Enter and View Report

Location of visit	Calderdale Royal Hospital (focusing on patients being discharged from hospital) Salterhebble, Halifax, HX3 0PW
Service provider	Calderdale and Huddersfield NHS Foundation Trust
Date and time	Tuesday 11 June 2024, 12:00 - 14:00 Thursday 13 June 2024, 10:00 - 12:00 Tuesday 18 June 2024, 10:30 - 12:45
Authorised Representatives	Joanne Douglas, Alexandra Semertzidou, Andrew Hare, Mary Simpson, Deborah Neary, and Lynne Keady
Contact details	Healthwatch Calderdale, Tel: 01924 450379 Email: info@healthwatchcalderdale.co.uk

Acknowledgements

Thank you to all the patients and staff, at Calderdale Royal Hospital who spent time talking to us about their experiences of using services or working there. Thank you to Lynsey Marsden for helping us to arrange our visit and to Jo Oates, Zoe Rowling, Dale Fletcher and for all the staff talking the time to talk to us about how the service operates and for showing us around the ward.

Disclaimer

Please note: This report relates only to specific visits and the report is not representative of all service users and staff, only those who contributed within the limited time available.

What is Enter and View?

Enter and View is a visit to a health or social care setting by Authorised Representatives of Healthwatch Kirklees and Healthwatch Calderdale as a means of gathering evidence of people's experiences. Enter and View is one of the many tools used by Healthwatch to gather opinions. The visits are not a formal inspection or part of an investigation.

Healthwatch Kirklees and Healthwatch Calderdale have a right to carry out Enter & View visits under the Health and Social Care Act 2012. Enter and View visits give service users, visitors, carers and staff the opportunity to speak to an independent organisation about their experiences of health and social care services. They may talk to us about things which they feel could be improved, and examples of good practice so that we can recognise and promote things that are working well. The visits may look at a single issue across a few settings or may be in response to local intelligence about a single setting or from an area we have not visited before or at the request of the service to understand how services work.

Contents

Background

Calderdale Hospital does not have a dedicated discharge lounge, therefore the Enter & View visits were spread across multiple locations over three separate dates.

Patients are discharged from individual hospital wards either from their hospital bed or seats in allocated discharge areas at Calderdale Royal Hospital.

The areas we visited are the allocated or 'holding' areas for patients waiting for their medications, care packages or transport home. Enter & View visits at Huddersfield Royal Infirmary's discharge lounge have already been carried out and the report can be viewed on Healthwatch Kirklees' website.

Why did we visit?

We decided to visit the discharge holding areas to gather feedback about hospital discharge as this is something people often talk to Healthwatch about. The Enter & View visits also support other work we are currently doing around discharge to intermediate care and reablement services.

What we did

As part of our Enter and View programme, we conducted three announced visits to Calderdale Royal Hospital. We visited at different times on 11 June, 13 June and 18 June 2024.

Visit 1 - Ward 2, as A, B, C, and D. On our first visit we spoke to 7 patients, 1 relative and 3 staff members.
Visit 2 - Ward 6, area B and C and also Ward 2, area A and C and spoke with 3 patients, 2 healthcare assistants, 2 senior nurses, 1 staff nurse and 1 discharge coordinator.

Visit 3 - Medical Same Day Emergency Care (MSDEC), Ward 6 and Ward 2, bays A, B, C, and D. We spoke to 12 patients and 3 staff members on this day.
We had planned to speak to patients from Ward 8 but due to the time of our visit no one had been discharged from this Ward at the time.

We spoke directly to patients who were waiting to be discharged and to staff working in the areas we visited.

Each visit was for two hours, and we visited as a team of two or four Authorised Representatives each day. We agreed that the visit would be informal, and we would speak to as many people as we were able to within the limitations of the time we had at the hospital and the number of patients who were using the service. We used prompt sheets with questions relating to:

- **Patients' thoughts on hospital discharge.**
- **What's working well when patients are discharged.**
- **Any suggested areas for improvements.**

Questions were not asked in a specific order, nor were all questions asked of all people. Patients were asked if they would like to speak to us and we noted their comments. In addition, we used the 'five senses' approach to report on the overall impression of discharge areas; this approach considers the atmosphere, smell, and appearance of the environment and whether patients seem comfortable in their surroundings.

Our online surveys ran at the same time as the visits, these were shared via the hospital Trust, but we also gave staff members a QR code and link during our visits so they could share their views too. Staff, volunteers, patients, and visitors were able to complete a survey about their experiences online if they were unable to speak to us on the day. The survey was available for the duration of our visit and for a short period of time after the visit. The survey closed on 21 June. 2024.
Overall, we engaged with 22 patients, 1 relative, and 17 staff members; 40 people in total.

How hospital discharge works in each area

Ward 2

During our meeting with Jo, the clinical manager, we were told that Mondays and Tuesdays are busy for discharge because of how busy it gets over the weekend via the Emergency Department and there's a backlog for tests. They get patients ready for tests and then discharge them straight from the ward, if appropriate.

Jo told us they started using Home First (similar to reablement) the day before our first visit, and have made 7 referrals so far. They are still getting used to it, but they think it will help with discharge. Ward 2 has 4 bays, A, B, C, and D. They are single-sex bays and we visited each bay during our visits.

We spoke to the patients identified by staff as 'confirmed for discharge' and 'query discharge'. A staff nurse explained what is meant by these terms: a patient who is confirmed is going home, they are just waiting for medication, transport, or care package. A patient who is query discharge is likely to be going home that day but this is dependant on further testing such as MRI. We were told at the beginning of the visit that patients being discharged from this area are risk assessed as being safe to do so.

We were told that the on-ward pharmacy team are able to start work on confirmed discharge and query medication early on in the day which helps speed things up. We noticed that the ward clearly has a quick turnaround. Most people are only there for a couple of days at most and so a smooth discharge process is important.

Ward 6

Ward 6A and 6B are both 16-bed wards that specialise in a wide range of conditions including complex care.

6A is a General Medical/Endocrine ward and ward 6B is General Medical, caring for a wide range of conditions including patients who may be living with dementia or have an acute delirium. Ward 6C is a cardiology ward. There are areas on Ward 6 which are typically long stay for patients who often need social care support to be put in place before they can be discharged.

Ward 6D is the day procedure area, patients here were pre-operative and, because of the time of our visit, patients were not at the point of discharge so we did not speak with patients in this area. We spoke to staff and patients on wards 6B and 6C. We were told by a senior nurse the nursing team are usually supported by a ward clerk, however, Ward 6B has been without a ward clerk for over 6 months.

Ward 6B and C are supported by the discharge coordinator; they are not there daily but staff have their phone number if they need to contact them.

We were told the majority of patients are discharged from their beds but at times when they have pressure to keep the hospital bed flow moving, and particular pressure from neighbouring Medical Assessment Unit (MAU) to free up beds, patients will be asked to wait for transport or medication in the waiting area, situated at the end of wards 6C and 6B.

Medical Same Day Emergency Care (MSDEC)

This ward provides urgent 'same day' scans (CT, X-ray, etc) and blood work etc. It was explained to us that patients are taken from the Emergency Department, 'walking wounded' with no need for bed or trauma care.

Referrals are also taken from GPs but the priority for referrals is given to those patients arriving via the Emergency Department. We were told when at capacity MSDEC will close referrals from GPs. This area is open 8 am – 8 pm and has been open since March 2024; it replaced Ambulatory Care. They see roughly 30 patients daily, most of these patients go home or stay for 1 or 2 days but are admitted to an inpatient ward in this case.

Overall impressions

Ward 2

The first visit was to Ward 2, which is the Medical Assessment Unit (MAU). On this day we spoke to patients in the 4 bays, plus the discharge holding areas C and D which are situated at the end of Wards 2C and 2D. The hospital ward is split into 4 bays, A, B, C and D. Each bay has 3 rooms with 4 beds in each room, plus some individual rooms.

A nurses' station is in the middle of each bay, so staff are accessible. Not all beds were full and not all patients were being discharged that day. There were two chairs on each side of a small table and two high-back chairs to the side against the wall in this holding area which is for patients able to sit before discharge. These areas (pods) are designated for patients to wait to go home. They are areas where the corridor is slightly wider with room for a couple of chairs. It was sometimes used by families. We observed that they are not private areas, but there were private rooms available.

As the wards are circular, there was a constant stream of people going past. It seemed to be a high-traffic area for staff, food/medicine trollies, equipment, wheelchairs etc. This made the area feel hectic and loud. It was busy also due to it being lunchtime. The ward was clean, and smelt fresh and there were many areas for staff and visitors to dispense hand sanitiser. The temperature felt comfortable. There were seats for patients to sit on beside their bed and there were no visible signs of damage. Some equipment was placed in corridors along the walls. There is a large window which makes the space light and open but no view as it was blocked by trees.

On our third visit, before 11am it felt chaotic, but as the doctors completed their rounds and briefed the nursing team, it calmed down.

Ward 6

The second visit was to Ward 6 and the waiting area for discharge is between Ward 6B and 6C.

The area used for discharge was clean but cluttered with filing cabinets and equipment such as hoists and moving and handling equipment. The temperature was comfortable, not too hot or too cold.

There's a lack of appropriate seating; chairs are hard plastic and no raised chairs.

There didn't appear to be a designated person to oversee patients who are discharged from this area.

There was access to gloves and a hand sanitizer station. We observed good infection control practices, with staff changing aprons, using hand sanitizer and blue gloves each time when entering into new room. We observed cleaners on the ward, sweeping the floor and emptying bins, talking to patients in a friendly manner. There are plenty of bins to place rubbish and they're labelled with what can be disposed in them. There were no unpleasant or overpowering smells. One of the cleaning rota sheets was out of date (May 2024) but others were correct.

There was one large table situated next to a large window with 3 plastic chairs around it. There was a large window with a view of car park and people coming and going.

There has been an effort to try to make the space welcoming and interesting with colourful bunting and artwork from previous patients displayed. There was information displayed including carers support information. We noticed a carers welcome board with affirmation/ pledges with aims to 'keep carers caring' and information about the carer lanyard. There's no TV or music which might give a more relaxing feel to the area.

On top of a filing cabinet, there were some board games that patients could use and magazines were available.

There was not as much passing traffic in this area (as there was in Ward 2) so it felt less hectic, but it is essentially a corridor, so staff and equipment are passing through regularly.

There were displays with thank you notes from patients and family, a board with information for staff training with a monthly focus and staff initiatives. Most of the information we noticed was current and relevant. We did reflect later that it was unclear who the notice boards were aimed at as there was a mix of mandatory information, campaigns, staff information, and patient information. Some leaflet holders were almost empty but there was an excellent one with information from British Heart Foundation on heart conditions.

On the door between 6A & 6B was a general visiting time notice which explained protected mealtimes and suggestions for carers visiting the ward and also information on John's Campaign in the discharge area.

There were safety measures in place with colour-coded notices on doors. Male/Female-only designated rooms were clear to see. There were no visible signs of wear and tear to the equipment, but the ward did appear to have a lot of equipment around. We were told that there was a day room for patients to wait but also told that it was not suitable for discharge. Patients were usually discharged from their beds. There was a table and chairs in a bay where patients could wait for transport.

Medical Same Day Emergency Care (MSDEC)

The waiting area has 18 seats of varying sizes. We were told if a patient has been waiting a long time and is visibly getting uncomfortable there are a couple of bed trolleys they can use in private rooms.

The nurses' station is situated directly in front of the waiting area so patients in the waiting area are visible to the nursing team.
A corridor leading off the waiting area has several private rooms where patients are assessed.

The area was clean and the temperature was pleasant – not too hot or cold. There were no unpleasant or masked smells. The environment felt calm as the waiting area was quiet – no background music or TV. There were books available for patients. There was one toilet for patients, the door to access this was in a corner of the waiting area with clear signage. The toilet is accessible and has call bells and grab rails.

There is a cold water dispenser and a hot drinks station where patients can help themselves to refreshments.

We were told a sandwich trolley comes on to MSDEC late afternoon and tea time (a tray of sandwiches was brought out and left on the front desk at nurses' station at around 11:30am).

There is a sign in the waiting area which signposts patients to the hospital tea rooms/ café to buy food and drinks – however, we were told by a patient who had been on MSDEC for 8 hours the previous day that he felt he didn't want to leave the area in case he was called to be seen.

Discharge planning and information sharing

On our first visit, we asked patients if they felt informed about discharge, and how they had received information about their discharge. One patient said they were grateful on how clearly the staff had kept them informed on what was needed before discharge. Another patient told us that information and follow-up appointment numbers to call after discharge had been discussed with a staff nurse.

One patient told us that they had been informed of discharge that morning after a discussion with a consultant the previous evening. Another found out they were to be discharged that day but hadn't had a conversation with anyone about this. We were unsure how long the patient had been on the ward, i.e. if it was a recent admission and quick discharge.

Most of the patients we spoke to were waiting for test results that day before their discharge could be confirmed the same day. Most patients said they had been given no indication of timescales.

"I would rather have [the MRI] here rather than outpatients later in the week." (patient comment about waiting on the ward for the scan now rather than going home and coming back).

A senior nurse told us that some patients who don't want to wait to be seen by the doctors leave after their scans and are happy to have their letters sent to the GP, saying that they will follow up with the GP to get results. Ideally, nursing staff want patients to be seen by the doctors before being discharged so they try to advise patient but can't stop them if they want to leave.

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We observed a staff nurse explaining to a patient we were speaking to, who was being discharged that day, that she would return shortly with the discharge paperwork and information. Another patient received an information leaflet and discharge letter while we were having a discussion with them.

Another patient said they had been given clear instructions on following up with their GP when leaving the hospital and had been told they would be contacted for further assessments. The family member of this patient also commented that they had been kept well informed by staff.

Three patients we spoke to said they would like a physical copy of discharge papers and via email, so they have a record of it. One mentioned that they would like test results this way also, they felt concerned that they would be discharged without knowing the results from tests and not given the medication they may need. One patient explained that they didn't want to receive anything on the App used by the Trust.

On our second visit, a patient on Ward 6 told us that their family are all involved and help look after th em, stating that their family visit daily. They said that they live on their own but hadn't been asked if they need support at home. However, they said they were in early stages of dementia so may have been told, but not sure. Another said they haven't been told anything else apart from they may go home that day.

Another patient from Ward 2 was told they would receive any information needed before leaving and said that the nursing staff had been attentive and answered any questions they had asked so far.

One patient on Ward 6 said that the staff were very busy, and they struggle to ask questions. They were waiting for more information and expected family to take them home.

On our final visit to Ward 2, the patients we spoke to had mostly all been on the ward around 24 hours and had been told they would be discharged that day. They were either waiting for tests or x-rays. Most had already waited in the Emergency Department prior to coming on this ward. One patient mentioned that they had been in the Emergency Department for too long, and at one point around 11 pm they were moved onto a corridor; they were given tea and sandwiches but it was never explained why they had been moved.

"I was told this morning that I am just waiting for an X-ray and then I will be allowed home, so the process has been clear, communicated and has been efficient."
(Patient comment, Ward 2)

Another patient explained they needed a heart scan and then told they could go. They were still feeling a little breathless but had some medication which has helped and said they feel confident in the doctors. They said they have been kept informed.

Another patient told us they had been admitted two days previously via ambulance with respiratory concerns. They were not fully aware of their journey through hospital but had been on Ward 2 for around 24 hours before being told they were suitable for discharge.

One patient told us they were re-admitted to hospital and during the first inpatient stay had been on various wards. The patient explained that when they came back on Saturday one doctor apologised when they reviewed them, but another was rude, their tone was off, not sympathetic and they didn't like how they were spoken to, especially when they felt so unwell.

"I came in last Monday and was here until Friday when I was discharged, but by Saturday I was back in again and needed to be, so I don't think I should have been discharged on Friday."
(Patient comment, Ward 2)

One patient said they use the NHS App and are happy for all their details to be added to that so they can read everything, but they didn't expect being discharged would be too difficult as once they have had one test, they are ready to go.

We were told by a staff member that many patients on Ward 6 are discharged from their beds but at times when they have pressure from MAU to free up beds, patients will be asked to wait for transport or medication in the holding area, but in these cases its usually only around 30 minutes to 1 hour that they are waiting in this area as staff do their best to push back on the demand until they know a patient is very close to going home.

Waiting for discharge

Timescale and duration

We were interested to find out the duration patients were waiting for discharge once it had been confirmed they were leaving the hospital. On Ward 2 it seemed patients were on the ward for around 1-4 days, most arriving from the Emergency Department, before being discharged. It was also noticed that some patients waiting for tests results to confirm their safe discharge were occupying a hospital bed (query discharge) and others were in a chair (confirmed discharge). We understood this was so the bed wasn't released until their discharge was confirmed. Patients seemed unsure about the precise time they were leaving and why they were still in a bed.

One patient mentioned her family member was on standby to collect them, which wasn't a problem for them as they were visiting at the time, but could see it might cause problems for others, given the short notice of discharge once results were back.

"The doctor told me it is likely to be done by 3 pm (4 hours after we spoke to them) so it is quite a quick turnaround from not knowing to 'yes you can go home'. If it turns out the timings are not correct and I'm still here I won't be happy, I like to know what is happening and when"
(Patient comment, Ward 2)

Another patient said they hadn't had any conversations about discharge as yet but expected it was because all they needed was some pain relief to go home with. They hadn't got any information to take home but were still waiting for a further test. They did feel that everything had worked ok for them so far.

Another told us they were hopeful after a scan they would be discharged that day after being advised it was likely, but had been given no indication of time for test or discharge.

Timescales for results, tests, and discharge were discussions that patients mentioned and the frustrations of not knowing. One patient in the holding area (seated) had been waiting there for roughly 1.5-2 hours and was still there 40 minutes later after speaking with us. One patient had their bag packed and family ready to take them and felt they did not need medication at discharge.

"I am ready to go home, I have a family friend who can come and get me, so I am just waiting for the MRI scan" the patient informed us they were coming back to the hospital later for this. They explained this hospital was further to travel for them but felt that was okay as the neurosurgeon is situated here.

While we were talking to patients in the discharge area on Ward 2 (area between 2C and 2D) we noticed that there was one single plug socket on the wall opposite the chairs which would not be practical if a patient needed to charge their devices. When patients wait in an area for a period of time, they are often using a digital device to pass the time.

Delays to discharge

On our first visit, a staff member explained that discharges were becoming less of a daily occurrence as patients are staying longer on Ward 2 than they used to. This can be because there is a lack of space on other wards, delays with care packages, or sometimes a lack of outpatient appointments readily available meaning its quicker and safer to keep the patient in get scans and tests done.

A patient we spoke to told us they were waiting for medication and transport – they had not been given a timescale of how long they would be waiting for these. Another had been told the previous day that they may be going home, depending on test results. Staff had been clear it was only a maybe but they had got the patient's hopes up so they were frustrated when they were told they had to stay another night.

"I'm happy to wait as long as needed for my medication but I can see that others are keener to get going sooner rather than later."
(Patient comment, Ward 2)

When we visited Ward 6 on our second visit. We were told by a staff member that delays can occur and it's often necessary to manage people's expectations about discharge. They feel it's important to be honest about how long it will take to get everything ready for patients. We were also informed that pharmacy delays are often given as a reason for delays - they're short-staffed and have to cope with the demands of the whole hospital. The cut off point for medication requests is 3 pm for dosette boxes and 4 pm TTO (to take out). medication. They said that as the doctor ward rounds are only once a day, in the morning, it means that patients who have been given the green light to be discharged are aware of this in the morning.

Medication requests are sent to the pharmacy after the ward rounds but it's usually the case that it can take up to 6 pm for medication to arrive on the ward. *"It always seems to be right up to close of play we are waiting on medications"* (staff member comment). Sometimes when pharmacies are very busy they may just provide TTO medication for the next day and then the rest of the prescription (14 days' worth) is sent to the patient – or family are asked to collect where possible – *"organising this is another admin job left for the senior nurse on the next day's shift' 'it can take up a big chunk of the day."* (staff member comments)

Staff feel they face a lot of pressure from hospital management to 'keep the flow moving' but often the delays to discharge are things out of their control. Patients can be medically fit for weeks but cannot be discharged until social care is in place, *"If for example, a patient is waiting to be assigned a social worker, we know they will be with us for weeks."*

Another staff member on Ward 6 said delays in discharge can happen due to transport issues.

Feedback from staff was reflected in patient comments also as they told us they were waiting for medication, or more support such as monitoring at home and were waiting to see if there is a monitor available. They said they had been told this could be arranged afterward so it shouldn't stop them from going home. Other patients mentioned that they knew they were going home but were unsure of the timescale. One patient told us that although they had been informed that they were due to be discharged by the doctor, no one had mentioned anything else about this. Another patient said they were waiting to go home but had no details and had family to care for at home. One patient said they were waiting until the rounds were over and hoped that the nurse could give more information then.

Another staff member explained to us that most patients are elderly and frail which makes it difficult to discharge them from their beds to a waiting area.

"We avoid using it as much as we possibly can but at times when the hospital is under a lot of pressure to keep flow moving, we are forced to move patients who can move out of their beds and ask them to wait in waiting area." (staff member comment)

"We avoid it if we can as we are conscious it's not the most suitable set up. Our patients are elderly and it's not appropriate for us to move them from a bed and ask them to wait at the end of the pod where we don't have eyes on them for hours on end."
(staff member comment)

Patients we spoke to on MSDEC told us they did not have to wait long for test they were there for but expressed frustration at having to wait a long time for a doctor to review the results and discharge them. One patient we spoke to said he had been told his blood results would be reviewed within an hour but waited 5 hours for a doctor to be available.

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Patient experience of environment, staffing, and care

The environment

Most of the patients we spoke to on Ward 2 said they felt comfortable, and the temperature was okay. A couple of patients mentioned feeling a little cold but one praised the response time from staff providing extra blankets.

One patient said their experience had been comfortable, the staff supportive, and quick in responding to any needs they had. Another patient told us that they felt they could ask staff questions if needed. Another said they were confident they could and would be able to get to the nurse's station to ask for anything they needed.

"Staff respond quickly if you press the button for help. They also use my name each time when they speak to me which I like."
(Patient comment, Ward 2)

There were concerns about noise at night on Ward 2 by some patients.
"The only complaint I have is about noise, sleeping isn't easy, but they keep opening the door and leaving it open and I keep getting up to close it."
(Patient comment, Ward 2)

There were more comments on day three of our visit to Ward 2 about the noise. *"It has been noisy, I haven't slept"*, said another patient. *"I can't say I have slept much; it is the nosiest place in the world if you want to sleep."* (Patient comment, Ward 2)

The food provided wasn't given a good rating by patients, many mentioned that although meals are offered, there have been issues and mix-ups with orders, running out of food requested, and very odd combinations together. One patient commented that the food was like school dinners and *"could improve without spending any more money"*. Another said that they had ordered lunch earlier but had declined it when it arrived because they would rather just get home. The ward housekeeper explained that refreshments were provided to patients. She also assists patients with packing up their belongings ready for discharge. A patient mentioned they had been offered refreshments by housekeeping.

One patient told us they were struggling to access the internet on their phone and felt they needed some help to log onto the NHS Wi-Fi.

"I have no complaints, I am comfortable and well cared for, I do wonder why I need this bed though. I am taking up a bed when I am just waiting for an MRI scan. I can do that elsewhere. I am not poorly, I expect to go home after the scan and not waiting for any test results, so I feel I could be discharged from this ward and be somewhere more suitable."
(Patient comment, Ward 2)

"I am cold while I wait, I had 3 dressing gowns last night. I was left on a trolley for a long time before I came here (to the bed) and I would rather stay here than move somewhere else while I wait for a scan."
(Patient comment, Ward 2)

A patient who spoke to us on day two of our visits on Ward 6 said they felt comfortable and warm enough on the ward.
Another told us that they had been offered drinks but were unsure if they were going to be having something to eat for lunch before they went. Another patient confirmed they had been well looked after saying lunch and tea have been ordered so if they were still waiting for medication then they didn't mind, as long as they are fed they are happy to wait.

A patient told us the only thing they think could be improved, is room compatibility. They explained they were in with someone who was shouting and moaning all the time, and said it felt *"uncomfortable and draining"*.

Staff

We asked patients if they were able to ask for help if they needed it. Patients mentioned a few times that the staff were busy.

"Staff are very busy and I think if I was in here and very poorly I would struggle as I wouldn't want to have to keep asking them for their help."
(Patient comment, Ward 6)

"Staff are always busy. I will ask them about the cream. When I do ask the staff anything they say they are busy and I will have to wait!"
(Patient comment, Ward 2)

"The facilities have been brilliant, as have the staff."
(Patient comment, Ward 2)

"All the staff are amazing, I've been well looked after, they will talk and explain what is happening, I just want to go now I have my appointment and don't need to be here."
(Patient comment, Ward 2)

Another patient said they had been brought onto this ward (Ward 2) at about 2 am and a nurse told them their family member wasn't allowed to stay. They explained their past experience and, with consideration to some personal circumstances, they 'politely argued' they should stay, so the family member sat in the chair next to them until this morning.

"We believe they are quite rigid about the rules because some families all want to stay, and I understand that, but 1 person at 2 am in the morning should be allowed."
(Patient comment, Ward 2)

We spoke to a patient who told us they were neurodivergent and usually struggled to be in clinical settings and to speak with clinicians but said *"all staff have been excellent at communicating with me on what is happening throughout my stay"* and that the stay had been 'easier than was expected' because of this. Another said that they had seen many doctors during their stay and said they had all been lovely but there were some differences in what their opinions were regarding their condition.

Patients we spoke to at MSDEC told us that the nurses were good at communicating with patients when there were delays. One said the nurses would often come out and sit in the waiting area with them to check on them.

Another patient told us that whilst the staff were very apologetic about the wait they did not offer him any food until much later in the day and did not ask if he was in pain – which he was and would have appreciated some pain relief if possible.

Health and safety

On Ward 2 a staff member told us that they have to think about patient safety and patient experience, so they can't just put people at the end of the ward when they're ready for discharge. They have pods where a support nurse who works 9-5 can oversee the patients there and support with transport and so on. We were told they have a room for patients who are more vulnerable, with dementia for example, so there is privacy.

Our visiting team noticed that on Ward 2 holding area, there were no call bells available, but it was a short distance from the nurses' station on 2C and 2D. The exits were clear of obstruction. However, it was noted that several fire doors were propped open.

During our first visit, a patient told us the consultant had explained how they should take their new medication the previous evening but the patient said they wanted to discuss it again with someone as the information had 'gone over their head as there was a lot to take in'. As we were having this discussion a staff nurse approached the patient with the new medication and began explaining it to them. We took a step back to allow the patient to have this conversation with the nurse in private. During our observations we witnessed serval people and equipment moving through the environment whilst the patient and nurse were speaking. The environment felt very busy and hectic and not an ideal environment to listen to and take on a lot of information.

Another patient we spoke to had a hearing impairment. Their hearing aid was broken so with their permission we informed the nursing team as the patient was unsure if they knew. We wanted to make sure there wasn't a barrier to understanding information.

The wards felt safe and several staff had badges as 'safeguarding champions'. One Authorised Representative said they had seen staff responding quickly whenever a call bell was heard.

Care, Choice, and Dignity

A staff member commented on the holding area not being a private space but did say when a private area is needed for a conversation with patients or with family they are taken to a private room or behind the nurse's station to have conversations with them. Our visiting team had noticed this also, but there didn't seem to be much choice, given the layout of the ward. We noticed a small room for confidential discussions with patients and families but this was being used for equipment at the time of our visit.

We spoke to a patient who sat in the holding area of Ward 2 on our first visit. When we asked how the area felt they said, *"I'm okay waiting here"* and said they understood that *"beds are needed so it is what it is."*

One patient on Ward 2 explained how consent was sought from staff for what they do, they ask *"is it ok if we take your blood pressure?"* which they found considerate. They went on to say *"I have been in hospital a few times (NHS and private) and I feel this experience has been as well considered as what I have paid for. Maybe A&E was a little slow, but there is a lot for them to do, I appreciate it and the nurses especially have shown kindness and the doctors forthcoming and open to conversations."*

On Ward 2, we witnessed staff speaking to colleagues and patients in a warm friendly manner, dignity maintained as curtains were pulled around when treatment was offered.

Leaving hospital and homeward travel

Do patients feel ready to leave?

On our first and second visits, the patients we spoke to said they felt ready to leave the hospital. One patient explained that their daughter was coming to collect them and all medication had been arranged.

"Yes, ready and eager to get home."
(Patient comment, Ward 2, who was waiting for new medication)

"I am healthy and feel ready for discharge, I just need a diagnosis so I know how I can improve."
(Patient comment, Ward 2)

"Yes - feeling much better - been given a course of antibiotics and told how I should follow up with GP if no change."
(Patient comment, Ward 2)

"I have been very impressed with my experience on Ward 2, the doctor has given me great confidence that I haven't had a heart attack which is what you fear with chest pains. I feel reassured and that given me confidence in going home."
(Patient comment, Ward 2)

A staff member told us that sometimes patients' personal circumstances can cause delays as some patients don't want to go home or their families don't want them to go home. They get them to a point where they are medically fit to go but then at the point of discharge, they tell staff they don't want to leave because there are issues at home such as unsafe housing or they are isolated or family tell us they are no longer able to cope with the care needs. At this point referrals have to be made which can take weeks and cause delays.

Homeward bound or onward travel

A staff member told us that patient transport will give a 4-hour window of time they expect to collect patients from the ward and get them home, so nursing staff have to call family or care provider to ensure there is someone available at that time to receive the patient and make sure the discharge is safe. On our first visit, 6 of the patients we spoke to were able to go home with family members, and 4 of these patients informed us they did not need reablement support after discharge. One patient was waiting for hospital transport, but they were unsure how long the wait would be.

While we were on the ward, 2 members of Yorkshire Ambulance Service were looking for a patient they had been called to transport. We saw them in 2 parts of Ward 2 and as they were leaving one of them said *"you wouldn't like to know what we think of what's happened this morning"*. They were too busy to speak but were being directed to a different ward to collect their patient.

Our Authorised Representatives found parking at the hospital extremely difficult and wondered how family members collecting patients manage to get close enough when there are mobility issues.

On the second visit to Ward 2, patients we spoke to told us that a family member was picking them up, although one said they hadn't told staff as no one had asked. One patient said they were making their own way home.

A staff member on Ward 6 explained that the ward staff phone the transport team to book for the patient. Usually, there are no issues with the ambulance service and patients are picked up within a 4-hour window. They are very good at communicating delays. At times when the ambulance service is overwhelmed, there is a 'private ambulance' service that the Trust has commissioned, however, there is always lots of confusion about which number ward staff should call to book this and they spend a long time just being passed around and given different numbers to call. When they do get through to the private ambulances there can still be difficulties: *"Always a lot of push back and reluctancy for them to book in a patient"*, a staff member commented.

Additional feedback from staff, students, and volunteers

The staff were busy during our first visit to Ward 2, but we managed to speak to a few.

We were told that they have a review meeting at 4pm/5pm with the ward doctors. If the doctor prescribes something new for a patient during the review, it is too late for the ward pharmacy team to get this organised. It then has to be sent to the hospital pharmacy which takes longer to process. This closes at 6pm so they cut off prescribing around 5pm; this can often mean the patient is not able to be discharged or the patient may be sent home without medication (if they have had their dose for the day already) and then asked to come collect the next day. This can lead to problems such as the patient or family not being able to return, or staff can't contact them so the medication is never collected. A staff member has witnessed this leading to readmission on a number of occasions.

Sometimes medication is sent to the patient in a taxi which is costly.

Staff feel the pharmacy should be available later in the day to accommodate medication changes from the review. Many staff mentioned the medication timings. A staff member also stated nursing staff are often pulled off nursing duties to perform admin roles such as calling patients to collect medications or chasing transport, chasing care package, etc.

Another staff member told us that training and guidance for staff on discharge, especially for new staff would make a difference. Also, the staff often felt rushed by managers to get patients out of hospital.

One staff member said, *"if a ward does not have experienced staff, they do not chase pharmacy, or social services needed for discharge. They don't prioritise these things or don't have the experience to manage their time to be able to do this."*

Another staff member said it was difficult to have an understanding of all the different processes for setting up social care. Each district Calderdale, Kirklees, Bradford, etc. have a different referral process for a social worker or reablement care. They said they had received no formal training on discharge and commented that, initially, they were not even aware of what the term 'reablement' meant. Instead, they have had to gradually learn things on the job and are still not able to deal with a discharge on their own, needing to ask for support from the team.

They said they were new to working in the UK and said that for the staff who are trained in the UK, discharge is an easier process for them to pick up but for staff coming from outside the UK there is a need for more formal training in this area.

"If staff are not discharge-focused (often the case with bank or agency staff) they do not prioritise discharge because it's a lot of work for them on the day. Ultimately if they are only on the ward for one shift, it's the person on the next day who must pick it up". They also commented that *"Staff on MAU are more discharge-focussed because of the nature of the ward, they have a constant pressure of a clearing space for patients from the emergency department".* They also commented on this leading to pushing that pressure onto other wards and, in their experience, staff on MAU making *"risky call"* to discharge a patient when potentially they aren't ready *"sometimes it works, sometimes it doesn't".*

A few staff mentioned the pressure from hospital management to discharge to keep bed flow moving. "They come onto the ward and pressure the nursing team to move patients who are waiting to go home out of their beds. They call it *'sit patients out'* but it's ironic because our response is always *"sit them out where?'"* . A member of staff then described a situation where management were pressurising nursing staff to 'sit out' a patient who had a sight impairment and said there was little understanding of the risk. The nursing team had to push back on this and disagree.

On another occasion, pressure was added to 'sit out' an elderly patient who didn't eventually leave until 8 pm. If the nursing team had released this patient's bed they would have been sat for 7 hours. The nursing team said they had to 'put up a fight' on this occasion also.

They said they understood where the pressure was coming from, particularly when Medical Assessment Units (MAU) are under such high pressure to clear beds when A&E are at capacity, but they said *"all decisions to move patients out of their beds must be safe and it is unfair to pressure the nursing staff teams to make those calls when it is not safe to do so".*

They feel the need is great for a designated discharge lounge to support the bed flow safely, and feel it is something that must be addressed sooner rather than later. They feel that patients need to be moved to a safe place to wait, somewhere they can be monitored and it can be checked that everything is in place for them before they leave *"pressure leads to rushing, which leads to mistakes"* said a staff member.

They also commented on occasions when the pharmacy have made mistakes with To Take Out medication or not sent enough and its not been picked up by the ward staff before sending the patient home - again because they are being pressured to rush the discharge.

A staff member on Ward 6 told us of some communication issues, stating that as ward rounds are carried out by the doctors at around 9/10 am. The nursing team do not do the rounds with doctors so are not there when the doctors tell the patient 'you can go home today'. Often this means patients think they are going home imminently, and the nursing team are then left to follow up with the patient and let them know there are several things to get into place first before they will actually be leaving. Patients are encouraged to still order all their meals for the day as it's likely it will be the later afternoon when they leave – this is not made clear enough by the doctors. They explained that when patients ask the nursing staff how long they will be waiting and how much longer their medication will take to come, they feel it's always best to be realistic with the patient.

"I'll always tell patients the pharmacy doesn't close till 6 pm so don't expect to leave before then" (Staff comment, Ward 6). Whereas they have witnessed inconsistency with how other staff manage the expectations of patients and said some give responses such as *"won't be long now"* etc. which they feel is not the best approach. *"Even if it's not what the patient wants to hear I feel it's best to be honest and realistic with them"*. This advice is not always taken on board by all staff.

One staff member was concerned that the hospital didn't have protected mealtimes.

A staff member told us that Ward 6B has been without a ward clerk for over 6 months, which means the responsibilities of this role are then absorbed by the senior nurses, adding to their pressure and taking them away from clinical work. They felt that the ward needed this role but were aware there were issues with recruiting. Another staff member said, *"Ward clerks are vital to support the nursing staff with admin of discharge"*.

A staff member mentioned that they felt very well supported by colleagues and management, and they have a clear understanding of their role. They were not involved in the process of discharging patients but did feel there was a lot of pressure on staff for bed spaces. They felt it was a bit messy and sometimes they saw patients had been waiting in the designated area for hours. They said having patients that they had previously been looking after on the ward and discharged to the designated space felt to them like they were *"dumping them and their belongings"* and said it might feel like this to patients too.

Another member of staff described how complicated discharge could be - just getting 14 days of medication for someone depended on whether they were going home, to a care home, whether they had a dosette box or not. Direct discharges home are straightforward but involvement with other services makes it very complicated. The discharge coordinator often sorts out the complex discharges.

We were told that patients' families are crucial to their care when they get home and there are different cultural considerations for different communities. Often people with learning disabilities need 24-hour care. Some people prefer to go home with community services and some families want to learn to care for their relative.

We were told about something called Language Line which provides information in different languages and helps with translation. Family and friends can help with translation but not with the final decision.

A staff member commented that there was no designated discharge lounge at Calderdale Royal Hospital. Another staff member suggested that it would be a good idea to have a discharge lounge with more written information available for patients.

"The reality of the situation here is that we'd prefer a dedicated discharge area, they are doing it in Huddersfield where there will be a Hub that brings together care, social services and so on and we hope that when that is introduced and assessed it will come here."
(Staff member comment, Ward 2)

Suggested improvements

Suggested improvements from patients, staff, and authorised representatives:

- The food ordering system came up a few times with patients, either the lack of available products, mistakes to orders after ordering or the quality of the food.
- A staff member felt that some improvements could be made in the holding/discharge areas, and the two visitors rule should be enforced for patients ready to be discharged as it leads to a hectic and at times (such as mealtimes) hazardous environment. It's a busy space with passing staff, trolleys and equipment. They mentioned that this can be made worse when family come to visit and choose to stay with patients whilst they wait to be discharged, particularly when more than 2 family members with the patient.
- One of our Authorised Representatives noticed that the acronym for the Medical Same Day Emergency Care (MSDEC) was used on the signage. They feel most patients would be unaware of what this represented, so putting the full name would address this.

- Another patient said they would like to see an improvement in getting a sick note, explaining they cannot go back into work but to get a note they have to go to my GP, who hasn't been involved in any of this. *"It's an extra burden on me while I recover and an extra burden on a different part of the NHS. Maybe discharge notes can include things like a 7-day sick note (or however long the doctor suggests)"*.

Conclusion

The Enter & View visits revealed a number of insights into the discharge process, patient experience, and the overall environment of the wards we visited.

Ward 2, the Medical Assessment Unit, often felt chaotic due to high traffic and noise levels. Patients experienced discomfort with the noise, especially at night, and the discharge holding areas were not very private. Ward 6 had a slightly calmer atmosphere but was cluttered with equipment. In both wards, there were delays and inconsistencies in the discharge process, leading to patient frustration.

The Medical Same Day Emergency Care (MSDEC) unit provided a more calm and organised environment, but patients sometimes felt reluctant to leave the waiting area for food or drinks, fearing they might miss their call to be seen and discharged. Delays in discharge from this area tend to arise when there is a shortage of doctors to review tests and scan results.

Overall, the areas being used for discharge do not feel fit for purpose. This is not just concerning in terms of the physical aspects of the areas, but the potential impact on patients' emotions, as they may be anxious about their discharge and next steps.

All wards were generally clean, well-maintained, and equipped with necessary infection control measures. Staff were observed to be professional, caring, and committed to patient care.

Discharge is often more problematic than it should be at this hospital due to the lack of a designated discharge lounge. Without this type of 'hub', discharge can feel chaotic and uncoordinated. Patients are sat in holding areas which are little more than a hospital corridor with chairs, often in high-traffic areas, which is not conducive to comfort and good patient saftey.

Patients want better information about the timing of their discharge. They are sometimes not given an accurate picture of what needs to happen before they can be discharged from hospital, so end up frustrated by long waiting times.

Staff commented on the pressure they often feel to discharge patients quickly which they say can compromise patient safety at times.

It's clear that complex discharges, for example where patients require a social care package, medication and transport, are incredibly time-consuming. These discharges are more challenging when new, inexperienced staff have this task and when a discharge co-ordinator and ward clerk are not available to support with the process.

Delays in providing medication in a timely way can cause significant delays to the discharge process which is frustrating for staff and patients.

Our recommendations highlight several areas for improvement around the discharge process and patient communication.

Recommendations

Our recommendations	Managers comments
We recommend Considering whether a dedicated discharge lounge is feasible at Calderdale Hospital, to bring it in line with Huddersfield Royal Infirmary.	
We recommend Reviewing the potential impact on patient safety caused by the pressure on staff to rush discharge.	
We recommend Reviewing training and guidance available to staff on the discharge process. Create detailed training modules covering all aspects of the discharge process including specific sessions on understanding district-specific social care process.	
We recommend Involving nurses in conversations with patients about discharge during doctors rounds.	

We recommend Waiting times are to be made clearer for tests and discharge, so patients have a greater understanding and realise they may need to order food, inform family etc.	
We recommend Considering extending pharmacy opening hours to avoid delays to discharge and patients being sent home without medication.	
We recommend Offering private rooms for patient conversations in the 'pod' areas. Also, more comfortable chairs, access to Wi-fi/plugs in the pod areas.	

Response from Calderdale & Huddersfield NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust are grateful to our partners at Healthwatch for undertaking a review, of the discharge experience for patients, carers and colleagues at Calderdale Royal Hospital.

The Trust is pleased that many aspects highlighted within the report and recommendations had already been identified by the Discharge Quality Group. This has resulted in the Discharge Quality Group already starting to develop and deliver actions which will make improvements for patients, carers and colleagues through the discharge process. The group has representatives from across the organisation, including pharmacy colleagues.

Actions already underway include reviewing and developing additional training to support colleagues with discharge processes; A pilot which has used developing a form of words as a mechanism for improving communication, to enable pharmacy colleagues to prepare take home medication up to 48 hours in advance. The pilot will provide additional insight as we continue to identify actions to improve the experience patients have when receiving take home medication. A further action underway is one which supports nurses to attend a “board round” (where team members share and update each other to develop a plan for individual patients), with doctors and other members of the multidisciplinary team at least once a day if not twice. Each of these aspects will support clearer communication both with patients and colleagues, and are supported by colleagues experienced with discharge processes, and senior leaders through quality improvement initiatives each week.

The Trust is delighted to hear Healthwatch partners recognise the professional, caring and committed colleagues we have, and the Trust anticipates that through programmes taking place both nationally and locally at the Trust to improve patient safety and provide person centred care, the experience of patients, carers and colleagues throughout the discharge process will continue to improve. In response to the feedback our partners have shared within this report , we will add a specific action to the plan for the Discharge Quality Group: To make sure that all areas identify a private room for patient conversations for individuals waiting in the pod areas, and to monitor progress with this action.

We note the reference to our ward teams being asked to sit patients out of bed who are waiting to be discharged and we recognise the concerns that some colleagues have about this. It is important to balance the demands across all of our services to be able to maintain the safety of all our patients and manage risk, this is often felt more acutely at ' front door ' services such as the Emergency Department. In order to create capacity and maintain flow through the hospital, we support teams to sit patients out who are ready for discharge, so that our patients who are acutely unwell can be accommodated. We will continue to support our teams to do this, taking on board feedback about the environment and patient comfort and dignity.

We recognise the Trust is limited by the current space / estate, we are closely monitoring the impact of having a new discharge lounge space which we call the "Integrated Flow Hub", on the Huddersfield Royal Infirmary site to better understand aspects we can replicate at Calderdale.

In the meantime, we will continue to strive to improve communication, with patients involved in decisions about their discharge, and with up to date and clear information about their plans. We will also ensure that recommendations from this report feed into our new clinical build in addition to current improvement work. These include ensuring a range of comfortable chairs are available, and that patients have access to plugs and access to WIFI, and that signage is clear and without abbreviations.

The Trust would like to formally thank our partners from Healthwatch for sharing their insight, and look forward to continuing to work together through the Patient Experience and Involvement Group, and the Discharge Quality Group to review the impact of the discharge focussed improvement work at the Trust.