healthwatch Havering

Enter & View
Queen's Hospital, Romford: Discharge Lounge

6 July 2015

One of a series of connected
Enter & View visits to Queen's Hospital in 2015

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

Healthwatch Havering decided initially to visit the Discharge Lounge and Ambulance Waiting Area at Queens Hospital to explore a number of issues that had been raised relating to discharge from the hospital, including:

- During Enter and View visits to various care homes within the borough, care homes staff had complained that their residents had been discharged from Queens Hospital after 6pm and in some cases as late as 11pm, which they considered unreasonable, as returning residents

would be disorientated and their arrival at the home could be disruptive for other residents;

- Care home staff also complained that residents were often discharged with very limited information covering medication and clinical diagnoses – it was not always clear if newly-prescribed medication replaced their original medication or merely supplemented it;
- Notes on medication might not arrive at the GP's surgery to prevent old medication being prescribed inadvertently in repeat prescriptions even when new medication had replaced old medication;
- Some care homes had suggested that patients had been discharged too soon before tests and biopsy results had been received on the ward; and
- Waiting times for ambulance transport or to receive patients' notes To Take Away (known as TTAs) appeared to be unduly lengthy in some cases.

The team that carried out the visit wanted to identify whether delays in pharmacists dispensing medication or in medical staff prescribing were the main causes of delay in patients receiving their TTAs. They also wanted to investigate whether the availability of ambulances at certain times was causing problems with discharge.

The Discharge Lounge and the Ambulance Waiting Area, although clearly functionally linked, are physically separate and are managed separately. The team carrying out the visit therefore split into two and accordingly there are two separate reports on the visit, though they can be read in conjunction with each other. Arising out of the visits, further questions arose about the management of pharmaceutical services for patients awaiting discharge and in relation to general reception arrangements for patients and visitors and these points are also addressed in separate reports, which should also be read in conjunction with this report and that on the Ambulance Waiting Area.

The Discharge Lounge

On entering the general area where the Discharge Lounge was situated, it was noted that that there was no signage in the corridors or in the nearby lift identifying the area as the location of the Discharge Lounge.

The team was met by the person-in-charge at the entrance to the Discharge Lounge and was warmly welcomed. The team also met the Patient Experience and Staff Experience Manager.

The team was told that there are usually three qualified staff on duty – a person in charge and two staff nurses – and five Health Care Assistants (HCAs), who are permanent staff. The person in charge's shifts were either 8am to 4pm or 12noon to 8pm. When they are away, the two staff nurses are in charge.

There are five beds for patients, 24 chairs with arm rests and two recliner chairs.

At the time of the visit, there were about eleven patients in the Discharge Lounge waiting to be discharged. Staff said that the day of the visit (a Monday) was a relatively quiet day for discharges; Thursdays and Fridays are usually much busier. It was explained that most patients were awaiting their medication; three patients were waiting for relatives to arrive to pick them up. Some of the relatives would be picking the patients up after they had finished work, so those patients could expect to be in the Discharge Lounge for a protracted period.

The Discharge Lounge has been in operation for eight years; before its introduction, patients would have been held on wards even though they were ready to be discharged.

The discharge process

The process of discharge is started when the Ward from which the patient is to be discharged sends papers to the pharmacy for patients' medication to be taken home with them. At this point, the person in charge faxes the pharmacy with the patient details to make sure that they have received the

request for medication from the Ward. The person in charge then phones the pharmacy every 20 minutes to check on the status of the medication delivery. Two pharmacists at present provide services to the Discharge Lounge but they are not dedicated solely to it. A view was expressed that having one pharmacist dedicated to the Discharge Lounge would make the discharge process much easier to manage and also ensure a quicker provision of medication for discharged patients.

In the past, Monday had been a very busy day for discharge, as patients were not discharged over the weekend; but since the introduction of weekend discharges, there is not so much pressure on Mondays, which has been a great improvement.

Where it is known that a care home will not accept discharged patients after 4pm, their residents are given priority.

The two pharmacists liaise to facilitate the discharge process. The person in charge of the discharge lounge gets information of patients to be discharged early in the day and informs the pharmacy in order to begin the discharge process while patients are being brought down to the Discharge Lounge by porters. Two porters are available to fetch patients before 10 am; there are three porters between 10am and 4pm; and then two porters until 10pm at night. The ward sister starts the process by asking the ward clerk to order ambulances for patients who are to be discharged. Sometimes, however, the instructions from the ward are not correct and the person in charge of the Discharge Lounge can override instructions if there are errors. Errors on the medication paperwork can take time to resolve, as can accessing doctors to correct prescriptions or to resolve discrepancies.

In response to a question whether patients were discharged at any time, HWH representatives were told that during the past winter (i.e. between November 2014 and February/March 2015), patients were being discharged at any time. However, that is no longer the case and patients are not sent home in the middle of the night; rather, patients due for discharge are kept on the Ward overnight but will be discharged by 8am the next day.

While the team was conducting the visit, two semi-conscious patients were wheeled in to the bedded area of the Discharge Lounge. The team was advised that these patients were being returned to care homes by ambulance.

Ambulance transport arrangements

In answer to a question whether a lack of ambulances is a major reason for delays in discharging patients in a relatively short time, representatives were told that there is no issue during daytime, when ambulances are in good supply; issues regarding ambulances tend to centre around

- whether or not a patient requires to be transported using a stretcher; and
- many patients in fact not needing ambulance transport but believing that they have a "right" to it irrespective of their actual health needs; many patients who are discharged with ambulance transport could instead be sent home by taxi.

There may, however, be insufficient ambulances after 6pm, although patients can be discharged after 6pm if relatives are willing to take them home.

G4S ambulances have the main ambulance contract to take patients home. SS ambulances are subcontractors who also provide ambulances for discharge patients. Occasionally LAS ambulances are used.

On the day of the visit, HWH representatives were told that ambulances had been booked for patients and all had arrived within 10 minutes. The level of discharges that day was considered light as the weather had been good and Mondays were generally light days for discharges. As a general rule, after 6pm, G4S ambulances may be delayed as fewer staff would be on duty.

Whilst in the Discharge Lounge, patients have access to tea, coffee and cold drinks when they want them. Lunch, with six hot meal options, is also provided, as are yoghurts, fruit and jelly. Tea and lemonade are served at 3pm. Supper is served at 5pm as well as warm meals or salads.

Provision of care plans

The team were told that availability of Care Plans (CPs) is not a factor in delaying the discharge process from the Discharge Lounge. Care Plans are started as soon as patients come into a ward. A folder is provided for the patients' CPs and these are brought to the Discharge Lounge with the patient. CPs identify if patients live alone and have help or are cared for by relatives.

The team were told additionally `that, initially, the Discharge Lounge used an electronic system on which medical and clinical details were recorded as on the ward, called the Electronic Discharge Summary (EDS), which provided a typed version of the patient's medication and treatment notes that could be sent to care homes with patients, sent with the patient to the patients' own home or emailed to GP surgeries. However, this system was no longer available on the Discharge Lounge; instead, the person in charge has to use a paper version whereby three different coloured copies of the handwritten notes (doctors' handwritten notes) are used i.e. the notes To Take Away, or TTAs. The patient has the blue copy as the discharge letter; the White copy is posted by Royal Mail to the GP surgery (a potentially risky approach); and the Pink copy is kept in the patient notes in the hospital. The person in charge sometimes photocopies the top copy for the patient to take away as it may be clearer.

The person in charge expressed preference for the re-introduction of the electronic system, as this would allow the notes to be emailed to the home or the GP, the information would be clearer and there would be less chance of error. On the TTA, medication that has been added when the patient is in the hospital is marked on the form as NEW so it is clear that it is new medication.

The team were told that a good working relationship had been forged with the ambulance ordering department, which will accept any changes that required to the ordering of ambulances, such as requiring stretchers for patients or cancelling the stretcher as it is no longer necessary on health grounds. However, the person in charge felt that there should be a protocol

in place to allow Discharge Lounge staff to change the details from their experience and knowledge rather than simply having to rely on a "good working relationship". It was understood that that the control centre for ordering G4S ambulances would be moving from the hospital to Chelmsford, which could impact adversely on the efficiency of the ordering process.

Healthwatch representatives said that they had knowledge of patients being discharged with wounds stapled and that they had been told that their GP could not take the staples out. In response, they were told that this should not be a problem as such patients are discharged with the staple removing equipment which could be used by the GP or the district nurse and thus the patient should not have to return to the hospital to have their staples removed or to go into the Harold Wood walk-in-centre for that purpose. Clips are often used for knee surgery and these patients are referred to a COPE Nurse. In answer to a question whether patients are ever discharged too early, the team were told that it did happen and it can result in patients having to be readmitted.

Questioned how soon after discharge the GP will receive the discharge TTA notes, staff responded that in the past the notes were emailed to the GP when the EDS system was working but latterly they had to revert to the TTA paper system and notes have to be posted to the GP. If patients have Clexane (to prevent deep vein thrombosis after surgery or strokes), this information is faxed to the district nurse or GP. Some patients are asked to take the TTA themselves to their GP but if patients cannot, or forget to do this, the GP will not have the information to provide the continuity of care. Moreover, as the back copy of three can be faint on a hand written TTA it is difficult to avoid mistakes, which is why it is imperative to get the EDS system up and running again, urgently.

Asked if patients often go home before test and biopsy results have been received, representatives were told that this does happen quite often because cultures can take a long time to develop the results. This can be stressful for patients and delay their getting results and treatment, sometimes for significant periods.

Patient Experience Leaflets (PELs) are available for patients on the Discharge Lounge to record details of their stay in the unit, but they are not given to patients to fill in as a matter of course. Some of the PELs have been filled in by patients but these have not been analysed as to date they have remained in the unit. The Healthwatch representatives suggested that these forms should be made available for analysis as they could provide valuable information and be helpful in improving patients' experience of the discharge process.

As some nursing homes are very strict on timing, the person in charge of the discharge lounge will sometimes suggest that a patient is sent home to a nursing home before their medication is ready in order to return to the home before 6pm; in such cases, they arrange for the medication to be sent by taxi to the home. In the Discharge Lounge sitting area there are lists of homes and information on the time when they will no longer allow patients to be sent back to the homes.

A common problem is that patients have to be sent back to care homes or discharged from hospital in the charge of relatives still clothed in hospital gowns and with no foot-ware. In such cases, non-slip socks (of the TOTES-type) have been provided by the discharge lounge staff as ambulance crews are reluctant to take patients if they are not wearing shoes or non-slip socks. While visiting, the team observed that one elderly patient, who was waiting for an ambulance to take them back to the care home, was in a hospital gown and had non-slip socks on. This situation HWH representatives were told was all too common and is very undignified for patients: in warm weather, it is not so bad but in the winter, patients may be discharged in their hospital gowns, wrapped in two hospital blankets and with non-slip socks. The team felt that this was very demeaning for patients and could pose a safety risk, particularly in winter with cold temperatures. Care homes and relatives rarely return these clothes.

Another issue flagged up was that soiled clothes, in which the patients entered the hospital, were often kept on the ward until discharge and sent to the home or sent home with the patient's relatives. Relatives and care homes tend not to provide clean clothes for patients to be dressed in for

discharged. Sometimes clean clothes are found in the patient's belongings when sent down from the ward but the patient has not been dressed in them. Patient's relatives – and care homes – often do not think to get clean clothes for the patient or take home the dirty clothes to be washed. This is an infection risk as well as a dignity issue for the patient. Thus urging relatives and care homes to provide clean clothes in a timely fashion for discharge should be encouraged and addressed. It also poses a problem from the point of view of loss of hospital property providing hospital gowns and blankets which are often not returned to the hospital.

The team felt that there should be an investigation as to whether a supply of clean new clothes could be provided by a charitable group in order to make available suitable clothing such as warm dressing gowns and non-slip socks for patients who otherwise would have to be sent home in flimsy hospital gowns.

The team was told that care home representatives generally only visit patients in hospital if they have been newly assigned to the care home; patients already at a care home when they were admitted to hospital, are not often visited as care homes do not generally have the staff to do so.

Ambulance staff may refuse to return patients to their home who have been discharged too early or who do not have anyone to care for them when they are at home and in these cases may bring them back to hospital. The person in charge of the discharge lounge may send food package home with patients who are on their own so that they can have some refreshments until their carers come in or until they are able to go to shops themselves, for example if they are discharged late in the afternoon when shops are not open.

Interviews with patients sitting on chairs in the Discharge Lounge ward.

One patient interviewed at about 3.45pm had been waiting in the Discharge Lounge from 1pm for delivery of their medication. The patient was happy with their care whilst in hospital and felt that the staff had done a good job and should be congratulated. The patient, who had been in hospital for ten

days or so, accepted that in any system things could not be perfect but was very happy with the care given. They had noted some tension between staff at times, mainly concerning issues regarding that they thought that certain duties were not their responsibility. Whilst the patient had been waiting in the Discharge Lounge they had had a cup of coffee, which was all they wanted, and had been offered meals. Asked if there was there anything that might make their wait more pleasant they said no as their main desire was to be discharged as quickly as possible. The patient said that they had been treated with consideration whilst in the Discharge Lounge.

Another patient had been waiting in the Discharge Lounge since 2pm and was waiting for medication. By 4.50pm the patient's medication was delivered and the patient left the Discharge Lounge.

A third patient had been waiting in the Discharge Lounge since 2pm and was still waiting for medication and paperwork at 4.40pm, at the time of the interview.

Another patient had just arrived in the Discharge Lounge from the A&E at 4.50pm. This patient had received their medication from A&E and was waiting for an ambulance to take them home.

A further patient had been waiting an hour. This patient was waiting to be picked up by a family member who would be arriving after work.

The Discharge Lounge does not have a television as there is no signal reception in that part of the hospital. IN any event, the shape of the ward makes it difficult for a TV to be positioned where patients could all view it, and as staff are frequently moving around the Discharge Lounge, it would be difficult for many patients to hear. However, the ward situation allows patients to use mobile phones, as mobile signal reception was good.

Kitchen area

The team saw the staff kitchen and representatives were told that staff had requested a bigger fridge so that there would be more room for staff and patient food to be stored. The team also noted obstacles on the kitchen

floor in the corridor outside that appeared prominent and could pose a safety hazard, and were told that some personal injuries had been sustained recently through trips and falls. The team also noted that staff left their personal items in the kitchen area, which might be a safety or hygiene risk.

End of Life Care

The person in charge of the DL also expressed concern that it appeared that some patients were being sent to hospital from care homes for end of life care; she felt that it was inappropriate for care homes to send residents to hospital for their final days. Given that care home staff had expressed strong views to Healthwatch Havering about premature discharge and that some residents' carers or relatives have concerns that patients are too easily referred to hospital for their final days, there is clearly a need for dialogue between the hospital and care homes on these issues.

Recommendations

- The Electronic Discharge Summary (EDS) system should be reinstated for discharge from the Discharge Lounge so that a copy of medication and clinical notes could be emailed to GPs and Care Homes, ensuring that those who need to know about medication and health issues receive the information in a timely fashion and with less risk of error through misreading of handwritten notes.
- The main sources of delay in getting patients through the discharge process when in the Discharge Lounge are waiting for dispensing of TTAs and waiting for ambulances. In general, it was felt that the provision of ambulances was seldom a problem during the day. A pharmacist should be assigned to the Discharge Lounge to help reduce the time waiting for medication by patients and also speed up the process of discharge. That pharmacist could more easily have dialogue with the doctor about any discrepancies.

- A protocol should be introduced to ensure that the sister (or nurse in charge) at the Discharge Lounge can over-ride an order for ambulance transport by stretcher if it is deemed no longer necessary. Such an arrangement should not need to rely on the excellence of a personal relationship forged between the Discharge Lounge sister and the ambulance ordering department, but should be embedded and work equally well whoever is on duty. The change of location of the ambulance-ordering department to Chelmsford increases the necessity of such a protocol
- As many patients believe they have a "right to ambulance transport" even though there are no medical grounds and ordering a taxi would be preferable, there needs to be patient education regarding not wasting resources.
- It is unacceptable, from both a dignity and health and safety point of view, for patients to be discharged back to care homes or private homes in hospital gowns and wearing only socks rather than normal day clothing and shoes. It is also a waste of hospital resources when this happens as gowns and blankets are rarely returned to the hospital
- Care homes or relatives should be asked to ensure the availability of clean clothes for the patient to be discharged in, and should be encouraged to take home dirty clothes for cleaning whilst patients are in hospital, to avoid bags of soiled clothes being left in the hospital and sent home with the patient when they are discharged
- Patients should not be admitted to hospital for end of life care. Care homes should be encouraged to observe the Gold Standard Framework for End of Life Care and the hospital should enter into dialogue with care homes about this issue.
- Patient Experience Leaflets (PELs) are given out to patients in the Discharge Lounge with the intention that they are collected and analysed for opportunities to learn from feedback. Although some had been completed there appeared to be no analysis of the forms.

- For efficiency, both the Discharge Lounge and the Ambulance waiting area should be co-located, on one floor. It seems to us that the siting of the Discharge Lounge within the hospital at the moment is not practical: it is inconvenient for staff and patients, and ambulance staff have to go up and down in lifts with patients on stretchers. It is strongly recommended that the two lounges amalgamate at some stage.
- Discharge forms need to be correctly filled in before a patient leaves the ward in which they have been staying. These forms are an essential part of the discharge process: If they are not completed correctly by clinicians then incorrect information will be sent to the patient and their GP, with potentially disastrous results.
- Patients need to be re-assessed regarding Do Not resuscitate status no more than 24 hours before discharge.
- Patients' levels of mobility need to be assessed correctly before transport is booked for them in order to ensure that the correct type of ambulance – if indeed one is required - is ordered.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 6 July 2015 and is representative only of those patients, carers and staff who participated. It does not seek to be representative of all service users and/or staff.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
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