Discharge Planning Survey
Summary Report

June 2013

If you would like an electronic or paper copy of this report or a copy of the full report, or if you have any queries relating to it, please get in touch with the following contact.
Lesley Baxter, Public Involvement Coordinator, Edinburgh Community Health Partnership, NHS Lothian, Canaan Park, Astley Ainslie Hospital, 133 Grange Loan, Edinburgh EH9 2HL
Telephone: 0131 537 9290
Email: lesley.baxter@nhslothian.scot.nhs.uk

This summary report can be accessed on the following website:
Contents

Foreword: What NHS Lothian will do with the survey results 3
Melanie Hornett, Nurse Director, NHS Lothian

Introduction / Methods used / Survey development workshop / Workshop structure / Survey development / Results - outline 5 - 6

Survey results - Summary 7 - 10
Foreword: What NHS Lothian will do with the survey results

I am delighted to have been asked to write the foreword to the Discharge Planning Survey Report. This was a small snapshot of the patients and publics perceptions of discharge from many hospital sites in NHS Lothian in 2012. We know we are on a journey with discharge and helpful feedback enables us to plan our services better to improve the discharge journey. The following recommendations from this report have been developed in conjunction with members from the North and South Public Partnership forums.

What NHS Lothian will do with the survey results?

- You asked us to carry out a full and comprehensive mapping to ensure that all services, agencies and organisations and patients and carers are involved.
  - We have agreed that Discharge Planning will be one of the first work streams for the Patient Centred Programme, a National programme for improvement. The aim of the programme is that by 2015 all health and care systems will have the patient / person at the centre of service delivery. So essentially all people who use our services will have a positive experience and get the outcome they expect. Discharge planning is very unique to each individual discharge and therefore needs to be planned in that way with the patient at the centre.

- You asked us to involve people to work with NHS Lothian staff to identify issues that would benefit from immediate action
  - We have agreed that ‘people’ should be involved in specific pieces of work within NHS Lothian and one mechanism for this will be the Improving the Patient Experience Group.

- You asked us to investigate how technology can be used (e.g. TRAK) to electronically send letters to GPs and other professionals who need to be informed about discharge arrangements
  - Electronic solutions are now in place so that discharge letters could be sent directly to General Practitioners. TRAK is the electronic system for community practitioners, so electronic information is available on the patient’s hospital and community journeys. However information sharing and communication continues to require to be monitored to ensure improvement.

- You asked us to develop a check list / pathway / flow chart to illustrate the ‘Pathways / Journeys of the Discharge Planning Process for patients (in conjunction with patients and carers).
  - We are currently developing information for patients and work is ongoing in this area we would be delighted to be assisted in the development of these resources

- You asked us to develop robust evaluation and monitoring for the Discharge Planning Process
  - We currently are unaware of any tools that would robustly help us evaluate and monitor the discharge planning process but will investigate further and report back if any such tools are available to use. We believe this is an excellent idea and would be happy to implement once such a tool is either found or developed.

Discharge can be one of the most complex areas for a variety of reasons but I think working in partnership will help us improve outcomes for all patients.

Melanie Hornett
Nurse Director, NHS Lothian
Introduction

Throughout 2011, the topic of patient and carer experience of discharge planning was discussed at both North and South Edinburgh Public Partnership Forum (PPF) meetings. PPF members occasionally recounted patient and carer stories concerning discharge planning experiences however, it was recognised that it would be helpful to gather more robust evidence.

In the same year, following an audit, NHS Lothian updated its discharge planning policies and procedures which were then ratified by the Clinical Policy Group. An implementation group led by Lynda Cowie, Chief Nurse, Edinburgh Community Health Partnership (ECHP), ensured that the new streamlined discharge planning checklist documents were distributed to the three acute (hospital) sites in Lothian (Royal Infirmary, Western /General / St Johns). In May 2011, two members of the implementation group attended PPF meetings to deliver a presentation to members about the updates.

In discussion with the ECHP Public Involvement Coordinator (PPFs), the PPF members agreed it would be helpful to carry out a survey to record patient and carer experiences in a format which would help to inform future public involvement activity as well as future policy, procedure, service development and improvement. This was also discussed and agreed at the ECHP Performance Management Sub Group.

Methods used

A workshop was held to develop the questions for the survey (see following section). Survey Monkey was chosen as the preferred survey format as it is a recognised and accessible online survey tool. It also allows paper copies to be generated and the data can then be entered onto the online Survey Monkey system.

Survey development workshop

On 8 February 2012, twenty nine members of the PPF and the City of Edinburgh Council (CEC) Edinburgh Equalities Network were joined by twelve service managers from NHS Lothian and the CEC at a workshop at the Faith Mission in Gilmerton Road to develop the survey questions.

Six staff from CEC, NHS Lothian and the Scottish Health Council scribed at the workshop.

Workshop structure

The service managers and leads gave an overview of the services they are responsible for and how these services work together to provide care to patients before and after being discharged from hospital.

Service managers and leads then facilitated the discussion groups with the support of the scribes. Examples of a Survey Monkey form, ‘sample’ questions and section headings were provided to aid the discussion. Each group then developed themes and questions for the survey form. The workshop evaluated very well.

Survey development

Following the workshop the topics and questions were collated and themed and the survey was developed. There was a mix of ‘tick-box’ questions and free text options. The draft survey was circulated for comment to the people who attended the workshop and it was ‘live’ from 5 July 2012 to 5 October 2012.
It should be noted that when the plans for the survey were being formulated, the intention was for the Public Partnership Forum members to use their local networks to circulate the survey. However, due to the interest in the survey topic from various groups and networks, the opportunity was taken to circulate the survey more widely than originally envisaged.

To ensure that the responses reflected the current discharge planning processes, only patients who had been in an Edinburgh hospital, or St John’s hospital in Livingston, in the previous twelve months were requested to complete the survey.

**Results - outline**

The survey ran from 5 July 2012 to 5 October 2012.

Survey Monkey reported that 87 survey forms were started and 78 (89.7%) were completed. Survey Monkey identified how many people skipped each question.
Survey Results - Summary

Demographic information and information about the patient’s last hospital stay

- 29 (35.8%) people had been in hospital less than a month before they completed the survey. 15 people (18.5%) were in hospital three to six months ago, 15 people (18.5%) one to three months ago and 22 people (27.2%) six to twelve months ago.
- The majority of responses were from people who had been in either the Royal Infirmary of Edinburgh (RIE) or the Western General Hospitals (WGH)
  - RIE – 59 people = 78.6%
  - WGH – 22 people = 29.3%
- 14 people had been in hospital under 24 hours, 32 people over 24 hours and up to a week, 23 one to four weeks and 13 over a month.
- 53 admissions (67.9%) were an emergency and 25 (32.1%) admissions were planned.
- The biggest response of 36 (45%) was from people in the working age bracket of 26 – 65. Next was 76-85 year olds (24 [30%]) and the next highest was 66-75 year olds (12 [15%]).
- Gender of respondents:  Female (45 [56.3%]) / Male  (35 [43.8%])
- Ethnicity of respondents:  96.3% - ‘White’ / 2.5%) ‘Mixed or multiple ethnic group’ / 1.2% Asian, Asian Scottish or Asian British.
- A good spread of responses was received from 18 ‘EH‘ postcode areas.

Section 2 concerned arrangements for support that people may have needed when they left hospital.

Questions 10 and 11 concerned practical, personal and social support as these can affect recovery at home or in the community following a hospital stay.

- People were asked to rate how involved they felt in their discharge planning and whether their family and home situation was discussed with them while they were in hospital. Most responses were positive however a significant number replied in the negative therefore it may be helpful to do some further work in this area.
- Practicalities such as whether or not there is food and drink in the house or whether the house is warm for the person arriving home can influence and affect recovery. The responses reflected that further work in this area may also be helpful.

Patient quote: “I was not asked any of these as they just told me that I was going home because I was feeling better”.

The remaining three questions in this section related to the following.

- Paperwork associated with discharge (e.g. letters to GPs, follow up appointments, fit for work notes)
  - A recommendation from this survey (see page 2) is to investigate how technology can be used (e.g. TRAK) to electronically send letters to GPs and other professionals who need to be informed about discharge arrangements.
- Explanation given about illness and condition and patients understanding of same
  - The majority of people indicated they understood their illness or condition however a small number did not which should be noted.
- Issues concerning medication
  - Various issues with medication were highlighted including problems with repeat prescriptions (e.g. if letter had not been handed in to GP), discharge delays waiting for medication, variations in doses, dosette boxes not filled properly.
Carer quote about medication: “There has been a mix up on one medication that this lady takes. We had to check with her GP whether or not to give it. We were told not to give this and GP would contact hospital.”

Section 3 concerned the day the patient left hospital

- People were asked if they had been asked how they would get home. 59 said they had been asked, 15 said they had not and 2 couldn’t remember however, the patient may not have been asked these questions directly if the staff had already discussed it with a carer or the family.
- The time of day when people are discharged can be important as it links to the practical, personal and social support issues covered in Section 1. A discharge late in the day can have an impact on various needs such as availability of support (statutory or community) or access to food and drink.
- The majority of people (43) were discharged between 12 noon and 6.00pm. Two were discharged between 9.00pm and midnight. Further work would however be needed to draw conclusions as these patients may have experienced an emergency admission but discharged without any complications or further support requirements.
- The majority of people went home in a car with family or a friend.
- Most people weren’t delayed when they were being discharged. For those that were the two main reasons were that their medication or discharge letter wasn’t ready.

People were asked to add any other comment about the day they left hospital. Twenty seven people provided additional comments. Eleven people said they were happy with their discharge and pleased to be home. Comments included how kind and helpful the staff had been and how well they had been looked after.

Patient quote: “I was delighted to be discharged one day early and was assured by physio, occup-ther and medical staff that I was fit for home which was the case.”

Other, less positive comments, concerned issues such as transport (including assistance to a private vehicle), care at home and patient information.

Patient quote: “I was sent home in patient transport on a cold November day dressed only in a nightie, dressing gown and slippers plus a blanket. It was a very cold day and there were other people dropped off before me. This was unacceptable and undignified. My next of kin was given no opportunity to bring clothes in for me.”

Patient quote: “I asked a number of doctors and nurses about what I should and shouldn’t do to aid my recovery. I got a different answer every time so I went back to my GP for advice.”

Section 4 related to the patient’s General Practitioner

People were asked if they saw their doctor (GP) after they got home. 34 (46.6%) answered ‘Yes’ and 39 (53.4%) answered ‘No’.

Those who answered ‘yes’ to the previous question were asked if their GP knew they had been in hospital, that they had been discharged and if the GP knew that their medication had been changed. Answers were generally favourable although if a letter was sent electronically to GPs these numbers may be able to be improved.

People were invited to give more information about their GP practice that was relevant to their hospital visit. 24 people added more comments. Examples are as follows.

Responses linked to medication or help with follow up care:
Patient quote: “My GP phoned. He knew I had been in hospital and discharged. He was also aware my medicines had been changed. He made sure I had a sufficient supply.”
Patient quote: “I called the GP but never saw me but told me he could not change my tablets till he got letter from the hospital.”

Comments about communication between hospital, GP and / or patient
Carers quote: “Follow up letter to the GP never got to her until 5 days after my wife’s discharge. When she came to visit my wife she used our discharge letter to go over her medication.”
Patient quote: “GP acknowledged failure to make contact after discharge and has apparently changed policy on this, to make contact a standard procedure.”

Section 5 – three questions were asked in this section about overall satisfaction with discharge arrangements.
54 (72.9%) people were either ‘very satisfied’ or ‘satisfied’ with their discharge planning arrangements with 27% responding as ‘not satisfied’. The majority of people were therefore positive about their discharge arrangements and their return to either their own home or community accommodation however, less positive comments will provide an opportunity to improve the service.

To take advantage of and to learn from patient experience, question 23 asked what, if anything, would have made the discharge process better. Answers were grouped under one of six main headings as follows. One patient or carer quote is given for each heading.

Transport arrangements, journey home and arriving home
Patient quote: “If I had had outdoor clothes on or had been sent home in an ambulance not Patient Transport which was uncomfortable and cold.”

Medicines / Equipment
Patient quote: “OTs available at weekends. More thorough checking of the home environment and care needs. Medication ready to coincide with discharge and at weekends. Do not remove the dosette box I came in with - use these meds and discharge with what’s left plus any new meds required.”

Patient not ready to go home
Carers quote: “Felt discharge was too quick as further issues transpired in less than 1 week.”

Care after arriving home
Patient quote: “GP contact immediately on discharge. Even a phone call to establish the position would have been reassuring.”

Information / Communication – after care, aids to recovery
Patient quote: “Clear information about what I should and should not do to aid my recovery. It was a very large open hernia surgery with mesh so this was key information.”

Other and / or multiple issues
Patient quote: “Being discharged during the day not in late evening.”
Patient quote: “Proper assessment of physical limitations and pain level.”
People were asked for any other comment about their discharge from hospital.  25 responded. The comments received were varied. Two positive and two less positive comments are as follows.

Positive comments

**Patient quote:** “I was put in touch with my local district nurse team to assist with my situation daily and they have been wonderful - very helpful and fantastic giving me any help and advice I've needed.”

**Patient quote:** “Period in hospital was comfortable, pleasant and a lot of care shown. First class treatment throughout.”

Less positive comments

**Patient quote:** “Particularly for dementia patients and the elderly in general RIE is too quick to discharge. However Liberton very good at managing the care of the whole person/package. RIE are quick to patch people up and send them home without considering if it’s the best thing. Mum recently had a urine infection which makes her more confused and at risks of falls. Hospitals don’t appreciate that by preventing further possible injuries it’s a safer and cheaper option all round rather than rushing people home and putting burden back onto carers. This surely can’t be best for all, particularly patients and carers.”

**Patient quote:** “Home assessments and care packages were talked about but at time of discharge none of this had been put in place. Coping with pre-existing health problems (dementia and osteoarthritis) and a fractured pelvis in a new environment (due to bereavement one week before admission of spouse). No follow up or support offered. Exceptionally poor communication between hospital personnel and family.”