Enter & View visit to Holly Ward, Milford Hospital – Stroke Services

Name and Address of unit visited

Holly Ward, Milford Hospital Tuesley Lane, Godalming GU7 1UF. The Day Hospital section has now been renamed a Diagnostic and Treatment Centre.

Day, date and time of visit

8th December 2014

Authorised Representatives

Gareth Jones and Jagadish Chakraborty supported by Jane Shipp

Contact

Healthwatch Surrey 01483 533043

Service Provider

Virgin Care

Met by Mary Kelly – Matron

Disclaimer

Please note that this report relates to findings observed on the specific date as above. The report is not a representative portrayal of the experience of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit

To revisit the provision of in-patient stroke rehabilitation in community hospitals as changes have taken place following the Stroke Pathway Report in 2102.

Pathway Activity Information

Activity year 2011/2012	Activity year 2013/2014
32 patients received stroke rehabilitation	47 patients received stroke rehabilitation
30 patients were over 65 years	47 patients were over 65 years
2 patients were under 65 years	0 patients were under 65 years
32 patients were admitted from RSCH	largely RSCH, exact number not known
16 patients went home, 10 to nursing home, 2 to acute hospital & 4 unrecorded	18 patients went home, 3 other NHS hospital provider, 13 recorded as blank and 13 unrecorded
The average length of stay was 47 days	The average length of stay was 45 days
13% bed occupancy	22% bed occupancy

First Impressions – access

The Hospital website relates more to Virgin Care than directly to the Hospital. Car parking is free but there is no public transport access. There is a possibility of a "Family Bus Service" in future. The receptionist was expecting Healthwatch visitors.

There are 2 wards, Holly Ward and Oak Ward, both with 17 beds giving a total of 34. At the time of the visit 4 beds were occupied by stroke patients but the number can increase to 12.

Both wards are for complex elderly patients and the stroke patients tend to be placed on Holly Ward.

There are two rehabilitation gyms, one on the ward and the other in the Day Hospital. The ward gym is very busy and there are timing issues for groups. The gym in the Day Hospital is not fully used but there are "lone worker" problems in its use. Therapy is not available at weekends. A Stroke Consultant makes a weekly ward round. OOH GP cover is provided by a local Practice. Corridors which have patient toilets are not dementia – friendly as all doors are the same colour. In the toilets contrasting colours are used.

Signs are not consistent with both "Day Assessment" and "Diagnostic & Treatment" in the same unit. Notice boards are not well laid out and some documents are not laminated.

Visiting is limited to 2.30 – 4.30pm and 6.30 – 8.30pm.

Observations

Patients are dressed and then eat together. Food is cook/chill with a menu on each table. Patients select at the time rather than in advance as there is a tendency to forget pre-orders. Red jugs are available for thickened fluid and vegetarian options are available.

Pathway Experience

When a patient is transferred from an acute hospital there is a telephone conversation between the nurses at the two hospitals and the patient's notes accompany the patient. This is an informal process but works well given the individual contacts.

Wherever possible contact is maintained with families over discharge but some problems arise. There may be delays in Social Services making any necessary adaptations to a patient's home although the hospital has its own store of some adaptations and the means to deliver them. When patients are to be placed in a Care Home there are frequent delays because of funding queries and provision of wheelchairs can take 2-4 weeks so wheelchairs are borrowed from the British Red Cross. In some cases care homes cannot provide wheelchairs.

Conversations with staff and patients

A female patient had been at Milford for 5-6 weeks but had no idea when she was likely to be discharged to a care home as her husband is already in a Home. She was happy with the care and food provided.

In another instance a relative commented that his mother, who needed to be placed in a Nursing Home, was ready for discharge but liaison with Social Services was poor

Recommendations

1. To improve liaison between hospital, patient and social service to make discharges smoother.
2. Improve signage so it is consistent

Response from the Provider Virgin Care

All our referrals come from RSCH.

With regards to ward rounds we have 4 visiting consultants who make 4 rounds.

When there is a transfer of patients, there is a referral process - the coordination of discharge from the acute service is carried out between the discharge coordination team and the ward directly. Discharge is agreed between the services prior to transfer then there will be liaison between the wards formally about transfer.

We do not supply wheelchairs for patient going into care homes.

In relation to the comment regarding discharge and a lack of liaison with Social services. Social services are based on site and attend the discharge planning meetings and liaise with family/carers. The issue at the time of the visit was down to lack of availability of suitable nursing homes.

In response to Recommendation 2

Thank you for highlighting this -diagnostic and treatment centre is not part of the inpatient area however signage has been raised with NHS Property services who own the building to be changed in recent months.

Report reviewed and authorised by:

Robert Hall
Enter and view Co-ordinator, Healthwatch Surrey