healthwatch Leicestershire

Unsafe Discharge for Vulnerable People

Special Inquiry Findings

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Executive Summary

Overview

Healthwatch Leicestershire (HWL) conducted a study in the summer of 2014 to understand in greater depth the impact unsafe discharge can have for patients. The study forms part of the Healthwatch England programme of research[1], and focuses on the experiences of homeless people, people with mental health conditions and older people.

Aims

The aims of the investigation were to:

1. **Establish a deeper understanding of patients' experiences when they are discharged from a healthcare setting.**
2. **Focus on understanding the experiences of homeless people, those with mental health conditions and older people.**
3. **Use Healthwatch statutory powers to influence national and local policy and practice.**

Methodology

The research involved two major components:

1. **A series of case studies involving in-depth interviews with 15 patients and three staff of support services aiming to provide rich detail of the patient experience, and shed light on the factors that facilitate positive patient experience.**
2. **Evidence gathered from focus groups.**

Key Findings

The findings from HWL reveal in detail that:

1. **There was an inconsistent pattern in how hospitals and healthcare settings approached discharge planning resulting in a lack of a holistic assessment.**

   This extends to:

   - The consideration of additional health problems known to the patient at the point of admission and/or discovered at the time of discharge.
   - Assumptions surrounding family, accommodation and community support.
   - The involvement of patients in decision making.

1 Information on the national programme of research commissioned by Healthwatch England can be found here: http://www.healthwatch.co.uk/then-what-special-inquiry

2. **When the discharge guidance is followed the process works well for patients. However, there were some cases where patients reported failures in the use and adequacy of discharge protocols within a setting.** In most cases patients were given a clear treatment plan, but in other cases a treatment plan was not adequate. In the worst-case scenario, a treatment plan was absent.

3. **Patients reported readmission and repeat visits to healthcare services because of unmet needs.** Often, this was related to the same problem and associated with premature or poorly planned discharge. Patients felt they were not well enough to leave the healthcare setting at the time of discharge. They felt they were being rushed through the system to create bed space.

4. **Patients reported breakdowns in communication, and failures at moments of transfer and transition between services and systems.** This was also associated with the access to, and availability of community-based support, and patients' experiences of delayed discharge.

5. **The interviews with patients show that the impact of unsafe discharge is an increased concern for certain 'high risk' groups.** For example, the impact of not having family support or support available in the community can have a more pronounced effect on homeless people, people who have experienced poor mental health and older people.

6. A number of patients provided some suggestions for ways in which the discharge process could be improved, typically including **wider coverage of community based support and more communication with the patient to ensure they are at the heart of the decision making process.**

Recommendations

Healthwatch Leicestershire has set out a series of workable recommendations based on the findings as follows:

University Hospitals Leicestershire (UHL) and Leicestershire Partnership Trust (LPT)

1. **The highly regarded discharge guidance should continue to be rolled out and adhered to** as part of the wider strategies to promote positive patient experience.

2. **Targeted work aimed at vulnerable groups of patients**, who are more likely to be affected by unsafe discharge. More research is needed in this area, followed by targeted intervention work with identified groups to ensure holistic assessments take place, involving all stakeholders in the 'cycle of care'.

Leicestershire County Council (LCC), Clinical Commissioning Groups (CCGs) and Better Care Together Programme

3. **Better pathways between healthcare services and the Voluntary and Community Sector (VCS)/.** The VCS is well placed to provide safety nets for people affected by unsafe discharge.

4. **Better resourcing and support for carers.** Arrangements need to be made to ensure that the needs of those who are caring for the patient are considered.

Healthwatch Leicestershire (HWL)

5. **Further research in the area of patient discharge** to gather experiences from a wider group of patients.

Introduction & Background

Unsafe discharge from healthcare settings is consistently identified as a key concern for patients. There is a mounting body of evidence to suggest that this absence of support leaves patients feeling isolated and increasingly marginalised. In its most extreme manifestation, it can be detrimental to health and blight a person's life in the long-term. Alongside the human costs, unsafe discharge has been identified as a cause of hospital readmission. It is likely to result in the use of more resources and further costs to the UK health economy if unchecked and care remains the same.

Aims

The study pursued the following aims:

1. **To present an overview of the patient experience when they are discharged from a healthcare setting, with respect to:**
   - Previous experience of discharge
   - Reasons for admission
   - General treatment by healthcare staff
   - Discharge planning
   - Discharge itself
   - Post discharge
   - Experience of good practice.
2. **To focus on understanding the experiences of homeless people, people with mental health conditions and older people, with respect to:**
   - Previous experience of discharge
   - Reasons for admission
   - General treatment by healthcare staff
   - Discharge planning
   - Discharge itself
   - Post discharge
   - Experience of good practice.
3. **To use Healthwatch England's statutory powers, with respect to:**
   - Influencing national and local policy and practice.

Methodology

HWL undertook a series of case study interviews with 15 patients and three staff of support services (seven older people, seven people who have experienced poor mental health and one homeless person). The qualitative research aimed to contribute to the national research by Healthwatch England and informs our local understanding of the issues.

The line of questioning was drawn up in consultation between Healthwatch England and a team of experts who have extensive experience in the health and social care sector. These interviews allowed patients to best express their feelings or direct us to the issues most important to them. Some of the sessions were hosted and facilitated by:

- LAMPdirect[2] – a voluntary organisation working to promote good mental health for everyone in Leicester, Leicestershire and Rutland;
- Action Homeless[3] – a charity based in Leicestershire dedicated to tackling the causes and consequences of homelessness; and
- Melton Borough Council[4] – who provide a range of residential services for older people in Leicestershire.

Staff working at the groups carried out some of the interviews because it was felt that someone trusted by patients would be better placed to ask questions.

When taking part in the research, patients were provided with a covering letter detailing the reasons for the research and what would be done with it. The scope of the research was also provided, including a brief introduction of what 'discharge' is.
This helped to ensure all patients were aware of what we were asking them to talk about.

The interviews took around 30-45 minutes to complete dependent on the nature of the person's experience and level of detail provided.

2 LAMPdirect website (2014) – About LAMP at http://www.lampdirect.org.uk/lamp

3 Action Homeless (2014) – About Action Homeless at http://actionhomeless.org.uk/about-us/

4 Melton Borough Council (2014) – See www.melton.gov.uk

Key Findings

What happens when patients are discharged from healthcare settings

Discharge planning, discharge itself & general treatment by healthcare staff

Summary

One of the most obvious aspects of discharge planning was that patients were given a treatment plan. When a treatment plan was provided, there were cases where it was not adequate. At worst, there were cases where a treatment plan was absent.

Some patients reported additional health concerns at the point of discharge. This is concerning because, at times, additional health problems were not considered at the point of discharge.

In some cases patients did not feel ready to leave the healthcare setting, meaning they did not feel involved in the decision-making process.

Patients told us that healthcare services made assumptions about family support networks, including accommodation and community support.

Patients were very positive about their visit to the healthcare setting, both in terms of the treatment they had received and how healthcare staff treated them.

However, patients felt a degree of stigma directed towards them because of the circumstances they found themselves in (there were four negative comments where patients felt they were badly treated by healthcare staff).

The following case studies are drawn from our 15 patient interviews each is denoted by a reference e.g. OP1/7 Older Person (seven people overall), HP1/1 Homeless Person (one person overall), MH1/7 Mental Health (seven people overall).

There were some cases where patients did not receive a treatment plan highlighting failures in the use of discharge protocols in place within a setting.

> I was supposed to have a care package in place. This never materialised and I had to be readmitted to hospital. When I was discharged again the same thing happened.
> - OP1/7

In the majority of cases, the treatment plan provided was understood and followed by the patient. When it was not provided, this resulted in complications further down the line. For example, some patients requested more guidance about the medication they received because they were not sure about the arrangements. It was also reported that patients had difficulties obtaining and following discharge instructions. For example, patients reported difficulties in accessing appropriate medicine, and difficulties in attending appointments with other healthcare services.

> Following discharge, the carer went to the pharmacy with the prescription and the pharmacist explained that there were two sets of medication missing. When the carer returned home the carer rang the hospital and were told that the hospital was aware that the patient had not taken all of the medication. When the carer rang the department the staff had already gone. The nurse explained that the patient would need to go in and pick up the prescription and that the patient would have been fine

without the medication. The carer felt that this was not good enough and after much discussion the nurse agreed to send the medication to their home and it was delivered by taxi.

- OP6/7

During our interviews, patients reported additional health problems, which were known by the patient prior to their admission or discovered at the time of receiving care. Patient experience highlighted that hospitals and care settings approached patient discharge in different ways, with some considering additional health needs at the point of discharge and others passive with no consideration.

"No, disability was not considered. I was supposed to have had a package of care set up for me to help me cope with being on the outside."

- OP1/7

The interviews showed very clearly that some patients felt they were not ready to leave the healthcare setting for a range of different reasons. For some patients, there was a need for further support. For other patients, they felt they were being rushed through the system to make hospital beds available.

"I did not feel well enough when being discharged. I would have preferred to stay in hospital until I was a little bit better. The trouble is it takes months. The hospital does not have enough space to keep all the people in. The Psychiatrist at the time was not a good one; I could not talk to him and say I did not feel ready to come out.

I did not think he was a good Psychiatrist because the hospital would put you out in 8 weeks. I think because you get institutionalised so quickly they want to rush you out, but I had to come out. I did not feel involved in the decision making process to leave the hospital."

- MH1/7

A health worker felt that the impact of not having family, accommodation or community support is amplified for homeless people and not considered when deciding to discharge patients. The health worker told us that a homeless patient received treatment and then was discharged at 11.30pm on the street with no transport arranged. The same patient was found on the street the next morning outside the office quite distressed as the discharge process had not taken into account the transport or accommodation for the patient.

Overall, patients had a highly positive attitude towards the treatment they received. This feeling was particularly evident among older people who felt they were treated well during their hospital stay.

There were virtually no negative comments about how patients were treated by healthcare staff. However, there were some exceptions for people across the three consumer groups, where there was a general feeling of stigma towards them because of the circumstances they found themselves in.

"I was treated very well by healthcare staff, although at times I did feel like I was getting on their nerves. Yes, I felt stigmatised and discriminated against."

- MH2/7

What happens when patients are discharged from healthcare settings

Repeat visits and collaboration between services

Summary

Patients reported repeat visits to healthcare services. Often, this was result of premature or poorly planned discharge. Repeat visits were more of an issue for older people.

There were breakdowns in communication and failures at moments of transfer and transition between systems, resulting in delayed discharge.

There was a large degree of variability in the amount of collaboration between health and social care services, reflecting that improvements could be made with better links between health and social care.

Concerns around adequacy of community-based support and rehabilitation services also featured highly among patients.

Some patients, and their carers, were not made aware of the benefits and social care support they were entitled to.

The interviews conducted with patients provided important insights into the impact of unsafe discharge. When HWL asked about the number of times patients had been discharged, patients reported readmission and repeat visits to healthcare services because of unmet needs such as the reoccurrence of a problem. This was particularly evident among comments from older people. This insight was also evident among staff and professionals interviewed as part of the research.

> I had a fall, went into hospital, come out and came back in [due to] collapse and weakness. Other health conditions discovered at the time. First stay around four weeks, then discharged to home for two weeks under carers. Then had to be readmitted.
>
> - OP2/7

There were examples where patients had to be readmitted into healthcare because of being poorly prepared for home or as a result of inadequate care in the community.

> We do not understand why the hospital changed medication without informing other services. When patient is being discharged from hospital, and having medication changed as well can cause patient deterioration and delay in hospital. It has an impact on patient's wellbeing. Getting information to GP is important as delays can compound and escalate into more problems. Such delays costs more.
>
> - Health Worker

Patients reported breakdowns in communication between services, highlighting the failures in the flow of information between systems. HWL heard that effective channels of communication need to be present within healthcare services in order for follow-up activities and aftercare to take place. Even the most routine matters, like sharing patient notes, can prevent significant challenges for some healthcare settings.

Ambulance staff did not pass on information on patient, notes and medication when the patient was admitted to Leicester Royal Infirmary (LRI). The family were unable to travel with the patient to hospital. The hospital staff asked the patient for information, but patient did not know and appeared confused due to Dementia.

- Health Worker

A number of patients were provided with access to social care and support in the community, patients themselves also recognised a number of ways in which the aftercare package fell short of their expectations.

I was was given a treatment plan involving free carers for 6 weeks. It is basic care, microwave food, out of the freezer and put in the microwave, cuppa soup... that sort of thing. Once I was sick and the carers did not even wash my face or change my jumper. No physio, the carers are supposed to be getting me back on my feet. The idea was to get me strong again and look after myself...Some carers did not know what they doing so I had to pull them up, saying I am supposed to be having this, I am supposed to be having that.

- OP2/7

In other cases, the support offered was not tailored or personalised to the individual.

Day treatment offered which involved activities but it was not really doing it for me - I liked the art but I did not get on with deep meditation and positive self - not quite ready for that when you have just come out. It was only one session per week.

- MH2/7

In the worst-case scenario, community based support was absent altogether.

When I was discharged I was told that a carer would come to put me in the bath on Saturday. I waited and waited and the carer did not turn up so I tried to put myself in the bath with the help of my husband. My fear is – what would have happened if I slipped and fell in the bath. My husband has lost the use of one hand.

- OP7/7

Some patients and their carer(s) were not aware of the benefits and social care support they were entitled to. This prevents patients accessing aftercare services.

Patient taken into LRI with a stroke and some time later moved to St Luke's Hospital in Market Harborough, but deteriorated quite quickly and needed additional care, so transferred to a care home. When the patient had to go into the care home, the Social Worker did not explain that the patient would be eligible for Continuity of Care and so the family funds the patient and they received no support.

- Health worker

What patients think could be improved

It is important to note that the process works well for patients when the discharge guidance is followed.

A number of patients provided some suggestions for ways in which discharge processes could be improved and/or extended, typically including wider coverage of community-based support and communication with the patient to ensure they are at the heart of the decision making process.

Establishing links between the Voluntary and Community Sector (VCS) was seen as an especially important factor.

Examination of the discharge process provides insights into good practice. From interviews with staff and patients there are examples where patients are at the heart of the decision-making process and where community based support is well coordinated.

> Community Mental Health Team are very easy to keep contact, I have had meetings at home, at hospital and at the community base. I have experienced no difference in the care offered and received. I have also visited my GP and the care coordinator got in touch to see how I was getting on.
> - MH3/7

The discharge process works well for patients when all stakeholders involved in the 'cycle of care' communicate and follow the existing discharge procedures. For example, having a named lead consultant was considered an important factor in facilitating a positive patient experience. It provides a sense of reassurance and facilitates good communication at each stage of the discharge process. This feeling was evident among both patients and staff of support services.
Despite significant improvements in the discharge process, there are a number of individuals who were dissatisfied with the care arrangements in place.

Both patients and staff of support services recognised that discharge planning, processes, and arrangements for aftercare could be improved. Many patients drew specific contrasts in the way in which health and social care services worked together, making suggestions to promote better collaboration. This extends to better housing, accommodation and residential options, as well as better links between hospitals and other care services (including charities).

> An example of good practice is where there is a better link between hospitals and crisis teams. For example one case where the patient was treated at hospital for detox. Following treatment they were transferred into the alcohol unit and referred for follow up care. Where patients do not meet the criteria for hospital and social care services they can be referred to the VCS.
> - Health Worker

Communication between services was cited as a potential area for improvement:

> Patient was sent home late but communication was made with the staff on site (24 hours out of hours staff/ service) that were able to accommodate and put arrangements in place following discharge. The appropriate care was well done with the Homecare Assessment and Reablement Team Service (HART) team coming in to support the patient.
> - Health Worker

Options for care in the community could be improved to allow patients to exercise choice to support their individual 'needs'.

Patients valued the role of the health sector with respect to providing support at times of crisis, while staff felt the VCS sector could play a significant role in helping to reduce unnecessary admissions to primary health care services.

> All fine. More classes and visits to day treatment with classes that I enjoyed - more than once a week. More beneficial classes for me as well.
> - MH2/7

Patients also felt there should be information provided regarding entitlements for both the patient and their carer(s).

> Ensuring patients and their carers are advised on benefits available to them.
> - OP2/7

Case Studies

Mental Health

This case study provides an in depth overview of the patient experience when being discharged from a healthcare setting.

Reasons for admission

Patient was discharged once in the past 18 months from an acute mental health ward at Glenfield Hospital for older people. Admitted with severe anxiety and clinical depression. Also had physical health condition at the time – arm in plaster and was awaiting surgery to correct a previous operation as this had not healed properly. Admission lasted 10 months.

Treatment by healthcare staff

Generally treated well by healthcare staff. However, Consultant Psychiatrist changed during admission, which had a significant effect. The first Consultant Psychiatrist was intending to discharge before the patient felt ready and reduced medication without any consultation with the patient. The second Consultant Psychiatrist put the patient back on their original medication which the patient felt was more at their pace as the patient moved towards discharge. Patient did not feel stigmatised or discriminated against.

Discharge planning

Patient had required surgery whilst still an inpatient. Patient was made aware that a follow up operation in Orthopaedics would be required. The consultant Psychiatrist and ward staff involved family in discharge planning and a family meeting was arranged but this was against the patient's wishes.

The patient was discharged with support of a Community Psychiatric Nurse (CPN) and a Mental Health Advocate from LAMP. The Mental Health Advocate arranged a Volunteer to visit (independent of hospital) with the patient, which the patient felt worked very well. The first Consultant Psychiatrist planned to discharge 4 to 5 months into admission; patient still felt unwell and tried to harm herself, whilst on leave.

The patient was brought back to hospital and due to ward reorganisation was placed under a different Consultant Psychiatrist. This time the patient said that they were discharged when they felt ready - planned at patient's pace with periods of day and overnight leave (away from the ward). Admission lasted 10 months in total. Community support was in place on discharge. On the first occasion patient did not feel at all involved in the decision-making process; on second occasion the patient did.

Discharge

The patient was aware of their treatment plan – CPN following up within two weeks of discharge. Volunteer Coordinator visited the ward prior to discharge and arranged an introduction. No other rehabilitation or therapy services involved. No operation appointment follow up. Family member took patient home, following consultation with ward staff. Patient was discharged home with support from Community Mental Health Team.

Post discharge care

No readmission. CPN / Mental Health Advocate / Volunteer still involved. Follow up arranged for arm with Orthopaedics. This is as planned upon discharge.

Summary

The patient had two very different experiences on the same ward. The patient would have preferred not to have felt pressured into being discharged too early when under the first Consultant Psychiatrist, which led the patient to leave the ward in desperation and self-harm. Discharge planning on the second occasion was a much better example of good practice and done in consultation with patient.

This case helps to shed light on the inconsistent approach to patient discharge. In the first instance, there was a clear lack of patient involvement, where as, in the second instance they had a very positive experience and felt part of the decision-making process. This case also highlights the crucial role of the voluntary sector with respect to providing support to the patient throughout the process.

Older People

Case Study

This case study provides an in depth overview of the patient experience when being discharged from a healthcare setting.

Reasons for admission

Patient aged 99 years old, previously discharged from Accident and Emergency Department (A&E), admitted for hip injury following a fall. Other physical health conditions present. Discharged to residential care home straight after x-ray results and physio assessment.

Treatment by healthcare staff

Treated well by healthcare staff but admission and discharge seemed rushed. Carer (patient's daughter) did not feel she was given time to get satisfactory answers to questions about patient's care and treatment.

Discharge planning

Medical staff were aware patient lives in a residential care home and carer thinks assumptions were made regarding the care homes staff's ability to cope. Following discharge the care team struggled to support the patient. Patient repeated that he did not feel well enough to be discharged - if he had been kept in for observation, staff may have picked up that patient had sustained a fracture, which was missed at the time. The patient and the carer did not feel involved in the decision-making process to leave the hospital.

Discharge

Patient was discharged to residential care home, where patient had resided for many years. Patient did not receive a treatment plan, or rehabilitation/ therapy services. Transport was arranged in conjunction with the care home. Care staff were to administer and supervise medication.

Post discharge care

Patient was not readmitted but sought healthcare via General Practitioner (GP) as he was in pain. Carer feels GP did not examine patient properly to diagnose problem and could have done more. The GP prescribed morphine, which had confusing effect on patient at the time. There was no follow-up, other than pain relief. Family believes assumptions were made about the care home's ability to cope, as it was a residential care home, not a nursing home. Discharge notes stated patient could stand with two people; however, patient could not stand at all. The GP was called out several times.

The patient and family felt he would have benefited from being kept in hospital overnight for observation. This would have reassured family and prevented the strain on the care home staff. Patient would have also benefited from community physio follow up. The family feel he was discriminated against because of his age.

Summary

The series of failures highlighted in this case study illustrate the importance of a holistic assessment, taking into account additional care and a detailed discharge plan involving the patient and their carer in decision-making.

Recommendations

This study provides a small sample of patient experience involving discharge from hospital. The qualitative evidence provides valuable insight into the varied experiences from patients' own perspectives. We offer the following recommendations to providers of health and social care services alongside what we at HWL plan to do next.

University Hospitals Leicestershire (UHL) and Leicestershire Partnership Trust (LPT)

1. **Discharge guidance and practice should continue to be rolled out, extended and embedded as part of wider strategies to promote a positive patient experience.** This should include, but is not limited to:
   - Ensuring the patient is fit and ready to leave the healthcare setting with appropriate support to continue care at home or in the community.
   - Effective communication between services, the individual receiving treatment, and their carer(s).
   - Support for additional health problems diagnosed prior to admission or discovered at the time of discharge planning.
   - Ensuring arrangements for aftercare, treatment plans and processes for follow-up are suitable and understood by the patient and their carer(s).

2. **Targeted work aimed at vulnerable groups of patients**. Vulnerable groups of patients are more likely to be affected by unsafe discharge. More research is needed in this area, followed by targeted intervention work with identified groups to ensure holistic assessments take place involving all stakeholders in the cycle of care.

Leicestershire County Council (LCC), Clinical Commissioning Groups (CCGs) and Better Care Together Programme

3. **Better pathways between healthcare services and the Voluntary and Community Sector (VCS).** The VCS is well placed to provide safety nets for people affected by unsafe discharge. These resources could be therapeutic services (e.g. counselling, peer-to-peer mentoring) or housing support. Involving the VCS may reduce the burden and take up of other healthcare services.

4. **Better resourcing and support for carers,** Arrangements need to be made to ensure that the needs of those who are caring for patients are more fully considered. This extends to awareness of the discharge arrangements, ensuring there is appropriate support and respite for the carer(s) themselves, and ensuring patients and their carer(s) are aware of the entitlements available to them.

Healthwatch Leicestershire (HWL)

5. **Further research in the area of patient discharge** to gather experiences from a wider group of patients.

Acknowledgments

Healthwatch Leicestershire would like to acknowledge the contributions from everyone involved in the project. We would particularly like to thank Action Homeless, LAMPdirect and Melton Borough Council for facilitating access to patients and providing information throughout the project.

Healthwatch Leicestershire

Healthwatch Leicestershire is the independent consumer champion committed to gathering and representing the views of the public. Healthwatch has a role to play at a national and local level, and works to ensure the views of the public and people who use health and social services are taken into account.

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