

APPENDIX 1: SCOPE DOCUMENT

Scope Document for the Hospital Discharge Scrutiny Review

Date: 13th March 2008 (revised on 12th June 2008)

Review Title: Hospital Discharge / Re-admissions Scrutiny Review

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| | |
| 1. Which of our strategic corporate objectives does this topic address? 1.1 To Improve Health and Well-being for all, ensuring people who require support are full participants in mainstream society. | |
| 2. What are the main issues? 2.1 High re-admission rate 2.2 Is there adequate support on discharge from hospital? 2.3 Are people who live in care homes disproportionately represented in the group who are re-admitted?. | |
| 3. The Committee's overall aim/objective in doing this work is: 3.1 To reduce readmissions to hospital for people aged over 60 years 3.2 To put systems and services in place in order to ensure a satisfactory individual experience of the discharge process. | |
| | |

4. The possible outputs/outcomes are:

- 4.1 Better understanding of the reasons for re-admissions
- 4.2 Reduce the number / rate of re-admissions
- 4.3 Improve the experience of individuals in order to drive service improvement
- 4.4 Improve joint working between the various agencies
- 4.5 Identify further work in a similar area

5. What specific value can scrutiny add to this topic?

To use patient-centred experience to drive any changes which would lead to the outcomes listed in section 4 above.

6. Who will the Committee be trying to influence as part of its work?

- 6.1 Wirral PCT
- 6.2 Wirral University Hospital Trust
- 6.3 Department of Adult Social Services, Wirral council
- 6.4 Appropriate Cabinet members, Wirral Council

7. Duration of enquiry?

Aim for the final report to be available before the Social Care & Health Scrutiny Committee due to be held on 20th January 2009

8. What category does the review fall into?

- | | | | |
|------------------------------|----------------------------|------------------------|--------------------------|
| Policy Review | X <input type="checkbox"/> | Policy Development | <input type="checkbox"/> |
| External Partnership | <input type="checkbox"/> | Performance Management | <input type="checkbox"/> |
| Holding Executive to Account | <input type="checkbox"/> | | |

9. Extra resources needed? Would the investigation benefit from the co-operation of an expert witness?

The review will be conducted by councillors with the support of existing officers. However, the Panel are looking for advice from people with expertise on this topic.

| | |
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| 10. What information do we need? | |
| <p>10.1 Secondary information (background information, existing reports, legislation, central government documents, etc).</p> <p>10.1.1 Recent Committee reports</p> <p>10.1.2 Output from the workshop on hospital discharge held on 10th October 2007</p> <p>10.1.3 Copy of a questionnaire used for a similar project organised by Sunderland City Council</p> <p>10.1.4 Relevant Department of Health documents</p> <p>10.1.5 Reports from other councils into similar topics</p> | <p>10.2 Primary/new evidence/information</p> <p>Assessment of the 'patient experience' using a target population based on those patients who:</p> <ul style="list-style-type: none"> - have been re-admitted - are aged 60+ - give a good geographical spread across the borough - are either 'living at home' or in residential / nursing home care. <p>10.2.1 Letter to be sent to those patients who have been re-admitted to hospital within a specified month (Average monthly rate for re-admissions is approx 320). Depending on the feedback, this may be followed up by subsequent interview / focus group.</p> <p>10.2.2 Experience of 'family and friends'</p> <p>10.2.3 Additional experiences based on focus groups and other individuals</p> <p>10.2.4 Interviews with key officers</p> |

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|---|---|
| <p>10.3 Who can provide us with further relevant evidence? (Cabinet portfolio holder, officer, service user, general public, expert witness, etc). Contacts may include: Former patients. Family & friends of former patients.</p> <p>Maura Noone (Head of Service, Commissioning, Health & Wellbeing, Wirral Council).</p> <p>Kathy Doran (Chief Executive, Wirral PCT). Heather Rimmer (Joint Commissioning Manager, Intermediate Care, Wirral PCT).</p> <p>Pat Higgins (Directorate Manager, Wirral University Teaching Hospital NHS Foundation Trust).</p> <p>Dave Carroll (Service Manager, Occupational Therapy and Visual Impairment, Wirral Council).</p> <p>WUHT officers. Key Social Services officers. Members of local charities who represent older people. Strategic Health Authority. Possible visits to the discharge lounge and rehabilitation wards.</p> | <p>10.4 What specific areas do we want them to cover when they give evidence?</p> <p>10.4.1 Current arrangements</p> <p>10.4.2 Areas for improvement</p> <p>10.4.3 What is the relationship between those people who suffer from falls and the readmission rate?</p> <p>10.4.4 What is the relationship between 'End of Life' care for people with cancer and the re-admission rate?</p> |
| <p>11. What processes can we use to feed into the review? (site visits/observations, face-to-face questioning, telephone survey, written questionnaire, etc).</p> <p>11.1 Contact letter / Questionnaire (as described above)</p> <p>11.2 Follow-up focus groups or interviews of patients, family & friends either by telephone or face-to-face</p> <p>11.3 Desk-top analysis</p> <p>11.4 Interviews of staff</p> | |
| <p>12. In what ways can we involve the public and at what stages? (consider whole range of consultative mechanisms, local committees and local ward mechanisms).</p> <p>12.1 Former patients, family & friends, especially older people (as described above).</p> <p>12.2 Press release / use of the free papers - requesting comments from the public.</p> <p>12.3 Focus groups organised with relevant organisations such as Older People's parliament and Age Concern</p> | |

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Wirral Hospital Discharge Review Report

December 2008

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Wirral Hospital

Discharge Review

Report

Issue and Revision Record

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Summary

Mott MacDonald conducted 3 focus groups with people who had recently (June and September 2008) been through the hospital discharge procedure at one of Wirral's hospitals.

The main purpose of the study was to understand patients' experiences of the hospital discharge process, identify their opinions of the process and to gain their views of any improvements that could be made to the process.

Overall, experiences of the discharge process were mixed, with many inconsistencies apparent between hospitals and within patient groups.

The main concern was this lack of consistency in the discharge process and the apparent lack of a structured repeatable process and a lack of communication about the process. Often patients were left 'in the dark' as to whether they had been discharged and how long the process would take.

Other issues that were felt to require improvement include:

- A follow up check in the community immediately following discharge
- A check that there is someone at home to help care for the patient you and your home is suitable for your return
- Good communication with the GP regarding the medication the patient is on and their post discharge condition
- Quicker access to medication during discharge
- A specific discharge time (a plan of the discharge process)
- Access to a sign language interpreter so that deaf people understand what is happening
- Continuity of care
- Taking account of carers and also patients' own caring responsibilities

1 Conclusions and Recommendations

The groups were all well attended and patients were able to give valuable and in depth feedback. This was clearly a subject of real interest with participants being keen to express their views on their hospital admission in general as well as their experiences of the discharge process.

It was clear that, for these elderly patients, being admitted to hospital can be a frightening time for patients and a feeling of vulnerability can continue through to and following their discharge. It is therefore vital that the discharge process goes some way to allaying this sense of vulnerability.

As part of this reassurance process patients need structure at the point of discharge and need to know what they should expect to happen and when.

However, one of the principal findings to emerge from the project is the lack of knowledge among patients of any discharge procedure and the lack of consistency in the application of the discharge process. This meant that the experiences of patients varied greatly and the experiences of those who followed an identifiable procedure had more positive experiences than those patients who perceived the process as being random.

Ensuring that proper discharge protocols are in place and that there is consistency in their application is an obvious area for improvement. In addition to this, these protocols needs to communicated effectively to patients, with patients being informed of any changes to the process.

Another factor driving feelings of patient vulnerability was the perceived attitude of hospital staff at the point of discharge. Many patients felt that they ceased to be important at the point of discharge and that they were made to feel surplus to requirements. While it is understandable that hospital staff will concentrate their efforts on incoming patients, greater awareness of the feelings of discharged patients could encourage hospital staff to behave in a more inclusive manner.

In addition to the above, specific areas of improvement that were suggested are as follows:

Transportation

These elderly patients were often concerned with transport arrangements and more help to ensure that adequate transport has been arranged would relieve anxiety.

Many patients complained that wheelchair facilities were not on offer when leaving the hospital and that this typified the perceived attitude among staff that now the patient was discharged they were no longer important.

Length of time it takes to be discharged

There is often a delay between the point that patients are told that they can be discharged to the point that a doctor actually discharges them. Greater communication about the length of time that it takes would alleviate this; as would the possibility that members of staff other than a doctor could formally discharge the patient (e.g. a senior nurse)

Check of adequate care when home

While most patients were asked if they had care available at home, some of those who did need assistance support were not provided any support.

Adequate Communication throughout the discharge process

Lack of communication and information about the discharge process was a key criticism of the process. Keeping patients informed about procedures and timescales would increase satisfaction with the process.

Medication

Many patients complained about the length of time it took to receive their medication – again, adequate communication could alleviate many of these concerns.

Facilities while waiting for discharge

Many patients were not aware of the discharge lounge – greater use of this would help the discharge process as it would allow patients a comfortable place to wait and, by giving them a bespoke area, make them feel that they are not in the way of hospital staff.

Involvement of carers

There was a feeling that carers were not as involved in the process as they should have been and that there was a lack of communication with the patient's carer.

Information and support post discharge: Specialist, GPs, information/care plan

Overwhelmingly, in all groups, the subject of suitable and accessible aftercare was mentioned as a key issue and a key concern for participants. They advocated greater levels of information and advice for themselves and their carers, a contact number or helpline to call with concerns and support from the community when 'handed back into their care'.

Provision of Signer for deaf patients

It was clear from the experiences of the deaf patient included in the survey that provisions for deaf patients were inadequate. The ability to communicate about health issues was seen as understandably vital for deaf patients.

2 Introduction

2.1 Background & Objectives

Wirral PCT and the Social Care, Health & Social Inclusion Scrutiny Committee are currently undertaking a review on the Wirral hospitals' discharge process. As part of this review, Mott MacDonald MIS was commissioned to carry out an exploratory study into patients' perceptions of the process from their experiences of admission into one of Wirral's hospitals.

The main purpose of the study was to understand patients' experiences of the hospital discharge process, identify their opinions of the process and to gain their views of any improvements that could be made to the process.

Topics covered in each of the groups included:

- Patients' recent stay in hospital;
- Experiences of the hospital discharge process;
- Opinions of the hospital discharge process including staff, understanding of the process, timeliness and facilities, access to medication, transportation, support at home and the suitability of the home environment after discharge;
- Improvements to the hospital discharge process

2.2 Methodology

Three focus groups were carried out to gather qualitative data on patients' perceptions of the hospital discharge process. The venues were local Council and voluntary sector premises in Wirral – Heswall Hall, Heswall; The Lauries Centre, Birkenhead; and Liscard Community Facilities Complex in Wallasey.

Participants who had been admitted to a Wirral Hospital earlier in the year, and discharged in June or September 2008, were sent a letter explaining the purpose of the research study and asking if they would like to be involved. A reply card was included for return if they wanted to be involved in a focus group. Those who returned reply cards were contacted by telephone and sent written confirmation of the group they were to attend.

2.3 Participant Information

There were between 10 and 12 participants recruited for each focus group. The numbers of those who attended varied between groups and are shown in table 2.1 in the Appendix. Each participant was provided with a £15 cash incentive and reimbursed for their travel expenses where required.

2.4 Topic Guide

The topic guide (Appendix A) was designed by Lindsey Dodd from Mott MacDonald, in conjunction with Wirral PCT and the Social Care, Health & Social Inclusion Scrutiny committee. The groups were moderated by Lindsey Dodd and Sarah Swan of Mott MacDonald. All focus groups used a skilled facilitator to steer the conversation and ensure all topics were covered, without introducing bias and make sure that everybody had their say.

2.5 Analysis of Transcripts

Each of the focus groups was recorded in order to preserve a verbatim record of responses that could be collated. All recordings were treated as confidential including names and addresses of participants. No comments were attributed to individual participants.

The analysis procedure involved a form of content analysis involving a thorough scanning of the detailed transcripts, drawing out the thoughts, experiences and reasoning of the participants to understand the key themes and arguments of each discussion.

3 Main findings

3.1 Experiences in Hospital

Participants were asked to recall their most recent hospital admission. They were not asked the reason for their admission, but about their hospital stay in general. Participants had all been admitted to hospital in the last year and had stayed in hospital for between 1 and 17 nights. Views were mixed with some participants having had positive experiences and others having some concerns about their stay in hospital.

3.1.1 Positive Experiences

Some participants had had positive experiences in hospital. These participants commended the care they received and any issues raised were seen as relatively minor, such as ward closures and having to duplicate lost forms:

“I went into Arrowe Park Hospital in the Urology Ward in June for an operation on my left kidney and the only thing that started to go wrong was the ward I was supposed to go to was closed for refurbishment and some staff didn’t quite know where the other ward was. Anyway we found it eventually and I was more than happy the way I was treated in hospital.” (Heswall Group)

“I was in Clatterbridge for a knee replacement and the only thing on admission was that they’d lost my original forms for post op and my operation, so I had to sign all the forms, that was the only thing. Somehow they’d got lost. I had to sign all again but the general care was... I can’t fault, I have to admit.” (Heswall Group)

Participants made the following positive comments about their stay in Arrowe Park Hospital:

“It was quite straightforward. I found everything was fine.” (Heswall Group)

“In Arrowe Park yeah and I’ve got no complaints.” (Heswall Group)

“When I came out of the theatre, I was five to six days in the High Dependency Unit...so the care I got in there was absolutely fantastic, probably because the nurses who volunteer for that sort of work are specialist people who want to be involved in that circle. I cannot complain. Every time I put my hand up for anything, no matter what time of day or night it was, somebody came and somebody sorted me out really and when you’re in the High Dependency Unit you do need that sort of treatment and I certainly got it.” (Heswall Group)

“Yes I was admitted in July and I went in from the out of hours and they were absolutely wonderful.” (Birkenhead group)

“I went in and I can’t really remember the date and it was say about three months ago for a biopsy on my kidneys. Fantastic treatment no problem at all.” (Birkenhead group)

However, experience had also taught some that it was rather a ‘luck of the draw’ situation, whereby some experiences at Arrowe Park would be positive and some negative:

“Arrowe Park has been everything from the most horrendous place in the world to the most wonderful place in the world.” (Wallasey Group)

“One ward was heaven and the other was hell.” (Heswall Group)

Furthermore, it seemed that Clatterbridge Hospital, in particular, received more praise than any other Wirral hospital. Indeed, there was a perception in all of the groups that better care is provided at Clatterbridge Hospital, compared to Arrowe Park. This superiority was related to the demeanour of staff, the cleanliness of the hospital and the length of time taken to receive medication on discharge:

“The care from the consultant, down to everybody that looks after me when I go, the neurology nurses, they are all wonderful.” (Birkenhead group)

“Clatterbridge is fantastic. Totally different hospital. I had a hip replacement there, it's fantastic.” (Wallasey Group)

“Oh, I agree with you about Clatterbridge - I've been under Clatterbridge for 17 years. Renal. And I always see my consultant.” (Wallasey Group)

“I mean in general, Clatterbridge is fantastic, clean and bright and you can't fault that and I mean if you could eat, the food was really good.” (Heswall Group)

“I can't fault them and the theatre staff are just great, they really are. They take away nerves you've got and things like that.” (Heswall Group)

“The whole process is made so easy for you.” (Heswall Group)

“It's really comfortable.” (Heswall Group)

“I've been going to Clatterbridge since 1966. And I couldn't have been looked after better...And I can't fault what I've been through” (Wallasey Group)

Some attributed Arrowe Park's perceived inferiority to the fact that it is a teaching hospital and so the staff are still learning, so the service may not be as good as other hospitals:

“Yeah. It's a different hospital. But the difference is, you see - Arrowe Park is a teaching hospital. And, you see - the thing is - when you get senior house officers - they're getting taught how to do the job, you see.” (Wallasey Group)

“So sometimes there's got to be a bit of leniency there, for these people to be trained up.” (Wallasey Group)

3.1.2 Negative Experiences

There were also negative comments made by participants about their admission to, and stay in, hospital. There were complaints about bedside buzzers not working which, as a patient in a very unwell state, and being unable to alert nurses was a worrying situation. Furthermore, there was a complaint from one participant about the efficiency of the nursing staff in tending to patients in need:

“I felt that the actual nursing staff fell down a bit because you could ring a buzzer at night time and no one would come.” (Heswall Group)

"I was left - our whole section was left two and a half hours on our own. Like beached whales." (Wallasey Group)

"Well everything was fine, except for waking up and my buzzer not being plugged into the wall and of course I couldn't move to get it so and I really wasn't aware that anybody came to check on us in the night." (Heswall Group)

"There was a gentleman opposite me with MRSA, he was dying really and he was going to be sick. He was lying in his bed and he couldn't move and I got out of bed and went for a nurse. It was a male nurse and he came down and he put this thing on his chest and left him. So it ended up, I ended up with a pair of gloves on myself and gone over while he was sick and then I went and got the nurse and said this man's, this man needs attention. He needs care and when I said that four nurses appeared and he got the care but it took that." (Heswall Group)

Moreover, there were complaints from participants about mixed sex wards. All participants, being elderly, strongly disagreed with the concept of a mixed wards and some claimed to be appalled at untoward behaviour that was occurring at night between male and female patients on the same ward. This was felt to be very distressing for the other patients and a completely unnecessary and unacceptable way of treating vulnerable unwell people.

The majority of participants, typically, complained about the length of time they had to wait in A & E before they were seen and one participant was even seen by a nurse in a communal area where there was no privacy to discuss his condition.

Participants also objected to being moved from one ward to another. One participant was moved to and from four different wards, she had difficulty breathing and was woken up and moved twice during the night. Most participants agreed that it was important to stay in one place, with the same staff and once they arrive at a ward they would expect to stay there:

"We need your bed. I said how many times has this got to happen? You know, I'm not in the mood for moving about. I said I could hardly breathe so she said oh you should be settled soon. So anyway this happened four times. I said I'll be glad when I get to the door to go out. It was horrendous really. It really was." (Heswall Group)

"I was on four different wards - in twelve days, it was four different wards - so you don't see the same person at all" (Wallasey Group)

Another key concern mentioned by participants was the cleanliness of the hospitals. Some felt that their wards were clean, but others felt that cleanliness was an issue. The blame was laid squarely at the feet of those who made the decision to employ agency staff for cleaning rather than a specific cleaner per ward employed by the hospital. They argued that employing someone on this latter basis would be more likely to invoke a sense of pride and responsibility towards that ward and, therefore, a better standard of cleanliness:

"The other thing I was concerned about I was waiting in Outpatients some time ago. I watched some of the cleaning staff and the cleaning is a very important part of the hospital. We were talking about MRSA and everything else. I saw staff going around with their bare hands emptying bins and children playing with things in the bins and going out and I reported one of the staff... I just felt that the cleaning side of it ought to be more closely supervised, especially in Outpatients waiting areas and everything else." (Heswall Group)

"...and they used to have one mop for the toilets and one mop for the wards, now they don't. The same mop's used right the way through." (Heswall Group)

"Straight out of the toilet and into the sink and things like that." (Heswall Group)

Communication was also cited as an issue by a number of participants, in terms of patients not being informed about not eating prior to a procedure, reducing their medication prior to a procedure and procedures being cancelled and rescheduled up to four times:

"Like this lady said it was the communication and I think that is what is the matter." (Birkenhead group)

"Well I went in Arrowe Park a year last July. That was before the, the operation being cancelled twice. Third time I was in the hospital already to go in the operation theatre, emergency came, go home so the fourth time I got in." (Heswall Group)

Similarly, it was also reported that there is a general lack of information for patients, whether it is about their condition, when they will be discharged or what is going to happen next:

"Well I'd been asking what was happening and I wasn't getting any information." (Heswall Group)

One participant who was profoundly deaf, had a very problematic experience in hospital. She was taken in by ambulance and her difficulties started from the moment she needed to call the ambulance. Due to her deafness she could not communicate with the ambulance dispatcher and even though she has a text phone, when you are seriously unwell it is not practical or easy to use a text phone. When she arrived in A and E there was no interpreter available and no one could use sign language and she could not communicate with anyone which left her feeling frightened and vulnerable:

"Can I just say when I started, oh, when I had chest pain I tried to mini com for an ambulance but the problem with mini coms you have got to wait for a response and then they ask you a question and then you have got to reply and they ask you another question and all this time I have got heart, chest pains and so it is not really better because we were waiting. Half an hour it took for the ambulance to come because of a delay in communication." (Birkenhead group)

"The ...[paramedic] he was trying to gesture and we were communicating through gestures and it wasn't good and that was in the ambulance because me and my partner are both profoundly deaf and so it is very difficult. I still don't know what is wrong with me." (Birkenhead group)

"I had a problem myself with my heart. I had palpitations and my partner couldn't phone so the opposite neighbour came and asked and they were just asking loads and loads of questions as we were phoning and it was somebody else who had to phone and it just seemed to take so long before they said, right, they would send an ambulance out. By the time I got to hospital I couldn't communicate, there was no interpreter in A&E. It would be better if there was an interpreter based in the hospital so that I wouldn't have to get to hospital and wait an hour for the interpreter arrived because I can't lip read. Everything that was going on I wasn't understanding and I didn't understand anything which made the experience a lot more emotional and people going backwards and forwards it was different people and some people were easy to understand and saying at Clatterbridge, they were asking me questions and I don't understand it and also the letters that I have sent out. I am not understanding any of this information it is very difficult for me. Both me and my partner

are deaf and so we can't phone or phone for an ambulance or anything and so I do have a lot of problems with communication in hospital. RNID do try and sort out hospital, an interpreter for me but sometimes particularly if it is during the day there isn't anybody there and so it is a big problem for me and particularly Clatterbridge. They don't understand what the problem is because I can't communicate with them." (Birkenhead group)

This participant went on to say that the same issue applies every time she is in hospital, because no one can communicate with her, the doctors still do not know what is wrong with her and she stills feels unwell and nothing can be done about it:

"No that is right. I have been to the hospital two or three times for the same appointments, ECG machines and all sorts but the doctor is at a loss to know what is the matter. I have forgotten the name of the doctor. He is a heart specialist anyway and the communication is non existent." (Birkenhead group)

"I have been waiting round for the doctors and they come and talk and I am like can you just explain what is going on and they say oh just wait it is ok and I have been worse and worse and I can't hear and I don't know what is going on and I know that they are all talking about me. It makes me quite angry to be honest and I feel quite angry and then they patronise me and they say oh calm down and you will be fine and I am waiting not knowing what is going on." (Birkenhead group)

She complained that she is never asked if an interpreter is required before an outpatient appointment and when she has to stay in hospital she does not have access to an interpreter. She complained that there is often no interpreters available in an emergency but she feels that some of the hospital staff should be trained in sign language so there is always access to an interpreter on every shift, should a deaf person come in.

The group all agreed that if this had been a foreign speaking patient an interpreter would have been employed and that patient would have been able to communicate about their condition through this interpreter. However, there was no such provision for the deaf participant. The participant explained that she has access to more information when she visits her doctor but there is still no interpreter provided:

"It can be the same there is no interpreter there but the doctor will type on the computer and he does spend a little bit more time and make notes for me." (Birkenhead group)

She suggested that an interpreter be based in the Lauries Centre who could be on call and go to the hospital when required. Other participants felt there should be an interpreter in the hospital at all times or at least a member of staff who can sign.

This was thought to be a problem in both Arrowe park and Clatterbridge hospitals:

"Both hospitals, Arrowe Park is say slightly worse. Clatterbridge is not bad but Arrowe Park is particularly from my experience at least." (Birkenhead group)

Overall, it was clear that very few participants had experienced a totally smooth stay in hospital. Some issues are clearly more difficult to circumvent than others. However, it is clear that the perception is that patient wellbeing is not always top of mind for hospital staff.

There were also a number of concerns regarding staff. Participants commented on both the lack of staff at night and the differing demeanour of the night staff and the day staff:

"Well I think this lady is right as well. It depends on the staff. I mean you can get the day staff are wonderful, you get the night staff who were ...Non existent." (Heswall Group)

"I noticed that nearly all the staff at night time were old age pensioners and that's how I'd classify." (Heswall Group)

Participants mentioned staff being disrespectful to other staff in front of patients and staff discussing their private lives in front of patients:

"They slagged her off in front of the other patients terribly, so much so that we all said that you can't talk about a member of staff like that and one was a qualified nurse and the other one was an HSA and they were appalling and they just sat back and she was run ragged because she didn't ask she just carried on doing it and she was actually lovely." (Heswall Group)

"Different things yes but I think the staff to discuss their private lives, a member of staff in front of patients is appalling behaviour." (Heswall Group)

It was felt that some nurses lacked compassion and did not assist with the basic aspects of care such as washing and helping patients to the toilet. Some reported staff actually having been rude to patients and lacking understanding and empathy for their condition:

"...and also, they expect the patient - I don't know about you, but patients who have had massive surgery - and I can speak of one in particular who was expected to get up and go and wash and do in the bathroom the next day. And he had had massive surgery." (Wallasey Group)

"And when you see people in the beds who have not even had a wash, not been given a bowl - or anything" (Wallasey Group)

"Some of the nurses were so discourteous as regards one looked in the ward and says have you all washed? You need a shower. The man had wet himself and smelt but I mean to me that's the sort of thing where you should go across and say ...Excuse me, you need a shower. Discreetly, one to one. We all heard that and it was disgraceful." (Heswall Group)

"Then you've got your lovely ones that care and said like your feet look sore, there were some lovely, lovely nurses but there were some who shouldn't have been nurses." (Heswall Group)

"The staff were very good but as we all say they have so much to do, they try to do their very best but you can't do it all and some pull their weight and others don't which is sad really." (Heswall Group)

"And some people are caring and others aren't." (Heswall Group)

"That's one of the things that you notice, there is (sic) some nurses ... They've just, they've got no feelings for you." (Heswall Group)

Indeed some participants were so concerned about the attitude of the staff that they suggested that a nurse's caring ability should be checked at appraisal:

"There should be one of those things on their...should be what's their feelings about care, are they are caring person and does it show in their work because some of those nurses it's just non existent and I feel they shouldn't be in the game at all." (Heswall Group)

Some participants did find the staff helpful, but there was a general consensus that that nurses used to be a lot better and due to the modern demands of computers and the time taken up with them, they have less time to actually care.

"Oh yeah, they generally try to be helpful, but they're only going on orders, aren't they - you know - they're reading notes that go missing" (Wallasey Group)

"I don't think nurses are the nurses that they used to be." (Wallasey Group)

"Oh it's understanding really, because I was an auxiliary nurse myself and you know, you do care for people but it isn't the same anymore, it really isn't." (Heswall Group)

"They don't seem to have the passion they used to have. It's a job, and they're here to do the job. I'll give you medication" (Wallasey Group)

"I'm going home at five o'clock." (Wallasey Group)

"They're on the computer" (Wallasey Group)

"You say - we need help here - oh, I've got to do this. Got to write up" (Wallasey Group)

"Well, you know - they're busy. And the computer - it takes over all" (Wallasey Group)

"Most people who are in charge of wards, like the sisters - they're ward managers now. So they don't even get involved in the ward. They just computerise everything that's going on - to cover costs" (Wallasey Group)

"And even the students - nurses - there to observe, really, a lot of the time. Whereas if they do the simple things like bed-making, and stuff like that - they get used to dealing with the patients without being able to do any harm. And, you know - I just think they miss out on all that. The training was so different. And I think it was much better. And I'm not biased - I've experienced both. But I do think the old type of training was much better. Like an apprenticeship." (Wallasey Group)

Participants also complained that they had seen doctors who had not washed their hands between patients.

"I also complained while I was in Ward 34 about two doctors. They again treated this man with MRSA and he had other problems. I mean that was one, he was a dangerous patient in my book because we're all vulnerable and these doctors went over into the files, straight after, didn't wash their hands. I called a nurse over and said look those doctors haven't washed their hands. I said I notice you've got your stuff by your side and you wash your hands so I says good on you but they haven't. He was in attendance with the doctors so he went over to the doctors and he said something and the next I see that they looked at me, like one was a consultant and the other was a doctor and that was ok. The next minute they started treating a man next to me who was a diabetic and had trouble with his feet and they hadn't washed their hands. Now when you're in bed, in a full bed, you're watching everything. You've got nothing else. You've no television so you see life as it is. So I got out then and went and saw the Ward Sister and said I want to complain about these two doctors. So she says right and she went and attacked the problem right away and an hour later she came back and she says thanks very much. I've reported that to the matron so that's it." (Heswall Group)

Furthermore, some felt that the doctors do not address the patient often but discuss the patient with the other doctors as though the patient is not there.

“Can I just say something about these consultants, when they come round, and I use this as a general opinion that I have of them, is that I don’t know whether they find they are above you to speak to you as a person but I found that in Arrowe Park there were certain consultants and registrars they come round and you know they all stand around your bed and they have a meeting and they will all be jabbering amongst themselves and some of them don’t speak perfect English and that is only an observation not a criticism and so you are having difficulty in understanding what they are saying to each other and also they don’t actually talk to you as the patient they are talking to each other and then they just go oh yes that is right and they walk away.” (Birkenhead group)

“One doctor he is a chest doctor and he talks about you to the other doctors but not to you personally and in fact I classed it as rudeness.” (Birkenhead group)

3.2 Experiences & Opinions of the Discharge Process

Participants were asked to talk about their experiences of the hospital discharge process and their opinions of the process overall.

Firstly, participants spontaneously discussed the discharge procedure in general, in relation to their experiences. They were mixed in their views of the discharge process and all their experiences differed. Although there appears to be a number of negative points made about the discharge process, it is important to note that the purpose of the discussion was stated to be a 'review' and this type of forum often leads to a critique of the service involved. Such negative experiences are balanced with positive accounts throughout this section.

3.2.1 Positive Experiences

One participant felt that overall, his experience of the discharge process was good, particularly because he was assisted in leaving the hospital by staff and a wheelchair:

"I was in hospital twice this year ... as regards the discharge, absolutely everything went the way it should. They got a wheelchair, they took me to the car park, took me to the car. I've got nothing but praise and when I was in that Ward 27 I really felt that it was the nearest thing to a private hospital I could be in it was that good, for nurses, for doctors, for information, the lot." (Heswall Group)

Similarly, another participant, who has to stay frequently in hospital, is always very pleased with her discharge experience. She explained that upon discharge, the hospital liaise with the care company she uses and the ambulance service and make sure that she has everything she needs. She noted that she feels secure that everything will be in place for her when she gets home:

"July this year, I was in for seven weeks. I suffer from black outs and I have epileptic fits because I were in and out of ...like a yoyo. You might as well have me on a bit of string and pop me there and back all the time but the ambulance always takes me and an ambulance always brings me home and anything I need, you know for home, the hospital provide it for you like bread and milk or stuff like that. I have a care worker of a morning and a care worker of a lunch time and a care worker at night because I am not allowed to use anything that is electrical in case I have a black out and I can scald myself. So I have never had any trouble and I have been in and out of there since it first opened." (Birkenhead group)

"Yes everything is arranged for me yes. The hospital phone up my care worker company I have and then they tell the hospital what day they will come because you have got to give them twenty four hours notice." (Birkenhead group)

3.2.2 Negative Experiences

There were, however, some negative experiences also reported. One participant in particular had a fairly negative experience of the hospital discharge process, due to the lack of support and aftercare. She found herself in a situation whereby she had an operation and was sent home the next day when she had no one at home to help her or look after her, she had no discharge letter, she had no information about what she needed to do at home to care for her wound, no information about what she should do if she needed assistance and no transport arranged for her to get home. Furthermore, she had been told that she would be

in hospital longer and had informed a relative as such and then when she was discharged early no one was aware she was home alone. She felt that the hospital could have taken responsibility to inform someone she was coming home early and upon realising she would be at home alone, provide some care or keep her in hospital:

“Well I had the operation in the afternoon and the next morning they sent me home, they knew I lived on my own, didn’t offer me any way of getting home on my own, didn’t tell me anything about the dressings they leave on you, you know, didn’t say look don’t shower or anything like that. Just basically go home. What was worse, they told my daughter on the Thursday when I had the operation that I’d be in until the weekend and so she came in on the Thursday night and I was still unconscious and then they sent me home on the Friday morning and they denied ever doing that and even friends had sent flowers and things in and they got lost because I’d been discharged.” (Heswall Group)

“They didn’t even give me a discharge letter which they should have done. They sent one by fax to the GP. They didn’t give me one and they did admit in the letter when they finally wrote back that they should have done that.” (Heswall Group)

3.2.3 Specific Aspects of the Discharge Process

Aside from these general issues participants were also asked to comment on some specific elements in the discharge process.

Staff

Participants complained that there was little or no continuity of care and they were seen by many different nurses. Generally, all participants saw different members of staff throughout their stay and discharge, dependent on staff shifts and what ward they were moved to:

“Different staff, different experiences.” (Birkenhead group)

“Well it depends who’s on that shift and which doctor has been round to see you. You couldn’t necessarily see - If you’ve got a primary care nurse that looks after you, and the day you’re being discharged - probably be her day off. So the person that’s discharging you doesn’t know anything about you.” (Wallasey Group)

“Different areas of a ward, can be a different set of people. And so you could have only been - maybe, if you move down the ward, from the critical case at the top end - move down - by the time you’ve got to your individual room for - and you’re out, then you’ve got different - they’ve got different nurses anyway.” (Wallasey Group)

“Oh yes. Because you start off in one place, and then you might get a bed in another place. But because they’re desperate for that bed, you might go to another part.” (Wallasey Group)

As well as being uncomfortable for elderly patients it was felt that this lack of continuity can impact upon discharge. For example, at the discharge stage the nurse may have limited knowledge of a patients condition, potentially leading to confusing messages in relation to medication:

“...and then when it comes to discharging you, the medication side - forgetting the pharmacy - we’ve dealt with that one. Well - What medication did you bring in? Did you bring that? Or - Does this belong to us? And things like that. You know, it’s not very good. Supposed to know exactly what’s going on.” (Wallasey Group)

“Oh, they take you off them. I thought you had something else - and you don't know where you're up to.” (Wallasey Group)

They also mentioned foreign staff who they could not understand. This concerned participants because when there are medical issues at stake it is paramount that both patient and the medical representative are understood, potentially impacting on the discharge process:

“And one thing I've noticed you know, you've got various people from all over the world haven't we, nursing, and sometimes you can't even understand them. It's so difficult and we had an old lady on our ward and she said I want to see an English nurse please.” (Heswall Group)

“They were very kind, the nurses but they didn't understand us, we didn't understand them.” (Heswall Group)

Understanding of the Process

Generally, participants in the Wallasey group felt that they did understand the discharge process – it being a matter of medical conditions reaching a specific point:

“Well you heard them say you can go home.” (Wallasey Group)

“Yeah, I think so. I would say so.” (Wallasey Group)

“If your blood pressure stays down, and I'm watching the monitor, yes - I think we'll let you go home later.” (Wallasey Group)

“Yeah. Well I would say mine - mine was sort of helpful - which, as I've told you, it was helpful to me. So mine was sympathetically done” (Wallasey Group)

“And they check that you understand.” (Wallasey Group)

One participant in the Heswall group, had a very positive, informed discharge experience. He felt very much as though all boxes had been ticked. He received advice whilst in hospital, advice on what to expect afterwards, an allocated member of staff and a discharge note with information about who else receives a copy.

“I've got the actual discharge summary, copy, four copies printed, one to the GP, one to Case Notes, one to the patient and one to the consultant.” (Heswall Group)

“They allocated me a Sister at the hospital, the ward managing Sister and I got advice following the procedure.” (Heswall Group)

“Now on each time I've been kept fully informed of all procedures. On entry and on discharge, including aftercare, and on each occasion my wife has been with me and that's been encouraged, and quite honestly I feel that I've been one of the very lucky ones. I mean I have got absolute praise for the three units, Clatterbridge, Arrowe Park and Wallasey.” (Heswall Group)

“I've had nothing but the best and there's written evidence there recently to show for it.” (Heswall Group)

Furthermore, a few participants in the Wallasey group also commented that they had received information upon discharge.

“There was two information leaflets” (Wallasey Group)

“Given an appointment card for your next visit.” (Wallasey Group)

“They gave some printed paperwork apropos - you know - the incision, and how to look after it. And go along to - in ten days' time to have the stitches taken out. It wasn't totally substantial, so there's nothing really to moan about.” (Wallasey Group)

However, it was worryingly clear that some participants in the Heswall group felt that there did not actually appear to be a proper discharge procedure. They complained that the whole process appeared random and ad hoc. Participants highlighted that they were not given information about when discharge will occur, who will action the discharge, what will happen at discharge and after they leave hospital. They also commented that some had been discharged by a nurse, some by a doctor and some by a nurse who had not even been caring for them before that point:

“So that is something I've got against it because no senior staff, because you never see a doctor afterwards at all, they just don't come near to check on patients because I presume that the practice nurse on the ward, the nurse in charge, really is doing discharges without seeing patients at all, just going on the physio's say so that you've got enough control you can go home.” (Heswall Group)

“It's very sort of informal, it's just you know, your husband's here, you can get dressed, so you get dressed on your own.” (Heswall Group)

“Nobody checks your locker to make sure everything's out.” (Heswall Group)

“Nobody asks would you like a shower before you leave so that you've got somebody there.” (Heswall Group)

A number of participants in all groups also commented on the lack of any written documentation at discharge, for example, no discharge note or useful information:

“They gave me the medication to go home with, they didn't give me a discharge note and they sent a physio appointment and I did get that but basically it was sort of quite weird that nobody else comes round or anything.” (Heswall Group)

“No, [it was] verbal. I haven't seen any paperwork.” (Wallasey Group)

“Never had anything like that.” (Wallasey Group)

Patients clearly felt a little abandoned during the process and requested a formal written procedure be given to all patients – how long the process will take, who makes the decision, when they will receive results and any outpatients appointments they will require:

“Now the only problem I found was that when they were discharging me I said when would I find out the results from this and they said well you will be going to see your specialist in about two months time.” (Birkenhead group)

It was felt strongly by participants that there should be provision for deaf people upon discharge, so that they fully understand what is wrong with them, what medicine they need to take and what they should do if they need further assistance. However, the deaf participant

again explained that she received no interpreter on discharge and did not understand what was happening and still does not understand what medication she is on and why:

“I didn’t have an interpreter on my discharge. They didn’t find an interpreter it was just me and my partner there. They didn’t check things like am I ok on my own, how was I getting home. No.” (Birkenhead group)

“And he [GP] has been trying to check my tablets are appropriate for me recently because I am on a lot of tablets at the moment. I don’t know what they are for? This hasn’t been explained. I know that some of them are for my heart. Well I guess some of them are for my heart but I am not exactly sure.” (Birkenhead group)

Another participant who suffers from occasional deafness agreed, saying that nurses should ask about special needs during the discharge process and check the patients understanding of everything because they may not be clear due to their disability:

“I am quite deaf...I am not deaf if I am in the right circumstances, like in here, but if somebody is standing behind me and asked me to do something then I have no idea what they have said, I don’t even know they have spoken necessarily and quite often if you do know they have spoken you make a guess on what they might have asked for so the consciousness of deafness is probably something that they should have on the admittance and discharge form really. Have you any deafness?” (Birkenhead group)

Overall, it was apparent that the success of the discharge process varied wildly from patient to patient. Many felt they were left in the dark about the process while a smaller number were clearly well informed.

Timeliness of Discharge Process

Participants complained about the length of time it takes for a doctor to officially discharge a patient. Many claimed that after they were told they can be discharged, leaving the patient and their partner or relative waiting in a state of readiness only for a considerable time to pass before any action:

“At the Clatterbridge it was very good. The only thing is when you say discharge they say oh we will discharge you in about an hour and that hour can be two hours, three hours but then that is down to getting hold of the right doctor.” (Birkenhead group)

“I’ll be expecting it to all be over, and it’s another three hours” (Wallasey Group)

Again an explanation of the process would assuage some of these concerns.

Participants were also unsure as to whether it had to be a doctor or whether a nurse could discharge patients. It was suggested that a clear ‘You can go home’ needs to be communicated and that it should be possible for a nurse to do this as it would mean that patients could be discharged more quickly:

“Oh yes I would say the only thing is that doctors, well they are so busy that I think with the quality of nurses that we have got these days I think that the nurses should actually be able to discharge a patient.” (Birkenhead group)

“Yes that would speed up the process.” (Birkenhead group)

“A senior nurse.” (Birkenhead group)

One participant had been discharged by a nurse and felt this was a far more efficient process:

“I was sitting around waiting... waiting for hours to be discharged and he said I will make an executive decision and discharge you and he did.” (Birkenhead group)

“Well I was waiting a couple of hours and then they said, they said that they couldn't get the doctor to discharge me and then this {name omitted - nurse} said to me I will make an executive decision on this and then he said you will have to come and send someone back tomorrow for your medication and the pharmacy are busy and we couldn't get it all down in time.” (Birkenhead group)

Ultimately participants were happy to wait to be discharged if they had an understanding of the process and that it could be a three hour process. Leaving patients uncertain and unclear increases the level of stress and worry.

Facilities whilst waiting for discharge

None of the Heswall or Birkenhead participants had been offered the opportunity to sit in a discharge lounge – few were aware of their existence - and some were made to feel ‘in the way’ while they waited as they were taking up a bed:

“The discharge process, that was very good and the consultant had to come and see me...but I was then hanging around and I got out of my bed because they were waiting for it...and you just feel as though you are in the way. Now had there been somewhere where I could have just gone to sit to wait.” (Birkenhead group)

“I have been in a situation where I did go and phone up for my husband to come and fetch me, and when I came back to get my stuff ready they were changing the bed anyway, because somebody was coming in it. So that was me out.” (Wallasey Group)

They suggested that there could be a common discharge lounge on the ground floor for people to wait following discharge, while they wait for relatives or medication:

“Down on the ground floor near for your husband to find you.” (Birkenhead group)

“The whole hospital could use that then and you could go and sit with your magazine.” (Birkenhead group)

“I was in the way and I felt that could have been sorted.” (Birkenhead group)

Participants in Wallasey had waited in the discharge lounge and were positive about the facilities, describing it as a comfortable area where they could easily pass some time:

“It's where the television is, and all the magazines” (Wallasey Group)

However, they complained that they were not kept informed whilst waiting and they had to continually ask where they were up to with their discharge.

Participants did not want to feel ‘in the way’ or as having an impact on the day-to-day running of the hospital. If the process automatically moved patients to a comfortable discharge lounge (with books and magazines) all would be pleased.

Accessing appropriate medication

A high number of participants reported having to endure long waits for their medication. In fact this was one of the biggest issues with the entire discharge process:

“Two or three hours for medication.” (Heswall Group)

“Mine was for the physio but when the physio said I could go well that’s it, I waited two hours then [for medication]”. (Heswall Group)

“Waiting for your medication. Yes, for two hours, over two hours.” (Heswall Group)

“I had to go back the next day.” (Birkenhead group)

“Three hours later I was still there and so I left and I had to come back for it.” (Birkenhead group)

However, all participants were pleased they were given the correct medication:

“And they also checked over what medicines I was on, the correct medicines.” (Heswall Group)

Despite all receiving the correct medication a number said they would like to see more clarification in relation to taking the medication and explaining what it is for. A number were concerned about people getting confused and take it incorrectly:

“Yes. They have to send a pharmacist to go through it with you. Whereas in the past they would just send the medication up, it was given to you, and you went home. But now, the pharmacist comes and goes through everything that you’re on. And even then, they fail to put something - which I did - you know - it wasn’t on the list - I didn’t know whether I was supposed to stop it, or - I had to ask my GP. They didn’t know whether I should stop it. And, you know - it was actually the aspirin. You know, and I’d been on it for a long time.” (Wallasey Group)

“And suddenly he put me on something else, and there was no mention of the aspirin. So I didn’t know whether it was a mistake, or whether...” (Wallasey Group)

Interestingly it was reported that there was a much shorter wait or no wait at all for medication at Clatterbridge hospital again reflecting inconsistencies in service.

Overall the main positive for participants was that they all received the correct medication. However, unexplained delays and limited support information were reported.

Transportation

Transportation is clearly an important issues, with many patients being incapacitated by operations and conditions. It was felt by all participants that there should be assistance for patients leaving the ward, by way, for example, of wheelchairs.

A number of participants had had operations affecting their mobility and some have elderly partners who cannot always assist them physically for the long walk to the car park. However, this was not always the case:

“Well I went in for a hip replacement, complete and I didn’t get my wheelchair on the way out.” (Heswall Group)

“I walked out and nobody offered me anything.” (Heswall Group)

“You would think they would provide a wheelchair regardless of what you’ve had done really.” (Heswall Group)

“It’s a basic need yeah. And the same thing I had a cholecystectomy on my gall bladder and like this lady I was discharged the next day and it was a terrible walk from the ward, the car park but nobody said ...” (Heswall Group)

Participants perceived the fact that they were not offered wheelchairs as a sign of the staff’s apparent disregard for patients once they have left their ward:

“You can be holding up the wall and leaning but nobody seems to care once you’ve left that ward, that’s it, you know.” (Heswall Group)

“Yeah it would seem as if once you got off the ward they’ve done a wonderful job.” (Heswall Group)

“They didn’t link up, they don’t come down and see that you’ve got transport home.” (Heswall Group)

One participant gave the example where her son had asked to borrow a wheelchair and instead of checking if she was alright and needed any assistance, the staff simply sat in the staff room as they struggled and shouted a reminder to bring the wheelchair back:

“When we left the staff were all sitting in the staff room and all they, somebody shouted don’t forget to bring the wheelchair back.” (Heswall Group)

“They were more concerned about the wheelchair, to take it back.” (Heswall Group)

Another participant, who had received assistance with this aspect, felt that there was inconsistency in the level of care received by patients, depending upon the staff involved. The group agreed that there should be a consistent approach to assisting patients leave the hospital and this should be part of the discharge process:

“I had the opposite experience. I mean I was only in overnight but I was taken to the car in a wheelchair.” (Heswall Group)

“It depends on staff.” (Heswall Group)

“I take the points made about the wheelchairs. I think that should be part of the service for people that have had an operation, that should be part of the service taking them to the cars, but personally I cannot complain about any of the treatments I’ve had either at Arrowe Park, Victoria or Clatterbridge.” (Heswall Group)

Most participants had a relative or partner able to collect them from hospital. However, only very few were actually asked if this was the case. Those who were asked were then told to contact this person to arrange collection. No one was offered the arrangement of transport and in only a handful of cases did the nurse actually contact the relative to arrange collection:

“Well they just asked me you know, was somebody picking me up and I said yes.” (Heswall Group)

“They do ask you.” (Heswall Group)

“My ward wouldn’t let you go unless you had someone to pick you up.” (Heswall Group)

“No it was a case of I had arranged it all because I have got my sons and just ring them up and say come and get me.” (Birkenhead group)

“Well they let me go and use a phone but I went into a little office to use the phone.” (Birkenhead group)

Again apparent inconsistencies exist suggesting that there is no clear discharge policy. Participants recognise that hospital staff are busy but often elderly patients can be confused or lacking in confidence or expertise in arranging their own transport.

Support at home following discharge

Only one participant had care already arranged at home and this had continued after her discharge and was all arranged by the hospital.

Generally participants were pleased that most had been asked if there was anyone at home to help look after them during their discharge:

“Yes they do ask if anyone is at home to look after you.” (Birkenhead group)

“They checked and they asked that I wasn’t going to be on my own that night because I was having general anaesthetic and this has happened to me before, they have said, when I was going home. They rang my partner and he came for me and picked me up and took me home. So I found it...I found at Arrowe was very good.” (Birkenhead group)

“When I was admitted they asked me did I have anybody at home and I said yes I did which was fair enough.” (Heswall Group)

However, one participant reported feeling disappointed that this aspect was not checked when she was able to go home. She was simply told that if the physio said she could go home, she could. However, she argued that it was not just her physical well-being that they should have checked but whether she was fully prepared and fit for discharge and that she had someone to help her at home and that she could actually get home. She had to make her own arrangements for collection and there was no wheelchair provided for her to get to the car park. When this was requested the nurses reportedly were most concerned about the wheelchair going missing rather than her inability to walk to the car park:

“It didn’t really matter to me too much because I did have somebody at home but the fact that I hadn’t eaten for five days and nobody came and I had to go home or anything like that it was just up to whether I was quite good with my knee and that so the physio was quite happy about it. When I came to go, someone came to pick me up, he had to ask for a wheelchair because it was quite a way from the ward to the car park so they said oh yes you can take one but don’t forget to bring it back, so in effect nobody came with us. Now I’m an ex nurse and as far as I’m concerned the staff are responsible for any patient until they leave the ward, the hospital, on that wheelchair.” (Heswall Group)

“Nobody said are you going to be able to manage to get to the car park and ...but it would have been quite exhausting, the walk.” (Heswall Group)

Furthermore, there were some participants, who needed assistance, who were sent home alone, but did not have any support at home. The nurses apparently were aware that they did not have anyone at home but did not provide any support or keep them in hospital:

“And I think as well - when you've had major surgery, I think it's important that they say - And I know - I've been on wards where people have been discharged, and they live on their own but they've - you know - their daughter will come and pick them up or something and they say - don't - make sure for the next 24 hours you've got somebody with you. But I know very well that their daughter's going home - she's going to feed her family of three, and that lady is going to be left on her own.” (Wallasey Group)

“But a lot of people go home and they don't have anybody with them.” (Wallasey Group)

Indeed, the deaf participant complained that she was not asked if she had support at home and she was sent home with her husband who is also profoundly deaf and who was not able to look after her properly as she could not attract his attention in an emergency. This participant was also disappointed that she was not given any information about community support after her admission:

“No didn't get any information was just sent home. I got a letter of discharge but that was it.” (Birkenhead group)

“Can I just say, I have that problem, I have difficulty washing myself because I have got arthritis and obviously I can't shout to my husband because he is profoundly deaf so if something happens I have to wait and wait until he comes up and then he helps me and it is doubly difficult because we are both deaf. He has to come actually into the bathroom to check that I am ok because I can't shout if anything happens. We haven't been offered any equipment and I have been refused equipment and I am not sure why. Same old story. I have asked them...and so we can communicate and so if I press a button it will vibrate and if he has it on his waist he will know something is wrong and come up but at the moment I have just got to wait. We wouldn't be able to work the chord because we are deaf.” (Birkenhead group)

One participant felt that hospitals are under pressure to discharge early and this results in people being sent home, often alone, who are vulnerable and then have no care from the hospital or the community.

Overall, for the majority checks were put in place regarding in-home care. However, there was concern that this was again inconsistent with patients generally unclear as to what they were entitled to request.

Information following Discharge

It was felt by participants that patients do not receive enough support post-discharge and the information can be rather general, rather than the condition, or even patient, specific:

“You need specialist advice.” (Wallasey Group)

“...and it's also quite general, isn't it. What you're given. Whereas you need something specifically direct to you and your problem.” (Wallasey Group)

Some participants felt it would be useful to have a simple fact sheet, detailing what may happen after the operation, who they can call if something goes wrong or if they need advice and when they should next see a professional at the hospital or in the community:

"I did have on the ward on my discharge it said if you have any problems in the next couple of days I could ring the ward and speak to somebody. I had occasion to phone the ward and I was told go to your doctor." (Heswall Group)

Some participants were given information on discharge from the hospital but this differed across the sample. A small number were given information about their next appointment, what medication to take and what to do if they needed urgent medical attention upon discharge:

"I got my discharge letter and it listed all those other people that got a copy of it, my GP and all that kind of thing." (Heswall Group)

"But then on the good side of it that's a letter telling me that I've got my appointment and where I had to go, this is advice on admission, this is supplementary advice on the medication they sent me before I went into hospital. That's giving me the allocated nurse and what is happening and the advice following it." (Heswall Group)

However, others received no information at all and no discharge note:

"No one ever explained anything but I knew, that's why I was saying to them give me a discharge letter, you don't have one, I said yes I do, no you don't, your GP will get one and that'll do sort of thing. I said no, I should have one with all the medication on." (Heswall Group)

The lack of information was a key concern for many. A majority in the sample left hospital with a lack of understanding about the next step in the treatment. In addition, only a small minority were actually aware of the discharge process itself. Previous experience has taught that often patients when confronted with medical staff are more likely to say they understand information presented verbally. In reality it is likely that they do not. Equally, many questions and concerns are only formulated 'after the event'. To receive key information in a written form enables easier digestion of conditions, treatments and consequences but also can serve to allay many fears about subjects not fully understood.

Support Post Discharge

It was felt strongly that there is a lack of support for these recently discharged patients. One participant reported that, when she had a colostomy bag fitted, she was told she would simply 'have to live with it' which conflicted with other information that she received which stated that she should receive counselling:

"(The nurse) said you'll have to live with it, just said you'll have to live with it. And now I've got my paperwork, and it said - extensive counselling will be given. Half an hour. And I thought extensive counselling? I've got to have somebody I can talk to about this. And believe you me, this is major stuff, this. I'm a pretty stalwart person, but this is major stuff. And luckily - And I rang them up and I said can you give me somebody to talk to? And they gave me a wonderful woman in Liverpool. And she had me genned up before I went in. Hence your - I admire that. She had me genned up. And I was ahead of the game when I went in. But it was only thanks to her." (Wallasey Group)

Another participant was very ill after discharge and despite being told to call the ward 'any time' there was nobody there to help her and she ended up back in hospital. This participant would have liked a 'helpline' in the first days after discharge, where staff know the patients problem and can offer advice and reassurance:

“And each time they have said to me - right, here's your discharge papers - they've told me who to go back to on the ward - discharged Ward 17 - and each of the teams that I - surgical teams I've been under - have said to me - just get in touch, any time, and we know your problems, we'll deal with them. No. There's nobody to get in touch with, and nobody wants to know. And you have to - at half past ten at night, with projective vomiting and excruciating pain, and shakes - you have to supposedly get in touch with your doctor, who will then get in touch with your specialist's secretary, who will then make an appointment for you. Or you go and ring up the ward, and there's nobody there that knows anything about you, and you'd better go to out of hours or A&E. You go to A&E, and you sit there for two hours, and you're falling asleep in the wheelchair with your sick bowl in front of you, and you've taken your own blankets - and you've fallen asleep on your husband's shoulder - and then a doctor tells you to go home and take a laxative and you'll be fine. So, two days' later you end up back in hospital again for a week.” (Wallasey Group)

“That's kind of an ongoing - And it's just a nightmare. You're trying to phone with one hand, and keep yourself intact with the other one. And it's - it's been my experience four times.” (Wallasey Group)

This thought was echoed by other participants who felt that a helpline after discharge would provide reassurance for patients and avoid readmissions:

“I think we need more aftercare for patients.” (Birkenhead Group)

“But I would have thought that on things like major surgery, which unfortunately I seem to always end up doing - major surgery - that there should be a group of people that 24/7 you can ring up on call. And they will sort you out.” (Wallasey Group)

“You don't know what's going to happen to you. You've got no idea what's going to happen to your body.” (Wallasey Group)

“Yeah. And I'm only asking for major surgeries, and I'm only asking for four days or five days afterwards. But it's a whole lot better than me ending up back in hospital for another couple of days.” (Wallasey Group)

“Your really worried, and really frightened - and that's what it comes down to - it's fear in the end. You're really frightened.” (Wallasey Group)

“The back-up is needed, when things do start falling apart. But you can't stay in hospital indefinitely, waiting for these things to happen. You know, and I don't anticipate them happening. And I don't - Personally, I would sooner it happened at half past ten in the morning when I could get to the doctor.” (Wallasey Group)

One patient who had severe health issues following discharge found he had to follow the same route as any emergency to seek treatment and then had to endure a long wait in A & E. It was felt that perhaps the needs of recently discharged patients could be prioritised so recent patients who have been discharged can be seen sooner if their problems are known:

“You have got to go through the same process as if you fell into a - when you were drunk and you fell down - in the street. There is nothing. There's no priority for you.” (Wallasey Group)

“Well when you've been cut open - you know - from top to bottom, and everything's been taken out and bits have been put back in - you know - And you're out in five, six days, and you're depending on people at home caring for you - And I'm pretty agile and pretty determined, so I'm up and going. But when the vomiting starts, and shock sets in, and things

like this - you don't know where you stand. And there is literally nobody to go to.” (Wallasey Group)

Support post-discharge was generally viewed negatively with many reporting little or no help. Discharge from hospital tends to result in the patient returning to the status of ‘new patient’ despite a recent detailed knowledge of their care and condition.

Support from Community Practitioners

Participants reported an apparent lack of communication between the hospital and the community nursing team/doctors surgery regarding aftercare. Many participants were shocked that after a stay in hospital, their recovery was not checked or facilitated by a community practitioner. They reported feeling confused, alone and unsure of how to treat wounds or gain advice if required:

“Well, that's it. You want reassurance. I think this is what we're talking about. Reassurance. And maybe then - and the long-term maybe help where it comes in. So that I think the local surgeries should do more, personally, than what they do.” (Wallasey Group)

“The only complaints I had was when I came out I still had stitches in and they failed to tell the District Nurse. I had to ring up my GP and say you know, I need somebody to come and take some stitches out and to be fair they came pretty quick.” (Heswall Group)

“I have no complaints whatsoever and I think that's why we were disappointed, my wife and I...the discharge was the opposite. I got all my tablets like people say and I got a copy of the bits and pieces stating what tablets I was on. I think it also said what they were for and everything associated with the tablets and everything else and my wife was a bit concerned because I was on about twenty-five, twenty-six tablets a day because I caught pneumonia whilst I was in as well and so you're on fairly strong antibiotics to get shot of that but when I got home she was then concerned and wondering if she was doing the right thing but there's no one to turn to for advice or help so for five or six, I came home on the Monday and by the Friday she was getting a bit worried, no nurse, no District Nurse or whatever we call them these days, no doctor, nobody had been near and yet on the text that they sent to everybody, somebody said they listed the names, one was listed for my GP. Now, after five days nobody came near so on the Friday my wife said can't go another weekend, I want somebody to advise me what we're doing is right so she rang up and was told 'we don't just send in a nurse like that.’” (Heswall Group)

Some reported that their GP was not even made aware of their stay in hospital or the aftercare required. Others commented that their GPs did not seem to have all the information about their treatment:

“Information. They don't know anything about your case. You have to explain everything. Even your doctor didn't know.” (Wallasey Group)

“My doctor didn't know what I'd had. And he tried to stand me off about six months ago, and said well you're damn lucky you haven't had cancer. And I said please will you look at my records for 2001 and find out that I had rectal cancer. And he said - when was that? I said nine eleven, 2001. Oh, you had a polyp removed. And I said yes, and what was wrong with it? And he said oh yeah - did have cancer, didn't you” (Wallasey Group)

“Well, you know the answer - change your doctor. I'm sorry. I wouldn't get that in my doctor's.” (Wallasey Group)

Furthermore, another participant, was appalled at her discharge experience as she was sent home, alone, and was not given any support in the community at all and was very unwell after her operation. She discovered that a letter had been sent to her doctor stating that she had been discharged with an 'uneventful recovery' but she totally disagreed with this and felt she needed aftercare.

She was disappointed that the communication between the hospital and the community appeared to have broken down. She was given some information about what medication to take but she was upset that a patient in need, with no family nearby, can be sent home in a taxi and left with no community representative checking on their welfare:

*"My letter said I had an uneventful recovery... and I had anything but an uneventful. I had a very painful time, very, very bad reaction to the procedure and I had several biopsies and I was monitored all in the night, all the next day, until about three o'clock and then they said I could go home but what I was bothered about was the lack of communication. My letter said I had an uneventful recovery and I sort of said it should be had up on the trade description, you know laughing, it was a nurse that discharged me but I wasn't well enough to get to my doctor's for some time and I then found that that was the same letter that my GP got. He was quite surprised to discover that it wasn't uneventful... Not a good communication to me."
(Birkenhead group)*

It was felt that, as community teams are available in their areas, they should be able to provide decent aftercare:

"But they've got community teams. They have district nurses, they have OTs, they have physios in the community. So, you know - the facilities are there. They might be very busy, but the facilities are there." (Wallasey Group)

"Do you know what I think? I think the surgeries - We've heard about different surgeries, what they have. I think that even that our own surgeries should have that sort of a facility. Where you know that you can go there, without having to say well when can I come? Oh well, next Tuesday - the appointment is. Whereas that sort of thing - if you'd like to say - well, call in - when people who have got problems can go in and have a discussion with the nurse, and if it's anything really - problems - she can move on from there." (Wallasey Group)

"Or give you advice. And if it was done in the local surgeries, then we wouldn't have far to go, and we know the surgeries." (Wallasey Group)

"I think probably that was the original idea for the walk-in centre." (Wallasey Group)

Communication, or the apparent lack of it, was the main cause for concern. A discharge 'pack' should include relevant contact details for those in the community who will take on care after discharge.

Suitability of home environment following discharge

For the most part, there were no major changes required to participants' homes after discharge from hospital. This aspect was discussed with most participants prior to discharge:

"Equipment-wise they do. I've had a hip replacement, but that wasn't what I've come - you know - on this one. And yes, they do sort you out then with equipment afterwards." (Wallasey Group)

"Oh yes. Yes. They do a - they do an assessment inside. You have to be able to do things" (Wallasey Group)

“Be self-sufficient.” (Wallasey Group)

“They assess you, and then they’ll say what you need and then come to your home to sort that out.” (Wallasey Group)

“Yeah, they deliver it before you get home. Because I didn’t go to my own home after the hip op. Because I was living on my own.” (Wallasey Group)

For two participants, there were certain adaptations required to their homes because their mobility was impaired. They were very pleased that all of the equipment was sorted out for her and it was ready when she got home:

“Yes, they sorted all that out for me.” (Heswall Group)

“Yes they did all that for me, the chair, the toilet, everything. Even measured my bed to see whether it wanted lifting, they were very, very good.” (Heswall Group)

“I had a new knee and they came out to, what this lady said, you know, toilet and your bed and your chair, you know, to make sure your chair’s high enough.” (Heswall Group)

One participant received part private/part funded domestic help and personal care and this continued after discharge as the hospital liaised with the care company. This participant was very pleased with this element of the discharge process.

There were some less positive stories. One participant had had major bowel surgery and felt that the accessibility to a toilet should have been checked before he was allowed home:

“With having a bowel thing, we had a downstairs loo put in for my mother, under the stairs. But I mean, the point is that if I had to come out after major surgery, and I’ve had to go up and down stairs to the loo – that should have been really checked, I would have thought. There have been some cases of people who were in the section with me that that would have been the case - So that caused me a bit of concern as well, these people going home on their own, and also the fact that I knew their loo was upstairs.” (Wallasey Group)

Another participant was admitted via A & E and they stated that nobody discussed the issue that they had left their home in chaos following their emergency admission:

“No, there was nobody.” (Wallasey Group)

Generally it appeared that most participants were positive about the help they received regarding their home environment. However, once again some inconsistencies meant a minority felt ‘let down’.

Caring responsibilities

Participants were asked if they thought their carers felt involved in the discharge process. It was agreed that carers would like to be more involved as they are not currently as included in the process as they would like:

“And as I said - for a carer - for my husband - he’s just completely left out of the loop altogether.” (Wallasey Group)

“Yes. You’re not really in the loop. You’re outside the loop. So it would help if you could” (Wallasey Group)

“Well you’re just not - not included.” (Wallasey Group)

"You're not really kept informed as the carer." (Wallasey Group)

"I think just to be accepted as a carer would go a long way. You know, if somebody said oh, are you the carer" (Wallasey Group)

"And they said oh - she's - you know - she's under anaesthetic, there's no point. So I thought - yes, but - you know - even if somebody's maybe out more or less cold, they still - there's still a contact there. For the carer." (Wallasey Group)

"I mean, I've been under anaesthetic and someone's come and held my hand and that, and I've been aware. I couldn't say anything, because my throat was - with the anaesthetic and that. But she knew somebody was there, and caring. And that's - I think that's important." (Wallasey Group)

Some would have liked to have more information about what happens afterwards and who to contact for help if needed. They felt that there are benefits to including a carer in the discharge process. The carer is a second 'filter' for information, knows the impacts on the condition and needs to know the impacts on their role as a carer upon discharge:

"Two heads are better than one, basically. Aren't they." (Wallasey Group)

"Because I mean if you've just had major surgery you're not taking everything in. And the carer can - not being under anaesthetic, or the remnants - can hear what the patient needs to hear" (Wallasey Group)

"And you can interpret it more." (Wallasey Group)

"It helps the healing process anyway, to anybody, if a carer's there and knows what they're doing." (Wallasey Group)

"See if you're going to carry the caring on after the treatment, you've got to be aware of what's going on so that when you do go back home you're doing the right thing" (Wallasey Group)

In addition, some of the sample were also carers as well as recent patients. None had been asked if they were a carer for someone else and most had to arrange for someone to take over their caring responsibilities while they were in hospital:

"I had a relative dying of cancer and he was in two days before I had gone in and I was in for three weeks and in that time I did tell them that I had a relative and I was next of kin and he needed to see me and I said when will I be out and they said we can't tell you." (Birkenhead group)

"Yes my daughter had to take that responsibility on and go and deal with it and he was dying fast." (Birkenhead group)

"No they didn't seem to be concerned about that." (Birkenhead group)

Overall, it was apparent that participants wanted their carer involved throughout the whole process. In addition there were requests for questions about patients caring roles to be asked.

Care plan

A large majority of participants were unaware of any care plan put into place. They all agreed that the concept was extremely useful. They thought that this should be a plan of what exactly was going to happen and who was responsible for each part of the process – in this case the process of discharge from hospital:

“No. Not at all. Never.” (Wallasey Group)

“No. I didn't even know I was getting a district nurse until she arrived two days' afterwards.” (Wallasey Group)

“I had a dietician. Yeah, because I couldn't eat properly. So they sent one round. I didn't know they were coming. They sent one round to my house to write out menus and things.” (Wallasey Group)

“They sent the colostomy nurse round, and I was just about to take my - doing the shopping in Birkenhead, and we literally tripped over - on the front doorstep. We knew nothing about it. She was with us for half an hour, and left. And I didn't - it went - woosh - didn't want to know, wasn't interested. Didn't need it. This time, they just came out of the blue again” (Wallasey Group)

“Some of the time they must be wasting their time, because they turn up and nobody knows they're coming and they may not even be there.” (Wallasey Group)

“They've come to an empty house.” (Wallasey Group)

Only one participant thought that there was a care plan in place but was not aware what this entailed and could not recall whether this had been discussed with him.

3.3 Improvements to the hospital discharge process

Participants were asked to list the main aspects of the discharge process that they felt could be improved. These issues are highlighted below.

A follow up in the community following discharge

There were widespread concerns from participants about the lack of support and advice following their discharge from hospital. Participants strongly felt that there should be a standard follow up by a medical professional from the community, even if only by phone, to all relevant people who have been in hospital:

“An automatic follow up by someone, either from your GP or from the hospital. A visit, a physical visit from someone within a week of discharge to make sure that the medication you’re on ...is correct.” (Heswall Group)

“And they should remove that little piece on the paper that says if you’ve got any problems phone the hospital, this ward. Because it’s non existent. It doesn’t exist.” (Heswall Group)

“I think it’s essential that when you do get home that there is an immediate follow up. You can go on taking medication for too long and I found that.” (Heswall Group)

“There should be an active follow up within a number of days in case there is any change of medication required.” (Heswall Group)

A check that there is someone at home to help care for you and your home is suitable for your return.

Participants thought that it should be checked that all patients have support at home following discharge, it should not be assumed.

Good communication with the GP regarding the medication the patient is on and their post admission condition.

Participants suggested improved liaison with the community following discharge so that GPs and community nurses are fully aware of the patients condition and can then follow up on it:

“I think sometimes they’re very slow in getting information to your GP.” (Wallasey Group)

A clearer understanding of what happens after discharge and who to contact for advice. Participants felt that they would benefit from clearer advice about what happens after discharge and what to do if something goes wrong:

“My wife was wondering did she need to bathe the wound because they took the clips out before I left and if so what to bathe it with so but until the doctor came which was a week later there was no one to ask so we were just left and the doctor said well I never received a copy of it so she didn’t know what to clean the wound with or when to clean it or if she was allowed to clean it at all so that part of the care plan for us was non existence.” (Heswall Group)

Quicker access to medication

Participants felt that the speed at which medication is available after discharge could be improved, to avoid long waits:

“Getting the pills to the ward on time before you leave.” (Heswall Group)

“Quicker access to medication.” (Heswall Group)

“I think that’s one of the problems in the hospital today. I noticed it’s going back a year or two or more, is they wait from Pharmacy to getting the pills. I think that’s something that could be addressed. If they know you’re going out they have the times when Pharmacy deliver to the wards but if they know a patient is about to be discharged there should be some procedure in place where the medication that’s going to that person can be delivered with the normal delivery to the ward in the morning say or whatever if the person’s discharged and then handed to them with the discharge advice etc rather than having to wait. I think that’s something that could be addressed.” (Heswall Group)

A specific discharge time

Participants felt that the discharge process could be better organised so that people are given a more specific discharge time, to avoid long waits with little information:

“A specific time when you know that the consultant who is going to discharge you because you can be told you’re going out tomorrow, I’ve been told I’m going out tomorrow and waited for practically the whole day before someone comes round to tell you. There’s nothing worse. You know you’re going home.” (Heswall Group)

“And your bed has been cleaned up and possibly even getting allocated to someone else but you still don’t know when you’re going home.” (Heswall Group)

“I think that if you are going to go home or be discharged shall we say and they say you can go home, they should do it there and then when they are by the side of your bed and not leave it and so you keep saying to the nurse can I go, can I go?” (Birkenhead group)

Access to a sign language interpreter so that deaf people understand what is happening.

Participants agreed that access to an interpreter for deaf or non English speaking patients should be a standard part of the discharge process so that patients have a full understanding of the process. A fully-trained interpreter should be available on all shift patterns.

Continuity of care

Continuity of care was a big issue for participants, seeing the same staff and consultants from admission to discharge:

“You see the consultant first time - and then after that, you never see them again.” (Wallasey Group)

Caring responsibilities

An acknowledgment of the role of the carer in the discharge of a patient and also the patient’s caring responsibilities where appropriate.

Other Issues

Other issues relating to the discharge process were also discussed. Participants were asked if they had filled in a questionnaire before leaving the hospital. Some had received and filled in such a questionnaire. They thought that this would be a useful feedback medium but there was some level of cynicism as to whether any comments were actually read and acted upon:

“If they read it.” (Heswall Group)

“Providing they follow it up, yep.” (Heswall Group)

“Only a tick-sheet, you know - didn't take long to fill in” (Wallasey Group)

Participants were keen to know that any comments would be dealt with. They requested a feedback route where what was being done to overcome any problems could be identified. There were many requests for a copy of this report.

Ultimately, aside from practical issues, it was clear that the discharge process was perceived to be ad hoc and lacking in a real actionable process. If a process actually exists then communicating this to this sample would be a useful step. Clearly setting out, in written form, how the process should be manifest, in terms of who makes the decision, how long it takes, help with transport, follow up care and communication processes with after care organisations, would be beneficial. Simply knowing where they are in the process and what to expect can alleviate many cases of stress and concern.

Appendix A Topic Guide

Wirral PCT Hospital Discharge Review – 250872

Topic Guide

Introduction

- Introduce self and Mott MacDonald, an independent market research agency who have been commissioned by Wirral PCT to conduct a piece of research.
- The focus groups are part of a review being undertaken by the Social Care, Health & Social Inclusion Scrutiny Committee. The committee are working in partnership with the PCT to carry out this process.
- Introduce subject: to gain your views on the hospital discharge process
- Introduce format of the group
- Explain MRS Code of Conduct and Data Protection, all anonymous and no attributions in reports.
- Explain audio recording and ask permission to record.
- Participant introductions.

1. Your recent stay in hospital

Objective: To enable the participants to recall their last hospital admission in order that they can reflect upon their experience later in the group.

- You have all recently needed to stay in hospital or you may care for somebody who has recently needed to stay in hospital. We would like to talk to you about your experiences of the discharge process – the process where you are transferred back to your home environment after a stay in hospital.

You do not have to talk about the reason for your stay in hospital but could you tell the group...

- When you/the person you care for were last admitted to hospital?
- How long did you/they stay in hospital?
- Which hospital were you/they staying at?
- When were you/they discharged?

2. Experiences of the hospital discharge process

Objective: To identify participants' experiences of the hospital discharge process, either as a patient, or a relative/carer of a patient.

- Tell me about your/their experiences of the discharge process, when you were coming to the end of your stay in hospital and were due to go home.
- Were they good or bad experiences? Why is that? Tell me about them.

3. Opinions of the hospital discharge process

Objective: To identify participants' opinions of the hospital discharge process, either as a patient, or a relative/carer of a patient.

Overall

- How did you/they feel about the discharge process? Did you feel that the discharge process worked well?
- Did you feel involved in the process? Why/not? How?
- Did you feel that you were consulted about your care/discharge? Why/not? How?
- Tell me about why you think that?

Staff

- Was your discharge dealt with by the same nurse who had been caring for you during your stay in hospital? If not how many different people were you dealing with?
- Did you feel there was adequate continuity of care in terms of the staff who looked after you? Tell me about why you think that?
- How would you describe the demeanour/attitude/ of the staff? Was this appropriate?
- How helpful were the staff?

Understanding of the process

- Did you feel you understood the discharge process?
- Did you feel you had enough information about what would happen when you were discharged from hospital?
- Where did you get this information? How was it presented to you? Was this how you would have liked it to be presented? Why/not?
- If verbally: How would you describe the tone of those who gave you the information? what makes you say that?

Timeliness of discharge process & facilities whilst waiting for discharge

- Did you have to wait to be discharged? If so, what was your experience like?
- How long did you have to wait? How do you feel about this length of time?
- Where did you wait? Did you go to the discharge lounge? Tell me about that.
- Were you kept informed during this wait? Who by? How often?
- Did you have to seek information yourself? How do you feel about that?

Accessing appropriate medication

- Were you given medication/access to medication upon discharge?
- Were you given the correct medication when you were discharged?
- Was the correct medication available at the time of discharge? Was any waiting time experienced? If so, how long?
- How did you feel about this aspect of your discharge? Tell me about why you think that?

Transportation required

- Did you require transport to take you home from hospital?
- Were you offered this transport?
- What did you think of this provision? What was the quality of this provision?
- Did you have to wait for the transport? How long? How do you feel about that?

Support at home following discharge (community nursing/social services etc)

- Did you receive help at home before you went into hospital? If so, was this help resumed when you went home?
- If not, were you asked if you needed help at home or was it recommended to you?
- What kind of help did you receive? How long did you receive help for? What did you think of the help you received?

Suitability of home environment after discharge

- Was your home properly prepared for your return?
- Did hospital staff check your home was ready for you (e.g. for people who have had a fall at home, is the house just as unsafe as it was beforehand?)
- If the patient was admitted as an emergency, the home (and life in general) may have been left in some disarray. Was support available to sort out any outstanding issues?
- Did you have any privately funded domestic help or personal care before admission? What has happened to that whilst they were in hospital? If you are in for a long stay, or

need intermediate care afterwards, you may have lost your private care. Or you may need extra for a while. Is hospital helping to identify and sort all these issues?

Consideration of your caring responsibilities, if a carer

- For those of you who are carers, what impact did the discharge process have on your caring ability?
- Was your caring responsibility taken into account at discharge? In what ways?
- Did you feel part of the process? Did you feel included?

Care plan

- Was there a care plan in place? Were you aware of your care plan and was it discussed with you? In what level of detail? Was this sufficient?
- How clearly was it explained to you? Did you feel confident in what the care plan set out? Did you feel confident that it was explained well enough and that you understood the plan?
- Was this a written care plan? Did you receive a copy?
- If yes, was it useful?
- If no, would this have been useful?

3. Improvements to the hospital discharge process

Objective: To identify whether they think any part of the process could be improved.

- Whether you have experienced the discharge process directly or indirectly, do you think anything about it could be improved? *Spontaneous, then prompt if necessary:*
 - Continuity of care staff
 - Hand over to community nursing team
 - Understanding of the process
 - Level of information received
 - Improved links with Social Care upon discharge from hospital
 - Accessing appropriate medication
 - Facilities whilst waiting for discharge
 - Transportation required
 - Suitability of home environment after discharge
 - Consideration of your caring responsibilities, if a carer
 - Absence of care plan
 - Support at home following discharge
 - Timeliness of discharge process

Other issues

- Did you get a questionnaire from the hospital prior to discharge? Did you complete it?
- Would a questionnaire have been useful? What makes you say that?

Sum up

- Are there any other comments you would like to make about the hospital discharge process?

Appendix B Moderator Notes on Discharge Process

Hospital discharge policy notes for moderator

The Wirral University Teaching Hospital and Primary Care Trust discharge teams have developed a policy, based on the Department of Health “Discharge from hospital: pathway process and practice guidance”, which aims to ensure the safe transfer and discharge of individuals to and from their usual care environment.

The Nurse / Midwife is responsible for ensuring that:

- All communication with the patient is recorded in the patient case notes
- The name of the responsible nurse should be clear to all those involved in the patient’s care and clearly documented in the patient’s case notes
- Co-ordinating patient assessment, using the Adult Common Assessment Framework and any specialist assessment
- Discussion with the patient regarding potential discharge/transfer dates takes place within 24 hours of admission and is recorded in the patient’s case notes
- Discussion with the patient’s relatives and carers a potential transfer/discharge date and destination as early as appropriate after admission and record in patient’s case notes
- Following a thorough assessment of the patient’s needs, ensure that timely referrals are made, results are received and any delays are followed up
- The Continuing Care checklist is completed for every patient once clinically stable (appendix 1)
- If Carers issues are identified that a referral is made to Social Services
- Discharge Action plan is initiated and completed (appendix 1)
- Referral to Intermediate Care Discharge team (ICDT) is made on the identification of patients who require an Intermediate care bed
- All patients who meet the discharge lounge criteria (appendix ?) are transferred to the discharge lounge by 10am (Monday – Friday)
- Mental capacity assessment is undertaken for patients presenting with cognitive impairment
- Discharge letters are given to the patient on discharge

The Integrated Community Discharge Team (ICDT) is responsible for:

assessing patients who may require an Intermediate care bed
ensuring that referrals to the District nursing service are sent to the correct locality
Fast tracking discharge arrangements for dying patients
Ensuring that pressure relieving equipment is identified and ordered in time for the discharge date
Validating the decision support tool assessment and making recommendations

Process for Discharge

The process for discharge begins on admission with the commencement of the discharge action plan
When identified fit for discharge the Discharge Action plan is completed.
Between 8am and 8pm Monday – Friday - All patients are transferred to the discharge lounge at 10 am (except Bank Holidays).

Process for Discharging Dying Patients

The Dying patient will be referred to the Integrated Community Discharge Team for fast tracking discharge arrangements.

Process for Discharging Homeless Patients

The Trust's formal admission procedures should be adhered to, ensuring homeless people are identified on admission and their pending discharge is notified to the relevant primary healthcare services and to homelessness services.

Process for Discharging Patients whose First Language is Not English

The Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare professionals. It is not appropriate to use children to interpret for family members who do not speak English or who have a sensory impairment

For assistance with translators / interpreters, staff must contact the Patient & Public Involvement Manager on extension 8437 during office hours or the Hospital Co-ordinator out of office hours.

Patients with a Sensory Impairment

Wards and Departments all have access to communication aids, for example hearing aid loops, communication boards, etc. For guidance, contact the Trust Disability Advisor on extension 2869.

Process for Planned Discharge Out of Hours

The process for discharge out of hours (Bank holidays, weekends & after 8pm) is the same as usual except that:

If a district nurse / midwife is required a referral should be faxed to the GP Out of Hours service

Ensure the relative / carer is informed and is aware of the discharge time

Transport will be provided if required

Documentation Provided on Discharge

Patients will have the following documentation provided on discharge:

- A discharge letter
- Clinic appointment if required
- Prescription chart if required
- Relevant Information leaflet
- Transfer documentation for Residential / Nursing Home discharge
- Adult Community Assessment Framework documentation for an Intermediate care bed

APPENDIX 3: MEETINGS HELD DURING THE EVIDENCE-GATHERING STAGE OF THE REVIEW

Meetings were held with the following individuals during the evidence gathering stage of the review.

1 Wirral University Teaching Hospital

Pat Elliott, Deputy Divisional General Manager, Medical Division
Janine Wharton, Manager, during visit to Discharge Lounge (August 2008)
Mandy Chapman, Divisional Lead Nurse during visit to Rehabilitation ward, Arrowe Park Hospital
Melanie Maxwell, Director of Clinical Effectiveness
Heather Gassab, Manager, during visit to Discharge Lounge (January 2009)

2 Wirral NHS (PCT)

Tina Long, Director of Strategic Partnerships
Heather Rimmer, Integrated Commissioner, PCT / Department of Adult Social Services

3 Wirral Council, Department of Adult Social Services

Rick O'Brien, Head of Service, Access and Assessment
Dave Carroll, Service Manager
Jeanette Hughes, Manager, Care Management Team based at Arrowe Park Hospital

4 Voluntary Sector

Susan Cassapi, Manager and Advocate, WIRED (Wirral Information Resource for Equality and Disability)
Sue Newnes, Manager, Alzheimer's Society – Wirral Branch
Sharon Gould, Volunteer, Citizen's Advice Bureau, Arrowe Park Office
Annette Roberts, Chief Executive, VCAW (Voluntary Community Action Wirral)



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Patron for Ethnic Minority Groups: Lady Irene Chan

Wirral Older People's Parliament

Hospital Discharge Survey July-September 2008.

Initial Report

About 700 copies of our questionnaire were distributed during the late summer, and exactly 200 completed questionnaires were received by the end of September. We thank Parliament members and associates, plus professionals within the NHS and Adult Social Services who helped by giving out questionnaires. We thank the 200 people who took the time and trouble to fill in the document. We also thank the Wirral PCT who agreed to fund the Freepost service, and Livi Parkins at Age Concern Wirral, who transferred the data onto a spreadsheet.

Responses came from across Wirral, with a significant proportion from the Pensby area

There were more women than men, and the biggest age group was people in their 70s, although 60s and 80s were nearly as well represented. There were seven respondents in their 90s. Almost half lived in a house with stairs, and almost half lived alone. For half the group, this was their only hospitalisation in the past year, but over fifty had been in once or twice before in the year, and one respondent seven times. Well over half were in Arrowe Park, twenty six in Clatterbridge and about twenty in various other hospitals around Merseyside and Cheshire. Only twenty two reported being offered a choice of hospital, although almost half of the 200 had been admitted as an emergency, and are unlikely to have had a choice. Those who had a choice said that they chose for convenience(10), doctor's recommendation or medical reasons(5) and shorter waiting list (3) For thirty eight this was a readmission for a previously treated condition.

We asked how many nights they had stayed. Twenty five had Day Treatment. The rest ranged from 1 to 90 nights. About one third were home within the week. About two thirds had more than one ward during their stay – though I realise that A&E admissions may have found it difficult to be sure what constituted a ward. However, twenty five stated that they stayed in three wards, and one person claimed six! Two of the people told us that they had been readmitted within three days in an emergency.

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We tried to find out how patients recalled any assessment they received on the ward in preparation for discharge. Twenty five thought that they (or a family member) had completed a self assessment document. Sixteen thought that they had done one at some other time. About one third were clear that a member of the hospital staff or a social worker had discussed how they might cope after discharge. About half thought that they had been given enough information to cope after discharge. One quarter were clear that they had not, and many of the individual comments relate to feelings of fear and anxiety about what to do once they were away from the ward.

We were surprised that almost half of the respondents claim to have had a day or less notice of time of discharge. Twenty four of them said that they had one hour or less warning, and there were some written comments about how difficult this can be. Almost all were returning to their own home. Five stayed for a while with family or friends; six had intermediate care and one moved into a care home. Exactly half reported no delays in getting their medicines for discharge, but forty two had unacceptable delays. Sixty four say that they went to the discharge lounge, but under half of this number stayed there for over an hour. Ten suggested that their stay there was far too long ("most of the day" "ages" "too long" "eight hours" etc) Over half were taken home by family or friends. Three used volunteer drivers and three public transport. Thirty four went with the Ambulance Service. An alarming number of our respondents mentioned difficulties that their driver had had in parking near the main entrance for pick up, and the biggest single suggestion on the questionnaires is that there should be a short stay pick up bay at the main entrance (or some other hospital door).

We looked at preparations which might have been made by others to get their home ready for discharge. Forty had not had anyone to do this, and there were several distressing comments about the problems. These ranged from someone having four days worth of diarrhoea-stained bedding from pre-admission to deal with, to someone contacting her son in Scotland to order shopping via Tesco Direct. Someone else persuaded the District Nurse to shop for her, since she didn't have anything in the house. Over a quarter said that no one checked that they were going to be able to get around the house and manage the basics. This is an area needing urgent action for the significant minority who live alone without anyone to prepare the house for them.

There were, however, far more adverse comments about medical needs after hospital. Many of them clearly relate to anxiety and lack of knowledge. When one is

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in hospital, most people feel that help is at hand if something feels wrong. Many of the group living alone, or living with their spouse obviously felt very “alone” and “vulnerable” Several felt that they should have had nurse visits to change dressings or that their GP should have been notified on the day of discharge and checked on them. Forty six reported having visits of a health professional arranged before discharge . Several others thought that they had been told to expect OT or physio follow-up which did not materialise. One respondent reported a week at home before the OT aids were delivered.

Only sixteen reported a home care support package arranged by the local authority, and a further twenty three told us that they arranged extra help privately. Our question aimed at exploring the possible offer of an individual budget did not get much understanding or response. One person said that the care assistants from a local authority funded agency were incompetent, and were cancelled. There were several remarks of this type “ I wasn’t well enough to look after myself. Knowing somebody would come in to do some little jobs for me while I was recovering would have been nice”

Nearly half felt that overall their discharge had been well planned; but thirty two said it had not, and this number is concerning. Eight people had not felt ready to go home, but, on the other hand there were a few who said that they had wanted to leave before they actually did.

Although the biggest single suggestion was a pick up point near the door to take patients home, there was a collection of comments which add up to a major concern, which we are very anxious to see addressed. They all fall into the category of lack of information and poor communication between agencies and the patient. This is typical:- “I would have liked more information as to my estimated time of stay, when I could expect my discharge, and what was available for me as after care as I live alone” “It would have been nice to have advice about care and help at home.” “The discharge was chaotic. The overall impression was one of I was deemed to be a liability and just in the way and to be rid of asap. Would have liked someone to sit and go through with me what my most immediate needs are and how can they be best met, and if they can’t, how can we proceed” “I went in as an emergency. It would have been helpful to speak with the consultant regarding future prognosis. He never spoke to me at all. I would have liked to speak to staff about possible establishments if my family can’t help. I needed information about the possible effects of medication

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and what to look out for. I would have liked the telephone numbers for emergency doctors, and more rapid transfer of information to my doctor.”

To counterbalance the concerns, we must stress that about half of our sample were very happy with their treatment and discharge. A follow up report will look in more detail at where the difficulties lie, and how the patients who were treated outside the Wirral fared on discharge. Our immediate recommendations are:-

1. Make it easier for discharged patients to be picked up at an entrance to the building.
2. There are still some long delays for discharge medication. How can this be speeded up?
3. Identify patients who have had no-one to prepare their home for discharge. (Consider the new “Home from Hospital” service being set up by VCAW.) In general, patients who live alone are extremely anxious about possible problems.
4. Look at ways in which all teams (hospital and community) can communicate better between themselves and with the patient. The high levels of anxiety, often due to lack of information, experienced by discharged patients were very evident in the comments on the questionnaires.

To quote one of our respondents “Explain procedures and what is going to happen. Waiting for things to happen stresses a patient. It’s like waiting for a bus that never comes”

Sandra Wall
Health and Social Care Committee of Wirral Older Peoples Parliament

APPENDIX 5: PROPOSED ‘PERSONAL / HOME CIRCUMSTANCES CHECK LIST’ (AS ORIGINALLY PROPOSED BY WIRRAL OLDER PEOPLE’S PARLIAMENT)

These questions are not about the medical and nursing care and treatments you might need. They are about the practical things which might not be easy when you have been ill.

- | | | |
|---|-----|----|
| a. Do you normally have other people living at home with you? | Yes | No |
| b. Do you care for anyone else at home ? | Yes | No |
| c. How are they being cared for at the moment? | Yes | No |
| d. Will your home be clean and tidy for you when you go home? | Yes | No |
| e. Will there be someone to do your laundry while you are in hospital? | Yes | No |
| f. Will there be someone to get shopping in for your return home? | Yes | No |
| g. Will someone have dealt with your mail while you are In hospital? | Yes | No |
| h. Will there be someone to take you home when you go? | Yes | No |
| i. Will someone have dealt with any bills for you? | Yes | No |
| j. Will someone have looked after any pets you have? | Yes | No |
| k. Have you got a bit of money for your stay in hospital? | Yes | No |
| l. Do you think you will be able to cope at first when You get home? | Yes | No |
| m. Have you got family or friends who will be able to help if necessary when you get home? | Yes | No |
| n. If you think you will need extra paid care for a while when you get home, can you afford to pay? | Yes | No |

- | | | |
|--|------------|-----------|
| o. Will you be able to get round the house to the bathroom, kitchen, phone etc? | Yes | No |
| p. Will you have a door key for your return home? | Yes | No |
| q. Will someone be able to bring in clothes for your return home? | Yes | No |
| r. Is there any medication at home that you are taking regularly? | Yes | No |
| s. Have you got any worries we have not mentioned about your return home? Please let us know what they are. | | |

Would you like to give us the name and phone number of the main person who will be helping you when you go home?