healthwatch Redbridge

From Hospital to Home:

A Patient Discharge Journey……..

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Introduction

Healthwatch Redbridge (HWR) have been conducting a number of projects to assess the quality and safety of Hospital discharge procedures and rehabilitation services throughout the borough following a number of issues and concerns raised by patients and carers.

It should be noted that some of the support provided by Healthwatch Redbridge was technically outside of our remit insofar as we should have supported the patient (Mrs H) to engage with an independent advocacy service. However, we took the decision to follow the patient journey and to intercede on her behalf in order to review the complete discharge pathway.

Background

On 20 October 2016, we were contacted by Mrs H, a 78 year old lady who lives in the West of Redbridge. She contacted us as she was facing problem regarding her discharge from Whipps Cross Hospital.

The first time HWR visited Mrs H she was extremely distressed and said,

'I feel like throwing myself under a bus, I can't go on like this'

(Mrs H)

She felt that she had lost her independence. She told us that since being in hospital she is having to wear incontinence pads, and can't do anything unaided. Prior to fracturing her ankles she told us that she was able to live independently, walk with support of a tri-wheeler frame and to go out on her own. She told us she feels that her mobility has been taken away from her. At this visit HWR obtained written consent from the patient allowing them to contact service providers on her behalf.

In December, HWR contacted Redbridge Clinical Commissioning Group (RCCG) to ascertain the discharge pathway for Redbridge Patients admitted to at Whipps Cross Hospital. Written information was provided in March 2017 from Redbridge CCG which stated the a teleconference takes place between the hospital, Redbridge Social services, North East London Foundation Trust (NELFT) and the continuing Health Care Team in the CCG for any Redbridge patients that are ready to be discharged. A plan is agreed, taking into account the health & social care responsibilities linked to the patient.

Mrs H spent 6 months in a nursing home before being discharged to her own home with a package of care.

The journey after discharge from Hospital

Mrs H was admitted to Whipps Cross hospital due to fracturing both her ankles. After staying in hospital for a few days (Bracken Ward), the ward doctor told her she was ready for discharge. However, she was non-weight bearing and needed a nursing home placement for 6-8 weeks until she was able to weight bear.

She was anxious and concerned that she did not know what would happen. She also felt it was clear from the conversation she had with the doctor that he was unsure of the discharge pathway for Redbridge residents as he told her '*The pathway for Redbridge Patients attending Whipps Cross Hospital was not clear*'.

This statement was later confirmed by a friend of Mrs H who was present when the Dr spoke to her.

On 25 October, Mrs H was discharged to a local nursing home. She said that neither the discharge arrangements nor care plan were discussed with her prior to discharge.

Mrs H faced a number of additional problem with the services at Whipps Cross Hospital in regards to appointments, communication between departments and a lack of information at each stage of her journey, for example:

- When she attended the fracture clinic in November she was not given details of follow up appointments. She was provided with Air boots to wear until she saw the consultant and told that she would need rehabilitation but not told how it would happen.

- Mrs H had to continuously telephone the departments at the hospital to obtain information regarding follow up appointments.

- Mrs H also contacted Patient Advice & Liaison Services (PALS) on numerous occasions regarding the problem she was facing and as a result of this the doctor that had discharged her from Bracken ward called her at the nursing home. He tried to sort out a follow up appointment although there was confusion in regards to when the appointment was to be made (3 months written in the notes but Mrs H was told to return in 3 weeks). He was able to arrange an appointment for the following week for her to see the orthopaedic consultant.

- The doctor from Bracken ward also told HWR once the patient is discharged it is the responsibility of the orthopaedic team and IRS to arrange the next stage between them. The doctor told HWR that prior to discharge the Intensive Rehabilitation Service (IRS) had been sent a

telephone referral which they did not accept as weight baring status was not known and neither was discharge destination.

- The doctor also said that once the plaster casts were removed the Community Therapy service had become involved and visited Mrs H at the nursing home but was not able to provide any therapy. The doctor also contacted the IRS team who had said they would contact the Community Therapy team.

- HWR spoke to the consultant's secretary and a follow up appointment was made with an orthopaedic consultant.

- When Mrs H attended the orthopaedic appointment she was given a letter for physiotherapy. When contacted the IRS team and they said that they would need a letter from the hospital to say Mrs H is now weight bearing before they could start any physiotherapy.

- Once it was confirmed that she was 'weight bearing', she was told she would need additional support, however she was not told who to contact regarding physiotherapy.

- There was a lack of communication between the hospital and the Intensive Rehabilitation Services (IRS), prior to and after discharge. HWR contacted the IRS team and were told that:

> *'The patient referral was not completed by Whipps Cross Hospital staff to IRS, thus IRS didn't have notification of discharge and did not pick up as unaware of the patient.'*
>
> *'The patient had a pre-existing referral with Redbridge health and social care physiotherapist.'*
>
> *'On assessment by the team (Community Physiotherapist) no weight bearing status for the patient had been recorded and they have been chasing the hospital for this information.'*
>
> *Lead Physiotherapist, NELFT*

- A letter was obtained by HWR from the secretary of the orthopaedic consultant so that the IRS team could start physiotherapy.

- Between December 2016 and January 2017, the team attended the Nursing home to provide physiotherapy for about 28 days. At this stage she was able to walk with a frame, make a cup of tea and transfer from the bed, so they said she would be safe to cope at home.

- The IRS team referred Mrs H to Community Health & Social Care services and said a social worker would contact her.

HWR arranged for Mrs H to meet with the Patient Experience Lead (PEL) from Whipps Cross Hospital to discuss her concerns. HWR staff supported Mrs H to develop some questions that she could raise at the meeting. The meeting took place in April. The responses received by MRS H were copied to NELFT in order for them to comment.

Some of the responses to the questions are shown below:

1. We have been told that IRS were not informed of Mrs H discharge date and destination. Please can you clarify why this might have occurred?

   Barts Health response:

   Whilst a referral was made to IRS the discharge destination was not known so IRS would not accept the referral. In retrospect the ward should have waited until a discharge destination was known or called IRS back. This has been taken forward as learning and we apologise for not doing this.

   A physiotherapist from the Community Therapy Service saw Mrs H after she had her cast removed and she informed Mrs H there was not much she could do for her. IRS confirmed that the physiotherapist had contacted them via a phone referral but they did not have the capacity to take the patient and asked her to call back on Monday, but it appears she did not.

   There was a breakdown in communication between Community Therapy and IRS, both are managed by NELFT not by Barts Health.

   NELFT response:

   T*he process regarding non-weight bearing referrals has been shared with all hospitals. A patient that is referred for a CCG funded bed should be discussed with IRS before completion of the written form. The form is then completed and submitted to the CCG. When discharge date and destination is found for the patient, a referral for IRS should be made. No referral was made for Mrs H although it was identified that she was to be referred for a non-weight bearing bed*

2. Mrs H asked why she was not given a follow up appointment by the orthopaedic team when she had the plasters removed from her ankles. She said she had difficulty contacting the doctor's secretary. HWR rang

the secretary and I think PALS intervened, as well the Dr from Bracken Ward and she was finally given a follow up appointment.

Barts Health response: Barts Health have taken this as an action point to raise the communication and follow up processes with the Associate Director of Nursing responsible for the fracture clinic

3. The patient said she was sent to a nursing home as she was non weight bearing but she was not aware of a care plan and she was just told she was going there. She said that no-one discussed this with her. She told us she did not know if she had a social worker

Barts Health response:

Whilst it is clear from the notes and numerous Multi-Disciplinary Team (MDT) meetings it is not clear these meetings included Mrs H. There are also references in the notes that discussions took place re discharge to the nursing home and assumptions made that she would retain this information and understood the importance of it.

In 2016 the non-weight bearing pathway was not fully in place which had a negative impact on Mrs H discharge.

There is a pathway for Redbridge patients and Mrs Harbour was referred to IRS as a part of this pathway. However this did not happen we are sorry this did not happen for Mrs H.

NELFT response: Mrs H was not referred to IRS for therapy as part of the non-weight bearing process.

4. The patient was told by a doctor on Bracken Ward that ' there is no clear pathway for Redbridge Patients' is this the case. If it is not then why do the clinicians not know the clear pathway?

Barts Health response:

The organisation acknowledged that at the time of Mrs H discharge this did appear to be true but reassured that that progress had been made since. They apologised for the negative experiences Mrs H had faced. The medical team have now been made aware of the non-weight bearing pathway.

5. Mrs H said that when she went to see the consultant and had the Air boots removed, she was given a form for physiotherapy but no other information. Please can you clarify this? She did not know who to contact, why did the Consultants team not contact the IRS team?

Barts Health response: In general the more able patients are able to make their own appointments and attend their physiotherapy appointment in the department. I do not believe this was the best option for Mrs H. We are unable to comment as to why the consultant did not contact the IRS.

Please apologise to Mrs H on our behalf, a meeting will be held with the therapy team to highlight the importance of clear communication.

This case will be discussed to ensure this does not happen again.

Other issues faced by Mrs H.

1. Whilst at the care home the patient informed HWR of the lack of care she receives at the home. She informed us of problem regarding staff shortages and waiting too long for personal care to be dealt with. **HWR have informed the local Quality Surveillance Group regarding this and they have said they will visit the home.**

2. Mrs H informed us she was not told that she would have to pay for a carer to accompany her to hospital appointments. She only found this out when she received a bill from the home.

3. Mrs H felt IRS were an excellent team and she felt really positive about being able to do the things she could after the physiotherapy they provided.

4. Due to the pain in her knee and her other health problem she was unable to do the exercises unaided and she informed us that the carers at the home had told her they were not trained to do these exercises with her.

5. When being discharged by the IRS team they told her that she would be referred to the Continuing Health & Social Care Service (CHSCS); a social worker would contact her as she was safe to return home. The social worker conducted an assessment but Mrs H felt she was not able to cope at home and refused to return home as she felt she would benefit from some inpatient rehabilitation. She asked the Social worker to refer her to the Ainsley Ward at Whipps Cross Hospital (inpatient rehabilitation).

6. HWR spoke to the social worker who had been told by the IRS team that Mrs H would not be eligible for further inpatient rehabilitation, however he did not agree with this response.

7. The social worker felt that Mrs H would benefit from inpatient rehab as she did not have any, (or insufficient) follow up from the nurses at the nursing home with physiotherapy exercises/mobility (after IRS ended their care) which has led to her weakness and deconditioning.

8. After speaking to the social worker HWR contacted the nursing home manager to ask questions regarding the care plan, discharge summary from IRS, wheelchair access etc. HWR are awaiting a response from the nursing home.

9. Mrs H informed HWR that the social worker had told her that her funding would end in 2 weeks and she did not know what to do. HWR called her social worker who said he would try and extend it.

10. The social worker asked the CCG to extend the funding until the patient had the opportunity for further rehabilitation.

11. The local MP, John Cryer, had also become involved and contacted different organisations on Mrs H's behalf.

12. The funding was extended and the IRS came to the nursing home for about 15 days to provide further physiotherapy.

13. When the IRS team discharged Mrs H she was able to stand assisted by 2 people and mobilise using a gutter frame assisted by 2 people. They suggested that she could return to her home with a double handed care package. Furthermore, she would benefit from some further therapy once she is back in her own home.

14. On 5 May Mrs H returned to her own home with a care package. This package consisted of four calls per day with 2 carers and two domestic calls per week. She informed us her GP is also referring her to community physiotherapy.