HAVERING
LINk

IMPROVING THE PROVISION OF HOSPITAL DISCHARGE IN THE LONDON BOROUGH OF HAVERING

A REPORT BY

HAVERING LOCAL INVOLVEMENT NETWORK
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INTRODUCTION

Havering Local Involvement Network (LINk) is a network of voluntary individuals, local people and community groups who work together to improve local health and social care services. It was set up to give local communities a stronger voice in how their health and social care services are delivered.

LINks were introduced under the Local Government and Public Involvement in Health Act 2007.

Havering LINk:

- Asks local people what they think of local health and social care and suggest improvements directly to the service providers
- Looks into specific issues (like reports of a dirty hospital or the proposed closure of a care home) makes recommendations and gets a response from decision makers
- Asks service providers for information and gets answers in a specified time
- Is able to carry out spot checks and visits to see if services are working well (checks are carried out under safeguards)
- Can refer issues to the Council's Overview and Scrutiny Committees if it seems action is not being taken

Why We Investigated Hospital Discharge

As a result of a survey carried out by Havering LINk and issues raised by the public and LINk members concern has grown that there appear to be gaps in the process of hospital discharge in the borough. The LINk is of the strong opinion that the process of discharge from a hospital can for some people be a trying time. Patients may need extra support when leaving a hospital which can involve making changes in their homes for improved accessibility and greater ease of physical movement as well as the practical support required due to the change in the person's circumstances.

For these reasons the LINk set up a Patient Discharge Sub Group last year and over a period of 18 months, the LINk has met with many different service providers. These are listed overleaf

- London Borough of Havering Adult Social Care, Hospital Discharge Team
- Patient Discharge Team, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
- Saint Francis Hospice
- Directorate of Workforce and Transformation, NHS Outer North East London
- Havering Direct, London Borough of Havering
- Rehabilitation Service, London Borough of Havering,
- Chief Pharmacist, BHRUT
- Logistics Procurement (Transport) BHRUT
- District Nursing Service, NHS Outer North East London
- Feedback from the public, LINk members and care homes

Recommendations:

To BHRUT

- 1.1 The current process of completing the two main pieces of discharge paperwork simultaneously ("section 2" and "section 5") should be discontinued. Section 5 should only be completed when the date the patient is to be discharged has been agreed
- 1.2 An advocacy centre should be introduced at Queen's Hospital
- 1.3 More use should be made of the voluntary sector to assist where appropriate with patient discharge
- 1.4 BHRUT and NHS ONEL should work together to ensure the greater availability of rehab beds and hence reduce delays to discharge
- 1.5 The inclusion of "awaiting rehabilitation beds" as a reason for delayed discharge should be scrapped; those in rehabilitation beds should be separate from the main list
- 1.6 The Health Needs Assessment form should be shortened and in the case of a patient needing a third party to act for them the ward should have the name of an appropriate adult/advocate
- 1.7 Paperwork to discharge patients to be started earlier, in order that care plans are finalised in advance and not on the day of release
- 4.2 Elderly or vulnerable patients should not be discharged after 6pm other than in exceptional circumstances
- 4.3 Patients and their families/advocates must be informed in good time when they are to be discharged
- 5.1 "To Take Away" (TTA) prescribed drug forms to be completed on the ward, preferably a minimum of 24 hours before discharge
- 5.2 The installation of the new pharmacy software should be completed as a matter of priority
- 5.3 The medication order should be timed and dated in order to streamline the discharge process
- 5.4 The "Green Bag" system for storing prescribed medicines should be publicised more and the Trust should work with charitable organisations on this subject. Ambulance staff should be encouraged to ask a patient if they have the bag on their person
- 5.5 Relevant supplies of drugs should always be available and should be stored on the ward as seen in the Paediatric and Gynaecology wards
- 5.6 More nurses and technicians should be trained to prescribe to enable them to complete the "To Take Away" TTA forms
- 8.3 Any medication given prior to discharge should be noted on the discharge form with the time and date clearly visible particularly for prescribed medication such as Clexane or Insulin
- 8.4 Correct medication to be dispensed with the patient on discharge

- 8.5 All discharge letters should be clearly written and given to the patient on discharge. Any faxed copies must also be fully legible
- 8.6 There should be more liaison between hospital transport and discharge staff to ensure that District Nurses are kept up to date about the date of a patient's discharge

<u>To North East London NHS Foundation Trust/North East London Community Services (NELFT/ NELCS)</u>

- 1.8 Occupational Therapists should carry out home visits in order to speed up the process whereby a patient's needs can be quickly identified
- 8.1 The District Nurse Team should always be invited to multi-disciplinary discharge meetings
- 8.2 An independent discharge co-ordinator be put in place in order to improve communication between the various parties involved in patient discharge
- 8.3 Any medication given prior to discharge should be noted on the discharge form with the time and date clearly visible particularly for prescribed medications such as Clexane or Insulin
- 8.7 A sticker should be placed on the Patient Held Records such as "do not remove from the patient's home"

<u>To the London Borough of Havering</u>

- 2.1 All care homes commissioned by the Council should not expect care home staff to attend training sessions in their own time and all training should be mandatory
- 2.2. Commissioners should ensure more effective training of care home staff in order that inappropriate admissions to Accident and Emergency are reduced
- 4.1 The utilisation of day centres, where community rooms are not used should be explored. This could enable Occupational Therapy to be carried out and support to be offered
- 6.2 In order to improve rehabilitation and hence smooth the discharge process, more use should be made of interim beds as a step down from hospital admission

To NHS Outer North East London

- 1.3 More use should be made of the voluntary sector to assist where appropriate with patient discharge
- 1.4 BHRUT and NHS ONEL should work together to ensure the greater availability of rehab beds and hence reduce delays to discharge
- 6.1 A common language should be used to describe blister packs/dossets
- 5.4 To NHS ONEL and The London Ambulance Service:The "Green Bag" system for storing prescribed medicines should be publicised more

The Findings of the LINk

1: How the hospital discharge process works:

There is a protocol process in place which was established under the Community Care Act of 2005. Section 2 of the Act states that there has to be official notification from the Hospital Trust that a patient may need social services support to enable the patient be discharged. This information comes from the ward under the proviso that the patient has agreed to see social services. A care package is then put in place i.e. if a patient needed residential care/nursing home equipment; this process is initiated as soon as possible, preferably on admission.

At BHRUT both Section 2 and Section 5 are served simultaneously which can cause problems (see recommendation 1.1) Pressure is placed on the hospital discharge team if the criteria are not met and this leads to delayed discharge. Monetary penalties are placed on the Trust or Council depending on who is considered to be responsible. The LINk feels that if there was an advocacy centre in the hospitals whereby a third party is employed in order to streamline the process of discharge, this would assist matters (see recommendation 1.2) Exploring using the voluntary sector more in patient discharge would also assist the process (see recommendation 1.3).

The LINk were advised by staff spoken to that it would be more economically viable to work with NHS ONEL, as sometimes rehabilitation beds are not available at the NHS and this can cause delays (see recommendation 1.4). The Hospital Trust includes "awaiting rehabilitation beds" as a reason for delayed discharge and it appears this is the only Trust in the country to do this (see recommendation 1.5).

Senior staff were of the view that community based services should deal with repeat admissions who do not need hospital treatment. The GP should be the first port of call for patients of this type. Interim beds at St George's Hospital are slow stream and less intensive. The number of rehabilitation wards has

been reduced. This causes problems as patients should not have to wait for rehabilitation beds.

It was established during discussions that families or advocates are required to sign a health needs assessment form and this can be as long as 80 pages (see recommendation 1.6)

The delayed discharge sheet for the week has to finalised by midnight on Thursdays and the department is called to account every week, placing enormous pressure on the patient discharge department. Targets have now been scrapped by the Government. Financial rewards for meeting the targets have been removed but if the targets are not met the fines remain in place. Delays can be attributed to other hospitals or families being on holiday and not being able to sign the relevant paper work (see recommendation 1.7).

In the opinion of senior managers, the process of co-operation with care homes in the borough is lacking. Sometimes the hospitals have to wait some 3 or 4 days before the Care Home Manager would complete the Discharge Assessment Form. Occupational Therapists do not usually carry out home visits despite it being the role of Occupational Therapists to determine what the care needs of a patient are (see recommendation 1.8).

Some delays to hospital discharge are caused by:

- The NHS not having enough rehab beds
- Lack of the correct equipment for the patient at home
- Lack of liaison with relatives
- Care package not completed in time
- The reports of Occupational Therapists not being sent to Social Services
- Nursing homes not signing the discharge forms
- Urine infections not being investigated properly and in some cases hence incorrect diagnosis of dementia when symptoms are caused by other conditions such as dehydration

Recommendations

- 1.1 To BHRUT: The current process of completing the two main pieces of discharge paperwork simultaneously (“Section 2” and “Section 5”) should be discontinued. Section 5 should only be completed when the date the patient is to be discharged has been agreed
- 1.2 To all service providers: An advocacy centre should be introduced at Queen’s Hospital
- 1.3 To all service providers: More use should be made of the voluntary sector to assist where appropriate with patient discharge
- 1.4 BHRUT and NHS ONEL should work together to ensure the greater availability of rehab beds and hence reduce delays to discharge
- 1.5 To BHRUT: The inclusion of “awaiting rehabilitation beds” as a reason for delayed discharge should be scrapped; those in rehabilitation beds should be separate from the main list

- 1.6 To BHRUT: The Health Needs Assessment form should be shortened and in the case of a patient needing a third party to act for them the ward should have the name of an appropriate adult/advocate
- 1.7 To BHRUT: Paperwork to discharge patients to be started earlier, in order that care plans are finalised in advance and not on the day of release
- 1.8 To NELFT/NELCS: Occupational Therapists should carry out more home visits in order to speed up the process whereby a patient's needs can be quickly identified

2: The Hospice Sector

In the opinion of a senior clinician at the local hospice it is preferable that those close to death stay in the care/nursing home rather than be admitted to Accident & Emergency. Staff in care homes are expected to attend training courses in their own time and attendance at such courses on preventing hospital admission has been poor (see recommendation 2.1).

The local hospice has encouraged the providers to work in partnership with care homes identifying what patients' needs are but in the opinion of senior clinicians this does not happen in Havering. It is hoped that introducing this way of working would lead to fewer unnecessary admissions to A&E (see recommendation 2.2).

Recommendations

- 2.1 To The London Borough of Havering: All care homes commissioned by the Council should not expect care home staff to attend training sessions in their own time and all training should be mandatory
- 2.2 To The London Borough of Havering and NHS ONEL: Commissioners should ensure more effective training of care home staff in order that inappropriate admissions to A&E are reduced

3 The Primary Care Sector (NHS ONEL)

In the opinion of senior officers at the cluster Primary Care Trust, GPs in each borough should do checks on the elderly who are on their lists. In Havering it would appear that this is not the case and in the opinion of senior staff all patients especially the elderly should be assessed as to their fitness levels. There should be a single point of access where people go to for advice and guidance. Havering LINk was given the example of Age Concern, Waltham Forest linking up with two GP practices each year. A joint letter and questionnaire is sent to those patients over the age of 65. Assessments are undertaken, for example if someone requires a rail for access to their garden. This practice has proved to be more productive and quicker than their local social services and the GPs involved have said that the experience was useful and effective. All information gathered is sent to the GP practices and this enables the GP to be aware of those patients on their list aged over 65 who are frail or vulnerable.

Senior staff from NHS ONEL were of the opinion that the London Ambulance Service is too often called out by care/nursing homes for patients who are dying and who have expressed a wish to die in the care home which is their place of residence. Training of London Ambulance Service crews/staff is being carried out on this subject but a less intensive team from the Ambulance Service is needed to support the patient and their family. The LINk feels families and next of kin need to be educated. Care home staff should be able to ensure that patients can choose where they wish to die. Treatment for patients from care/nursing homes can in some cases can be carried out in their place of residence. It is also costly for a patient to be treated in A&E but there are often times when a patient is admitted needlessly with de-hydration or urine infections. The utilisation of District Nurses should also be explored more (see recommendation 2.2).

A view repeatedly expressed to the LINk is that the various health providers should work more closely with charities in order that there is one point of contact that the next of kin can access and that an independent advocacy centre should be set up (see recommendations 1.2. and 1.3).

4: London Borough of Havering Adult Social Care

Senior practitioners are of the opinion that there is a lack of communication between all the teams involved in patient discharge which emphasises the importance of having a central point of call.

The issuing of the Section 5 Hospital Discharge Notice was again cited as a problem. There is not enough time for the Council's social care team to facilitate discharge following the issuing of this Section by hospital staff. Sometimes it is served the day before the team has been informed that the patient in question is going to be discharged. This does not allow enough time for discharge planning (see recommendation 1.1).

Social care officers felt that doctors should carry out home visits when required. The main aim is to keep the patients in their own home and if communication was improved with GPs then this would help facilitate the discharge process.

Outside the borough there are facilities available where a patient can be observed. The patient undergoes tests and this stops the unnecessary and sometimes unpleasant practice of sending them to A&E. There was such a facility available in Havering at St George's Hospital but this is now unavailable.

The possibility of having one main point of contact where all the checks for patient discharge can be confirmed as completed was also supported by Council Staff. There have been cases where an elderly patient has been discharged late at night on a Friday and told to contact the social services

team on Monday morning. If there was a main point of contact this would counteract such a dilemma for the patient (see recommendation 1.2).

Once a patient is at home there should be support from Health and Social Care. For example a facility in day centres where occupational therapy could be carried out. Physical training could be given which would offer the chance for a person to socialise and carry out light exercise. This facility should not just be offered to the elderly but to any vulnerable patients receiving support from health and social care (see recommendation 4.1).

There have also been detrimental reports about patient transport in the borough, some patients not being settled in well after discharge or being kept waiting for transport for some hours (see recommendation 4.2).

There have been reports that some wards do not inform the patient’s family or even the patient themselves that they are to be discharged. In the opinion of senior hospital staff at least 20% of discharges encounter difficulties and these figures need to be examined (see recommendation 4.3).

Recommendations:

- 4.1 To the London Borough of Havering: The utilisation of day centres, where community rooms are not used should be explored. This could enable Occupational Therapy to be carried out and support offered
- 4.2 To BHRUT: Elderly or vulnerable patients should not be discharged after 6pm other than in exceptional circumstances
- 4.3 To BHRUT: Patients and their families/advocates must be informed in good time when they are to be discharged

5: Pharmacy Issues

The Pharmacy department encounters problems with the “To Take Away” (TTA) Forms. These forms are completed by the hospital consultants and their teams. The forms enable the patient to be discharged in a timely fashion. In the opinion of the pharmacist the TTAs should be completed on the day before discharge but this is not usually the case. Sometimes patients are waiting 4 or 5 hours for their medication. The majority of prescriptions are written by junior doctors who can make mistakes. The doctors need to be encouraged to write the TTA from earlier, preferably the day before as this enables the prescriptions to be checked if needed (see recommendation 5.1).

When a patient is admitted for planned surgery the date of the admittance is usually known and there are not usually too many problems. There are problems however particularly in acute medicine and care of the elderly wards. Very few are sent home on a sudden decision and this is usually taken the day before discharge.

The Trust is in the process of changing the practice of the pharmacist endorsing prescriptions on the wards. Every morning new admissions will be examined (these take the longest time to process as the history of the patient must be scrutinised). There are plans to have two teams in place, one team to examine new admissions and the other team to cover all other prescriptions.

Once the doctor completes the prescription the form goes to the pharmacy either by an airpod or if the pharmacist is on the ward it is taken down manually. This medication order is not timed. There is a software package available which enables the ward to track the prescription as well as the pharmacist being able to input details (see recommendations 5.2 and 5.3).

There is a policy in place that if a patient has hospital transport or has made arrangements to be collected then that patient's prescriptions are marked as urgent and the pharmacy telephones the ward when the form is ready. The aim is to complete the urgent forms within two hours but this can place huge pressure on the pharmacy unit.

It is not formally recorded how the prescription form has left the ward. If mistakes have been identified then the relevant doctor has to be located which can take up time and there are many hundreds of doctors at the hospital prescribing medication. It was acknowledged by the Pharmacy Team that at least 50% of prescriptions that come down to the pharmacy have errors – either the wrong drug being prescribed, patients not being checked for blood clots, or allergies or pre-existing medical conditions not being considered. The pharmacy on every occasion checks with the ward as to what allergies the patient has.

It was emphasised that some of the doctors are in the early stages of training but they are supervised by consultants. Junior doctors are in the training process and are just out of medical school as is usually the case in acute hospitals. They are in their Foundation Year 1 and prescribing is a relevant part of their training. It was re-iterated that to have the forms completed 24 hours earlier would enable the entire process to be streamlined and become more efficient. There is an education programme in place whereby patients are encouraged to bring their own medicines with them when admitted. This system includes a “Green Bag” programme in partnership with the NHS and two drug companies which enables a patient to bring their medication when admitted to hospital.

The Trust has also worked with the London Ambulance Service (LAS) and they are willing to ask the patient if they have their Green Bag with them, ambulances are not allowed to carry the Green Bag to give to patients (see recommendation 5.4).

Some departments such as Paediatrics and Gynaecology have pre-packed medicines available on the ward which allows the discharge process to run more smoothly (see recommendation 5.5).

Some nurses are able to prescribe and on some wards there are transcribing technicians who are able to complete the TTA form and then get a doctor to sign it (see recommendation 5.6). There are 2 – 4 technicians at the Trust who are authorised to carry out this practice and 4 pharmacists who work a shift system covering weekends and the hours of 9am to 7pm. The hours are however reduced at weekends.

The pharmacist sees every drug chart and does query prescriptions if a possible problem is spotted. The issue is that the decision is made by the doctor just before a patient leaves and sometimes prescriptions can be changed on the point of discharge e.g. from the results of blood tests. Once again it was stressed that if the form was completed 24 hours earlier then the process of discharge would not be so long (see recommendation 5.1.).

The LINk was informed by hospital staff that consultants are encouraged to write up prescriptions in advance and some are doing so but the majority are not.

There is a new drug chart which should facilitate accelerated prescriptions, this chart will have reminders and risk assessments for clotting and other medical conditions. The risk assessment is completed when a patient is admitted.

Recommendations:

- 5.1 To BHRUT: “To Take Away” prescribed drug forms to be completed on the ward, preferably a minimum of 24 hours before discharge
- 5.2. To BHRUT: The installation of the new pharmacy software should be completed as a matter of priority
- 5.3 To BHRUT: The medication order should be timed and dated in order to streamline the discharge process
- 5.4 To BHRUT and The London Ambulance Service: The “Green Bag” system for storing prescribed medicines should be publicised more and the Trust should work with charitable organisations on this subject. Ambulance staff should be encouraged to ask a patient if they have the bag on their person
- 5.5 To BHRUT: Relevant supplies of drugs should always be available and should be stored on the ward as seen in the Paediatric and Gynaecology wards
- 5.6 To BHRUT: More nurses and technicians should be trained to prescribe to enable them to complete the “To Take Away” TTA forms

6: Reablement Issues

Royal Jubilee Court became the principal reablement centre for Havering in 2009; this centre came into being when it was identified that there is a requirement for patients, who have been discharged from hospital, that need rehabilitation before returning to their own homes. The centre provides

a service which is not met by hospitals. The scheme was set up to ease pressure on St George's Hospital and to facilitate faster hospital discharges.

The process of rehabilitation is to ensure that the patient can start to live independently. Each flat at Royal Jubilee Court has its own telephone in order for a patient to be more independent and able to use the usual help lines such as GPs, District Nurses and order a taxi etc. Food is not provided but each flat has a microwave and other kitchen utensils.

Delayed discharge from hospital can be caused because a patient is waiting for medication (see recommendation 5.3) – discharge should therefore be planned in a timely fashion. There have been reports that patients wait in the hospital discharge lounge without being offered refreshments. There also appears to be no common language for blister packs/dossets (see recommendation 6.1).

Hospital prescriptions were again raised. The delay that this can cause is enormous as a prescription will often not be written until the day of discharge (see recommendation 5.1).

There is a fear that the services provided at Royal Jubilee Court may be oversubscribed in the future. Some patients may need support while their home is being repaired or altered to meet needs. Interim beds may therefore be required at other facilities (see recommendation 6.2).

There is a Rapid Response team at Royal Jubilee Court and the facility enjoys good partnerships with HUBB, Family Mosaic, HAD, Age Concern, the Pension Service and mobile wardens.

Recommendations:

- 6.1 To NHS Outer North East London: A common language should be used to describe blister packs/dossets
- 6.2 To the London Borough of Havering: In order to improve rehabilitation and hence smooth the discharge process, more use should be made of interim beds as a step down from hospital admissions

7: Transport at BHRUT

The patient transport department is responsible for bringing to and from hospital some three to four hundred patients a day which includes out patient activity. The booking of transport takes place the previous day up to 4pm. From 4pm the planning takes place and the drivers work from 8am.

The department's criteria are based on patient's medical needs as assessed by an authorised senior clinician. The patient's GP is responsible for the first appointment but thereafter the arrangements are supposed to be made by the senior clinician. The initial assessment

relies on the patient to communicate their needs e.g. if the patient lives on the fourth floor of a block of flats. The GPs are furnished with the Trust's hospital transport booking form. This is a continuous assessment as a patient may come in for a number of specialities and some visits may not warrant hospital transport. Those patients under the age of 16 are entitled to an escort.

If a patient is coming from a care home and suffering from dementia, this will be recorded under the criteria. Under the assessment it should become apparent if a patient needs a two-man crew on the transport. If there is no escort a two-man crew should be requested by the GP/senior clinician. The care home is responsible for ensuring the patient is booked for the appointment.

The number of vehicles used by the Trust is not vast. The vehicles can take 5 to 6 people but the department has a policy where there should be a maximum of 4 patients in a vehicle.

In the past the system has come in for abuse from patients and that is one of the reasons that the GP is only responsible for the first assessment. Nurses can make assessments on out patients only.

The Trust allocates more than adequate time, especially when picking up less mobile patients. The Trust makes in excess of 80,000 patient transport journeys a year.

Some care homes will not take a patient after 5pm, others not after 9pm. From A&E discharge to a patient's own home the service is 24/7. As regards planned admittances, the Trust tries not to discharge a patient after 9pm although the LINk feels this may still be too late (see recommendation 4.2).

Recommendation

- 4.2 To BHRUT: Elderly, vulnerable patients should not be discharged after 6pm other than in exceptional circumstances

8: Havering District Nursing Service

The main role of the District Nurse is to prevent admission to hospital and improve the education of patients and families. The District Nurses are professionals who have many skills and knowledge with palliative care. They provide a 24 hours service, 365 days of the year.

They also visit patients in residential homes who have nursing needs. The district nursing team would like to see improved communication between secondary and primary care especially when patients haven complex needs

and at present the team are not always invited to multi-disciplinary discharge meetings (see recommendations 1.4 and 8.1).

Referrals to the service come via St George's Hospital and from Community Liaison based in Barking & Dagenham. Referrals from single point of access are received within office hours whereas Community Liaison referrals tend to be at the weekends. Sometimes patient discharges work very well and sometimes the process does not go smoothly. The district nurses may have a referral requesting a visit up to 4 times a day and may also have to deal with how families react. There can also be risks to the patient and staff if a discharge is not planned correctly (see recommendation 8.2).

When a patient is discharged from hospital the patient may need insulin or pain control to take home on the morning of their discharge. When the district nurse visits at 8.30am they have to check the discharge form which has been faxed to them, as the medication may not have been authorised (not signed in the relevant space) by the ward doctor (see recommendation 8.3).

There have been late referrals, when a patient has gone home but the district nurse has not been informed as the hospital staff may not have asked if the patient is "self caring". There can be problems with a late referral as the hospital may not have the medication to give to the patient who is then discharged without it. The patient may also not know how to get the help that they need at home.

The most serious concern is for a palliative care patient who may have been discharged without essential medication or who may have to wait long periods of time for their medication before they can be discharged. If a patient needs injections the district nurse has to check back to see when the patient had their last injection as it has not been recorded on the discharge form. Some discharge letters are not fully legible and given to the patient on discharge (see recommendations 8.4 and 8.5).

Senior staff cited examples where patients may be discharged without a social care package, with no food at home and with no money to hand. If an independent co-ordinator was in place then such oversights should be avoided. Also the use of charitable and voluntary organisations should help overcome this problem (see recommendations 1.2 and 1.3).

Transport for patients attending appointments may come as early as 8am but the district nurse day service does not commence until 8.30am and the night staff may have to help with insulin, medication etc. There are more staff on duty during the day.

Ambulance staff sometimes take the "Patient Held Records" with them and these records can get lost. The records should be kept in the patient's home (see recommendation 8.7). Ambulance staff should be reminded to ask patients if they have the green medication bags with them before being taken to hospital. The patient can take their own Green Bag with them but as reported above the ambulance cannot carry them (see recommendation 5.4).

There have been cases when a district nurse visits a patient at home to find the patient has gone into hospital or been discharged without notification to their service. There can also be inappropriate referrals from the hospital

such as patients who are not house bound or who are mobile and request visits or transport.

All staff are committed to providing a high quality service as all patients should have access to the same service. Staff work very hard but there is always a risk of “burn out” when resources are stretched.

Recommendations:

- 8.1 To North East London Foundation Trust/Outer North East London Community Services (NELFT/NELCS): The District Nurse Team should always be invited to multi-disciplinary discharge meetings
- 8.2 To NELFT/NELCS: An independent discharge co-ordinator to be put in place in order to improve communication between the various parties involved in patient discharge
- 8.3 To NELFT/NELCS: Any medication given prior to discharge should be noted on the discharge form with the time and date clearly visible particularly for prescribed medication such as Clexane or Insulin
- 8.4 To BHRUT: Correct medication to be dispensed with the patient on discharge
- 8.6 To BHRUT: All discharge letters should be fully legible and given to the patient on discharge
- 8.6 To BHRUT: There should be more liaison between hospital transport and discharge staff to ensure that District Nurses are kept up to date about the date of a patient’s discharge
- 8.7 To NELFT/NELCS: A sticker should be placed on the Patient Held Record such as “do not remove from the patient’s home”

Conclusion

Havering LINk would like to thank all those who gave up their valuable time to assist us with our research.

All parties that Havering LINk met with were found to be completely professional and above all caring about the patients' requirements. We hope that this report reflects this.

The LINk hopes that the report and recommendations contained within it form a positive contribution and a potential solution to the vital area of patient discharge.

The LINk will continue to work on this subject in the coming months and years and all relevant parties are welcome to contribute to this process.

For further information about Havering LINk and its work please contact:

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Appendix 1

Patients Views given to the LINk

The following issues and points were raised by members of the public during the course of the LINk's review:

- There have been reports that a discharge care plan is not in place, particularly when a patient is transferred from BHRUT to surrounding hospitals outside the borough
- Reports and discharge letters from doctors on the wards being illegible and GPs not being able to read them
- Lack of equipment which is essential to the patient not being given. This includes wheelchairs and the necessary equipment for those with sensory deprivation
- Home visits not being made which can cause the wrong equipment to be given to the patient. The LINk has heard reports for example of a wheelchair not fitting in a person's front door
- The wait for medication which has been highlighted in this report
- The lack of communication or delay in informing GPs of patients' needs
- There have been reports that a nurse does not accompany the consultant/doctor when they are doing their hospital rounds

. **Appendix 2: Care Homes:**

Havering LINk contacted all the care homes in the borough and the following issues were raised:

- Discharges late at night are disruptive and not beneficial to frail elderly people
- The wrong medication sent home with service users which causes difficulty in maintaining good health and continuity
- The transfer letter sent with service users often gets mislaid and hospital staff phone repeatedly for the same information
- When residents are discharged from Accident and Emergency they often come back to their care home with no information. For example details of any treatment given, any medication and diagnosis made. This should also include any follow up treatment to be given
- Trying to book an appointment with a named GP can be difficult
- The acquiring of blood test forms can be difficult
- The discharge of patients after 6pm is inappropriate and after 8pm the night staff do not have the resources to receive the service user appropriately
- Lack of information from hospitals makes it difficult to maintain continuity
- The lack of a discharge letter or if received it can sometimes be illegible