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Executive Summary

Insights into Hospital Discharge

A study of patient, carer and staff experience at Princess Alexandra Hospital

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Executive Summary

This report summarises our multi-method research study into hospital discharge at Princess Alexandra Hospital, providing insight into the experiences of those involved; patients, patients' relatives and carers, and hospital-based staff who administered the discharge process. Princess Alexandra Hospital in Harlow is a 544 bed District General Hospital with a full range of general acute services and serving a population of around 285,000 people. We present here our findings and offer recommendations on how the experience of patients and their families can be improved. This is the third in a series of reports based on research carried out by Healthwatch Essex. Reports on hospital discharge at Broomfield and Colchester General Hospitals can be found on our website,[1] and a final report based on our analysis of all three hospitals will be published alongside them at the end of July 2016.

Background

The experiences of patients and their carers preceding and following hospital discharge are often unsatisfactory and, following a number of high profile national reports and widespread media coverage about cases of unsafe discharge, there is growing concern among the public about discharge from hospital. In some areas of the country a number of serious failings causing patient harm have been highlighted, including cases where patients had received poor care relating to hospital discharge practices. Problems such as miscommunication, incorrect diagnoses and delayed and premature discharge have been identified. In 2015 Healthwatch England undertook a national enquiry of people's

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[1] These reports will be available at www.healthwatchessex.org.uk/what-we-do/our-reports/

experiences of hospital discharge and reported that many people were experiencing both delays and a lack of co-ordination between services, and that patients were not sufficiently involved or informed about decisions involving their care. Nationally, problems related to hospital discharge are not new, but growing emergency hospital admissions in England; an increasing ageing population (often with accompanying complex discharge needs); a reduction in social care expenditure; and rising hospital deficits have all contributed to the challenges in achieving a timely, safe and satisfactory discharge for patients.

Aims

- To develop insight into the 'lived experience' of hospital discharge processes at Princess Alexandra Hospital.
- To identify both the challenges and positive attributes that facilitate, or inhibit, an effective and safe discharge from hospital for patients.
- To engage with stakeholders throughout to maximise the impact of the research study to improve patient and carer experiences of discharge.

Methods

To best understand the complex factors involved in participant experiences of discharge, we adopted a mixed-methods approach. We used survey methods, audio diaries, interviews and ethnographic observation methods to produce in-depth accounts of patients' and carers' lived experiences and a rich description of the cultural practices and processes surrounding the formal procedures of discharge. Our design was premised on our initial understanding that hospital discharge is a fluid process that begins once a patient is admitted to hospital, and carries on throughout their stay and after being discharged. It is a dynamic negotiated process involving a number of key people – patients and their relatives/carers, doctors, nurses, discharge team staff and other healthcare staff. Our study was co-produced, meaning that we engaged with patients, the public, and hospital staff in preparing the study design. Senior staff from West Essex Clinical Commissioning Group (CCG), East and North Hertfordshire CCG, Essex County Council and Princess Alexandra Hospital will also be invited to attend a meeting to discuss the study's recommendations.

Ethical approval for the study was granted by NRES Committee, (East Midlands, Nottingham 1) in March 2015 and data collection took place between May 2015 and December 2015. In total we gathered the following data:

- Survey interviews with 91 patients (six of these with the help of a friend or relative, or member of staff) in the discharge lounge on day of discharge.
- Interviews with six patients and two carers (recruited soon after admission and followed up after being discharged).
- Four patient diary recordings recorded during their stay in hospital and after being discharged.
- Fifteen in-depth interviews with clinical staff involved in discharge (eight staff from the discharge team and seven ward staff).
- 65 hours of ethnographic observation of discharge team processes (this involved shadowing discharge team staff).

Findings

Quality of care

The majority of patients who participated in our study were elderly and could be classified as having undergone a relatively simple discharge process from hospital, insofar as most were being discharged with little or no additional support or care. Nevertheless, similar problems and negative experiences of hospital discharge were identified across the patient spectrum.

Most patients spoke well of staff, praising their efficiency, and felt that they were doing their best given that they were very busy and at times appeared to be short staffed. However, our findings indicate that there is a lack of consistency with regards to the quality of care patients receive. Whereas some participants were involved and informed about their discharge-care preparations and received good follow-up care, other participants were neither involved in their discharge, nor did they receive good follow-up care. Our participants' stories illustrate the physical, mental and social consequences of uncoordinated and poorly planned care for patients transitioning from hospital to their home. Some patients felt ill-equipped for discharge because they had not been instructed on their post-discharge medication; its potential side-effects, and how to generally manage their illness once home. Nearly half of respondents didn't know who to contact if they were worried about their health post-discharge. This contributed to patients reporting that they felt they had little involvement in their own discharge. Some patients were further concerned as they had not been contacted with follow-up appointments, which they had been led to believe they would receive.

These issues generated anxiety for patients once home and left them feeling disempowered in terms of managing their ongoing health conditions.

Communication, information provision, and patient involvement

Our data analysis reveals that information regarding discharge was not always readily available to patients and poor communication is a recurring theme throughout. The vast majority of patients in our study were elderly, had undergone an emergency admission and as such had generally had no prior plans in place to support them once discharged. Acute hospitals aim to discharge patients once they are deemed medically fit and while assessments for patients' social care support are often made available, our data suggests that the support of family and friends is often highly valued by patients in the post discharge period. Relatives and carers also need to be provided with information on the patient's progress towards discharge and how to care for them post-discharge if they are to be treated as 'partners in care'. Indeed, as other research has shown, though the role of carer/relative is often overlooked, it is considered to be of primary importance for successful patient discharge experiences (Bauer, 2009; Borthwick et al., 2009; Glasby et al., 2006). However, families were sometimes seen by staff as an impediment to timely and effective discharge, often because discussion with families about a patient's discharge did not occur early enough in the discharge process.

We also identified communication problems between staff and patients, such as staff not enquiring about patients' home situations or whether their living conditions made it appropriate for them to be discharged without some form of support. Our study identifies some instances where patients experienced anxiety about their safety once home. Our patient data also revealed that some patients felt that they were being discharged too early, without sufficient help or support in place. This aspect of miscommunication also demonstrates the need for better integration and communication between health and social care staff.

Systemic issues

Ward and discharge team staff informed us that the complex systems for administering discharge, coupled with a shortage of resources (including support in the community, funding and nursing staff shortages). All led to serious challenges for staff discharging patients safely and in a timely manner. Systems for triggering services and support to be put in place for patients prior to their discharge were often further hampered when the patient was being discharged to a destination in Hertfordshire, rather than Essex, as local authorities and CCGs there had different systems and criteria in place. Staff also often felt under considerable pressure to discharge patients quickly and in some cases 'too quickly'.

In making the following recommendations, we focus on areas where we believe there to be practical solutions which, if implemented, would improve patient experience of being discharged from hospital as well as improving their confidence, care and support once discharged. We believe that discharge should be person centred and take full account of individuals' social and healthcare needs.

Recommendations

Instigate information and communication systems

- Upon admission to a hospital ward, patients and their relatives or carers should be provided with simple and easy-to-read information about the discharge planning process. This should include information relating to short hospital stays typically provided by acute hospitals and general advice about post-discharge support and care.
- In addition to the collection of medical information, healthcare professionals should be involved in the collection of information relevant to a patient's social situation (i.e. whether they live alone, proximity to relatives or networks of support). This should include information about a patient's relatives and carers.
- Develop and establish a rigorous system (i.e. forms) that will facilitate professionals in systematically collecting and continuously updating the above information.
- Upon discharge ensure that all patients' questions regarding diagnosis, medication, follow-up care and post-discharge care are answered and communicated in verbal and written forms (i.e. discharge letter).

Provision of integrated care

- Having identified the medical and social care needs of patients upon admission, care professionals should examine how these care needs may affect a patient's discharge. Hospital-based health and social care services should work together to continue developing systems of care that put patients' needs and values at their core.
- We recommend that East and North Herts CCG, West Essex CCG and associated local authorities work together to improve the co-commissioning of services, as undoubtedly the lack of integrated services and variation in systems adds further complexities and unnecessary delays in hospital discharge and care for patients.
- At some point patients will experience discontinuity of care (transition from generalist to hospitalist care and vice versa). It is important for primary and secondary care services to strengthen their interface to provide better continuity of care. This is particularly important for the elderly population, who experience frequent care transitions.

Education and training

- Provide Continuous Professional Development (CPD) training for ward staff about hospital discharge processes and teach them how to engage with patients and their carers as partners in care.

Pharmacy and transport

- Delays on day of discharge due to problems with transport service arrangements and pharmacy hold-ups need to be addressed.

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