Action for Carers Surrey

healthwatch Surrey

Carers' experiences of hospital discharge
Summer 2021

A report exploring the impact of hospital admission and discharge on the wellbeing and outcomes of patients and their carers between Summer 2020 and late Spring 2021

Executive Summary - Purpose and Methods

Purpose

This project was undertaken to investigate the experience of Discharge to Assess from the perspective of Carers of those admitted to hospital. Our aim is that this insight will guide development and implementation of the D2A programme to maximise safe, successful hospital discharges.

This was a joint project between Action for Carers and Healthwatch Surrey.

Methods

Online/paper survey

- Spring 2021
- Self-selected sample; all self-defined as carers
- 78 completed responses; 23 with new care needs post discharge

Depth interviews

- 12 respondents recontacted for 60min+ individual depth interviews.

Patient Stories – one very positive experience, one less so

https://youtu.be/TNBoc4uUSP8

https://youtu.be/CbSMF2nRqpE

Respondents have given permission for their stories to be shared with organisations responsible for commissioning and providing services.
Names have been changed to protect anonymity.
Videos created from interviews taken in Summer 2021.

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Executive Summary - Key Findings 1

Key findings

Even during the restrictions of Covid, we did hear positive stories of safe, patient-centred discharges

However, this was a self-selected sample and inevitably we heard more negative experiences than positive.

Key findings from the quantitative survey

- **Poor communication between ward and carers:**
  - 57% felt hospital communicated poorly or very poorly when patient was on the ward
- **Poor levels of inclusion in post-discharge planning:**
  - 74% said social worker did not make contact with carers
  - 72% were not asked if they could manage patient post-discharge
  - 58% felt carers views not taken into account
  - 56% did not feel consulted in discharge plans
- **Poor post-discharge signposting and support:**
  - 76% said the patient was not signposted to any support
  - 76% carer not given the name of organisations who could support
  - 68% of patients were not given the name of an HCP for advice or support

Key findings from the depth interviews

- Carers **unable to communicate a patient's baseline** to those providing treatment or arranging discharge
- **Contradictory, confusing information** – different family members contacted at different times, contradictory information given, unclear who calls are coming from or purpose of calls (especially unfamiliar names/job titles)
- **Carers not prepared for discharge** – timing, needs of the person post-discharge not as expected

Executive Summary - Key Findings 2 - Consequences of poor communication

Clinical

- Medication missed by hospital resulting in patient experiencing “*a massive seizure*” and suffering aspiration pneumonia
- Patient didn’t have dialysis for 2 days
- Parkinson's medication not properly administered
- Carer unable to tell ward staff about swallowing difficulties so patient discharged dehydrated and hungry

Discharge decision-making

- Patient with a diagnosed UTI and mild dementia admitted after a fall; discharged 2 weeks later with confusion much worse: *“she did not sleep night or day and talked, screamed and sobbed continually”* – attributed by hospital to dementia. Another UTI diagnosed at home 10 days later.
- *“They didn’t tell us he’d fractured his pubic bone – we only found out when he came home. We had no idea what this would mean…we assumed he’d had a stroke”*
- *“Because of her severe LD she lacks the capacity to understand how what she’s being asked actually impacts her … they assessed her and deemed her fully capable of making her own decisions, which she isn’t”*

Stress and distress

- *“As she didn’t have her hearing aids professionals thought she had dementia. Actually she has full capacity but she lip reads.”*
- *“Patient extremely distressed as he did not know what was happening”*
- *“It caused overwhelming stress to patient and family”*
- *“It made my family sad and worried”*

Executive Summary – Key Conclusions

- Even at the height of the pandemic it was **possible for discharge to be collaborative, safe and enabling**
- The sub sample of identifiable D2A respondents is small but **5 of the 6 do seem to have received timely follow up assessments**

HOWEVER

- **Poor communication from staff to carers** at all stages of the journey is a substantial barrier to achieving good discharges
- **Carers are at a serious disadvantage.** They are often unaware of assessment processes, how decisions are made, who has responsibility for what actions. They cannot contribute to discharge, and cannot quality-check the discharge.
- These weaknesses can result in **actual patient harm**.

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Executive Summary - Recommendations

1. **Proactively identify patients who rely on unpaid carers.** Recognise carers may be unregistered/unacknowledged. Record a key contact for every patient and focus communication through that contact.
2. **Review practices and processes that govern hospital-carer communications.** Take the opportunity to develop new, post-Covid strategies that cover all touchpoints.
3. **Improve carers' understanding.** Explain the process of discharge including who's who, decisionmaking processes, what they should expect, and what support is available. Use co-design to develop a guide.
4. **Provide a professional, efficient handover of the patient to the carer**. As well as meeting the requirements of the current Policy and Operating Model this handover should be patient/carer-centric with appropriate language and contact information for all relevant providers/services.

DETAILED REPORT

Project aims and outline of methods

Project Aims

- Discharge to Assess is likely to become the permanent discharge model from both acute and rehabilitation settings for those with new care needs following a hospital admission
- This project gathered insight from carers with experience of hospital discharge including Discharge to Assess (D2)
- We have used this insight to make recommendations that will optimise the efficacy and safety of D2A. The recommendations span the patient and carer journey from admission to home.

Method

- Online/paper survey
  - Survey open late March 2021 – end May 2021
  - 78 responses; 23 with new care needs post-hospital
  - Self-defined as carers
  - Questionnaire covered experience from admission to post-discharge
  - Not all respondents answered all questions
  - We have reported in % for clarity

- Depth interviews
  - 12 Respondents for full interviews; further supplementary experiences

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Value and Limitations

What this survey IS

- Self-selected sample
- Completed by those with impactful experiences to share – good and bad
- Insight; fresh perspective

What it is NOT

- A representative, randomly selected sample
- A large sample

The findings

- shine a light on what can go well and what can go wrong
- reveal where the weak links are found
- expose the consequences of good or bad experiences on people and on the system

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Key Conclusions 1

- This project covered admissions and discharges during the second wave of the pandemic, when hospitals were under pressure, hospital visiting was limited to the final days of life, and care systems were working at unprecedented speed to deliver post-discharge support.
- Despite this pressure some people shared with us experiences of **collaborative, safe, enabling care where the hospital stay and Discharge to Assess process had worked to the benefit of all.**
- Unfortunately, we also heard stories of **poor communication and processes that excluded the carer, some of these resulting in actual harm to patients.**

Key Conclusions 2

- Everyone in our sample agreed they were "providing unpaid support to family or friends who could not cope without this help". All were carers.
- But the status of Carer was often unrecognised or unacknowledged - by those they care for, by staff, and by carers themselves.
- Poor communication with carers directly impacts patient outcomes
  - their unique knowledge of the patient's pre-admission health and strengths is ignored: hospital staff are unaware of the patient's baseline and cannot treat accordingly
  - assumptions are made about the carers' ability to care for patients post-discharge.

Key Conclusions 3

- **Carers are at a serious disadvantage when trying to navigate the discharge process and negotiate a fair, safe outcome for the patient and for themselves.**
  - Most of the carers we heard from had no previous experience of social services care assessments, and most patients were emergency admissions with no opportunity for preparation
  - Carers are often unaware of assessment processes, how decisions are made, or who has responsibility for what
  - This can mean they cannot play an informed and active part in ensuring the patient leaves hospital promptly and safely
  - Their expectations may not be realistic; and they may be unable to predict timelines and needs
  - They are unable to quality-check the discharge

Key Conclusions 4

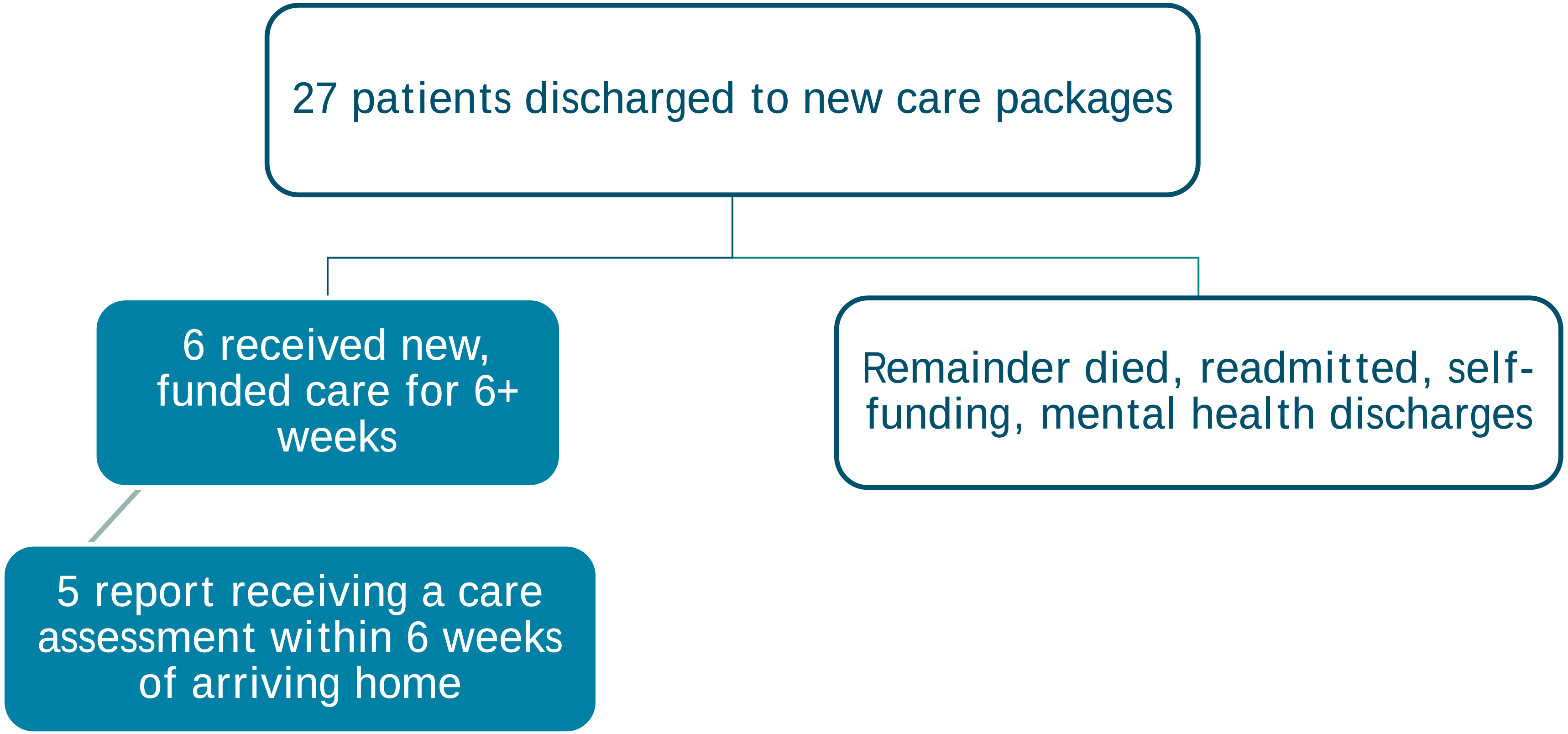
- There are **weak points** in the journey from admission to discharge and beyond:
  - **Communication between the ward and carers:**
    - 57% felt hospital communicated poorly or very poorly
  - **Carer inclusion in post-discharge care planning:**
    - 74% said social worker did not make contact with carers
    - 72% were not asked if they could manage patient post-discharge
    - 58% felt carers views not taken into account
    - 56% did not feel consulted in discharge plans
  - **Post-discharge signposting and support:**
    - 76% said the patient was not signposted to any support
    - 76% carer not given the name of organisations who could support
    - 68% of patients were not given the name of an HCP for advice or support

> Before discharge a determination must be made about the status and views of any carers who provide care, including that they are willing and able to do so.
>
> *Hospital Discharge and Community Support: Policy and Operating Model 5/7/21*

> Upon discharge, all people should receive information about who they can contact if their condition changes…clinical team who supported the person in an acute or community hospital… voluntary or housing sector partners…
>
> *Hospital Discharge and Community Support: Policy and Operating Model 5/7/21*

Key Conclusions 5

The sub-sample of identifiable D2A respondents is small but they do appear to have received follow-up assessments



27 patients discharged to new care packages

6 received new, funded care for 6+ weeks

5 report receiving a care assessment within 6 weeks of arriving home

Remainder died, readmitted, self-funding, mental health discharges

Recommendation 1: Carer identification and key contact

Identify patients who rely on unpaid carers

Record a key contact for every patient

- Some patients will have an **acknowledged unpaid carer** who will act as key point of contact.
- For those without recognised carers, the point of contact might be **a friend or family member** who will be providing care or support after discharge, or **someone holding power of attorney**.
- Identifying a single point of contact will **reduce the risk of confusion** and fragmented communication

Consider

- Staff inductions that include carer/home support awareness
- Utilise Action for Carers Surrey Hospital Carer Support Advisors to identify and liaise between carers and patients
- The ambulance service are well placed to collect contact information when in the home setting

Recommendation 2: Hospital/carer communication strategy

Review practices and processes that govern hospital - carer communications; take the opportunity to develop new, post-Covid strategies

- Approaches to communication seem to vary widely, not just from trust to trust but from ward to ward or consultant to consultant.

Consider

- Co-design with patients/carers/families to develop communication practices that enable safe, efficient, two-way communication
  - Proactive, planned communication from hospital to carer – to optimise quality and relevance, and reduce inbound calling
  - Management of expectations around comms
  - Consistency – same point of contact, ensure messaging is consistent with previous messaging
  - Well informed – right person, right message
  - Listening as well as talking
  - Planned face-to-face conversations as well as phone/video/email opportunities

Recommendation 3: Carer Education

Improve carers’ understanding

- Carers cannot contribute to safe discharge and assessment if the process has not been explained to them.

Consider

- A guide for carers of inpatients (co-design approach)
    - Who’s who on the ward and in discharge
    - The discharge decision-making process and assessments
    - Planning for the practicalities of discharge
    - What patients and carers can expect
    - Support available
- A staff induction module
    - How to identify the carer
    - How to support the carer
    - Who to refer carers to for continuing support

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Recommendation 4: Fully Informed Handover to Carers

Provide a professional, efficient handover of the patient to the carer

- It is a **handover**, not a discharge – most patients are being sent home to continue their recovery and will need care and support, much of which will be provided by informal, unpaid carers

Consider

- Does the handover meet the requirements of current Policy and Operating model re. fully informed carer consent
- Provide a written record of 'what next' - a discharge letter for carers
  - Patient/carer oriented/language
  - Who to contact if condition changes
  - Appointments
  - Contact details of providers of health/social care

'The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.'

The **National Patient Safety Agency**

FINDINGS

About our respondent: quantitative survey

All self-defined as carers: "A carer is someone of any age who provides unpaid support to family or friends who could not cope without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. The carer does not have to live with the person they are caring for"

Person they care for is their:

Parent or parent in law	51%
Spouse	22%
Child	14%
Other/not stated	13%

Age:

18-54	27%
55-64	47%
65+	22%

Including 3 over 75

Ethnicity:

White British	88%
Other white	5%
Indian	5%
Pakistani	2%

From the email address names we estimate 80%+ of our respondents were female

About the people they care for:

Pre-existing health conditions:

Mobility issues	57%
Physical disability	34%
Dementia	33%
Mental Health	32%
Sensory impairment	28%
Stroke	13%
Learning disability	11%
Other	30%

Where do they live:

With respondent/family	38%
With spouse/partner	29%
Alone	26%
Residential/nursing home	7%

Paid for care?

No paid care	69%
Self-funded care	16%
Funded care	11%

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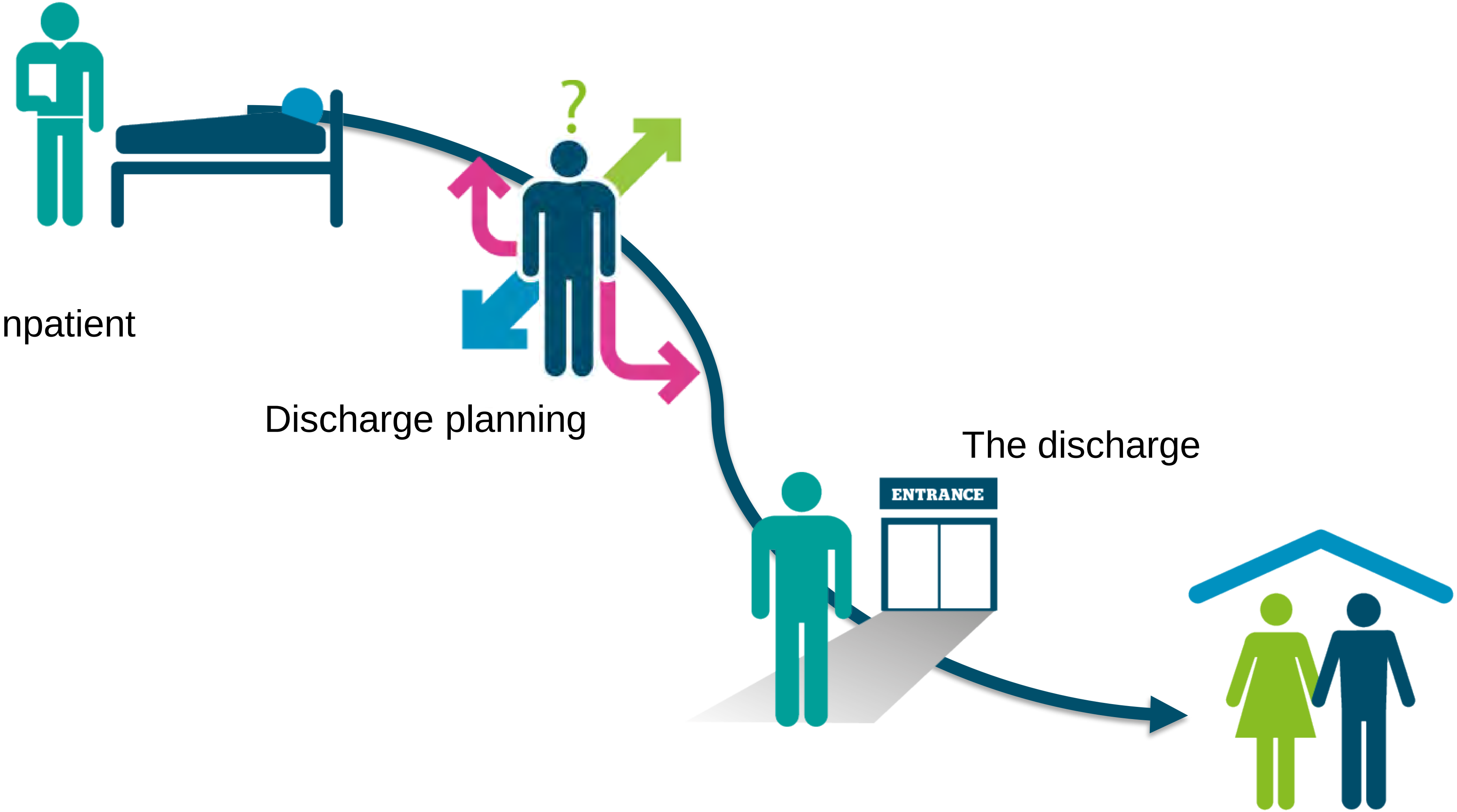
About our respondents: depth interviews

- 12 interviews lasting 1hr or more
- Some additional informal conversations and experiences
- Selected from the quantitative sample
  - Opted-in to a telephone interview
  - All discharged to new care arrangements
  - Selected for range and issues – positive and negative experiences included
- Mostly adult daughter (or daughter in law) of elderly frail parent
  - But included wife, support manager
  - Mental health, learning disability
- 2 failed discharges; 5 cases would fall into HwSy “Case of Concern”

Our sample: key points

- Self selected; not random; biased towards negative experiences
- Wide representation
  - Carers of parents, spouses, children; ethnic minority representation; elderly frail but also mental health, learning difficulties.
  - Range of trusts (nb. Not suitable sample sizes for comparison between trusts)
- Range of lengths of stay, but core around a week-a month
- Almost all emergency admissions by ambulance
- Majority with no experience of social care on admission

The patient and carer journey



Inpatient

Discharge planning

The discharge

Home again

INPATIENT EXPERIENCE

The Hospital Stay

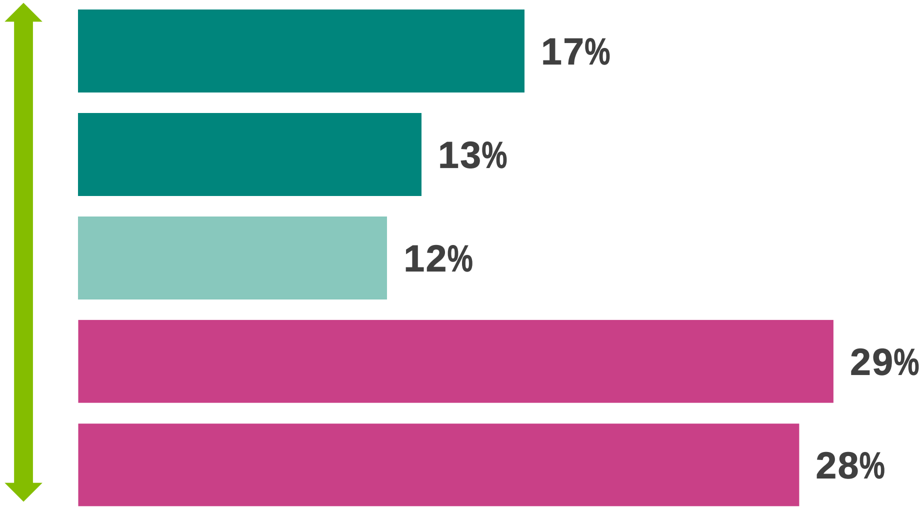
- Emergency Admission for all but 2
- Some mental health admissions
- From qualitative: mostly falls, +/-fractures, some medical.
- No admissions where covid was the primary condition.

Hospitals:	
St Peters	28% (21)
RSCH	22% (16)
Epsom St Helier	21% (15)
Frimley	12% (9)
Farnham road	6% (5)
East Surrey	3% (2)

Length of stay:	
1-2 nights	22%
3 nights-week	18%
Week-month	42%
One month+	19%

Over half our respondents reported poor communication between the ward and carer

The hospital communicated very well with me, I had all the communication I needed when I needed it



Communication was very poor, I was not able to get the information I needed

“The staff were fantastic, they called me in and allowed me to be with her” (NB: patient was critically ill after a medication error on the ward)

“One of the consultants was wonderful, he called every few days”

“Nobody came to me, I had to chase them”

“They would say ‘call back tomorrow for an update’ then nobody answered the phone”

“I gave up calling after a patient answered the phone”

“We had frequent updates but they were inconsistent – I didn’t always understand who I needed to be talking to and there was little staff continuity”

“I had to drag everything out of them”

“Everything we put in writing was ignored”

Ward/Carer communication “can you tell us more or give an example?’ ‘did anything happen as a result?’

“can you tell us more”?

Generally negative	61%	Generally positive	23%
Decisionmaking/care compromised	12%		
Clinical errors	7%		

“did anything happen as a result?”

Some negative consequence	70%	General positive	27%
General negative (no detail)	22%		
Stress, confusion, upset	22%		
Unsafe care	19%		
Unsafe discharge	12%		

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Examples of harm caused by poor communication:

Clinical

- Medication missed resulting in patient experiencing “a massive seizure” and suffering aspiration pneumonia
- Pt didn’t have dialysis for 2 days
- Parkinson's medication not properly administered
- Unable to give input about swallowing difficulties so patient discharged dehydrated and hungry

Decisionmaking

- Patient with a diagnosed UTI and mild dementia admitted after a fall; discharged 2 weeks later *“she did not sleep night or day and talked, screamed and sobbed continually” – attributed by hospital to dementia. UTI diagnosed at home 10 days later.*
- *“They didn’t tell us he’d fractured his pubic bone – we only found out when he came home. We had no idea what this would mean”*
- *“Because of her severe LD she lacks the capacity to understand how what she’s being asked actually impacts her … they assessed her and deemed her fully capable of making her own decisions, which she isn’t”*

Stress and distress

- *“As she didn’t have her hearing aids professionals thought she had dementia. Actually she has full capacity but she lip reads.”*
- *“Patient extremely distressed as he did not know what was happening”*
- *“It caused overwhelming stress to patient and family”*
- *“It made my family sad and worried”*

‘Future plans’ and ‘ReSPECT’ - misunderstood by most

- “Future Plans” – often understood as care plans, discharge plans
- ReSPECT – often not familiar with this
- By implication - discussions not held for all patients, or not held with the person answering the questionnaire

“I don’t know what that is but we did have a discharge team come to visit when she got home”

Minority of respondents had

- Pre-existing ReSPECT forms (4)
- Positive experience of new form completion (4)
- Negative experience of new form completion (4)

Call with the consultant to discuss respect form – this was done well and with sensitivity

After signing the respect form he believed he had been sent home to die. He is very deaf so had not understood and we were not consulted

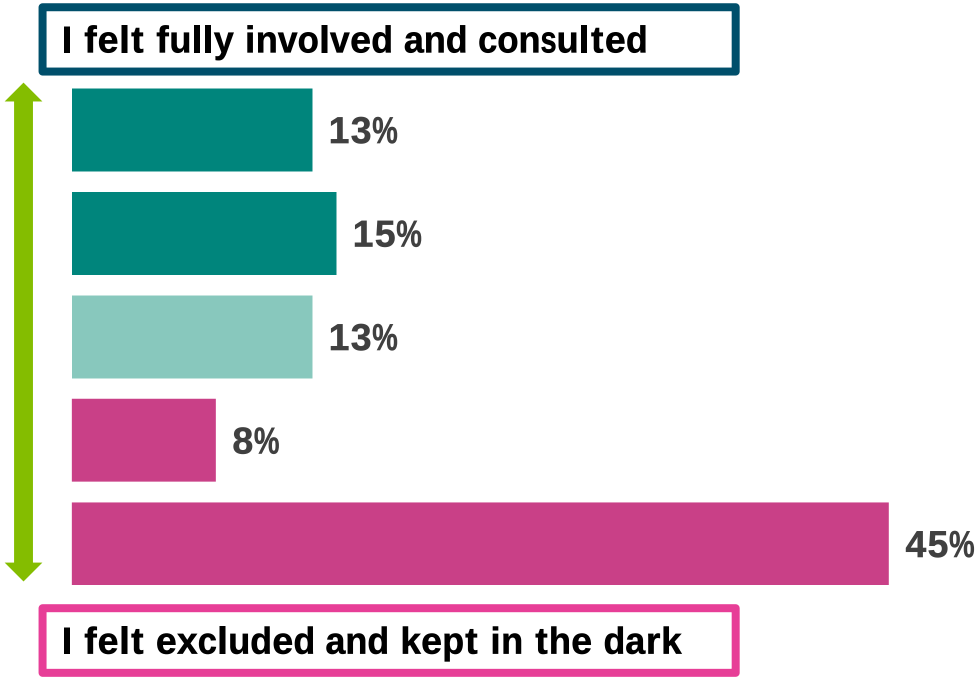
Ward/carer communication - key points

- Quality of ward-carer communication has a significant impact on carer and patient experience
- “Good” communication is regular, proactive, and informed.
- We heard more reports of poor communication than of good communication
  - We heard of cases where poor communication has led to actual patient harm: clinical errors and unsafe discharges
  - Poor communication is frustrating and upsetting for patients and carers
- There are indications that ReSPECT implementation remains patchy

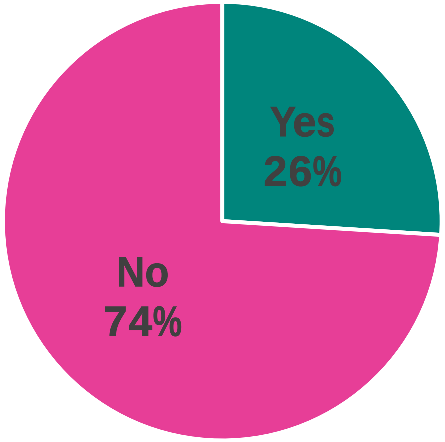
DISCHARGE PLANNING – CARER PERSPECTIVE

Over half our respondents did not feel involved in discharge planning

When discharge and care needs were being planned did you feel you were consulted or involved?



Did the social worker from the hospital make contact/give you their phone number?



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For those receiving paid-for care, involvement was not guaranteed

There was a good plan set up based on the help I could also give

Did you feel consulted or involved?

	Existing care	New care
Included	8	10
Neither/nor	2	4
Excluded	10	12

Did the social worker make contact?

	Existing care	New care
Yes	7	14
No	13	13

The social worker gave the impression that they just wanted to send him home regardless of whether he could look after himself. The family were made to feel guilty that we couldn't provide the 24/7 care he needed. We had to fight to get him transferred from hospital to respite in a care home (he was 92 years old)

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There is confusion over ‘who is who’ - revealed in the depth interviews

Most of our respondents have NO previous experience of funded social care

- No knowledge of ‘process’
- Confusion over job roles and job titles
- No face-to-face meetings during Covid – mostly unscheduled, unexpected phone calls

Inconsistency in who was communicating with who/multiple communications

- finance, “discharge lady”, OT, consultant, doctor, nurse
- patient, carer, other family members

Carer naivety makes it hard to establish whether correct processes were followed for our respondents

Most carers were not able to speak to the patient before being discharged about their discharge destination

Did you have the opportunity to speak to the person you care for before they were discharged about where they were being discharged to, and to make sure this was the right decision?

	Total sample	New care
Yes	40%	8
No	60%	19

- Most returned to their original home
- Some of those moving to residential care lacked capacity

BUT

- instances where communication was not enabled
  - *"Covid restrictions so no visiting, lost hearing aids so no phoning"*
  - *"He was transferred to a cottage hospital for two days then to the care home. We couldn't speak to him until he arrived at the care home"*

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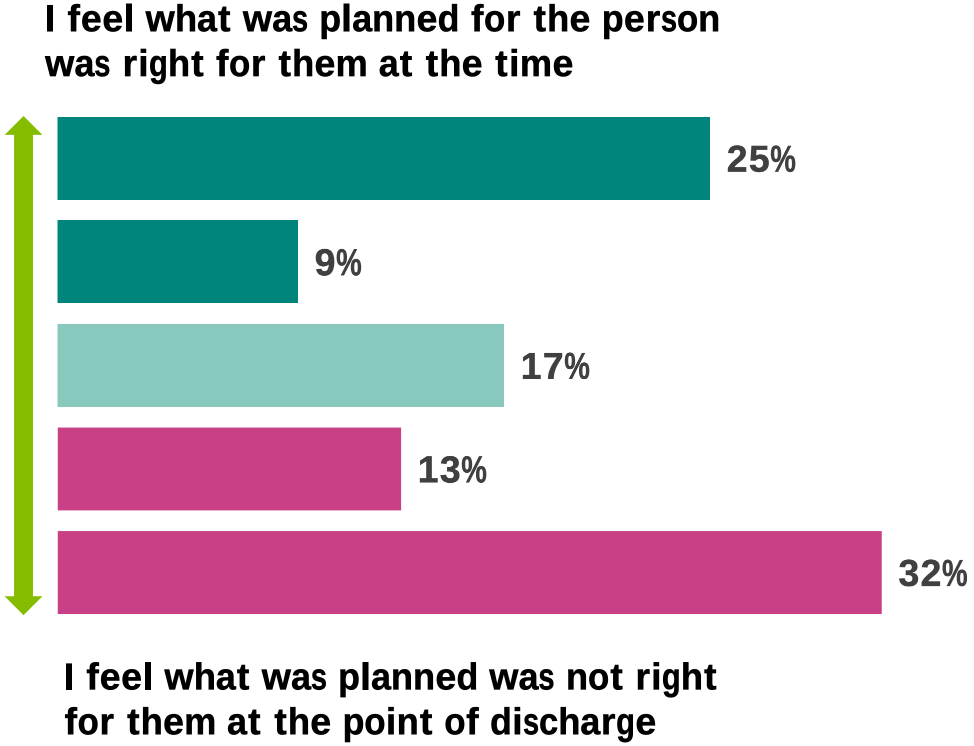
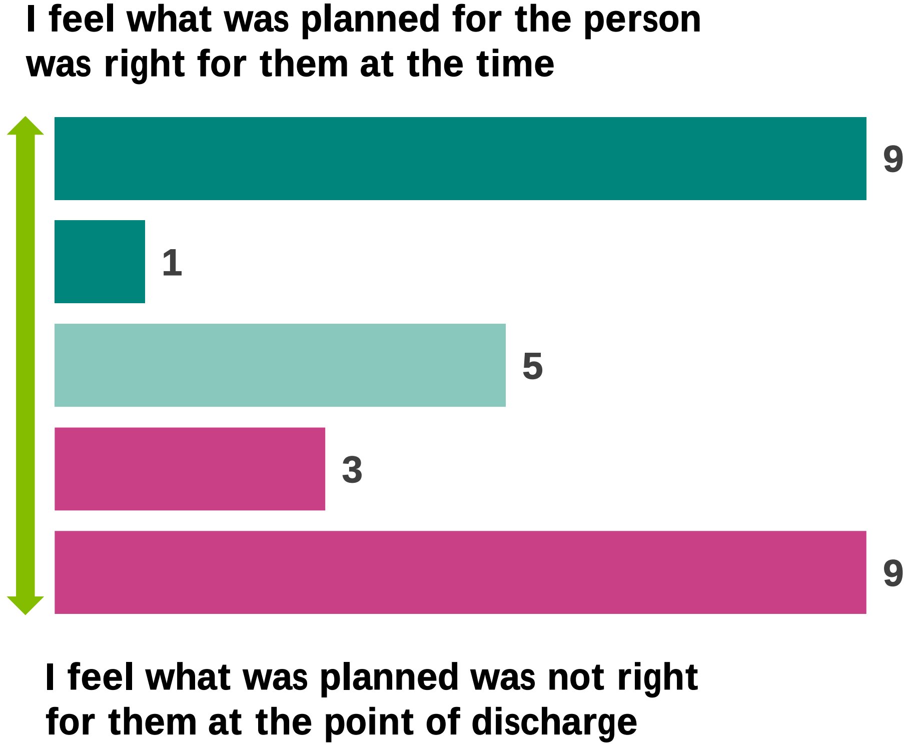
Only 1/3 of our respondents felt the discharge plans were right

Total Sample



Discharged to new paid for care



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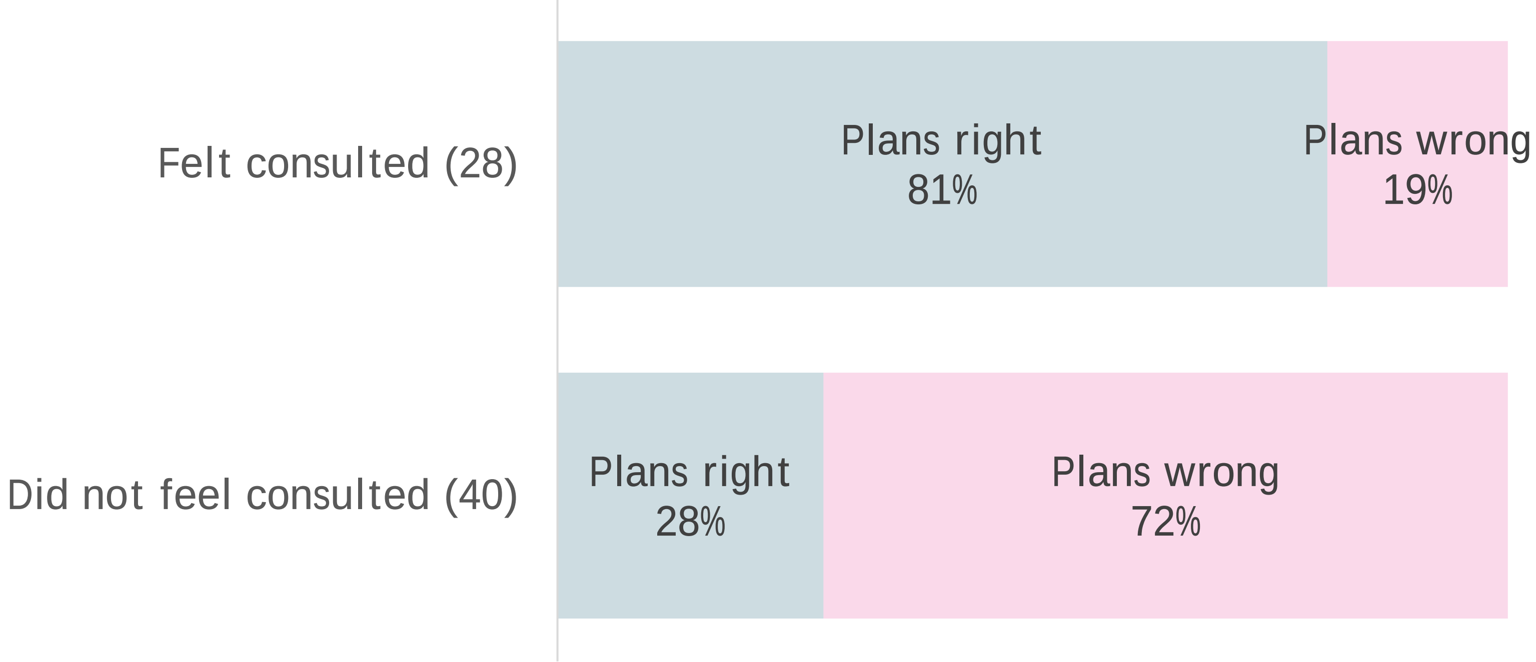
There is a strong link between feeling consulted and confidence in the discharge plans

4/5 of those who felt consulted also felt the discharge plans were right: only 1/4 of those who felt left out also felt the plans were right



What do ‘right’ and ‘wrong’ look like?

Right

- Felt involved and supported
  - *“It was really comprehensive. Very supportive including all the equipment”*
- Good communication
  - *“The care team was set in place & they communicated very well with the family”*
- Safe discharge
  - *“Made sure it was safe to go home”*

Wrong

- Patient not fit for discharge
  - *“Patient was readmitted by ambulance later the same day”*
- Inadequate planning/communication
  - *“it was totally unplanned, inappropriate and risky. It also was decided with no patient or carer input. It felt like they were trying to clear beds before the bank holiday.”*
- Inadequate care (clinical, social) at home
  - *“My sister’s deterioration on discharge was rapid due to lack of reablement and care plan”*
- Detriment to carers
  - *“I wheeled her to my car and took her home. Then realised I could not possibly leave her to get back to my own family”*

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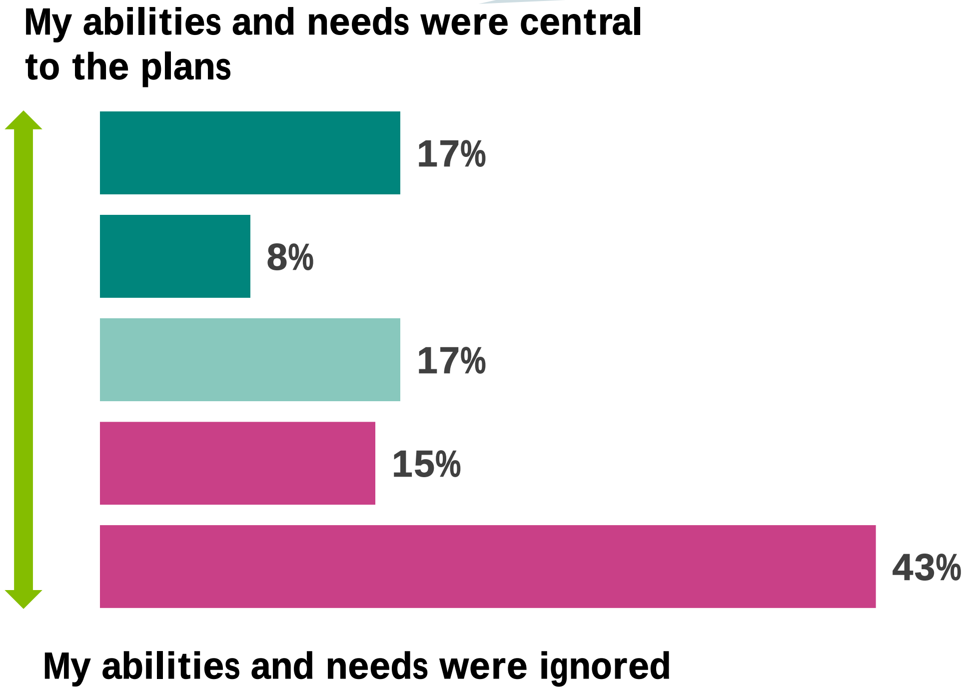
Discharge Planning/Carer Perspective - key points

- While there has clearly been good consultation and communication for some carers, more in our sample had felt excluded
- There is a strong link between exclusion from planning and concern about the discharge plan
- Carers do not know the hospital discharge/assessment process
- They often have no previous experience; no hospital visiting → reduced opportunity to learn from staff/peer visitors; none of our sample reported receiving any information or guidance on the discharge/assessment process
- Carers are unable to assess the quality/appropriateness of the discharge or identify process failures

SUPPORTING THE CARER

More of our carers felt their abilities and needs were not considered

The option of him coming back to live at home was discussed but I felt at the time that I could no longer cope with him at home

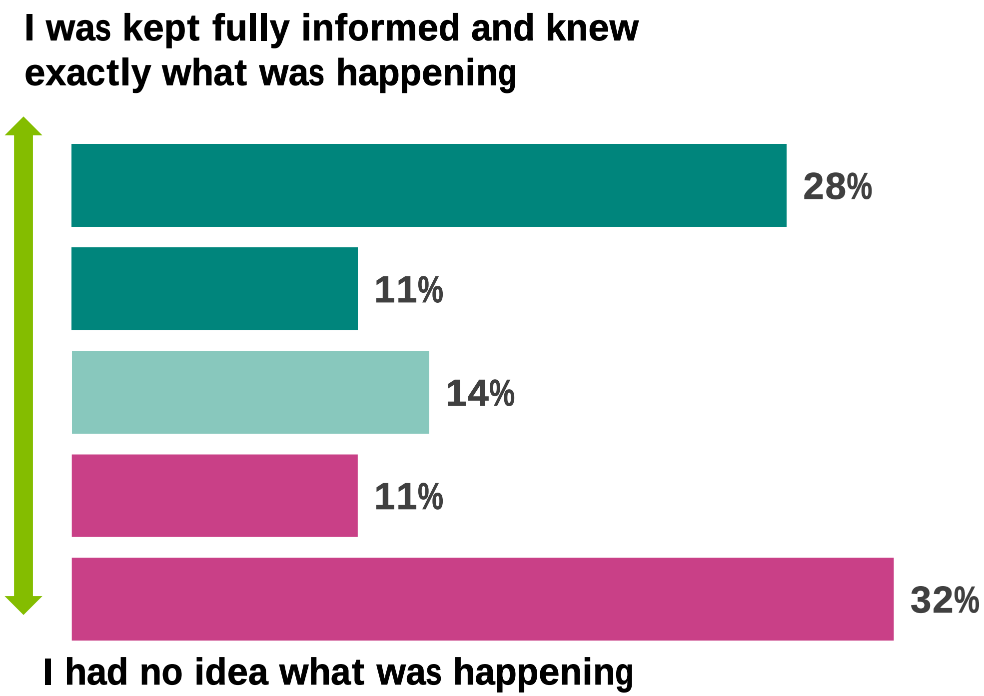


Were you asked if you felt able to manage the care that would be expected of you?

	Total sample	New care
Yes	25%	10
No	75%	17

I'm expected to carry on as usual

Communication about the discharge is a more balanced picture



Did you have enough time to make the arrangements?

	Total sample	New care
Yes	60%	18
No	40%	8

No, it was very much a case of us calling the hospital on Wednesday night to be told my Mum would be home either Thursday or Friday depending on availability of district nurses but hospital would do best to let us know. Got told late Thursday morning she was coming home Thursday afternoon

Only a minority of carers were signposted to support

Were you signposted to any support?

	Total sample	Existing care	New care
Yes - A4C	15%	3	6
Yes – other	22%	3	4
No	67%	14	18

Reablement team
Stroke team
Mental health services and charities
PALS
Palliative care

And many carers were left feeling unsupported after discharge

Now they have been discharged do you feel you have all the support you need?

	Total sample	Existing care	New care
Yes	33%	5	9
No	67%	13	17

It's all been Do It Yourself

I am very stressed and worried about how my family will cope whilst I am at work. I have not had any support myself personally - most of it has been to help my wife. I feel I need some counselling to talk things through as I am depressed

Arrangements for self-funded care

- Two of our depth interview sample were carers of patients with savings who had been admitted with no social care and discharged with new care needs
- Neither carer had been offered any advice or support in accessing care:

"We received a phone call regarding financial assessment but ***as my mother has savings I was told there was nothing they could offer****. I said I was prepared to pay for help but needed help in finding care workers who would come to the house" (she was NOT offered help in finding carers)*

I kept being told there would be a plan but it never seemed to happen. ***I gave up and arranged a self funding place in a nursing home…****I tried to find out what her needs would be I asked if a doctor could phone me but that didn't happen…I felt there was no support and no information, I felt I had to organise everything to make sure she would be looked after properly"*

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Carer consideration - key points

While we did hear some good practice, many carers felt taken for granted and were struggling to manage the care they were expected to deliver

- Their needs and abilities not taken into account with care planning
- Assumed they will be able to respond whatever the timing or decisions made
- Not signposted to support organisations

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DISCHARGE AND HOME SUPPORT

Over half our respondents did not feel the patient was ready for discharge

Did you feel they were well enough to be discharged?

My mother was hallucinating and was terrified and confused.

3 days post op. Now unable to stand and mobilise (she was extremely fit she went in).

Next day the GP queried his discharge as he was unresponsive and not eating or drinking

If no, why do you say that?

They had not improved/treatment not complete	*19/35*
Proven unsafe when home	*6/35*
Failed discharge	*5/35*
Care plan not in place	*4/35*
Burden on carer	*2/35*

Most of those discharged were clean and well cared for

	Total sample
Clean and well cared for	65%
New pressure sores	7%

“Other” comments (numbers)

Patient clearly unwell	*6*
Unwashed and uncared for	*4*
Missing possessions	*2*

Most came home with appropriate medication and discharge letter

	Yes %	No %	Na %
All the **medication** they needed	82	12	6
Enough **information** for **medication** to be safely given	75	15	7
Came home with **appropriate paperwork**, eg discharge letter	70	26	2
New **equipment** they needed	26	26	47
Referral to **continence** team/provided with appropriate supplies	9	43	48

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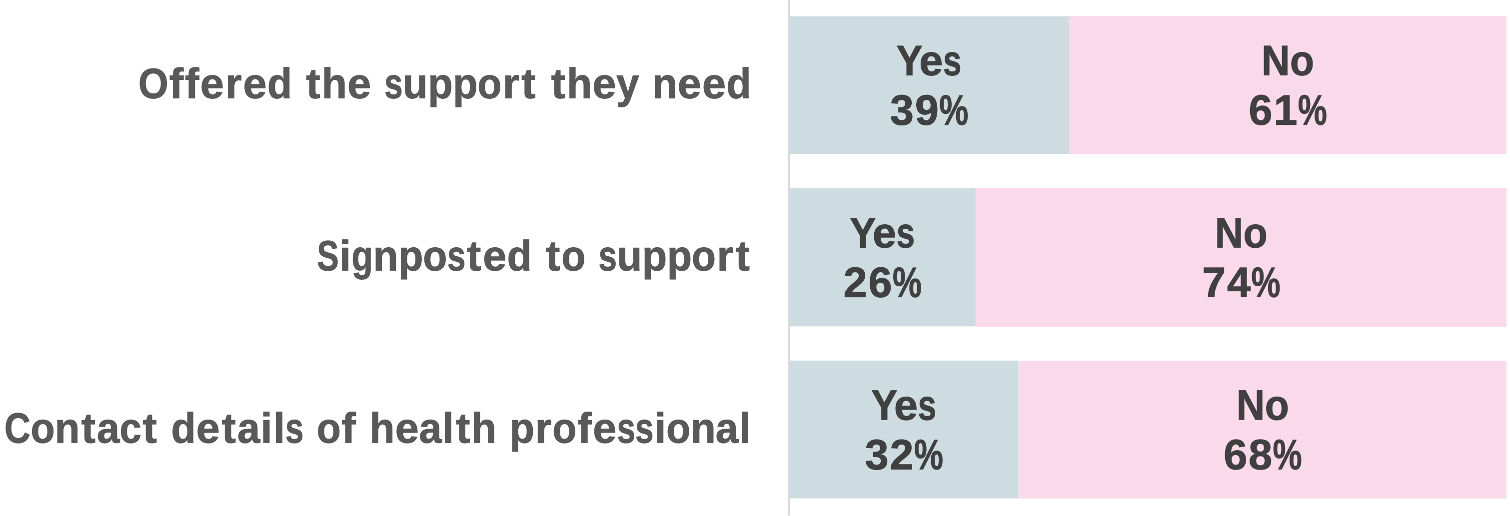
Many of the patients had been left without support or signposting



Have they been signposted to support?

- palliative/hospice, social care, community mental health

Have they been offered the support they need?

- None offered; district nurse team hard to access; continence support needed

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A minority have outstanding referrals and health assessments

Referrals

Outstanding referrals	37%
None needed	29%
All referrals made	34%

% waiting for:

CHC assessment	29%
Financial assessment	21%
Home OH assessment	25%

The occupational health assessment has helped massively as they have put aids in place so that my wife can manage more independently when her mobility declines following a seizure. Action for carers moving and handling team assessment also helped with small aids.1w2

The equipment required took 8 weeks to arrive. Help and support with managing seating was ignored told to look on the internet and make what ever purchases I felt

Is the D2A process being followed?

	Total sample	Existing care	New care
They had a care needs assessment within a day or two of being discharged	9%	2	3
They had an assessment for longer term care needs within 6 weeks of being discharged	19%	6	9
They have not had any assessments for care needs since leaving hospital	49%	6	10
Other (patient died, self-funding, patient in residential care + general comments)	30%	8	8

- Theoretically all patients with new care needs should have had an immediate reassessment and a second assessment within 6 weeks

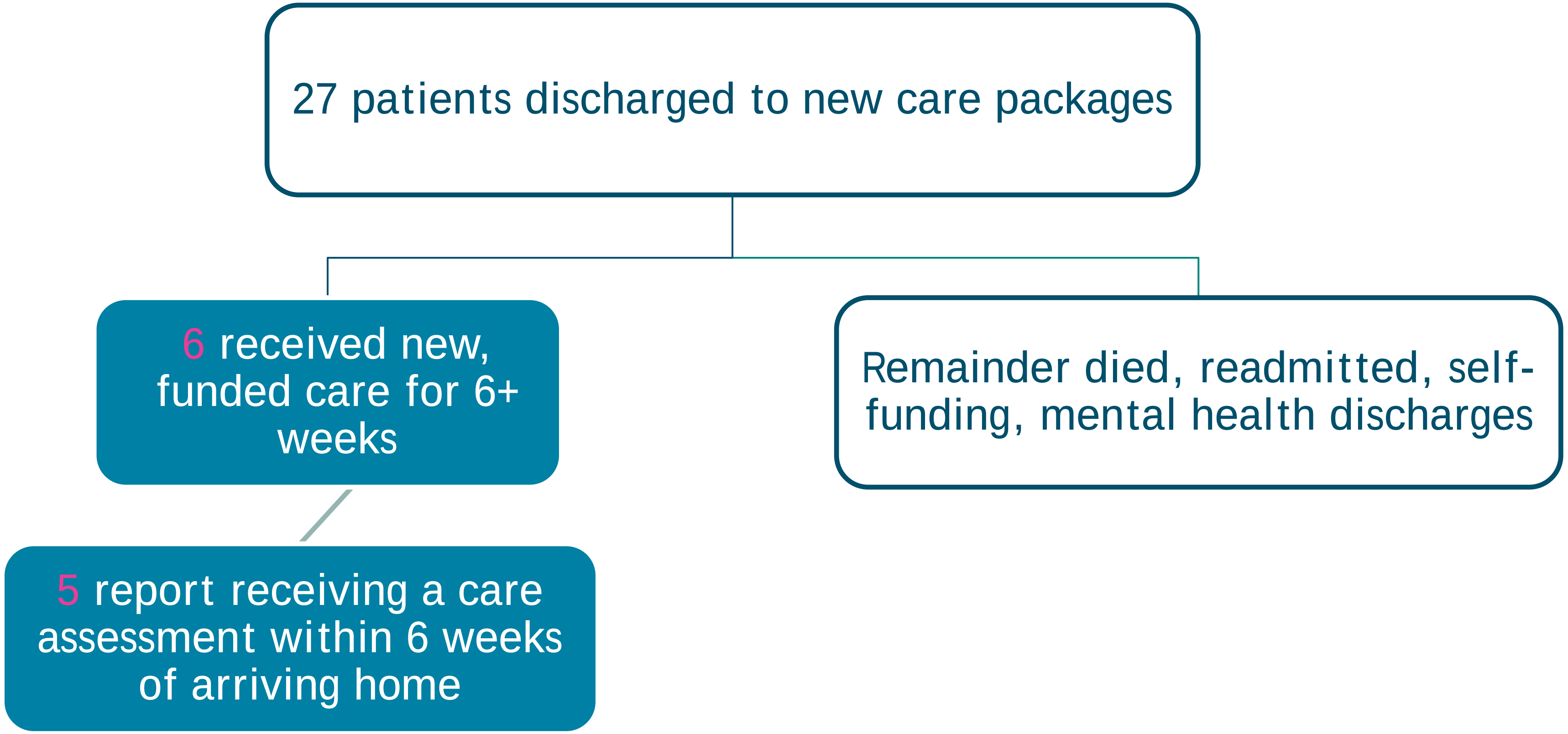
BUT

- the picture is muddied by self-funders, patients who have died, mental health discharges, carer status

AND

- carer naivety

The sub-sample of identifiable D2A respondents is small but they do appear to have received follow-up assessments



27 patients discharged to new care packages

6 received new, funded care for 6+ weeks

5 report receiving a care assessment within 6 weeks of arriving home

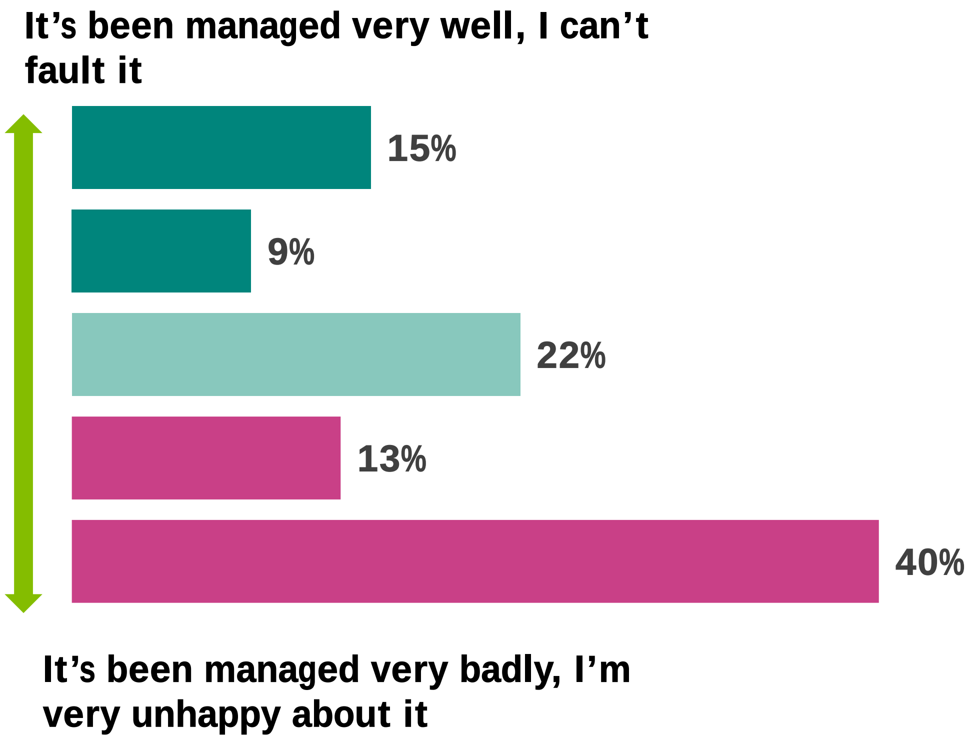
Remainder died, readmitted, self-funding, mental health discharges

The patient at discharge - key points

- Around half our carers felt the patient was not ready for discharge
  - For the most part these had expected or hoped the patient would be discharged in a better state of health: that the **hospital could/should have done more for the patient**
  - Many had not seen the patient since admission so had **no forewarning of the patient's condition** on discharge
- Only a handful of patients showed evidence of poor personal care in hospital
- But most had not been signposted to healthcare or support services post-discharge
- A minority have outstanding referrals and non-care related assessments
- Assessing D2A is difficult – our small sample seem to have received follow up assessments, either fast turnaround or within 6 weeks

Summing up

Overall, how well do you feel the whole process has been managed – planning, the discharge itself, support after discharge?



The discharge planning was faultless. The home assessment was thorough and my mother has all the equipment and fittings - bed included - to help her

I work in the NHS myself and I totally feel abandoned by my colleagues who I work with

Consequences

Has the quality of the whole discharge process had any effect on the health and wellbeing of the person you care for, or on you?

- Generally good outcome 10%

- Stress for the carer 34%
- Patient detriment 25%

This is an impressive part of the NHS. I am proud at the excellence of the discharge team for making it so.

Dad has recovered eventually from the experience but it was dreadful

Not sleeping, exhausted, depressed, unable to concentrate when at work, find myself daydreaming with everything I have to do, overwhelmed, worried

It has been a good experience, changed alot of things for the positive

The change of tablets and side effects made aunt feel poorly. Lack of hearing made her feel depressed as she couldn't interact with people or listen to tv.

We have both deteriorated since discharge.

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Summary

- Good communication from hospital (ward and discharge team) to carers enables accurate diagnosis, effective treatment and care, and safe, secure discharge.
- During Covid, when carers and A4C support staff could not visit wards, the established face to face real-time communication routes were cut off and new methods needed to be found.
- Some of those choosing to respond to this survey had excellent experiences – proactive communication, inclusion in decisionmaking, and timely provision of support.
- However, many more experienced poor communication from ward and discharge teams, and we have clear examples of how this resulted in actual harm to patients, and contributed to carer burnout.
- Some respondents also reported slow or poor support after discharge – delays to assessments, slow access to services and poor signposting.
- The role of D2A for our respondents is unclear – as a process it is invisible to carers, and not all our respondents would have had a care needs assessment. There is no evidence that D2A is better or worse than other discharge approaches.
- **However, there is a clear message that while discharge can be safe and timely, many discharges are not meeting the needs of patients or carers. As a consequence patients and carers are struggling, ultimately putting pressure back onto the already overstretched system.**

Contact information

www.healthwatchsurrey.co.uk

Healthwatch Surrey is an independent organisation which gives people in Surrey a strong voice to help improve, shape and get the best from local health and social care services.

https://www.actionforcarers.org.uk

Our vision is to enable all of Surrey's (unpaid) carers to have a voice, and access support to improve their quality of life and wellbeing.

The questionnaire can be seen here.

For more information about this survey please contact tessa.weaver@healthwatchsurrey.co.uk