BEDFORDSHIRE LOCAL INVOLVEMENT NETWORK (LINk)

BEDFORDSHIRE LINk's SURVEY INTO THE VIEWS OF CARE & NURSING HOME MANAGERS ON HOSPITAL DISCHARGE PROCEDURES

January 2011

ACKNOWLEDGEMENTS:

Derbyshire LINk

Bedfordshire LINk Social Care Working Group Members who formed the research group:

Bob Smith

Graham Abdullah Dinn

Ruth Featherstone

Ted Jolliffe

and John Rodgers, Patricia Ford, Paulette Rennie, Mike Newman, Bob White, Paula Hill, Max Coleman, Ray Gunning, Monika Elliott, Sandra Fielding

Bedfordshire LINk Acute Services Working Group

Bedfordshire LINk Host Team:

Charlotte Bonser

Lemar Walters

BEDFORDSHIRE LINk Survey into the views of Care/Nursing Home Managers on Hospital Discharge Procedures – January 2011

Aims and Objectives of Study

The aim of the survey was to determine how effectively discharge planning is being carried out for patients discharged from hospital into care and nursing homes in Bedfordshire and Luton. It is the first part of a study looking at outcomes for patients following discharge from hospital; it is hoped that a second study which may take place between 2011/12 will involve visits to a selection of care and nursing homes to look at the standards of care in line with Care Quality Commission guidelines.

Introduction

Discharge planning and procedures have been on the work programme of the LINk since 2009, as several cases had come to our attention where discharge had not gone well, including cases where the patient has had to be re-admitted to hospital.

During the early stages of our involvement LINk members looked at the discharge policies of both the L&D Hospital and Bedford Hospital, all of which said all the right things and policies and procedures seemed to be in place, including a multi-disciplinary team approach involved in the discharge of patients. But the LINk was aware that sometimes difficulties had arisen and had recorded several cases when this had occurred. We have now devised an incident reporting form in order to record such information **(APPENDIX 2).**

In December 2009, the LINk set up a meeting with the Lead Commissioner responsible for Acute and Urgent Care Commissioning, NHS Bedfordshire to map the whole area of discharge planning; to specifically look at the following areas: what should be happening before admission to hospital, in hospital, at the point of discharge and after discharge.

This meeting only resulted in the commissioner saying she required evidence of the experiences, which we provided, but it did not appear to result in any changes in the system. It did however highlight that some service level agreements with hospitals outside the area, were not always being progressed according to agreements made. Therefore a patient's right to choose a hospital for their surgery/treatment, sometimes resulted in a successful operation being overshadowed by a lack of support once discharged from hospital.

We continued and still continue to log information on inappropriate discharge. Our recent survey of the LINk membership for the *Quality Accounts – Bedfordshire LINk Bulletin No. 27, March 2011* response for both Luton and Dunstable and Bedford Hospitals have highlighted that this remains an issue for the communities we represent.

The issue of discharge procedures came up again at the LINk Social Care Working Group meeting in May 2010, and the survey undertaken by the Derbyshire LINk on inappropriate discharge from hospital into care/nursing homes was discussed. It was agreed that a similar exercise could be undertaken for Bedfordshire. Members of the group worked on adapting the survey questionnaire used by Derbyshire for Bedfordshire.

Methodology

Both the LINk Acute Services and Social Care Working Groups were looking at different aspects of discharge from hospital; the former group looking at the commissioning of services by the primary care trust and the latter at the impact of inappropriate discharge into the community and in particular into care and nursing homes. The above work items dove-tailed and formed the basis of this study.

Also, alongside this, one member of the LINk belonging to both working groups was involved in a piece of work with the *British Orthopaedic Association on discharge entitled "Patient Pathways (Models of Care) for patients who are to undergo planned orthopaedic operations (Feb 2011).* The correct process for discharge for these patients were highlighted in the *May 2010 Bedfordshire LINk newsletter*. This piece of work was in line with the *Department of Health's guidelines on Discharge from hospital pathway, process and practice (2003), DH "Our Health, Our Care, Our Say", better integrated health and social care (January 2006), NHS – DH Achieving Timely 'Simple' discharge from hospital (August 2004)*

The Derbyshire LINk report (May 2010) on the same issue was considered by the Social Care Working Group and it was agreed to use a similar survey to consult the 197 care and nursing home across Bedfordshire and Luton. Although our LINk covers the Central Bedfordshire area, it was agreed that in order to get a more representative sample of homes and because it was evident from accounts from the public and LINk membership that patients were not always able to get into care or nursing homes in their area of residence. The LINk also considered the possibility of holding a small focus group consisting of six home managers, but had to abandon this idea due to contraints on time.

The LINk adapted the questions used by Derbyshire, which required a yes/no response to 16 questions under the key headings of "**At Pre-Discharge Assessment**" and "**At Discharge to the home"**, with a space for written comments.

The survey was a postal survey sent out to care and nursing home managers on 10 January 2011, giving care and nursing homes a two-week period for responses by 31 January 2011. It had been intended to also send this survey out by e-mail and to follow up by telephoning to ascertain if the surveys had reached the care and nursing homes. However, due to constraints on time and resources of the LINk membership and host support team, this was not possible.

To fully understand the full impact and outcomes of the resident's journey from hospital to the care home, we have also commenced communication and liaison with the Local Authority's Compliance Team to understand the way they monitor care and nursing homes, and to ensure the LINk could work with the Council to monitor the homes in the future and independently if required. One of the Council's Compliance Officers undertook training with LINk members on enter and view visiting for members so they could understand our remit as a LINk.

Findings

The full record of findings from the survey are recorded in **APPENDICES 1, 1A, 1B**

There was a 20% response rate to the questionnaire, 40 returned questionnaires out of a possible 197.

Key findings relate to three areas:

- **The practical aspects of discharge relating to aspects of resident's privacy and dignity**

- **Lack of or missing information and possible resident safety issues**

- **Home managers suggesting ways to improve the information/discharge process**

The first two key findings were not dissimilar to that of Derbyshire in terms of two key areas, firstly, in relation to the practical areas of discharge e.g. on the time the resident is discharged and the way in which they are dressed on discharge, and in terms of the information they receive about the resident on discharge to the home. The third key finding is important to our findings, as there are several suggestions made by home managers to improve the discharge process for residents.

It is important to note that although there was generally a more positive response to the **pre-discharge assessment questions**, with 80% of managers saying they were allowed access to resident's notes and that they felt fully involved in the pre-discharge assessment, the responses were more critical to the second list of questions relating to the **discharge process for the patient to the care home**.

In fact if we consider the responses to the initial questions to both sections "*Do you always receive patients discharge information" and "do you consider that the discharge information you receive gives you sufficient information"*, the negative responses of 47.5% and 40% respectively indicates some challenges for managers .

It is important to read the quantitative data in conjunction with the qualitative data. Even where there is a 50% to 80% positive response rate to the question in relation to having access to the patients notes, there were comments indicating that this did not

always happen or managers saying *"On asking" for notes, or "Very rarely am I able to access full notes, daily records and charts", "We have often been given contradictory information".*

It is clear from the comments received in relation to receiving sufficient information, that the managers have suggestions for improving the system and practical ideas as to how information can be presented more effectively. There were seventeen comments suggesting improvements under this question. Some of the suggestions were quite basic, such as wishing to receive guidelines on discharge and not three to four days later, having a copy of the discharge plan, to receive a discharge letter and medication changes, having information in chronological order and to include current next of kin details, NHS Number and name and address, which are not always charted.

47.5 % of home managers indicated that the interaction with the hospital staff and care/nursing home team was done in an appropriate manner. But some of the comments received indicate there is an underlying concern that sometimes hospital staff are under pressure "or occasionally do not have time to answer questions" and can become "defensive and impatient" with the care home staff.

Question 8 – 11 which relates to the well-being and dignity of the residents being discharged all returned a higher negative response with between 47.5% - 57.5 % of homes responding that they felt that residents were discharged too early, sometimes at inappropriate times, e.g. late in the evening or in the early hours of the morning and in unsuitable attire and their continence care not seen to. It would appear from some of the comments that vulnerable residents, such as those with dementia or respiratory problems are sometimes discharged to homes when the patient is not fully ready for release, which has resulted in some residents having to be re-admitted to hospital within a day or two. There was, however, one comment that suggested sometimes residents are kept in hospital too long and would be better in the home surroundings.

45% of home managers indicated that they did not consider that carers of prospective residents were kept fully informed about the choice of home. Several comments indicated this area could be improved, it appears carers/families tend to be directed regarding which home the patient should go to, rather than it being an informed choice.

There was a 50% positive response to the question on prescribed medication from the hospital always being present and correct and errors to medication noted as rare. However, it is evident that sometimes there is a shortfall in the supply of medication or it is sent in the wrong form e.g. tablets instead of liquid form and sometimes nutritional supplements are missing.

Summary and Conclusions

Every day as a LINk we are confronted with and asked to comment on policies and procedures written to ensure that health and social care provision is administered to the highest standard, but as one LINk member put it in the Bedfordshire LINk

response to Quality Accounts for hospitals (March 2011) "*It's often not the failure of protocols, but the failure of management*" to get it right.

The Care Quality Commission circular on *"What standards to expect from the regulation of your NHS Hospital"* is very clear about what patients should expect from treatment in hospital and indicates very clearly the multi-disciplinary approach that is needed from the various health and social care professionals that the patient will come into contact with through the patient journey.

In the paper dealing with a Patient Pathways (Model of Care) planned orthopaedic operations, it clearly mentions that amongst other criteria, discharge should only happen "*according to a treatment plan, expected date of discharge identified on admission or within 24 hrs, and discharge support required identified on admission and active discharge plan in place.* Also*, "the patient should be medically/socially ready to go home – managed discharged to home or place of care*." The paper talks about a multi-disciplinary approach, so generally there is a template for a successful discharge from hospital.

There is evidence in the findings that discharge into such homes does go well, but when it goes wrong it appears to be in the areas of missing resident information, poor recording and sharing of information and in terms of the resident's care, lack of attention to their basic needs such as ensuring they are clean and warm when discharged.

It is very clear from care and nursing home managers who have responded to this survey, they know what a "good" discharge to their home should look like. It is reassuring to note that they are seeing the person at the centre of the discharge. Home managers have given ideas of what would improve the discharge process, and from their comments a seamless hand-over would be if there is a complete discharge plan handed over at the time of discharge, in chronological order with medical history, a note of expected appointments and problems experienced by the patient.

It is also very clear that the home managers are mindful of what is happening within the hospital environment in terms of the pressure on hospital staff having to release hospital beds, discharge at inappropriate times of day, a tendency for patients to move from ward to ward hence gaps in information and sometimes staff having no time to answer questions.

It would be easy to interpret the above failings as the fault of the nurses and staff on duty at the time, and recently nursing care has come into question in the media over the care of the elderly and dementia patients. The *Royal College of Nursing (RCN*) has been critical over the standards of nurse training, which changed with the removal of the State Enrolled Nurse qualification and the advent of Project 2000, which was more academically steered. Certainly there is a question about basic nursing care in this study as patients were discharged without their basic continence and attire needs being met. But is this the fault of the nurse or Ward Sister? Are there pressures being put on these staff from management to meet hospital targets and stop bed-

blocking so that some of the focus on important basic care is lost? Staffing levels and the use of agency nurses/bank nurses may also be an issue.

The LINk has been consistently advised that discharge begins before a patient enters hospital, so it often begins with GP referral or with the care home and social services who have devised a care plan for the resident in conjunction with the person's carers/relatives; a single-assessment that should go with a person throughout his or her journey through the health and social care system. In fact commissioners in the primary care and social care setting also have a very significant input into a patient discharge being successful. With the multi-disciplinary idea still in mind, discharge should include arrangements for all the care and support the patient will need on discharge, otherwise they should not be discharged. The CQC publication referred to earlier clearly states "*You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services*". The example given in the document was of an older person moving from an acute setting to his local community hospital for rehabilitation;" *the community hospital is told before he arrives about what he needs. They make sure that his bed is set up with protective rails and that he continues to get the special diet he needs."*

Our attempts to map the whole area of discharge planning in 2009 ended disappointingly, but looking at the different aspects involved in discharge it is not an easy process if all care providers are not fully engaged and there are targets and funding issues between each provider.

It would appear that there is already some progress with strategic visions and compacts being made by health and social care organisations and trusts in Bedfordshire, including commitments made by *NHS Bedfordshire in their Healthier Bedfordshire strategy 2010-11* and with the whole idea of QIPP, Quality, Innovation, Productivity and Prevention, which is a key focus in Bedfordshire at the moment. The Healthier Bedfordshire strategy's aim is to ensure care closer to home by creating effective support in the community to avoid admittance to hospital. The *QIPP Compact* signed by key partners from the health, social care and mental health trusts and organisations is a step in the right direction and as stated in the document *"The Compact builds on existing partnerships between health and social care organisations. Effective partnership is key to the successful delivery of comprehensive and efficient services*."

So in conclusion, this is an opportunity for these strategies and commitments stated in these important documents to be turned into reality with the person at the "heart" of the process rather than just being a part of the process. It may mean that the whole pathway of discharge needs to be dissected and every process looked at in depth, from reviewing basic nursing care to looking at the role of hospital managers and commissioners of services. Most importantly engaging and interacting with home managers who appear from this basic survey to be very passionate about their residents and do seem to have the patient at the "heart" of the process and recognise that this is the person's home and they should be treated with due respect and dignity.

Recommendations:
It would appear that the whole area of discharge planning should be the subject of a pilot project, led by the Commissioners in both health and social care and assisted by the voluntary sector through an organisation such as LINk/HealthWatch to map out each area of involvement in the process, how it comes together, and gather the experiences of patients through each part of the admission and discharge process; from before admittance to hospital to discharge in order to deliver an efficient and effective service for the population of Bedfordshire. Each organisation should remember that having protocols and procedures is one thing but making them reality is something totally different.

Bedfordshire LINk Social Care Working Group
January 2011

REFERENCES:

British Orthopaedic Association on discharge entitled "Patient Pathways (Models of Care) for patients who are to undergo planned orthopaedic operations (Feb 2011)

Bedfordshire LINk Bulletin No. 27, March 201, Quality Accounts, Hospital Trusts

Bedfordshire LINk newsletter May 2010

The Care Quality Commission circular on *"What standards to expect from the regulation of your NHS Hospital"(2011)*

Department of Health's guidelines on Discharge from hospital pathway, process and practice (2003)

DH "Our Health, Our Care, Our Say", better integrated health and social care (January 2006)

NHS – DH Achieving Timely 'Simple' discharge from hospital (August 2004)

NHS Bedfordshire in their Healthier Bedfordshire strategy 2010-11

The Derbyshire LINk report into Hospital to Care Home Discharges, Inappropriate Discharge, (May 2010)

APPENDIX 1

Bedfordshire LINk Survey on the view of Care/Nursing Home Staff on Hospital Discharge Procedures, January 2011

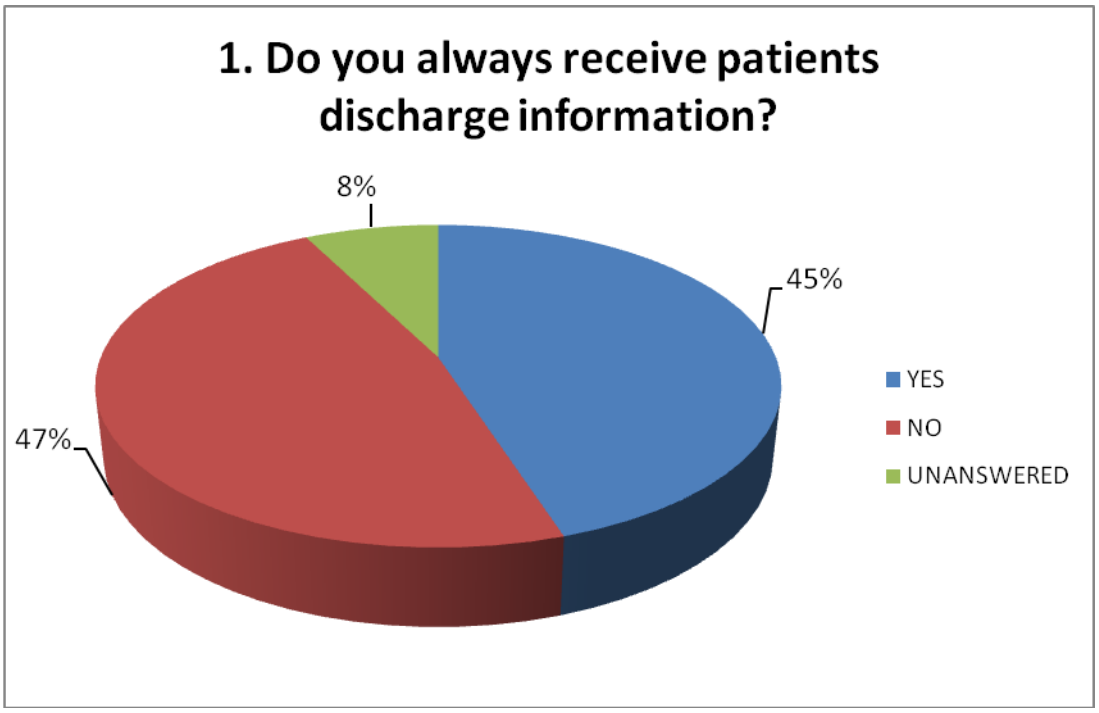
A total of 40 homes replied, which is 20% of respondents. *

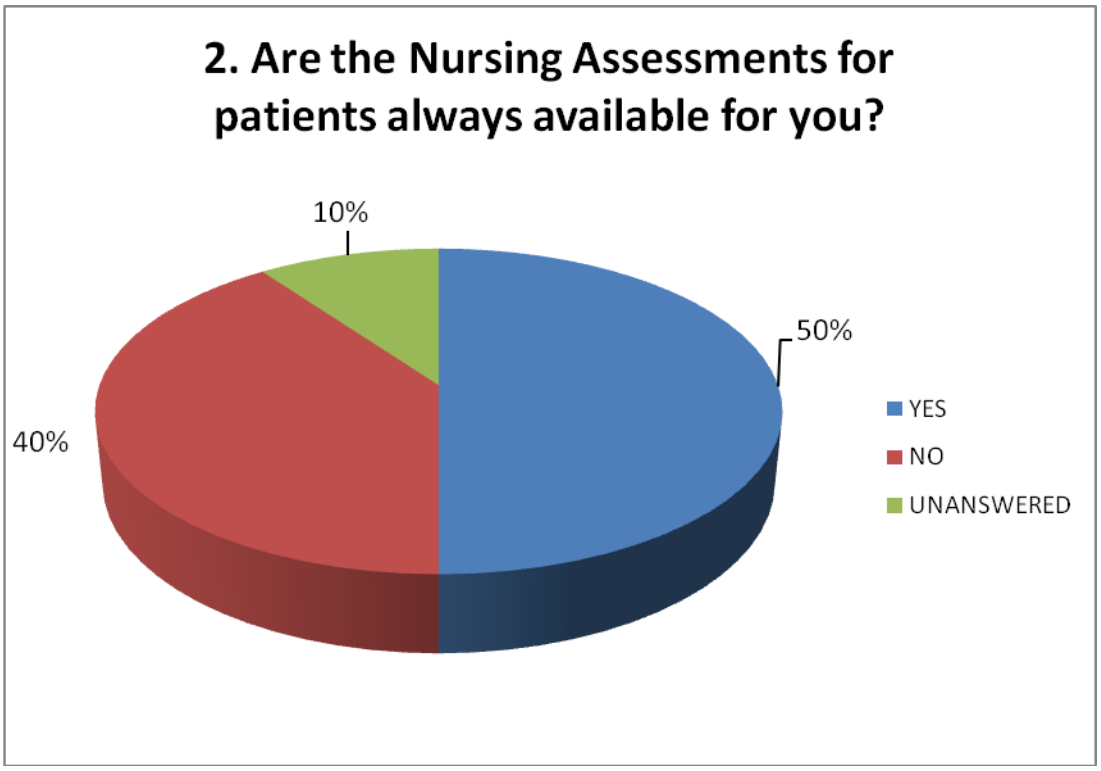
At the Pre-Discharge Assessment	YES (%)	NO (%)	UNANSWERED (%)
1. Do you always receive patients discharge information?	**18** (45%)	**19** (47.5%)	**3** (7.5%)
2. Are the Nursing Assessments for patients always available to you?	**20** (50%)	**16** (40%)	**4** (10%)
3. When making your assessment, were you allowed access to the patient's notes?	**32** (80%)	**3** (7.5%)	**5** (12.5%)
4. When undertaking the pre-discharge assessment, do you consider that you are fully involved in the process?	**19** (47.5%)	**15** (37.5%)	**6** (15%)
At discharge to the home			
5. Do you consider that the discharge information you receive gives you sufficient information? If not, how do you feel that the information could be presented more effectively?	**16** (40%)	**16** (40%)	**8** (20%)
6. Do you consider that an opportunity to include other information, for example psychological or social issues would prove helpful?	**34** (85%)	**1** (2.5%)	**5** (12.5%)
7. Is the prescribed medication from the hospital pharmacy always present and correct?	**20** (50%)	**15** (37.5%)	**5** (12.5%)
8. Do you experience any issues with repeat prescriptions from the patient's own GP regarding medicines prescribed by hospital medical staff?	**12** (30%)	**22** (55%)	**6** (15%)

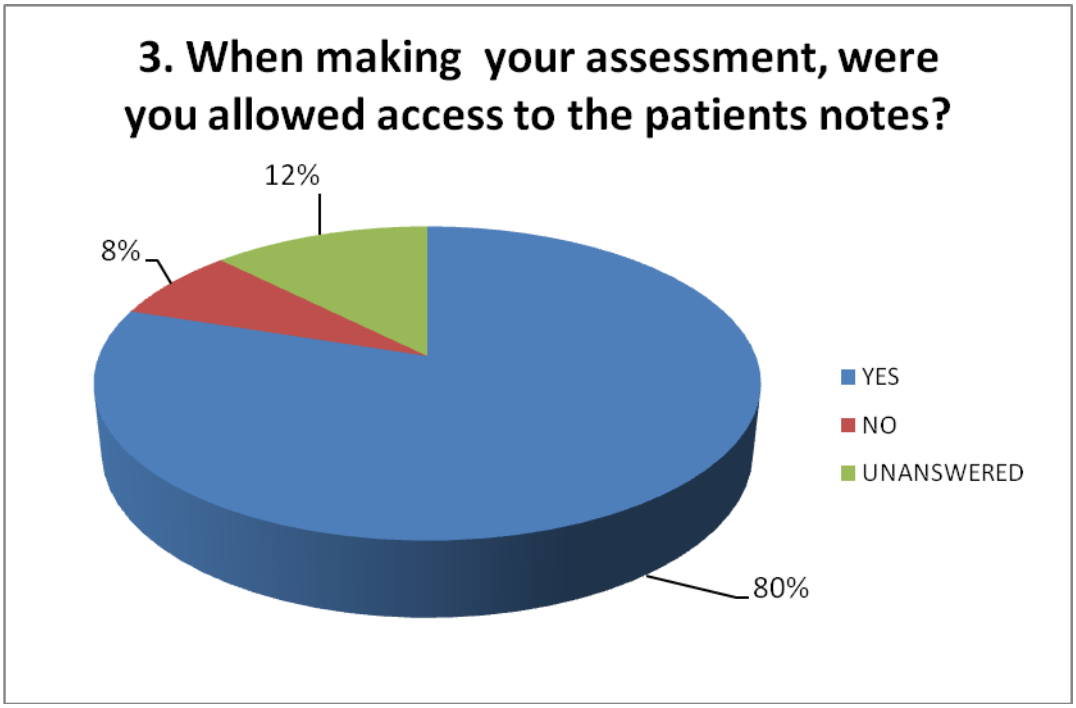
9. Do you consider that all patients are discharged from hospital at an appropriate time in regard to their physical recovery and their mental well being?	**11** (27.5%)	**23** (57.5%)	**6** (15%)
10. Do you feel that patients are discharged at an appropriate time of day and with appropriate notice?	**14** (35%)	**19** (47.5%)	**7** (17.5%)
11. Are residents always discharged in appropriate attire?	**17** (42.5%)	**19** (47.5%)	**4** (10%)
12. Do you consider that all hospital staff interact with you and your team in an appropriate manner?	**19** (47.5%)	**16** (40%)	**5** (12.5%)
13. Do you consider that the families or carers of prospective residents are fully informed about the choice of an appropriate home?	**17** (42.5%)	**18** (45%)	**5** (12.5%)
14. Do you consider that telephone discharges are always clear and effective?	**14** (35%)	**18** (45%)	**8** (20%)
15. Do you consider that all the hospital staff support you during discharge process with appropriate information?	**19** (47.5%)	**16** (40%)	**5** (12.5%)
16. Do you consider that you are able to refuse admission of a patient due to an inappropriate discharge?	**26** (65%)	**8** (20%)	**6** (15%)

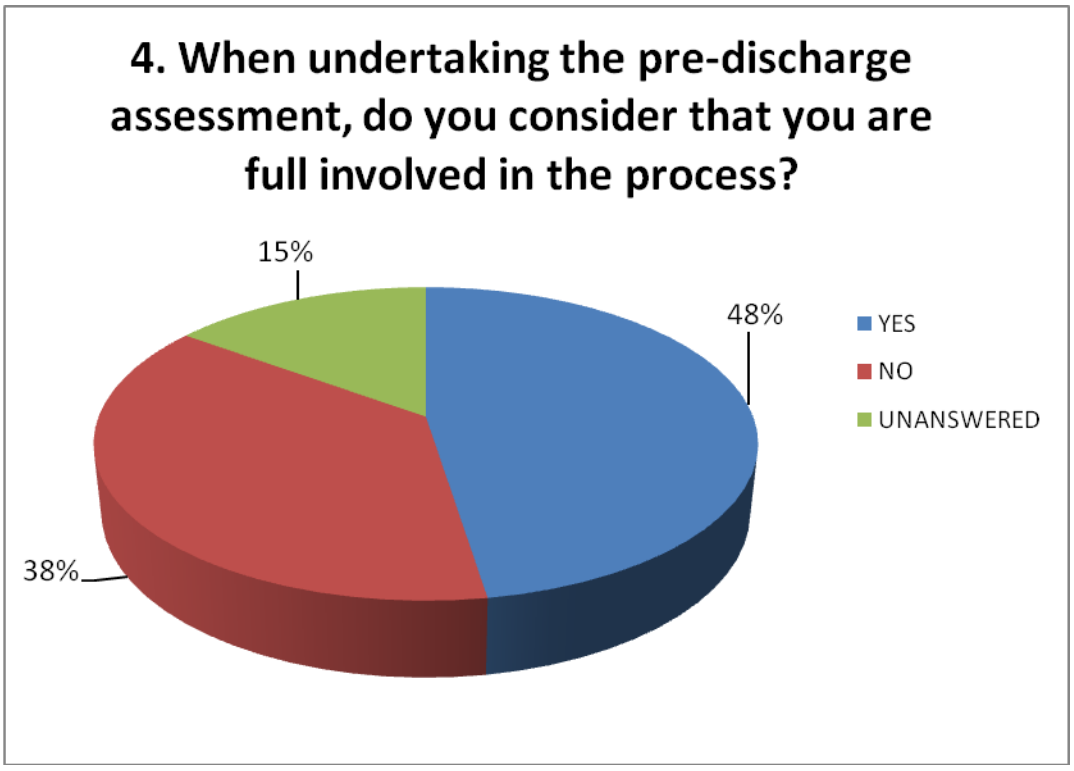
***Percentages quoted in this report are taken purely from the replies received – no account of non-replies is taken.**

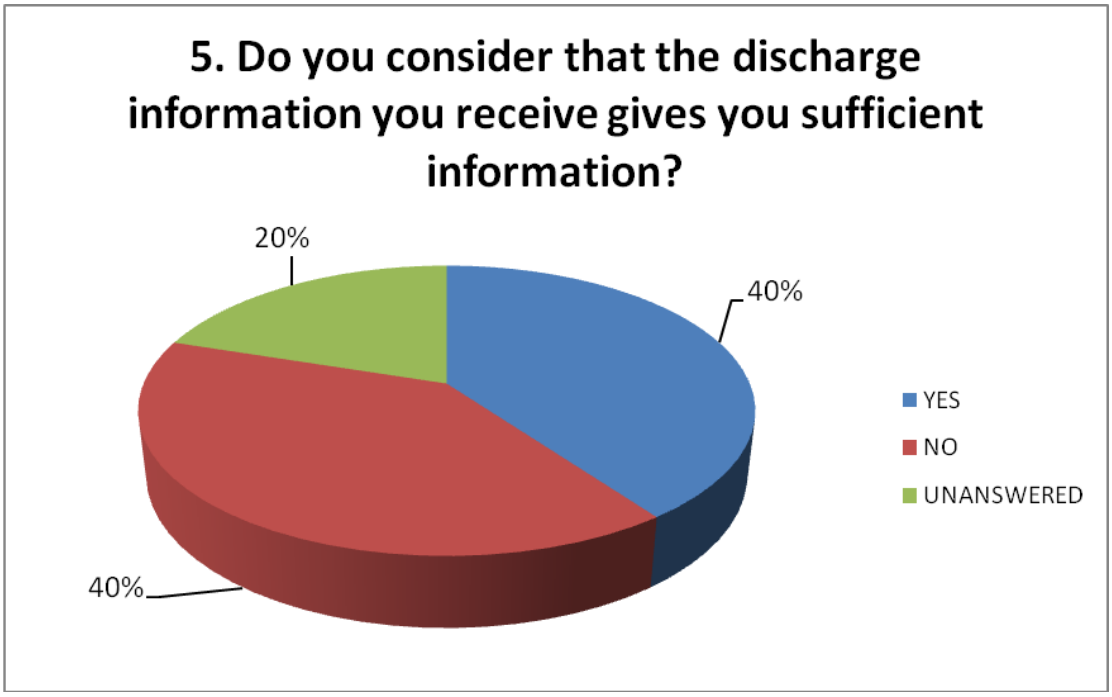
APPENDIX 1A – SURVEY PRESENTED IN GRAPHICAL FORMAT

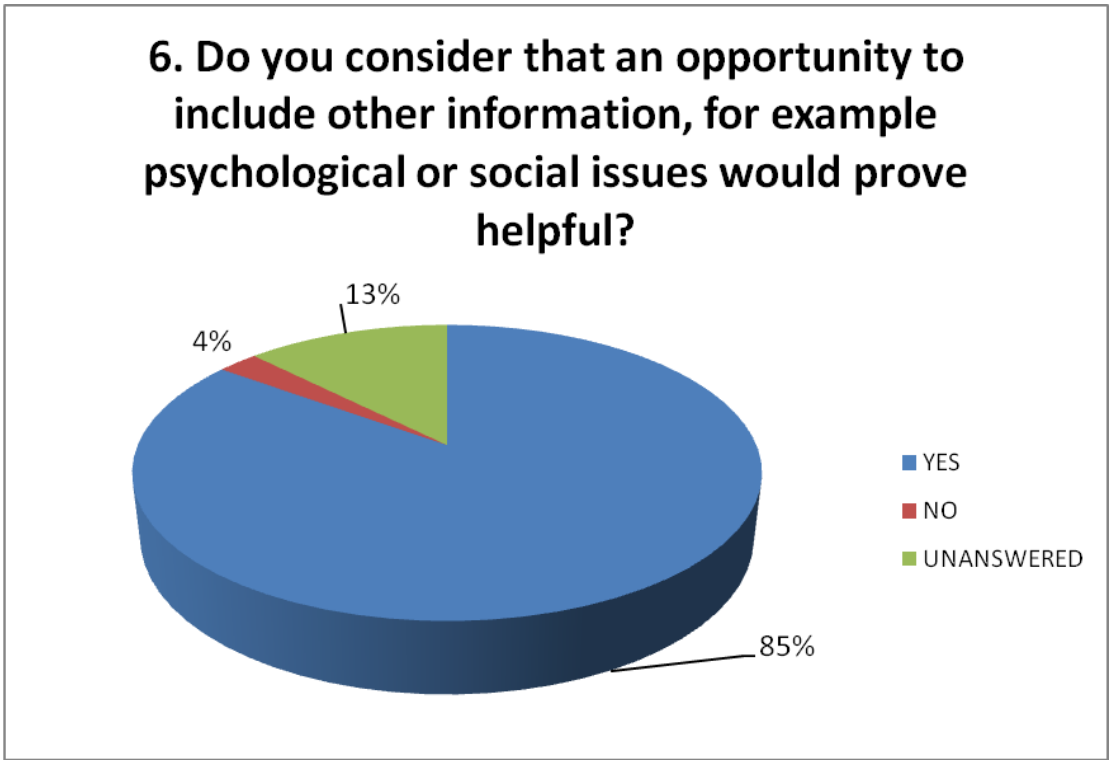


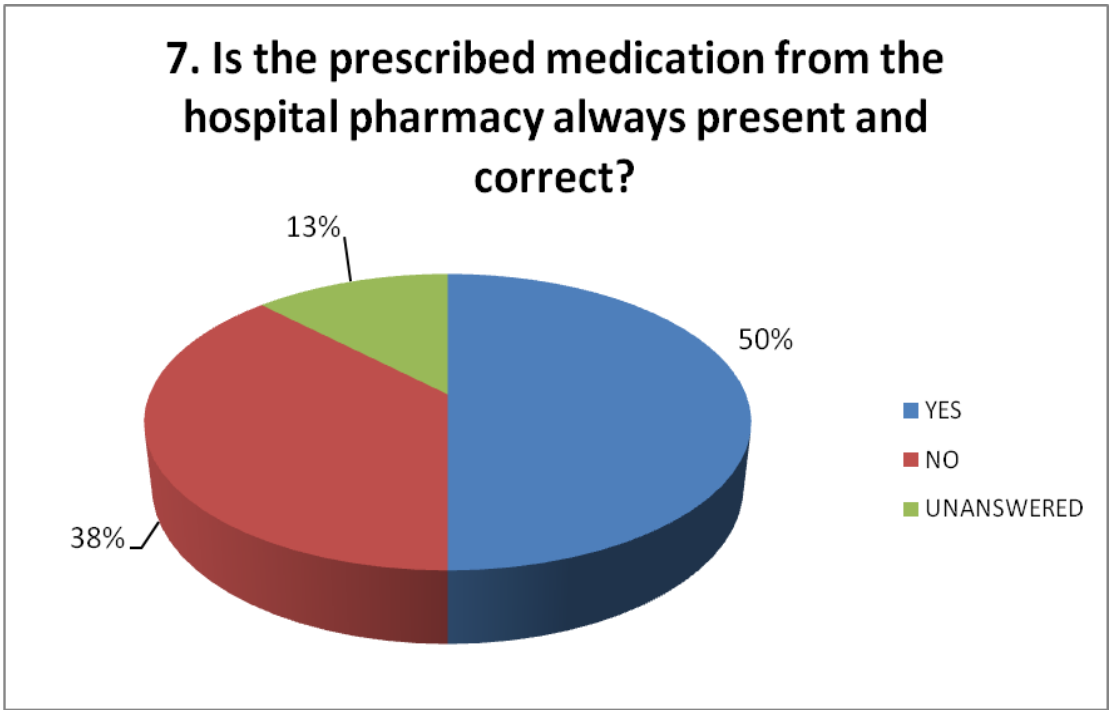



3. When making your assessment, were you allowed access to the patients notes?
12%
8%
80%
YES
NO
UNANSWERED

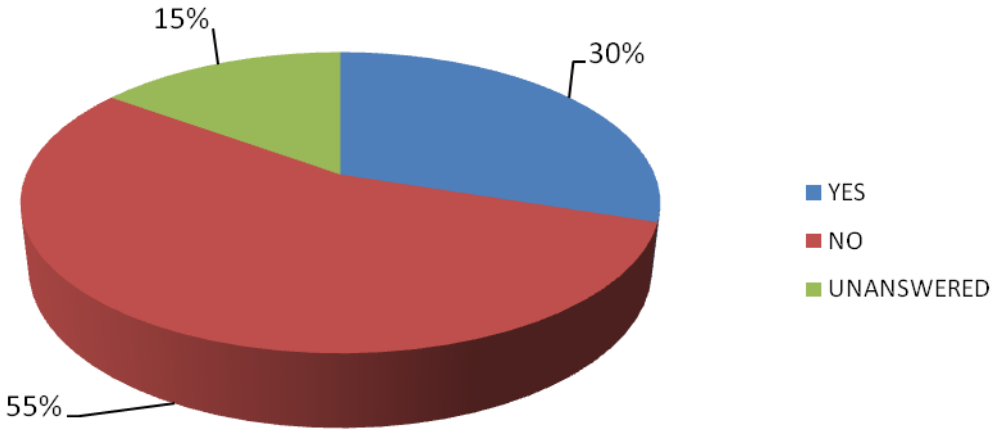

4. When undertaking the pre-discharge assessment, do you consider that you are full involved in the process?
15%
48%
38%
YES
NO
UNANSWERED


5. Do you consider that the discharge information you receive gives you sufficient information?
20%
40%
40%
YES
NO
UNANSWERED

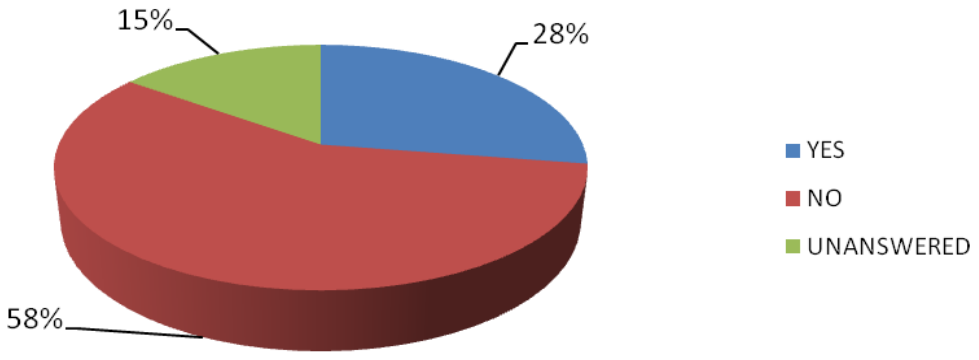

6. Do you consider that an opportunity to include other information, for example psychological or social issues would prove helpful?
13%
4%
85%
YES
NO
UNANSWERED

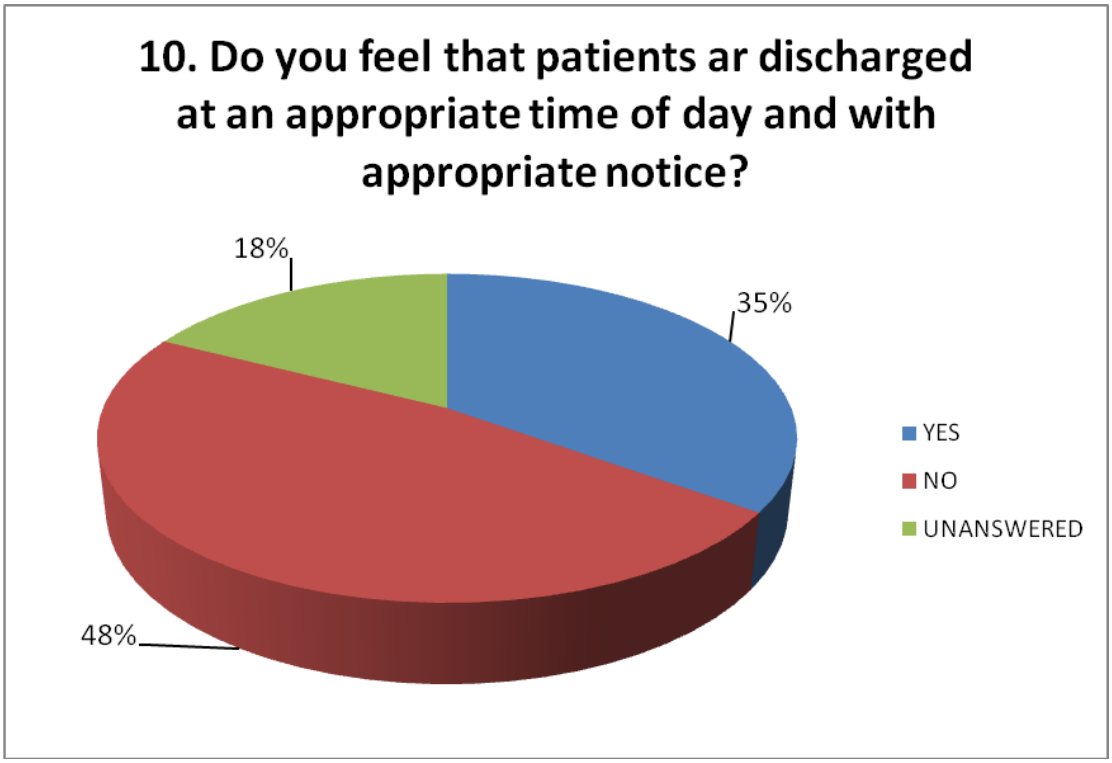

7. Is the prescribed medication from the hospital pharmacy always present and correct?
13%
50%
38%
YES
NO
UNANSWERED

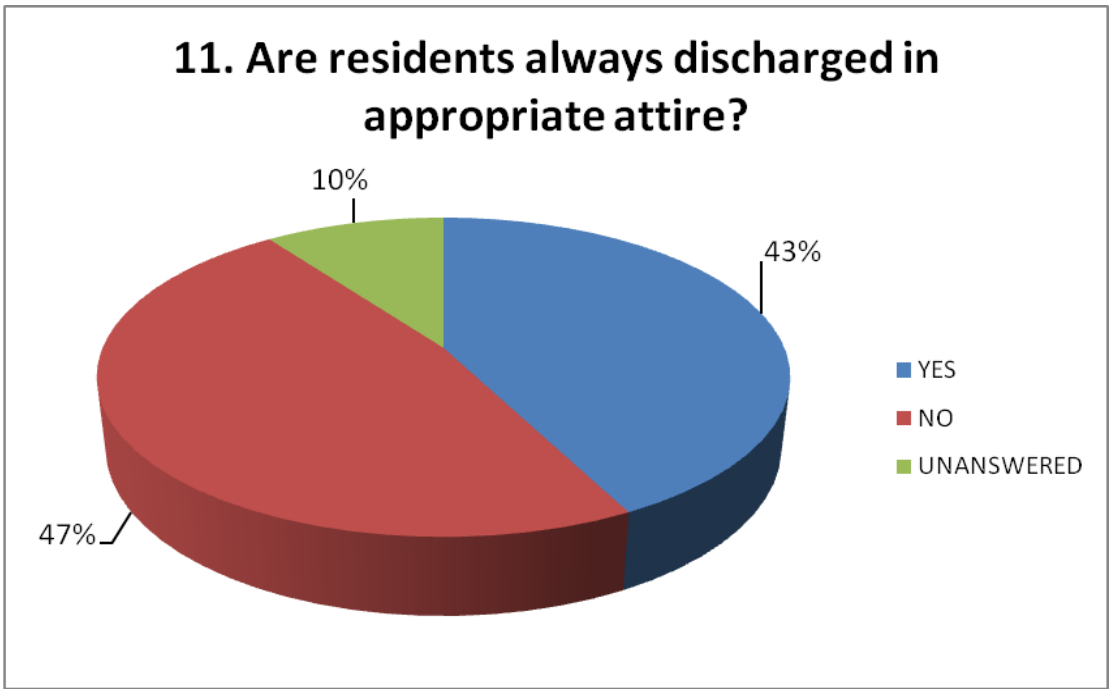
8. Do you experience any issues with repeat prescriptions from the patients own GP regarding medicines prescribed by hospital medical staff?

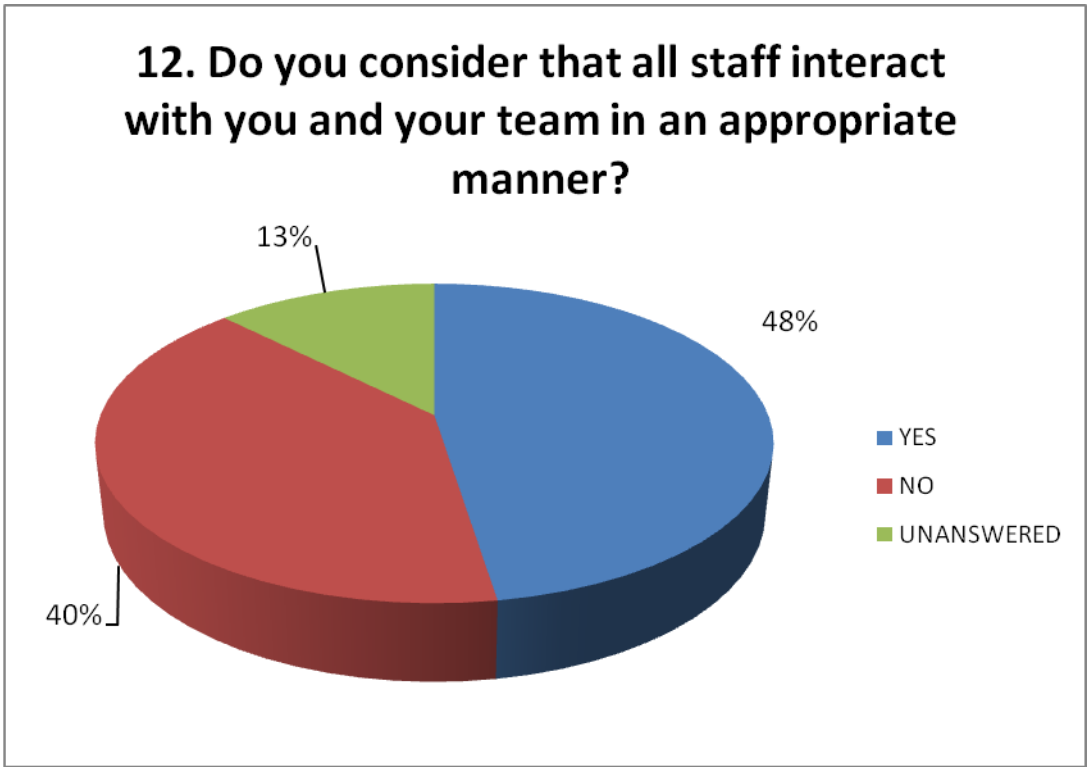


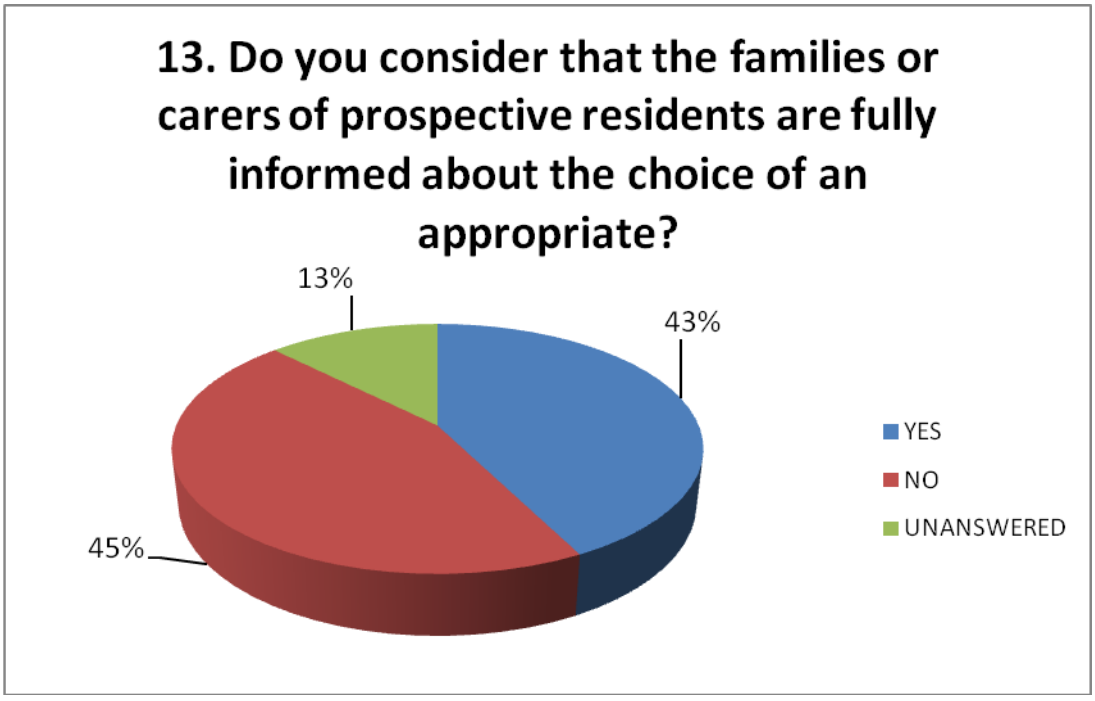
9. Do you consider that all patients are discharged from hospital at an appropriate time in regard to their physical recovery and their mental well being?

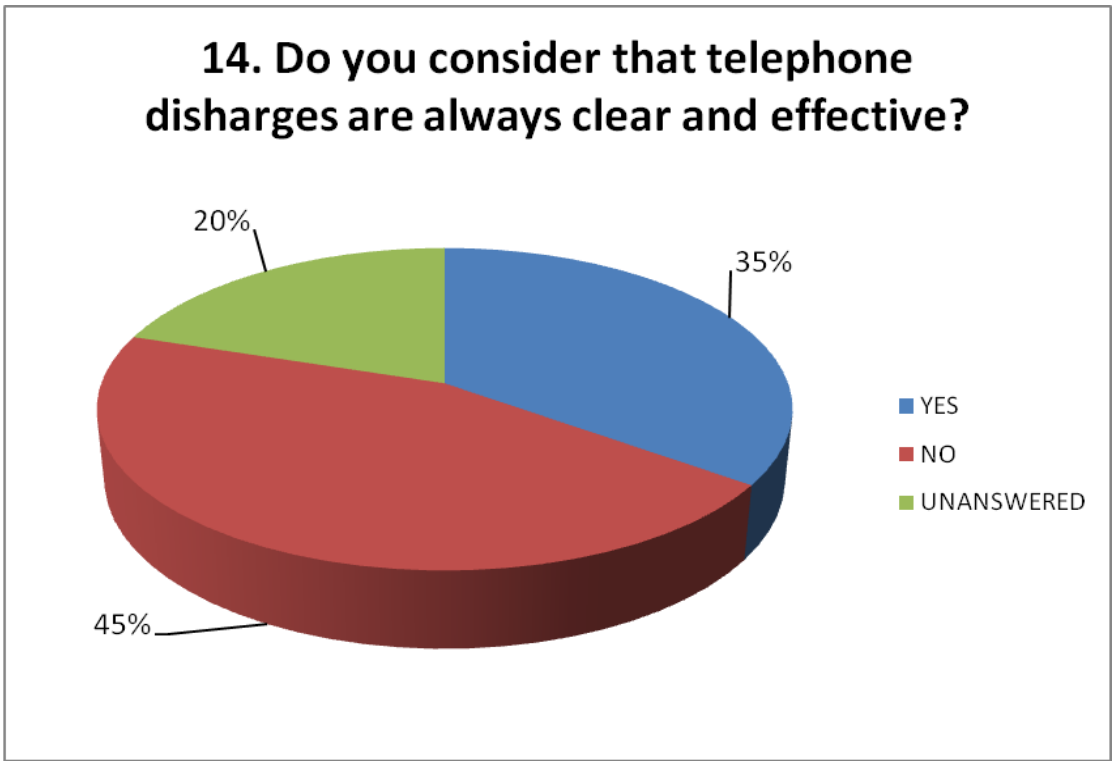


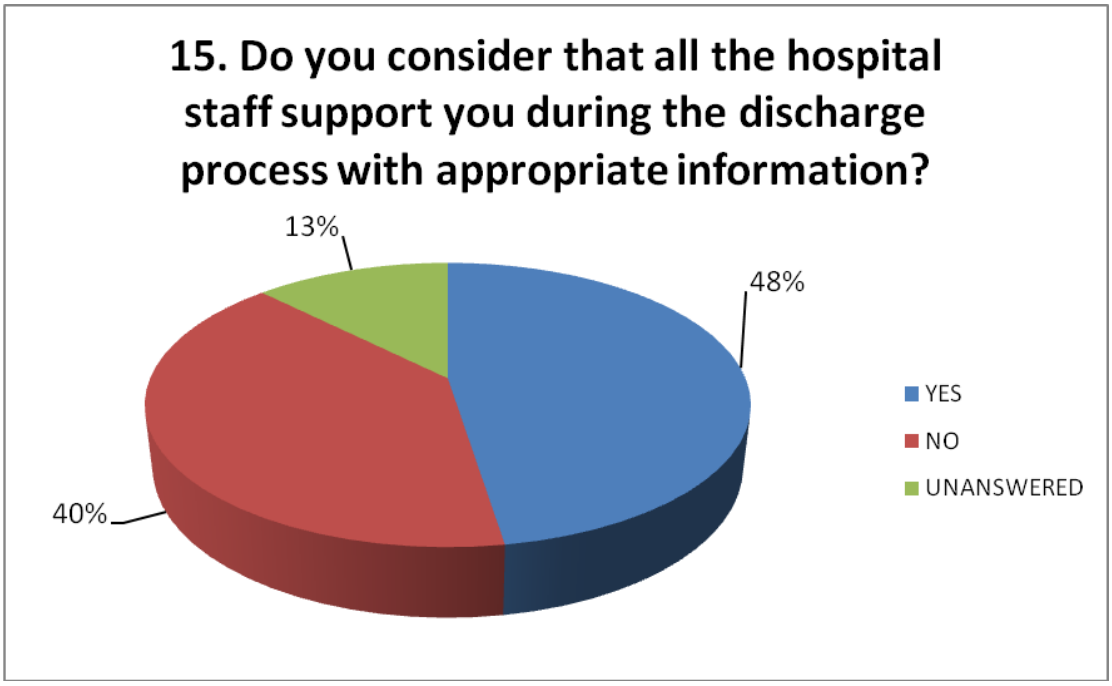

10. Do you feel that patients ar discharged at an appropriate time of day and with appropriate notice?
18%
35%
48%
YES
NO
UNANSWERED

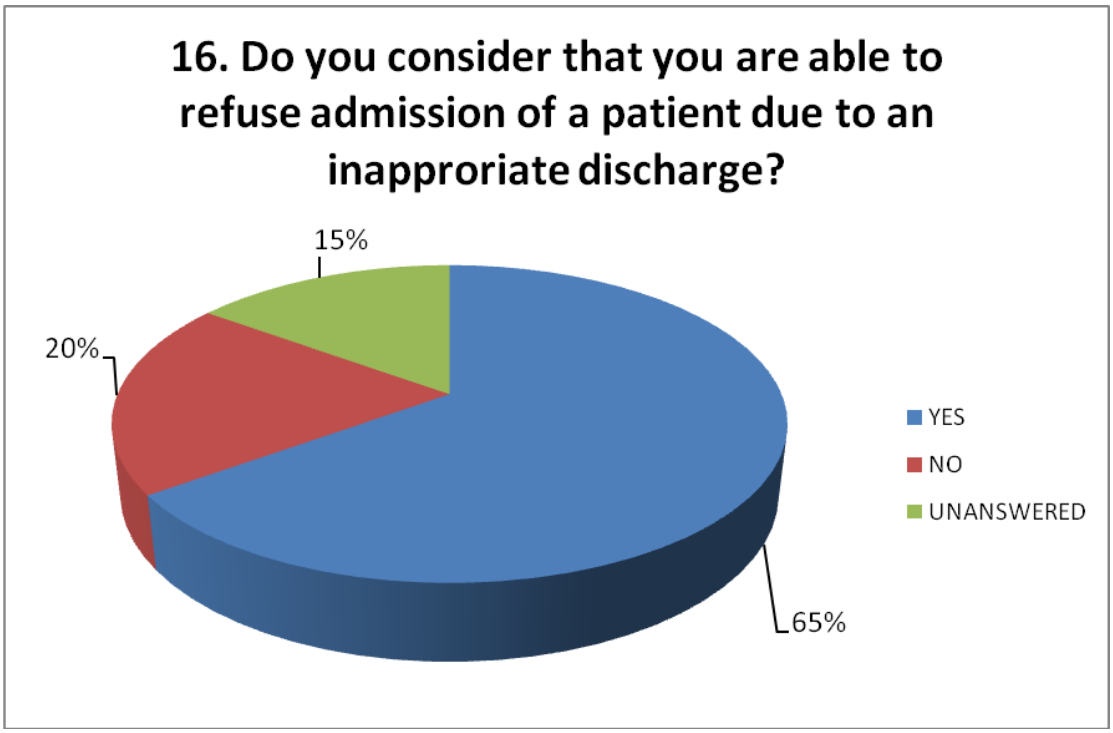

11. Are residents always discharged in appropriate attire?
10%
43%
47%
YES
NO
UNANSWERED


12. Do you consider that all staff interact with you and your team in an appropriate manner?
13%
48%
40%
YES
NO
UNANSWERED


13. Do you consider that the families or carers of prospective residents are fully informed about the choice of an appropriate?
13%
43%
45%
YES
NO
UNANSWERED


14. Do you consider that telephone disharges are always clear and effective?
20%
35%
45%
YES
NO
UNANSWERED


15. Do you consider that all the hospital staff support you during the discharge process with appropriate information?
13%
48%
40%
YES
NO
UNANSWERED


16. Do you consider that you are able to refuse admission of a patient due to an inapproriate discharge?
15%
20%
65%
YES
NO
UNANSWERED

APPENDIX 1B – INDIVIDUAL REPONSES

Bedfordshire LINk Survey on the view of Care/Nursing Home Staff on Hospital Discharge Procedures, January 2011.

1. **Do you always receive patients discharge information?**

   Respondent 68 – A lot of time no discharge letter is sent, we have to ring up and chase it.

   R87 – On one occasion a lady came back to … and I personally had to go to the hospital and collect paperwork.

   R109 – At times need to contact hospital to fax over and still do not receive.

   R128 – But not always informative, L&D did trial typed ones which were easier to read.

   R138 – Although they can be sketchy with information.

   R139 – Had wrong person sometimes.

   R161 – From A&E, residents frequently return with no paperwork.

2. **Are the nursing Assessments for patients always available to you?**

   R136 – Sometimes notes not on bed.

   R138 – Not always.

   R139 – Yes but not always filled in as moved to different wards.

   R161 – Usually, we often have to ask or use the file/notes.

3. **When making your assessment, were you allowed to access the patient's notes?**

   R20 - I have not asked for this in the past.

   R21 – Only when doctor arrived, did any notes appear on nurse's station.

   R87 – Not all documents but relevant to medication and condition.

R109 – On Asking.

R138 – Very rarely am I able to access full notes, daily records and charts.

R139 – Most of the time.

R161 – We have often been given contradictory information from ward staff. e.g. patient has transferred, patients has not been transferred and has not been out of bed.
R4A – Not always.

4. **When undertaking the pre discharge assessment, do you consider that you are fully involved in the process?**

   R87 - We carry out our own assessment before the patient leaves the hospital.

   R138 – Mostly

   R139 – Most of the time

   R156 – Sometimes

   R164 – Sometimes

   R176 – Always in re to mental health client otherwise it is questionable.

   R191 – Staff on the ward will phone.

5. **Do you consider that the discharge information you receive gives sufficient information? If not, how do you feel that the information could be presented more effectively?**

   R21 – If the Guidelines on discharge were not 3-4 days later.

   R68 – When we get it.

   R86 – By always receiving a discharge letter and medication changes, info of pressure area's gained in hospital. Physio follow-ups as we find our residents no longer walk after being in hospital. Bruises, UTI's.

   R93 – Copy of discharge plan.

   R109 – By hospital phoning.

R111 – For instance, time last medication given is not always available or how many PRN analgesic medication given in last 24 hours.

R113 – We sometimes receive patient's info that is not discharged to us. Wrong info, wrong patient.

R128 – If patient is new to us, a medical history would be useful as we only receive present issues.

R136 – When the nursing discharge is received, yes.

R138 – Would like it to be more detailed. Chronological, also any expected appointments or possible problems.

R139 – Ensuring the medication is on the home discharge to meet CQC regulation as usually only on GP.

R156 – Information coming from Bedford Hospital is usually good.

R168 – We require, 1. Current Next of kin details, 2. NHS No. 3. Name and address. Not always charted.

R176 – Clearer written notes, request management to reassess every time client being discharged.

R179 – The information is not always accurate or complete, we need a history of what has happened and treatment received.

R191 – Printed notes required.

R6A – Although not always up to date.

6. **Do you consider that an opportunity to include other information, for example psychological or social issues would prove helpful?**

R135 – Especially Psychosocial, Life History

R156 – Particularly as we care for very elderly people, an indication of these things does not necessarily prevent us taking the person but helps us prepare better.

R179 – Also referrals need to be accurate and followed through.

7. **Is the prescribed medication from the hospital Pharmacy always present and correct?**

   R83 – Only one medication error in the last two years.

   R109 – At times will send medication in tablet form, when they know the individual needs liquid form.

   R111 – No, usually sufficient quantity for two weeks but not always, sometimes none sent and we have been asked to contact GP.

   R113 – We have problems when we have to give half dosage, as our policy is not to give half medication.

   R138 – Although have found items like Thick and Easy or Fortisips Juice not supplied.

   R139 – The hospital pharmacy always ring us to check what medication is in the home, sometimes they are inform us they are on the way back.

   R161 – We usually ask only for items prescribed whilst in hospital.

   R179 – It is often short or with a few items missing.

   R5A – Mostly, it is helpful if we have a pharmacist contact the home prior to discharge to discuss medication.

8. **Do you experience any issues with repeat prescriptions from the patients own GP regarding medicines prescribed by hospital medical staff?**

   R68 – This is due to the fact that the surgery does not get a copy of the discharge letter.

   R87 – On occasion repeat description have been delayed.

   R111 – There is sometimes a delay in GP updating their systems but this is rare.

   R139 – We fax GP letter to them.

   R156 – Sometimes it depends what has been prescribed.

   R161 – Occasionally.

9. **Do you consider that all patients are discharged from hospital at an appropriate time in regard to their physical recovery and their mental well being?**

R20 – A vulnerable individual with a respiratory problem was discharged to … at 10pm

R55 – Some are discharged when it is obvious that there condition is such that they need an immediate return to hospital.

R68 – A lot of the time it is really late, after 8pm which is not acceptable.

R86 – Sometimes too soon, sometimes very late at night.

R109 – We have Dementia individuals that have been sent back too soon as hospital seem to want them discharged before the weekend.

R111 – Often we are aware that they have been waiting for transport all day, often post 5pm discharge, frequently discharged in skimpy clothing, incontinent.

R113 – We have a cut off time of 6pm

R138 – Mostly, although sometimes would like to see full assessment completed rather than a sketchy brief resume.

R139 – We have experienced some residents they have discharged early and have to be readmitted within a day or two.

R161 – Whilst they may be medically fit for discharge, little thought is often given to how a residential home will then care for them immediately after discharge. I have experienced residents needing re-admission 24 - 48 hours after discharge.

R164 – No always at suppertime, around 5pm.

R5A – I feel that patients are sometimes discharged too early, though not often.

R176 – Some of my very elderly clients have arrived back to my home in early hours of morning

R179 – I often think they have kept in too long and would benefit more from being at home.

10. Do you feel that patients are discharged at an appropriate time of day and with appropriate notice?

R55 – We have particular times when it is appropriate for us to receive discharge from hospital, this is usually agreed.

R68 – As above (A lot of the time it is really late, after 8pm which is not acceptable).

R83 – We had in the past received patients very late in the evening i.e. 11-12 Midnight

R109 – No, have been contacted a few hours before discharge and at night.

R111 – Notice, good (usually agreed with ward) Time of day.

R135 – We are consulted on discharge time.

R136 – Sometimes too late in the day.

R138 – Mostly although have had patients come to home in evening or middle of meal times.

R139 – No arriving back after 5pm, or a new admission coming at this time who has never been here.

R156 – Usually

R161 – If we insist an assessing first, ward staff have tried to insist we take residents back without this.

R164 – Sometimes.

R168 – On occasions due to transport and TTO's we are expected to take after 8pm. I feel this is inappropriate, as no consideration is given to the elderly person.

R176 – Very dependant on Ward/Hospital.

R179 – Often home very late into the evening although we do get notice.

R5A – No, sometimes patients are discharged too late in the day and arrive very disorientated and cold.

11. Are residents always discharged in appropriate attire?

R55 – I have had residents return in just a skimpy night dress and no shoes or blanket.

R69 – We dress and pick them up ourselves.

R109 – Residents have returned back wet, in a nightdress and no blanket.

R111 – See above (Often we are aware that they have been waiting for transport all day, often post 5pm discharge, frequently discharged in skimpy clothing, incontinent.)

R139 – We have had residents in the dark in night clothes and a blanket in the snow.

R161 – Usually.

R5A – Sometimes in night attire, always have blanket though.

12. Do you consider that all hospital staff interact with you and your team in an appropriate manner?

R18 - Most of the time

R20 – They are not flexible with the staff team here visiting the patients, a bit of flexibility to the support staff will benefit the patient.

R87 – On occasion staff have not had the time to answer questions that we feel were needed to give the right care.

R111 – Most of the time, very rarely do we encounter any negative attitude or support.

R128 – Some not all, we are not told if one of our residents passes away, it could be up to 48 hours before we are told.

R139 – Most of the time there are no problems.

R156 – Most are good but we are often made aware of the pressure they feel under, they can be defensive and impatient.

R161 – Usually, I appreciate the pressures hospital staff are under but a bullying approach has been used on occasion and we have been given the wrong information.

R169 – Patronising and ill informed.

R179 – Very rarely have contact unless we call them.

R4A – Mostly.

13. Do you consider that the families or carers of prospective residents are fully informed about the choice of an appropriate home?

R18 - This could be better

R21 – But it is improving

R55 – No, it is a complete mystery to them and they are usually directed to S/Services run homes and are not given a choice.

R139 – Social worker does this.

R156 – Possibly, they don't complain of coming to us but are often rushed and pressurised by the hospital.

R161 – It varies, usually, however families have told me they felt under pressure to find a home.

R179 – Have been told in the past they are given a booklet and told to "go find one".

14. Do you consider that telephone discharges are always clear and effective?

R21 – Not experienced one

R87 – For example mobility needs, physio etc.

R128 – Have never had telephone discharge

R139 – When done

R156 – Cannot comment. We have only once accepted a telephone discharge and it did not turn out well.

R179 – Do not accept discharge info over the phone.

15. Do you consider that all hospital staff support you during the discharge process with appropriate information?

R21 – In as much as they are able

R55 – Very little in the way of information comes with the patient.

R83 – We do sometimes have to contact the hospital for further information.

R109 – No, pharmacy most times at hospital always ring home for individual's information for drugs.

R111 – Usually.

R128 – In some cases

R139 – Most of the time

R161 – Usually.

R179 – If you know what to ask!

16. Do you consider that you are able to refuse admission of a patient, due to an inappropriate discharge?

R21 – Not always

R55 – Yes if I consider that the state of the patient is such that the GP will consider their immediate return.

R68 – Especially if it is late – we have a 7pm cut off.

R83 – I don't feel I can turn away a patient on arrival due to inappropriate discharge.

R87 – We are aware we can refuse but the patient remains the priority in all our decision making.

R109 – This is our policy at the home.

R139 – As they are sitting in the car park.

R161 – It usually involves conflict, on one occasion, a resident had been re-admitted and clearly needed nursing care. When I refused readmission I explained to the ward sister why, she then told the family I was wrong and would be reported to (the company). The resident however was assessed as nursing care and went to a nursing home. We often feel the resident's needs are irrelevant and freeing a bed is more important. We have also been lied to by staff to try and get us to accept residents back.

R169 – However hospital staff are rude and start saying "you have to …" Lack of understanding of the type of home, staffing levels etc. Lead to inappropriate discharge hospital staffs ignorance of any other service other than their own leads to the poor quality that they continually practice under.

APPENDIX 2

INCIDENT REPORT	**NO:**
DATE REPORTED	
REPORTEE	
DESCRIPTION OF INCIDENT:	

LOCATIONS INVOLVED:	
DATE OF INCIDENT:	
DETAILS OF PATIENT:	
CATEGORY OF INCIDENT:	
LOGGED BY :	
DATE LOGGED:	