HSC Public Health Agency

HSC Health and Social Care Board

10,000 TEN THOUSAND MORE VOICES

Experience of discharge

Patient, carer and professional perspectives

November 2018

Foreword

I am pleased to present the regional report on the findings in relation to Experience of discharge from hospital. This is one of a number of work streams on the 10,000 More Voices work plan for 2017/2018.

The 10,000 More Voices Initiative is commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to introduce a more person centred approach to shaping the way services are delivered and commissioned. It is based on the principles of Experience Led Co-Design, which have been adapted into a robust and systematic model, through which patients, clients, family members, carers and staff describe their experience of receiving and delivering health and social care in Northern Ireland. This is in line with the processes for co-production as outlined in DoH (2018) “Co Production Guide. Connecting and Realising Value through People”. This guide highlights the importance of partnership with service users, carers and staff to support transformational change.

The Bengoa Expert Panel Report, Systems Not Structures (2016), recognizes the unique skills of people who use services along with the importance for increased emphasis on listening to the experience, taking co-production to ‘a new level’. Similarly, the Ministers 10 year vision for Health and Wellbeing, Delivering Together (2016) outlines the importance of a “new culture of partnership, involvement and listening” within a quality health and social care system. Using the 10,000 More voices methodology is one of the ways in which we can begin to embrace this new culture of partnership and collaborative working by integrating the information we receive into shaping and delivering services for the future. When patients and their families are discharged from hospital we want to ensure that we are providing safe and effective care which is focused on the needs of the individual. I wish to acknowledge and say thank you to the people who took the time to submit their experience through this 10,000 More Voices project. Each individual story is important to the work we do through the 10,000 More Voices Initiative.

Mary Hinds, Director of Nursing and Allied Health Professionals, Public Health Agency

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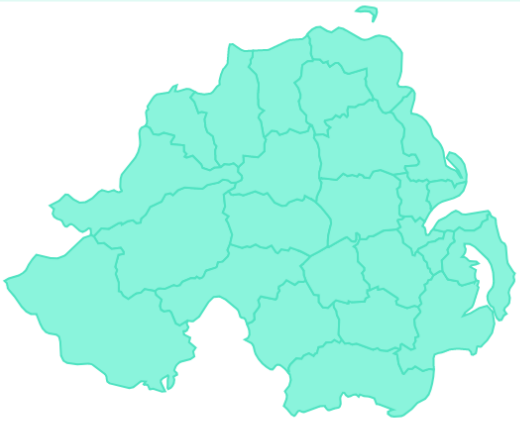
Demographic information



There were 817 stories from patients, family members and carers. There were also 27 professionals shared their experience.

723 respondents were from Northern Ireland. 40 from England, 25 from Republic of Ireland and 8 from Scotland

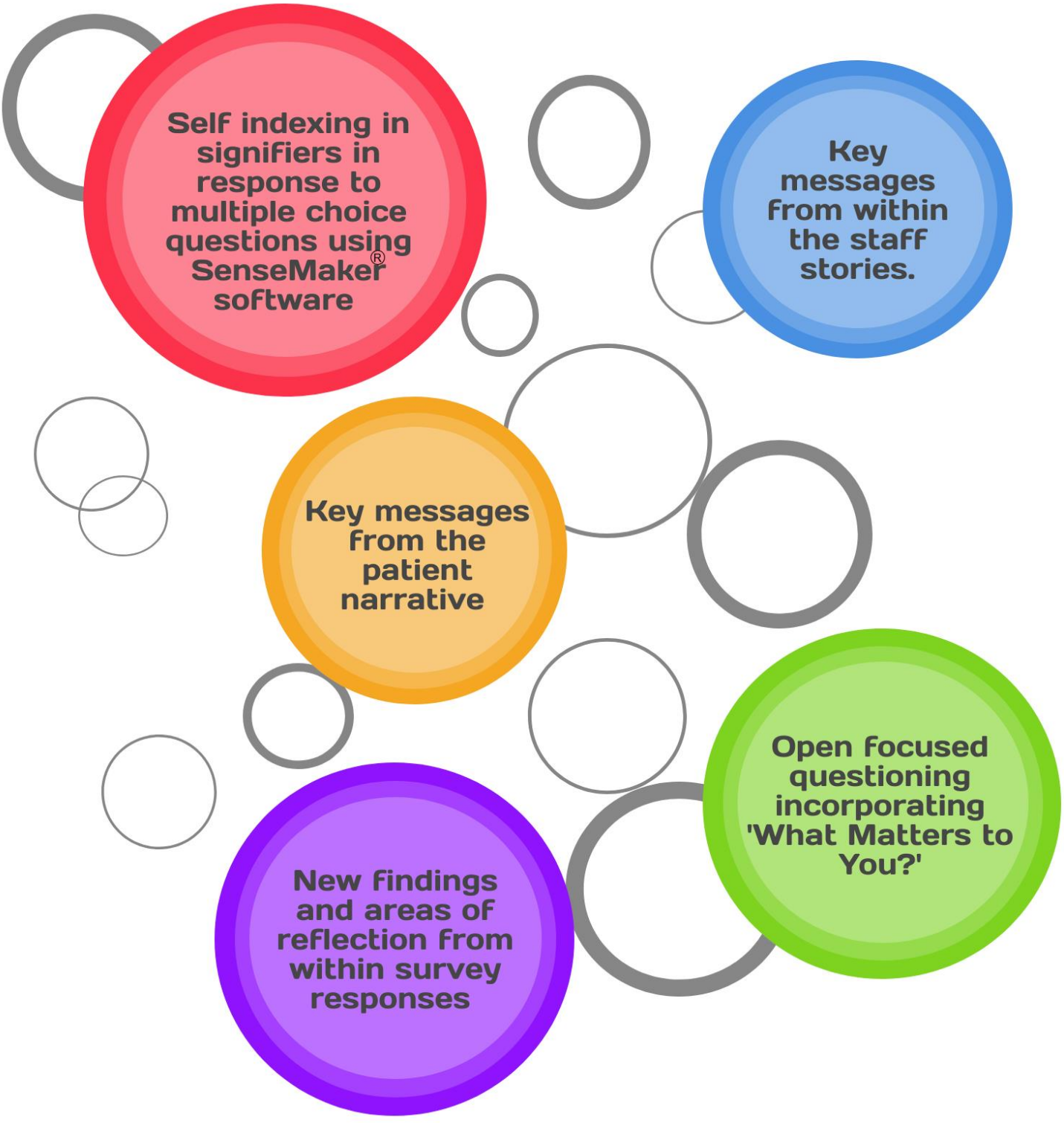
299 people considered themselves to have a disability.

707 respondents said they were heterosexual, 4 were gay, 3 bi-sexual, 1 lesbian and 102 people preferred not to comment

470 respondents were female and 340 were male. 7 people preferred not to comment.

Analysis of surveys

Recommendations highlighted in the report reflect the key messages from the following data sources contained in the surveys



Data findings from patient stories using SenseMaker®*

*Percentages are reflective of cluster responses only and do not account for all responses scattered in the signifiers.

1 Do you feel you were kept informed about your condition?

I was kept up to date regularly	78%
I had to keep asking	6%
I had no idea what was happening	6%

2 Were you kept informed about your progress throughout the time you were in hospital?

Yes I was fully informed	77%
I had difficulty in finding out	5%
Different people told me different things	7%

3 Do you feel that everything that was required for you to return home was communicated and co-ordinated?

It all went very smoothly	78%
It felt haphazard	5%
It felt very rushed	8%

4 How did you know who was looking after your discharge arrangements?

Staff informed me	78%
Staff may have informed me but I forgot	3%
I had no idea	11%

5 How did you feel staff managed your discharge arrangements?

They knew what mattered to me	54%
They involved me in decisions	17%
No one listened to me	6%

6 In relation to your discharge did you find the staff to be....

Approachable	48%
Compassionate	11%
Uncaring	4%

What was said

The following is an example of statements across the spectrum of strongly positive to strongly negative stories by patients and carers.

Attention from staff excellent and caring. Kept me well informed all the way from admission to discharge. Staff were excellent

My discharge was rushed out. I was given less than 10 minutes before being taken from my bed, put in a chair and sent to the discharge lounge without my notes or drugs chart.

I would have liked another day in hospital. I didn't feel quite ready. I felt rushed. I felt pushed out.

Quick discharge. Smooth and straightforward.

I was really quite surprised by how well my discharge was handled. I was told 3 days in advance when I was going home. To say I was doubtful is an understatement but everything happened exactly as they said it would.

There is a lovely atmosphere. They have done a great job with me and made me a new woman. They checked everything to make sure I can manage the stairs and at home and explained all about my painkillers and the do's and don'ts.

What Matters to You? Key Themes

When asked the open question "What matters to you?" the following key themes were identified.

Staff Stories Key messages

Available transport dedicated to discharge

Early planning with multidisciplinary team

Prioritise discharge letters and scripts during consultant ward rounds

Central discharge team/lounge focused on discharge process - to include a pharmacist and a doctor

Enhance working hours of OT, SW, Physio and Pharmacy to support discharge (inc evenings and weekends)

Contemporary updates on discharge plan with the nursing team

Available outpatient appointments to accelerate discharge.

More efficient process to discharge to a nursing home or residential home - a regional approach required

Written information to patient and families on expected discharge plans and sign post contacts on discharge.

Recommendations

1

Review of the discharge process with the multidisciplinary team to identify efficiencies and ensure safe and effective discharge plan. This includes working in partnership with the patient and carers in preparation for discharge.

2

Review of the resource for preparation for discharge to include written advice leaflets for patients and carers and contact details to support patients and carers post discharge. This also involves written advice on ongoing care and treatment plans

3

Application of Patient Client Experience standards - respect, attitude, behavior, communication, privacy and dignity should be evident throughout the patient journey including the discharge process.

1.0 Introduction

The 10,000 MORE Voices Initiative has been commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to provide a more person centred approach to improving and influencing experience of health and social care services. The initiative is integrated into the patient and client focus element of Quality 2020 (DoH) which states that all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

To date a number of work streams have been progressed across a range of service areas. It was agreed by the regional Patient and Client Experience steering group that capturing the experience of people in relation to discharge from hospital would commence as part of the 2016/2017 regional work plan and would be carried forward into the 2017/2018 work plan.

This report presents the findings received from patients/relatives/carers/staff in relation to their experience of discharge from hospital from 1st July 2017 – 28th February 2018. In total 817 stories were received from patients/family members/carers during this period. Appendix 3 demonstrates response by trust.

10,000 More Voices is underpinned by the principles of Experience Led Co-Design, of which partnership working between those who use and deliver healthcare services is a key element. Staff members were also encouraged to submit their stories in relation to providing care for patients when they are being discharged from hospital; 27 stories were received from staff.

2.0 Background and Context

Discharge from hospital has become a topic of interest and discussion over recent years and now widely recognised as a ‘process within the patients journey and not an isolated event’ (DoH 2003).

For the majority of patients discharge planning is relatively straight forward, however for other patients their needs will be more complex and therefore should involve the development and implementation of a plan to facilitate the transfer from hospital to an appropriate setting. Good communication is a prerequisite for ensuring this well-coordinated patient journey from admission through to discharge (RQIA 2014)**.**

Communication is also the basis for a successful patient-centred approach, which recognises the important contribution which can be made by both patients and carers. In the past, carers have reported that they often feel powerless, anxious and insignificant. They wish to have consistent information delivered in an honest and sympathetic way, which gives them confidence in the system, and allows a degree of control over what is happening.

Each individual patient and their carer(s) should be involved at all stages, and kept fully informed by regular reviews and updates of the care plan. Carers and Discharge – a carers’ guide to hospital discharge (DHSSPSNI 2010) states that: ‘when patients leave hospital without appropriate plans being put in place, there is a real risk that this could result in re-admission to hospital. It is important that you feel prepared for the patient returning home and that plans include information about how you will be supported once the patient leaves hospital or intermediate care.

The vision in Health & Social Care Northern Ireland is that everyone should be empowered to live longer, healthier lives at home or in a homely setting (HSC, 2018). The aim is that, regardless of the setting, care will be provided to the highest standards of safety and quality, that the individual is at the centre of all decisions and ensuring compliance with the values and standards of a good patient and service experience. These are outlined in Patient Client Experience standards as respect, attitude, behaviour, communication, privacy &dignity (HSC, 2016).

A key element in taking forward the findings of these reports and to contribute to achieving the vision for Health and Social Care is to capture the views and experiences of families who have been involved in the Discharge from Hospital process.

3.0 The overall aim and objectives of this project were as follows:

Overall Aim: The overall aim of this project was to improve the experience of service users in relation to the discharge process from hospitals

Objectives:

1. Develop a qualitative survey tool using Sensemaker® Methodology in collaboration with key stakeholders
2. To establish a baseline assessment of experience in relation to hospital discharge
3. To identify recurring themes from personal experience accounts to assist in the improvement of services

4.0 Methodology

The experience of discharge from hospital survey, which uses Sensemaker® methodology, was designed with public engagement through a stakeholder workshop at which staff and service users participated and co-designed the survey tool. A pilot was conducted across all Trusts during December 2016 and January 2017. In total 49 surveys were received during this period. Following the analysis of the pilot and adaptation of the survey tool it was agreed that implementation and story collection would commence in July 2017 across the region.

Respondents are asked not to give their name or the name of any staff who provided their care, they are advised not to worry about spelling or grammar and to write as much or as little as they wish.

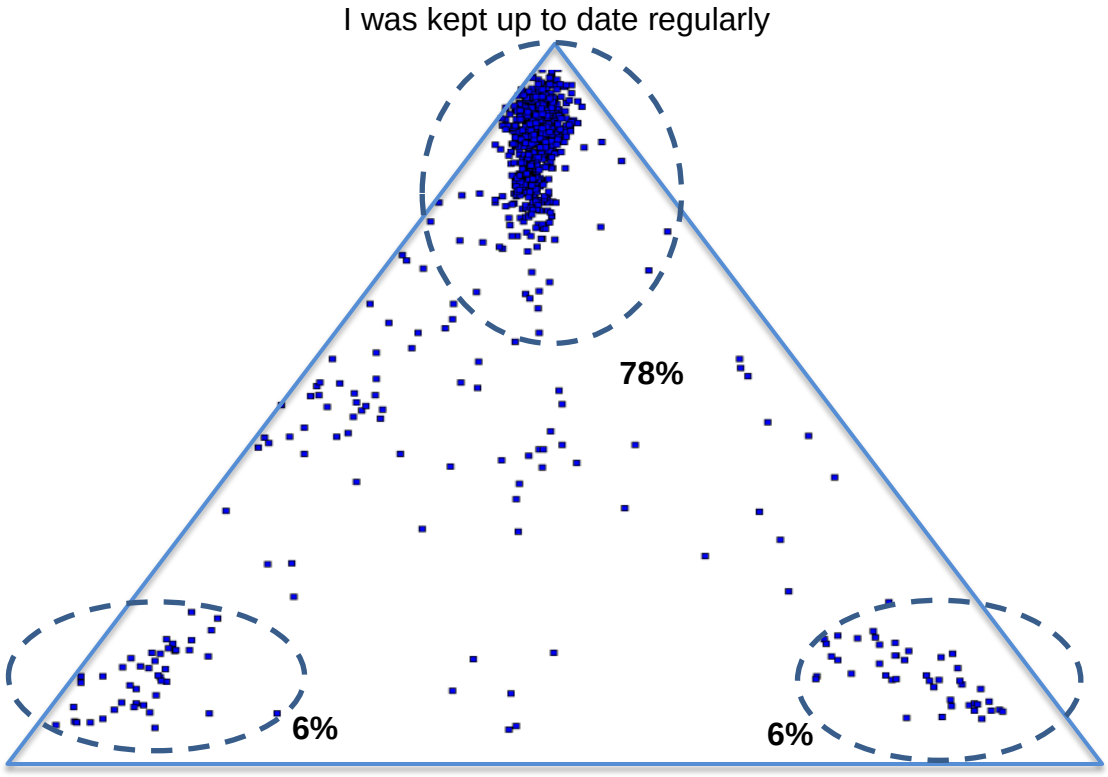
The project was promoted widely through regional and local engagement plans, which included HSCTs as well as through social media. In keeping with the agreed governance processes for the 10,000 More Voices Initiative, the stories were read on a weekly basis by the 10,000 Voices team and shared with the Regional Discharge Group for information.

Those completing the survey are asked to tell us about their experience of and receiving care in relation to discharge from hospital. The survey can be completed by the patient or someone acting on their behalf and they can choose to share all or part of their experience. The survey begins with asking the respondant to share their story as a narrative. Each respondant ia also asked a series of questions, known as signifiers, with defined responses which are presented in a triangle format. In each of these questions, the respondent reviews 3 defined responses and places their “dot” nearest to the statement that reflects their experience. In some cases their choice may be between choices, indicating that their response is a combination of two factors. If all three factors apply equally to their story, they would place their “dot” in the centre of the triangle**.**

5.0 Responses to Signifiers

Responses to the signifier questions are demonstrated in the following diagrams. It should be noted that the percentages are noted for the cluster responses only and do not account for the other responses scattered throughout the triangle. When conducting the analysis stage all stories are also reviewed and some extracts shared

Question 1: Do you feel you were kept informed about your condition?



Discussion/interpretation:

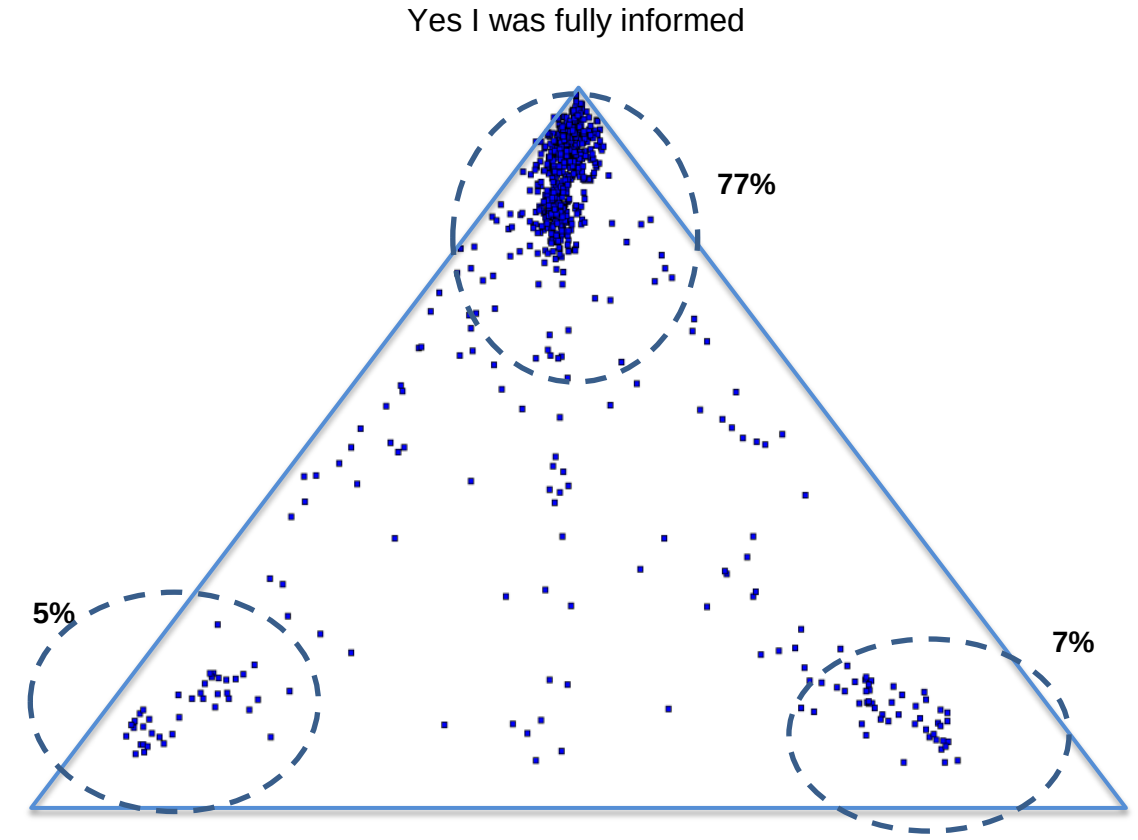
In total there were 792 responses to this questions, meaning that 96% of people responded. The majority of stories (**78%**) were indexed towards the top of this signifier indicating that on the whole most people were kept up to date regularly about their condition. In **6%** of cases respondents had no idea what was happening and a further **6%** had to keep asking staff about their condition.

Extracts from stories:

I finally had an information leaflet posted out to me the day before the operation, when I phoned up looking for information. It would have been useful to have some idea of post-op requirements before I went in.

I was kept informed about my condition at all times and all my questions were fully answered. I could not fault my experience from start to finish neither could I praise the staff highly enough. This was not the health service we hear so much criticism about.

Question 2: Were you kept informed about your progress throughout the time you were in hospital?



Discussion/Interpretation:

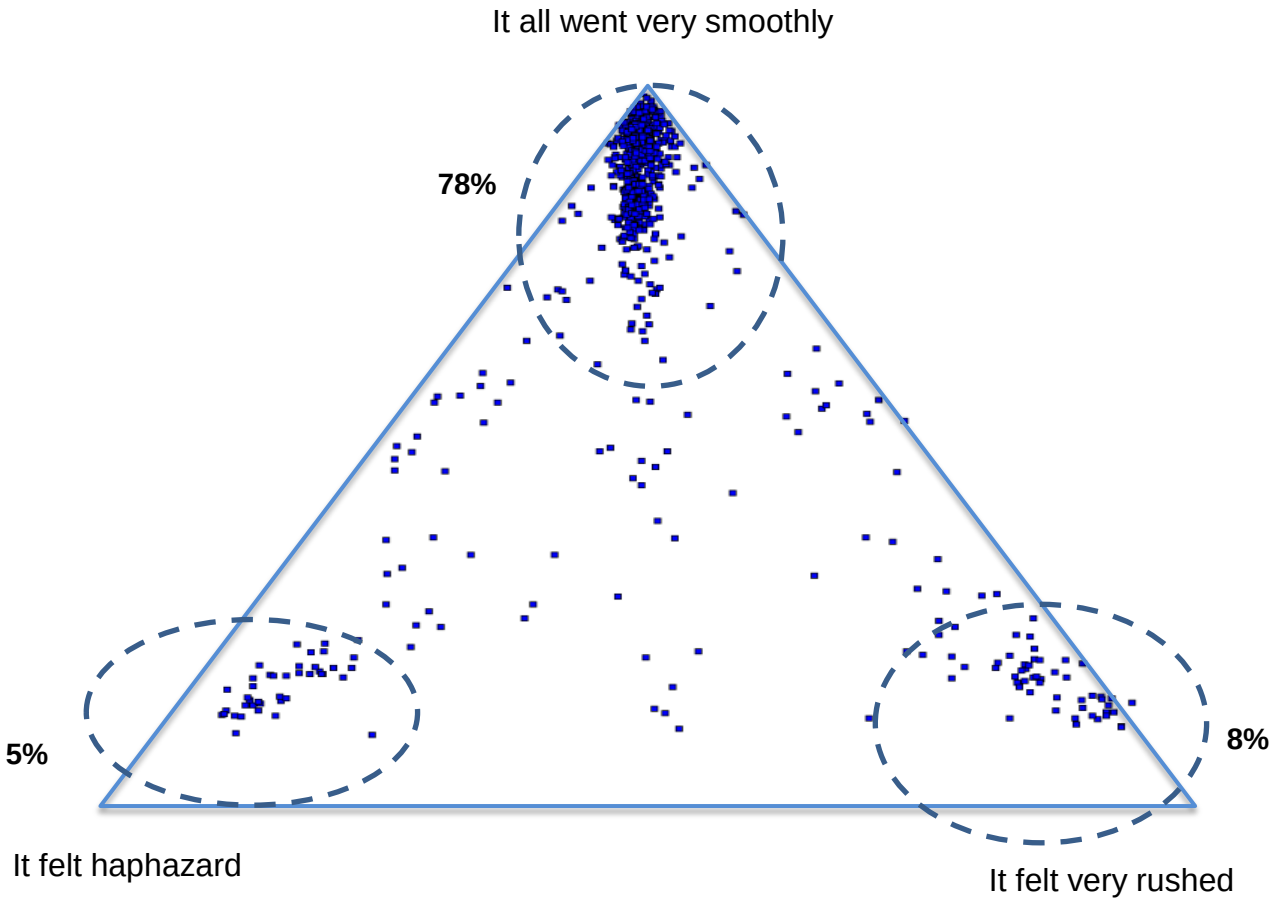
In total there were 795 responses to this question, meaning that 97% people responded. The majority of responses were indexed towards the top of the signifier indicating that 77% of people were kept fully informed about their progress throughout their time in hospital. For others (7%) their experience indicated that different people told them different things and in 5% of cases patients had difficulty in finding out about their progress.

Extracts from stories

I am profoundly deaf and use BSL (sign language) and lip reading I was never asked by staff if I wanted an interpreter. However, one of the nursing staff was learning sign language and this helped me a little.

He was treated for pneumonia on his left lung by IV injections and we were kept informed at all times of his condition and treatment. When he was discharged we were given all the help we needed. All staff from the wee man who brought round the milk and juice through to the cleaner, auxiliary staff to the nurses, doctors, pharmacists and occupational therapists were first class.

Question 3: Do you feel that everything that was required for you to return home was communicated and co-ordinated?



Discussion and interpretation:

In total there were 766 responses to this signifier, meaning that 94% of people responded. Most of the responses (78%) are indexed towards the top of the signifier indicating that for these people everything that was required for them to return home was communicated and co-ordinated smoothly. In 8% of cases people felt that the communication of what was required was rushed and for 5% of people they felt that is was haphazard.

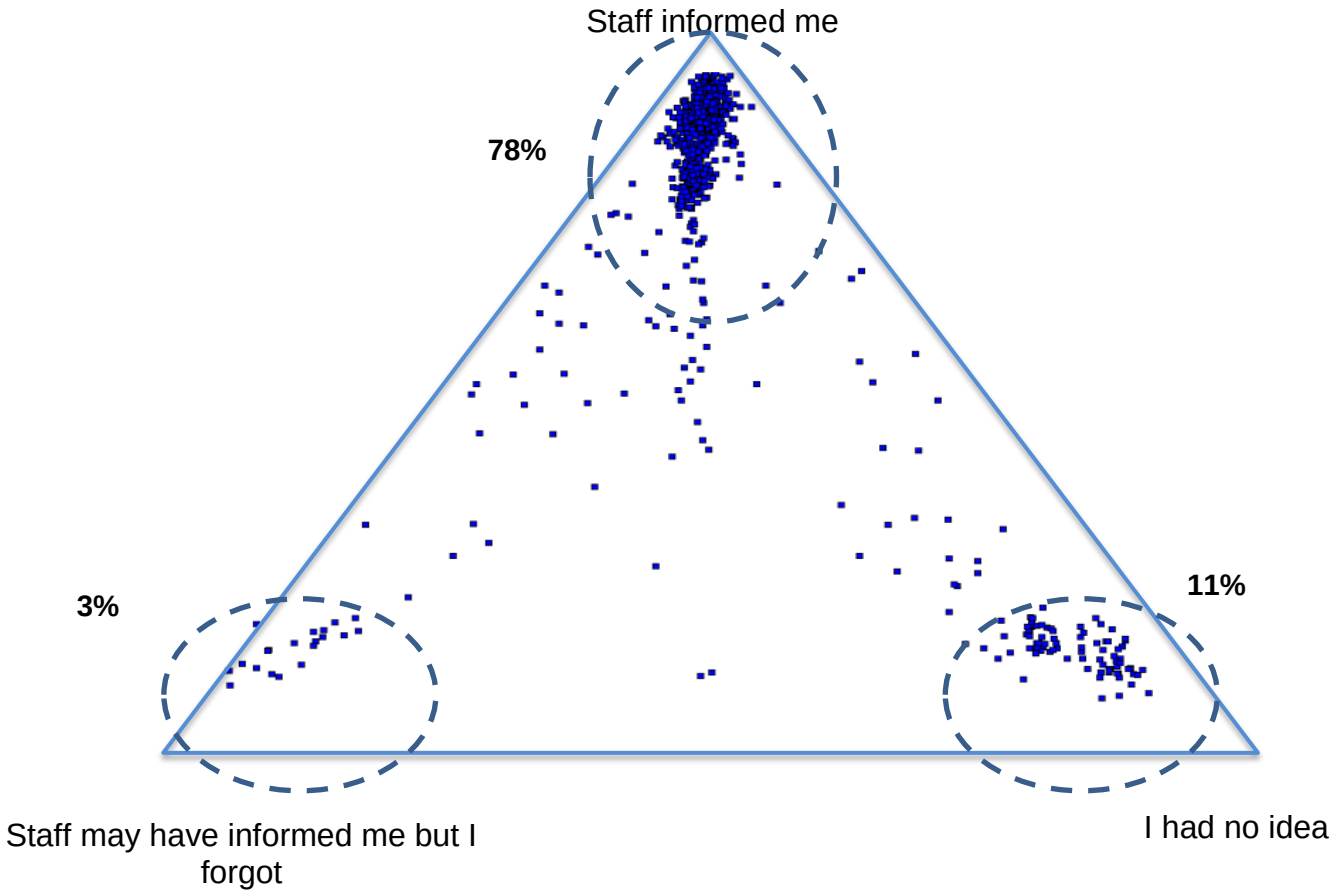
Extracts from stories

I feel I wasn't given adequate information about after care

Kept me well informed all the way from admission to discharge

The discharge from there wasn't good. I was too young for a care package. I went home with no care. I managed with help from my family. I was just told that day I was going home. I wasn't even examined by a Dr. I had asked to see a Dr and didn't get to see anyone. It was very rushed and I was discharged with no communication.

Question 4: How did you know who was looking after your discharge arrangements?



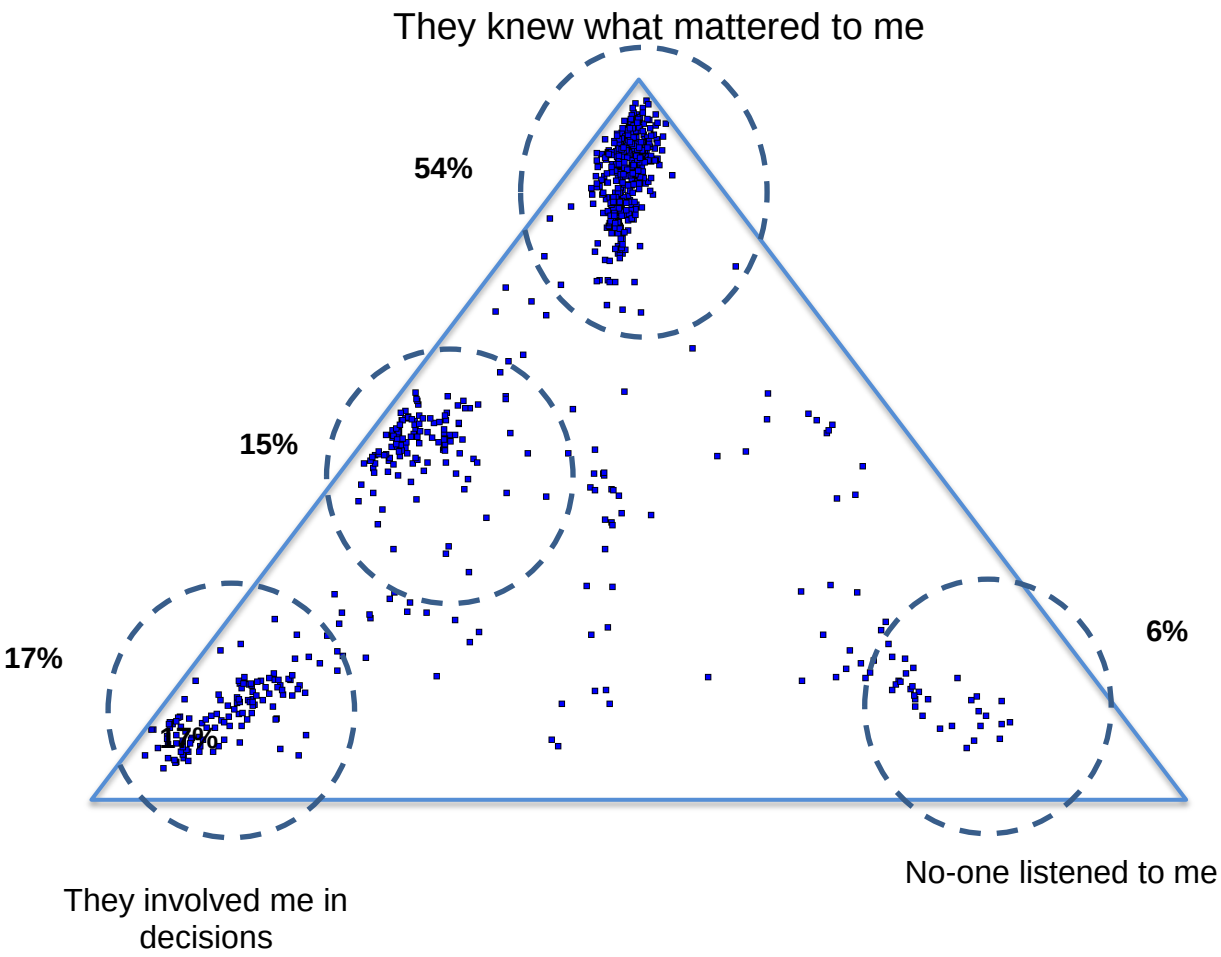
Discussion and interpretation:

In total there were 755 responses to this signifier, meaning that 92% of people responded. Most of the responses (78%) are indexed towards the top of the signifier indicating that these people knew who was looking after their discharge arrangements. In 11% of cases, these people had no idea who was looking after their discharge arrangements and 3% of people stated that staff may have informed them but they forgot.

Then a diabetic nurse came to see me. She asked a lot of questions about my diet etc. I think she wanted to make a plan for when I was discharged. She saw me again and gave me a lot of information. Then I was discharged. I think I have to see my GP. The staff in the discharge lounge went over more information with me before I left

Discharged after 14 hours in a ward with little or no information, had to walk quite a way to car and sent home with no pain relief whatsoever

Question 5: How did you feel staff managed your discharge arrangements?



Discussion and interpretation:

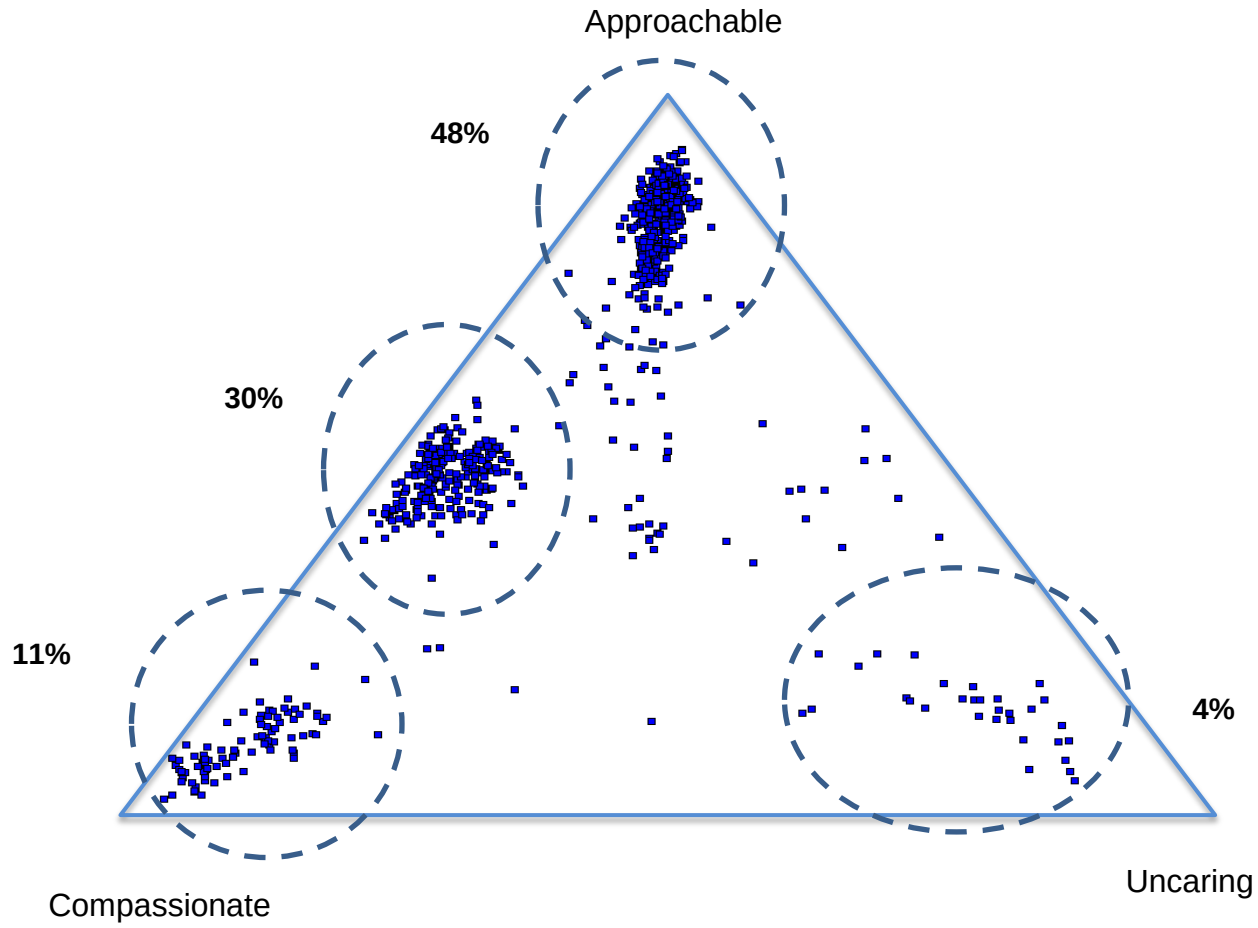
In total there were 768 responses to this signifier, meaning that 94% of people responded. Most of the responses (86%) are indexed towards the left side of the signifier indicating that these people indicated that staff knew what mattered to them and /or involved them in decisions. In 6% of cases people felt that no-one listened to them.

Upon discharge everything ran smoothly for my transfer back home and the care of the multi – disciplinary team within the community was second to none. I can't thank you all enough

Felt pushed out of hospital

The OT prepared my home with equipment to aid my recovery, I have had assistance from OT physio and nurses at home, and I am making good progress

Question 6: In relation to your discharge did you find the staff to be?



Discussion and interpretation:

In total there were 776 responses to this signifier, meaning that 95% of people responded. 89% of the responses are indexed towards the left side of the signifier indicating that these people found staff to be both approachable and/or compassionate. 4% of people stated that staff were uncaring.

I was just told that day I was going home

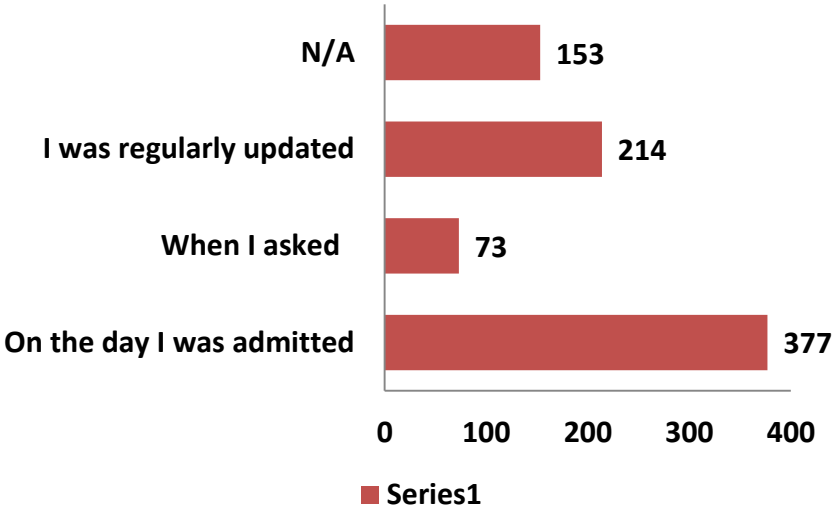
I have been totally overwhelmed by the care and attention I received in here

They listened to me and that meant a lot. Everything that has happened while I've been in here has been explained really well.

6.0 Responses to the Multiple Choice Questions

Respondants were also asked a number of multiple choice questions as illustrated below

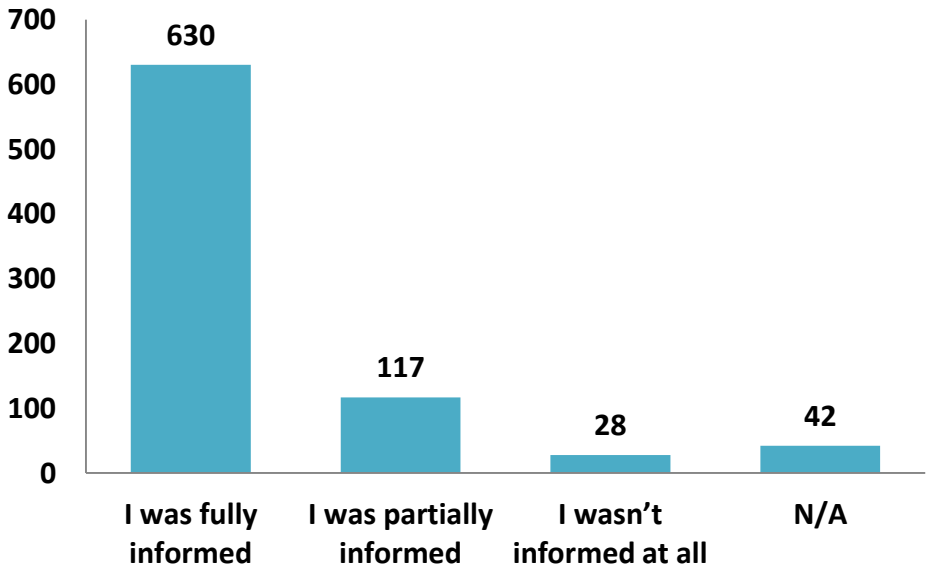
Question 7: When did you find out about your condition?



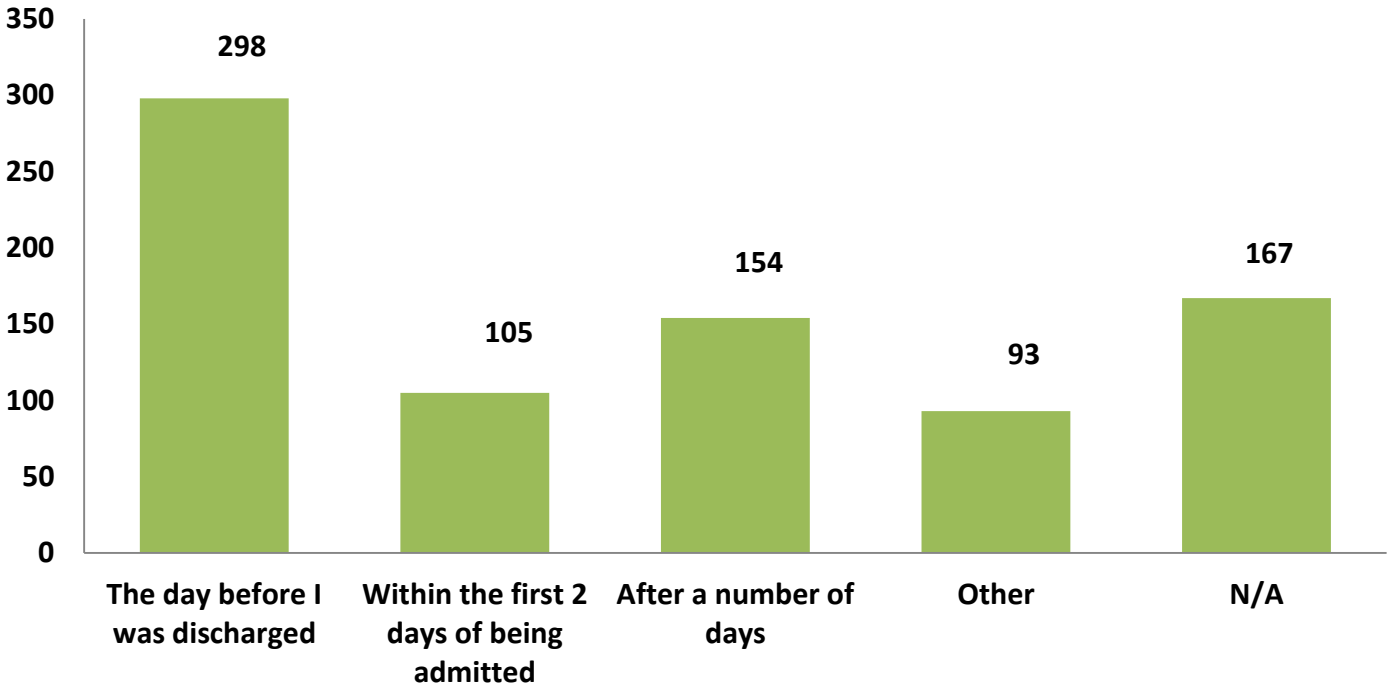
I was kept informed about my condition at all times and all my questions were fully answered. I could not fault my experience from start to finish neither could I praise the staff highly enough.

Question 8: Do you feel you were well enough informed regarding the investigations and proposed treatment(s) to make you better?

They started to do investigations and found out that the cancer was back. The doctors passed on my information but nothing was done

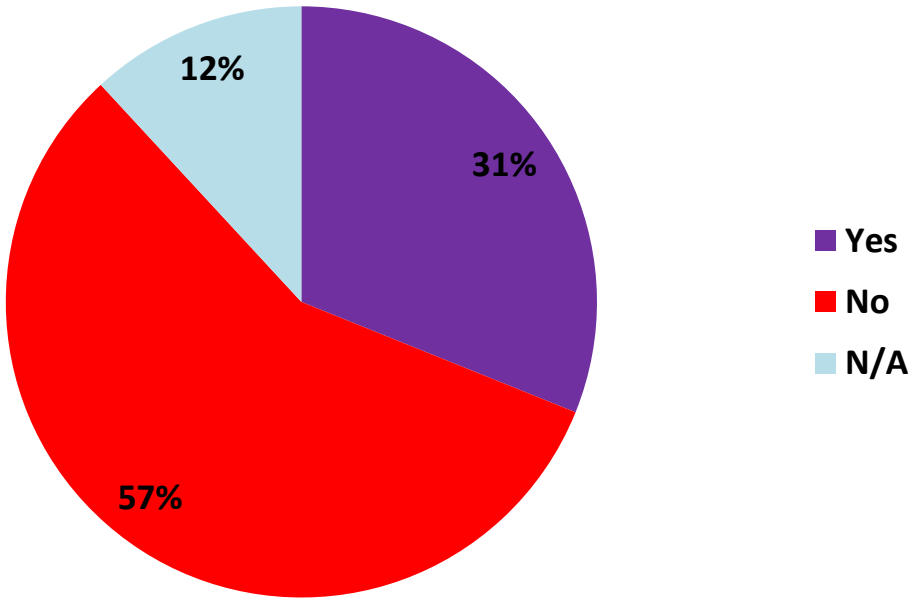


Question 9: When did the planning start for you to return home, such as assessments to determine if you/carer needed anything to support you to safely return to your home?



*(*it is recognised a number of trusts have implemented rapid response processes to ensure quick discharge following assessments and may have contributed to the high number of patinets discharged within 24hours of assessment; this has not been indicated in the survey)*

Question 10: Were you moved to another area (such as a discharge lounge) or "seated out" on the day you were to be discharged?



Comments in relation to being moved to discharge lounge or "seated out"

31% people were asked to move to a discharge lounge on the day of their discharge. Overall the experience for people in the discharge lounge appeared to be a positive one, with many stating that staff were helpful, kind, explained what was happening and food and drinks were provided. However some felt that the area was cramped and also highlighted that they had to wait for discharge letter and medications. Some of the comments are as follows:

I didn't know there was a discharge lounge staff told me today. It's actually very nice relaxed and comfortable. Tea & coffee available. Waiting on tablets, area would be better if it had a TV.

Very welcoming. Offered lunch a reclining chair most important a mug of tea as I love having a cup of tea…. very nice staff.

I was sat out I was told my letter wouldn't be long I was told my drugs were ready. None of this was true although not the staffs fault.

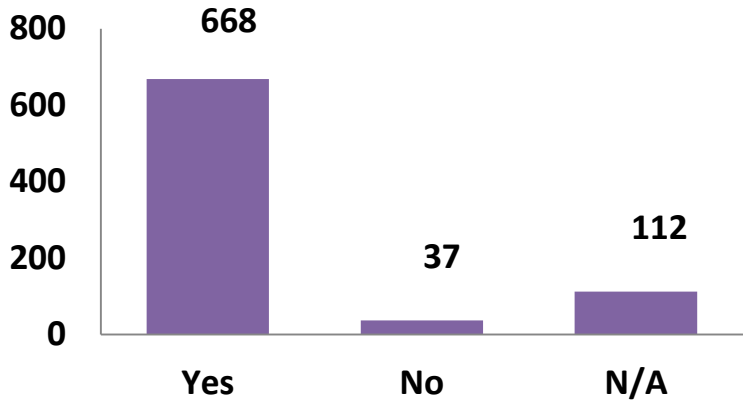
Moved to discharge lounge where there was no seats full of boxes and deliveries

Discharge lounge - Rubbish Too crowded not enough

There weren't enough staff to keep everybody informed. They were too busy.

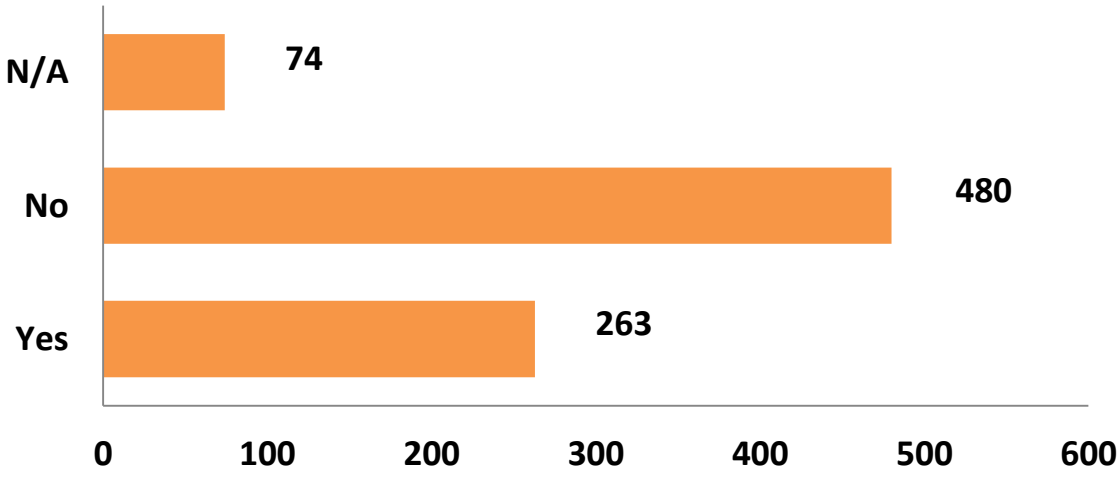
The staff in the discharge lounge were so warm & friendly. They made me a warm cup of tea and got me comfortable. They made contact with my son on my behalf and arranged at a time suitable. Staff asked me about my pain and if I needed any pain relief they could help with that. I was informed of communication made with my son.

Question 11: Were you given sufficient information about your medicines on discharge?

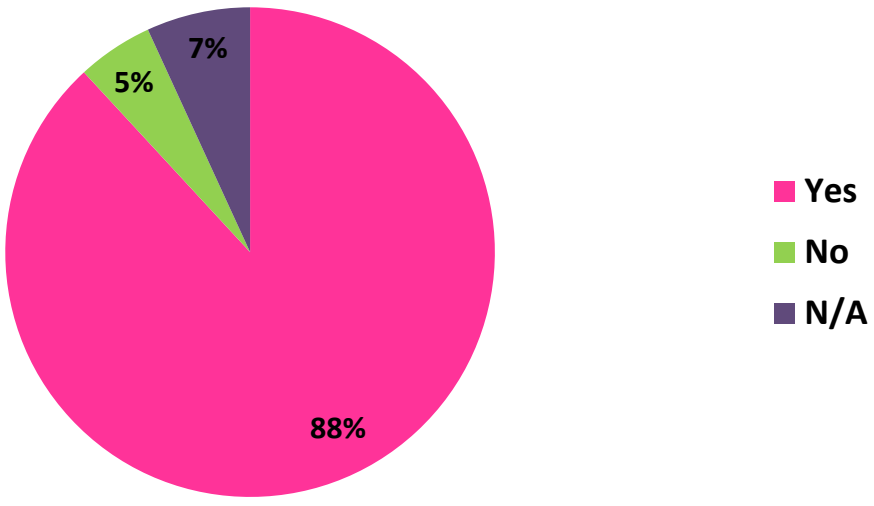


Pharmacist - went through all the medication for home with advice how to take

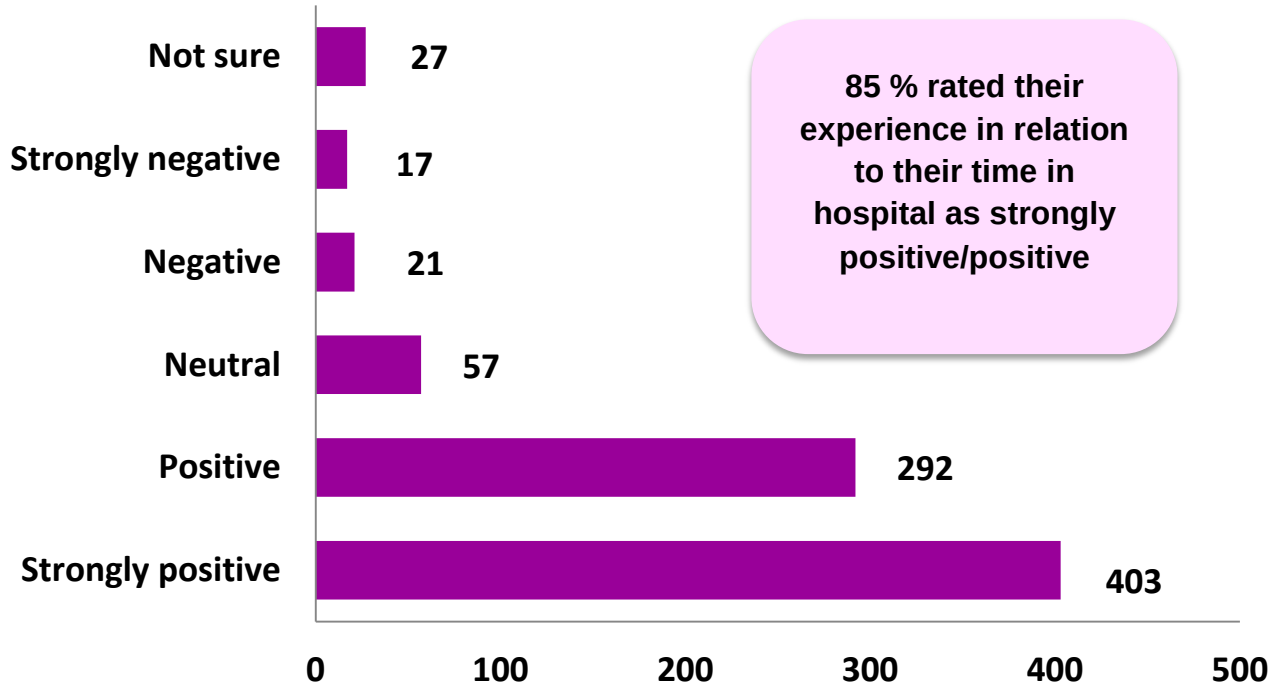
Question 12: Was this a booked admission for planned operation/procedure/tests?



Would you recommend for a friend or family friend to receive treatment and care in this facility?



Overall how would you rate your experience of your time in hospital?



85 % rated their experience in relation to their time in hospital as strongly positive/positive

I have had excellent advice from dietician, social worker, & nursing staff. I asked a lot of questions in the early stages, of the consultant & got clear & honest answers

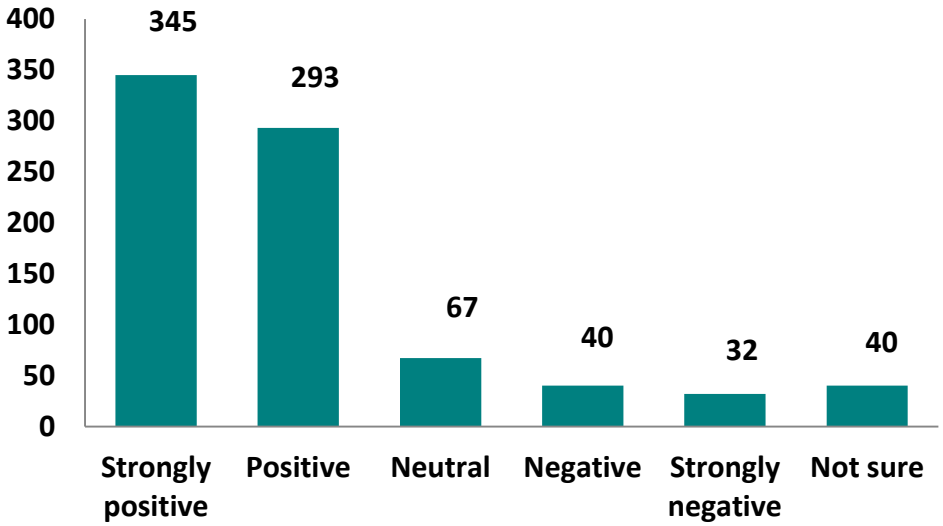
I was treated really well. I liked your own room, it was great but I was isolating but I think it's good because if your immune system is low it's better to be in a side ward and you can get a good night's sleep. Staff are all brilliant, do a great job. The open visiting was great especially for family who work

After my week I find myself stronger mentally and physically. My friends have remarked on me looking better and more relaxed. The physiotherapy was very helpful and gave me excellent advice to keep my body in control. The dentist was very very good, I never get to my local dentist of then due to my MS and being a wheelchair user, I am thankful for the treatment and advice in hospital. I would like to say that all staff seem to know my needs even up to discharge where they kindly packed my bags and helped me to my car. Please keep up the good work. Thanks from my wife and I. My wife had a verv restful week

No nurse came near me to introduce themselves, or give me any advice on what to expect with regard to treatment or care

Overall how would you rate your experience <u>in relation to the planning and support</u> for your discharge?

78% rated their experience in relation to the planning and support for their discharge as strongly positive/positive



I suggested that we call back that evening and collect her discharge letters which appeared to be the delaying factor and I was advised that that was not possible. Indeed it was against hospital policy and I would be going against medical advice! I eventually was allowed to take my mum home after some time and the nurse seeking permission from the medical team. We later collected mums discharge letters. This wasn't a quality experience

I had no idea it would take so long as nobody spoke to me about recovery at any stage.

I am being discharged today knowing how to take my medication and feeling confident, to go home

I got the best of care, food everything was excellent. Issue with waiting for the tablets, they told me this morning I could get home but waiting on the medications. Everything went well, all tests and treatment, staff were lovely.

There was no referral made to district nursing or community physiotherapy a referral was made to a technician within occupational therapy (who was very helpful). ……..required a hospital bed with the ripple mattress, safety side bars and monkey pole, a recliner chair, a sara steady and a wheelchair commode. This should have all have been in place prior to discharge. The stress of having to get all this sorted was terrible and very frustrating various pieces of equipment were being delivered at different times.

7.0 Key messages in the patient stories

It is reassuring to note that for the majority of people who shared their story, their experience in relation to discharge has been a positive one. The stories provide a rich source of information and help us to identify “what matters” to people in their experience, as well as identifying areas for learning and reflection. It was interesting to note that in sharing experience of discharge process, many people shared other aspects of the hospital journey from their admission, which also provides some very useful insights from the patient perspective.

What matters…….. to patients/ families and carers in their experience of discharge from hospital

- Being treated by staff who are respectful, caring and compassionate
- Having good explanations and information about their condition, treatment, care and being kept up to date with their progress and what is happening during their hospital stay
- Having consistent information about care, treatment and plans for discharge
- Feeling involved and supported in decisions about the plan for their discharge
- Having a good plan in place for discharge, which includes the following:
    - Care package in place prior to discharge if required
    - Explanations about medications
    - Advice on discharge
    - Discharge arrangements for day of discharge
    - Advice on after care and who to contact for follow up

Around 10% of people stated they had a significant wait for discharge letter and/or medications on the day of discharge

8.0 Key messages in the staff stories

In total 27 stories were received from a range of staff including, medical, nursing, occupational therapists and social workers. These stories highlight important messages from a staff perspective, some of which are closely aligned to the messages from the patient stories. These messages include the following:

- The importance of commencing discharge planning at an earlier stage and as soon as possible following admission, this includes assessments by the multi-disciplinary team and social work team
- Having increased input from pharmacists as well as increased pharmacy opening hours
- Having more availability of occupational therapists
- Access to members of multi-disciplinary team at weekends
- Reviewing how discharge lounges could be used more effectively

Extracts from the staff stories:

We need more staff.

I am an occupational therapist. I have worked in the hospital for 10 years and have seen significant changes in discharge planning in this period. In order to ensure a positive experience for patient I seek to assess patients as timely and comprehensively as possible. Challenges to this include, lack of understanding of some staff of OT role, busy case load, on occasions medical staff ignore concerns raised such as acute cognitive changes resulting in frequent re-admissions. Overall however I feel hospital staff communicate well in order to ensure each patient has a positive experience during hospital admission and post discharge support is sufficient. I listen to patients in order to achieve patient centred care.

The pressure for complex discharges and the paperwork and the organisation of outside sources is stressful as well as time consuming

We need more occupational therapists

I aim to improve high quality of service and ensure safe discharge planning for each patient. The challenges OTs face in relation to discharge are, lack of packages available, delays waiting on equipment e.g. hospital bed, shortage of OT staff to assess patients for discharge

The most of patients are happy when you inform them about discharge day and almost all disappointed when they have to wait a long time for discharge letter and medicine for home.

Provide good communication to client and family, be emphatic towards all. Show compassion to all. Be prompt in all actions including discharge. Face challenges from getting discharge letters written and patients waiting for take home medications. I know what is important, consulting with clients and family, listening to their concerns and pointing them in the right direction.

Challenges of outlying on wards.

I work on a ward that has a speciality. This includes pre and post op care and also pregnancy conditions under 24 weeks gestation, this includes pregnancy loss. At present the ward has a large intake of medical patients. I try to ensure I can give patients the attention and care of a high standard at all times and try to ensure prompt and effective discharge. The challenges I face with this are that medical staff do not commence a ward round until sometimes late in the afternoon, this can result in delayed scripts for patients and late evening discharges. It sometimes is difficult to get medical doctors to the ward as they have commitments to other patients across the hospital. I know what is important to my patients as I communicate with both them and family on every shift.

9.0 Areas for reflection/learning/action

- Ensure that communication about discharge is commenced in a timely manner - as soon as appropriate following admission so that adequate time is allowed for patients and their families to make the necessary preparations
- Discharge plan which is well communicated, smooth, with no unnecessary delays and does not make the patient feel they were rushed out
- Care package in place in preparation for discharge
- Preparation for day of discharge: discharge letter and tablets and transport well-co-ordinated
- Avoiding long waits on the day of discharge for letter/tablets
- Provide advice on discharge in relation to after care, to avoid the possibility of readmission
- Access to pharmacy and OT in preparation to discharge.

Additional areas for reflection and learning.

Although not part of the main objectives of the Discharge project the following key messages were evident in the patient stories and are highlighted for further reflection.

- **Being moved to another ward/wards** during hospital stay, can result in inconsistency in care
- **Feeling that discharged too soon** can sometimes result in readmission
- **Single rooms**: mixed views/ sometimes feel isolated

10.0 Recommendations

Due to the variation in services within each Trust, individual Trust actions plans are to be formulated in relation to discharge to support change specific to the Trust. The following recommendations are regional recommendations which should support and be integrated into the Trust action plans to ensure the key messages from patients, carers and staff inform service improvement and transformational change.

1- Review of the discharge process with multidisciplinary teams to identify efficiencies and ensure safe and effective discharge planning. This includes working in partnership with patient and carers in preparation for discharge.

Review of the resource for preparation for discharge to include written advice for example leaflets for patients and carers and [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

2- contact details to support patient and carers post discharge. This also involves written advice on ongoing care and treatment plans
3- Patient Client Experience standards – Respect, Attitude, Behaviour, Communication and Privacy & Dignity should be evident throughout the patient journey including the discharge process.

To engage the Trusts in the delivery of each action plan a follow up workshop will be hosted by PHA and supported by the Unscheduled Care User Group in August 2019.

References

DHSSPSNI (2010) Carers & Discharge – carers guide to hospital discharge. Department of Health, Social Services and Public Safety

DHSSPSNI (2016) Delivering Together Health and Wellbeing 2016 - 2026: Department of Health, Social Services and Public Safety

DoH (2003) Discharge from Hospital Pathway, Process & Practice. Department of Health

DoH (2016) Systems not Structures: Changing Health and Social Care. Department of Health.

DoH (2018) Co-production Guide. Connecting and Realising Value through People.

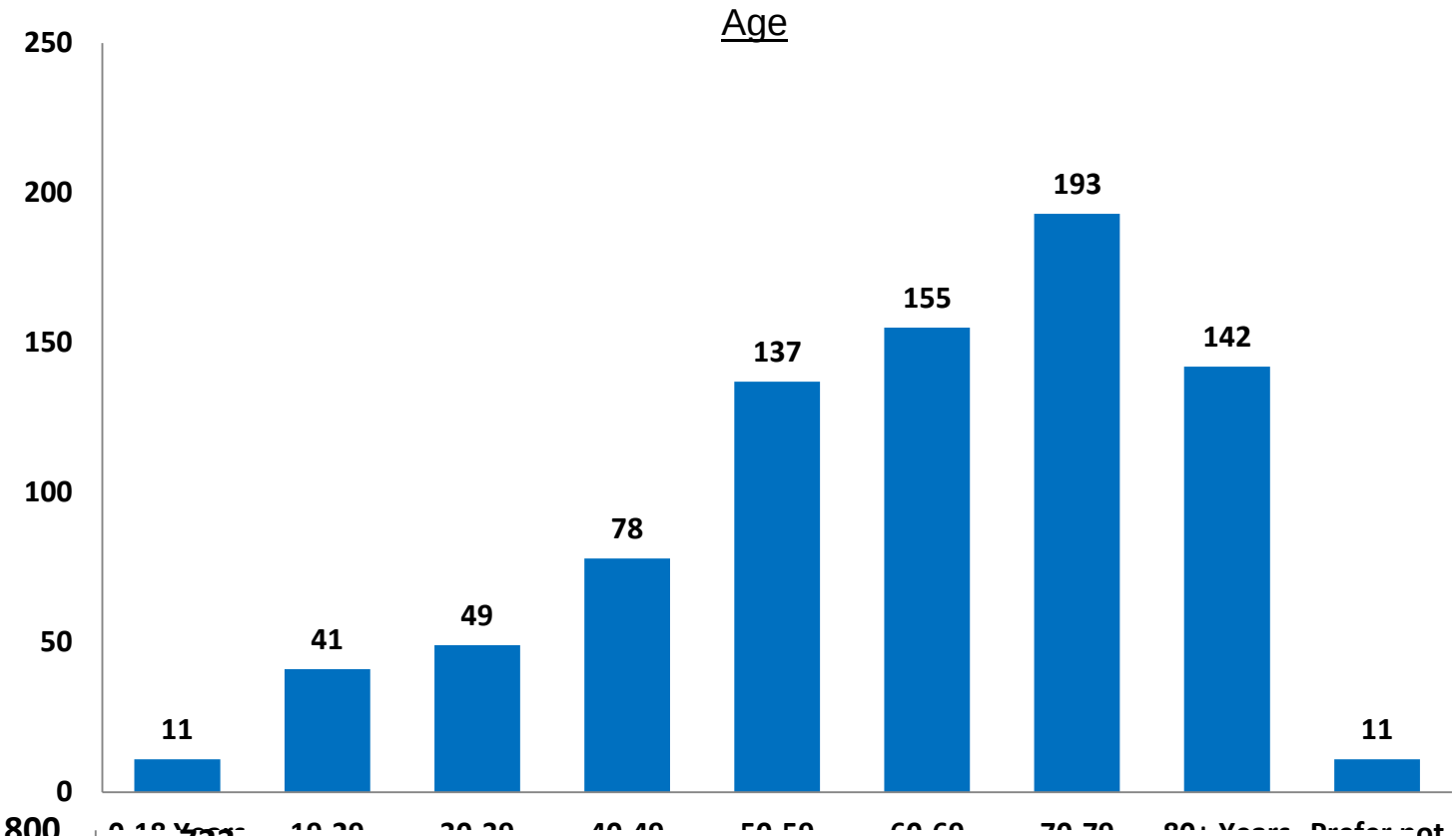
HSC (2018) Getting patients on the Right Road for Discharge Guiding Principles (draft) Health and Social Care Health & Social Care

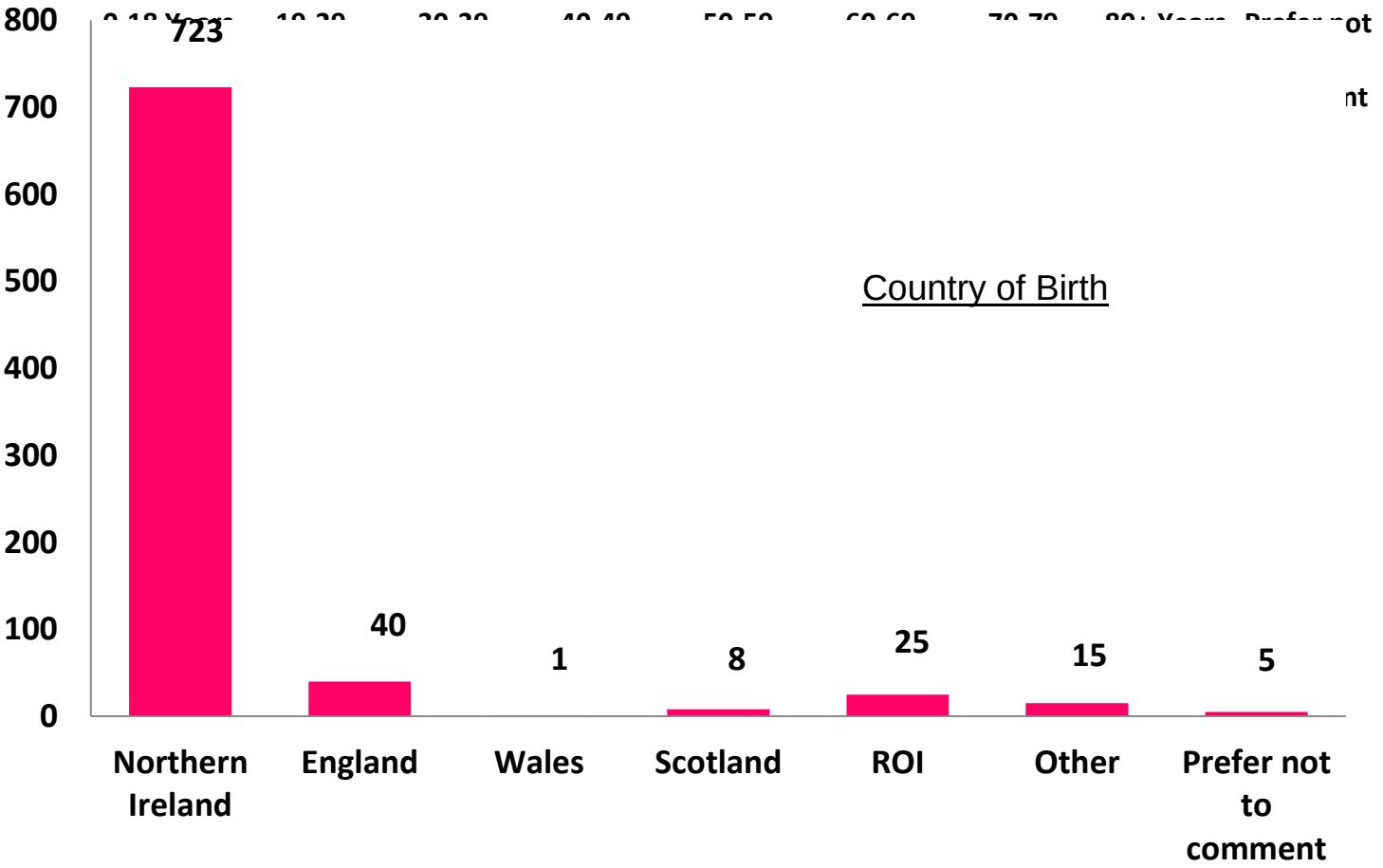
Quality 2020: A 10 year strategy to protect and improve quality in health and social care in Northern Ireland Department of Health, Social Services and Public Safety

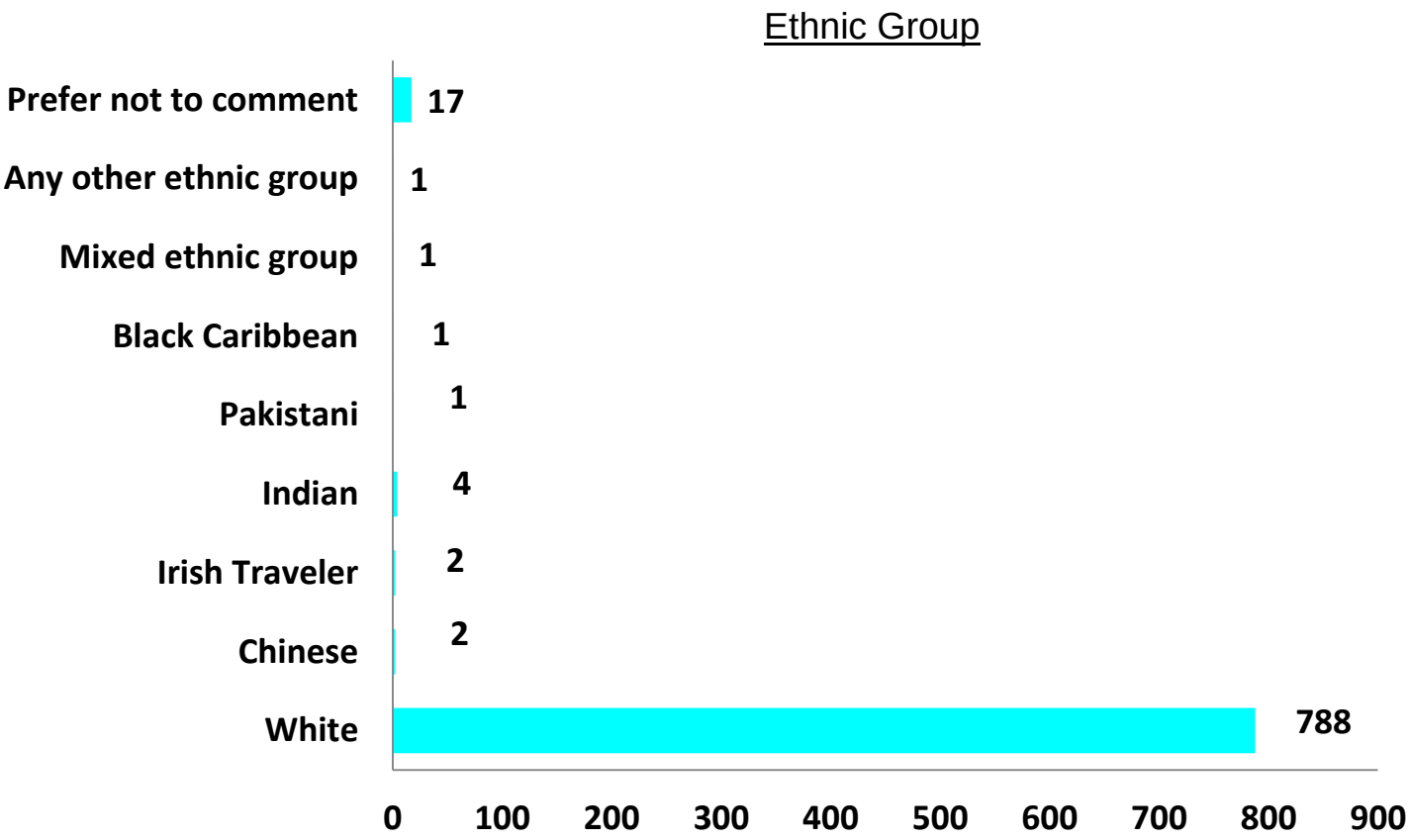
RQIA (2014) Review of Discharge Arrangements from Acute Hospitals. RQIA

Sensemaker® software produced by Cognitive Edge Pte

Appendix 1: Demographic information






Ethnic Group
Prefer not to comment
17
Any other ethnic group
1
Mixed ethnic group
1
Black Caribbean
1
Pakistani
1
Indian
4
Irish Traveler
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Chinese
2
White
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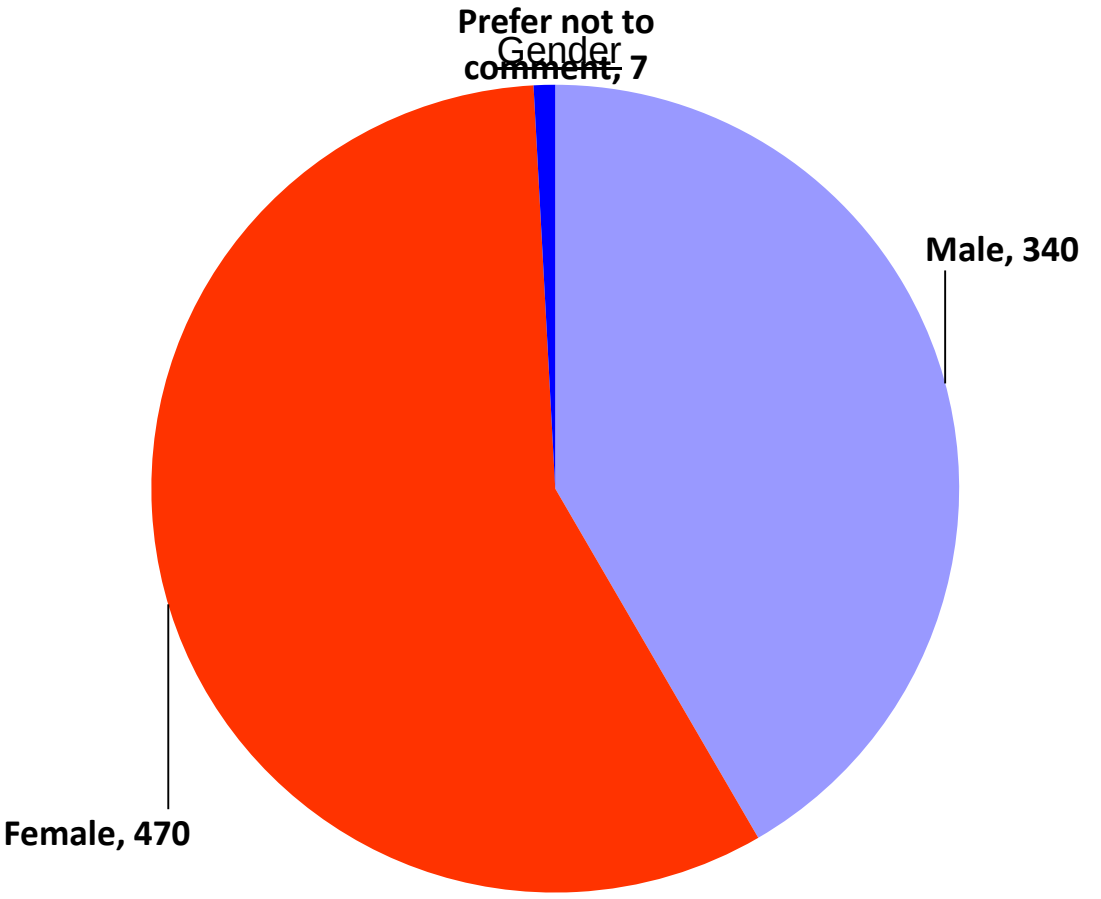
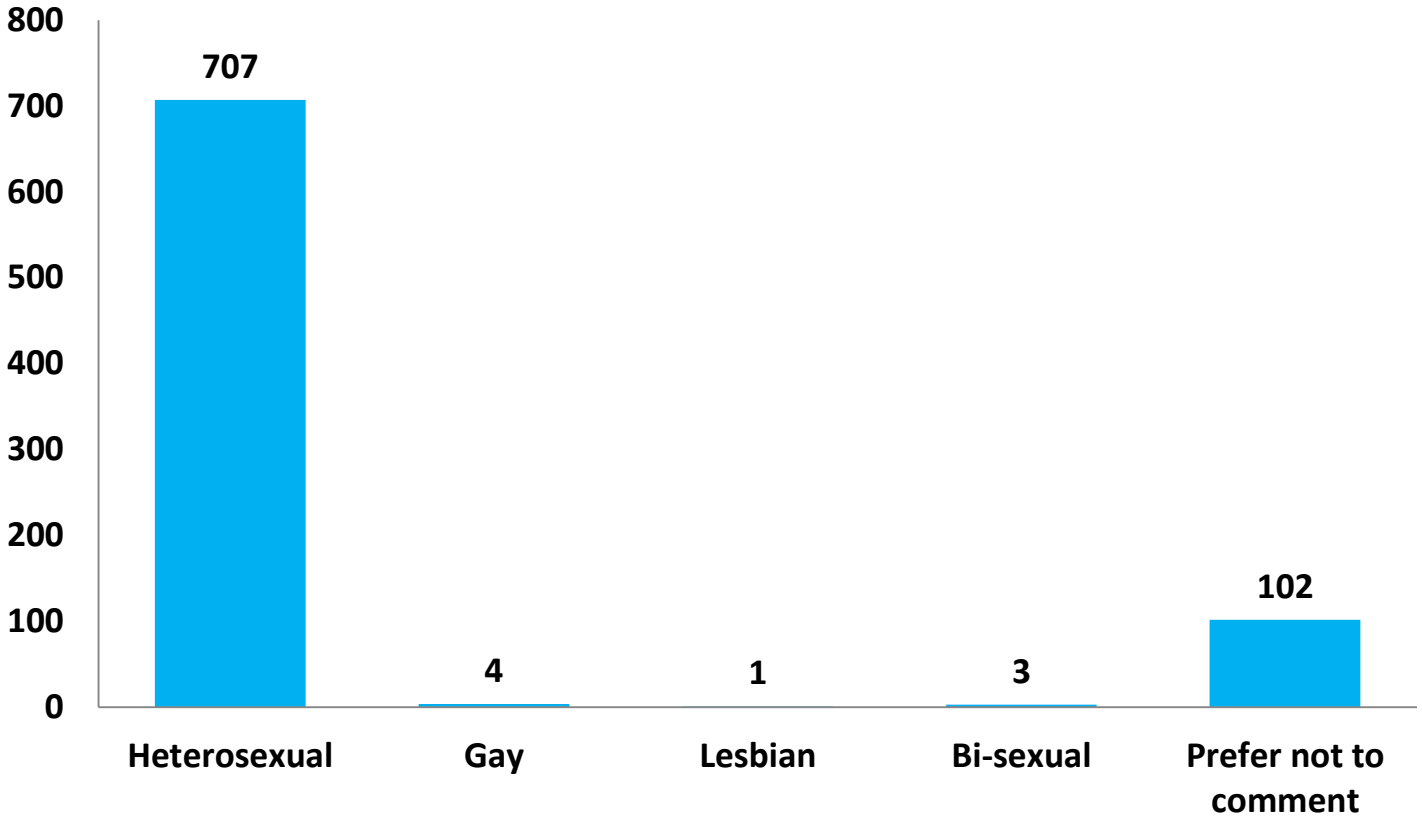
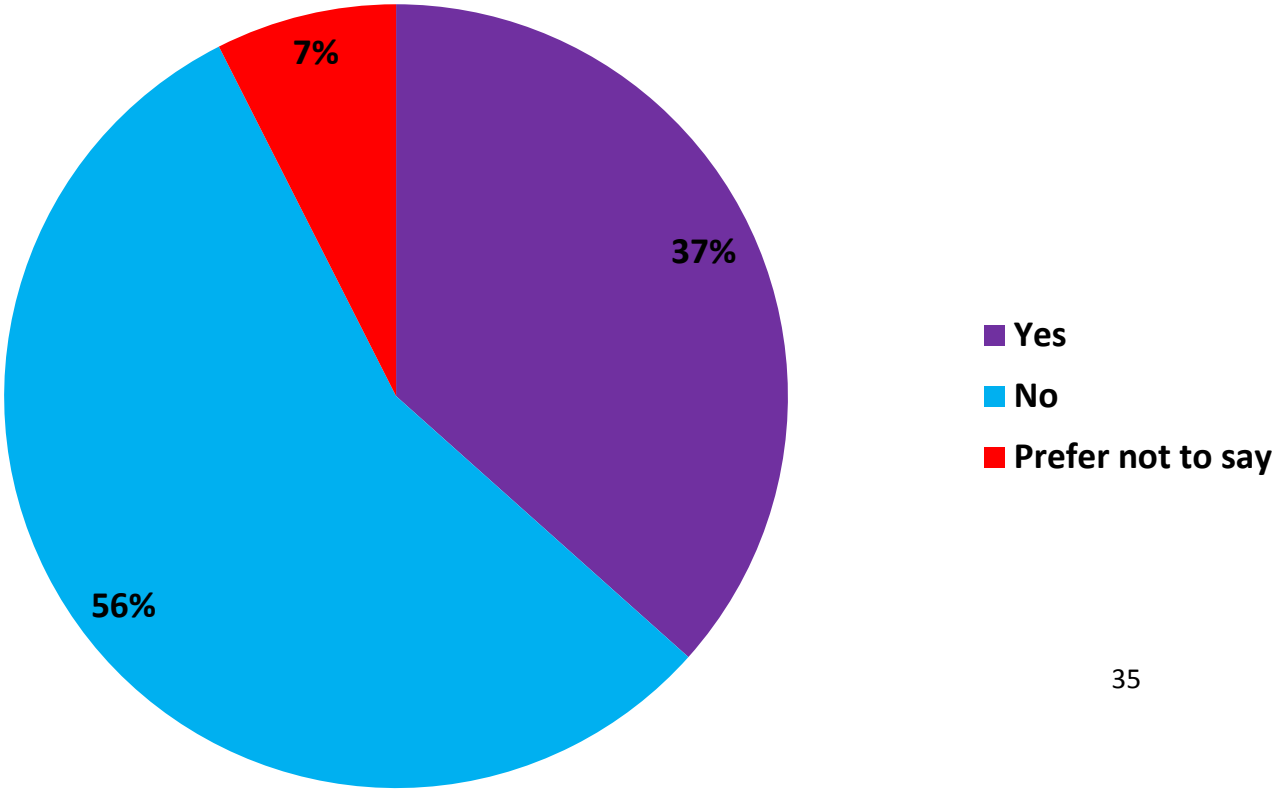
0
100
200
300
400
500
600
700
800
900


Gender
Prefer not to comment, 7
Male, 340
Female, 470

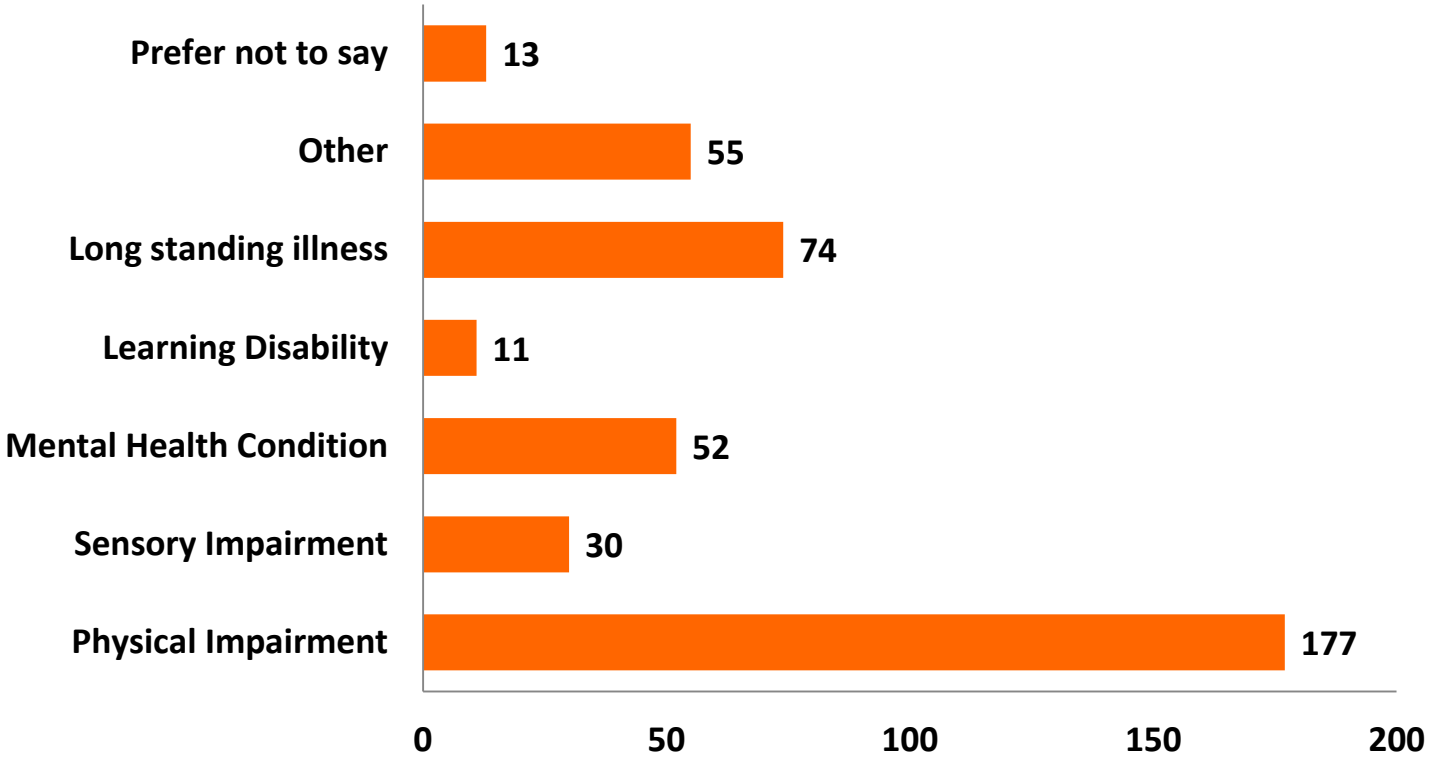
Sexual orientation



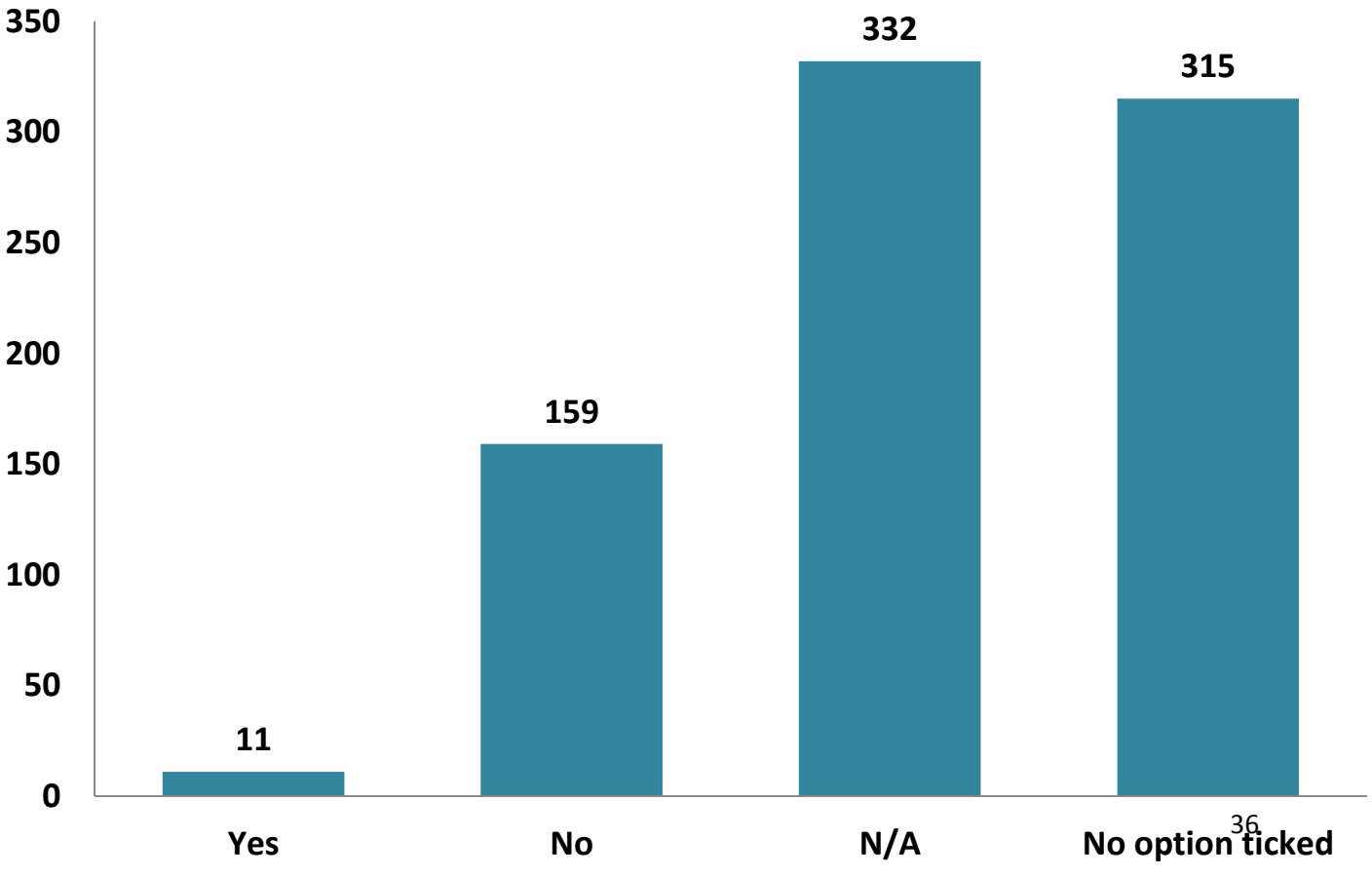
Do you consider yourself as having a disability?



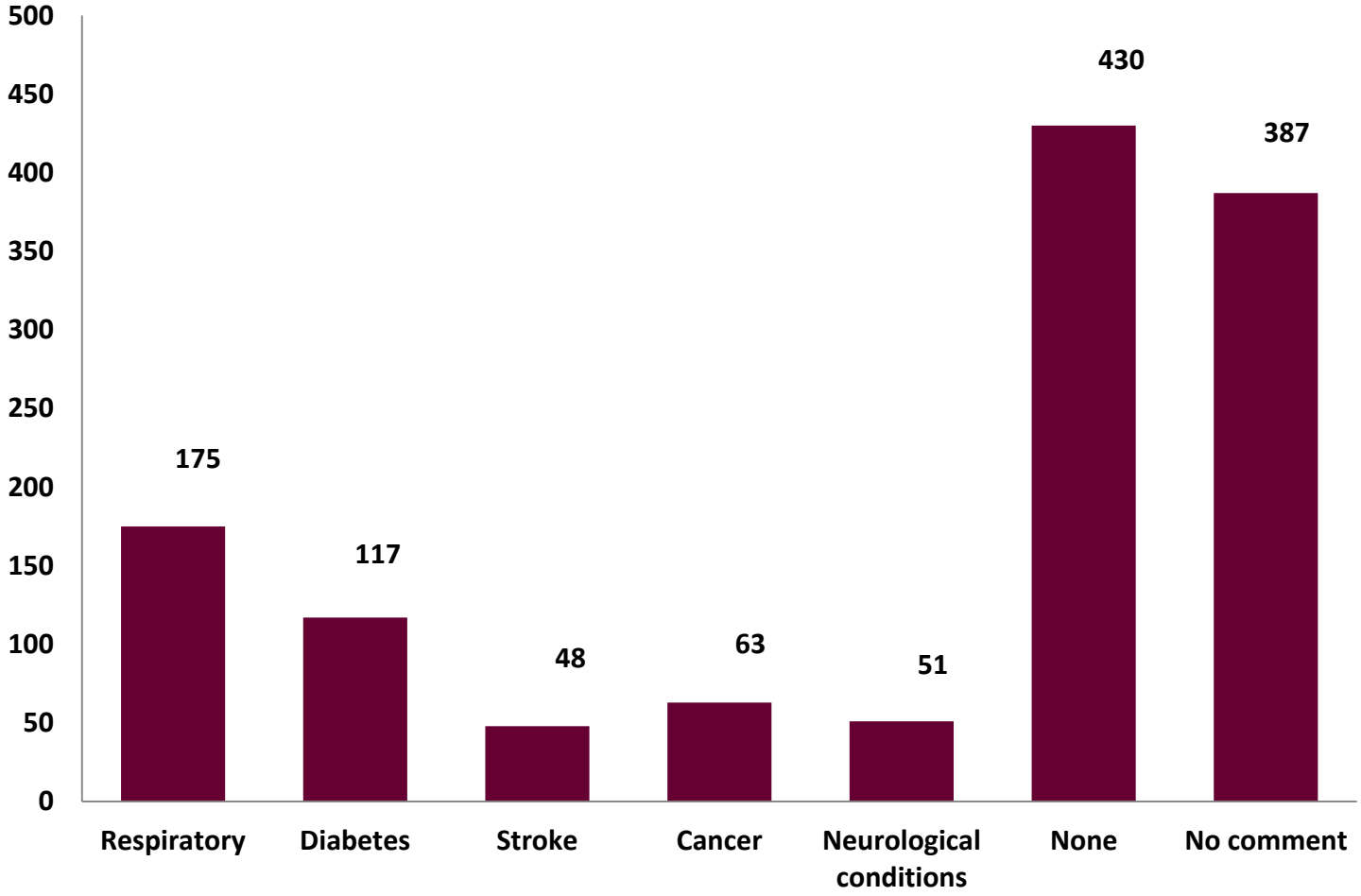
If yes, which type of impairment(s) applies to you?



Do you have a rare disease?



Do you have any of the following long term conditions?



Appendix 2 Staff Responses

How do you feel discharge could be improved?

- To facilitate discharge transport sometimes delayed especially if booked later i.e. the afternoon.
- Keep patient well informed. Start discharge planning on admission. Try to pre-determine any barriers.
- More staff to be able to spend more time with patient. Discharge letters on time and scripts quicker obtained from pharmacy.
- We could just give to them discharge letter after check from doctor and pharmacist and provide medicines for 2 days from ward stock. That makes everything quicker.
- Good communication. Having a Doctor long term in discharge lounge to provide discharge letter.
- Better use of discharge lounge in trust. Discharge team could book ambulances/transport.
- Patients with already established packages of care could be re-commenced by ward staff rather than having to wait for social worker to come to ward contact for care provider could be given on admission.
- OT better feedback live information on whiteboard not updated with regard as to who they have discharged.
- Verbal feedback also has to go to notes to see if they recommend POC/rehab. This is often later on as nursing staff are focused on patients.
- Weekend pharmacy late discharges difficult to facilitate afternoon/Sunday with cut off for scripts.
- Scripts to be completed by SHO as soon as patient deemed MFFD. If done on ward round and not waiting until doctors' return from tea break in mornings.
- Helpful if pharmacy staff on ward willing to follow patient to discharge lounge and check scripts there rather than waiting for them to do this on ward before being able to transfer them to discharge lounge.
- Early input from MDT especially social worker.

- Technician to assist with discharges.
- One stop dispensing.
- More pharmacists at ward level.
- More time to provide discharge counselling. Meet targets of medical recommendation of 24 hours.
- Improved access to MDT (physio/OT/social worker) at weekends.
- Access to an MAU hub for follow up of accelerated discharges.
- Pharmacy opening on a Sunday would be helpful for weekends.
- Further OT input does not assess until MFFD and does not give 24 hour prior notice so the nurses may end up W&D the patient and assessment delayed. Further family involvement where able. Letters to be prepped in advance or having a cut off time where able.
- Residential homes want to assess patients in hospital prior to return with no additional need requirements.
- More OT input throughout stay in hospital and not just assessed at day of discharge. This ends up delaying discharges.
- Letters to be prepped day before discharge if possible. Better use of resources in discharge lounge i.e. discharge lounge booking ambulances for patients.
- Pharmacy input on ward rounds and initiate scripts. Developments of MAU ambulatory to facilitate earlier discharge with follow up. Better integration of social care between trusts significant delays if patient lives outside hospital trust area. Ideally should be province wide.
- Scripts done earlier and doctors drop out of round to do at least one script/letter rather than finished ward round and then complete. Earlier input from MDT OT sometimes leaves patients for kitchen assessment until the afternoon of discharge.
- Too many teams getting involved in discharge (e.g. staff who have not seen patient and make decisions on discharge plans). Staff who are not working on ward.
- Discharge planning from admission patient transfer to appropriate units. Transition forms are very time consuming and repetitive.

- Discharge scripts being prepped on admission i.e. name address past medical history completed.
- Each day having a nominated person to leave ward round to completed script before breakfast of staff.
- Discharges could be improved by increased accessibility to care packages and placements. Reduced bed pressures by increased number of beds available reducing the number of hospital beds in moving to a new hospital when bed pressures were already on issues was simply ludicrous.
- Communicate with community based staff on more regular basis to ensure smooth transition from hospital to community OT services.
- If caseloads were not as busy I would have more time to spend with patients to develop rapport continue rehab and complete more extensive assessments.
- Occupational therapists could provide home risk assessment prior to hospital discharge/on discharge to ensure continuity of service.
- More timely referral to OT.
- More packages of care available in Belfast Trust.
- More levels of hospital staff would improve efficiency.
- I feel discharges could be improved by ensuring effective MDT. In some of the wards I have worked in there has not been a MDT meeting and I feel this affects effective discharge planning.
- Well planned discharge need - EARLY social worker intervention pharmacy input
- Patients not moved about wards when awaiting discharge.
- Have correct up-to-date info to give Pt + families - Knowledge of all their discharge schemes
- Doctors giving discharge letters priority early in day
- Discharge could be improved by having more computers available to write and at times other clinical tests take priority.
- Having pharmacy checking discharge medications is useful and safer as it can check that medication put on the discharge letter are what the patient is prescribed.

- Do feel most people are discharged appropriately and with enough time.
- Not sure given the system / budget / bed constraints there is anything that can currently be improved.
- Better communication. Nurse each end - specifically for discharges as complex - paperwork telephone calls.
- Explain everything simply + clearly, explain what support (If any) is available. Sign post to voluntary organisations if appropriate Give client contact number of local social services.
- More planning - communication to staff on who is going home and when

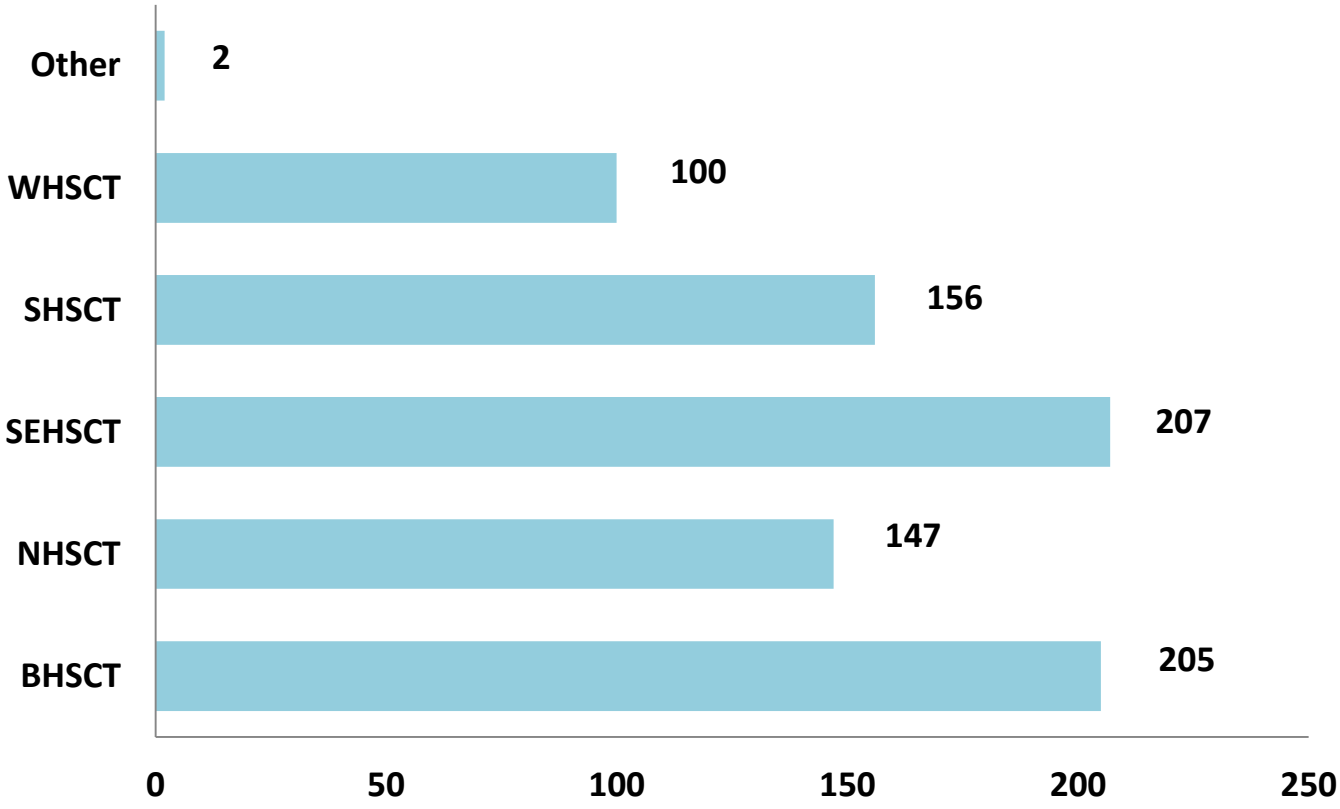
What do you feel could be done differently to support and assist you to deliver person centred, safe and effective care in relation to discharge of patients from hospital?

- Pharmacy could be more efficient very slow at times scripts go down at 9am and are only ready at lunch time 3pm.
- Pharmacy can be open more hours. Ambulance services to stay in place to support and assist us in helping people to reach their destinations i.e. Red Cross and St Johns.
- Pharmacists on each ward would be of great help to advise and expedite letters.
- Not feel pressure by bed manager. Enough staff.
- A social worker on ward from 9am to liaise with nurse in charge would be beneficial. Longer pharmacy opening hours.
- More staff. Mobile dispensing unit. One stop dispensary.
- As above. Expansion and support of hubs with medical/nursing/pharmacy support.
- Maybe a day time get together/handover with MDT/doctor and nurses to facilitate discharge effective documentation and handovers from MDT to say that tasks have been completed.
- On weekends especially more pharmacy input. MDT on ward at weekends so easily accessible/at least numbers to contact.

- Handover at lunchtime/afternoon of all MDT members including social work OT physio nurse to facilitate discharge plans.
- More support/input from pharmacy at weekends to help facilitate discharges.
- More OT input at weekends.
- Whilst allocation of social workers to ward has been a positive impact it would be good to have an earlier in day input e.g. 9am.
- More weekend AHP carers and better pharmacy cover.
- Daily review by consultant at weekend
- Again more timely discharge scripts for outlying patients.
- For patients with a loss (pregnancy) I would like more dedicated time with the patient to ensure they are fully informed and happy with any follow up care required.
- Discharge hub taking over time consuming transition forms.
- Nursing/residential home not waiting multiple days to assess patients for discharge when medically fit.
- Social care being Northern Ireland orientated rather than trust orientated.
- Ulster being a South Eastern Trust hospital in a. Assessments by MDT occurring earlier rather than on the day of discharge.
- Better access to appropriate assessment areas it is not appropriate to be completing OT assessments in a public waiting area in A&E yet due to bed pressures there are not even enough cubicles/rooms in order to take patients to a private area at times.
- I feel there are too many management meetings in order to highlight priority discharge. In reality staff on the ground are more in touch with priority discharge needs then management staff therefore there meetings are not only a poor use of staff time but they actually hinder effective prioritisation because often the people highlighted from those meetings are not actually the biggest priority on the floor. It would be better to have their staff on the floor helping with assessment rather than trying to prioritise patients from virtual information sources.
- Increased MDT meetings in order to clarify patient's abilities past medical history social issues and medical plan.

- The use of e whiteboards and keeping discharge dates and updating progress regularly helps prioritise patients and ensure effective care.
- Having ward pharmacy to ensure discharge medication completed. Families updated and nurse time freed up.
- Need to look at what available in discharge lounge. Only really suitable for patients waiting on transport.
- More care in the community.
- Better education of the public as to what is available to ensure more realistic expectations.
- Patients have been sent home as end of acute but packages of care were not in place There need to be more 'step down' etc. beds - places where a person can go between hospital + home.
- Less urgent bleeps + pressure to do discharge letters.

APPENDIX 3. Returns by Trust



*Under “other” the respondents did not specify which trust they belong too.