healthwatch
Surrey

Hospital Discharge – are you hearing what we're hearing?

A report on what we've heard about hospital discharge in Surrey over the past two years

Healthwatch Surrey
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Project Purpose

Minimising the length of stay in hospital is a core objective of the NHS Long Term Plan. At the launch of 'Where Best Next?' in 2019 NHS medical director Professor Stephen Powis said "we want to ensure that all patients benefit from the shortest possible stay on a ward, getting home as soon as they are fit to leave with the support they need".

This objective is reflected under Priority One of the Surrey Health and Wellbeing Board Strategy which has a focus on "A robust, integrated and preventative intermediate care offer… to improve hospital discharge and prevent avoidable readmissions"

Discharge is a complex process: it demands coordination across hospital services and integration with community health and social services.

And at the heart of every discharge is the patient – a person whose unique strengths and needs need to be factored into decisionmaking to ensure their discharge is both timely and safe.

In 2015 and again in 2017 Healthwatch England reported on people's experiences of hospital discharge. Healthwatch Surrey contributed to the 2017 survey and prepared a report (available on our website).

Locally we reported a mix of good and less good experiences in line with key concerns reported by Healthwatch England:

1. People not getting the information they need or not feeling involved in decisions
2. Delays and lack of coordination between services, especially medication and transport services
3. People feeling left without the support and services they need after being discharged.

In response to the findings Healthwatch Surrey developed a Hospital Discharge Checklist to empower patients to achieve a safe and timely discharge (available on our website.)

Every year over 1,000 Surrey residents share their experiences of health and social care with us, and we regularly hear experiences of hospital discharge. This analysis of two years' shared stories takes a fresh look at the local experience of hospital discharge: **what are the key challenges, and how do these impact on the wellbeing of local people who are leaving hospital?**

Our insight will be shared with all Surrey Hospitals, and we will be seeing views on our findings and on the challenges they face.

What we did

We reviewed all stories in our database where people had specifically commented positively or negatively on discharge from hospital following an inpatient admission. This yielded 150 individual patient experiences. We then subjected these stories to a thematic qualitative analysis.

Our aim is to ensure the lived experience of people is communicated in their own words. The stories we hear are often shared with us in face-to-face discussions and recorded verbatim; others are sent to us in emails or shared via our website link. We meet people in a variety of places and we accept stories from all those who wish to share with us. This gives us rich, personal insight: qualitative analysis allows us to preserve the voice of the people who are sharing their stories with us.

Inevitably we hear more negative stories than positive, and positive comments tend to be less detailed than negative.

Sources of stories

The stories we heard related to the following hospitals:

Hospital	Number
Frimley Park	33
St Peters	29
Royal Surrey County Hospital	28
East Surrey	19
Epsom	9
Ashford	5
Kingston, St Georges, St Helier	8
Community hospitals	4
Others/specialist	4
Unknown	8

And the sources of the stories were as follows:

Source	Number
Engagement events	72
Citizen Advice	25
Helpdesk	22
Advocacy	13
Citizen Ambassadors	6
Other	12

Key Themes

Most of the stories shared with us – positive or negative - fell under one of three broad topics:

1. Quality and Safety

Nearly half the people we heard from shared stories related to the **clinical security, quality and safety of the discharge.** These ranged from readmittance within days of discharge, leaving hospital with inadequate information, through to not feeling ready to leave hospital.

2. Discharge Process

Around three in ten issues concerned the **discharge process** – timing, organization, communication – and were primarily about lack of clarity and unexpected delays on the day of discharge.

3. Social Care

Around two in ten stories related to **arrangements made in hospital for social care following discharge**. These include experiences of assessment before discharge and finding care home placements.

1. Clinical security, quality and safety of discharge

The stories we heard under this theme all relate to clinical aspects of the discharge: they have the potential to impact the health of the patient who has been discharged, and all are under the direct control of hospital staff.

The concerns (and some praise) we heard about were:

- **Readmittance** and **misdiagnosis**
- **Medication and discharge letters**
- **Onward clinical care** – information about, self care, medication and onward referrals
- Feeling the **discharge was too soon**/feeling unsafe at discharge

Misdiagnoses

We heard a small number of stories about people who had been discharged following a misdiagnosis

- *After being discharged (around 7am) from the hospital, I wasn't happy with the diagnosis … the scary news from the tests [at a different hospital] was that my son had a bacterial infection of his blood and urine and had sepsis too.*

- *[the hospital] sought to discharge him. His wife refused to allow him home until he had been seen by a stroke expert which was done and a stroke immediately diagnosed and confirmed in scans.*

Early Readmission

A small number of people (around half as many as the number who '*felt*' they had been discharged too early) had been readmitted soon after discharge, or had had to seek care very soon after discharge

- *xxx had to be re-admitted to St. Peter's hospital because she was discharged before her infection had been cleared.*

- *I was bleeding internally and felt poorly but was discharged. I had to go back in again next day as was bleeding internally and I needed another operation to resolve it which resulted in several days inpatient care.*

- *patient has been unwell since her return [to her care home] and has required a doctor visit.*

Medication and Discharge Letters

A few people told us they had been discharged without medication or a discharge letter.

For some this was clearly an error:

- *When she went back [the day after discharge to collect medication], there was a letter but no medications. When she queried this, she was told there were no medications. The client has knowledge of the health system and said that there must be medications as her father had been on antibiotics whilst on the ward. A Dr came and ultimately, she received a bag of medications, including antibiotics and dosage changes to his regular medications.*

- *[the patient's mother] has had no Discharge note, no referral documents and apart from the A&E paper records, there are no electronic notes on the CAU system.*

For others the lack of medication may have been intentional but this had not been explained to the patient

- *the hospital was aware of the cellulitis when she was discharged but did not give her any antibiotics on discharge.*

Information, advice and followup

The value of good information and a secure handover to community care was reflected in some of the positive experiences we heard:

- *They bring the medication to the bed and the pharmacist comes and explains it all.*

- *The discharge plan was clear to read: splitting out ongoing treatment, community treatment and providing an explanation of acronyms used.*

- *They gave us a dedicated phone number straight to the ward: relief of having that and knowing we could come back.*

However, nearly 1 in 5 of all the stories shared with us were from people who **left hospital without having the information they needed to care for themselves after discharge, or without onward referrals to other healthcare providers** being in place.

- *She was sent home with a catheter but no instructions as to how to maintain it nor any discharge plan.*

- *Before I was discharged I asked the doctor that discharged me (another new face) was there anything I could do to take care of myself so that the condition I had doesn't*

happen again and he just shrugged his shoulders and said, that is in the hands of your maker, if you believe you have a maker?

- *No physio, no OT, no speech therapy until about 6 weeks after he'd got home. Too late, too little. The worst thing was no information. Nothing at all. Everything I found out was by asking around.*

Feeling unsafe at discharge

Some people told us they *felt* the discharge had been too early, but do not appear to have needed readmission or further care

- *She also feels that her mother was not ready to be discharged after her four-day admission and although she raised her concerns at the time regarding discharge, she doesn't feel she was listened to.*

- *I did feel I was sent home too quickly - around 18 hours after c-section, I was still in a lot of pain, they gave me liquid morphine to take home, but I don’t feel I was ready to leave.*

2. The Discharge Process

Around one in three stories shared with us were about the discharge event itself; primarily the speed of discharge and lack of certainty over the time of discharge.

We did hear some positive stories:

- *It was a quick discharge and they managed my expectations by saying I would be home by that evening, and I was.*
- *We had a smooth discharge and kept informed.*
- *Super quick discharge, I was told I was going home only a few hours ago and my partner is here collecting me now.*

However, we heard many negative stories about **slow discharge:**

- *[the lady's] only criticism was related to the discharge process. She was ready to leave after breakfast and morning rounds but due to delays with admin she was not discharged until 12noon.*
- *The discharge was delayed too for no apparent reason.*

We heard that many delays are **caused by waits for medication:**

- *During Sunday morning when his son was visiting him client was told by the ward doctor he would be able to go home that afternoon. The pharmacy had been asked to dispense the medication he would require and as soon as it was ready he would be able to go home…At 3.15 client's daughter received a telephone call from the ward doctor. She apologised and said the pharmacy had been closed for the day so client would not be able to go home until the following day.*
- *At 10am told I could go home and by 2pm I had enough and went to walk out, my lift was there. But medication not ready.*
- *I have been waiting in the discharge lounge for nearly two hours just for my medications so that I can go home.*

We also heard many cases where patients or families are not communicated with, are given **confusing or conflicting information** about discharge timings, or where there are short term changes

- *She was told to phone the ward at around 10 am the next day to confirm whether the discharge was going ahead.*

  She phoned at about 10.30 and having hung on for a long time, was finally answered to be told that no decision had yet been made and that she should call back in an hour.

  She called back at around 11.45. Again, a very long wait for the call to be answered. Again, no decision had been made but she was promised a call back as soon as a decision had been made.
  There was no call back.

  She tried phoning at 1.30. 1.45 and 1.50 - when the call was finally answered. The person who answered promised the client a call back. Again, no call back was received.

  She turned up on the ward at around 2.30 and was then told her mother WAS being discharged, immediately.

- *He received mixed messages from some of the junior doctors about when he might be discharged. He was told on the morning rounds that he might be discharged that day, but this was then overruled by Mr xxx, who wanted to keep a close eye on the infection.*

- *Rarely seen same person so views keep changing on discharge decision.*

It is easy to see disorganised discharge as no more than an inconvenience, but for many people it **does have negative impact on their wellbeing:**

- *It took 6 hours from telling me I was going home. You get emotionally ready to go home, **you arrange collection and then it drags and drags and no one knows why.***

- *The process took all day and **I literally felt awful like 'I was bed blocking'** and felt that the bed needed to be for someone else and I felt guilty and I know it's not my fault.*

- *Client had not actually been told by anyone on the ward he would not be able to go home. **He was very upset by this.***

- *I feel the discharge process could be improved. More information in quicker time to* ***avoid mis-communication and ill feeling*****.**

- *Just trying to get out of hospital was a struggle, and I really missed not being able to just be in my own bed after the birth, just all of us having a cuddle…We had to threaten to walk out in the end – actually get our coats on and stand over them at the desk before they'd discharge us. They told us that we would be discharged in time to pick up our son from school, and that didn't happen – we had no one else to pick him up, and we were just sitting around waiting.* **It was really stressful.**

3. Arrangements for social care following discharge

Arrangements for social care that are initiated while a patient is in hospital are seen as part of the discharge process. We frequently hear stories about problems relating to social care at discharge, and these stories cover a wide range of issues – there is no single problem that is more frequent than others.

We heard of people being discharged (or attempted discharges) with **no assessment** for care needs

- *I was discharged … with no ongoing care assessment or social services needs assessment. My wife, who is 80 and not physically strong enough to give the necessary support, needed help from 2 strangers to get me from the car into the house.*

- *They wanted to discharge him without putting any care in place. I refused to take him home until they had organised Reablement to shower & dress him every morning.*

A small number of people were **prevented from being discharged by** slow or late assessments

- *The process for establishing a care plan for Mother was not good resulting in my mother being in hospital longer than needed. This caused bed- blocking as mother was medically fit to go home but the care was not in place.*

People told us they had been **poorly supported to find nursing homes** for loved ones

- *she was told very bluntly to find a care home for her husband with no advice or support.*

- *They just told me they needed the bed so can you make arrangements to move into a care-home. Given less than a week's notice.*

And that patients had been **discharged to inappropriate care homes**

- *The gentleman's father suffers from Kennedy disease … as no permanent discharge home could be found the Cl's father was discharged to the current home on a discharge to assess situation. This care home is a dementia home and Cl's father has become withdrawn. He has not*

moved from his bed. Cl's mother took in a commode as the care home did not have one for him. They have no equipment to help him.

- *they want to discharge her to Caterham for rehab. The mother lives on the border of Surrey but her family live in Crawley, East Sussex. The family do not want the mother to go to Caterham as it is too far for any of them to visit the mother.*

In summary

The aim of this report is to share what we hear about hospital discharge with providers and commissioners. We are independent listeners and we gather our stories in a wide range of settings: **are we hearing what you are hearing?**

We were not surprised to hear stories about inconvenience and confusion on discharge day. Many patients are unaware of the complexity of implementing discharge (medications, discharge paperwork, transport) and are shocked at the gap between decision and 'release'. Taking the time to set realistic expectations might help reduce the stress of discharge for patients and their families.

More concerning is the number of stories we heard about people leaving hospital without medication, referrals, paperwork or information necessary to keep them safe and well in the community. Our previous work on hospital discharge told us that many people have poor understanding of their healthcare – they don't know what they don't know, and they are dependent on the hospital (or "The NHS") to put in place everything they will need when they leave. We do understand the pressure to discharge patients as soon as it is medically safe to do so but it is concerning if this pressure is resulting in unsafe discharges.