Stronger Local Voices

For Health and Social Care

Leaving Hospital Report

December 2011

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East Sussex LINKs report on discharge from hospital, following a series of visits to all community hospitals in East Sussex and to Eastbourne DGH, in week beginning 21 November 2011.

1. Introduction

These set of visits follow on from pilot visits to hospitals undertaken earlier in the year looking into the process and experience of patients leaving hospital. The pilot visits identified the need to speak to more patients from all hospitals across the East Sussex Healthcare Trust to gather more evidence and make recommendations. It was decided to visit all hospitals in East Sussex, including all five community hospitals and the two acute hospitals. Due to some changes taking place at the Conquest Hospital, in terms of setting up a discharge lounge, visits to this hospital were postponed for a number of weeks.

It was anticipated that the discharge lounge at Eastbourne District General Hospital would be central to the visit carried out on Friday 25 November 2011. However, we were informed on the morning of the visit that the discharge lounge was not operational that day due to pressure on beds.

2. Methodology

Prior to the visits, some key information was requested from the Trust, including the policy on discharge from hospital. A planning meeting was held on Thursday 17 November 2011 attended by all the Authorised Representatives who had agreed to be part of the visits. It was agreed that a set prompt/questionnaire would be used to obtain feedback from patients about their experiences regarding discharge from hospital (Appendix 1). A set form was also devised to obtain feedback from the senior nurse/person in charge at each location (appendix 2).

The following visits were carried out:
Monday 21 November 2011: Community hospitals at Lewes, Bexhill and Crowborough.
Wednesday 23 November 2011: Community hospitals at Rye and Uckfield
Friday 25 November 2011: Eastbourne DGH

There were teams of authorised representatives for each location, with at least two people at each hospital. Leaflets to outline who LINk is and their role were provided for all patients seen. The Trust had usefully identified someone to be the contact person at each hospital. These people were very helpful and introduced the authorised representative teams to the key nurse on each ward. We aimed to speak to as many patients as possible in each ward, but with a minimum of five people. We were often guided by the nurse in charge which patients it was not advisable to meet with, due to capacity or communication issues.

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The original intention was to seek the permission of each patient to contact them by phone a few days after they had been discharged from the hospital, to find out whether their discharge had gone well. However, for a variety of reasons only a small number of patients were contacted.

3. Issues from each hospital setting

Crowborough

We were informed that Crowborough Community Hospital has facilities for a 24 bedded inpatient ward, although currently operating at a maximum of 18 patients. On the day of the visit there were 14 patients. We were informed that the inpatient ward is mostly for rehabilitation following operations, with some palliative care.

We spoke with five patients. All patients were aware of their planned discharge from hospital, as this was on display on a white board above their bed. All patients, with the exception of one who had only been at the hospital a few days and was subject to a range of tests to assess possible dates of discharge, confirmed that they felt included in all discussions and kept fully informed what was going on. The person who was unsure of their date of discharge was also kept fully informed as to what was happening for her. Some knew their planned date of discharge from soon after they arrived at the hospital. For example, one patient stated that he was told the date of planned discharge the day after he arrived. Another person said that they were due to return home on 28 November and had been told this on 17 November. Patients were aware that sometimes the date had to be amended due to changing circumstances.

Generally, patients were unsure who made the decision but many stated that they thought it was a whole team decision. As stated above, patients felt included and informed. For example, one person knew that some adaptations had to be made to his house prior to his return home. Most felt the time scale for the discharge from hospital was about right. However, one patient said that they believed they could have been discharged sooner but was in the middle of a conflict over ”who funds” the care. At least two patients were waiting for a visit home with the Occupational Therapist (OT) and/or Physiotherapist to assess how they can manage at home and whether they will need additional support. Two people had dates for these visits. Where relevant, patients explained that their relatives had usefully been kept informed of progress and also informed of any decisions regarding returning home.

We discussed with senior staff on the ward the discharge arrangements in place for patients, sometime referring to individual patients. They confirmed that an expected date of discharge is decided soon after the patient arrives at the hospital. All staff spoken with stated that they involve the patient in all discussions about discharge and about their care. A multi-disciplinary meeting is held every Monday, including GPs, and this is when the possible discharge date for each patient is discussed and established. Staff spoken with confirmed that there is good communication between the disciplines but especially with OT and Physiotherapists. There is an assessment kitchen at the hospital which is used to help assess the practical abilities of some patients, where necessary. Staff explained that there is a range of documentation that is completed. This

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includes a discharge letter, which is given to the patient and faxed to their GP. There is also a Patient Information Booklet, which is given to patients and this contains good information about their discharge. Staff also stated that they make sure patients understand the medication they will be taking home with them and pass all relevant information to the pharmacist.

We were given a range of documents which are used as part of the discharge planning. These included; a discharge letter and prescription form, a Medicines Records Chart, to be given to patients, a 'FACE Background Information Form v6', and a document entitled 'Discharge Letter Crowborough War Memorial Hospital' and a transfer/discharge of care summary form. Some of these were from the East Sussex Downs and Weald NHS, from Sussex Downs and Weald PCT NHS, or from East Sussex Community Health Services. We were told that the documentation is currently being reviewed.

Patients also provided some general feedback about their hospital experience, even though this was not a focus of the visit. All patients spoken with were positive about Crowborough Community Hospital. For example, one person stated that the OT was "excellent". One person had experience of another hospital and stated that his care at Crowborough was "100% better" than at the previous hospital. "The hospital is fantastic and well run". Another patient said it is a "wonderful hospital".

In conclusion, very good systems are in place at Crowborough Community Hospital in terms of discharge from hospital, with patients being fully involved and informed of the date of discharge. They also were aware of what needed to happen to assist in their return home or move to another care setting. They are given written confirmation following discharge as they are given a copy of the letter sent to their GP. The authorised representatives who carried out the visit concluded that any delays in discharge are likely to be related to funding issues and waiting for the involvement of Adult Social Care.

Uckfield Community Hospital

We were informed that there were 13 patients on the day of the visit. We met with six patients. All patients were aware of their date of discharge as this was on a notice above their beds. There were some varied responses in terms of when they were informed and who by. For example, one patient stated that they were told of the date of their discharge "this morning, only because you were coming". One patient stated that the GP had informed them of the decision and date, whereas another patient stated that the GP/Doctor made the decision but the ward sister had informed her of the decision. One person felt they were able to return home prior to the given date of discharge. One patient stated that they were waiting for the OT to visit their home to assess it for any adaptations and to make sure it is safe for her. Patients stated that their relatives had appropriately been involved. Another patient thought the decision and date for discharge was about right but would want to postpone it if they do not feel strong enough to return home.

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Senior staff on the ward stated that a multi-disciplinary meeting is held every Thursday and decisions made regarding each patient and their possible discharge date. They also stated that the Hospital Discharge Booklet is used and given to all patients, although it was not seen being used or given to patients on the day of the visit. They referred to "Section 10” records as the main documentation for the discharge plan with this being updated regularly. Adult Social Care do not attend multi-disciplinary meetings but are called in if they need to be involved. This can cause some delay in obtaining their input and assessments, as well as delays if there are funding issues. For example one person said they were waiting for a visit from the social worker before they could go home. The hospital felt there are good systems in place to obtain the necessary medication for patients on their discharge.

One patient stated that they had received “wonderful care” at the hospital. Another said that “staff are very good” and are “friendly and nice”. Another described the nurses as “superb but overworked”.

We were given a number of key documents by ward staff. Some of these related to information about the hospital, a Medicines Record Chart, a Transfer of care summary form, used when a person is transferred to a residential care setting, and a document entitled ‘questionnaire to determine whether patients are given the information they require about their stay on admission’. The latter includes the following question; ‘were you told when you were likely to be discharged?’. There is also a ‘Link Letter’ which is completed and a copy given to the patient and copy sent to their GP. A ‘Discharge Planning Checklist’ form is completed for all patients once discharge has been arranged, with a copy given to the patient.

In conclusion, patients at Uckfield Community Hospital were aware of their intended date of discharge, as this is displayed above their bed. Patients are given written information on discharge from the hospital. The social worker is not part of the multi-disciplinary team based in the hospital and so this has an impact on the communication with Adult Social Care. As a result, there can be a delay in gaining their involvement and so a possible delay in the discharge from hospital.

Lewes Community Hospital (Victoria Hospital)

We were informed that there are two wards at the hospital with 14 beds in each. We met with five patients. Four of the five were unable to say what their expected date of discharge would be. The exception was someone who was being discharged on the day of the visit. She stated that the date of discharge had been decided two weeks ago. It was uncertain why the person had not left earlier. However, she was being transferred to a care home and this may have been the reason for the delay. Some patients were aware of a discharge meeting, but were a bit vague about it. Two patients were waiting a placement at a care home. One person said they were waiting for a visit from a social worker. Another person was seeing the social worker on the day of the visit and was hoping for a “quick discharge” after that. This person was disappointed that the meeting with the social worked did not happen the previous week. All patients spoken with said that their relatives had been appropriately involved and kept informed.

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Patients made some additional comments about their stay in the hospital. For example, one person stated "the level of care is wonderful". Another said "everyone has been great" and "cannot speak more highly".

Staff spoken with confirmed that the decision to discharge a patient is taken at a multi-disciplinary meeting, held every Tuesday, which includes nurses, OTs, Physiotherapists and a social worker. Staff also stated that feedback is given to each patient after these meetings. Staff reported that delays in discharge can be due to delays in the involvement of Adult Social Care and sometimes delays in getting medication sorted out from the Pharmacist. There is no named social worker for the hospital and so this was said to impact on the level of communication and efficiency of liaising with this service. Staff were unsure of the Trust's discharge policy. One member of staff thought the community hospital's policy was different to that of the acute hospitals.

Staff reported that similar documentation is maintained and given to patients as described above, for Uckfield. They work along similar lines. A range of documents are given to patients when they leave the hospital. For example, one patient was seen to be given the yellow Medicines Record Chart booklet. As at Uckfield Community Hospital, a copy of the 'Discharge Planning Checklist' is given to patients when they leave the hospital.

In conclusion, most patients spoken with were uncertain of the expected date of discharge and there was more uncertainty regarding the right policy the hospital should be working under in relation to discharge for hospital.

Bexhill Community Hospital

The inpatient part of Bexhill Community Hospital is the Irvine Unit. There are two wings; the West Wing and the East Wing. Fourteen patients were met with. Only three patients were aware of a possible date of discharge. Most of the other patients did not have any idea, although one person said he thought he would be in the hospital for about three weeks. One person was waiting to leave the hospital that morning. She was going to a care home for a few weeks to recuperate. Another patient was due to leave the following day and had had been told her date of discharge about three days previously. This person had visited her home whilst in hospital, with an OT and Physiotherapist, to assess how she could manage at home and whether she required any additional support. Another two patients had been assessed in a similar way about a week prior to our visit. Relatives were involved as appropriate. For example, one patient stated that her daughter had arranged everything in terms of the additional support she would require.

Many of the patients were very positive about the OT and physiotherapist involvement. One particular member of staff was particularly mentioned by many of the patients. There were a number of positive comments about the hospital, which were not related to discharge procedures. For example, one person described staff as "friendly". Another patient had found the care to be good, "nurses lovely" and "nice food". Another patient said "better food, better staffing

than at the Conquest". Another person described the care as "wonderful". However, one patient reported that Eastbourne DGH had lost her lower set of teeth. This was reported to the ward nurse.

The ward was very busy during our visit and this made it difficult to spend time with staff to obtain their views and answer questions on the discharge process. There was also an outbreak of an infection over the weekend and we had to have permission from the Infection Control Team before we were allowed onto the ward and so this was added pressure on the nursing staff. However, senior nursing staff confirmed that there is a weekly multi-disciplinary meeting where each patient is discussed to ascertain what progress they are making and to identify possible dates of discharge. Records of these discussions are kept on each patient. Staff stated that patients are kept informed of these discussion and any decisions.

It was hard to identify the records that are kept in relation to discharge from hospital and whether any written information is given to patients when the leave the hospital. However, it was ascertained that the Medicines Record Chart is given to patients. Patients, and their families, are not invited to the multi-disciplinary meetings or any other meetings unless there are quite complex packages of care that need to be set up.

In conclusion, most patients were unclear of any dates of discharge and there was less certainty over the necessary written information that would be given to each patient. However, there was evidence of good support from OT and Physiotherapists, which was much appreciated by patients and this played a positive part in their discharge from hospital.

Rye Community Hospital (Rye, Winchelsea and District Memorial Hospital)

We were informed that there were originally 19 beds in the inpatients ward, but that it was now reduced to a maximum of 14 beds. Two of these are available for private paying patients and were occupied at the time of the visit by people needing long term nursing support. There is also a private respite care bed. Seven patients were met with. None of the patients stated that they were aware of a date of discharge, apart from one person who was leaving the following day to return to the Conquest Hospital to have an operation. However, some patients explained that nursing staff had discussed this with their relatives and they were happy about this. One patient said no one had "talked about discharge yet". Patients confirmed that OT and physiotherapists are involved in supporting and assessing them.

Patients made some positive comments about the hospital, although not related to discharge. For example, one patient described the hospital as "immaculate" and "immaculately clean". They also commented that "staff work hard" and "staff are very attentive and helpful". Another patient said staff "treat me well". Another patient said "the nurses here are marvellous". Another person said the "hospital is cleaned and is spotless". Many patients praised the quality of the food.

The senior nurse explained that an estimated discharge date is identified within 24 hours of the patient arriving at the hospital. The aim is to keep to a maximum of 21 days, although there is

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some flexibility as it is dependent on the person being ready for discharge. There is a weekly multi-disciplinary meeting, held on Tuesday that discusses each patient. There is some physiotherapy and OT input, although this is limited. For example, the Physiotherapist attends the hospital only twice weekly, which prevents intensive support for patients, should this be required. It was reported that there is some uncertainly about the OT resource as this comes from a community OT and there are some questions about the time this person will spend at the hospital and supporting hospital patients. This may impact on delayed discharges. The social worker visits once each week.

Three key documents were shown to us as part of the discharge process. A 'Discharge Planning Checklist' is completed although this is for internal use only. There is also a 'discharge home identified risks' form which is competed when necessary and a copy given to key people including the patient. There is also a Link Letter form which is completed.

The hospital experience for one patient needs to be explored in some detail as it raises a number of key issues about discharge procedures. The patient had a fall at home on 1 August 2011, was admitted to Conquest Hospital and had some repair work completed on her hip. She was discharged home but fell again and readmitted to hospital, where it was decided that she required a hip replacement operation. She was transferred to Rye Community Hospital about six weeks prior to this visit and she had been waiting for her operation since that time. The patient has been in a hospital bed for that period of time, as she could not return home. This has been at great expense to the hospital and also to the person who has deteriorated physically. It was uncertain why she had waited so long for an operation, especially as this has been an expensive wait in hospital.

In conclusion, discharge from hospital is well planned, through the multi-disciplinary meetings, but discharge may be affected by the limited allocation of time to the hospital from OT and Physiotherapy involvement. It was not clear how information was passed to the patients in terms of their discharge and what information they are given at the point of leaving the hospital.

Eastbourne DGH

Accident & Emergency, Clinical Decision Unit (CDU), Observation ward

The CDU observation ward is part of the A & E and is for patients who need to remain in hospital for no more than 48 hours. They will then either return home or be transferred to another ward within the hospital. Four patients were met with and with one relative who was supporting his mother. Not all patients were able to clearly identify when they would be leaving the hospital or whether they would be moving to another ward in the hospital. One patient was due to leave that day at 1.00pm and her son was coming to collect her. She had been given this news on the day of her leaving. Another patient arrived at the hospital the previous day and was not yet sure when she would be leaving. Another patient hoped to leave on the day of the visit, although she was unsure of this. However, she did state that she felt that staff "tell you what is going to happen". The hospital had lost some clothes and the shoes of the fourth person, although these were soon

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found. The Physiotherapist was then observed assessing her mobility in order to decide whether she could return home.

The relative explained that his mother had a stroke some weeks ago and spent about six weeks in a care home receiving some rehabilitation. She then returned home but without the necessary adaptations. She then had a fall and had been taken to A & E. It is uncertain whether the lack of adaptations may have played a part in her fall.

This relative also raised a separate matter not related to this review which will be passed to ESHT to investigate via the LINks processes.

Patients made some positive comments about their stay in the hospital. One patient described staff as being “most helpful”. Another described the staff as “absolutely wonderful”. This person also explained that her partner had been in the same accident as her and had been taken to another hospital. The ward staff had been very good, keeping her informed of how her partner was and facilitated contact with the other hospital.

Various staff were spoken with. They explained that there is a good multi-disciplinary team who work effectively together. An OT and Physiotherapist were actively supporting and assessing patients on the day of the visit. In addition, a social worker was also present on the ward in order to facilitate any support Adult Social Care need to provide, to enable patients to move on from the ward. Staff explained that there is no documentation given to patients, although there is a transfer letter for those who will be moving to a residential care setting. A discharge letter is completed and signed the following day after someone is discharged and the letter sent to the person’s GP. It was also reported that any delays in terms of discharge of a patient were often related to outside factors such as lack of transport and access to the hospital Pharmacy. Transport ends at a set time in the evening after which it is limited, and there is also a lack of access to the hospital Pharmacy, which also closes at a set time each day.

Medical Assessment Unit (MAU)

Eight patients were met with. All, except one, knew when they were likely to be discharged, although a couple were waiting for test results and a final decision. We noted that there is a white board by the nurses’ station with the estimated discharge dates on for all patients. The nurse explained that this is updated daily, due to changing needs of the patients. Where appropriate, relatives had been informed and involved. It was good that the date on the white board indicating date of discharge was the same date given to us by patients. One patient explained that there had been some confusion between doctors and so was unsure exactly when she would be leaving, but expected to be leaving on the day of the visit. There were some general positive comments about the hospital and the ward. For example, one patient stated that “everything had gone very well” and they had been “well cared for”.

Staff confirmed that decisions about discharge are made by all those who have been involved in the person’s care including OT and Physiotherapists. Patients are verbally informed of any

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discussions but nothing is provided in writing. We were shown a document which included a section called 'MDT Discharge Planner' and a 'Discharge Checklist'. We were uncertain how this document is used or even if it is used consistently.

Chiddingly and Hailsham 4 wards

Both these wards are for surgical patients. Six patients were met with. Five of the patients were aware of the expected date of discharge from the hospital. This was also on display on a white board in the wards. Ward staff had informed patients when they would be leaving. For example, one person stated that they had been told the previous day that they would be leaving the hospital on the day of our visit. There was a pattern of responses from patients that the doctor made the decision about being able to leave the hospital and it was the nurses who had told them this information. Where appropriate, all patients stated that their relatives had been kept informed of what was happening.

Patients made a number of comments about their stay in the hospital and on these wards. For example, one person stated that they had been "handled very courteously, with sympathy at all times". Another patient described staff as "fantastic".

Staff spoken with confirmed that discharge is only considered once the patient has been stabilised and that they discuss the length of stay in the hospital and discharge with each patient as soon as possible. Daily records are kept to monitor progress. Many patients from Chiddingly ward are transferred to other wards in the hospital. Hailsham 4 aims for a three day stay and then discharge. A discharge booklet is used at Hailsham 4 and this is a way of informing the patients what is happening. The booklet is not used on Chiddingly ward. Authorised Representatives concluded that the discharge system and process on Hailsham 4 was well organised. Authorised representatives described Chiddingly ward as "very busy".

Seaford 3

Seaford 3 ward is for orthopaedic and trauma patients. Eight patients were met with. None of the patients was aware of any specific or expected date of discharge. However, some responded that this was being talked about. For example, one person stated that it could be in two weeks. Two patients seemed to be a bit confused about who had discussed with them about discharge from the hospital. For example one patient stated "so many people, I don't understand who they are". Having said this, patients generally knew what was happening and aware of progress they were making. Feedback was that it was well planned.

Patients made a number of additional comments. For example, one person described staff as being "very helpful".

The Trauma Assisted Discharge Scheme (TADS) is used on this ward. It is a scheme to try to speed up rehabilitation and to reduce the length of time people stay in hospital. A leaflet for the public about the scheme states that the scheme aims "to provide an opportunity for non-elective

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orthopaedic patients to continue their post-operative rehabilitation in their own homes". There are set eligibility criteria for referrals. Another document seen describes the 'client pathway'. This sets out what should be achieved over a 7-10 day period, after which the person should be discharged from the hospital. It includes interventions form Physiotherapists and OTs. There are some goals to be achieved and the pathway identifies which member of staff will assist on each of the goals. It includes OTs and Physiotherapist involvement when the person returns home, to complete the rehabilitation process. There is a ward based social worker, which means that there is good communication with Adult Social Care. There are two multi-disciplinary meetings held each week, where progress and possible dates of discharge are discussed.

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Conclusions

- There were variable responses to the question about patients being aware of their discharge date and details. This seemed to work better where the date was displayed on white boards, either by the nurses' station or over each individual bed.
- However, the pattern at the majority of settings was that patients were not actively involved in their discharge planning. Relatives often were involved where additional support would be required. Having said this, it is recognised that many patients may have been told, or had a discussion about, their discharge details, but may have forgotten these details.
- There was very limited evidence of patients being given anything in writing, as part of the discharge planning and process.
- There was evidence of good discharge planning, especially the involvement of multi-disciplinary meetings. The latter were evident in all community hospitals. This was particularly so where a social worker was actively involved in these meetings and in the hospital. Problems were voiced where there was no dedicated social worker for the hospital/ward or where they only came to the hospital on a weekly basis. There was evidence of good practices and multi-disciplinary working on several wards, particularly with OT and Physiotherapists being actively seen on the wards. This was particularly so in the community hospitals, where the emphasis is on rehabilitation. Some concerns were expressed about the level of OT support at Rye Community Hospital and whether this will be reduced in the near future.
- Different documentation was found in different settings and so there was no uniformity of documentation. Only one setting provided evidence that they are using the discharge booklet.
- Community hospitals did not provide evidence of a discharge policy, with one believing that one did exist for community hospitals. However, they were unable to locate this on the Trust's intranet.
- The main reason given by many members of staff we met with for delayed discharge was delays in Adult Social Care either becoming involved or delays in funding. Problems were also reported in obtaining medication prior to discharge.
- It is of concern that a patient was taking up a bed at Rye Community Hospital and had been for about 4-6 weeks, just to wait for an operation to be arranged at Conquest Hospital.
- The vast majority of patients provided positive comments about their hospital stay and experience. This was particularly so in the community hospitals which had a very different 'feel' compared to Eastbourne DGH. This was not surprising given the very different nature and role of these hospitals.
- The discharge lounge was being used as a ward and not specifically for discharge on the day of the visit. We were led to believe it had not been used as a discharge facility all that week.

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4. Recommendations and areas for further work

1. **The discharge policy needs to be reviewed to ensure it describes the process for community hospitals, where the circumstances will be different to those in the acute hospitals. The policy needs to be reinforced to all staff.**
2. **Documentation with regards to discharge from hospital needs to be streamlined and agreed, so that all settings use the same documentation, consistently.**
3. **Patients need to be more involved in their discharge planning and evidence of this needs to be in place. It would be good practice to provide some written information to all patients on their discharge. The discharge booklet, seen on some wards, could be used for this purpose.**
4. **More effective working relationships need to be set up in some wards and hospitals with Adult Social Care, to minimise delayed discharges.**
5. **Similarly, access to pharmacy and transport services, out of hours, may need to be investigated.**
6. **The individual situation at Rye Community hospital needs to be investigated as a separate issue.**
7. **Further work needs to be carried out to investigate whether people's discharge went according to how it had been planned. This could be carried out by liaising with the Trust, to identify a set number of patients from each hospital, and each ward visited at Eastbourne DGH, and contacting them or their relative and carry out a further questionnaire/prompt, to obtain their views.**
8. **The lack of a discharge lounge needs to be investigated to ascertain how often it is not available and whether this option remains viable and part of the long term plan for the hospital in terms of its discharge policy.**

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Contact details:

For any queries with regard to this report or for further information please contact:-

East Sussex LINk
1 Faraday Close
Eastbourne
BN22 9BH
Telephone: 01323 514510 Text: 078330 96622
Email: info@thecountylink.net Website: www.thecountylink.net

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Appendix 1

Prompt/ questionnaire for each patient in relation to discharge from hospital visit, carried out by East Sussex LINK in October 2011.

Initials of patient and phone number if agreeing to be part of the follow up call within 2 days of the visit:
1. How long have you been in hospital?
2. When were you told that you were ready to leave the hospital?
3. Who made this decision and who told you?
4. Do you think you were ready to leave the hospital sooner of was the decision just right?
5. Have your relatives and supporters been involved and aware of your return home?
6. Will you need some additional help when you get home and if so who is going to provide it?
7. Who arranged the additional support or made sure it was ready for you?
8. Were you involved in these arrangements or were they just made for you?
9. Has everything gone smoothly for you and are you happy with how your discharge has been planned and organised?
10. Any other comments or observations you would like to make?

Appendix 2

Prompt/ questionnaire for nursing staff re each patient in relation to discharge from hospital visit, carried out by East Sussex LINK in October 2011.

Initials and role of member of staff:
1. When was the decision made that the patient was ready for discharge and who made the decision?
2. How was this information passed to the patient and their relatives/supporters?
3. Where any other services/departments involved and liaised with (e.g. physio, OT, Social Worker)?
4. Is there a written discharge plan? If yes, who was involved in setting it up?
5. How was the patient and their relatives/supporters involved?
6. Were there any issues of capacity in relation to this patient? If so, how were they resolved?
7. From your perspective, was the discharge policy and procedure followed, was the discharge handled effectively and efficiently and did it met the needs of the patient?
8. Any other comments or observations you would like to make?