities] to walk
to the day room and the garden or do [group] exercise.
I didn't see anybody having a little walk other than when family came.
This is wrong, in my opinion. If [patients] are able to move, they should be moving."*

In addition, there was **widespread uncertainty over whose role it was to encourage and assist walking**: *"I don't know whether the [staff in the nursing team are meant to be] helping, or if it's against the physiotherapist's wishes,"* and *"When she went to the toilet or wanted to go for a walk, the nurses took her, not the therapists."*

Patients and relatives often cited **staffing pressures, workload and competing priorities as barriers to regular mobilisation**, **which seemed deprioritised in daily care routines, despite its central role in rehabilitation:** *"The [nursing staff] were rather busy to spend a lot of time with just the one person,"* and *"It would be nice if I could [mobilise] every day but the team can't obviously fit everybody in." A relative also commented: "Half the time staff were sitting around the desk, [or] you couldn't find anyone. Lack of staff, lack of training, maybe they couldn't be bothered. I don't know..."*

Family members sometimes played an active role in encouraging their loved ones to mobilise, acting as advocates and motivators for patients to support therapy activities patients might otherwise avoid. One relative described persuading his father to go to the toilet: *"They were get[ting] a commode. I said, let's see if we can get him to walk to the toilet. I mean, [he could] before he went to the QEH. He did it, which is great."* Another explained how some gentle encouragement helped his mother to attempt some walking: *"When staff offer, she'll just say [she] can't. But she will do it for me [when I say] mom, you've got to try."*

Limited opportunities to mobilise eroded not only physical recovery but also confidence in progress, readiness for discharge, and overall wellbeing. Some patients reported **concerns about their deteriorating strength and mobility**: *"My legs are getting weaker and weaker. I could hardly stand up this morning,"* and *"[Walking] has got very difficult because I am too weak now. This morning, I nearly fell off."* Others spoke of the **emotional toll of deconditioning**, expressing boredom and frustration at long periods of

inactivity: *"It's definitely not intensive rehabilitation… I've been sitting here since this morning and I'll sit here till bedtime,"* and *"Mum found it really hard sitting on the ward all day. You can soon get muscle wasted in your legs, I just think that's really unkind."*

Patients also described boredom, low mood, and lack of stimulation as undermining motivation. Staff interviews strongly reinforce this, with many describing patients who are **anxious, depressed, or demoralised**, but unable or unwilling to articulate this directly.

Staff described repeated attempts to engage patients in day rooms, activity groups, or social interaction — often with limited success. They noted that some patients prefer bed-based isolation, are accustomed to solitude, or feel emotionally disconnected from communal spaces. Others are simply too tired or fearful to engage. These insights align with patient feedback about wanting to go home, feeling low, or disengaging despite activities being available. Staff explanations highlight that **availability does not equal accessibility**, and that emotional readiness, familiarity, and trust are critical determinants of participation.

Overall, accounts underscore the **importance of everyday mobilisation to patients, who saw it as both a physical and psychological contributor to recovery**. While some patients benefited from consistent encouragement and opportunities to move, others experienced periods of inactivity. It is difficult to determine the extent to which this reflects individual differences in condition, age, or stage of recovery, or variations in the support and communication patients received about mobilisation. **The findings suggest that, for some patients, clearer communication and consistent encouragement could help support appropriate levels of everyday movement.**

Communication about rehabilitation

Quantitative data indicate mixed experiences in understanding information about rehabilitation goals, plans, and progress. When asked about their understanding of staff communication, only eight of the twenty-six survey participants who responded to the question (approx. 30%) reported that they understood it well (Figure 7). This suggests that a substantial proportion of patients and relatives experienced **uncertainty or**

partial understanding, which aligns with the qualitative reports of inconsistent, vague, or non-committal communication presented below.

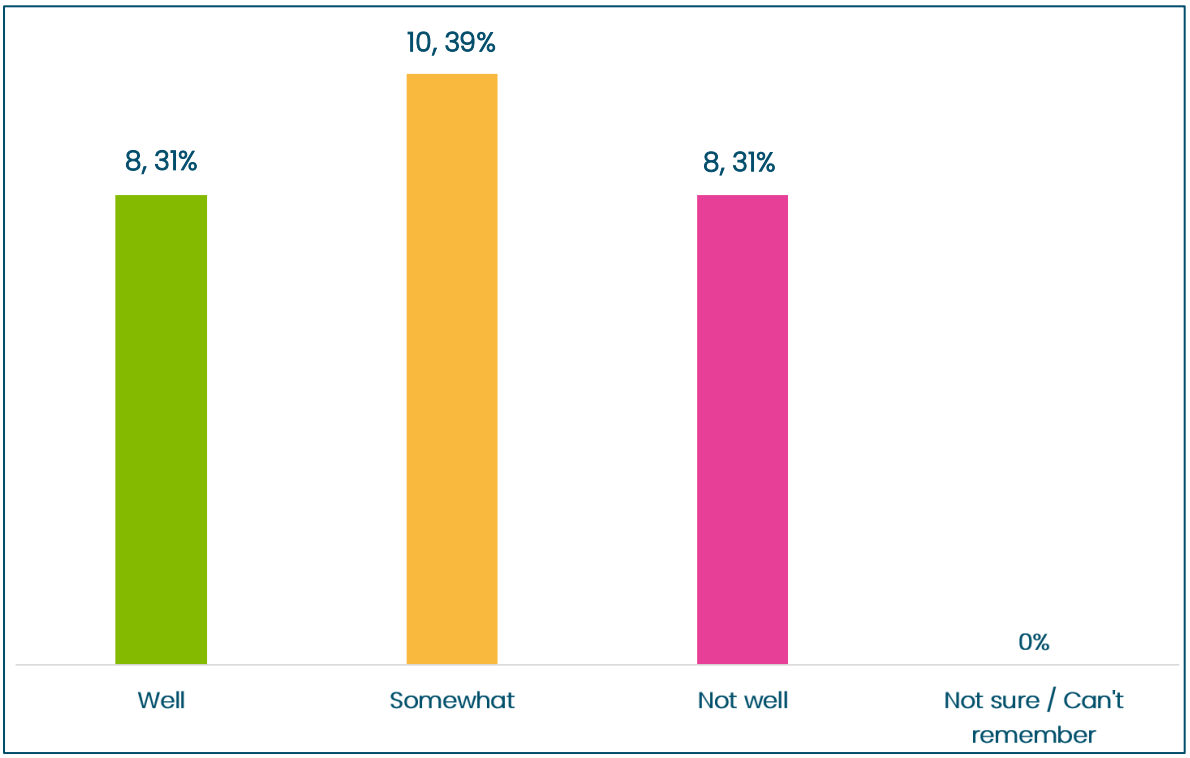


Figure 7. Percentage responses to the question: How well did you understand the information staff gave you about rehabilitation goals, plans and progress?

Although some patients were encouraged to contribute to goal setting, much of the feedback indicates that **goals were primarily determined by the therapy team rather than developed collaboratively with patients or their families**: *"There was no discussion of any target of any kind. No discussions like that."*

Therapy-led goals were largely framed around returning home safely and performing daily activities independently. One patient shared: *"The physio is the one that goes into detail [about goals], what I need to do to be able to go home."* Another recalled: *"[I have been told that] I've got to get [my] mobility back [to the point where] I am going to be able to manage on [my] own at home with various things [like] getting in and out of bed, using the frame and do[ing] things in the kitchen. But no specifics as to this, that, or the other."*

Staff interviews helped explain why patients struggled to answer when we asked them about specific targets. **Clinicians admitted they are sometimes reluctant to set concrete targets because it can be *"unfair"* or *"demoralising"* for elderly patients** if they fail to meet them. Instead, they prefer to use "*free flowing*" terms like progress. Staff also acknowledged that while initial goals are set on admission, they *"probably don't revisit them as much as we could,"* which may leave patients unclear about what they are striving towards day-to-day.

Therapists may deliberately emphasise the functional benefits of therapy rather than set measurable targets, potentially to avoid overwhelming or discouraging patients: *"[The] physios would say, 'We need to get you moving', but [not], 'You need to do so much before you can go home'. That didn't happen,"* and *"I haven't been told, 'You need to be able to walk that far or do this independently to [go] home by such and such a date'. Just every [session], they offer a different activity [towards that goal]. They're very cunning."*

Therapy teams typically set the overall rehabilitation plan to ensure safety and clinical effectiveness. As a result, **some patients described feeling dependent on staff decisions**: *"I can't tell them what to do with me. I'm in their hands. They're the bosses as it were so I go along with it,"* and *"My understanding is that they are trying to get him to walk, and I don't think that's anything else that they were planning for him."*

Alongside these therapy-led goals, some patients set their own rehabilitation targets, often tied to meaningful personal milestones and a strong desire to return home quickly: *"There was no discussion, I set my [own] targets: two weeks limit. They went with it, and I worked very hard."* Another said: *"The simple fact is I want to go home; it drives me to get better. They've asked me what my goal is and I've told them I'll go home when I can feed myself and when I can get to the toilet."* **Determination and persistence were key motivators:** *"It's amazing what you can do if you set your heart to it […], you just have to push the limit all the time and not give in,"* and *"I told them I [was] not having carers. Well, they said, if that's what you want, you've got a bit of progress to do to get there. Once I was up and about, they couldn't stop me."*

However, not all goals were aligned. Most families were satisfied with the incremental and realistic goals set for their loved ones: *"If she can just walk to the toilet with her*

walking frame, I mean that would be absolutely fantastic," and *"They are hoping to get [my mother] to what she was before her fall [but] I think she [has] a lot to overcome to walk again."* **A small number of relatives expressed concern that therapy goals were perhaps narrower than what they considered meaningful independence, highlighting a potential gap between clinical targets and personal aspirations for real-world functioning.** One family member remarked: *"The notes say [she must be able to walk] across the bay, but that's sort of [their] ideal [where] you've got a smooth floor [and] trained physios around. That's not [the] real world, unfortunately."* Another noted: *"I would like to ask what [my brother's] rehabilitation target is. What really bothers me at the minute [is that] he's not getting up to go to the loo, he's not getting dressed, he's not having a shower […]. He's mobile [but] there's a big difference between being able to walk with a frame and being independent."*

Patients and relatives also reported inconsistent communication regarding rehabilitation progress. Some found staff approachable, responsive and willing to provide answers despite competing demands:

> *"I am maybe on the forceful side [and] tended sometimes to beat them to it. They rang me or I would go to the hospital and ask to see them. They always came fairly promptly, and they were very open. If they don't know, they go and ask somebody "*

> *"Although I'm aware they've got six other things [to do], I feel that they're willing to give you time [to answer questions]. That's important. They're very impressive."*

Others felt frustrated and unsure about whether recovery was on track, and how long patients were likely to remain in the ward:

> *"What is [my relative's] long-term plan? Is there anything that is being worked on at the moment? Is he going in the right direction? How long is he likely to be here? They're the sort of things we want to know."*

This left most patients and relatives guessing about timelines. Some interpreted this as a sign that discharge was distant, **undermining motivation and engagement**, while others speculated that staff deliberately avoided giving definite information **to prevent raising false hopes:** *"Staff are assessing you all the time and can't say anything until they're sure. They don't want to over promise and disappoint."* While this caution is understandable, the overall impression was one of limited transparency and weak shared understanding of rehabilitation aims.

Information about progress was often reactive rather than proactive, with updates provided primarily when prompted by patients and relatives. **Responses were frequently vague, and non-committal, sometimes deflecting questions**. For some, this contributed to perceptions of disorganisation and uncertainty:

> *"Sometimes it does feel a bit like pulling teeth.*
> *They'll say, 'I'm not qualified to discuss'.*
> *They're encouraging but they don't want to commit […]."*

> *"One of the therapists would say, I think you are nearly ready to go home, some comment like that. And you say, well how ready? And I'd get a shrug."*

Some described **being passed from one person to another**, reflecting possible gaps in communication or staff caution about sharing information beyond their remit:

> *"I tried my best but it's not always possible to get answers*
> *because it's passed from one person to another,*
> *and they don't always know anyway."*

> *"It's hard to find someone to pin down to tell you what's going on.*
> *I don't know if [they are] unhelpful or they're just not allowed.*
> *I suspect they've got to be very careful [with] what they say."*

Patients and relatives also **perceived fragmentation in communication between staff**, noting **occasions when information appeared inconsistent or poorly coordinated**. These experiences sometimes created uncertainty about handovers and record-

keeping, and reduced confidence in the overall coordination of care. One patient reflected:

> *"One member of staff [would] say something, and another [would] contradict it. They had different versions or perhaps somebody hadn't documented or told anything? I don't think one hand knows what the other hand is doing at times."*

A relative added:

> *I'd ask one of the nursing team and they'd say talk to the physios. The dots are never joined up. It comes back again to clear documentation, clear notes. Why are records not updated? Why is there no communication between everybody? I accept they're very busy [and] they're working in difficult circumstances. But when you are in the middle of it with a patient, it is a worry."*

Difficulties in communication were not only due to system pressures, but also shaped by emotional, social and cultural factors influencing how patients and families engaged with staff.

Many patients and relatives described **hesitation in asking questions** about the rehabilitation, or challenging staff because of their **perception that staff were too busy**: *"What's the point? They've got so many people to see here in this hospital,"* and *"If I thought something was wrong, I would say something. But I can see they are run off their feet."*

Limited staff visibility on some wards further constrained opportunities for relatives to seek support or ask questions when relatives visited their loved ones: *"When I used to visit, I never really saw many staff,"* and *"I haven't really had much contact with the physios and my path [didn't'] tend to cross with the nursing staff much [either]. You'd sort of walk up and down the corridor trying to find someone. Where [were] all the staff gone?"*

Even when staff actively invited questions, patients sometimes felt reluctant to use this opportunity, **wanting to avoid adding to workload**:

> *"Well, they say, do you have any questions, don't they? And if there are any other concerns [to] let [them] know. On the other hand, you are aware that you are only one patient, there's others so you can't monopolise the staff."*

A few patients described **a passive or resigned approach to communication, often shaped by feelings of helplessness or emotional overwhelm**: *"If I felt it was really something worthwhile, I would ask otherwise I wouldn't. [It's] not worth the effort nine times [out of] ten, it's not,"* and *"I don't ask really too much. Well, I'm not going to be here much longer."* For some, this reluctance reflected **personality traits or social conditioning**: *"The problem is [that] he's quite a shy, retiring person. I guess he would never make a fuss about anything."*

A few relatives also described the **emotional toll of visiting or caring, explaining that fatigue and distraction limited their ability to engage**: *"I could go and ask someone what's happening [whilst I am visiting but,] by the time I've sat [with] mum for a couple of hours, I only remember about it five miles down the road on [my] way home."* **Emotional sensitivity and perceived power imbalances further affected willingness to communicate openly**, reinforcing a sense of compliance within the ward. Some patients admitted to deliberately holding back from questioning staff, out of empathy for staff pressures, or **not wanting to cause upset**: *"I wouldn't want to say anything to upset the girls because they're good and they're having to put up with a lot."* Others **worried about being seen as difficult or provoking potential repercussions**: *"[You don't want staff] to think you're being a nuisance. I think if you antagonise them too much, they'll be annoyed with you,"* and *"They've got all the power. You don't want to ruffle their feathers, do you? I think they'd take it out on you."*

For some people, reluctance to question staff **reflected trust and respect for professional expertise**. Patients, particularly from older generations, described a **tendency to defer to clinical authority:** *"That's the trouble with me, I don't ask questions, I*

think that's my era. As long as I'm getting better, I go along with the flow," and *"They're the health professionals, I'm not, so I left it with them to do what they thought was best."* This deference was often grounded in **confidence that staff knew best** and a belief that decisions should be left to the professionals: *"I think you have to trust the [staff] and that they're doing the right thing,"* and *"I mend cars and people trust me to [do that] properly. So, when it comes to healthcare, my philosophy is to let [professionals] get on with it. They know what they're doing, that's their job."*

Overall, these findings show that **communication barriers in rehabilitation wards rarely arise from a single cause. Rather, they reflect a combination of systemic challenges, emotional factors and cultural norms that reinforce deference to professional authority**. Addressing these barriers requires consistent, proactive communication strategies, such as visible points of contact, structured progress updates, and reassurance that questions and feedback are welcomed. Strengthening these practices could shift communication from a reactive process into a shared partnership, enhancing confidence, trust, and engagement in the rehabilitation process.

Experiences of therapy - Summary

Overall, patient and relative experiences of therapy in rehabilitation units reflect a combination of strengths and areas for improvement. Supervised sessions were generally skilled, personalised, and supportive, emphasising functional independence, safety, and gradual progression. Self-directed exercises complemented formal therapy, promoting autonomy, though effectiveness depended on clear guidance and ongoing support. Despite these strengths, therapy frequency and intensity often fell short of patient expectations, and opportunities for mobilisation outside formal sessions were inconsistent. Communication about rehabilitation goals, plans, and progress was sometimes unclear or reactive, leaving patients and families uncertain about expected outcomes and timelines.

Addressing these challenges requires adequate staffing to increase therapy provision, proactive encouragement for everyday mobilisation, and transparent, two-way information sharing to foster a shared partnership, enhancing patient and relative confidence, trust, and engagement in the rehabilitation process.

Respect for privacy, dignity and independence

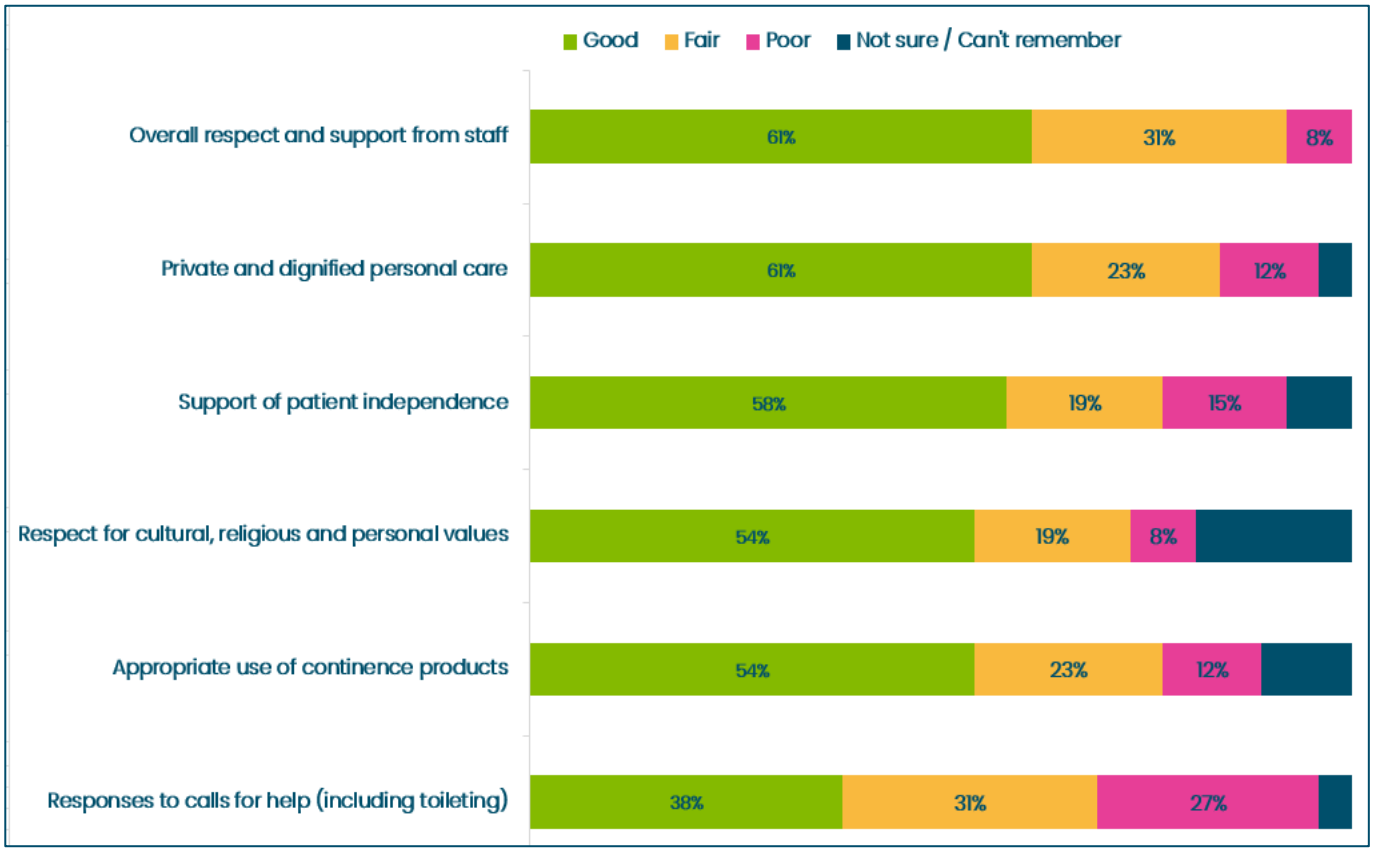


Figure 8. Percentage responses to the question: Overall, how satisfied were you with how staff respected your privacy, dignity and independence? Please rate each aspect.

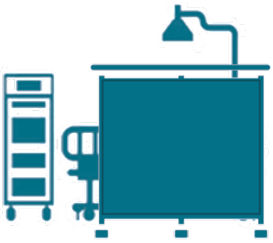
Survey responses from 26 patients (Figure 8) provided a useful snapshot of care experiences within the rehabilitation wards.

Overall, most respondents rated staff respect and dignified personal care positively, though a notable minority reported less consistent experiences. Support for independence and respect for cultural or personal values were rated slightly lower, suggesting variability in how individual needs were recognised. Continence care displayed a similar mixed pattern. **The lowest-scoring area was responsiveness to calls for support, particularly for toileting, which represented a significant concern for dignity, comfort and autonomy.**

Although limited in scale, these quantitative findings align closely with the qualitative feedback that follows, and which provides deeper context and explanation for both the positive practices and specific challenges reflected in the ratings.

Areas of strength

Qualitative feedback from patients and relatives highlighted **strong appreciation for staff and a shared belief that privacy, dignity, and respect are consistently upheld in rehabilitation wards.** One patient observed: *"[Staff] are caring and comforting. They look after everybody in the same decent manner."* A relative added: *"[I have seen] how [my father] and the other blokes in the ward have been treated. [The nursing staff] are good, lovely people."*



Patients told us that privacy on the wards was consistently respected through physical barriers such as curtains and closed doors. Patients described staff routinely shielding them during medical and personal care, noting that they *"put the curtains round. It's just nice to have everything done in privacy, you just feel comfortable."* and that staff *"always pull up curtains and shut the door when I go to the toilet."* These practices contributed to patients feeling comfortable, safe, and dignified.

However, the quotes also recognised the limitations of shared ward spaces. One patient acknowledged: "*Obviously you can hear conversations going on… but it's nothing out of the ordinary*," and *"That's a bit embarrassing doing what you do laying on a bed pan [but] everybody's in the same boat. [You] just have to accept it,"* suggesting that **auditory privacy remains challenging**. Importantly, staff supported patient choice, as shown when *"they asked her how she would prefer the toilet to be used. Did she want the door closed, the curtain closed, both or what?"* This demonstrates efforts to tailor privacy practices to individual preferences, reinforcing a patient-centred approach.

Emotional support, attentive listening and small acts of kindness were repeatedly noted as central to feeling well cared for: *"I've been very impressed with the kindness and the professionalism of the nursing staff,"* and *"The staff are amazing here. They do their best. Nothing's too much for them. They really listen and care. You can see they all love their job:"* **Many patients and relatives observed the visible dedication of staff, even during busy periods, and expressed gratitude for their commitment**: *"The girls are brilliant. They give it all, running around*

like lunatics trying to help everybody. Some look absolutely drained by the end of their shift."

Patients emphasised that attentive, person-centred care helped them feel respected and recognised as *"a human being rather than a piece of meat"* during times of vulnerability. A particularly valued aspect **was staff use of patients' names. Patients appreciated that staff asked how they preferred to be addressed and took care to remember these details**:

> *"[Staff] soon learn our names. I know they're written above the bed but, even when we meet them [outside of the bay], we haven't got name badges on… They come and say, well hello [Marcus*]. Nice to see you. Amazing to remember. You feel [you are] being treated as a person rather than a patient."*

** Not the patient's real name.*

Using patients' names is more than etiquette: it signals recognition, respect, and personal connection. This small but meaningful gesture helped patients feel *"treated as a person rather than a patient," or "just another number."* A relative noticed the positive emotional impact on his mother: *"That [they know her name] makes [my mum] happy, if you know what I mean."* However, one patient remarked that "*they're always calling you Love and God knows what else."* While, in this instance, the use of terms of endearment was perceived as warm and friendly, these accounts underscore the **importance of using patients' preferred names rather than assuming familiarity**, ensuring care feels respectful and individualised rather than patronising.

Staff communication played a key role in shaping patients' perceptions of dignity. Patients spoke of the emotional and physical challenges of needing help and expressed **heartfelt gratitude for staff's humour, kindness and empathy.** They praised staff for creating a **safe and comforting environment during personal care:**

"You can tell they care [and] they know how to deal with [messy] situations. Sometimes it reduces me to tears because it's not nice but they're superb. Don't worry, [they say], it's just one of those things, we'll clean it, we'll sort you. And they [do it] so well."

"[They] don't make a big fuss about anything. They're very good at looking after you. They draw the screen, [they're] very friendly, chatty, thoughtful. They tell you what they want to do, whatever it is. And they don't rush me."

Promoting independence was another way dignity was reinforced on the ward. Some patients described being **encouraged to do what they could for themselves**, with staff prompting participation while providing safety-conscious and individualised support. These practices were empowering rather than pressuring. One patient explained:

"[When] they're giving me personal care, they ask what I can do [and] encourage me to do [things] for myself. They'll say, if I bring the bowl, can you wash your top half? If I put your clothes there, are you all right? They say to do as much as [I] can and [then to] ring the buzzer so [they'll] come and do the rest.

Areas for improvement

While patients consistently reported positive experiences of care, they also identified specific areas where dignity and respect may have been compromised. **These related mainly to responsiveness to toileting needs, care during night shifts, personal and hygiene routines, and occasional lapses in staff communication or behaviour.**

Most patients reported **delays in staff responding to call bells, particularly when they needed the toilet**. Delayed responses, sometimes up to thirty minutes, often led to discomfort, incontinence and embarrassment, leaving patients feeling a loss of dignity and independence.

While patients understood that staff were busy tending to multiple people, awareness did not mitigate the **emotional impact of waiting for assistance:**

> *"The timeframe between asking and getting to the toilet was abysmal. Mum did say that sometimes she'd be waiting for the toilet for so long [that] she'd messed herself. It was just distressing. That shouldn't be happening really, should it?"*

> *"When you press the call button, you might have to wait twenty minutes or more for your turn [...], Because I got an infection, it is hard for me to wait. You keep tapping your legs, saying, please come down but they walk straight past you. Lots of times I [have] wet myself and I don't like that. I'm always reminded that there are other people needing their attention."*

Patients were reassured that **accidents were not an issue, and the use of continence pads was similarly framed as a practical alternative when staff were delayed**. While clearly intended to be helpful, kind and non-judgemental, these responses may not have fully mitigated the emotional impact on patients. Incontinence is deeply personal, and the encouragement to **use pads could, for some, give the impression that their needs were being deprioritised. Several patients shared feelings of shame, guilt for adding to the staff workload, and a sense of personal failure**, particularly when such situations were far outside their usual behaviour. A few patients and relatives also reported **physical consequences** such as skin irritation, infection, or a decline in continence:

> *"[If] you have an accident, maybe it isn't a problem to [them] but it is for me. [And] I don't want them girls cleaning all that."*

> *"I felt embarrassed because that's not the sort of thing I usually do."*

> *"[My mother] rang to go to the toilet and she [was] told, you've got a pad on, just wee in that and we'll come back and change it. She's got a terrible rash from this happening."*

A few relatives also noted that such practices could **inadvertently increase dependence on continence products:**

"[My dad] was only very slightly incontinent [before] he was here but now, rather than going to the toilet, he tends to do a number one in continence pants. I don't know whether it's him expecting his toilet needs to be taken care of through the pants, or whether encouragement to use the toilet [is lacking]."

"[My relative said he] need[ed] to go to the loo.
And I said, do I need to call someone?
He goes, no, I've got a pad on... Well, that can't be right.
Apparently, [the nursing staff] had told him to pee in his pad.
He's independent, he shouldn't be [doing that]!
He'll get sore and it doesn't encourage him to get better.
It's wrong on many levels..."

When delays forced patients to self-manage toileting, they told us that practical challenges and safety risks arose, including falls and injury. Attempts to act independently were sometimes met with **reprimand from staff**, which could feel infantilising, further undermine patients' sense of autonomy, and add distress to an already vulnerable situation.

"[My husband] went to the bathroom without help,
fell and banged his head.
[Staff] said they wish[ed] he'd stopped getting up on his own to go to the bathroom.
But if you've got to go, you've got to go, haven't you?"

"They were very annoyed for me trying to get [to the toilet] by myself.
I was in trouble. They said I needed to wait and be patient."

A relative also reported that their mother **restricted her fluid intake to avoid needing the toilet**, which could inadvertently compromise overall health:

"[Needing the toilet] is a very big issue at the minute [for my mother]. She's scared to drink in case she needs the toilet."

These accounts seem to highlight systemic issues in staff availability, workload management and response times, which can significantly affect patient safety, dignity, and emotional well-being.

Night shifts were reported as periods when responsiveness and person-centred care could be reduced. Some patients told us that fewer staff on duty at night sometimes contributed to **more rushed and task-focused interactions** rather than person-centred attention. **Slower responses to call bells and limited opportunities for sensitive communication sometimes** exacerbated vulnerability, leaving some patients feeling ignored and dehumanised, which **increased emotional distress:**

"I dread the night time coming. There's not so many staff on at night and they're really pushed. They do the job, but they don't see you as a person. They just bark orders. I was in tears once."

"It can be a little bit difficult at night. I get the impression that [the staff] are thinking, I wish I wasn't doing this. When they take you to the toilet, they can't get away quick enough."

A handful of patients noted that **short-term night staff were perceived as less committed or emotionally invested in patient-centred care than regular staff**. These staff were more likely to deliver directive care, which could feel upsetting, infantilising and further undermine patients' sense of dignity, autonomy, and well-being:

"There [are] always some [staff] that stand in for a night or two. They're not going to be here for five minutes. They don't care what they say and they're very good at telling you off."

"There is a big difference between [temporary staff] and regular staff. All they seemed to do was do their shift and that's it. They didn't seem to care."

One relative described significant concerns regarding her mother's personal care, handling, and experiences of intimidating behaviour during night shifts. Although these incidents were addressed following complaints, their recurrence suggests that **there may be a need for improvements in supervision:**

"A lot of happens during the nighttime [shift]. [My mother] rang to be changed, and they threatened to take [her] buzzer away if she rang it once more [and said] they would kick her out of the hospital. [When they changed her], they moved her so much, they actually hurt her. That has been dealt with. Apparently, the next day [that staff member] had left. Then [another] night, they put her on a bed pan but not properly, so [her urine] went in the bed. They told her that she didn't need a wee because it was empty. That's because it was in her bed!

Our findings suggest that factors such as higher patient-to-staff ratios, reliance on temporary staff who may be less familiar with ward routines or individual needs, fatigue, and reduced supervision may contribute to unsatisfactory experiences for patients during night shifts. They also point to the potential **importance of consistent, skilled, and empathetic staff presence, alongside robust supervision, in safeguarding patient dignity, safety, and emotional well-being overnight.**

Hygiene care was provided, though patients reported that quality, consistency, and attention to detail could vary. Some described receiving daily morning bed baths or washes, though **access to showers or baths was occasionally limited,** meaning that routines may not always have been consistent in timing or thoroughness:

"Not always [at] the same time [but] they give me a wash every day. They wash me from the bed until I'm cleared by the physio to [go to the bathroom]."

*"My hair has been washed three times since I've been here.
That takes a lot longer [than a shower] and they have to use the bath for it."*

Certain aspects of personal grooming, including hair care, oral hygiene, and nail care, were sometimes overlooked:

*"Her hair could have been combed, [and] her nails cut,
which sometimes hasn't been done.
Just minor things like that, [it makes you] look a little bit more respectful."*

*"I took toothpaste in [for my wife] and that hadn't been opened.
They wash[ed] her hair only once [in] nearly six weeks. [Her] shampoo wasn't used.
So, whether no one bothered or whether [they used other products],
I don't know. You see, I don't know hospital routines."*

These accounts indicate that **personal care may often have depended on staff availability, workload, or individual initiative**. Even minor omissions in hygiene could leave patients feeling neglected or experiencing a reduced sense of personal identity, potentially impacting dignity, comfort, and self-esteem. **This highlights the need for clear, standardised personal care routines whilst allowing for patient choice and autonomy.**

A small number of patients noted **occasional lapses in care, usually confined to a small minority of staff rather than to the team as a whole**: *"95% of the staff are very good [but] there's always some that don't do what they should"* and *"The majority of the staff are wonderful, very good, very caring although a couple are a bit iffy, off."*

Negative encounters included **isolated experiences of abruptness or rushed interactions**: "I *just didn't think that this person should have been so sharp with me on the circumstances in which I was asking her for help" and "If you are in a caring profession, you shouldn't let your feelings affect the patients."*

Although rare, some patients described **isolated incidents in which lapses in attention, communication, or empathy impacted their dignity, independence, and sense of safety**. These issues included dismissive responses to request of support and insufficient attention to detail in routine care tasks:

> *"One of the [staff] brought the commode and put it at the end of the bed, right up against [it]. No way would I have been able to [stand] up, turn around and got my backside [on it]. I had to ask one of the fellas[to] move it. That was careless, wasn't it?"*

> *"I asked for a drink of water. [The staff] said, well it's there, can't you reach it?*
> *I said, no I can't and she [replied], well try.*
> *If you're going to be like that, don't bother..."*

One patient described **feeling judged and demeaned** by a staff member during personal care for a medical condition beyond their control, which affected their self-esteem and sense of dignity:

> *"[Because of my condition], when I want to go to the toilet, I have to go.*
> *A member of staff made me to feel I was being a bit of a nuisance*
> *because I had wet the pads and [had] started to leak.*
> *I was told [I couldn't] keep going through these big [pads] at that rate*
> *because they're too expensive, which didn't make me feel a billion dollars."*

Another patient reported witnessing unprofessional behaviour with **staff communicating with vulnerable patients in a loud, impatient, and abrupt manner**:

> *"I would say some [staff] are a bit off and shout at [some of the patients].*
> *You've got to turn over this way, turn over that way...*
> *Don't shout at them! Some of them might be a bit senile [but] they're not deaf.*
> *Whether it's because the patients don't do what they want them to do, [or] they've got other things to do [and] that's why [they] get a bit frustrated."*

Such behaviour appeared to be influenced by workload pressures, but it was perceived as intimidating and undignified for patients, particularly those who were vulnerable or had cognitive impairments. It could also reflect **potential staff misperceptions about patients' abilities, highlighting the need for appropriate training and awareness**. As a

relative noted: *"I do worry about dementia training and things like that, whether they're equipped to deal with that type of patient."*

Addressing both systemic and isolated lapses in care may help safeguard patient dignity and support more consistent, high-quality, person-centred care, complementing the generally positive experiences already reported.

Summary – Respect for privacy, dignity and independence

Patients and relatives **praised staff for attentiveness, kindness, and person-centred care**, including maintaining privacy with curtains and closed doors, and using patients' names to foster recognition and respect. **Emotional support, empathy, and encouragement of independence** were frequently highlighted as strengths.

However, some accounts helped explain the lower quantitative ratings. **Delayed responses to call bells** sometimes exacerbated incontinence and caused discomfort, embarrassment, and reduced autonomy. These **issues were more noticeable at night**, potentially linked to lower staff-to-patient ratios and reliance on staff who were less familiar with ward routines and individual patient needs. **Inconsistent hygiene routines** and **occasional lapses in communication** or care were also reported as barriers to dignity.

Overall, while experiences were largely positive, these findings underscore the importance of responsive, consistent, and person-centred care to safeguard patient privacy, dignity, and independence at all times.

Emotional wellbeing and engagement with leisure activities

While privacy, dignity, and independence ensure that patients are treated respectfully and have control over their personal space and care, these principles also extend to mental health and wellbeing. **Supporting patients emotionally demonstrates a commitment to treating them as whole, respected individuals. Promoting mental health and wellbeing is closely linked to providing meaningful social interaction and opportunities for recreation,** which help patients maintain emotional resilience throughout rehabilitation.

Mental health and emotional wellbeing

Rehabilitation can be emotionally challenging for patients. Some struggled to see progress and felt **frustrated and demoralised with their recovery:** *"Two or three weeks in, I couldn't see that I was getting any better. I could just have cried and given up."*

Uncertainty about discharge timings could add to stress: *"Not knowing [when I will be well enough to go home] was affecting me. I didn't get suicidal or anything like that, but it was tough."* **Worries about future capabilities and life after discharge created further anxiety.** One patient remarked: *"I don't sleep a lot. My mind is turning. I do worry about what's going to happen to me."* And another explained: *"I have slight nerves about going home. [Will] I be able to cope? [Going home to a new normal] is a completely unknown territory. It's a country I've never visited before. And you think, do I know the language and will I get by?"* **Fear of physical setbacks**, such as falling again and re-injury, was another source of concern: *"I'm terrified of falling over again. Absolutely terrified,"* and *"Mum was scared of falling over again. That's really got to be messing with [her] mind. Some days, she was emotional, tearful."*

Fatigue, feeling unwell, and being away from loved ones and familiar environments often intensified these feelings: *"I absolutely went to pieces yesterday. I was in so much pain,"* and *"It sounds really sloppy, but I got quite low at times because I wasn't with my wife."* A recently bereaved patient noted: *"I wouldn't say I was depressed but I was still processing my wife's death. It was three weeks of not having anything to do all day*

except to sit and think. At times I felt very emotional, partly tiredness and partly terrible loneliness."

Boredom from extended periods of physical inactivity and lack of mental stimulation also negatively impacted wellbeing: *"Sitting around doing nothing all day […] would make anyone feel low,"* and *"[My husband] just couldn't wait to get away from the place. No mental stimulation. He was so depressed and crying."*

Many patients did not openly share their negative emotions with staff, often perceiving that mental health support was **outside the remit of the doctors and nurses on the ward,** who were primarily focused on physical health: *"I'm not expecting the staff to minister to my emotional journey. It's not what they do,"* and *"That's not what the doctors are here for. They've got other things to look after."*

At times, patients also felt that **disclosing emotions would be futile**: *"If I did [speak], it probably wouldn't really make much of a difference."* Others withheld their feelings out of courtesy for staff, **not wanting to burden** them when they were already busy: *"They've got other things to look after,"* and *"I try not to cry. I let them get on with their job."* Some patients **downplayed or suppressed their emotional needs** as a coping mechanism, and to **avoid appearing vulnerable**: *"I don't need emotional support. I'm convincing myself. I don't,"* and *"My mother's not one for crying in public. She probably didn't ask for any emotional support."* Others expressed **discomfort at showing emotions** and **relied on self-soothing strategies**: *"I wouldn't get upset in front of [staff] actually. I'd do it on the quiet, sit on the bed and have a little tear,"* and *"If I feel it's not a good day, I'll just go and lie on the bed, [I can be] asleep in no time."*

Staff support for emotional wellbeing seemed to vary. A small number of patients felt that their **distress went unnoticed or unacknowledged** with staff appearing to prioritise other duties over emotional needs. One relative reflected, *"[My husband] said that he did get upset but he didn't think anybody had noticed,"* while a patient recalled *"I just started crying. I couldn't stop. [The therapist] saw but carried on talking like normal."*

In interviews, **staff fully recognised the *"huge impact"* of mental health on recovery** but several expressed frustration that they often *"don't get the time"* to provide the

emotional support they know is needed. They described **a tension between clinical priorities - such as personal care and medication - and the *"luxury"* of sitting and chatting with a distressed patient.** Staff admitted that when they are short-staffed and stressed themselves, they can become *"task-focused,"* potentially appearing less responsive to emotional cues.

However, most patients described receiving excellent, compassionate support when individual staff members took time to sit with them, listen, and offer meaningful reassurance or physical comfort:

"I got myself in a right state because I was so anxious about [a visit to the hospital]. The Ward Manager sat with me for quite some time, she talked me through [what would happen], reassured me and she was brilliant. When I came back, she came to see me again. 'How did it go? I told you you'd be all right'. I'm so grateful to her. She was really lovely."

"I was talking to the occupational therapist, [and] I just broke down, started to cry. She just talked to me, held my hand and calmed me down. I was well supported."

"The healthcare assistant put his arm around me and said, don't upset yourself. He stayed with me until [pain relief] kicked in."

In addition to the support offered by staff, **many participants described personal relationships as central to their emotional wellbeing** during rehabilitation. **Family members and close friends were often the people with whom patients felt safest expressing vulnerability, and whose reassurance carried the greatest weight.** One patient explained, *"Any emotional support I get is from my wife, I don't rely on the staff. They're not that close to me."* Friends also offered important outlets for emotional release, as reflected by one participant who said, *"But I've had friends come, we had a good cry together. You have got to let it come out, haven't you?"*

Engagement with recreational and social activities

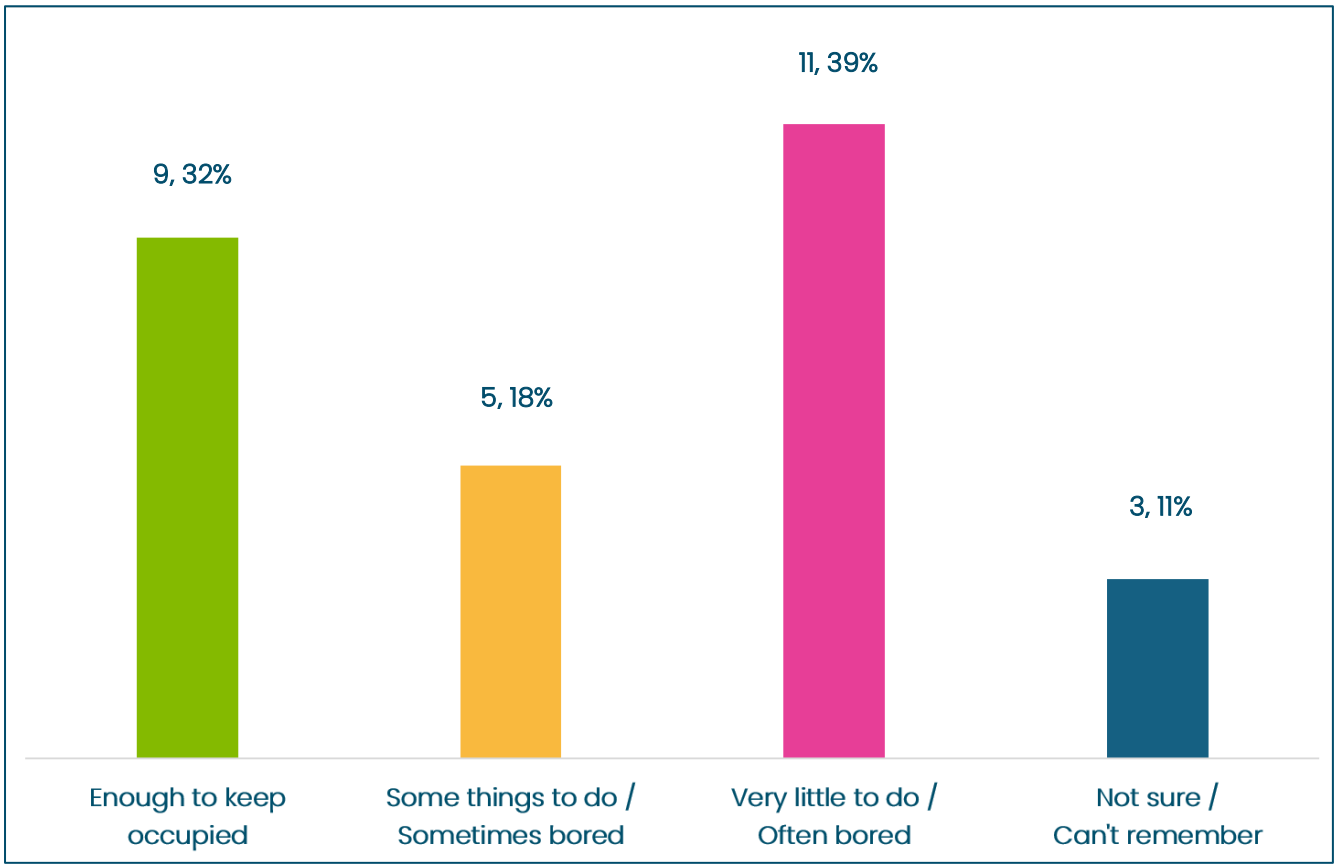


Figure 9. Percentage responses to the question: Did you feel you had enough to do to pass the time?

Twenty-eight survey participants responded to the question of whether they felt they had enough to pass the time during their rehabilitation stay (Figure 9). Only nine respondents (32%) reported not being bored, while sixteen (**approximately 60%) indicated that they had limited opportunities for social or recreational engagement.**

As highlighted earlier, **boredom and loneliness were significant contributors to low mood and emotional vulnerability. Many patients told us that they spent long periods sitting in bays with little meaningful interaction**, which intensified anxieties about their illness or recovery. One relative explained: *"[My loved one] had excellent care and physiotherapy. My only issue is [that] he [was] in a bay with three other men who happened to be all hard of hearing. [So], he spent all day sitting, doing nothing, [just] looking at a clock, watching the time go by. I was concerned about his mental wellbeing."* Another observed: *"I think you could very easily become institutionalised if*

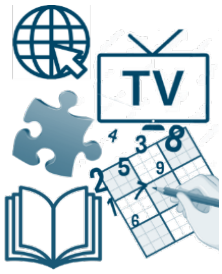
you're not engaging. It's very easy just to dwell on what's happening If you are in [the ward] for a long time."

Patients and relatives valued social interaction and mentally engaging activities for their positive impact on wellbeing. Some described engagement as a welcome **distraction:** *"I suppose it tak[es] your mind off things,"* and *"[You] need to keep occupied otherwise you're going to go downhill."* **Conversations also fostered shared understanding and mutual support**: "[*[Having] a little chat [with other patients] has been very good. I'm not saying we've all suddenly become lifelong friends, but we realise we're all in difficult situations, and we want to support one another a bit."* A few patients highlighted that keeping the mind active helped **preserve cognitive function:** *"Mix[ing] with other patients, it keeps your brain going."*

The following sections explore both informal and structured opportunities for recreational and social engagement on rehabilitation wards, alongside the barriers to participation and suggestions for improvement.

The structured routine of the hospital day provided an important framework for patients, helping to fill time and give the day a predictable rhythm. Many described activities such as personal care, meals, and visits as naturally occupying much of the day, leaving few long stretches of unstructured time.

One patient explained: *"In the mornings there's a lot going on in the ward, and then it's mealtime. [Afterwards], I'll probably doze off for a bit. Then it's tea time and sometimes I get visitors in the evening."* Others echoed this sense of continuity: *"It goes quite quickly. We just get through the day, there's always something going on,"* and *"They wake you up at six, then you get your breakfast, […] a wash. Before you know it, it's lunchtime, then visiting time, and bedtime. So actually, the day goes pretty quickly."*



Many patients relied on self-directed activities to occupy their time. Activities tended to mirror what they would do at home: reading, puzzles, watching television, mobile devices or resting were frequently cited as sources of entertainment and cognitive engagement:

"I watch who's coming and going, I read, do puzzles or just shut me eyes," and "I like to watch a [film] of whatever on my laptop and then I'll read my paper and hopefully get some sleep."

Some patients drew on ward-based resources, such as the library trolley service, to access reading materials: *"I do find it good on a Monday because the library people come round. They're kind enough to bring you magazines, papers, books off the trolley if you want them."* **Games and puzzles available in communal areas** also offered occasional relief from the monotony of ward routines: *"In the dayroom there's lots of puzzles, word searches, crosswords and things like that. I did a sudoku."*

Patients who were already accustomed to spending time alone at home often coped better, and familiar hobbies transferred easily into the ward environment. One patient explained: *"I'm such an avid reader and I also love crosswords and sudoku, so that keeps me occupied in here."* Another added: *"I live on my own so, I am happy to keep myself occupied. I go on my mobile phone and, If I want to watch something, I just put it on my iPad."*

A recurring theme was the reliance on television and personal digital devices to help pass the time. However, **access to these was uneven**. At the Willow Therapy Unit, televisions were not provided in bays, while in other facilities shared TVs sometimes caused tensions: *"The telly was on all day. [One] person had control over it,"* and *"There Is a television for four people in the [bay] but that's awkward because one might want the television on, and the others [off] or different programmes".* **Limited and insecure Wi-Fi was another common frustration:** *"There's no Internet. I managed to get on the ward Wi-Fi but it's not secure. So, you're not going to do a lot of things online."* Poor connectivity restricted not only entertainment but also patients' ability to stay in touch with family.

Social interaction emerged as a critical component of ward life, offering patients a sense of community, emotional support and cognitive stimulation. Camaraderie, and in some cases surprisingly close bonds, developed naturally within shared bays. Patients described finding comfort in shared experiences and enjoying informal conversations.

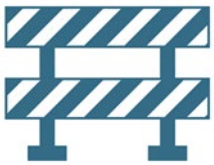
As one patient reflected, *"We all looked after one another. One night we sat till half past 11 talking about fish of all the subjects to talk about."* Another said: *"I've got lovely people I'm sharing it with. We smile, wave at each other and talk."* A relative similarly observed: *"My mother gets on very well with the other patients. They are lovely and encouraging."* Shared meals in communal areas also provided additional opportunities to connect: *"It can be all a little bit quiet on the bay. I enjoy having community meals because you've got other people to talk to."*

Visits from family and friends played a central role in maintaining patients' emotional wellbeing, helping to alleviate loneliness and provide meaningful stimulation. Many patients described visits as an important part of breaking up the day and staying connected to life outside the ward. As one patient shared: *"I do get quite a few visitors, that sort of passes the time."* Another noted: *"[Having visitors is] very important… I've got a good network of friends who've been to see me."* However, the frequency of visits varied, and some patients had few or no visitors. This disparity was noticed by others on the ward: *"I only saw the gentleman next to my husband have a visitor once the whole time I was there. I used to talk to him."* One relative reflected on the impact of limited social contact, suggesting that *"[those who don't] get visitors may need that bit more stimulation [elsewhere]."*

Visiting volunteers provided additional opportunities for engagement and social interaction, though visits were sometimes infrequent. One patient explained: *"We had a visit from the volunteer today. She comes on a Thursday. It keeps my brain going."* Another recalled: *"The volunteer apparently comes here once or twice a week. It's the first time I'd seen her. She spoke to me for a little while, which was quite interesting."* Communal activities led by volunteers, such as group games or therapy dog visits, were also appreciated: "*They've got volunteers who come to the day room. We do silly things like play bingo. It is nice to be with other people and to have a chat,"* and *"[A volunteer] went in with a [therapy] dog, sat on [my wife's] bed. She was telling me all about it."*

Interactions with ward staff further contributed to patients' social and emotional wellbeing. Even amid busy clinical workloads, staff were frequently praised for their warmth, humour, and ability to engage in brief but meaningful conversations. Patients valued these small moments of rapport, which helped humanise the hospital

environment and offered a sense of normality. One patient explained, *"I like to chat to the nurses when they've got time, bless them, because they are busy,"* while another recalled, *"The young girl said, 'You're Irish?' Then she told me her dad was from Cork."* **Friendly exchanges with catering and cleaning staff were also appreciated**: *"The visiting staff that come in with the food and drinks… seem to be very jolly people and he looks forward to that,"* and *"The cleaner was very friendly and chatty."* Such interactions, though brief, provided reassurance, companionship, and small but meaningful opportunities for social engagement within the daily ward routine.



Having recreational and social activities available on the wards does not guarantee patient participation. Many patients and relatives described days as long and unstimulating, with minimal social or cognitive engagement.

One relative noted: *"I don't really know what [my father] does during the day, to be honest. I don't get the impression that he's doing an awful lot. I don't think there's anything really to stimulate him as such."* Another remarked: *"I don't think there's anything [for patients], is there? I haven't heard of any [activity] and whenever I've walked past the day room, it's been empty."* People told us that **multiple factors can limit access**, including a lack of awareness about what is offered, insufficient encouragement or assistance from staff, and cognitive or physical difficulties that make engagement challenging. **Understanding these barriers is essential to ensuring that patients can benefit fully from the activities that are provided.**

Low awareness of recreational activities and facilities was a common barrier, suggesting that without clear information or guidance, patients may miss out on opportunities for social interaction and cognitive engagement:

> *"I don't know what they do and what goes on."*

> *"Mum had been there three weeks*
> *before she knew there was a day room with a TV."*

> *"My grandson wanted to take me out [of the bay] in a wheelchair."*
> *Oh, I said, they don't do that.*
> *Honestly, I didn't know you could go to the day room or out to the garden."*

Some staff agreed that **day rooms and gardens are often underused**, attributing this to **a lack of staff to transport and supervise patients in these areas**. They also admitted that information about activities is generally **verbal and ad-hoc**, meaning **patients are not always aware of what is available**. Furthermore, staff noted a *"disconnect"* where some patients decline activities because they view games as *"childish"* or simply prefer the safety and familiarity of their bed space.

Another significant barrier to participation mentioned by patients was a perceived lack of active encouragement and physical assistance from staff. While opportunities for engagement and leisure existed, they were not always clearly explained or facilitated. One patient reflected:

> *"I don't go very often [to the day room].*
> *If there is a communal activity, you wait to be told.*
> *So how organised it is, who goes or how many can go, I don't know.*
> *If it was available every day, I would go."*

Another recalled:

> *"Somebody [gave me an] invitation to the Breakfast Club [the next morning].*
> *I wasn't sure [if] that invitation that to come every day.*
> *The second day somebody said, are you going to Breakfast Club today?*
> *The third day, I think it was assumed I was going."*

Patients also highlighted the need for physical assistance to participate, particularly when mobility was limited. One explained:

> *"I can't get to the activities. If I was able to move, I would say yes.*
> *[But] I'm having to depend on someone to do things for me."*

While recognising the constraints of a busy workload, a few others suggested that staff could play a more proactive role in supporting engagement:

> *"They could have wheeled me down in a wheelchair, I suppose."*

"[Staff should] encourage socialisation. More work for the girls, but you have to do it."

These accounts suggest that **without consistent encouragement and practical support, patients may default to remaining at their bedside**, missing out on opportunities that could enhance both their social and rehabilitation experience.

Cognitive and physical limitations were frequently cited as barriers to meaningful engagement with ward activities. Several relatives described the concentration or stamina required for certain tasks as challenging, particularly for patients living with dementia or other cognitive impairments, as well as those experiencing fatigue or the effects of strong pain medication. Some relatives shared their loved ones' experiences:

"We have probably half an hour of good conversation and then he drift[s] off a little bit. It's difficult to keep maintaining interest."

"My mother unfortunately was on morphine and had reached the stage where she wouldn't have been capable [of] doing puzzles or [going beyond] line 2 of a book."

"Things that Mum used to enjoy, she can't do anymore."

These insights underscore that, **without adaptations to accommodate the full range of cognitive and physical abilities, patients' engagement with ward activities may remain limited.**

Patients and relatives suggested a range of ways to improve engagement, emphasising that activities should be low-pressure, socially oriented, and accessible for those with cognitive or physical limitations. Ideas included **low-impact group exercise**:

"[I'd like] a club where you do exercises sitting down."

Communal and mentally engaging activities, such as table-top games, quizzes, or handicrafts, were valued for promoting interaction, companionship and cognitive stimulation:

> *"Just bingo and chat and cup of tea."*

> *"Board games and having a cup of tea with someone sat at the same table as you."*

Summary – Emotional wellbeing and engagement with leisure activities

Patients' mental health and emotional wellbeing were central to their experience on rehabilitation wards. **Anxiety about recovery, uncertainty about discharge, fear of setbacks, fatigue, and periods of isolation all contributed to low mood and emotional vulnerability**. Compassionate support from staff, alongside reassurance from family and friends, were vital in helping patients manage these challenges.

Social interaction and recreational engagement were closely linked to mental wellbeing, providing cognitive stimulation, companionship, and a sense of routine. However, many patients faced **barriers to participation**, including limited awareness of activities, insufficient encouragement or physical support from staff, and cognitive or physical limitations. Addressing these barriers by **offering low-pressure activities that accommodated diverse abilities** could help foster both engagement and emotional resilience during rehabilitation.

Returning home and post-discharge care

Experiences of patients in discharge planning

Patients were interviewed around two to three weeks after their rehabilitation stay, which may have influenced how precisely they remembered the timing and content of early discharge conversations. Nonetheless, their accounts revealed **wide variation in when discharge planning was first introduced and in the information initially provided.**

Initial discussions: timing and content

Some patients recalled being approached by a discharge coordinator **soon after admission:** *"I think it was a few days before people started telling me things,"* and *"I think I first spoke to [the discharge coordinator] within the first week [of arriving in the ward]."* However, others said they **did not meet a discharge coordinator until much later, in some cases only a day or two before returning home:** *"I know [the discharge coordinator] was doing things behind the scenes, but she didn't come and introduce herself right until the very end when I was ready to leave,"* and *"I never saw the discharge coordinator until six weeks [after I was admitted]."* **Often therapists acted as the main point of contact, passing information to discharge coordinators on patients' behalf**: *"[The] lady that was dealing with the discharge said that she would look into equipment for me. And then I saw physios and occupational therapists [who] were speaking to [the discharge coordinator] on my behalf."*

Many patients **did not recall receiving an overarching explanation of the discharge planning process** during early discussions. Instead, initial conversations were generally remembered as focusing on **practical matters related to home environments, adaptations, and assistive equipment**: *"The first conversation was about my mobility, how I was managing [and] what equipment I would need at home,"* and *"[The discharge coordinator asked] me details about the house."* **A smaller number of patients did remember early discussions that touched on wider care needs or post-discharge support:** *"The first and only conversation I had [with the discharge coordinator], she said I [was] nearly ready for discharge* [so she] needed *to set a care package. I was told that carers, physios and my local practice would be in touch,"* and *"She told me that there*

was support out there that I could have [and] they would assess me to see [what package of care I would need]."

Staff interviews help explain why initial discussions may feel disjointed to patients. One staff member acknowledged: *"I think because of the lack of consistency between staff, it's probably a bit jolty and disjointed. The discharge probably starts from when the patient comes in but does every patient and family get educated about the process or what we do? Probably not."*

Professionals also acknowledged that, because different staff members see patients each day, there is often a lack of continuity, meaning discharge plans are not always consistently reiterated. Staff also noted that they often focus early conversations on immediate practical assessments - such as obtaining furniture heights to order equipment - rather than explaining the full discharge trajectory. They admitted that while discharge planning technically starts on admission, it often feels like a *"rush"* at the very end once care and equipment are finally secured.

Understanding and retention of information

Beyond these early contacts, **patients' experiences of communication and involvement in discharge decisions varied considerably**. Some felt well informed and supported, describing clear, consistent explanations that enabled them to participate actively in planning their post-discharge care. Others felt that decisions were made for them rather than with them.

Survey responses from twenty-one patients provide a snapshot of these experiences (Figure 10 and Figure 11), while qualitative insights help explain the reasons behind differences in understanding and engagement. When asked how well they understood and remembered the information shared during discharge planning, 14 survey respondents **(approximately 65%) said quite well or very well**, while 6 participants (**approximately 30%) found it challenging** (Figure 10).

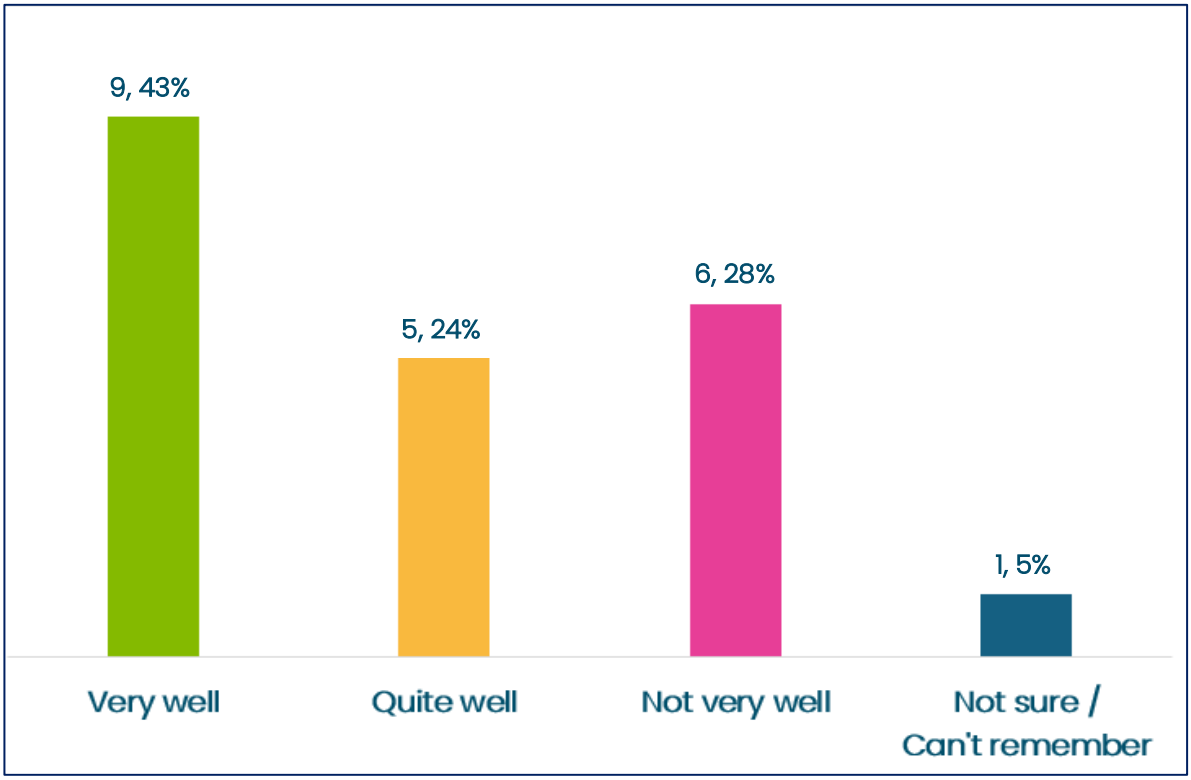


Figure 10. Percentage responses to the question: How well did you understand and remember the information shared with you during discharge planning?

Most patients believed that communication was generally easy to follow, with staff taking time to explain plans and check understanding: *"I totally understood everything [the discharge coordinator] told me,"* and *"[Staff] talked me through everything. I've been quite happy."* Reiterating plans and providing regular progress updates was particularly effective in helping patients feel informed and able to remember the information. One participant described this approach:

> *"They told me what they were thinking of putting in place. It was quite well handled and mentioned more than once. They kept giving updates."*

However, **several factors contributed to partial understanding or difficulties recalling information. Timing was important**: some patients felt that information came too late to process, while **Intermittent contact with discharge coordinators** reduced continuity and understanding: *"[The discharge coordinator] suddenly appeared and was talking about discharge, but then I didn't hear any more from her until the day before I left,"* and "I felt that I would like to have known more over a longer period." **Seeing multiple staff** members

without a clearly identified coordinator **could also create confusion and blur recollection:** *"I remembered someone coming around but I couldn't [say] who they were,"* and *"To be quite honest, I can't remember [with] all the different people I [saw]: this one, that one and so on and so forth."*

Stress, fatigue and illness further affected patients' ability to process information, making one-off explanations insufficient:

> *"Information might have just gone right over my head because I was too busy thinking about other things."*

> *"To be honest, I can't remember [what was discussed]. I [was] very tired [and not] in careful listening mode. It probably drifted over me a bit."*

> *"I weren't a hundred percent [so] these things don't sink in."*

For patients with cognitive impairment, families emphasised the need for tailored communication and active reinforcement. One relative whose mother is living with dementia explained:

> *"I don't think she had much understanding of what was going on. Communication [did not fully] take her [fluctuating] mental capacity and needs into consideration. I don't think they spoke to her enough each day. Repeating [plans] to her [was] what she needed [for] things to actually stay in her mind."*

Another relative raised **concerns that leading questions might prompt patients to give quick affirmative responses without ensuring true understanding,** potentially overlooking support needs:

"My [loved one] heard the discharge coordinator talking to another patient about going home. The questions were very much led. 'Do you feel ready to go home?' [He is] going to answer yes, [he] can't wait to go home! 'Do you feel you'll be able to look after yourself?' [Again], the answer is yes. There wasn't a line of questioning [where the patient] had to think. The answers could just always [be] yes. Do [patients] actually understand? It is worrying to me."

Staff strongly echoed the finding that patients struggle to retain information, attributing this to the *"information overload"* of the hospital environment. Professionals recognised that patients are often fatigued, in pain, or disorientated, meaning they might agree to plans in the moment but fail to remember the conversation ten minutes later. As one staff member told us: *"They must be worn out because they're feeling unwell anyway and we are pushing them a little bit".* Staff mentioned **the difficulty of getting patients with cognitive impairments to retain information** about their discharge journey. Some professionals also suggested **a generational factor may be at play**, noting that many older patients are *"passive"* and **unlikely to ask questions because they trust that *"medical people know best".*** Despite this awareness, **staff acknowledged that time constraints limited their ability to address these barriers adequately:** *"There's not always enough time to […] sit down with [patients], which is a shame."*

Patient involvement in decision-making

Survey responses also captured perceived level of involvement in discharge decisions. Of the 21 respondents, 8 (**approximately 40%) reported having a lot of input,** while **a further 40% felt they had some influence**. **A smaller number** of survey participants (3, approximately 15%) **claimed that opportunities to contribute their views had been very limited** (Figure 11). These quantitative findings are consistent with the qualitative accounts, which shed light on the factors influencing patients' ability to have a meaningful voice.

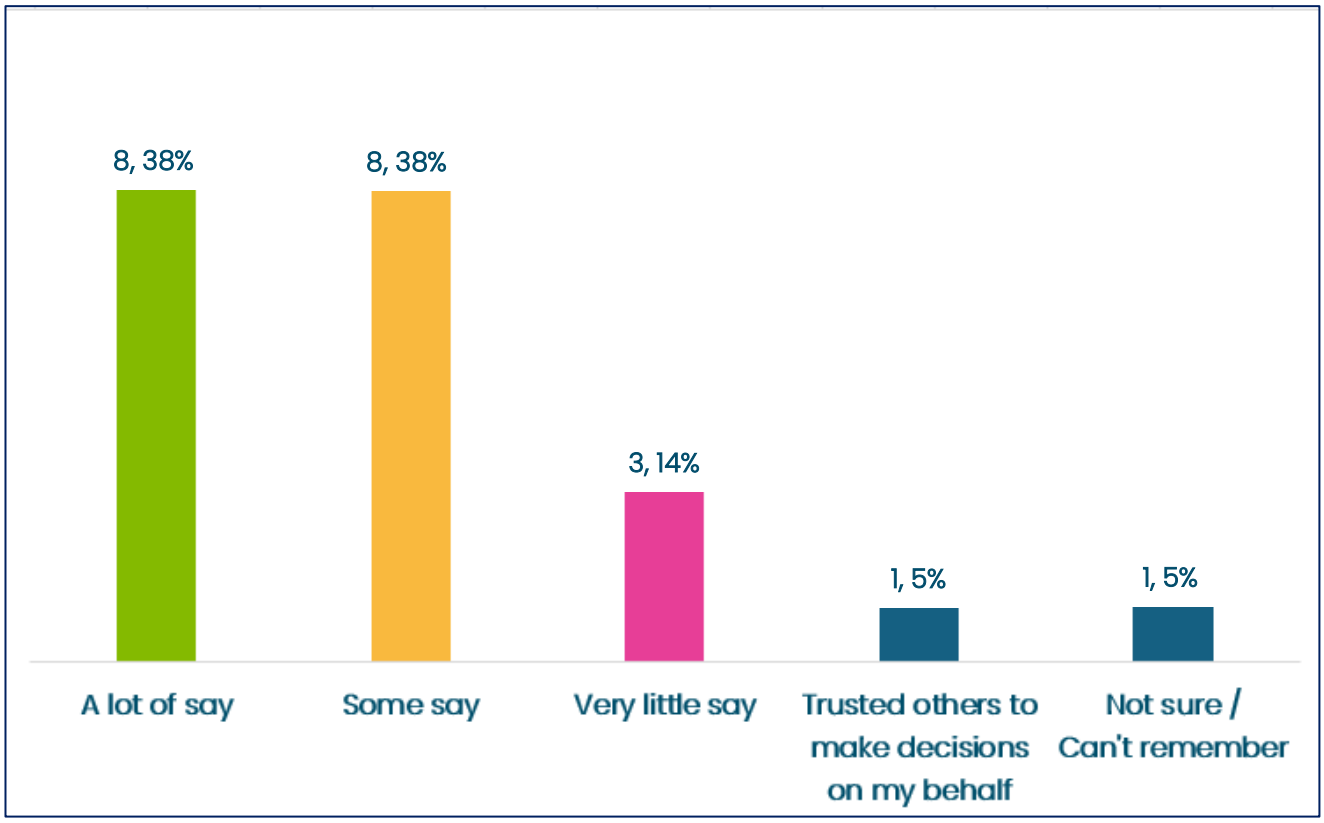


Figure 11. Percentage responses to the question: How much of a say did you have in discussions and decisions about discharge?

Some patients described clear examples **of genuine shared decision-making.** One patient recalled staff seeking her agreement throughout the planning process:

> *"They asked my opinion [on] whether I agreed to the different [assistive equipment] they suggested, and the carers as well. They kept saying, 'Now we're doing this; are you happy for us to do [it]?'"*

They shared that staff **worked flexibly to accommodate their preferences, needs or concerns:**

> *"I was included. Oh, yes! [The discharge coordinator] spoke to me [about the package of care she recommended]. I explained to her that I had already somebody [helping me at] lunchtime. She arranged [a new package] around this."*

"[I had a say] in a roundabout way.
I told her [about the suggested assistive equipment]
that I thought would be a problem.
Then she actually came out to the house and looked around with my wife.
[In the end] she said, 'Right, we [can] do this, this, and this.' "

"The Friday, they started talking to me about going home [after the bank holiday].
There was going to be no physios coming in on that weekend.
I thought, oh my goodness, I'm going to be sitting here on my own.
So, I asked to leave.
Everything [was] put in place on the Friday. That was very helpful on their part."

A recurring pattern was that **patients were more likely to engage actively when asked to contribute concrete information about home environments and equipment needs.** Many reported providing details about home set-ups or asking questions about specific items of assistive equipment:

"I was asked if it was possible for a relative to take photographs of where I was going to be sleeping, my chairs and things like that."

"It went along with what the discharge coordinator said but I did query but about the toilet seat and other [assistive equipment] once or twice."

These decisions were often easier to engage with because they related to goals patients understood well and were reinforced through therapy.

In contrast, **involvement was markedly lower for potentially more consequential aspects, such as care packages and discharge timing. These decisions were more often experienced as predetermined and weakly negotiated**. Care packages depend heavily on professional judgment and organisational constraints, which many patients viewed as outside their expertise. As a result, they rarely felt able to challenge decisions

and therefore tended to defer to clinical authority. People told us that such decisions were often presented **late and framed as already settled, leaving little time for negotiation**. Some patients described an even more passive stance, assuming staff would manage everything appropriately and therefore tuning out of discussions:

"To be honest, there was no real conversation. It was more her telling me what's what and I went along with it. I wish I would have said something, but I didn't."

"I was told by the discharge lady that I would be having carers [and] I just accepted that. I thought, well, they know better than I do."

"I must admit I just accepted what was happening as the correct thing."

Confidence played an important role**. Patients who felt more self-assured, or had support from relatives or friends, were more likely to question decisions or assert their preferences**:

"I was expressing some concerns about [the timings of my discharge] to a friend.
She said [I was] perfectly within [my] rights to say I [did]
not want to be discharged until I [felt] safe about going home.
And that's what I said to [the discharge coordinator], I should just refuse."

"They knew I didn't want carers. They tried to argue.
I stood my ground. I said, don't worry, I will manage.
I don't care if you put me in a home, [but] I am not having carers."

Staff observations largely aligned with patients' accounts of limited involvement in certain decisions. One therapist noted: *"Some people are very on board and really kind*

of think the way we do, but then others don't and it's hard to get through. They think that just because they were fine at home before they're going to be fine again."

However, staff also described genuine efforts to involve patients when capacity allowed: *"If they've got the capacity, obviously, even if somebody hasn't got capacity, we still keep them involved in the decision making as much as safe to do so. It's their life at the end of the day, isn't it?"*

Experiences of patients in discharge planning – Key takeaways

Overall, patients' ability to participate meaningfully in discharge decisions varied, with **some expressing a clear desire for active involvement and others indicating comfort with clinicians taking the lead**. Meaningful participation depended on **early and consistent communication, clear coordination, and confidence in voicing concerns**. Patients who wished to be involved were most engaged when decisions were explained early, reinforced through therapy, and linked to familiar goals (e.g., equipment needs). In contrast, **more complex decisions - particularly those related to post-discharge care arrangements - often involved greater reliance on clinicians' judgement and required tailored support, repeated conversations, and structured opportunities for input.** Recognising and responding to differing patient preferences for involvement may help improve satisfaction, safety, and confidence during the transition home.

Family engagement in discharge planning

Extent of family involvement

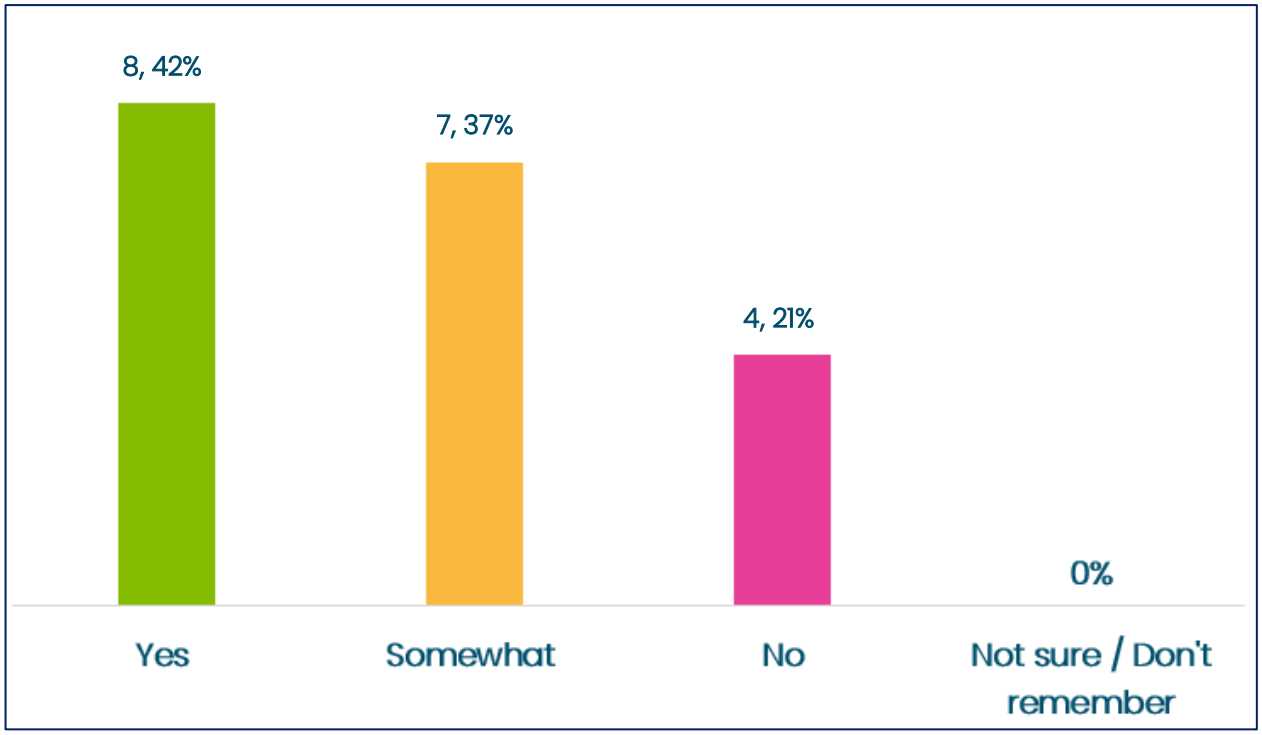


Figure 12. Percentage responses to the question: Were your relatives included in discussions and decisions about discharge, as much as you would have liked?

Nineteen patients answered the survey question about whether their relatives had been included in discharge decisions as much as they would have liked (Figure 12). Responses were mixed: 8 respondents (42%) said yes, 7 (37%) somewhat, and 4 (21%) no. This variation was echoed int he qualitative accounts that follow.

Family experiences of discharge planning ranged from active, supportive involvement to minimal or passive participation, with clear inconsistencies in how relatives were recognised, informed and invited to contribute.

Relatives who maintained a regular presence on the ward often felt more involved and could provide real-time input: *"I was visiting [my father] most days for two and a half hours in the afternoon. They would stand in front of both me and my dad just to confirm what was happening. If they were talking when I wasn't there, then obviously I wouldn't*

know. You take it as you find it, I guess?" However, **many families described discharge planning as directive rather than collaborative, reporting limited or reactive inclusion in decision-making.** They were informed of discharge decisions after they were made, with care plans, discharge dates and transport arrangements presented as already decided:

> *"[I was not included in decisions about my husband coming home], no.*
> *They [just] said what was going to happen.*
> *I was just told he was coming home the next day [with] transport arranged for 10 o'clock [and] the carers had all been set up."*

Other relatives described **selective involvement, mainly around practical tasks** such as describing home layouts and equipment needs. While relatives did not comment directly on staff decision-making, **it is possible that staff that engagement with families is influenced by the extra time required and the pressures of maintaining patient flow in busy rehabilitation units.** While this approach might streamline processes, it may also unintentionally exclude families from broader planning. For example, staff only sought a family's advice on the appropriate level of care support for their loved one when cognitive difficulties prompted a need for clarification:

> *"Mum gets a bit muddled with things.*
> *A lady called about two days before Mum came home.*
> *She said, 'Do you think [your] mum would manage with the one carer calling in?'"*

Another relative described a compromise with the discharge team regarding care for his wife with dementia:

> *"Some of [the staff] were not listening to what I wanted.*
> *They were thinking I wasn't going to be able to cope.*
> *I suppose it was a compromise in the end.*
> *They said she couldn't come home until she had carers.*
> *So, we had the carers [but now] we're managing very well without."*

Families of patients with cognitive impairments sometimes felt their perspectives were undervalued relative to the patient's expressed choices:

"We just felt a little let down], it was very disjointed.
They just told us they were putting in carers four times a day.
When they know that [Mum] has dementia,
our opinions should count a bit more than what Mum's wishes are."

These situations may reflect **legal requirements under the Mental Capacity Act (2005)**, which presumes that adults have capacity unless there is evidence to suggest otherwise. When a patient is assessed as having capacity, staff are obliged to prioritise the patient's own decisions, even when relatives disagree. If there isn't a Health and Welfare Lasting Power of Attorney in place, family views are considered advisory rather than determinative, and staff may only involve relatives when their input is necessary.

In addition to whether families were included, **the quality and tone of the communication played a central role in shaping families' experiences.** Two relatives shared instances of rushed, abrupt and dismissive interactions, where plans were communicated with little flexibility or consideration of their prior knowledge. These encounters left them feeling disregarded and stressed.

"When they wanted to send [my mother] home,
they said, 'Can she come home on Wednesday?'
And it was very sort of blunt. I literally got snapped at
because [I said no as I had] my own hospital appointment to go to that day."

"They [kept] saying [we were] entitled to X amount of free care.
And I kept trying to say, we've already had that this year, it will be self-funding.
Nobody seemed to listen to me too much in that department
until they went, 'Oh, it'll have to be self-funding.'
Well, yeah. Told you... What do I know? I'm just a bloke."

Family role in home assessments

Where family involvement was most prominent was in supporting **remote home assessments.** Relatives were routinely **asked to take photographs of room layouts and provide measurements for furniture and fixed features** such as toilets and steps.

The information collected helped determine the need for assistive equipment and home modifications:

> *"I was asked if it was possible for a relative to take photographs.*
> *My son emailed them to the physiotherapist.*
> *It was on the strength of those measurements and [images]*
> *that [they decided] what equipment needed to be delivered."*

When communication was clear and staff involved relatives appropriately – for example, seeking permission to contact family members; engaging with them early; or providing follow-up regarding equipment delivery and setup - **the process was viewed as professional, thorough and supportive**:

> *"Within the first week [of my father's admission],*
> *the head physiotherapist [asked] me to take photos*
> *and [provide] descriptions of his home setup.*
> *With this she [organised] equipment to help him come back [home]."*

> *"They [asked] me, 'Is it all right if we ring your sister?'*
> *They did keep my sister fully informed because*
> *she was the one taking acceptance of the deliveries*
> *So, yeah, that was all fine."*

However, **experiences were not universally positive**. Some families described limited **communication about remote home assessments, with little follow-up once information was submitted**: *"Well, they didn't ask personally, they just emailed us," and "We filled [the form] and gave it back. That's the last I heard of that."* These accounts suggest that a lack of in-person contact could leave families feeling disconnected from the process, uncertain whether the information they provided had been received, acted upon, or was even accurate. This placed considerable responsibility on families and, on occasions, may have resulted in **patients receiving equipment that was unnecessary or poorly suited to their home:** *"I didn't need everything they delivered," and "I've got so much equipment, some of it I haven't used because [one] argued with another when they tried to [fit them] into my small bathroom."*

The process could also be burdensome, requiring significant time, effort, and coordination, particularly for families living at a distance or with other commitments. One relative described fraught communication and poorly timed visits that created friction and much stress for herself and her siblings:

> *"Staff wanted to come and assess [my mother's] house.*
> *They expected us to wait in all day for someone to turn up when we were at work.*
> *They'd phone up and say, 'Can someone be at the house in five minutes?'*
> *Well, I teach and my brothers are not local. No, we can't...*
> *It got a bit uncomfortable, they just couldn't understand*
> *we [were] not available at the drop of a hat.*
> *[A] lady phoned [my brother] quite abruptly,' I'm here, where are you?'*
> *He got there as quick as he could.*
> *She literally just walked around the house, measured the bed and walked out.*
> *And that was it."*

Staff confirmed that they rely heavily on families for practical inputs, such as providing measurements and photos of the home environment. They also highlighted the **tension between patient needs and family capacity**. Staff described situations where families are *"burnt out,"* yet the discharge plan must still be built around the patient's needs rather than the family's ability to provide extra care. This aligns with family reports of feeling pressured to take on responsibilities they felt unprepared for.

Caregiving pressures and support gaps

Some relatives, particularly those who were already assuming care-giving duties before their loved-ones' admission, described **feeling under pressure to take-on additional caring responsibilities.**

This pressure often arose from **implicit assumptions from staff that family members were readily available and willing to provide ongoing support**. Several relatives observed that professionals planned discharges based on presumed family involvement rather than through a careful assessment of their actual capacity. As one relative explained:

"The team kept saying [to my sibling],
'Have you asked [your sister] to do this? Have you asked [her] to do that?'
I'm thinking, it's all very well, but how dare you?
I haven't got the capacity to just have all this stuff dumped on me."

Another relative described the difficulty of setting reasonable limits and emphasised that safe discharge required adequate formal support:

"I said to staff, at the end of the day, you are the experts.
[But] I can't be there every minute of every day to look after him.
I will do as much as I can to help but I need to know he will be safe at home
[with the package of care that is being planned for him]"

For some families, **pressure came less from staff and more from patient's own preferences**, especially when their expectations conflicted with what relatives felt able to manage:

"[My mother] cannot be independent [but is insisting] on going back home.
[Carers] can't be with her 24 hours a day, which [is] honestly what she needs.
Do you think I was consulted? No, but I will have to deal with it.
Not very good at all... It completely stops your own life. [But] what can you do?"

At the same time, many other relatives framed their caring roles as **personal or moral duty, motivated by loyalty and love** rather than something pushed upon them:

"Nobody has put any pressure. [My father] needs help and,
if it's not me that [will be] looking after him, then I don't know who [will].
As long as I can help him stay at home, which is what he wants, I will do it."

"There's not much that I won't do [for my mother].
I'll do what I have to do, it's my job by all accounts to look after Mum."

Across these accounts, a consistent picture emerged: even when families were willing to help, the **emotional and practical impact of caring** was significant. While some Carers mentioned receiving guidance or signposting to resources, more reported **feeling unprepared or unsupported for their caring responsibilities:** *"No support or training offered. Not that I can recall. My mother was just sent home and that was it," and "I didn't know anything was available. I'm making it up as I go along. The only support group is the one I found online. Good old Google."*

Family engagement in discharge planning – key takeaways

Meaningful family involvement in discharge planning depended not only on whether relatives were included, but how they were engaged. Family input was often task-based rather than decision-based, and support was sometimes assumed rather than actively requested. Communication quality was pivotal: timely, clear and constructive interactions helped families feel informed, valued and able to contribute. However, limited, rushed and directive communication sometimes created stress, confusion and a sense of exclusion. **Strengthening communication, actively inviting family input where appropriate, and offering practical support or signposting for new Carers** could enhance the experience of discharge planning for both patients and relatives.

Experiences on the day of discharge

Feeling ready, safe and supported to return home

Patients and families reported varied experiences of discharge from rehabilitation. **Approximately half felt ready, safe and supported to return home, while about a third described being discharged too early. The remaining interviewees were ambivalent, often deferring to the judgement of staff.** These contrasting experiences highlight the factors that contribute to effective and safe discharge.

Many patients and families described discharge as timely and appropriate. Their views reflected **a combination of reaching rehabilitation potential, growing independence and confidence, trust in staff judgement, and a strong desire to return home.**

Families frequently considered discharge appropriate when their loved ones had progressed as far as was realistic, particularly where **age or long-term conditions limited the likelihood of further improvement or a full return to their pre-admission baseline**. Staff sometimes reinforced this by explaining that patients had achieved the goals set for them or that additional gains were unlikely:

"They [were] dealing with an 89-year-old [who] has not been great on his legs for some time. So maybe they thought, 'Well, we've done as much as we can with him. If he wants to go home, we're not going to stop him.'"

"I think that was the right time because she'd had sufficient physio. I don't think they could have done much more really."

Patients often judged readiness based on improvements in strength, balance, mobility and independence. **Being able to mobilise with more confidence and handle small functional tasks without supervision made the idea of returning home feel feasible and safe:**

"I was gradually building up strength and practising walking. I just felt that it was the right time really. I was ready to go home. I felt as safe as I could be. I don't think they could have done any more in hospital."

"Once I was up and about, they couldn't stop me. The physios said that I was doing so well. They put 'independent' above the bed, so I didn't even have to have someone with me anymore."

Patients often placed significant **trust in staff assessments**, believing that clinical teams would not discharge them before they were ready. Professional reassurance helped patients feel confident about coping at home.

"The professional people felt that was the right time for me to come home. In a sense, that proved right because I've been increasingly able to care for myself."

"It was the right time.
Obviously, it's their responsibility that the patient is ready and that they're not sending them home too early. It's still difficult at times, but I'm coping."

Emotional readiness played a role too. Some patients described being eager to leave long before their physical recovery was complete. Feelings *of "being institutionalised"*, boredom and frustration at long stays, along with a strong desire for the comfort and familiarity of home, meant that discharge felt welcome and appropriate:

"I mean, emotionally, I wish I could have gone home earlier. It was just a question of whether I was ready physically."

"If he hadn't been discharged, he'd have probably packed his bags and walked out. He just couldn't wait to get away from the place."

In contrast, c**hallenges and concerns** arose when patients felt unprepared or unsafe. Factors included **ongoing mobility limitations, low confidence, unresolved health issues, and perceptions that discharge decisions were influenced by organisational pressures such as bed availability**.

Several patients described still **feeling physically and emotionally unsteady or unable to perform basic activities independently** once back at home:

"I didn't think I was ready to come home. I weren't very good at all walking. I wouldn't dare go into the bathroom and that on my own. I felt I needed a little bit longer."

Even when patients were able to manage functional tasks within the rehabilitation unit – an environment designed to support mobility and safety—these **abilities did not always translate to real-world settings**:

"Whilst in hospital [my mother] could perform the relevant manoeuvring tasks quite well for about 20 minutes, but once she got home, she could hardly move."

"I don't think Mum was ready to come home.
[In the unit] her mobility wasn't really too much of an issue because she could move on a lovely smooth floor with trained staff around [her].
Home [is] a small house. And [she can't] slide across the carpet.
I can push as far as saying that maybe it was even unsafe [for Mum to be discharged] because [she] is very scared about falling and shakes whenever she needs to move."

Ongoing health issues after discharge also contributed to perceptions that patients were discharged prematurely. Two families reported that their loved ones were discharged while still experiencing active medical problems, which compromised safety and led to readmission to acute hospitals:

"He had a UTI on the day he was released. He didn't seem very well at all to me.
The first day he got home he fell over. The Swift team got him up off the floor.
If you cut a corner in one place, it causes a problem somewhere else.
I just wonder how many people are just going around the loop because they're going home [when] they're not really capable of being there."

"[The discharge coordinator] rang me to say that Mum was being discharged the next day. They deemed her ready [but] she came out with chronic diarrhoea.
[She ended up back in] King's Lynn Hospital for just over a week.
She had saline and they did some tests."

A further theme was that **discharge decisions sometimes appeared influenced by organisational priorities rather than individual readiness to return home**:

> *"They did seem as if they wanted me out quicker than I really wanted because I'd achieved [my goals].*
> *They said this [was] a rehabilitation hospital, not a care [home].*
> *[But] I feel as if I'm still rehabilitating."*

> *"I personally would've liked to have stayed until I had my post-op checkup.*
> *I hadn't fully healed [and] I did feel a little bit vulnerable.*
> *I didn't say that to anybody because the ball was already rolling.*
> *There wasn't any point. They needed the bed."*

Several staff members also mentioned the **expectation to work within specific organisational timeframes**: *"I always tell them that we commission for the 18 days. Sometimes it does take a little longer, sometimes it's a little less, but that's what we are aiming [for]. So, we need to work within that."*

Staff also described **challenging situations where patients insisted on going home despite professional concerns**: *"Sometimes it does get tricky when that patient doesn't have capacity and we have to involve family… sometimes when they have power of attorney, they make the decision for them."* One clinician reflected on the ethical tension: *"If they've got capacity, then there's nothing really that you say, give them the Swift's number and helplines and this sort of thing and safety net them as much as possible. So, it's a bit tricky when they don't always, it goes against your better judgement."*

These accounts suggest staff sometimes felt constrained by both patient autonomy and system pressures, supporting concerns that discharge decisions did not always prioritise individual readiness.

Notice of discharge

Survey responses from 20 patients and relatives provided a snapshot of experiences with discharge notice (Figure 13). **Most respondents (13, 65%) reported being satisfied that they had been given enough notice to prepare**, while four (20%) felt that some notice was provided but preparations felt rushed. Two survey participants (10%) said they received little or no notice. These findings broadly align with the qualitative insights from interviews.

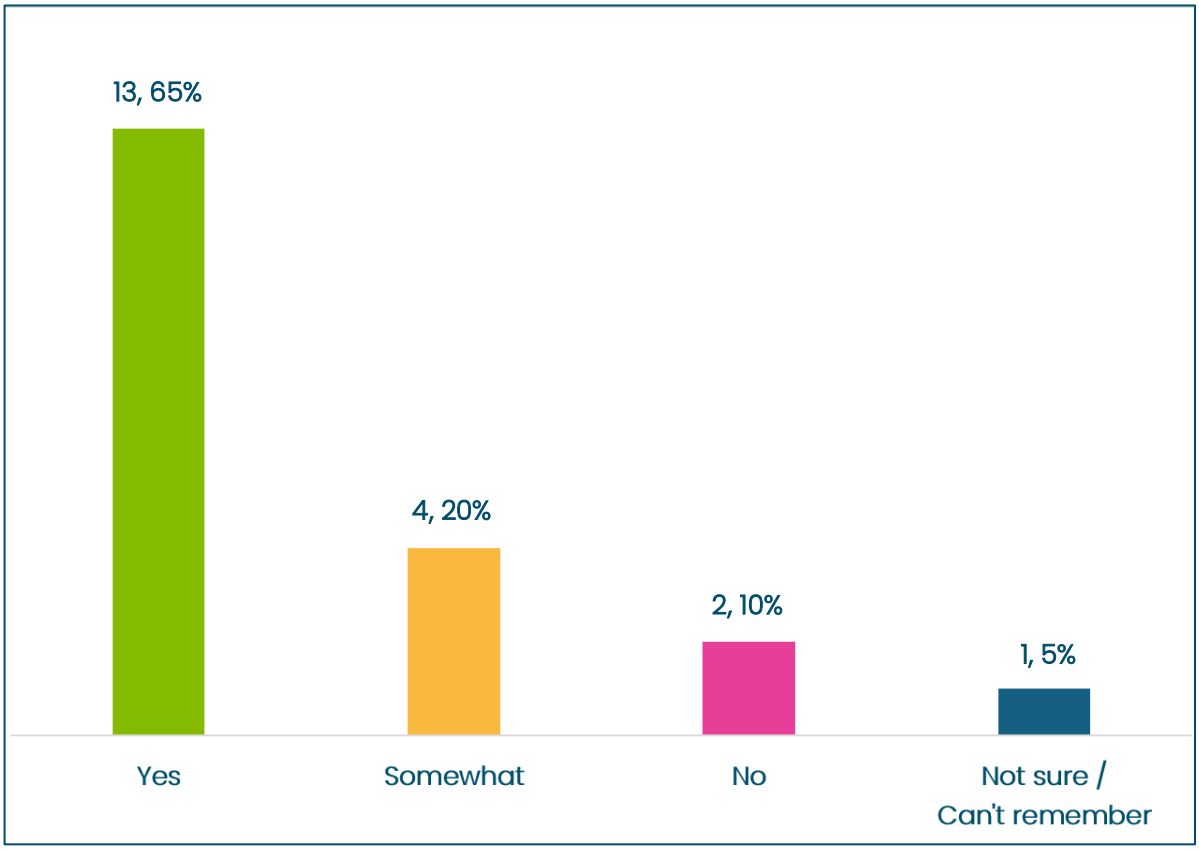


Figure 13. Percentage responses to the question: Were you given enough notice before being discharged?

Discharge was often contingent on the timely delivery of equipment and the finalisation of care packages. Patients and families generally understood that discharge would occur as soon as these supports were in place. However, **delays could cause uncertainty and stress, with some families waiting weeks on standby** before their loved one could return home. When notice was finally given, it was usually brief - typically a couple of days - but often sufficient for last-minute preparations.

Two relatives recalled:

> *"I knew discharge was imminent, it was just a case of getting the care package in place. That took a couple of weeks to get fully organised. [Waiting] was the painful bit, but we got there... In the end I [had] 48 hours' notice before she came home. I nipped to the shop, [got] some milk in and that sort of thing."*

> *"Discharge was synchronised with the care package. They told me [my mother] would be discharged as soon as they could sort things out, so I was on standby. There was no [timing] given until the night before."*

Staff explained that the *"sudden"* nature of discharge is often intentional to avoid confusion. Professionals described waiting until they have a *"clear idea"* of the plan before confirming a date to avoid giving patients false hope or confusing those with cognitive impairment. Once the necessary equipment or care package is confirmed - often after a delay - the team moves quickly to discharge the patient within *"the next couple of days,"* contributing to the feeling of a sudden rush at the end.

Communication about discharge timings was sometimes inconsistent. While some families received conflicting updates; others felt well-informed:

> *"We kept phoning and asking [for a discharge date] but there was just so much miscommunication. We've got carers now. We don't have carers. We don't know if we've got carers. It was like that all the time."*

> *"I got a phone call to say the carers were coming the next day at seven o'clock. And then another a few minutes later from a nurse saying my wife [was] coming home [the next day]. It was a bit of a surprise [as] they couldn't get carers for three weeks."*

Short or last-minute notice occasionally caused stress or emotional upset, with some patients reporting feeling anxious, shocked and unprepared for the speed of their discharge:

"It was just such a shock.
I was hoping [discharge] was going to be that week,
but then to say, 'You are going tomorrow; the ambulance will be here at 9am.'
And then it all happened: getting the prescription, sorting out my clothes.
Of course I didn't sleep. I [was] thinking about it all night."

"They just said, 'We've got news for you, you are being discharged tomorrow.'
That was a bit of a shock to think that
one day I was there and then the next day I was going home.
I must admit this [was] a bit too sudden, I cried.
I'd rather have been told a couple of days before to get used to the idea."

Information provided at discharge

Verbal instructions provided essential information for immediate practical planning, but were often brief and **focused primarily on equipment provision and upcoming home visits from carers and community nurses or therapists:**

"They just told me that the care package would start the next day and that somebody from the care company would discuss that with me as well. I knew the community nurses [would be] coming, but I wasn't given a date."

""[The information given was that] the care agency would come in for the prescribed number of visits. I don't recall anything else although we have since had a letter from physiotherapy saying that they will visit at some point. Really, that's it."

"I was told that I was going to be having carers in and that I'd got equipment already in place in my house, and that was it really."

A few patients mentioned receiving **leaflets with *"emergency phone numbers [for] if anything happened",*** as well as **promotional content for products and services related to independent living and safety at home**.

These materials were generally regarded as supplementary rather than essential at the point of discharge, with one relative dismissing the additional paperwork as "*all that rigmarole [patients] come out with".* Some patients echoed this sentiment: *"I've got lots and lots of paperwork that, to be perfectly honest, I haven't read,"* and *"Quite honestly, some of it, you don't need. Why would I want to sit and do a lot of reading? Unless [I]'ve got a query, I don't want to do it all."*

Some staff also recognised the limitations of written information, with several expressing concern about information overload: *"My concern is that I know we are looking at things like that, but I just worried sometimes there's too much paper and they get overwhelmed."* One staff member admitted: "*I know myself, you handed me a bit of information, I didn't read it.*"

The most valued documents were discharge summaries. These typically detailed reasons for admission, therapy progress, current health status, medical interventions, and medication lists. One relative described his father's paperwork: *"There were two sheets of paper, a summary of what [my father's] current state of health was [and] his medicines on discharge. I think that was all."* A patient added: *"They gave me a form that said all the things that I'm capable of doing, health conditions, allergies and a list of medications."*

Although these summaries included a broad range of information, **they were not always read in full.** As one patient noted: *"I didn't read everything that was there in detail."* Instead, **medication lists and instructions, were consistently prioritised**. These were viewed as the most actionable and immediately relevant components of the discharge package, critical to day-to-day self-management after leaving rehabilitation. As one patient explained, *"[The summary papers] were mostly about what drugs I've been taking and what drugs they were sending me home with,"* while another emphasised, *"I just need[ed] the bit the information about medication because that [was] the more important thing. I skipped over the rest of it at the time."*

Understanding of discharge letters varied among patients and family caregivers. Some found them straightforward: *"I think everything was quite clear," and "I read it [and] understood it all."* Others, however struggled, with **medical jargon which sometime made treatment or medication instructions difficult to comprehend.** One patient recalled, *"[I understood] within reason. I mean, obviously there's a few technical terms in there, medical terms I wasn't quite sure about. But overall, yes, they're easy to understand."* Another expressed more difficulty: *"A lot of it made no sense to me."* Several people commented that discharge summary letters were primarily intended for healthcare professionals rather than patients. As one explained, *"The paperwork's a bit bewildering: I think it's for the professional, not for the actual subject,"* while another added, *"I think the letter wasn't written for the layman, [more as] a doctor-to-doctor document."*

Some staff acknowledged these were primarily designed for healthcare professionals: *"It's mostly for the benefit of the GP practise. But they do get a copy."* Some staff attempted to make content more accessible - *"I try to make that less [technical by] avoiding using some medical terms"* - but recognized limitations: *"In terms of diagnosis, you can't avoid it."*

Many patients received discharge paperwork with little opportunity for staff to review content or check comprehension. Several highlighted that a proactive walkthrough would have reduced anxiety and improved understanding.

One patient recalled: *"They just gave me the envelope; it was like that. The head nurse said, 'If you've got any questions, please call'."* Another echoed this experience: *"The ward sister said, 'Your discharge papers are in the bag with your medication.' I didn't read [them] until I got home. I didn't have any queries. If I had, I would have rung them."* This may reflect standard practices, time pressures, or assumptions that patients could self-manage. However, this approach places the **burden on patients to seek delayed clarification**, assuming they have the confidence, knowledge, and presence of mind to do so, which is not always the case.

Many patients and caregivers emphasised that they would have welcomed the **opportunity to review their discharge papers with staff,** a practice which can improve comprehension, reduce anxiety, and ensure safety at home. One patient observed:

"Everything seem[ed] rushed. I would've liked a chance [to look at my discharge papers] but they didn't talk me through it." A relative added: *"I would have liked staff to be a bit more proactive, a bit more forward and asking you if you understood. They assume that we're all going to be okay and get on with it. Not everyone is geared up for it, are they? And not all people have got the common sense to ask."*

The emotional and cognitive state of patients sometimes limited their ability to engage fully. Some patients described feeling distracted or confused: *"I can't remember [if someone went through the papers with me] as I was so excited to get home,"* and *"I can't remember to be honest. There [was] so much going on; in one ear and out the other."*

Staff described varied approaches to reviewing discharge papers with patients. While one nurse explained, "*I do try to go through the discharge summary so they've got an understanding of what's going on,*" others indicated this wasn't standard practice: *"I dunno how we do with the discharge letter. I don't know… whether they actually go through them. I've not seen that done."* This confirms patients' experiences of receiving paperwork without explanation and highlights some inconsistency in practice.

Medicines and other supplies at discharge

Patients were routinely discharged with a fortnight's supply of medication. One relative explained: *"The medication came back with [my mother], about two weeks of supply*. **Most interviewees reported that receiving medicines and supplies was straightforward.** However, a minority described experiences marked with uncertainty, inconsistency, and avoidable errors.

Some families were uncertain when their **loved ones returned home with prescriptions that differed from those they had before their hospital stay, and expressed confusion about how to obtain repeat prescriptions**, with responsibility often falling on patients and relatives to seek clarification. One noted: *"She came home with a different prescription to what she went with in hospital. No explanation of why. I then had to phone the doctors to find out if this one [was] right and go to the local pharmacy and see if they had the next prescription. There was no communication to help us, to give us a smooth transition. Little things like that you find really hard."* Someone else shared this concern: *"I don't know*

if the repeat prescription comes automatically or whether I've got to get in touch with the surgery. I'll have to ask." Others conveyed confusion about Medication Administration Record (MAR) charts, and who was responsible for completing them: *"What's that huge MAR chart thing? I have no idea whether I'm supposed to have been filling that in or not,"* and *"I was given a MAR chart for my mother's medication [but] was not told anything about it. I don't know how to [use it]."*

One relative described a mismatch between what was listed on [her husband's] discharge summary and the medications actually supplied. Some drugs were missing while others appeared in the bag without any explanation: *"The medication that was on the discharge letter and what was in the bag didn't match. Three of the items in the bag weren't on the medication list, I didn't think it was very professional. I found it quite alarming. I phoned our doctors and they advised what he still should be using and what he didn't need."*

Two families also highlighted potential gaps in medicines reconciliation, telling us that their loved ones had been discharged with medications reintroduced incorrectly or with the potential for harmful interactions with existing treatments. One relative reported: *"[My father] was given a drug on discharge. I wasn't a hundred percent sure what it was for. I found out on investigation that it [was] a blood sugar regulator. My father is long-term diabetic. The Boots pharmacist was wondering why that would've been prescribed as well as having his insulin. She seemed to think that it [would] drag the blood sugar down quite a bit."* Another observed: *"There was a drug that was reintroduced to mum that she hadn't had for three, four years. In the [rehabilitation unit], they put her on it daily, which could lead to side effects like a dodgy stomach, [which she had by the time she returned home]. The surgery rang me back and said, 'You have done the right thing by stopping it'."*

Some patients reported insufficient or missing medical supplies or consumables: *"They gave me only a couple of [dressings] for my wound. They'd run out",* and *"I was having to do injections in my tummy, and they hadn't provided a sharps box. I rang [the ward] after I got home. The community nurse who came the next day brought that."* A relative described a similar gap in the supply of continence care products: *"They said to me, 'When he comes home, we'll give you a good supply of pads and the cream he needs for his soreness.' And of course he was discharged with no pads, no cream. I called the*

hospital and [they] brought some over." She added, *"Sometimes it feels everything's been done in such a rush that things are being missed. If I wasn't there at the other end to capture some of this, what would happen?"*, highlighting the **reliance on informal support to chase missing items and the vulnerability of patients without family or Carers to help.**

Transition home

Seventeen survey respondents answered the question, **"How did things go for you on the day you left the rehabilitation facility?"** Approximately half (eight respondents) described the day of discharge as good, three (18%) rated it as fair, and six (35%) as poor, indicating **considerable variation in experiences** (Figure 14). These findings broadly reflect the qualitative insights presented below.

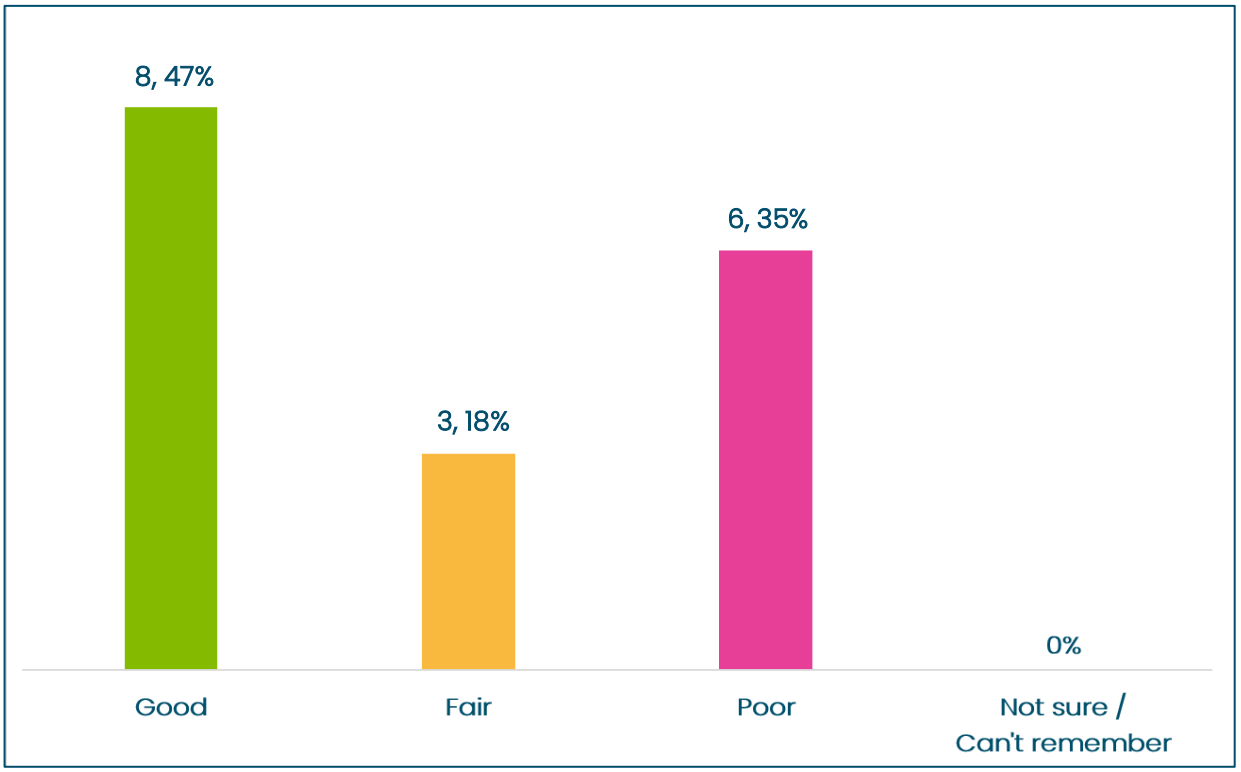


Figure 14. Percentage responses to the question: How did things go for you on the day you left the rehabilitation facility?

Many patients and relatives described positive experiences of returning home, highlighting that **well-coordinated discharge activities, timely transport, and clear**

communication helped reduce worry and provided reassurance at what can be a vulnerable moment. One patient commented on how smoothly the arrangements ran: *"I think I was told that I would be going at two, and it was round about that time. I wasn't kept waiting."* Relatives also appreciated being kept informed of timings: *"I was given a phone call to say that [my father] had left hospital and [to] expect him within sort of half an hour. They weren't far off their estimated time."*

Staff were described as organised, attentive and supportive, attending to both practical needs and emotional comfort. **Patients particularly valued advance notice and straightforward explanations about the steps involved on the day of discharge**. **Efficient preparations** also helped avoid last-minute stress. One patient summarised the process:

> *"Everything went as planned. No surprises, no delays, nothing.*
> *I was clearly told [what would happen on the day].*
> *[Staff] came in the morning and got me ready. I was first in the shower.*
> *[Everything] I was taking home got documented.*
> *The ambulance came on time. That was all done very well."*

Some patients also reported **positive experiences with transport home and continuity of care**, which contributed to a sense of comfort, safety, and confidence:

> *"[Staff] packed me up, they were very helpful.*
> *They took me out in the wheelchair and into the ambulance.*
> *I got back [home at] about one o'clock.*
> *[The ambulance crew] were very good, very pleasant.*
> *[They] saw me into the bungalow, into this chair that I'm sitting on,*
> *made sure I was comfortable.*
> *And then they said that a carer would [be coming] later in the afternoon."*

Conversely, many others described more difficult returns home. **Delays were a recurrent issue**, with patient transport often arriving hours later than scheduled. In some cases, delays were associated with vehicle availability, breakdowns, or wider service pressures. **Such delays frequently caused anxiety and discomfort,** particularly for patients who were physically unwell or fatigued while waiting to leave the ward. **Uncertainty about timing often compounded the stress**:

"The ambulance was supposed to pick me up between one and three,
and they finally turned up at half past five.
I did think I might be better off lying on the bed [waiting],
but I was on the chair until the ambulance actually came."

"A car had been arranged for two o'clock.
I [was] ready, sitting in the reception area by quarter to two.
It got to half past five, I said, I can't sit here any longer and [arranged] a private taxi.
I was just so tired."

"That must have been about at least two hours later [than expected] before the ambulance turned up. I was twisting my fingers around a bit, waiting for [the ambulance] to come."

Communication about delays was experienced inconsistently. **Patients and relatives who received timely updates were generally more understanding,** recognising the practical challenges of hospital transport logistics and patient prioritisation:

"They said she was going to leave [at] about 10 o'clock
but there was a problem with the transport.
She came home at three o'clock.
[Staff] were on the phone straight away.
Things happen, vehicles break down, there's delays. I fully understand that bit."

However, others were left uninformed, causing worry and **requiring them to contact the [rehabilitation ward] themselves**:

"We were told transport [was arranged] for 10 o'clock in the morning.
By quarter past one, he hadn't come home [and] I was getting worried.
Nobody had phoned me to say there was a delay.
I'm sure it wouldn't have taken two minutes for somebody to pick up the phone."

"There was a delay and [my father] arrived home a lot later than we thought.
When I rang up the ward [about] where he was, they were unsure,
which was rather worrying."

In a small number of cases, prolonged delays had knock-on effects on care continuity, especially when families or care packages had been timed around the expected arrival. One relative noted:

> *"I was told transport would pick Dad up at 2pm.*
> *He eventually left at about 10pm.*
> *He had to be put into bed fully clothed by the transport guys*
> *as it was too late for carers.*
> *Dad was left feeling extremely confused and tearful."*

Overall, the **transition from rehabilitation to home was emotionally significant for patients**. Many described feelings of relief, happiness and motivation, valuing the familiarity, autonomy, and comfort that home provided:

> *"[I felt] fantastic [to be back at home], relieved. Cloud nine.*
> *I know there's still a lot of things I can't do,*
> *but I am getting better quicker because I'm at home "*

> *"Mum literally got home, got in her chair and cried.*
> *I think it was out of relief of being home. She's a lot happier being home."*

At the same time, **several other patients experienced mixed emotions**. Those who had been away from home for extended periods often felt **disoriented and vulnerable**, particularly **while adjusting to new routines and coping with the absence of hospital support.** These feelings generally stabilised over time as patients adapted to their home environment and regained confidence in daily activities:

> *"It is lovely being home.*
> *But [that was] a shock having to acclimatise to the house,*
> *not being able to walk, and [being given] two carrier bags full of medication.*
> *It was just everything in my face all at once."*

> *"It's a big deal coming home.*
> *I was pleased to be back with my little dog [but] I felt safe in [rehabilitation].*
> *[With the] safety net of nurses and healthcare assistants gone, I did feel a bit*
> *vulnerable and overwhelmed for a couple of weeks."*

Staff reflections on discharge process effectiveness

Staff acknowledged some systemic challenges affecting patients' experience of discharge. Multiple clinicians identified lack of continuity as a problem: *"Sometimes we have a different ACP [Advanced Clinical Practitioner] here. Sometimes we have a different person in almost every day of the week. And that makes it really hard then to make a discharge plan because there's not that consistency."*

Communication across the multidisciplinary team was recognised as fragmented: *"Perhaps better communication between everyone as to when they're going. I mean generally I think that's quite good, but sometimes a patient will think that [they] won't be told that they're going till quite last minute."*

When asked what single change would improve discharge, staff consistently emphasised time and space for conversation: *"I think more time, more time to discuss it and discuss the options in a quiet place. More privacy and more time."* Another reflected: *"I think there could be an improvement. It might even be that maybe nursing could get more involved if it's their bay, they could remind the patient that this is what's happening."*

Staff also identified information provision as an area for development: *"Oh, it's always verbal, so it'll usually be me. We don't really have anything that kind of outlines what their care package will be. I mean that's probably not a bad idea. If we had some pre-populated letters that might have it so that we can put in how much care they get in and things like that."*

Several staff members mentioned the challenge of balancing thoroughness with overwhelming patients: *"You don't want to kind of bombard patients with information,"* and recognising that *"It is a good point. You can give somebody as much verbal information as you want, but it's very easy to forget it."*

These reflections demonstrate staff awareness of many issues patients and families experienced, suggesting improvements that may require organisational changes, such as enhanced staffing, improved coordination systems, and standardised information resources, rather than simply changing individual practices.

Experiences on the day of discharge – Key takeaways

Patients and families reported varied experiences on the day of discharge from rehabilitation. Many felt ready, safe, and supported, reflecting improvements in mobility, independence, and trust in staff, while others felt unprepared due to ongoing health issues and low confidence. Effective discharges were characterised by clear communication, timely notice, coordinated care packages, and reliable transport, whereas last-minute notice, confusing paperwork, medication errors, or delays caused confusion, stress and, in some cases, readmission. Emotional readiness and adaptation to home were key, with most patients ultimately relieved and motivated, though some initially felt vulnerable. These findings highlight the importance of individually assessing readiness, proactively communicating plans and instructions, ensuring safe medication and supply transitions, and supporting patients emotionally as they return home.

Post-discharge recovery, support and care

Early recovery and life in the first few weeks after discharge

Two to three weeks after leaving rehabilitation, people described a mix of adjusting to home life, slow but steady progress and, for a few, early setbacks.

Most were gradually regaining mobility, strength and independence, even while managing ongoing limitations. One person explained: *"I haven't done much, [mostly] watching old television programmes and reading and that. I'm just beginning to be a bit more adventurous, now my hand is getting a little bit better. I couldn't do up the zip on my top even three days ago [but since] I have watered my lawn. I can slowly do more things."* Many were adjusting to new routines and learning to navigate their homes using walking aids and other supportive equipment: *"It surprised me how easy it was to move around the house using the walking frame,"* and *"I can stand and balance for quite a long while now and do more things [but] I've still got [a walking frame] for support. Every day, I'm getting better. Eventually I'm not going to need it."*

A smaller number experienced complications or regression after returning home. One relative described a sharp decline in his father's mobility and general health: *"[My dad] came back walking, but he's not now, he's bedbound. And we've had issues with a UTI*

[and] blood sugar crashes." Another relative explained that his mother suffered another fall, leading to the decision that she could no longer live independently at home: *"My mother] had another fall. There wasn't any [serious] damage except for being a little bit bruised and battered. I said to her that [living at home] wasn't sustainable so she's in a local residential care home now."*

Emotionally, most felt relief at being home, though some struggled with the slow pace of recovery: *"I feel like I'm not progressing [quickly enough]. It is affecting my mental health really."* One person recognised the **need for patience and persistence:** *"It's just a completely new way of life. Never mind, I'm coping okay. I must be more patient, take it slowly [and not] expect miracles. It all takes time."* Another explained that she missed the social environment of the rehabilitation unit: *"Of course I play games on my computer and watch TV but you get cheesed off after a while. [It] does get a bit lonely in here. I miss the camaraderie we had in the hospital."*

Equipment, home adaptations and follow-up occupational therapy visits

Equipment and home adaptations were usually arranged through occupational therapy and discharge teams, and supplied by Medequip, a company providing community equipment services on behalf of local authorities and NHS organisations. Medequip supplies, delivers, installs and collects assistive equipment that supports mobility and safe discharge from hospitals or intermediate care settings, including inpatient rehabilitation units.

Patients frequently received substantial adaptive equipment on discharge, including:

- Walking aids (e.g., frames, crutches),
- Grab rails,
- Raised toilet seats and commodes,
- Hospital-style beds and pressure-relieving mattresses or cushions,
- Shower stools and bathing equipment,
- Transfer aids and hoists.

Delivery was generally described as timely and well-handled:

"[Delivery] was all arranged [between] my neighbour and Medequip. They phoned to give her a time, [she] came round and opened the doors for them [to] put the equipment in."

Community occupational therapy teams conducted **follow-up home visits to assess the home environment, support safe access with grab rails, and determine whether any equipment required adaptation or replacement:**

"The OT came over a week ago. She helped me get out the front door and down the steps. Then she organised grab rail and measured where they should go."

"The occupational therapist came to visit. Her aim was to assess the house and she organised to have rails fitted at the kitchen door to help with steps up from where you park the car. She also helped [my husband] practise walking with two walking sticks."

"They [have ordered] a new toilet seat because we realised we couldn't shut the door with this one."

In some cases, **patients supplemented NHS-provided equipment with their own purchases** to improve convenience, independence or fit where provision was inadequate or impractical:

"The only problem is the Zimmer frame and the chair I've got in my kitchen are sort of too big to each other. So, my son's ordering another chair on wheels [with a tray where] I can put stuff on."

"They couldn't do anything about the [bathroom]. I've still got to the bath taken out and a walk-in shower put in. That is something that has to be done privately, down to me and my money."

Home visits from community physiotherapy teams

Patients and relatives reported **mixed experiences with community physiotherapy following discharge. Access to home visits appeared uneven, shaped by clinical need, service capacity, and the ability of patients to advocate for appointments.**

Many patients described **community physiotherapists as supportive, practical, and confidence-building. Regular visits**, often weekly for several weeks, were seen as highly effective in restoring mobility, improving confidence, and ensuring safety at home. Physiotherapists provided tailored exercises and guidance on walking, using stairs and other functional tasks, with clear evidence of progress:

> *"The physio came around and was very helpful with a new set of exercises"*

> *"[The community physiotherapist] has been in [once] a week [for] about three weeks.*
> *[He has] got me out of bed and showed me how to do exercises.*
> *I'm now able to walk up to my kitchen, very pleased with the way I've got on.*
> *He's going to get me up the stairs on the stairlift,*
> *I didn't think I was ever going to manage that."*

Patients valued reassurance that they could call for additional support if needed, though they recognised that physiotherapy time was rationed according to need:

> *"I'm getting there, I'm doing quite well on my own.*
> *If I do need any more assistance from the physios, all I've got to do is call.*
> *But they've got other people [on their lists] that are more needy than me."*

However, **many other patients reported delays, lack of follow-up, or minimal contact, relying solely on exercise sheets provided during their rehabilitation stay rather than receiving face-to-face support.** Long waiting lists and inconsistent communication were common, reflecting capacity constraints and unequal access with higher-need patients prioritised:

> *"I have had no physio. I'm on the waiting list.*
> *I've got the leaflet of exercises from the hospital I've got to do."*

"The only message that came was that physios were aware of the situation and would visit at some point in the future, but no dates were offered [and nothing] has moved from that point yet."

Delays or absence of physiotherapy support sometimes had significant consequences with a few patients and relatives reporting **deterioration in mobility and functional ability:**

"As for physiotherapy, I haven't heard anything from anyone. Probably the less said the better because [my mother] can barely move [now]."

"I'm not getting any physio. Physio would be important as my legs have stiffened up [but] I'm still waiting. I have been warned, it will take a few weeks before anyone contacts me."

Access could sometimes be improved through patient or family advocacy, or by highlighting urgent functional needs during triage:

"I rang them and they said that there was thirty people in front of me and that I'd have to wait. I said to them, all I wanted [was] to go upstairs to my bedroom. I [didn't] know what damage I [was] doing to myself if I [did] it the wrong way. So, she triaged me on the phone [and] they accelerated my appointment."

Follow-up consultant care and community nursing support

Most patients received follow-up appointments with hospital consultants after discharge, providing ongoing oversight of their recovery and confirmation that progress remained on track. These reviews sometimes resulted in patients being formally discharged from specialist care, although not all were signed off immediately. One patient described a typical experience of continued monitoring:

"When I went to the hospital a couple of weeks ago, the consultant said the bone was healing really good, but I've got really bad arthritis and that's sort of delaying the walking a bit. I've got another appointment in 10 months."

Alongside these outpatient appointments, patients often relied on community nursing teams for essential clinical care at home. Community or district nurses played a crucial role in supporting recovery post-discharge, particularly for those with wounds, pressure sores or skin integrity issues requiring regular monitoring and intervention. Their visits helped ensure continuity of care once hospital oversight reduced:

"The visiting nurses have been monitoring a wound on his backside, which was notified on his paperwork on discharge. It's an ongoing thing, [community nurses] change bandages and check his groins because sometimes they flare up."

"[My wife was discharged with] a very bad sore on her left heel. It's still weeping badly [but] a district nurse [is visiting] twice a week to sort it out. No problem there."

While many patients received timely and effective support, **access to specialist input could be delayed**. For example, a patient explained that visits from continence nurses were slow, with waits of four to six weeks. During this period, she had to self-fund incontinence pads:

"Long waiting lists for the incontinence nurse, think four to six weeks even though I should be near the top of the list because I'm non-weight bearing. I would like to have everything sorted because at the moment, I'm paying for the pads myself [whereas] you can get them free from the [continence team]".

Short-term reablement

Most of the patients we interviewed during their rehabilitation stay were discharged home with short-term reablement support. In Norfolk, this is provided for up to six weeks by Norfolk First Support, part of Norfolk County Council's adult social care services:

> *"I was told by the discharge lady that I would be having carers from Norfolk First Support, the six-week [reablement] package from Norfolk County Council. That's [what] they always use. I just accepted that, they know better than I do."*

This **free, home-based service focuses on gradually restoring independence by helping clients regain skills, build confidence in daily activities**, and identify any longer-term support they may need to manage ongoing health conditions. Typically, within a few days of discharge, reablement assistant practitioners visit clients at home to create **personalised support plans**. These plans are designed to support the transition from the rehabilitation unit to home, **monitor mobility and safety, and encourage clients to manage their own personal care and basic meal preparation**. One service user described this support:

> *"It was a six-week [reablement] package.*
> *The morning [visit] was about helping me get to the bathroom, wash and get dressed.*
> *The midday [support worker] was helping me with [a light lunch].*
> *[In the afternoon], she ran behind me just while I [did] my balance exercises.*
> *[And then at] bedtime, she was helping me put my pyjamas on and get into bed."*

Support workers often acted as facilitators, **encouraging independence rather than doing tasks for clients:**

> *"They're not really carers, more like observers, I suppose.*
> *They're there to sort of supervise and watch what you're able to do."*

> *"I have a carer come in the morning [and] another in the evening to encourage me to slowly do more for myself. They're coming to be worked out of a job."*

While the reablement service was **highly valued by many** - *"They're very good actually. It's helped [my husband] so much with his recovery. They just come in, do what they've got to do and have a quick chat. They're so friendly"* – some clients and relatives noted **limitations. These included issues with punctuality, short, task-specific visits and variation in support depending on the individual carer**, which sometimes left informal Carers to manage broader needs themselves:

> *"They're not here when they're needed. Are they really?*
> *[And] they only came in for half an hour at a time. What can they do in half an hour?*
> *They sometimes came in at 11 o'clock in the morning.*
> *[I had already helped my wife] dress and have breakfast. I was doing all the work."*

"[They came] once in the morning, just to help my mother with her wash.
Some of them were more helpful with Mum than the others
[who] didn't want to help with anything else.
I found [that] a little bit frustrating."

"I thought that they could do a bit more, but they didn't, it was limited.
Some [support workers] left me to my own devices, couldn't wait to leave, rushing [me].
Another was really caring and [showed] a lot of empathy,
'Can I help you with anything else you need?'
I think it depended on the individual."

Some frustrations arose because clients and relatives expected reablement to function like traditional domiciliary care, which typically involves paid carers providing ongoing help with personal care, medication, meals, and household tasks. In contrast, reablement has the primary goal of restoring independence. **When this distinction was not clearly explained or understood, clients often perceived the service as inconsistent or insufficient.**

Many clients improved quickly and allowed visits to be reduced earlier than planned. Others withdrew from the reablement service because support felt limited, or they preferred help from family:

" I just feel that I'm okay and I've weaned myself off now really.
The bedtime [support] was the first one I stopped quite early on.
I also cancel[led] lunchtime because [my brother] was doing the meals for me.
To be honest, I don't think I'm going to be keeping
[the other two daily visits] for the full six weeks."

"I was doing so well and improving [with support workers] doing less for me.
It got to the point where I decided that I actually didn't need them anymore."

In several cases, **support was formally ended once supervisors established that clients could safely manage independently**, though some felt the service was keen to *"move them off the books"* once key milestones were achieved:

"Well, I was initially told a month [but] they only came for about a week [at] lunchtime. Obviously, there are people who do need their help and I didn't. The boss came around to double check and left me an emergency phone number in case I suddenly was unable to lift a saucepan."

"They're just very much into washing and dressing and get[ting] your own meals. Once you can do all that, they don't want to know, they're just more or less finished with you."

Clients who required support beyond six weeks were informed that this would usually need to be financed privately:

"They said that [social services] would provide a six-week initial care package and then we would be free to keep it going or tailor it further if we wanted to, at our expense."

Ongoing domiciliary care from paid carers

A smaller number of rehabilitation patients returned home requiring ongoing domiciliary care from paid carers, either immediately on discharge or after completing the six-week reablement period.

Arranging this care frequently involved brokerage services such as Xyla, a UK-wide independent social care organisation that works with local authorities and NHS trusts to match people's assessed care needs with suitable home-care agencies.

Xyla's role is both advisory and facilitative, guiding families through provider selection, funding arrangements, and placement logistics:

"Xyla started looking at care providers to see who was both the most cost effective and the most suitable locally. They came back with three care agencies and then asked me to pick one."

In practice, however, families found that **choice was frequently constrained by provider capacity, quality standards, and geographical location:**

"Most companies can't take on new people [as] most of the carers don't have capacity."

"They emailed me a list of three providers. One of them didn't have any CQC recommendation. A friend of ours didn't recommend [another], and [the last] one didn't have any contact details or history. So, I thought, well, not a lot to choose from there, none of them appealed unfortunately."

"The first and most local [care provider] we did not have a good experience with. A second was based in Sheringham, which simply was too far away. We went for [the last option]."

Clients receiving domiciliary care **typically had two to four daily home visits from carers to support personal and medical needs**. The care was often highly valued for its tailored support, enabling clients to maintain as much independence as possible while receiving essential assistance with daily tasks:

"I'm paying for my own care, and I have got two carers coming in twice a day. One to get me out of bed, one to get me into bed at night."

"Carers look after me four times a day. They get me up in the morning, they wash and dress me, get me breakfast, put me in [my] chair and then they go off again. They come back at about 12.30pm and I have a couple of biscuits and a cup of coffee or tea. [They're back in the afternoon] to prepare my evening meal and then they come back to get me in a bed at night. I also get my groceries [...] and my prescriptions picked up every week by one of the ladies."

Many clients emphasised **reliability and responsiveness, even in challenging situations**:

> *"I mean, I can't fault any of them.*
> *They turn up when they're meant to turn up*
> *[and even] in between when Mum was really not very well.*
> *Yes, it's a lot of money, but you can't get anything good for free"*

Whether a client must self-fund their domiciliary care package depends on a financial assessment by the local authority. Those with limited income, savings or assets may receive full or partial funding, while clients with sufficient resources are usually required to cover the cost themselves.

For people requiring intensive or frequent support**, costs could be substantial, sometimes provoking shock or distress when the full financial burden was revealed:**

> *"I thought, oh my goodness, we can't afford to do this."*

> *"I was told I would have to be means tested. I refused point blank;*
> *my finances are nobody's business!*
> *Social services worked out that it was going to cost me £1400 a month.*
> *It's an awful lot of money [and] I got very upset."*

Some clients viewed **financial assessments as invasive or unfair**:

> *"You've worked and saved all your life, you've got the money in the bank,*
> *and then you have [to pay]."*

Nevertheless, some clients accepted the **expense of private home care as necessary to maintain dignity, independence and receive quality support:**

> *"I pay nearly £700 a month for four visits a day.*
> *I do have to pay that, but when you take it down weekly, that don't seem so bad.*
> *All being well, I'll keep them as long as I can."*

"Obviously I only got six weeks of free [reablement]. The lady from social services [gave me] a list of numbers. I found this [company] for three half-hour visits a week is £48 a week, which isn't too bad."

In contrast, **others cut back or declined care due to affordability**, relying instead on informal family support to provide the necessary help:

"Because I have to pay, I want [the care package] cut down as soon as possible"

"Mum's over the threshold so she'd have to pay for carers basically. So now it's down to us to keep an eye on her."

Overall, these experiences point to a need for more consistent and clearer communication about the nature of reablement services and paid care provision ongoing throughout discharge planning. They also underscore the importance of providing families with more accessible information from ward-based social workers regarding funding and financial assessments, alongside stronger support for families as they navigate complex care decisions.

Additional post-discharge services

Other support services, such as fall-prevention programmes and rapid response services for emergency help at home, are also available following discharge from rehabilitation. However, none of the patients or relatives we interviewed had experience of these services. This suggests either limited uptake or awareness among recent rehabilitation patients.

Organisation and coordination of post-discharge care and support

Patients and relatives reported **mixed experiences of how post-discharge care was organised and coordinated**. While some described fragmented support, delays and communication failures, others experienced highly effective, well-coordinated care.

Clear communication, proactive coordination, timely follow-up, and effective interagency working were key factors contributing to positive experiences. For instance, a relative described contacting Norfolk Swift Response - a service for urgent, non-medical support at home provided by Norfolk County Council – and being reliably **redirected to the appropriate team** which answered her queries and concerns:

> *"I've got a phone number for Norfolk Swift Response. [Both] times that I've rung, they've put me onto the correct telephone number, and I've been able to progress it from there."*

Some patients described a well-organised, joined-up system **where information flowed smoothly, services were aligned**, and the burden on patients to navigate post-discharge care was minimal. Staff were consistently well-informed about the patient's situation, and services were generally described as responsive and reliable:

> *"The spinal unit people [got] in touch. Doctors [have] been trying to sort out my medication [and] said [they would] put [me] in touch with the social prescriber. I had another lady that came and talked to me about whether I needed to carry on with carers. So, I feel that it's all flowed quite nicely. I think they've all been great."*

Carers, nurses, therapists and social prescribers arrived knowing the purpose of their visit, which contributed to a perception of coordinated care:

> *"Everybody else that has turned up to the door, all the nurses, health visitors and what have you, they've known what they're coming to do and have been helpful as well."*

> *"I've got no complaints at all. I think they've all been marvellous Everything has gone very smoothly and slotted in very well, and I think I've been treated very well."*

Patients also valued **transparent, consent-led information sharing between teams**, which helped hospital teams, community therapists, district nursing, and social workers remain aligned:

> *"I know they do [share information] because they've always asked me whether they can or not, and I've said yes."*

However, not all patients and relatives experienced this level of coordination. Many reported challenges that undermined continuity of care, safety and confidence in the system.

Communication failures were common. Key documents and updates did not always reach relevant services, leaving families to chase information themselves. One relative described how his mother's discharge letter never arrived at the GP despite assurances it would:

> *"The discharge coordinator said that [my] mother's discharge letter [would] be sent to the doctor. This has happened before, the doctor never received it. She said, 'They will receive it from us, our systems talk to each other, give it 48 hours.' So, I went to the doctor [and] he hadn't seen anything on the system. So that failed..."*

Miscommunication between services sometimes delayed essential treatment. For example, a patient reported repeated problems obtaining antibiotics for an infected wound:

> *"The district nurse said [I] need[ed] antibiotics.*
> *A doctor rang me and said [the] prescription [would] be ready*
> *at Tesco's from 10 o'clock. [There], they didn't know anything about it...*
> *I rang again. [Second time around] the antibiotics weren't ready,*
> *but they did know about them."*

Bureaucratic inefficiencies were also reported, with patients often waiting for outcomes from assessments or follow-up care:

> *"I have had an assessment by the County Council [but]*
> *I've heard nothing at all, nothing is rushed."*

> *"Too many cooks spoil the broth...*
> *Lack of communication between*
> *different departments and different people.*
> *With mum not being very well, and I was getting really stressed.*
> *I just need people from different departments to start talking to each other."*

Patients and families frequently experienced multiple visits from different carers, care agency supervisors and social care staff, **performing assessments which appeared overlapping or duplicated**. This created confusion for patients about roles and responsibilities and lessened confidence in the integration of care:

> *"I came home and a carer came in that evening.*
> *She did an assessment of what I needed.*
> *The next day, a new carer came in.*
> *She wasn't really happy with the setup and made some suggestions.*
> *Then I got a phone call from somebody else at Norfolk County Council,*
> *she came and did another assessment in the afternoon.*
> *To be perfectly honest, I'm not sure why she was there or who she was."*

In addition to organisational and communication issues, some patients described **visitors as task-focused and impersonal**. Some felt treated as *"numbers on a to-do list"* rather than individuals:

> *"Carers walked through the door and then, about a minute later,*
> *there's another chap standing in the room as well.*
> *I said, excuse me, who are you?*
> *'I'm from management, I've come to see what [these two carers]*
> *do with your wife for half an hour'.*
> *I said, you should have introduced yourself.*
> *Things like that annoy me.*
> *They just walk in the doors as if they own the place."*

> *"They are so rushed, they don't really stay any longer than they need to.*
> *It's nice if they just make a little relational comment or [have] a discussion*
> *just for a second or two before rushing off to the next person.*
> *[That] just personalises it a little bit, makes it more friendly."*

Patients also reported **confusion about the purpose of visits and the identity of those attending**. Clear identification of visitors, along with an explanation of their role and the reason for the visit, was considered crucial to reduce anxiety and ensure safety:

"There were so many different people, from so many different agencies coming or contacting me that it [was] a bit confusing at times. I [was] not always sure where they [were] from. If people made it very clear who they're representing, that would be of help."

Overall, these accounts demonstrate that communication failures, bureaucratic inefficiencies, and unclear roles and responsibilities can create frustration, stress, and even safety risks for patients and families. In contrast, well-coordinated post-discharge care – underpinned by clear communication and effective interagency collaboration - fostered confidence, reassurance, and smoother transitions from hospital to home. These findings underscore the **need to improve information flow, clarify the responsibilities of different organisations for patients, ensure consistent coordination across services, and support patients and families in navigating the complex post-discharge landscape.**

To address some of these challenges, **Norfolk County Council, and health partners across the Norfolk and Waveney Integrated Care System (ICS), have introduced a single point of contact designed to connect patients and families to a coordinator or navigator who can triage their query and direct them to the appropriate service**, whether that be social care, community nursing and therapy, equipment provision, or other specialist support. However, **this arrangement does not yet appear to be effectively communicated to, or well understood by, patients**. As one patient noted: *"Nobody's actually said to me, look, if you do need help, call this number. No, I haven't had anything like that at all."* Instead, patients overwhelmingly reported leaving rehabilitation with multiple individual numbers for different services:

"I've got lots of individual numbers. I wrote them down. When I need to contact them, I have to check up in my book."

"If I wanted help from the carers, then obviously I'd ring the care service. If I wanted help from the district nurse, I'd obviously ring [them]. I've got all the numbers."

Post-discharge recovery, support and care – Key takeaways

Following discharge from rehabilitation, patients and families in Norfolk accessed a wide range of community health and social care services. These included district nursing, community therapy, reablement and home-care support, equipment and adaptations, social work input, voluntary sector support, and specialist services such as emergency assistance and falls prevention programmes.

Experiences of these services were mixed. Well-coordinated care with clear, proactive communication supported smooth transitions home and timely interventions, and a strong sense of being well supported during recovery. However, many others encountered fragmented services, overlapping assessments and communication gaps, leaving them to act as their own coordinators and chase updates during an already challenging period.

Overall, these findings show that while high-quality, joined-up post-discharge care is already delivered in some areas, greater consistency is needed across the system. Strengthening information flow, clarifying roles and responsibilities, and ensuring effective interagency collaboration would help reduce confusion and help more patients experience a safe, confident transition from hospital to home. Simplifying access through measures such as a single point of contact could further support patients and families in navigating post-discharge care efficiently, reducing delays and frustration.

An evaluation of the Guide for Unpaid Carers

The *Guide for Unpaid Carers – Hospital Stays: What to Expect from Admission through to Discharge* was co-produced with Carers, Carers Voice Norfolk and Waveney, and staff working across health and social care in the region.

Healthwatch Norfolk invited relatives and unpaid Carers of people who received inpatient rehabilitation at Swaffham Community Hospital – where the guide was being piloted - to take part in a focus group. **The aim was to explore how useful and effective the guide is in supporting Carers and the people they care for throughout their hospital journey.**

This section summarises the focus group feedback, **highlighting the guide's key strengths and identifying areas for improvement before it is rolled out across all hospitals in Norfolk and Waveney.**

Guide organisation and design

Focus group participants reviewed the guide's design and organisation, including format, font, colour scheme, text layout, and use of images. They were invited to discuss whether the visual style and structure of the information effectively supported navigation and enabled readers to locate content quickly.

Overall, there was a strong consensus that a professional, well-designed booklet is more likely to be noticed, trusted and kept for reference compared with leaflets and loose papers, which can be easily lost or ignored. While the final format of the booklet is still under review, one participant emphasised that when a document *"looks the business, you sort of tend to take more notice and […] draw on [it] whenever you want to",* indicating **that a professional presentation enhances perceived importance, trustworthiness, and practical value.**

The front cover image of people holding hands divided opinion (Figure 15). Some found it "*nice and heartwarming*", while others felt it was overly sentimental. As a participant observed, *"Carers tend to be a fairly robust bunch"* and may respond better to

authentic visuals than to idealised imagery. Similarly, the photos on the introduction page of the Carers Ambassador and Sponsor for Carers at the Norfolk & Waveney ICB were seen as unnecessary.

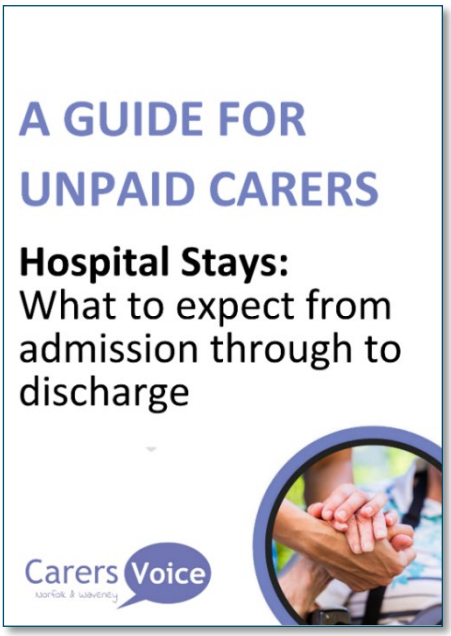


Figure 15: Image showing the front cover of the Guide for Unpaid Carers.

The simple colour scheme was generally appreciated, but **some participants raised concerns about the font size (12pt)**, which could be challenging for readers with poor eyesight, attention difficulties, or other disabilities. One participant noted the necessity of following NHS guidelines while another acknowledged potential accessibility limitations:

> *"All documentation for the NHS has to be in 12-point Arial and it's all blue and black except obviously on a colour photo. So, the general layout and format meet these criteria."*

> *"It's good to [have] this simple font and layout. [However], if I ever produce anything, [it's] always in [size] 14 because a lot of people are cut out [with smaller text] because of their disabilities and eyesight."*

Participants suggested that clearer section breaks could reduce visual fatigue caused by the uniform and somewhat dense layout. They recommended **more prominent headings** - for example, by using bold highlighter-style lines or coloured title boxes with contrasting text – to signal section transitions and improve readability and engagement, particularly if the guide were adapted for digital use.

> *"[You need] more obvious breaks than these dotted lines and [bolder] headings to stand out when you're changing section. I had to read [the guide] twice before I understood there were different sections. You get a bit snoozy reading [the guide], it is just a bit too uniform."*

Constraints such as NHS branding, budget limitations, and the need for frequent updates were acknowledged. Participants highlighted the **importance of indicating when the guide was last updated so users know they are accessing current information:**

> *"Making [the guide] cheap to reproduce, is important because information can go out of date very quickly. So, [while] the guide has got to have a reasonable shelf life, [it should also be easy] to update and reprint".*

Readability and accessibility

The guide's structure follows the patient's hospital journey from admission to discharge, which participants found logical and reassuring. However, the volume of information and wordy passages – such as the section on recommended summary plan for emergency care and the introduction on preparing for discharge - **could feel overwhelming at first glance.** Some readers may need to spend extra time reviewing the content to fully understand it:

> *"I flip[ped] through [the guide]. There's a lot here. What is it? What is that? [I needed] to pay attention, read it again through a fine-tooth comb. And then, it starts[ed] to make sense."*

"Not everybody is well-read...
A lot of people are going to think that there's a lot to read [in this guide]
and will [leave it] for later.
I'm a little bit like that.
Some of this I find a little bit confusing."

Concerns were raised that some **explanations were overly complicated and formal, with jargon-heavy language, making them difficult to understand at times.** For instance, using terms such as Lasting Power of Attorney, Discharge to Assess or Patient Advice and Liaison Service assume prior knowledge of medical and legal terminology, potentially creating barriers for Carers without prior healthcare background or experience:

"If I didn't know anything about healthcare,
and was handed a [guide] like this,
I [wouldn't] be completely daunted but I'd think
'Whatever does that mean?'
Professionals assume everybody understands everything
about the hospital environment and jargon
but that's not the case...
[Some people] might fall through the net
[while] they need the help. That's my concern."

"Patient Advice and Liaison Service.
I understand PALS because I've been through to them myself
but [many] probably would not have a clue [that they're helplines]
and would not have the nerve to ring them full stop.
It needs to be simplified."

Reducing jargon and focusing on plain and direct phrasing would help make the guide clearer and easier to use.

Reliance on hyperlinks and QR codes used to direct readers to online resources raised further concerns. Long web addresses are impractical to type manually and QR codes may not be accessible to Carers with low digital confidence or limited access to technology. Including phone numbers wherever possible was strongly recommended to ensure information is widely accessible.

> *"All of these [web addresses] need to be shortened because [they] are going on forever. No one in their right mind is going to type [them] into [their] browser."*

> *"Technology is not accessible to everyone. QR codes are only good for those that know how or want to use them. They're of no interest to anybody else."*

While the print version of the guide was preferred, participants acknowledged an **online format could help Carers with cognitive difficulties or sensory impairments**. Accessibility tools can support engagement with written material. For instance, text-to-speech functionality on smartphones allows users to listen to materials they might not be able to read. The **importance of translated versions** was also highlighted to ensure inclusivity for Carers for whom English is not the first language.

Finally, attendees stressed the need for in-person support to maximise the guide's value. Suggestions included **clear signposting of who to contact if information is unclear, and brief orientation from hospital staff** when distributing the guide. Having someone available to *"go through this with you"* and answer questions was seen as essential to help Carers engage with the guidance effectively.

> *"For Carers who need a bit more support, there needs to be a back-up system. [It would be useful to have] something in bold at the back of the guide that says, 'If there's anything that you do not understand, please ring this number'."*

Guide content and effectiveness

The discussion then focused on the guide's ability to provide practical guidance for navigating hospital admission and discharge, as well as preparing Carers for conversations with healthcare professionals and social workers.

There was broad agreement that **the guide is a useful and reassuring resource.** Participants praised it for **going beyond a basic overview** by providing Carers, regardless of background or experience, with a **structured framework to help them understand hospital processes and contribute to informed decisions. Its main strength lies in serving as a reliable reference and orientation tool,** building confidence and reducing uncertainty, particularly for new Carers.

More experienced Carers found the material largely familiar but appreciated the guide as a **consolidation of information.**

> *"I am a bit clearer on the discharge process.*
> *I can now see how it hangs together a bit better. It's been very helpful to me.*
> *It gives me a good starting point and information to fall back to"*

> *"For people new to caring with no idea how to deal with anything,*
> *and for those [uncomfortable] asking questions,*
> *[this guide] would be a lifesaver."*

> *"[You can't] assume any Carer knows the whole nine yards.*
> *What they put together is a good working plan to guide you in the right direction."*

Participants noted that the guide would be "*different things to different people*" depending on individual circumstances. It should be made clear when the guide is distributed that it is **not intended as a strict checklist requiring every item to be**

completed. Instead, Carers should be encouraged to "*read through [the guide] and take out what [they] want that is relevant and skip [the rest].*" In addition, **the guide can serve as a prompt, encouraging Carers to consider issues *"that they perhaps had not thought about"* and function as a *"tick-box guide",*** allowing them to track completed actions while identifying areas that may need attention.

Participants highlighted that **a key benefit of the guide is its ability to empower Carers to advocate for their cared-for person**. It helps Carers anticipate what they need to know about hospital processes, discharge, and key decisions, fostering a sense of control and confidence. As one attendee mentioned: *"It makes you think about what you need to know for when that time comes."* It also **supports more productive conversations with healthcare professionals and social workers by equipping Carers with the right questions to ask, and the knowledge of which staff or organisation to approach.**

In addition, **the guide gives practical guidance on organising or requesting important documents,** such as ReSPECT forms – which record preferences and recommendations for emergency situations – or Lasting Power of Attorney papers, which strengthens informed advocacy.

> *"Is it a safe discharge or not?*
> *[Before, I did not know about] the discharge letter and asking for a copy.*
> *[The guide informs you] about what control [Carers] have over some decisions.*
> *So, I feel much more informed, more empowered*
> *and [that] makes [me] a much better support [for the person I look after]."*

However, the group recognised that the guidance is not a cure-all. While the instructions are clear - *"Do this, call this number, email that person"* – real-world barriers often complicate matters. One attendee cautioned: *"[Guidance] is sort of black and white and, unfortunately, things don't always happen as you want them to in real life. Even with all that information, you [may] hit a brick wall. Still, it's a good guide to have as it stands, very useful to draw on."*

Taken together, these reflections underline the **dual role of the guide: it provides clarity and structure for new Carers while also serving as a quick-reference guide or checklist for more experienced Carers.** In addition, it **empowers Carers to advocate for their cared-for person,** giving them the knowledge, questions, and practical tools needed to engage confidently in discussions with healthcare professionals and make informed decisions. The challenge lies in maintaining a balance - offering comprehensive information without overwhelming readers.

Suggested amendments and additions

Recognition of the essential role of unpaid Carers

> *"Carers do an awful lot for very little reward…*
> *To bring a little bit of flowery stuff at the beginning [of the guide] to […] recognise unpaid Carers play a vital role in ensuring continuity of care and emotional support, [as well as making it clear] that the guide [was] made especially for [them] to help make [their cared-for-person's hospital] journey easier might draw them in."*

Participants agreed that incorporating a brief acknowledgment of unpaid Carers at the very start of the guide would help draw them in and make them feel more valued. Carers provide essential emotional, physical, and practical support, often with little formal appreciation. Recognising the vital and challenging role they play helps them feel more valued and respected. Such recognition may increase Carers' engagement with services and resources, ultimately improving outcomes for the people they care for. **The introduction should clarify that the guide is intended to support Carers although it can be discussed with the person receiving care.**

A Prompt for Carers to share key patient information

"I thought about the role of the Carer and one of the important things you need to do is to notify the hospital about [key information about the person you care for] such as medications, allergies, cognitive impairments, that sort of thing. [These are] things we can share that make their hospital journey less confusing and more personal. So, [there needs to be] something in the guide to flag that up."

The guide should encourage Carers to share essential information about the person they support when they are admitted to hospital, including medications, allergies, cognitive and communication needs and daily routines. Hospital staff do not always ask for this, which can result in gaps in person-centred care. **Carers should also be signposted to the Alzheimer's Society's *This Is Me* booklet** for people living with dementia, delirium or communication difficulties. Using it helps hospital and social care professionals provide care that is more personalised, responsive, and effective.

Clearer practical guidance and enhanced signposting

The guide covers important topics like Lasting Power of Attorney (LPA) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms, but these sections are formal and technical. They could be **clearer and include signposting to help Carers access and use the information more effectively.**

A simple explanation would help Carers understand the two types of LPA: A Health and Welfare LPA allows a trusted person, such as a Carer, make decisions about daily living and medical care if someone loses mental capacity. A Property and Financial Affairs LPA covers financial matters. **Adding links and contact information for the Office of the Public Guardian** (Office of the Public Guardian - GOV.UK), where LPAs are registered and managed, would make this guidance more practical and actionable.

Similarly, the guide could **explain simply that a ReSPECT form records a person's wishes and preferences for emergency care**. It is created through discussions with the person, their family, Carers, and healthcare professionals, ensuring treatment decisions reflect their choices if they cannot communicate. **Signposting to the Resuscitation Council UK**

website (ReSPECT for patients and Carers | Resuscitation Council UK) would provide additional guidance on the purpose and process of ReSPECT.

Participants also stressed the **need for signposting on other practical aspects of caring**. For example, linking to Acas (acas.org.uk) would give Carers free and straightforward **advice on workplace rights**:

> *"I'm not entirely sure that there is enough information about unpaid leave entitlement but [...] linking to something like the Acas [would] explain a bit more."*

Carers also described **parking and accessibility at hospitals as an ongoing challenge.** Disabled parking is often limited, and the cost of long or repeated visits can be high. Information about car parks, drop-off points, ramps, toilets, and other accessibility features is also not always easy to find. **Including links or contact details for resources on hospital parking, disability rights, and support for Carers with disabilities or long-term health conditions would be valuable.**

Finally, while dementia is only one of many reasons someone may require care, participants pointed out the **value of signposting to dementia-related resources, as well as broader mental health support.** Cognitive impairment is common among older patients, and factors such as stress, disrupted routines, pain and medication can contribute to mental health decline during a hospital stay. Awareness of these issues can help Carers provide emotional support and advocate for patient needs. A short section with links to trusted organisations such as **Dementia UK** would give Carers reliable information and practical support, while keeping the guide concise and relevant.

> *"Many of the people [we look after] have got advancing cognitive impairment. A link to dementia UK and one or two others [would be] good."*

Practical guidance for a safe discharge

Participants explained that receiving clear, **practical guidance on the discharge process is essential** for supporting the safe transition home of the person they look

after. While the guide notes that Carers should be involved in discharge planning with the patient's permission, some expressed anxiety about their role and authority if they feel that their cared-for person is discharged too early or without adequate support. They wanted the guide **to set out practical steps for raising concerns about early and unsafe discharge.**

Carers also stressed the value **of prompts that flag common issues and risks once someone returns home**. These included confirming safe access to the property (keys, key safes and codes) and checking whether the person has a personal alarm, as well as who is notified when it gets triggered.

Questions about equipment were another priority, with Carers calling for clear guidance on what hospitals provide versus what families must arrange themselves. They also wanted **relevant contact numbers or links to community occupational therapy services** to clarify equipment delivery, installation, and returns:

> *"[The person I care for] didn't come home with anything other than a sling. I had to do get a shower seat and a frame organised. That isn't all that clear what further equipment might be needed. Something in the guide to direct you to community OT [would be helpful]."*

Overall, Carers felt the guide should **include a straightforward discharge checklist** with essentials such as medication, discharge letters, equipment, follow-up appointments, and key contacts. This would help them feel better prepared and more confident to safeguard the wellbeing of the person they support.

Addressing sources of confusion and anxiety for Carers

Participants described **practical challenges when supporting a loved one admitted to hospital**, such as not knowing what items to bring or assuming services like laundry would be provided. As one participant explained: *"I didn't realise that I'd have to keep bringing clean clothes [for the person I care for] and take dirty laundry home to wash. I thought community hospital [were] more like care homes."*

Sudden hospital admissions can catch Carers off guard, adding stress during an already difficult time. **Encouraging Carers to always keep a hospital "grab bag" ready, along with clear guidance on what to pack, can help them feel more prepared when the person they care for faces an unexpected hospital stay.**

Carers reported **uncertainties about who is responsible for managing ongoing medication** when the person they care for is admitted to hospital. One participant shared a story where their cared-for person's ran out of medication, and without their involvement, they would have missed vital treatment:

> *"If [the person you care for] is admitted to hospital, who is actually responsible for the continuation of their [medication]? If I hadn't visited that day [with medication supplies from home], the person I care for may have been left without that weekend…"*

The guide should clearly advise what medication to bring to hospital, who to inform about ongoing prescriptions, and how these are managed once the patient is under hospital care.

Some participants described the **emotional and practical challenges of supporting a loved one whose health, abilities, or personality may have changed after a hospital stay**:

"The [person I care for] and love
is a completely different person now
[to what they were before their hospital stay].
It's really hard to accept and it's completely out of my control.
[They live with me] and
it can get very intense and cause a lot of friction."

These changes can make full-time caregiving more demanding, placing strain on family life and personal wellbeing. The guide should acknowledge that this might happen and provide **signposting to support services, including practical strategies for managing stress, coping with change and managing family dynamics.**

Another common source of **uncertainty is the role of short-term reablement services**. Some patients may receive a short-term reablement package after leaving hospital. The primary aim of these services is to help them regain some independence, not to provide household help or relief for the Carer. Misunderstanding this can lead to frustration for both the Carer and the person receiving care:

"[The person I care for] thought that [people from the reablement service]
are there for her use, to empty her dishwasher and do other chores.
That is not what they're there for!
[They come to] give support to encourage independence."

The guide could support Carers and their loved ones by clearly **explaining the purpose of reablement services** and what to expect to set realistic expectations and reduce stress or frustration.

Helplines and key contacts: clear and easy access

Participants said that information about the Patient Advice and Liaison Service (PALS) could be confusing. They suggested the guide should **make it more obvious that PALS**

are helplines, for example by including the word in the section heading. In addition to improved labelling, the guide should explain in plain language the purpose of these services and **indicate that Carers need to contact PALS for the specific hospital where the person they care for is or was treated**.

Participants also pointed out the value of **including a directory of all key contact numbers and websites on a single page at the end of the guide**. Even if this duplicates information, it will give Carers **quick access to support**. One participant explained: *"You don't want to be wasting time [reading through the guide] during times of stress or crisis".* Another added that while the guide offers useful information, it cannot cover every situation and "*answer everything in four lines"*. Contacting the right organisation directly is often the easiest way to get answers, so having these numbers handy can offer vital day-to-day support for Carers.

In summary - Key findings

- **Design and structure**: The guide's professional appearance encourages trust, engagement and retention. Its contents logically follow the patient journey from admission to discharge, making it easy for Carers to navigate hospital processes.

- **Strengths:** The guide acts as a go-to reference for Carers at all experience levels, helping them understand what to expect during times of uncertainty. It also supports confident advocacy by equipping Carers with the right knowledge and questions to engage effectively with healthcare professionals and influence care decisions.

- **Challenges:** small font size and dense layout may limit accessibility; language can be overly wordy or complex; hyperlinks and QR codes are not always practical or accessible.

- **Recommendations**:
  - Acknowledge Carers' role and contribution to draw them in,
  - Reduce jargon and simplify language,
  - Improve layout with clearer section breaks and more prominent headings,
  - Include practical checklists,

- Consolidate signposting of key contacts and resources on a single page.

Implementing these changes will improve usability, inclusivity, and impact, helping Carers support patients effectively while reducing stress and confusion.

What this means

The project aimed to engage patients, their relatives, and staff to gather insights into the inpatient general rehabilitation service provided by Norfolk Community Health and Care NHS Trust (NCHC). It explored the full rehabilitation journey - from transfer from acute care, through the rehabilitation stay, to discharge - identifying both strengths and areas for improvement.

A key conclusion from this work is that communication about rehabilitation in acute settings was inconsistent and often insufficient to support meaningful patient understanding. From a system perspective, this means that patients frequently entered rehabilitation with unclear or unrealistic expectations, which could contribute to anxiety, disappointment, and disengagement. Improving the consistency and timing of communication - through standardised messages and repetition of key information at multiple points along the pathway - is therefore essential if rehabilitation is to function as an active, goal-focused process aimed at restoring independence and function, rather than a passive stage of care.

A further key issue was that rehabilitation delivery often fell short of patient expectations. The mismatch between expectations and reality appeared to affect patients' perceptions of progress, confidence in readiness for discharge, as well as their overall wellbeing. While increased staffing would ideally support more frequent supervised therapy, a more immediately achievable approach is to provide transparent and timely communication that better aligns patient expectations with what rehabilitation services can realistically offer, alongside consistent and collaborative discussions about therapy goals, plans, and progress. This shared approach is likely to foster trust and stronger engagement in the rehabilitation process.

Workforce pressures appeared to underpin many of the challenges in sustaining patient-centred care. These findings seem to reflect a system operating close to its capacity, where staff were balancing institutional efficiency, clinical priorities, and individual patient needs and preferences. These tensions can inadvertently undermine

comfort, dignity, and autonomy, while increasing the potential for safety risks, especially for patients with cognitive difficulties. Furthermore, patients' mental health and emotional wellbeing were central to their experience on rehabilitation wards, with meaningful social interaction and access to recreational activities closely linked to motivation and engagement in rehabilitation. Addressing these challenges requires a strategic focus on workforce capacity and supervision to meet the complexity of patient needs. Ensuring adequate staffing would support truly patient-centred care and positive recovery outcomes.

Finally, experiences of discharge planning and the day of discharge varied widely. These experiences suggest that discharge processes can sometimes prioritise procedural completion over meaningful engagement. Fragmented or rushed communication from staff - compounded by stress, fatigue or cognitive impairment – could limit patients' understanding and ability to contribute, leaving some feeling uncertain, unsupported, and emotionally vulnerable at the point of transition. For families, reduced opportunities to be involved in decisions, or reactive rather than planned interactions, could create stress and a sense of exclusion, particularly when caring responsibilities were assumed rather than explicitly discussed. Timely and well-coordinated discharge planning, with clearer timelines, structured opportunities for input, practical support for carers, and effective handover of medications, would enhance confidence, preparedness, and emotional readiness, supporting safer and more satisfactory transitions home.

Recommendations

1. **Enhance communication about rehabilitation to support meaningful patient understanding and manage expectations**

   - Strengthen links between acute and community teams to ensure consistent understanding of and communication about what rehabilitation entails.
   - At transfer from acute care, provide clear, standardised written and verbal information about what rehabilitation involves, including its active goal-focused approach to restore independence and function, multidisciplinary input, likely therapy intensity, and expected duration.
   - Repeat and reinforce key messages at multiple points throughout the rehabilitation stay to support understanding and retention.
   - Use accessible language, visual aids, and tailored explanations; staff should check patient understanding and address questions, taking into account pain, fatigue, cognitive difficulties and emotional state.

2. **Improve patient awareness of rehabilitation activities to encourage engagement and better support therapy delivery**

   - Provide information about the full range of rehabilitation activities, including physiotherapy (structured sessions, self-directed exercises, and everyday mobilisation), occupational therapy, clinical input, and, where appropriate, participation in recreational activities. Clearly explain the purpose of each component to encourage participation.
   - Establish consistent, collaborative discussions between patients, families, and staff about therapy goals, plans, and progress, ensuring expectations about outcomes and timelines are realistic and aligned with available resources.
   - Support self-directed exercises and everyday mobilisation with tailored guidance and practical assistance.

- Consider increasing the frequency and intensity of supervised therapy where appropriate and feasible.

3. Strengthen patient-centred care through workforce capacity and support

- Align staffing levels and skill mix with the complexity of patients on the wards, ensuring adequate coverage during night shifts and periods of high demand.
- Provide targeted support and supervision to enable staff to deliver personalised care that upholds comfort, dignity, and autonomy, including strategies for patients with cognitive impairments or challenging behaviours.
- Prioritise staffing and workflow to ensure timely delivery of core personal care (toileting, hygiene, eating/drinking) and facilitate patient engagement in recreational activities.

4. Improve discharge planning and day-of-discharge experiences

- Implement timely and well-coordinated discharge planning, providing patients and families with a clear overview of the discharge process and procedures. Include follow-up conversations to reinforce understanding, review plans, and offer opportunities for input throughout the rehabilitation stay.
- Assess patient readiness thoroughly, considering ongoing health or mobility challenges, and provide emotional support to reduce stress and anxiety.
- Enhance discharge support by providing clear guidance on equipment and follow-up care, verifying understanding of discharge documentation, and ensuring effective handover of medications.
- Actively involve Carers in discharge decisions, clarify caregiving expectations, and provide support, including a copy of the updated *Guide for Unpaid Carers* to help them, and the person they care for, manage the transition from hospital effectively.

Response from Norfolk Community Health and Care NHS Trust

Dear Healthwatch Norfolk,

Re: Inpatient General Rehabilitation Project – Report for review response

Thank you for submitting the Healthwatch Norfolk 'Experiences of Inpatient General Rehabilitation' report, we acknowledge and agree the findings and recommendations of the report.

The report has been shared with the Intermediate Care Leadership team and working with the Ward Mangers they have created an action plan to address the report's recommendations.

Key initiatives from the action plan include:

- Joint working with acute Trust colleagues to clearly define and understand the rehabilitation pathway and support consistent communication with patients and families
- Review and update of all relevant patient leaflets
- Encourage regular updates from all members of the multidisciplinary team with patients and families about the next steps in the rehabilitation journey and discharge planning
- Promote the use of the Accessible Information template as part of the SystmOne patient documentation
- Develop ward based activities that enhance the traditional therapy sessions
- Continue the roll out of the Carers passport across all in patient areas

- Support the development of the Trust dementia strategy and the support given to patients and families on the general rehabilitation units
- Develop a dementia awareness training package for all staff members
- Review nurse and therapy staffing levels as part of the annual establishment reviews

We would be happy to provide regular updates on the progress of the action plan through the Patient and Carer Experience and Involvement Steering Group.

Yours sincerely

Corwen Hull
Clinical Director - Intermediate Care and Urgent Community Response

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Appendices

Appendix 1 - Demographic data

Demographic profile of patient and relative interviewees

A total of 25 patients were interviewed. Their demographic characteristics are summarised below.

Gender:

- 19 (76%) female
- 6 (24%) male

- Age:
  - 2 (8%) aged 50-60
  - 2 (8%) aged 61-70
  - 5 (20%) aged 71-80
  - 11 (44%) aged 81-90
  - 3 (12%) aged 91 or older
  - 2 (8%) did not disclose their age

- Ethnicity: 96% (24) identified as White British

- Health and caring responsibilities:
  - 17 (68%) reported a long-term health condition
  - 10 (40%) had a physical disability or impairment
  - 5 (20%) had a sensory impairment
  - 2 (8%) were Carers

In addition, interviews were conducted with 10 relatives of patients admitted for rehabilitation. All relative interviewees identified as White British, there was an equal gender split, and four participants were registered unpaid Carers for their loved one.

Demographic profile of staff interviewees

The demographic profile of the 25 rehabilitation staff we interviewed is outlined below:

- Gender:
  - 23 (92%) female
  - 2 (8%) male

- Age:
  - 5 (20%) aged 20-30
  - 5 (20%) aged 31-40
  - 5 (20%) aged 41-50
  - 2 (8%) aged 51-60
  - 2 (8%) aged 61 or over
  - 6 (24%) did not disclose their age

- Ethnicity:
  - 17 (68%) identified as White British
  - 3 (12%) were from another White background (Polish)
  - 5 (20%) were from other ethnic backgrounds (Arab, Asian and Black)

- Professional role:

Table 1

Professional Roles of Staff Interviewees

Roles	Number of respondents
Ward Manager	1
Advanced Clinical Practitioner	2
Nurses	7
Physiotherapist	4
Occupational Therapist	2
Clinical Support Worker / Healthcare Assistant	5
Discharge Coordinator	3
Social Worker	1

Demographic profile of survey respondents

The survey was completed by 31 respondents. Of these, 24 participants provided demographic information, which is presented below:

Gender:

- 12 (50%) female
- 12 (59%) male

- Age:
  - 1 (4%) aged 50-60
  - 3 (13%) aged 61-70
  - 5 (21%) aged 71-80
  - 13 (54%) aged 81-90
  - 2 (8%) aged 91 or older

- Ethnicity: 96% (23) identified as White British

- Health and caring responsibilities:
  - 11 participants (46%) reported a long-term health condition
  - 5 (21%) had a physical disability or impairment
  - 2 (8%) had a mental health condition
  - 3 (13%) were Carers

Demographic profile of focus group respondents

Four Carers attended the focus group. There was an equal gender split among participants, and all identified as White British. Participants were aged 59, 65, 67, and 71. One Carer reported living with a long-term health condition, while another disclosed a mental health condition.

Appendix 2 – Survey questionnaire

Experiences of rehabilitation in Norfolk's Community Hospitals

This survey is for **people who were admitted to inpatient (bedded) general rehabilitation wards between July 2024 and July 2025**, as well as **their relatives and carers** who supported them during their stay at one of the following facilities:

- **Alder Ward** - Norwich Community Hospital
- **Foxley Ward** - Dereham Hospital
- **North Walsham and District War Memorial Hospital**
- **Ogden Court Community Hospital** - Wymondham
- **Pineheath Ward** - Kelling Hospital
- **Swaffham Community Hospital**
- **Willow Therapy Unit** - Norwich Community Hospital.

Who is Healthwatch Norfolk?

Healthwatch Norfolk is the independent voice for patients and service users in the county. We use feedback from people to shape the future of local health and care services.

What is this survey about?

Healthwatch Norfolk is working with Norfolk Community Health and Care (NCHC) NHS Trust to review their general rehabilitation service in community hospitals across Norfolk. We want to hear from patients, their relatives and carers, about their experiences, including:

- The ward environment,
- The quality of the nursing care and therapy,
- Planning to leave the community hospital and
- Care after leaving hospital.

Your feedback will help us understand what is working well and where improvements are needed, so the rehabilitation service can better meet the needs of the people who use it.

Survey details

The survey will take **15-20 minutes to complete**. Some questions are optional.

Everyone who completes the survey in full will be entered into a draw to **win one of five £50 Tesco vouchers**.
The draw will take place at the end of September 2025.

Accessibility

If you would prefer to do this survey with us over the phone, please call Healthwatch Norfolk on 01953 856029 and we will arrange a time to ring you back to complete the survey. Alternatively, please email: enquiries@healthwatchnorfolk.co.uk for further support.

How the survey results will be used

Survey responses will be collected and analysed by Healthwatch Norfolk. You can read our full privacy policy at: www.healthwatchnorfolk.co.uk/about-us/privacy-statement.

All responses will be anonymous. The survey findings will be used to make recommendations to NCHC on how to improve the inpatient general rehabilitation service, as part of a project report. The report will be publicly available on our website and may be used in other Healthwatch Norfolk communications.

Want to keep in touch?

To stay up to date with what we are doing at Healthwatch, you can sign up to our newsletter via our website: www.healthwatchnorfolk.co.uk

If you do not use email, you can call Healthwatch Norfolk on 01953 856029 to ask to receive our newsletter via post.

Healthwatch Norfolk produces fortnightly newsletters about health and social care in Norfolk.

If you'd like to receive this newsletter please leave your email here:

Please note that questions marked with an asterisk (*) require responses.

1. **Please tick to confirm your suitability for this survey. ***

   ☐ I have read and understood the information provided.

2. **Which rehabilitation facility were you admitted to? *** Please tick one option:

   ☐ **Alder Ward** – Norwich Community Hospital

   ☐ **Foxley Ward** – Dereham Hospital

   ☐ **North Walsham and District War Memorial Hospital**

   ☐ **Ogden Court Community Hospital** – Wymondham

   ☐ **Pineheath Ward** – Kelling Hospital

   ☐ **Swaffham Community Hospital**

   ☐ **Willow Therapy Unit** – Norwich Community Hospital

3. **Are you completing this survey as : ***

   Please tick one option:

   ☐ A **patient** who received rehabilitation

   ☐ A **family member** / **carer** who supported someone who received rehabilitation

   <u>Family members and carers</u>: please answer questions on behalf of the person you supported.

SECTION 1: BACKGROUND INFORMATION AND ADMISSION EXPERIENCE

4. **What was the main reason for your admission to a rehabilitation ward? ***
   Please tick one option:

   ☐ Recovery **after surgery**
   (e.g. hip or knee replacements, spinal surgery, fracture fixation, …)

   ☐ Recovery **after trauma or injury** that did not require surgery
   (e.g. accidents, falls, non-surgical fractures, …)

   ☐ Regaining strength and function **after a long illness, hospital stay or frailty**

   ☐ Other (please specify): _____

   Please write here where you were before moving to the rehabilitation facility:
   (e.g. N&N, QE Hospital, care or nursing home, own home, …)

5. **How long did you stay at the rehabilitation facility? *** Please tick one option:

   ☐ Less than 1 week

   ☐ 1 to 2 weeks

   ☐ 3 to 4 weeks

   ☐ 5 to 6 weeks

   ☐ Longer. Please specify: _____

SECTION 2: WARD ENVIRONMENT, COMFORT AND WELLBEING

6. **Overall, how satisfied were you with the comfort and environment of the rehabilitation facility?** Please rate each of the following aspects below:

	☹	😐	☺	**Not sure**
Cleanliness and general condition of the ward	☐	☐	☐	☐
Comfort of the bed and furniture	☐	☐	☐	☐
Ease of access to safety and adaptive equipment *(e.g. call bell, walking aids, grab rails, …)*	☐	☐	☐	☐
Space to move safely around the bed	☐	☐	☐	☐
Temperature and ventilation	☐	☐	☐	☐
Lighting quality, control and comfort	☐	☐	☐	☐
Noise levels in the ward	☐	☐	☐	☐
Meals - Quality and quantity of the food *(e.g. presentation, temperature, taste)*	☐	☐	☐	☐
Meals – Variety and considerations for dietary needs and preferences	☐	☐	☐	☐
Visiting arrangements for family and friends *(e.g. distance to travel, hours, parking, access to refreshments, …)*	☐	☐	☐	☐

7. **Did you feel you had enough to do to pass the time during your stay in the rehabilitation ward? *** Please tick one option:

☐ **Yes** - There was enough to keep occupied

☐ **Somewhat** - There were some things to do but I sometimes felt bored

☐ **No** - There was very little to do; I often felt bored

☐ I am not sure / I don't remember

Please write here any comments you may have regarding recreational activities:

8. **How would you describe your mood during your stay in the ward? ***
(for example: confused, lonely, sad, worried, relieved, content, calm, hopeful, …)

9. **Were you able to talk to staff when you needed emotional support?**
Please tick one option:

☐ Yes

☐ No

☐ I preferred talking to family members or friends for emotional support

☐ I didn't need or ask for emotional support

☐ I am not sure / I don't remember

SECTION 3: RESPECT FOR PRIVACY, DIGNITY AND INDEPENDENCE

10. **Overall, how satisfied were you with how staff maintained your privacy, dignity and independence? *** Please rate each of the following aspects below:

	☹	😐	☺	**Not sure**
Staff being respectful and supportive	☐	☐	☐	☐
Staff respecting patients' cultural, religious and personal values	☐	☐	☐	☐
Staff supporting patients' independence, allowing them to do things for themselves, even if it takes longer	☐	☐	☐	☐
Staff responding quickly and appropriately to calls for help, including toileting needs	☐	☐	☐	☐
Use of continence products (e.g. pads, liners, disposable underwear and catheters) explained and appropriate	☐	☐	☐	☐
Staff providing personal care in a gentle, patient and non-judgemental manner while providing privacy	☐	☐	☐	☐
Staff protecting the privacy of patients during personal conversations	☐	☐	☐	☐

Please write here any comments you may have regarding privacy, dignity and independence:

SECTION 4: COMMUNICATION

11. **Were you asked about any communication needs - for example, needing help with hearing, speaking or understanding and remembering things - while in the ward? *** Please tick one option:

    ☐ **Yes**, but **I didn't have specific communication needs**

    ☐ **Yes**, and my **communication needs were noted and addressed**

    ☐ **Yes**, but my **communication needs were not fully addressed**

    ☐ **No**, I was **not asked** about communication needs

    ☐ I am not sure / I don't remember

12. **How well did you understand the information staff gave you about your medical care, rehabilitation plans, goals (what you hoped to achieve before leaving the ward) and progress? *** Please tick one option:

    ☐ **Well** – I understood everything clearly

    ☐ **Somewha**t – I understood most things but some were confusing

    ☐ **Not well** – I didn't understand much of what was happening

    ☐ I am not sure / I don't remember

SECTION 5: QUALITY OF THE REHABILITATION

Rehabilitation means all the support you received in the general rehabilitation facility to help regain strength, independence and quality of life after surgery, injury or illness. This includes:

- Therapy (physiotherapy and occupational therapy),
- Help with managing daily routines
- Managing pain, self-medication and night-time needs,
- Preparing to return home

13. **How would you rate the overall quality of the rehabilitation provided in the ward? *** Please tick one option:

    ☐ Good

    ☐ Fair

    ☐ Poor

    ☐ I am not sure / I can't remember

14. **How often did you receive rehabilitation therapy from physiotherapists and occupational therapists? *** Please tick one option:

    ☐ **More often** than I expected

    ☐ **About as often as I expected**

    ☐ **Less often** than expected

    ☐ I **did not have expectations**

    ☐ I am not sure / I can't remember

15. **How often were you encouraged and supported to sit out of bed and move around?** Please tick one option:

    ☐ **More often** than I wanted or needed

    ☐ **About the right amount**

    ☐ **Less often** than I wanted or needed

    ☐ I am not sure / I can't remember

Please write here any comments you may have about rehabilitation on the ward:

SECTION 6: DISCHARGE PLANNNING AND THE DAY YOU LEFT HOSPITAL

Discharge planning is the process of preparing a patient to safely leave the hospital, return home or move to another setting, and continue their recovery with appropriate support and care.

16. **How well did you understand and remember the information shared with you during discharge planning?** *

    This may include details about medication, equipment, what care and support to expect after leaving the ward, the duration of care, and any costs involved,…
    Please tick one option:

    ☐ **Very well** - Everything was clear and easy to remember

    ☐ **Quite well** – Most things were clear, but some things were confusing or hard to remember

    ☐ **Not very well** – Much of the information was confusing or hard to remember

    ☐ I am not sure / I don't remember

17. **How much of a say did you have in discussions and decisions about discharge? ***
    Please tick one option:

    ☐ **A lot of say** – I was fully involved and felt listened to

    ☐ **Some say** – I was involved but not in all decisions

    ☐ **Very little say** – I had little or no involvement in decisions

    ☐ I (they) did not want to be involved in discussions and **trusted staff and family/carers to make decisions on my behalf**

    ☐ I am not sure / I don't remember

18. **Were relatives/carers included in discussions and decisions about discharge, as much as you would have liked? ***
Please tick one option**:**

☐ **Yes** – Family/carers were involved **as much as I wanted**

☐ **Somewhat** - They were involved but **not as much as I wanted**

☐ **No** – They were **not involved even though I wanted them to be**

☐ Not applicable – **I didn't want or didn't have family/carers to involve**

☐ I am not sure / I don't remember

19. **Were you given enough notice before being discharged?** Please tick one option:

☐ **Yes** – Enough notice was given to prepare for discharge

☐ **Somewhat** – Some notice was given but preparations felt a bit rushed

☐ **No** – Very little or no notice was given before discharge

☐ I am not sure / I don't remember

20. **How did things go for you on the day you left the community hospital?***
Please tick one option:

☐ **Good** – My discharge went smoothly or only with minor issues

☐ **Fair** – Some problems, confusion or delays affected my discharge

☐ **Poor** – The discharge was stressful, disorganised or involved long delays

☐ I am not sure / I don't remember

Please use the space below to share any comments about your discharge day, including any delays or issues you encountered and how they affected you:

21. Were you discharged home or moved in with family, friends or unpaid carers? *

☐ **Yes** – Please proceed to section 7 (care after you were discharged)

☐ **No** – Please proceed to section 8 (demographic information)

SECTION 7: CARE AFTER YOU WERE DISCHARGED

22. What care or support did you receive after discharge? * Please tick all that apply:

☐ Follow-up medical appointments at GP practice or in hospital

☐ Visits from community nurses
(e.g. wound care, health monitoring, continence care, mental health, …)

☐ Physiotherapy or occupational therapy at home

☐ Equipment or home adaptations
(e.g. mobility aids, grab rails, shower chair, hospital bed, hoist, stair lift, …)

☐ Falls prevention advice or services

☐ Emergency help or rapid response services

☐ Short-term reablement support to regain independence
(usually funded by Norfolk County Council)

☐ Ongoing care from paid carers (either self- or council-funded)
(e.g. for personal care, meals, chores, mobility and transfers, …)

☐ Visits from social workers

☐ No care or support was received

☐ I am not sure / I prefer not to say

☐ Other (please specify): _____

23. How well coordinated did the care and support seem? *

☐ **Well-coordinated**
The care and support seemed joined-up and well organised

☐ **Partly coordinated**
Some aspects of the care and support worked well, but not all

☐ **Not well-coordinated**
The care and support seemed disjointed and poorly organised

☐ I am not sure / I don't remember

SECTION 8: YOUR DEMOGRAPHIC INFORMATION

In this next section we will be asking you some optional questions about yourself. Remember: all your answers are strictly confidential and the survey is anonymous.

❖ **What is the first half of your postcode? (Example: NR18)**

❖ **How old are you?**

❖ **What is your gender?**

☐ Man
☐ Woman
☐ Non-binary
☐ Genderfluid
☐ Questioning
☐ Prefer not to say
☐ Prefer to self-describe:

❖ **What is your ethnic group?**

Arab:

☐ Arab

Asian / Asian British:

☐ Bangladeshi

☐ Chinese

☐ Indian

☐ Pakistani

☐ Any other Asian / Asian British background

Black / Black British:

☐ African

☐ Caribbean

☐ Any other Black / Black British background

Mixed / Multiple ethnic groups:

☐ Asian and White

☐ Black African and White

☐ Black Caribbean and White

☐ Any other Mixed / Multiple ethnic groups background

White:

☐ British / English / Northern Irish / Scottish / Welsh

☐ Irish

☐ Gypsy, Traveller or Irish Traveller

☐ Roma

☐ Any other White background

Other:

☐ Any other Ethnic Group

☐ Prefer not to say

If other, please specify: _____

❖ **Please select what applies to you:**

☐ I am a carer
☐ I have a long term health condition
☐ I have a physical impairment
☐ I have a sensory impairment
☐ I have a learning disability or difficulties
☐ I have a mental health condition
☐ None of the above / I prefer not to say

❖ **Where did you hear about this survey?**

☐ GP website
☐ Healthwatch Norfolk Event
☐ Healthwatch Norfolk Newsletter
☐ Healthwatch Norfolk Website
☐ News (website / radio / local newspaper)
☐ Search Engine (e.g. Google)
☐ Social Media (e.g. Facebook / Instagram / Twitter)
☐ Through communication from NCHC / general rehabilitation service
☐ Through work
☐ Other (please specify):

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