Public Meeting

1st October 2014

Hospital Discharge: “Harnessing the Power of Your Experience.”

Report

Healthwatch North Somerset
3rd Floor, The Sion
Crown Glass Place
Nailsea
BS48 1RB

01275 851 400
contact@healthwatchnorthsomerset.co.uk
www.healthwatchnorthsomerset.co.uk

Hospital Discharge: "Harnessing the Power of your Experience."

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Public Meeting

Hospital Discharge: “Harnessing the Power of Your Experience.”

1st October 2014

Background to the public meeting

The hospital discharge process has become a topic that requires attention in North Somerset, and across the country. A core function of Healthwatch North Somerset is to listen to public views and experiences, and work towards converting those views into positive changes. While it is important that patients receive the best care possible during their time in hospital, it is just as important that the same level of attention and care is paid when patients leave hospital and return home.

The Healthwatch North Somerset Hospital Discharge: Harnessing the Power of Your Experience workshop provided members of the public with the opportunity to voice their views, personal experiences and suggest improvements that could be made to the existing discharge processes.

Healthwatch North Somerset’s statutory duty and remit, which is laid out in The Health and Social Care Act 2012, is to provide a voice for people who use health and adult social care services, by:

Influencing

- Giving people an opportunity to have a say about their local health and social care services, including those whose voice isn’t usually heard
- Taking public views to the people who make decisions – including having a representative on the Health and Wellbeing Board
- Feeding issues back to government via Healthwatch England and the Care Quality Commission (CQC)

Signposting

- Providing information about health and social care services in the local area
- Advising people on where to go for specialist help or information (signposting)
- Helping people make choices and decisions about their care
- Working closely with other groups and organisations in the local area.

Setting up the meeting

The meeting took place at Nailsea Methodist Church on Wednesday 1st October 2014. Consideration was given to the time and location of the event, as we acknowledge that any chosen time or location could exclude part of the population. To ensure Healthwatch North Somerset meetings are widely accessible to the public, Healthwatch North Somerset seeks to ensure public meetings vary in terms of time, weekday and venue.

The meeting was advertised in the local press – Weston Mercury and North Somerset Times, and was widely advertised through local community websites, community newsletters and social networks. Details of the meeting were emailed or posted to all Healthwatch North Somerset's members and contacts and via Voluntary Action North Somerset's database of over 700 contact and invitations were also sent to stakeholders. Details were added to the Healthwatch North Somerset website and social media.

This report is a record and reflection of the opinions and experiences raised at the workshop and were recorded by independent facilitators in each group.

The meeting

The meeting began with a short presentation by Linda Redmond, Community-In-Reach Nurse, North Somerset Community Partnership, who introduced and explained the process of Hospital Discharge from her perspective as a Community-In-Reach Nurse. Healthwatch North Somerset would like to thank Linda for attending and supporting the workshop.

The thirty four people who attended the workshop were asked to join one of three groups that represented their experiences or interests:

1. **Bristol hospitals**
2. **Weston and Clevedon hospitals**
3. **Specialist Services**

The groups were facilitated by independent volunteers and were asked to consider three questions:

1. **Your Vision: What does the best hospital discharge look like?**
2. **Where are we now? Share your experiences.**
3. **What do you consider needs to occur to achieve your vision of best practice in hospital discharge?**

Each group discussed their views, experiences and ideas and these were shared with the rest of the attendees at the end of each question session. This report provides a summary of both the individual and whole group discussions.

Question One: Your Vision: What does the best hospital discharge look like?

The question was designed to provide a view of what the groups considered were important factors in the provision of the best possible discharge for patients.

All the groups agreed that the best hospital discharge follows a cohesive, co-ordinated procedure, with the patient at the centre of the process at all times. It involves a team of people working together, with an integrated approach from all parties involved: the patient, the hospital staff, the patient's family/carers and community/homecare support.

Medication

They also agreed that patients often have to wait a long time for their medication to be issued after they have been signed off for discharge by a doctor. The group representing Specialist Services suggested that a good discharge procedure would ensure appropriate staff were available to sign off the patient for discharge and issue medication at the point of discharge, rather than needing to wait. Somebody said "I had to take my partner home and then return for the drugs later," indicating their experience of a process that lacked coordination.

It was also considered important that doctors explain carefully to the patient how medication should be taken and to take time ensure that the patient understands this fully.

Waiting for discharge

The group representing Weston and Clevedon hospitals said it is common for patients to have to wait "for hours" in the Weston General Hospital discharge room, and that a much "speedier exit" was required.

Infection control

All groups agreed that infection control procedures should continue to be adhered to throughout the discharge process for example stating that a patient may have a lowered immune system when they leave hospital for example following medical procedures such as chemotherapy, and are therefore at higher risk of infection. The risk of transmission of infection should be considered at all times, and precautions must be taken to avoid its occurrence.

Returning home

The three groups also considered what should happen when a patient leaves hospital and returns to their home. One person in the group representing Bristol hospitals suggested that a good hospital discharge procedure would include an assessment of each individual, based on their home safety, medication, access to food and their mental and physical needs.

The Weston and Clevedon hospitals group recommended that preparations for the patient leaving hospital and going home should be made a few days before patients are planned to be discharged, rather than leaving it until the day of discharge. There are preparations that can be anticipated in advance and work could begin on putting those in place much earlier.

It is vital that patients have the support they require available once they return their homes. The groups from Weston and Clevedon hospitals and Bristol hospitals both agreed that patients should be given contact details after leaving hospital in case they need support or advice. Providing adequate post discharge information will help reduce anxiety that can occur after discharge because information given in the hospital is not always easy to take in and remember.

Signposting

The importance of signposting was raised by each group and all agreed that in a good hospital discharge system, clinical staff are open and clear about available support services and what they offer, and patients understand about the services available to them.

It was also mentioned that patients are not always totally honest about whether they have help available to them at home. This is often because they are eager to leave hospital and either don't want help or think that if it appears they need help their discharge will be delayed.

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Transport

Hospitals should be clear as possible about each individual's situation in good time before discharge, so appropriate transport preparations can be made, i.e. if the patient is to be picked up by a family member or requires an ambulance service.

Guidelines

The group representing Weston and Clevedon hospitals made the point that guidelines are in place for the hospital discharge process, but they are not always followed. This may indicate that there is room for some systems to be tightened up to improve the discharge process for the patient. The Bristol hospitals group agreed with this point adding that there could be a better understanding of the discharge process by hospital staff with the team working together more effectively. The Specialist Services group added that in the best hospital discharge, all the guideline criteria of the process are met.

Staff know or have a reasonable idea of when patients will be discharged and preparations should be put in place as soon as it becomes apparent that discharge is imminent. Those patients that were awaiting an ambulance to take them home were thought to be dealt with first, leaving those making their own way home to wait longer before they could leave the hospital. Ideally discharge planning should start on admission to hospital.

The best hospital discharge

The best hospital discharge keeps the patients at the centre of the process at all times. The service provided should be tailored to fit each individual patient's needs. Good hospital discharge is safe and well-co-ordinated, with good communication and understanding between patients, doctors, nurses, and those who will provide support and care for the patient after they have been discharged. The best discharge is planned in good time and patients clearly understand how and when they must take any medication, transport home is arranged in good time, patients understand what services are available to them once they leave hospital and relevant contact details are provided should they be necessary once they are home. The key points are communication, organisation, and efficiency.

Summary of what the workshop considered constitutes best discharge practice:

- Patient led discharge
- Planning ahead; discharge planning starts at admission
- Availability of medication at discharge to avoid waiting
- Individualised – knowledge of the patient and their situation
- Develop more smart ways of working
- Coordination at discharge
- Patient understands any follow up required and appointments

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- Reducing or eliminating waiting after discharge
- Seamless discharge with efficient procedures
- One named contact for patient
- Responsible and accountable practice
- No blame service between hospitals
- Good liaison between nurses
- Links and good liaison between clinical/statutory/ voluntary organisations
- Understanding capability
- Infection control adhered to
- Good signposting
- Family involvement
- Safe discharge and good risk management

Question Two: Where are we now? Share your experiences.

This part of the workshop gave attendees the opportunity to share their own experiences, and to create an image of the current situation regarding hospital discharge based on personal feedback.

As well as commenting on the improvements that could be made, there was a good amount of positive feedback. The group representing the Specialist Services praised the work of the Red Cross, and also described the voluntary sector service provided by Crossroads Alliance as “invaluable”.

Specialist equipment

With regards to the availability of specialist equipment for patients, the Specialist Service group commented that the provision of some items of specialist equipment, such as beds, would benefit with being better co-ordinated, but agreed that end of life special equipment provision is good.

Transport

The group representing Weston and Clevedon hospitals also had some positive points to share. The transport services for Weston and Clevedon Hospitals during the day, were praised. Someone commented that transport was working well in Weston and there were positive comments about transport at discharge from Clevedon Hospital. It was thought that Clevedon Hospital offered a different experience for patients as it was considered their staff had time to care.

There was also some less favourable feedback about transport from hospital and there was a suggestion that more coordinated transport services would reduce the amount of time a patient needed to wait to go home after discharge; it was commented that

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this is often a considerable time for many patients reliant of hospital transport. Someone questioned whether SWAST (South Western Ambulance Service NHS Foundation Trust) was "really for patients?" claiming their experience of the service was "diabolical".

Waiting to leave hospital

The frustration of waiting for discharge, dressed and ready to leave, for four hours in Weston Hospital discharge room was recalled by one person. Another mentioned being taken off the ward at 10am ready for discharge and waiting until 6pm for medication, mentioning that "there was no bed to lie on just an uncomfortable chair". A comment was also made that the waiting area for discharge was "unhealthy, with everyone ill and weak, with coughing and infections, all in one area" waiting to leave.

Medication

There was a general plea to make the process for prescribing medication more streamlined and quicker. One person in the Weston and Clevedon group said they thought drugs could be dispensed more quickly, "they should do the drugs a different way" and suggested if the current system is not effective, perhaps another system of prescribing should be considered.

Discharge

Unfortunately, the discharge experiences shared by the Bristol hospitals group were not positive. One person commented on the "inadequate sharing of information between professionals i.e. matrons, GPs and different hospitals." Somebody added that a patient "was told he was ready for discharge, then was later told otherwise by the doctor." There were also delays in discharge waiting for a doctor to sign off for discharge. These issues are upsetting and stressful for the patient and indicate a lack of communication and cohesion between staff.

One person also noted that their overall experience at Clevedon hospital was good, adding "although it is a smaller hospital, so they have more time available for planning."

The Weston and Clevedon Hospital group mentioned that they thought the high staff turnover at Weston Hospital may have a negative impact on the patient experience at discharge.

Planning

Points were raised with regards to who was and should be involved in the discharge process. There were comments that "relatives are not involved in decision-making, but carers are" and that "patients need to be listened to." These link back to the points made in Question one above, which emphasise that the patient should be at the centre of the discharge process, with their views taken seriously, and their

families being informed of decisions at all times. “People are not discharged on a whim, they know a day or two ahead, so planning ahead shouldn’t be that difficult.”

The group representing Specialist Services shared an experience which indicated a lack of adequate planning prior to discharging a patient. One particular patient was discharged by ambulance transport during the early hours of the morning from a Bristol hospital. Recalling that the ambulance crew wheeled the patient up and down as they “couldn’t find the house in the dark, at 3-4am”; although it was conceded there were no street lights which made it more difficult to find the house. Another person mentioned a vulnerable relative who was discharged at 5.30am.

It was commented that this did not inspire confidence in the organisation of patients discharge and the question arose of why someone was discharged at this time in the morning. It was commented that if the clinical staff didn’t have an understanding of the patient’s home situation it makes it difficult to avoid an inappropriate discharge.

Someone recited an experience of being refused a bed at Clevedon Hospital for being “too poorly”. Another person stated that they were moved between wards several times at a Bristol Hospital and felt they were too vulnerable and unwell to complain. There were some negative comments about discharge from A&E at Weston Hospital.

The Weston and Clevedon group strongly emphasised the point that the discharge of the patient should be in mind from the point of admission. Planning should begin from the start, and not left until the last minute. Without effective planning and communication between staff, patient and families and carers, the discharge process can become disjointed and disorganised during an already difficult and emotional time. One person shared an experience of a family member whose discharge they considered was delayed due to a lack of planning and coordination who subsequently died in hospital instead of returning home.

Individual needs

The Specialist Services group also emphasised the importance of checking the individual discharge needs of patients, such as have they got a door key? This group commented that staff members “sometimes” check these issues, but were clear that they considered they “should be checked every time.” Staff sometimes check for things like door keys, whether there is food in the house but this needs to be routine.

All groups agreed that providing a basic food pack to single older and vulnerable patients would be a good idea, since many patients do not have anything to eat in the house once they return home from hospital. The Specialist Services group added that in the past “diabetics have been sent home with no food in the house,” this could have serious consequences, and that “dementia patients need extra support.”

It was agreed that the Red Cross provide an excellent service as they can check a patients individual circumstances, take them home, make hot drinks and call the next day if appropriate.

This issues raised all contribute to the important point that each patient has individual needs which should be considered and understood by hospital staff. Appropriate planning should occur which includes taking time to ensure that each patient's circumstances are understood, recorded and shared with the discharge team.

Home adjustments

There were positive comments regarding home adjustments required for those with mobility issues. Indicating that when discharge has been planned well, patients received the resources to support their individual needs. There was also positive feedback about Occupational Therapy services and of adaptions made for patient's return from hospital.

Key points

The key points that emerged from these shared experiences are the need for planning and preparation, and the understanding and attention that must be paid regarding each patient's individual needs.

Summary of the issues the workshop considered would create a more positive discharge process:

- Better processes to prescribe discharge medications / reduce delays in providing medication
- Support in the home on discharge
- Provision of contact details
- Ensure food available at home / Provision of simple food packs for vulnerable people
- Planning for discharge started earlier
- Red Cross working well - voluntary sector should have more involvement
- Listening to the patient and offering more dignity / Clinical staff to take time to understand individual needs / Listen to the family
- Planning for discharge should begin earlier
- Decrease transport from hospital delays

Question Three: What do you consider needs to occur to achieve your vision of best practice in hospital discharge?

This question sought to understand what changes could take place that would enhance the patient experience of hospital discharge.

An emphasis was expressed by all groups, on the need for discharge to be considered and planned from the point of a patient's admission into hospital. This would then eliminate plans being left until the last minute, and would initiate good organisation and co-ordination from the start.

Barriers to communication

The group representing Bristol Hospitals suggested that barriers between health professionals need to be broken down so that they work effectively together. The Weston and Clevedon hospital group added that better co-ordination between GPs, hospitals and social care staff should be possible with more effective the use of IT systems. "An up-to-date database of a patient's medical records that is accessible to all involved in the patients care should not be out of the question in this day and age". These two groups also agreed that there is a need for better liaison and communication between departments, and consistency across all areas. It was recommended that IT and the inclusion of a good, reliable checklist would benefit the process.

Checklist

The Specialist Services group suggested that an official checklist, much like the 'WHO Surgical Safety Checklist and Implementation Manual" (published by the World Health Organisation (WHO) in 2008 to increase the safety of patients undergoing surgery), would be a useful guideline for all involved in patient discharge. Each patient has their own, individual needs which must be taken into account, however, it was agreed that a standard list of hospital discharge procedures that need to be undertaken would make a beneficial difference by ensuring that all discharge issues were addressed.

Ready for discharge

The groups agreed that while it is important that beds are freed up as soon as possible and that no one remains in hospital after they are medically fit to leave, it is important that a patient is ready to be discharged. The Weston and Clevedon hospital group advised that they considered "the bed situation must be improved". One person mentioned that they had a good experience at Clevedon Hospital but conceded the hospital was smaller and there seemed to be more time available for planning.

There were suggestions that "some rules" seemed unnecessary and "need to be abolished".

Care after discharge

The key issues raised by the groups on the topic of care after discharge from hospital was that of awareness of services and better use of existing resources. The Weston and Clevedon group suggested there could be better communication and greater public awareness of services available to patients on discharge, such as Home from Hospital and the Red Cross. Providing better co-ordination of care and support would in turn reduce the anxiety of patients on discharge. A collaborative focus on consistency, planning and team-work was considered important to ensure the best hospital discharge procedure.

Home from hospital services are already in place but one person suggested that greater use could be made of these. It was also suggested that links with other services, commissioners, clinicians and the voluntary sector could be strengthened.

Planning

It was suggested that clinical staff need to be more open about how services can be delivered to individuals but it was stressed that clinical staff do not always have the power to be able to provide services in another way. One person in the Bristol Hospital group suggested that barriers between professionals should be broken down and a single point of discharge created utilising the skills of community nurses and health visitors and stated that "planning, planning, planning" was the answer.

Summary of the issues that the workshop considered would achieve their vision of best practice in hospital discharge:

- Begin planning for discharge on admission
- Develop a more consistent and holistic approach to discharge
- Trust and communication between all involved in the patients discharge and working together to achieve this
- Develop check lists and record keeping
- Review procedures and highlight areas where they could be developed more effectively
- Prepare and provide timely discharge paperwork and timely paperwork to GPs
- Provide timely medication
- Better liaison and communication between all involved in a patients discharge including Trusts working together
- Single point of discharge – continuity for patients

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Conclusion

In conclusion, any stay in hospital for a patient and family is stressful. While there are many complex aspects to consider when it comes to hospital discharge, all agreed that the best discharge focuses on a consistent, holistic approach. The welfare of the patient, and the focus on their discharge, should be at the top of the agenda from the point of admission. A carefully co-ordinated, well planned and communicated team effort will decrease anxiety and stress at the point of discharge. Someone at the workshop said we are "not in as good a place as we should be" regarding discharge. No discharge process should elicit comments such as 'the family was not listened to' or 'I felt belittled' or leave a patient feeling they were not listened to or were deprived of their dignity. The feedback at the workshop indicates there is room for improvement, and that much of the improvement is achievable and affordable.

Recommendations

The key issues raised by the Hospital Discharge: "Harnessing the Power of Your Experience workshop are: communication, efficient connections and coordination between GPs, hospitals and social care staff, and better, realistic targets that can be met consistently. Many additional aspects must also be taken into consideration, such as transport, aftercare services, disabled access to homes and patient dignity.

Healthwatch North Somerset recognises that all recommendations should be Achievable, Evidence Based and Affordable and the recommendations below fulfil that criteria.

Healthwatch North Somerset Recommendations

1. Streamline discharge processes to avoid long waits after being advised they are to be discharged.
2. Streamline prescription processes so that patients receive medication on discharge and avoid long waits.
3. Development of a patient centred discharge process which is focused on the patient's individual needs.

This report which includes public feedback from the workshop will be forwarded for responses to Weston Area Health NHS Trust, University Bristol Hospital NHS Trust, North Bristol NHS Trust, North Somerset Community Partnership, North Somerset Clinical Commissioning Group, NHS England, North Somerset Council and Healthwatch England. This report will also be available on the Healthwatch North Somerset website and in paper and other accessible formats on request.

Appendix 1

Further Information:

Age UK

Discharge Factsheet
http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS37_Hospital_discharge_arrangements_fcs.pdf?dtrk=true

Alliance Homes

Home from Hospital Service
www.alliancehomes.org.uk/main.cfm?type=SUPPORTPLUS

BMA

Hospital discharge: the patient, carer and doctor perspective
bma.org.uk/-/media/files/pdfs/.../plg%20patient%20**discharge**.pdf

Clevedon Community Hospital

Inpatients information
www.nscphealth.co.uk/services/inpatients-at-clevedon-community-hospital

www.nscphealth.co.uk/cch-patient-info-updated-pdf

The Crossroads Alliance

www.alliancehomes.org.uk/main.cfm?type=THECROSSROADSALLIA1

Guidelines On Regional Immediate Discharge Documentation For Patients Being Discharged from Secondary into Primary Care

www.gain-ni.org/images/Uploads/Guidelines/Immediate-Discharge-secondary-into-primary.pdf

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Home from Hospital Services

www.housingcare.org/service/list/s-72-home-from-hospital/l-343-north-somerset.aspx

NHS

Discharge information
www.avon.nhs.uk/rehabilitation/documents/documents/Phase%202/NS%20Rehabilitation%20current%20state%20report%20v1.3.pdf

www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/discharge_planning.html

NHS Choices

Leaving hospital information
www.nhs.uk/NHSEngland/AboutNHSservices/NHShospitals/Pages/leaving-hospital.aspx

North Bristol NHS Trust

Helping you plan leaving hospital
www.nbt.nhs.uk/sites/default/files/attachments/Helping%20you%20to%20plan%20for%20Leaving%20Hospital_NBT002758.pdf

www.nbt.nhs.uk/patients-carers/coming-hospital/leaving-hospital

North Somerset Council

- **Home from hospital leaflet**

www.n-somerset.gov.uk/Social%20care/older_people/Documents/home%20from%20hospital%20leaflet%20%28pdf%29.pdf

- **Planning for when you leave hospital fact sheet**

www.n-somerset.gov.uk/Social%20care/advice_and_support/Documents/Planning%20for%20when%20you%20leave%20hospital%20%28pdf%29.pdf

- **Care Navigator service**

www.n-somerset.gov.uk/Social%20care/advice_and_support/Documents/Care%20navigator%20service%20%28pdf%29.pdf

- **Discharge from Hospital Working Group - First Report 2009**

http://apps.n-somerset.gov.uk/cairo/docs/doc20054.htm

- **Discharge from Hospital Equipment**

www.n-somerset.gov.uk/Social%20care/disabilities/Documents/factsheetequipmentservices_201202.pdf

- **Community Transport**

www.n-somerset.gov.uk/Transport/travel/Pages/Community-transport-FAQs.aspx
http://www.n-somerset.gov.uk/Transport/travel/Documents/community%20transport%20directory%20%28pdf%29.pdf

North Somerset Community Partnership (NSCP)

www.nscphealth.co.uk

Community in Reach: www.nscphealth.co.uk/services/community-in-reach

North Somerset Clinical Commissioning Group (NSCCG)

www.northsomersetccg.nhs.uk/

Nursing Times

- **Key principles of Effective Discharge**

www.nursingtimes.net/nursing-practice/specialisms/management/the-key-principles-of-effective-discharge-planning/5053740.article

Red Cross

www.redcross.org.uk/
www.redcross.org.uk/Where-we-work/In-the-UK/Southern-England/Wiltshire-Avon-and-Gloucestershire

- **South West Ambulance Service**

www.swast.nhs.uk/

- **WHO Surgical Safety Checklist and Implementation Manual**

  (published by the World Health Organisation (WHO) in 2008 to increase the safety of patients undergoing surgery)

www.who.int/patientsafety/safesurgery/ss_checklist/en/

- **University Hospitals Bristol**

www.uhbristol.nhs.uk/patients-and-visitors/after-your-treatment/

- **Weston General Hospital**

  www.waht.nhs.uk

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Formal Response to the Healthwatch North Somerset Workshop Report from Weston Area NHS Trust

I write further to your email of 18 December 2014 sent to Nick Wood, Chief Executive here at Weston Area Health NHS Trust, and have pleasure in providing the Trust's response to Healthwatch North Somerset's Report following the Hospital Discharge Workshop held on 1 October 2014, which we would like included within the final publication.

Over the last 12 months the discharge process at Weston General Hospital has been reviewed and as a result many changes have taken place in order to improve discharge, aiming to make it more patient-centred and efficient.

Case Management Team

The Discharge Liaison Team has, over the last six months, become the Case Management Team. The Team is made up of a Case Manager (healthcare professional) and a Pathway Facilitator (unregistered support staff). Each working day (Monday to Friday) a Team attends the admitting wards (MAU, SAU, Stroke and Hutton Ward) to review all admissions that have been highlighted by the admitting Nurse to have 'complex discharges'. The patient's discharge journey starts by meeting the Case Manager and Pathway Facilitator who will be looking after their case throughout their hospital admission. A discharge care plan specific to the patient's needs is drawn up by the Case Manager and actions are highlighted for each patient. There is a section for updates on the care plan and this is intended to be used by all members of the Multi-Disciplinary Team. This has been introduced to improve communication for discharge, and to ensure the process is patient-centred. When the patient is moved from the admitting unit to a longer stay ward, their Case Management Team follows them throughout the Hospital and they are the point of contact within the Hospital.

Discharge Planning on Admission

Discharge paperwork for nursing staff has been greatly improved, and for the last two months has been part of the patient's admission document. This paperwork has sections to be completed by the Registered Nurse on admission, after 24 – 48 hours of admissions, 48 hours before discharge and on discharge to ensure the discharge process is started on admission. This ensures that the ward has vital information on all aspects of discharge. This paperwork prompts referral to community services and the Hospital can now contact the Admission Prevent Team line in North Somerset to arrange services such as IV services and welfare checks. When this paperwork has been completed, it results in a patient-centred discharge process, with good communication. This paperwork follows the patient if the patient moves to another ward area.

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Green to Go List

Since January 2014, Weston General Hospital has been reporting medically optimised patients on the Green to Go database. Patients are reported on the database daily by the Multi-Disciplinary Team on the wards during 'Board Rounds', and details of progression of care are recorded on the database. This can then be seen by all staff with a secure log-in for the Green to Go database. Key professionals in Social Services and Community Partnership in North Somerset receive a daily report in order to ensure good communication between the community, Social Services and Clevedon Community Hospital. We have daily meetings in the Hospital with Matrons from medical, surgical and medical acute admissions and patient flow, and the Head of Nursing. During this process, we ensure patients' care is progressed during their stay in hospital, and any issues are highlighted and escalated to the appropriate agencies. Social Services send a daily update on all medically optimised patients in the Hospital. This whole process has resulted in better joined up working and communication with external agencies and Weston General Hospital.

Referral Procedures

Referrals to Continuing Healthcare and Social Services have now changed to electronic referrals within the Hospital. The process for referring patients can now be completed from the wards in a more timely manner, again improving the discharge process.

The Hospital has, for approximately one month, been able to use the new Admission Prevention Team hotline in the community to refer patients.

The Case Management Team has strong links with the Carers Support Service and Home from Hospital Service, both Alliance Living Services based in the Hospital. These services attend 'Board Rounds' and have daily communication with the Case Management Team regarding helping patients have a more successful discharge.

The Case Management Team have daily communication regarding patients to ensure a safe and successful discharge.

Assisted Discharge Service

The British Red Cross provide an Assisted Discharge Service based within the Hospital until midnight seven days per week. This provides a service for patients being discharged from an A&E attendance and inpatient wards. The service assists patients in facilitating a smooth transition of patients from hospital to home by taking patients home and providing non clinical support immediately following discharge for up to

two days. The service provides emotional support and companionship and monitors the patient's wellbeing, highlighting to the appropriate health professionals if there is any change in condition in the immediate days after discharge.

Food provisions

Home from Hospital can assist with patients' food shopping for home, if there are concerns of no food being available at home.

Vulnerable patients being discharged from the ward where there are concerns regarding lack of food provisions at home, are given bread, milk and sandwiches from the Catering Department.

Discharge Medications

Discharge medications have been a main focus of Weston General Hospital with an electronic discharge prescription being implemented. A greater focus has been placed on the day before discharge writing of prescriptions.

Discharge Lounge

The Discharge Lounge has recently been refurbished and has had an area where patients can rest on a bed if they require. Weston General Hospital is in the process of developing performance indicators to ensure patients do not wait in the Discharge Lounge for long periods of time.

Healthwatch North Somerset
3rd Floor
The Sion
Crown Glass Place
Nailsea
BS48 1RB

Tel: 01275 851 400

Email: contact@healthwatchnorthsomerset.co.uk

Website: www.healthwatchnorthsomerset.co.uk

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