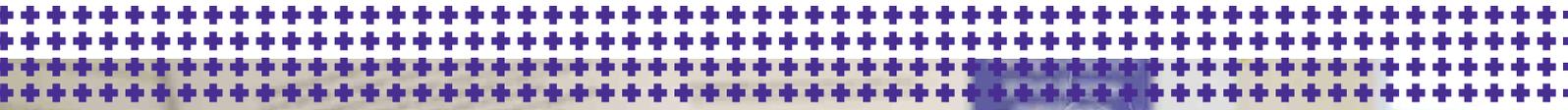


# Discharge planning

*Best practice in transitions of care*



# Contents

1. Introduction .....	3
2. Background .....	3
3. Approach .....	3
4. Literature Review .....	5
5. Consultation with Nurses .....	7
Focus groups	
Summary of focus group findings	
Online survey	
Results	
6. The Discharge Process .....	10
Who is affected?	
Informing the community nursing team of discharges	
Timing of discharge referrals to the community nursing team	
Day of discharge	
Time of discharge	
Liaison	
Multi-disciplinary working	
Hospital visit prior to discharge	
Contact with family	
Assessment	
Discharge co-ordinators	
Discharge key-worker	
Discharge plan	
Medication	
Social care package	
Equipment for the home	
Barriers to discharge planning	
Effective discharge planning	
Action to improve discharge planning	
Examples of best practice from the surveys	
7. Examples of best practice .....	29
8. Conclusion .....	31
9. Recommendations .....	34
10. References .....	37
11. Acknowledgements .....	38

## 1. Introduction

This report provides a summary of the work undertaken by The Queen’s Nursing Institute (QNI) on behalf of the Department of Health (DH) to identify the barriers and challenges preventing effective discharge from hospital to home.

The report seeks to provide key recommendations that contribute to an improved discharge experience for patients, carers and their families, and identifies examples of effective discharge planning. The report includes the background to the report, findings from the literature review, explanation of the methods used to collect the data, a summary of the main findings, examples of best practice and the conclusion and recommendations following the analysis of the data.

## 2. Background

Good practice in discharge planning has long been recognised as the cornerstone of a successful transition of an individual from a hospital environment to their home.

As long ago as 1979 Dr Lisbeth Hockey, pioneer of nursing research published ‘A study of District Nursing: The development and progression of a long-term research programme’ which described the responsibility of the District Nurse (DN) when patients were due to be discharged home from hospital. Hockey concluded that full communication with patients and between professional staff is critical to the achievement of effective coordination of ‘aftercare’ services. She stated that one of the major factors influencing the quality of early discharge is the preparation made in the hospital prior to the patient’s discharge home.

Thirty-five years later, in 2014, Oliver et al stated that: *‘Discharge planning needs to start at first contact with hospital and be standardised and embedded in practice, with older people and their carers fully and promptly involved in their own discharge plans and goals...’ (p33)*

Discharge planning was also identified as a major issue in 2014 when the QNI undertook a survey on the current challenges facing the district nursing service. The results of the survey were later published in the document ‘2020 Vision 5 years on: Reassessing the Future of District Nursing’ (QNI, 2014). The report was based on the views of more than one thousand District Nurses and one of the three key themes identified in the analysis of the data was a significant concern for patients, families and carers around the impact of ineffective discharge planning. The QNI was keen to explore this concern further and was successful in securing funding from the DH to undertake this work.

## 3. Approach

The QNI undertook a robust approach to gather a wide range of views and experiences of those who work within the area of discharge planning in a hospital setting and those who receive referrals for nursing care following an individual’s discharge from hospital to home.

Key activities included:

- A literature search and review to provide a summary of the existing published evidence on the barriers and challenges that prevent effective discharge planning from hospital to home
- Consultation with community and hospital based nursing staff through online surveys
- Consultations with stakeholders via focus groups
- Site visits to organisations where discharge planning was evaluated in the literature and professional networks as working well
- Analysis of data resulting in conclusions and recommendations.



‘The report was based on the views of more than 1000 District Nurses.’



Organisations representing key stakeholders were invited to disseminate details of the focus groups and the on-line survey to their membership to ensure a broad range of contributions. These included:

- The Association of District Nurse Educators (ADNE)
- Hospital based nurses (on-line survey)
- The National District Nurses Network (NDNN) (presentation given to members in Manchester on project work)
- The Queen’s Nurse Network at the QNI
- Higher Education providers.

As above, the project came about as a result of the recent QNI report, 2020 Vision Five Years On. One of the key issues reported by community nursing staff was the issue of seamless discharge from hospital therefore the focus was very much on the District Nurse (DN) experience. Whilst the care home experience was not the focus of this report, the findings from the surveys and focus groups included many nurses reporting their experience of working with care homes.

#### 4. Literature Review

A literature search was undertaken to identify the research regarding the barriers and challenges that affect discharge planning. Evidence included UK literature principally from the last 10 years and was community focussed.

A plethora of hospital specific evidence and disease specific articles on discharge planning were excluded, as the focus of the project was primarily community nursing. The following data bases were searched: British Nursing Index, Royal College of Nursing library, CINAHL and HMIC databases available on NHS Evidence. Key words used in the search included: discharge planning, community nursing, hospital discharge, patient satisfaction, readmission, concerns, good practice, best practice, patient outcomes, governance, policy, commissioning, older people, effective planning, Multi-Disciplinary Team, assessment, carers, outreach.

The key themes that emerged from the papers reviewed were poor communication between professionals and the lack of co-ordination between healthcare and social care provision. The lack of timely provision of medicines prior to patient discharge and the delay in the provision of equipment required to safely support a patient at home also featured prominently.

Hospital discharge is a complex and challenging process for healthcare professionals, patients and their carers and it was widely documented throughout the literature search that there are constant pressures to discharge patients from the ward as quickly as possible, allowing little time to organise and plan the care and support required for effective convalescence at home, or to assess holistically the patient’s needs prior to their discharge.

Research commissioned by the Royal Voluntary Services (2014) estimated that people aged 75 and older are more than twice as likely as those under this age to be readmitted back to hospital if they are not given enough support on discharge, particularly those who live alone or have long-term health conditions.

Knight et al (2013) explored the hospital discharge experiences of older people and their family carers in the management of medicines. Qualitative interviews were undertaken with people aged 75 or older and their carers, where the patient was taking more than four medicines, following discharge from hospital in the United Kingdom. The results showed that participants were generally dissatisfied with their discharge process,



‘Hospital discharge is a complex and challenging process for healthcare professionals, patients and their carers.’

due to inadequate explanations about their medication at the point of discharge and poor communication between the hospital and general practitioners or community pharmacists. A lack of partnership working between hospital staff and patients/family carers regarding the use of medicines following discharge was also cited as an issue.

A literature review of primary research studies by Carroll and Dowling (2007) identified key elements of best practice in relation to discharge planning. Their review confirmed that effective communication between patient and healthcare professional is paramount to the success of effective discharge planning, in addition to the other key elements of coordination, education, patient participation and collaboration between medical staff.

A review of literature published on hospital discharge of the frail, older person and the family carer's experiences (Bauer et al, 2009) suggests that inadequate discharge planning for older people can lead to adverse outcomes and an increased risk of hospital readmission. Many factors were shown to impact on the discharge process, and had the potential to close the gap between the care provided in hospital and the care required in the community. The research demonstrated the direct correlation between good quality discharge planning and a reduction in the rate of hospital readmission.

A key aim of effective discharge planning is to reduce hospital length of stay and unplanned readmission to hospital, and to improve the co-ordination of services following hospital discharge. The DH document, 'Ready to go? Planning the discharge and the safe transfer of patients from hospital and intermediate care' (2010), issued guidance on discharging older people from hospital and intermediate care services back into the community. It includes a ten step plan for successful discharge planning, but no literature was found that specifically evaluated the implementation and impact of this guidance.

An inquiry by Healthwatch England into discharge processes resulted in the publication of the report 'Safely Home: What Happens when People Leave Hospitals and Care Settings?' (2015). Evidence was gathered from more than 3,000 vulnerable people about their discharge experiences. Examples of good practice in England are cited, but the report states that many of the people questioned felt 'rushed' in their discharge home. The inquiry identified that communication breakdown between hospitals and community care providers, the lack of involving people in decision-making about their own care and the failure to address the needs of patients were amongst the key causes of ineffective discharge.

A study by Age UK, 'Older people's experience of emergency hospital readmission' (2012), found that older people frequently report uncertainty, a lack of confidence and a lack of support following discharge from hospital. Patients were asked about their experiences from their first admission to hospital through to discharge and return home, then their experience of subsequent readmission.

Key findings from the research suggest that patient experience of these care transfers was poor, with a common theme of the need of a more personalised care once they had left hospital. However, examples of good practice were also cited and several patients felt that staff in the community were able to give more time to care than hospital staff.

A key message from the report was that emergency readmissions to hospital are complex and that there are particular challenges in the transition between secondary and primary care and in guaranteeing that an appropriate personalised care package is put in place in the community prior to discharge.

The guidance from NICE (National Institute for Health and Care Excellence) launched in December 2015: 'Transition between inpatient hospital settings and community or care home settings for adults with social care,' also reflects many of the findings of previous studies.'

The report highlighted the wide range of health, social care and other services that are involved when adults requiring support are discharged from hospital to home, including the significant role of the family and unsalaried carers. NICE (2015:22) described the consequences when services do not work well together:

*‘..delayed transfers of care, re admissions, poor care and avoidable admissions to residential or nursing care.’*

This was illustrated by the following statistic: *‘Figures released by NHS England in August 2015 show that on 1 day in June, 5000 people were delayed in hospital.’* (NICE 2015:22). Figures on delayed discharges from hospital and transfers of care are collected and monitored by NHS England (NHSE), so trends are visible and can potentially be investigated and action taken (NHSE, 2015).

NICE (2015:22) reported that hospital discharge problems occur when people are kept waiting for:

- assessments of future care and support needs
- social services or NHS funding for continuing care
- further non acute NHS care (including intermediate care and rehabilitation services)
- nursing home placements
- residential home placements
- a care package in their own home
- community equipment and adaptations.

Hospital discharge problems can also occur because:

- the patient or family refuse the choice of services that have been offered
  - statutory agencies disagree about readiness for discharge or responsibility for ongoing care.
- (NICE, 2015:22)

## 5. Consultation with Nurses

### Focus Groups

Six Focus groups were held in London (two groups) and one each in Birmingham, Hull, Sheffield and Darlington between May and August 2015, each facilitated by a member of the QNI team experienced in managing focus groups.

The size of each group was limited to 20 participants to enable all attendees to contribute. Participants represented a broad range of community nursing staff, from DN students; DNs, community staff nurses through to service leads, managers and educators. All participants had experience in managing hospital discharge. Whilst no GPs or care sector representatives attended, those present commented on these as health and care providers in relation to discharge planning. All groups were oversubscribed.

The focus groups were conducted in the following way:

- General group discussion and feedback on the experiences of the attendees on discharge planning
- Group working to identify the barriers and challenges preventing effective discharge planning from the experience of commissioners, providers, clinicians, patients families and carers
- Group work to discuss the essential elements of effective discharge planning
- Feedback following group discussions to the whole group
- Open discussion and sharing of ideas around the topic.

### Summary of focus group findings

All the groups were dynamic in their contribution to the subject of discharge planning. Participants gave many examples of ineffective communication and poor co-ordination between services, resulting in poor and unsafe hospital discharges. Some examples are given below.

\*\*\*\*\*

*‘Older people frequently report uncertainty, a lack of confidence and a lack of support following discharge from hospital.’*



*As part of my District Nurse role, I always phone the ward prior to a patient coming home for end of life care as I do not rely on the often scant details given to the Single Point of Access phone line – as an example of poor communication (there are many) I phoned the ward to enquire when the patient was coming home as the family had been told at some point during the next week. I was told by the nurse on the ward that the patient was already on her way home in the ambulance despite the family being unaware!*

Single Point of Access (SPA) typically comprises a community provider’s dedicated phone line where the details about a patient due to be discharged from hospital to home are taken. Calls are received from the hospital with the patient’s details, their clinical condition and the services the patient requires in the community after discharge are requested, for example a request that a District Nurse visits on a certain day to undertake wound care.

*‘The communication between community and hospital and families and hospital are poor in our area. On several occasions the patient has arrived home without their prescribed medications, so they are driven to the patient’ home in a taxi! What a waste of NHS monies.’*

*‘A patient arrived home following discharge from the city hospital. The patient and family were not happy as he had come home with a carrier bag full of boxes of anti-coagulant injections despite the wife telling the staff that he was no longer having them. She was told that because he was still written up for the injections he would have to take them home. She submitted a complaint about poor communication and wastage of medicines.’*

A poor understanding of the role of the community nursing service by hospital services, a lack of available social care packages, problems with medications to take home, the poor provision of equipment and lengthy waiting times for hospital transport were also raised by participants in all focus groups.

*‘The appropriate equipment is ordered by the hospital and is in place at the patient’s home prior to discharge, but unfortunately the equipment provider in the community is different to the hospital provider so the District Nurse has to visit the patient soon after discharge and arrange to get all the hospital equipment collected and replace it all with an order to the community provider – the patient then has to be swapped onto the new equipment!’*

The community staff nurse who gave this example explained the challenge commonly experienced by the district nursing team that patients, whose equipment, which had been ordered from one provider whilst in the hospital, are required to have it replaced by the community equipment loans provider. The District Nurse places an order and the nurse has to be present in the home for delivery of the replacement equipment, and the collection of the equipment ordered by the hospital. Patients receiving end of life care who are bed-bound would have the disruption of being transferred onto the replacement bed, potentially resulting in discomfort and unnecessary stress to both the patient and their family.

In summary, the focus groups confirmed the findings of the literature review, that many practical barriers and communication challenges prevent effective discharge planning. The data collected from the participants in the focus groups also reflected the overall findings from the on-line surveys which are detailed below. Creating a common understanding of the barriers and enablers of effective discharge planning and transfers of care will enable organisations and practitioners to examine their own local practices and make adjustments accordingly.



**‘The focus groups confirmed that many practical barriers and communication challenges prevent effective discharge planning.’**

## Online Survey

Two online surveys were developed with the purpose of scoping the views of community and hospital based nurses involved in patient discharge planning. The survey for community nursing staff was open from 17th April to 10th July 2015 and a total of 608 responses were received. A further survey was developed to understand the views of hospital nursing staff. This survey was open from 21st July to 12th September 2015 and a total of 186 respondents were recorded.

The surveys were advertised within the general and community nursing press, social media and to QNI networks and stakeholders. Whilst the planned target of 500 responses was exceeded, it is recognised that the majority of nurses with whom the QNI regularly engages are working in the community and this is reflected in the balance of responses to the surveys.

## Results

The survey results from each group are presented separately below.

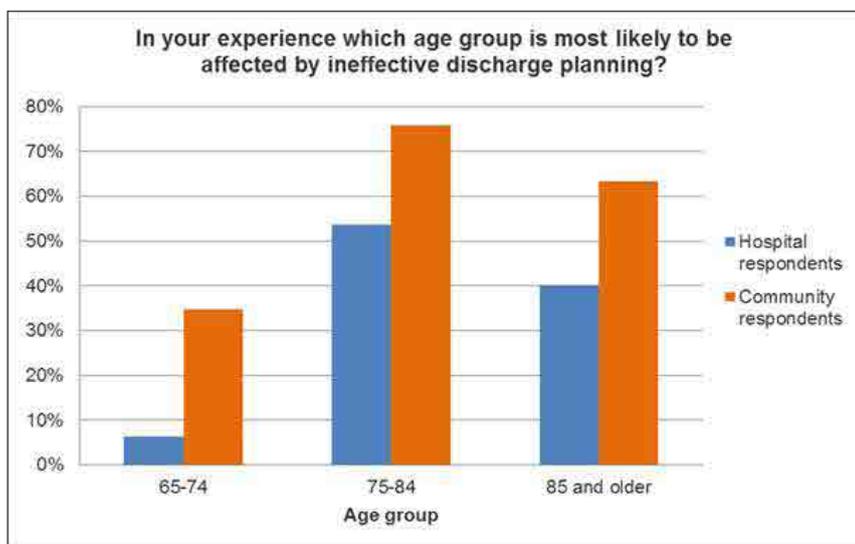
## 6. The Discharge Process

### Who is affected?

Respondents were asked in their experience which age group is most likely to be affected by ineffective discharge planning. Respondents could select more than one age group.

75.9% (n=337) of community and 54% (n=51) hospital respondents said that the 75-84 year old age group were most likely to be affected. 63.29% (n=281) community and 40% (n=38) hospital based nurses responded that they felt the 85 years and above age group were most likely to have a poor discharge.

### Graph 1



There appeared to be a consistent disparity between the two groups of staff in the perception of the impact of ineffective discharge planning. It might be speculated that community based nurses experience and manage the impact of ineffective discharge planning on the individual and their families in the home, which may contribute to this variance. However, the total number of respondents is relatively small and the reasons for this apparent difference were not explored within the scope of this work.

Several respondents chose not to identify difficulties with discharge associated with an age group, instead commenting on principles and issues which applied to all ages.

75.3% (n=384) community and 55.8% (n=63) hospital respondents felt that all people were affected,

irrespective of disease, as illustrated with a selection of comments below:

*'There are challenges getting staff to understand and implement that discharge planning begins (at the very least) when the patient is admitted into hospital. With a severe shortage of suitable homes/placements for patients needing increased care + complex care needs, and suitable for the needs of patients (e.g. wheelchair access) and housing needs of homeless patients (from UK as well as from abroad) can make discharge planning more challenging.'* (Community Nurse)

*'Term 'discharge planning' gives an impression of a time towards the end of a typically hospital stay to think about how a patient is going to get to their place of residence. A more whole systems thinking approach should be embraced to change the focus of care planning to embrace the totality of patient care which lends itself to a more proactive approach to seamless care particularly when research highlights transitions of care being problematic.'* (Community Nurse)

*'Poor discharge planning can have a negative effect both on the patient and their family, and on the nursing team who care for them in the community. It needs to be improved upon - perhaps sharing best practice will enable different areas to improve.'* (Community Nurse)

**Informing the community nursing team of discharges**

All respondents were asked how the community nursing team were informed of a patient's discharge. Many respondents chose more than one answer, confirming that there is no uniformity in the referral process between hospitals and community teams and a combination of methods is used.

52.3% (n=266) of community respondents said that they were informed by the Single Point of Access (SPA) system. This service, as described earlier, is typically a central hub or phone number, where referrals are received from hospital based nurses and passed on to community nursing teams. SPA was mentioned many times in the survey responses, but is not a single scheme with national coverage; rather, the provision of the locally tailored service is a strategic decision made by the local community nursing service provider as a method of managing referrals to the service.

The majority (53.3%, n=271) of respondents received referrals by telephone in their organisation, with 11% (n=56) reporting referrals were received by email and 37.3% (n=190) by fax. 22.2% (n=113) of respondents said that they were informed by another method but did not specify what this method was.

46% (n=51) of hospital based nurses said that they informed the community nursing team via the SPA, 57% (n=63) by telephone, 25.2% (n=28) by email and 50.5% (n=56) by fax. 27% (n=30) of respondents said that they informed the community team by other methods but did not say what these methods were.

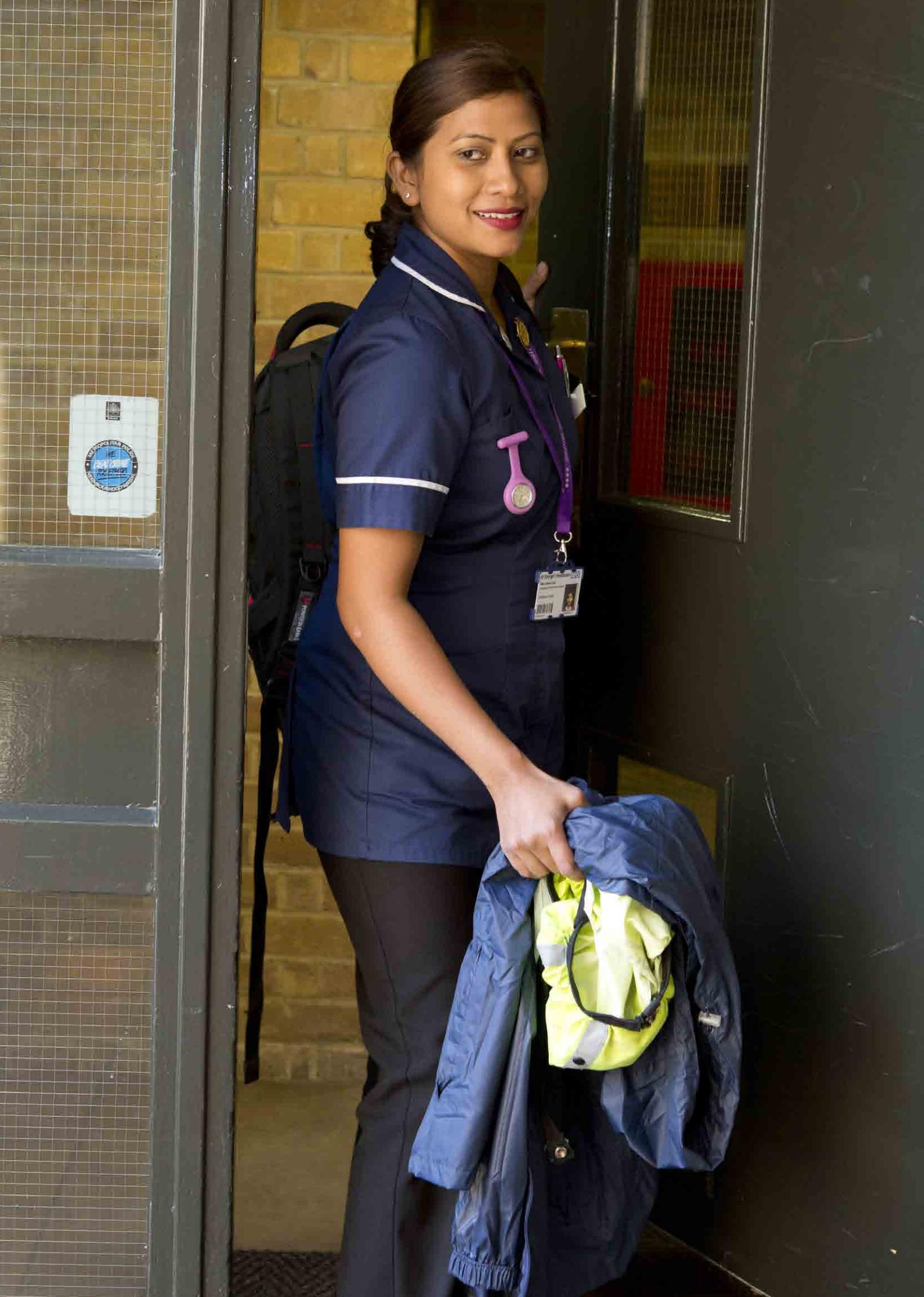
Reference to the SPA service was also illustrated with recent changes to the way in which the service was staffed, for example:

*'When clinical staff took all referrals via the SPA referral process ... this enabled all aspects of care to be scrutinized and ensure everything was in place prior to discharge. Now it is manned by non-clinical staff, who do not ask the same questions, therefore discharges are poorer.'* (Community Nurse)

An evaluation of the potential differences in outcomes for patients in the referral process within SPA services managed by clinical and non-clinical staff was not within the scope of this project. However, it may be helpful to explore variations in patient outcomes and the way in which the service is staffed, managed and resourced.



**'There are challenges getting staff to understand that discharge planning begins when the patient is admitted to hospital.'**



There were also references to the time and resource pressures that hospital based staff were under and the impact of this on patient discharges, even where there were robust systems in place. For example:

*'This organisation has good process in place to communicate with community colleagues. However, often this communication can break down when discharges are happening quickly.'* (Hospital Nurse)

### Timing of discharge referrals to the community nursing team

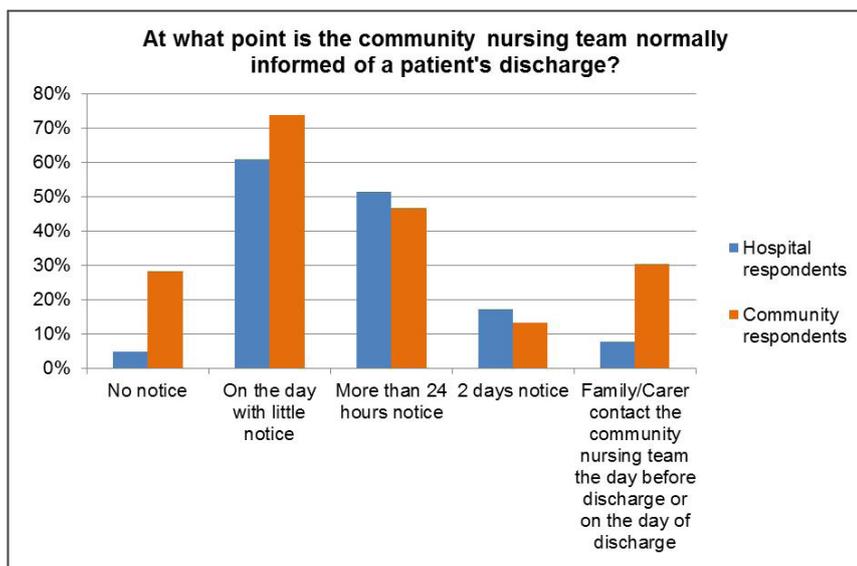
Respondents were asked at what point the community team were usually informed of a patient's discharge.

74% (n=333) of community nurses said they were informed on the day of discharge with very little notice, 30.4% (n=137) said that the family or carer contacted the nursing team the day before or on the day of discharge and 28% (n=127) said there was no notice given to the community nursing team.

In contrast, 61% (n=64) of hospital based respondents said that the community team were informed on the day of discharge with very little notice and 7.6% (n= 8) said that it was the family or carer who informed the community team.

The following chart shows the similarities and differences in responses between the hospital and community based nurses. It should be noted however that the hospital based figures are based on small numbers of respondents in some categories.

**Graph 2**



Comments included:

*'Some of the problems arise due to staff in both secondary and primary care not fully understanding the demands of each service or the roles of each other. Also pressures on all services mean things are often rushed and target driven.'* (Hospital Nurse)

*'Hospitals obviously keen to discharge patients home as soon as possible, but sometimes don't take into account the circumstances at home, or the way community nurses operate (i.e. we don't carry dressings*



*'Pressures on all services mean things are often rushed and target driven.'*

or incontinence pads!). Community nurses continually take on all hospital referrals into a service that has a fixed number of staff (ward without walls) therefore care may be compromised due to lack of facilities in the community. Time taken to plan the discharge could result in a more seamless transfer for the patient as well as less chance of a failed discharge.' (Community Nurse)

## **Day of Discharge**

The survey asked on which days patients most often get discharged home and 52.1% (n=264) of community respondents said Friday.

28% (n=32) of hospital respondents said that Friday was the most likely day for discharge, however 61% (n=72) said that there were no specific days for patients' discharge home. In total, in excess of 600 comments were received, with many of these centred around the problems encountered by Friday and weekend discharges.

These comments included:

*'Any day is problematic if the discharge is incomplete or inappropriate with little or no warning. Fridays tend to be the worst day as discharges are often rushed and we will get several in one day. Communication between acute care and primary care is ineffective and slow with things often being miscommunicated. The most effective discharge to me would involve face to face contact with lead ward nurse and patient where appropriate and the DN via video conference so you get all peoples input and a visual if the patient's condition.'* (Community Nurse)

*'The day of discharge is often not known about so becomes a last minute late unplanned visit, the times of arrival post discharge can also cause problems as patients arrive from mainland on any flight or the early morning ferry or are transferred within the county islands by ferry which are often late evening due to waiting for ambulance transfer or hospital discharge procedures to be complete.'* (Community Nurse)

*'If patients requiring high levels of input are discharged ineffectively later in the week this can be problematic. There is nothing wrong with Friday or weekend discharges as long as they are well planned.'* (Community Nurse)

*'Usually Fridays as if medication is incorrect then there is a lot of extra work involved. This is always problematic on a Friday as it gives you no leeway to amend things before the weekend. Friday is always additionally busy because of getting things sorted for the weekend when there is limited staff available'* (Hospital Nurse)

*'I think Friday evenings and over weekend could be as there are generally less services and staff available and could mean that community nurses may struggle to speak to relevant health care professional to resolve any issues occurring over the weekend'* (Hospital Nurse)

*'I've been a district nurse for 30 years and discharge on a Friday has always been a problem – why don't we accept this and increase staffing on a Friday to manage increased referrals?'* (Focus Group)

The last comment provides an indication of how the service needs to adapt to the patient flow and patterns of hospital discharges. It can be seen that with the move to a consistent level of NHS services to meet patient demand across 7 days of the week, the district nursing service will need to adapt accordingly.

## **Time of discharge**

The survey asked how frequently patients are discharged home after 8pm – 66.5% (n=330) of community based respondents said that this happened 'sometimes' with a further 10.2% (n=51) saying that late discharges 'often' happened, as much as at least once a week. In contrast, 72% (n=75) of hospital respondents said that this 'sometimes' happened, 20% (n=21) said that this 'never' happened and 7.6% (n=8) said that they 'did not know'.

Comments included:

*'Other experience is of patient being admitted during late afternoon/early evening and then no requirement for admission and they are discharged home late at night. Sometimes these patients live alone or in winter they are returning home to a cold house.'* (Hospital Nurse)

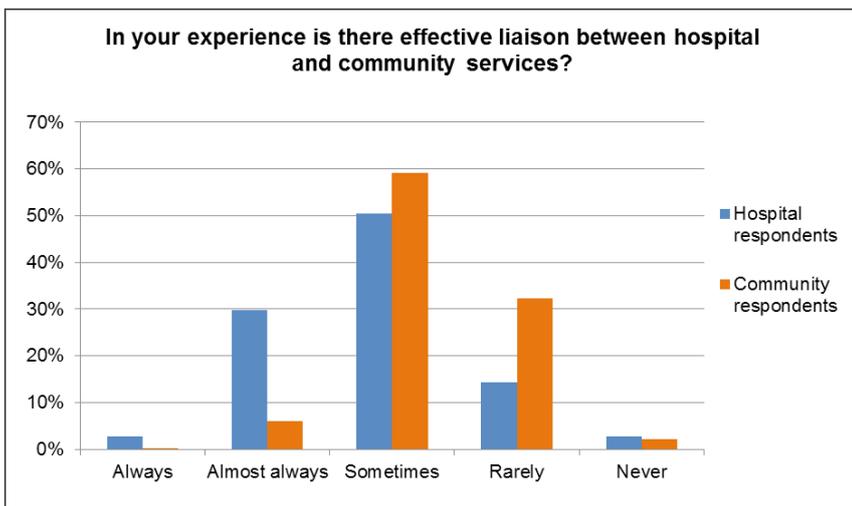
**Liaison**

Respondents were asked if they felt there was effective liaison between hospital and community services.

59.1% (n=300) of community based respondents said that 'sometimes' there was effective liaison between hospital and community services with 2.1% (n=11) of respondents saying that there was 'never' effective liaison. There was a similar picture from the hospital based respondents, where 50.5% (n=56) considered that the liaison was 'sometimes' effective and 2.8% (n=3) that there was 'never' effective liaison between the services.

Overall, it appears that there is much work to be done to improve the liaison between the two nursing services and move to a position where the responses would be 'always' or 'almost always'.

**Graph 3**



The following comments illustrate the feedback received to this question:

*'I feel that discharge planning appears to be more often about bed space than the optimum provision of best care to patient, relatives and community teams. I understand the burden and time pressures on staff and beds, but if patients are 'bouncing' round the system or discharged to an inappropriate environment this would be beneficial to all to stop. Discharges that I have experienced range from excellent through to unsafe and positively embarrassing making the NHS and staff appear uncaring and incompetent and at times dangerous for the patient and relatives. Financial consideration between social services and health 'who does what' and 'who pays for what' appear to be more of an issue depending on social worker assigned to case. Sometimes patient and relative expectations and demands are met when they are unrealistic and unnecessary, taking time and resources from those in need. Discharge planning is not given sufficient respect for the time required to plan and carry out effective discharge for every patient at all times, it would appear to*



*'I feel that discharge planning appears to be more often about bed space than the optimum provision of best care.'*



*be a negotiable thing with nurses trying to manage daily routine, managing discharge of a patient they have only just met on that day and are relying on others to have everything in place for safe and effective discharge. I believe that if discharge planning were given the respect that this specialist area deserves outcomes would be radically improved for patients, relatives and community teams, and then for the NHS in terms of patient safety and satisfaction.’ (Community Nurse)*

*‘Discharge planning has been an ongoing problem for years and despite the amount of time put into dealing with it there never seems to be a lot of difference. The general rule is that discharge planning starts on admission to a service whether acute or community but this is not usually what happens. It is often a reactive response rather proactive.’ (Community Nurse)*

### **Multi-disciplinary working**

Respondents were asked if the District Nursing team was involved with hospital multi-disciplinary team decisions prior to patient discharge.

52.5% (n=261) of community respondents said that the community team was ‘rarely’ involved and 31.5% (n=157) said that it was ‘sometimes’ involved.

44% (n=47) of hospital respondents said that the District Nursing team was ‘rarely’ involved and 38% (n=41) said they were ‘sometimes’ involved. Comments included:

*‘District Nursing Teams are rarely invited into hospitals to assess complex patient, discharge letters sometimes do not give complete nursing picture of patient. Patients come out of hospitals with an unrealistic perception of community services. There is limited focus of self-care in the hospitals and therefore discharged patients have very high care needs that do not necessarily need a nurse to complete. This can lead to frustration and anger from the patients which can damage the building of working relationships.’ (Community Nurse)*

### **Hospital visit prior to discharge**

The respondents were asked if the community team visited patients with complex needs in hospital prior to them being discharged home. Only 6.6% (n=32) of community nurses said they visited patients with complex needs prior to discharge, 47% (n=225) said they ‘sometimes’ visited and 46.4% (n=223) responded that they did not visit.

There was a similar response from the hospital based respondents, where 49.5% (n=52) said that the community team did not visit and 35.2% (n=37) that they ‘sometimes’ visited prior to patient discharge.

*‘Feel in past this used to happen, or we went to MDT [Multi-disciplinary team] meeting prior to discharge, less often now although feel able to contact hospital though especially specialist nurses very helpful regarding discharge.’ (Community Nurse)*

*‘Being involved from the beginning - being kept informed and invited to MDT I have recently attended a MDT about a patient who needs x3 calls a day for PEG medication- I attended the MDT twice - met all involved - was kept informed and updated - The discharge happened quicker than was planned but as I had been involved I was already prepared and was able to implement his care needs and subsequent visits easily - including briefing and updating our out of hours nursing team who were to be involved also.’ (Community Nurse)*

This positive comment was from a community nurse about her personal experience of working within the MDT. It was notable that the use of technology such as Skype was not mentioned as a method of liaising



**‘Patients come out of hospitals with an unrealistic perception of community services.’**

with the hospital team prior to the patient's discharge by any participants in the study; it may be helpful to explore the use of such technology in future work on the transfer of care between settings.

### **Contact with family**

The respondents were asked if they contacted the family or carer of patients with complex needs prior to their planned discharge home. Just 20% (n=97) of community respondents said they did contact the family or carer, with 56% (n=274) of respondents saying that they 'sometimes' made contact.

Comments included:

*'As a DN team we do try to keep information about the patient in hospital asking the family to keep us up to date with events, but this is not always the case and sometimes the family are unaware that their relative is going to be discharged.'* (Community Nurse)

*'Sometimes as the hospital team you are left as a kind of 'middle man' communicating between the community and the family rather than them communicating directly which can be frustrating and sometimes you are left communicating plans that you know the family/patient will not be happy with and you don't necessarily agree with either!'* (Hospital Nurse)

### **Assessment**

Respondents were asked if the hospital undertook a family/carers assessment for support services prior to the patient being discharged.

Just 5% (n=26) of community respondents said that they did have an assessment, whilst 17% (n=86) said they did not receive an assessment and 40% (n=202) said that an assessment was 'sometimes' undertaken. A concerning number, 37.7% (n=190), were unaware whether assessments were undertaken.

In contrast, 42.5% (n=48) of hospital respondents said they did have an assessment prior to discharge and 29.2% (n=33) said that the family/carers sometimes have a hospital assessment. 18.5% (n=21) responded that they did not know.

A solution focussed comment provided in response to this question is provided below:

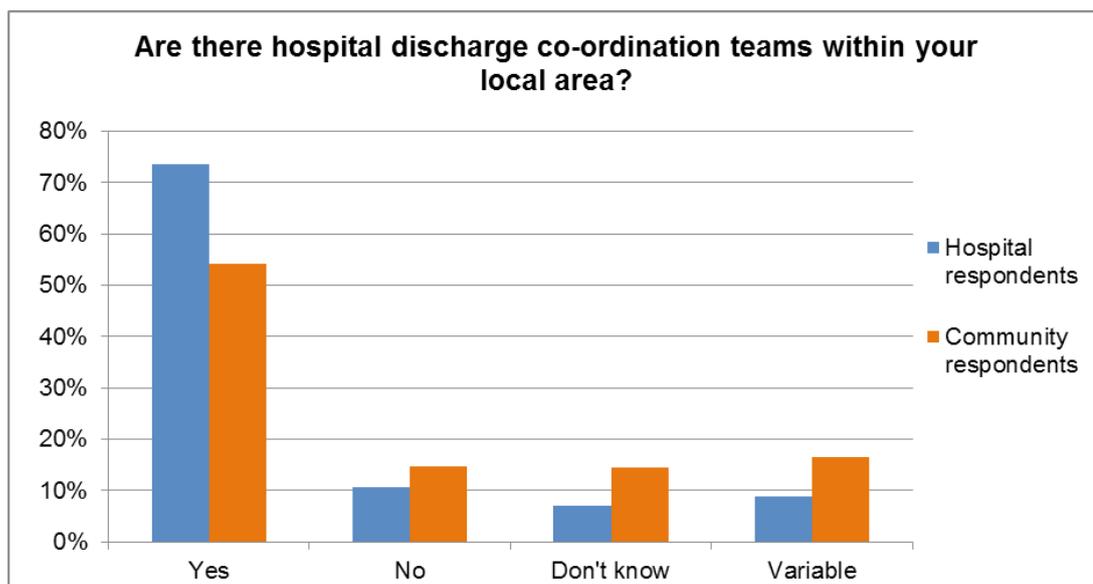
*'We need to work in a more integrated way with our local hospitals to create a cooperative, rather than them and us, approach putting the needs of the patient first. All student nurses should receive good discharge planning training and given examples of patient stories where discharge planning has been problematic showing the detrimental impact on the patient and their family and carers.'* (Community Nurse)

### **Discharge co-ordinators**

Respondents were asked if there were discharge co-ordination teams in their local area: 54.2% (n=271) of community respondents said there were teams whereas 14.4% (n=72) said that they did not know.

73.5% (n=83) of hospital respondents said that there were discharge co-ordination teams, but 10.6% (n=12) said there was no team providing this service and 7% (n=8) said that they did not know and 9% (n=10) said it was variable.

**Graph 4**



Comments included:

*'Adverse discharge reporting scheme with the discharge coordinators - always get fast response to the problems reported and they deal directly with the wards involved to try and establish what problems have been to avoid them happening again.'* (Community Nurse)

*'There is a need for better communication between hospital and community staff. Discharge co-ordinators in hospital need to come out into the community to see the complex patient needs in the home setting to develop their knowledge, understanding, emotional intelligence of patient/family/community nurses needs for care at home. This is so different now compared to 10-15 years ago. Need for better co-ordination: Poor understanding of services/duplication and need to meet targets and get beds in the acute setting.'* (Community Nurse)

*'Excellent discharge coordinators - keep in touch regularly; inform us as early as possible regarding discharge plans. Effective equipment provision including out of hours service.'* (Community Nurse)

**Discharge Keyworker**

Respondents were also asked if there was a discharge keyworker in their community nursing team: 94.3% (n=467) of community respondents said they did not have a keyworker in their team.

60% (n=68) of hospital respondents said that they did not know if there was a discharge keyworker in the community team, 29.2% (n=33) said there was no keyworker and just 10.6% (n=12) said there was no keyworker.

The above data show the lack of understanding within both groups of the role of the community keyworker for discharge planning in the nursing team and overall, there is a disappointing lack of knowledge of the potential of each group to facilitate smoother discharge experience for the patient.



*'We need to create a cooperative - rather than them and us - approach, putting the needs of the patient first.'*



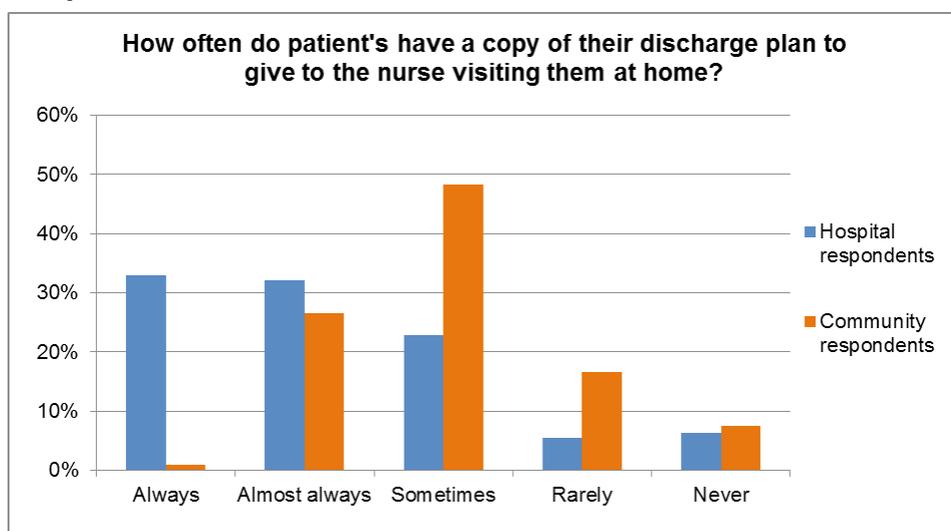
## Discharge plan

When asked how often patients are discharged home with a copy of their discharge plan to give to the community nurse, 48.2% (n=242) of community respondents said that patients 'sometimes' had a copy, 26.5% (n=133) said patients 'almost always' had a copy and just 1% (n=5) responded that patients are always given a copy of their plan.

23% (n=25) of hospital respondents said the patient were 'sometimes' discharged home with a plan; 33% (n=36) said they 'always' had a copy on discharge and 32% (n=35) said 'almost always'. 11% (n=13) said that patient were 'rarely' or 'never' given a copy of their discharge plan.

The most striking discrepancy in the data is where the hospital based respondents stated that one third of patients were always provided with their discharge plan and just 1% of community respondents believed this to be the case.

**Graph 5**



Comments included:

*'GP surgeries don't always receive their electronic discharge info in a timely manner either - often our way of 'gleaning' info prior to new patient visits.'* (Community Nurse)

*'Patients very occasionally have a difficult to read 4th carbon copy of a discharge summary which gives a brief outline of diagnosis and any surgery and TTOs [To Take Out – medications for the patient to take from the hospital when discharged home] but there is no discharge plan.'* (Community Nurse)

*'We use a joint health and social care plan, a copy is given to the family and patient on discharge and a copy is sent for the nurse or other care provider.'* (Hospital Nurse)

*'Discharge plans are done by both the ward doctor and ward staff. Every patient should have a discharge plan to give to the nurse who visits at home but sometimes they are forgotten by ward staff, sometimes sent to the GP accidentally and often lost by the patient or relatives in transit home.'* (Hospital Nurse)

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 'Hospital nurses stated that 1/3 of patients were always provided with their discharge plan whereas just 1% of community nurses believed this to be the case.'

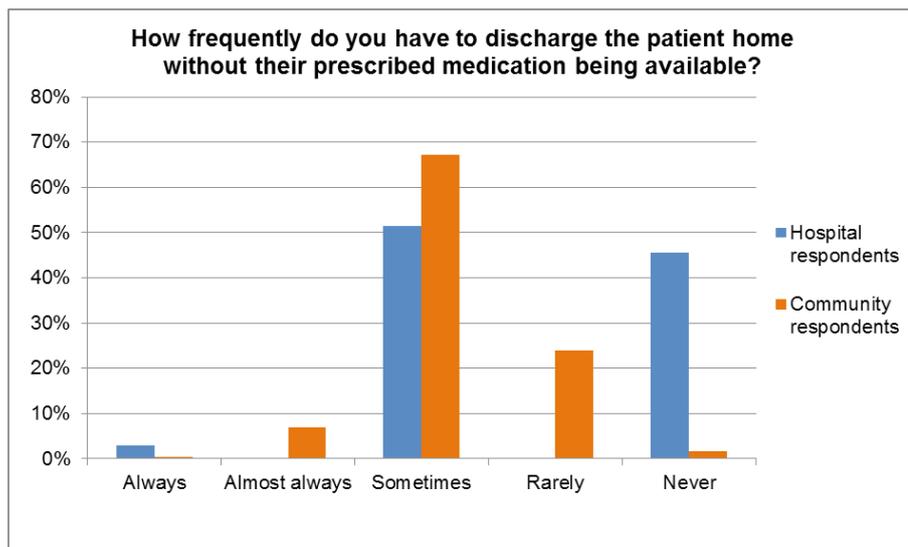
## Medication

The survey asked how frequently patients are discharged home without their prescribed medication.

67.2% (n=340) of community respondents said that this 'sometimes' happens to their patients with 24% (n=121) of respondents saying that 'rarely' happened.

Of the hospital respondents 51.5% (n=52) said that this 'sometimes' happens; 45.5% (n=46) that this 'never' happens.

### Graph 6



Comments included:

*'Ward staff often do not have enough time to address discharges. Obtaining prescriptions takes far too long and hospital transport is thin on the ground.'* (Hospital Nurse)

*'Home medications is the most problematic when patients are sent home. Hospital staff do not release the amount of extra work involved when patients are not written up for medications correctly, on the wrong forms, wrong medications send home, patients unaware of their treatments etc. the list goes on. Community staff are constantly trying to sort our medication errors, lack of medication and doctors signing the wrong forms constantly. This takes over a lot of time for community staff, time which we are in very short supply of because of the lack of staff.'* (Hospital Nurse)

*'Most of the time when bed needed for other patient we send patient home without medicine and ask them to come back on the evening to collect their medicine.'* (Hospital Nurse)

## Social Care package

Respondents were asked if delays to discharge occurred due to the lack of a social care package for patients. There was a consistency in the answers from both community and hospital based respondents. 55% (n=274) of community respondents said that delays happened sometimes in comparison to 48% (n=53) of their hospital counterparts.

11.2% (n=56) of community respondents replied that the lack of a social care package always delayed discharge and 17.1% (n=19) of hospital respondents were of the same view. Similarly, 33.5% (n=167) of community nurses and 36% (n=40) of hospital based nurses said that delays almost always occurred due to the absence of a social care package.

The following comments illustrate the issues concerned with social care packages:

*'Getting the appropriate package of care in is always a problem. District nurse staff are expected to support personal care to patients awaiting care package from social work which deflects nurse services which causes me great frustration.'*(Hospital Nurse)

*'This is very variable. This invariably depends on the social worker assigned to the case. In my experience we can guarantee within the team when there will be major hold up on discharge depending on this. At other times we are confident discharge will be timely and all assistance will be given by social worker and surprisingly fast and efficient discharge can be achieved. On occasions I am aware that setting up packages with suitable carer availability is 'difficult due to location' of patient. I am also aware of delayed social care packages due to client having exhausted all companies prepared to take on their care because of difficulties with client historically.'*(Hospital Nurse)

*'Yes, at times we have great difficulty accessing a provider for pts living in particular localities, though a contingency bed will often be offered and sourced for patients to allow a step out from acute, the pressure is then on the community SW [social work] team to find the package and reduce the spend on the contingency bed.'*(Hospital Nurse)

*'Absolutely the problem! Ironically not because of a lack of funding but lack of people interested in social care work due to the oil/gas industry etc. paying high wages and very low (<1%) unemployment. Also no private sector agencies providing care packages operate here.'* (Community Nurse)

### **Equipment for the Home**

Respondents were asked whether appropriate home equipment was ordered by the hospital prior to the patient being discharged home; only two community respondents said that this 'always' happened, with 55.8% (n=279) stating that this sometimes happened, 18.2% (n=91) rarely and four responded that equipment was never ordered.

In contrast, 79% (n=85) of hospital respondents said that the equipment was 'always' ordered by the hospital; 19.4% (n=21) said it was 'sometimes' ordered and just two said it was 'never' ordered by the hospital prior to patient discharge.

These responses are clearly in complete contradiction to each another, although the reason for this is unclear and may indicate that a further exploration of this issue is required.

Comments included reference to the challenges of ensuring that appropriate equipment is provided for patients in the home prior to discharge:

*'Pressure relieving equipment doesn't always match what patient needed in hospital. Often need the same when home as discharged still unwell/ immobile and scared to mobilise on their own, so DN has to update equipment.'*(focus group)

*'Can be inappropriate as environment not assessed, i.e. too small for hoists, beds etc. or asked for hoist but unsure re slings or sliding sheets, often no consideration to who will move furniture, remove divan beds etc., who will be there to take receipt of equipment.'*(Hospital Nurse)

Respondents were then asked if the equipment ordered by the hospital arrived before the patient arrived home. 5.8% (n=29) of community respondents said it 'always' arrived, 46.2% (n=233) said it 'almost always'



**'Ward staff often do not have enough time to address discharges.'**



arrived in time, 42% (n=212) said it 'sometimes' arrived in time and 6% (n=30) respondents said that the equipment 'rarely' or 'never' arrived on time.

In contrast, 68% (n=74) of hospital respondents said that the equipment 'always' arrived in time; 24% (n=26) believed it 'sometimes' arrived before the patient gets home; 6.5% (n=7) said that they 'didn't know' and two respondents said that the equipment 'rarely' or 'never' arrives before the patient needs it, although it is unclear how they measure or are able to report this.

The comments illustrated the practical issues with deliveries of equipment to the home prior to discharge home:

*'Usually the discharges are all very last minute, rushing around to get equipment in place and as a result having it delivered at the highest cost of delivery as it is required within 24 hours. Plus exceptionally poor and frequently incomplete referrals which then have to be chased to get all the information required'. (Community Nurse)*

*'Depends on where it is needed- the nearer to the hospital the location, the more the chance- the more remote or rural it is, the more likely it is that it will not arrive -possibly ever.' (Hospital Nurse)*

*'Always ordered at last minute so large delivery costs due to lack of notice and then often patient is not discharged on that day.' (Hospital Nurse)*

*'The ward staff frequently inform the community teams that they can't order home equip because the ward would then be billed for it.' (Community Nurse)*

### **Barriers to discharge planning**

Respondents were asked for their views on the top three barriers that prevented effective discharge planning. This question allowed free text responses. Responses from community and hospital staff were very consistent with 'poor communication' appearing to be the biggest barrier, 'poor equipment services' and 'lack of care packages' available, particularly for patients who lived in rural locations. Other barriers mentioned were problems with 'hospital transport' and 'medications' being ready for patients to take home in a timely manner.

The following themes emerged from the analysis of the comments provided:

1. A lack of time to adequately involve key people to ensure plan is appropriate and workable.
2. A lack of awareness by hospital teams of both the capability and scope of the District Nursing service and also of the challenges in relation to, for example, access to drugs and community health equipment loans.
3. Differing information technology (IT) systems in hospitals, GP surgeries and community providers, which result in duplication of entries and fragmentation of records and frustration for the users.
4. Poor communication between hospitals/social services and community based teams.
5. Hurried ineffective discharges due to the pressure on beds in hospitals and a lack of understanding of what is available in the community or 'step down' services to ensure optimum care of patient and suitable placement.
6. A lack of knowledge regarding medication management services within a community team and limited or no rehabilitation in hospital to ensure patients who are capable of self-care regarding medication maintain their independence.



*'The ward staff frequently inform the community teams that they can't order home equipment because the ward will be billed for it.'*

The following are three example comments:

*'Patients and relatives are often given unrealistic/untrue information regarding what is available on discharge, e.g. patients who are self-caring with insulin injections given referrals for eye drop/s involving up to 35 miles round trip for evening calls'. (Community Nurse)*

*'Sometimes waiting a long time for patients to be reviewed for fitness for discharge by the responsible consultant team. Also, patients who require ambulance transport home cause delays'. (Hospital Nurse)*

Information technology was frequently referred to as a barrier, which confirms the findings within previous QNI reports in 2012 ('Smart New World'), the District Nursing report (2014) and the conference proceedings captured within 'District Nursing in the Digital Age' (2015).

The comment below illustrates a common issue concerning the need for shared information technology systems to prevent barriers to effective discharge planning:

*'We all need to be on the same computer system. I have 19 different passwords to enable me to keep up to date with my paperwork on at least 5 different systems. I feel like I spend my life cutting and pasting from one system to another'. (Community Nurse)*

### **Effective discharge planning**

The survey further asked the opinions of the respondents for the top three components that enhance effective discharge planning. Responses from community and hospital staff were analysed and again there was consistency between the two groups with 'effective communication between teams' most prevalent, 'appropriate care packages' and 'multi-disciplinary team working' also cited by a large percentage. Concerns were also raised around medications not being ready to take home from the ward, timely transport to take patients from hospital to home and the impact of the day of the week chosen for discharge, with Friday being a particular challenge.

The importance of effective communication was repeatedly stressed in this context:

*'I feel that communication from hospitals is still very poor. Patients with care packages are discharged without necessarily reviewing if that package is still adequate. I feel district nurses try and communicate patients' needs to staff in hospitals but often that does not get shared adequately so patients are still discharged without the district nurses knowing anything about it. I also think that when discharge planning is done well the lack of home care for patients is the main reason for delayed discharge'. (Community Nurse)*

*'We have referral form that we can fax to other organisations if we transfer care and we would also ring to discuss that patient in more detail. We also ensure patients that require equipment in place that it is there ready for when they get home as long as the hospital inform us that the patient requires it in the first place'. (focus group)*

*'Focus on complex discharges, focus on medically stable patients and focus on collaborative working'. (hospital nurse )*

### **Action to improve discharge planning**

Both groups of respondents were asked via open questioning if there were any activities planned or in place within their organisation to improve discharge planning. Responses from community and hospital based nurses were received from which a selection of comments include:

*'A ward based discharge pilot has just begun, where a member of the discharge team leads patient discharge. Also the discharge team has recently transferred from the Division of Medicine to the Care Closer to Home Division'. (Community Nurse)*

*'Our team has a link nurse who has been meeting with a representative of the hospital discharge team and is due to attend a Sisters' meeting to improve the discharge planning process'. (Hospital Nurse)*

*'I am currently having regular meetings with the discharge liaison team at my local acute Trust to discuss ways in which to improve discharge planning. I have full access to all incident reports relating to poor discharge planning and can highlight recurring themes and particular incidences.'* (Community Nurse)

*'Our team try to avoid Friday discharges unless into a guaranteed safe environment. Patients met at home by team to ensure ability to manage and safely. Continual contact made with team taking over care to ensure seamless transfer of care. Reductions of visits to ensure patients are managing before withdrawing service. Ensuring all medication as patient able to manage in place prior to discharge e.g. blister pack.'* (Hospital Nurse)

### **Examples of best practice from the surveys**

Respondents were asked if they were able to give examples of best practice in their organisation around discharge planning. 384 responses were analysed. It was evident that many did not know if any plans were in place. Of those who were aware of initiatives to try and improve the situation, there was no unifying approach. Many reported increased recruitment of discharge co-ordinators. Efforts were being made to ensure multi-disciplinary meetings took place, and increased efforts to communicate in advance of discharge.

A selection of comments by community and hospital respondents illustrates a positive approach:

*'Staff can raise, via a multidisciplinary update meeting, any issues/challenges that may or is affecting discharge planning for any patient, with a view to identifying solutions (Problem Solving). We have resident social workers in hospital, aids identifying and resolving social services issues with community social workers. We have a member of staff who liaises with patients who may be eligible for appropriate benefits.'* (Hospital Nurse)

*'Discharging of patients to home or residential home for end of life care. They are discharged with all equipment ordered and in place in the patient's home. All medication is sent with them including [medication to be taken as needed] and DNAR [do not resuscitate order]. Discharge coordinator will contact relevant team prior to discharge. Care package established.'* (Hospital Nurse)

*'Patient flow centre with hospital and community staff to identify patients requiring services on discharge and to facilitate timely and efficient discharge revised transfer documentation; electronic personalised care plan for patients with long term conditions ; improved integration and interoperability of local IT systems; developing single point of referral hubs.'*(Community Nurse)

*'Permission for Hospital Discharge Team to order equipment from Integrated Community Equipment service for discharge patient into the community.'* (Community Nurse)

In addition to the examples of best practice provided by individuals via the survey, organisations were invited via QNI networks, nursing press and social media to submit examples of how they have improved their discharge planning process.

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*'I have 19 different passwords to enable me to keep up to date with my paperwork on at least 5 different systems.'*



## 7. Examples of best practice:

Some examples are given below and further information will be available in more detail on the QNI website in 2016.

### Serco/ Suffolk Community Healthcare

At Serco/Suffolk Community Healthcare the community equipment store (CES) is managed in house. This provides an excellent link with the clinical staff and CES staff to ensure the right equipment is available for patients. It recognised the need for urgent orders to be fast tracked for end of life patients from acute care to be facilitated in the community. The CES staff in conjunction with clinicians developed a set of equipment which would be available on a pallet and accessible for 4 hour delivery, 7 days a week during the day. The pallet contains a hospital bed, high grade pressure relieving equipment, commode etc. and all or some of the equipment can be left with the patient depending on the need. This system saves valuable time in requesting these items individually and reduced the number of duplicate deliveries for additional equipment. Staff are also able to link with satellite stores where they have access to smaller items such as medium grade pressure relieving equipment, commodes, walking frames etc. This is available on a 24/7 basis to enable patients to remain at home and prevent admission to acute care.

### Western Sussex Hospitals Foundation Trust

Example given by focus group participant and Nursing Times (September 2015). Older patients discharged home from Worthing Hospital are given 'Welcome Home Packs' containing a sandwich, milk, fruit and other basic food items to help frail and isolated people feel more comfortable on their first night back in their home. The idea came from a Patient First meeting where staff discussed ways to improve services for patients. The contents of the packs are provided by four giant commercial operators to make the discharge of local older people living on their own a better experience.

### Lincolnshire Community Health Services NHS Trust

Assertive In-Reach Teams work with patients in two hospitals out of the county but who are registered with a Lincolnshire GP. Experienced nurses work closely with the hospital teams to identify patients who are medically fit for discharge. The nurses then work with the patient, their family and carers in arranging a safe discharge back into the community and liaise with other health and social care colleagues to ensure the patients transfers smoothly from the hospital to home. An Independent Living Team of therapists, nurses and care staff then support patients to gain confidence and independence following their discharge back into their own home or local care home.

### Norfolk Community Health and Care NHS Trust

The Rapid Assessment Team at Queen Elizabeth Hospital, Norfolk is multidisciplinary and recognises that patients would wish to remain at home rather than being admitted to hospital. Patients are referred to the team from emergency care areas, the Ambulance Trust and outpatients clinics for additional assessment to assist hospital discharge in a safe and timely way. They also accept referrals from the patient or their relatives and are responsible for the falls pathway through assessment, follow up and referral to the community teams for patients over 65 years who have attended the hospital following a fall. The team offers a wide service including assessment and provision of equipment, assessment of need for having help/carers visit on discharge to home and provide a link to community services and hospital teams in and outside of Norfolk

### Sheffield Teaching Hospitals NHS Foundation Trust

#### 'Discharge to Assess'

The Discharge to Assess (D2A) model of discharge for frail older people was referenced as 'best practice' in

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'Older patients are discharged with a 'Welcome Home Pack' containing a sandwich, milk, fruit and other basic food items.'

NHS England Guide for Commissioners (February, 2014) and by Philp (2012, Health Service Journal). Patients are discharged once they are medically fit and have their assessment with the appropriate members of the community intermediate care team and members of the social care team in their own home.

D2A in Sheffield was developed as part of the Trust's wider work to further improve patient flow through the emergency care pathway. The first ward to introduce D2A saw a significant reduction in length of stay, a lower number of patient falls and no increase in readmission rates. The model ensures the frail older patient is discharged from hospital as soon as they are medically fit, with assessments and care packages put in place in their home rather than staying in hospital for assessment of their needs. The frailty unit is based on the patient need and not on age recognising that frailty can affect a wider range of patients and not just the older person. Once the patient is on the frailty unit an assessment is completed with access to a full multi-disciplinary team specialising in frailty to identify patients who could be supported at home and facilitating discharge from the unit. Active Recovery is a jointly provided service between health and social care that puts in place interventions and treatments to support patients in their own homes. The service receives referrals from GPs and other community teams and can respond within 2 hours to assess the patient in their own home: reducing-necessary admissions to hospital. Active Recovery is the service which provides the Discharge to Assess pathway in the community responding to provide meet at home or same day assessment from referral to discharge from hospital depending on patient need. The community teams and hospital teams that were involved in supporting discharge from hospital were reviewed and subsequently combined. A single transfer of care team now facilitates the front door turnaround of patients in the Emergency Department, Medical Assessment Units and Frailty Unit utilising appropriate community pathways, including Active Recovery. A dedicated team of experienced transfer of care nurses work with each speciality area in the hospital facilitating discharge of complex patients.

### **Additional comments**

The survey concluded by offering the community and hospital respondents the opportunity to provide open text comments around discharge planning. 215 responded and a selection of representative comments is given below:

*'People are increasingly more vulnerable on discharge, however as much as it is good to provide care in the home, the patient has to remain safe at every stage of the discharge and while at home, and more often than not that requires planning and organisation by the community nurses - they require effective communication and time to put things in place to ensure this happens'. (Hospital Nurse)*

*'It is complex and there is no quick fix but it is crucial that staff are made aware of the complexities that people face who do not live in the Acute sector and we must not make assumptions about how people live!!!! They have a choice and DNs are their guests in their homes. It is the most fantastic job/vocation in the world. We must learn from previous issues and work together to improve'. (Hospital Nurse)*

*'Sometimes patient and relative expectations and demands are met when they are unrealistic and unnecessary, taking time and resources from those in need. Discharge planning is not given sufficient respect for the time required to plan and carry out effective discharge for every patient at all times, it would appear to be a negotiable thing with nurses trying to manage daily routine, managing discharge of a patient they have only just met on that day and are relying on others to have everything in place for safe and effective discharge. I believe that if discharge planning were given the respect that this specialist area deserves outcomes would be radically improved for patients, relatives and community teams, and then for the NHS in terms of patient safety and satisfaction'. (Community Nurse)*

*'Hospitals obviously keen to discharge patient home as soon as possible, but sometimes don't take into account the circumstances at home, or the way community nurses operate (i.e. we don't carry dressings or incontinence pads!). Community nurses continually take on all hospital referrals into a service that has a fixed number of staff (ward without walls) therefore care may be compromised due to lack of facilities in the community. Time taken to plan the discharge could result in a more seamless transfer for the patient as well as less chance of a failed discharge'. (Community Nurse)*

*'District nurses have a pivotal role within the community. We are specialist practitioners, yet our view and opinions are rarely asked for and we are not included in appropriate workshops/discussions. Inclusion would be effective in developing/informing future planning'. (Community Nurse)*

*'Hospital staff still do not get the complexities of people being looked after in the community and despite putting a lot of work into a student nurse to get them to understand the importance in communication and telling us exactly what we need to know, not what they think we should know and allowing time to have a discussion with family and staff, ensuring the complex cases are not discharged on a Friday, which clearly hospital staff have forgotten we do not have a 7 day service and we do not have GP's at hand on the weekend'. (Community Nurse)*

## 8. Conclusion

This report illustrates that whilst there are still challenges in achieving excellent practice in the transfer of a patient's care from hospital to home, there is a significant willingness and commitment from nurses based in both the hospital and the community to improve the patient experience.

It is disappointing that given the evidence available to support good practice, discharge planning continues to remain such a challenge today. A well-planned discharge significantly improves the patient's health and wellbeing, reduces the likelihood of risk and harm, reduces inappropriate hospital readmissions and in general provides a positive patient experience.

This study has provided evidence that communication between community and hospital professionals and between professionals and patients, family and carers must be improved in order to promote effective discharge planning from hospital to home.

The report focussed on the perspectives of hospital based nurses concerned with the transfer of care when discharging patients from the hospital to the community and the perspectives of community based nurses receiving the patients into their care. Other perspectives, such as that of social care supporting smooth discharges and importantly, the experiences of the patients, carers and families themselves would provide additional dimensions to this work. Whilst this focus on the nursing perspective may be viewed as a potential limitation of the work, to expand it too widely would be to move away from the original purpose.

The findings presented in this report demonstrate that all people, irrespective of age, can experience challenges with the discharge process. However the frail, older person, 75 years and older is most likely to be affected by ineffective discharge planning.

Discharge planning for patients requiring end-of-life care appears to be more effective, with many examples of services working well together to enable patients who wish to die at home or care home to be able to do so.

Numerous comments were received about poor discharge planning for patients going home from hospital on a Friday. However, nurses also confirmed that problems could be avoided if a suitable level of staffing and services were in place, not only on Fridays but at weekends too, thereby preventing readmission to hospital due to lack of planned support after discharge home on a Friday.

Interestingly data from the community and the hospital on-line surveys demonstrate similar problems and concerns on the challenges and barriers preventing effective discharge planning, with communication



**'It is disappointing that discharge planning continues to remain such a challenge today.'**



between services cited as the main factor, lack of suitable care packages available particularly for people living in rural areas, poor equipment services, timely provision of medicines to take home, lack of hospital transport, poor integration between services and misunderstanding of district nursing services cited most frequently.

The importance of getting hospital discharge right for the patient and their family/carer has been highlighted by respondents throughout the surveys and by participants at the focus groups.

Many respondents gave examples of disempowerment of patients whilst in hospital and inappropriate referrals to the District Nursing team for the administration of medications that patients are able to administer themselves, e.g. insulin or anticoagulant injections.

There is willingness among both community and hospital nurses to improve the discharge planning process for patients, their families and their carers, but it is evident that existing systems and cultures contain barriers to effective discharges and this needs to change. There needs to be greater understanding of the boundaries, not only of each other's roles but also the capacity of their services.



‘There needs to be greater understanding of the boundaries, not only of each other’s roles but also the capacity of their services.’

## 9. Recommendations

Three key themes emerged which would enable effective discharge planning: Improved communication, improved co-ordination of services and improved collaboration.

### Communication

- Clear, precise discharge summaries should be provided to include key information for every patient (and, where appropriate, the patient's carer) requiring community nursing services;
- Multi-disciplinary team assessments and planning should include the community nursing team when appropriate to minimise delays in discharging frail, older patients;
- Alert systems should be developed to inform the District Nurse of a patient's admission (where they are already a patient on the DN caseload);
- Information should be provided to the patient on discharge to include relevant contact numbers. They should also be given information about the role of the community nursing service.

### Co-ordination

- Discharge planning must commence on or soon after patient admission and involve the community nursing team in decision making for patients with complex health needs.
- Vulnerable older people should not be discharged from hospital until appropriate support services and care packages are in place.
- Transport arrangements should be confirmed as soon as the discharge time is known.
- Patients should be discharged at a reasonable time to allow safe, effective care to be provided in the home.
- Appropriate staffing levels in the community should be in place to allow for Friday and weekend discharges.
- A 'single trusted assessment' should be used to prevent repeated assessments by different professionals involved in the patients care - thus improving patient experience.
- Provision of medication/dressings/continence sundries should be provided for a 2 week period following discharge.
- D2A – 'discharge to assess' should be implemented as soon as the acute episode of care is complete in order to plan and deliver post-hospital care in person's own home.
- There should be a named nurse or key worker (in the community) to track the patient through admission to discharge. This recommendation was cited many times within the focus groups as an example of how to improve practice. A key worker is described as an existing member of the multidisciplinary team delivering care to a patient at home, who takes responsibility for the coordination of a patient's care, in partnership with the person and their family. An example of a 'key worker' for patient being cared for at home at the end of their life would be the District Nurse, who would ensure coordination of the delivery of all health and personal care services, preventing any duplication of visits and minimising the disruption to the family.

### Collaboration

- Patients, families and their carers must be invited to be involved in decision-making prior to discharge home.
- The hospital-based multi-disciplinary team should seek ways to collaborate more closely with the local community teams to facilitate timely discharge.
- Collaborative pathways and interventions should be developed within the hospital teams to prevent delayed discharges due to patients waiting for: medicines to take home from the hospital pharmacy; community equipment and/or adaptations in the home; hospital transport; social care assessments and a package of care and a discharge letter.
- Information Technology – IT systems are required that can be accessed from hospital, primary, community, local authority and independent sector providers.

This report has identified the barriers and challenges that prevent effective discharge planning from hospital to home, identified areas of good practice and made key recommendations to improve the discharge experience for patients, carers and their families.

All organisations responsible for the governance of transfers of care from the hospital to home should work together to look at adopting and embedding good practice initiatives in the discharge planning process. The report should be considered by Executive Nurses and Medical Directors in their reports to governing bodies of provider organisations. The report will also be of interest to Non- Executive Directors as this evidence could potentially have implications for financial savings, in particular for hospital providers with regard to reducing readmissions of patients who have been recently discharged. Most importantly however, the focus for the provider organisations should be on improving the patient, family and carer experience in the transfer of care.

It is recommended that commissioners and provider organisations examine the local processes they have in place for discharge planning, ensuring that services share a vision and that transfer of care between services is planned around the needs of patients, families and carers at all times.

At a practitioner level, there needs to be willingness from nurses both in hospital and community to improve partnership working across service boundaries, to ensure that patients, carers and families experience a seamless service when discharged from hospital to home, with good discharge planning and post-discharge support.

Nurses in every part of the NHS and care systems are at the heart of effective discharge planning and must continue to be the advocate for the patient at a practice and system level in the pursuit of excellent practice in transfers of care.



‘Nurses in every part of the NHS and care systems are at the heart of effective discharge planning.’



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