

Project Rationale

This project was initiated to investigate the experience of the Discharge to Assess (D2A) processes introduced during the pandemic, from the perspective of carers of those admitted to hospital. Our aim was that the insight gathered would guide development and implementation of the D2A programme to maximise safe, successful hospital discharges.

However, because discharge planning starts at the point of admission the project needed to cover the patient journey from ward through discharge planning and discharge.

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

Dual methodology

- Questionnaire widely distributed through partners, groups, social media
- One-to-one depth interviews by phone/video among a subsample of those responding to the questionnaire
- Interviews related to discharges between Summer 2020 and Spring 2021

Sample

- **Opt-in, self-selected sample: it is not representative of all hospital discharges and inevitably is biased towards negative experiences.**
- 78 responses to the questionnaire
- Self-defined carers: 50% caring for parent; 25% for spouse
- Almost all patients were emergency admissions by ambulance
- All local acute trusts represented
- 12 depth interviews selected to gather a wide range of experiences

On the ward

- 57% said there was poor communication between ward and carer
- Evidence of clinical impact, compromised decisionmaking and stress as a result
- *Medication missed resulting in patient experiencing "a massive seizure" and suffering aspiration pneumonia*
- *"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"*
- *"Patient extremely distressed as he did not know what was happening"*
- Some gold standard experiences
- *"One Doctor was excellent and phoned several times"*

Discharge planning

- 74% had no contact from social workers during discharge planning
- 72% were not asked if they could manage patient post-discharge
- 56% did not feel consulted
- Confusing communications
- *"I was being told by a nurse my father was very ill and would be in hospital over Christmas. At the same time a Dr was on the phone to my mother saying dad could come home."*
- Most carers had no previous experience of discharge – unaware of what the process is, who they should be talking to, what to expect
- Those who told us they felt consulted were more likely to feel the discharge plans were right – and vice versa

Carer Support

- 58% said they felt their abilities and needs were ignored
- Only 25% were asked if they could manage the care that would be expected of them
- 67% said they felt they did not have all the support they needed after discharge
- *"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)*

Discharge and home support

- Most came home with medication and paperwork; 1/3 had outstanding referrals
- Nearly all came home clean and well cared for
- 54% of carers felt the patient was not well enough to be discharged
- *"she was still hallucinating"*
- 68% did not have contact details of a health professional
- 74% had not been signposted to support
- Hard to ascertain whether D2A had been followed – lack of understanding; readmissions, deaths, carer status

Conclusions

- **Poor discharges can have serious consequences** for patients and carers alike
- **Carer recognition remains an issue** – staff, patients and carers themselves may fail to recognise their role
- **Carers are often at a serious disadvantage** trying to navigate discharge and negotiate a fair, safe discharge – they have no experience or knowledge, don't understand the processes or job titles, and so are unable to quality-check the discharge
- **Weak points can occur all through the patient's journey**
 - Poor communication between ward and carer during treatment
 - Poor inclusion in discharge planning
 - Poor post-discharge support and signposting
- **Good discharges can happen:** despite the pressures of the pandemic some people shared experiences of safe, collaborative, enabling discharges where the D2A process had worked to the benefit of all

Recommendations

1. **Carer identification and key contact identification.**
Work to reveal patients' unacknowledged carers
Focus communication through a single point of contact where possible
2. **Review processes and practices relating to hospital-carer communications – how do wards/teams contact carers?**
Consider codesign of communication pathways with patients and carers
3. **Explain the discharge process to carers: include job titles and named staff**
Consider codesign of a guide for inpatients/carers
4. **Think HANDOVER, not 'discharge'**
Provide a professional, efficient HANDOVER of the patient to the carer

Please use this QR code or <https://www.healthwatchsurrey.co.uk/our-work/reports-and-papers/project-reports/> to access the full report
Patient experience videos are at <https://youtu.be/n7QaeR3MDuc> and <https://youtu.be/NEKchHgsShw>

For more information, please contact research@healthwatchsurrey.co.uk or call us on 01483 301448

