

# B&NES Care Services Provider Forum

## Wednesday 19 October 2011



### Attended:

Mik Alban	Care and Support South West
Sue Arthur-Stevens	Dorothy House Hospice
Yvonne Bonifas	NHS Bath and North East Somerset
Pam Bourton	Bridge Care Ltd
Caroline Burfield	Carewatch Bath
Justine Button	Care Quality Commission
Ruby Choms	Shaw Healthcare
Chris	Cedar Care Homes
Kim Dominey	Somerset Care at Home
Pam Dunn	Carewatch Bath
Jayne Evans	Action on Hearing Loss
Ruth Gretton	Dorothy House Hospice
Tracey Halladay	Care Quality Commission
Estelle Harvey	Agincare
Melanie Hodgson	Bath and North East Somerset Council
Cath Jarvis	Sirona Care and Health
Belinda Lock	Way Ahead Care
Barbara Lowe	Way Ahead Care
Sarah Lucas	Candlelightcare
Alex Massey	Royal United Hospital Bath NHS Trust
Roger Morley	Leonard Cheshire Foundation
Diane Piekarski	Stanton Court Nursing Home
Sharon Prowse	Freeways Trust
Karen Riddle	Sirona Care and Health
Sarah	Cedar Care Homes
Angela Smith	Bath and North East Somerset Council
Helen Storey	Crossroads - Caring for Carers Bath and North East Somerset
June Thompson	Sirona Care and Health
Karen Webb	Four Seasons Health Care

### Apologies:

Jay Bissessur	Action on Hearing Loss
Ena Caddy	Salvation Army
Sarah Darling	Candlelightcare
Mandy Davidge	Anchor Society
Lorraine Davis	Whitehaven Care Home
Sara Downing	
Sue Harris	Dorothy House Hospice
Tara Kahan	Mimosa Healthcare No 4 Ltd
Sally Ann Parry	Sirona Care and Health
Caroline Round	Bath and North East Somerset Council
Aubrey Sibaya	Cedar Care Homes
Natasha Waite	Way Ahead Care

## **Presentation: Alex Massey, Operational Support Manager, Royal United Hospital**

<http://www.thecareforum.org/assets/files/Volunatry%20Sector/Presentations/Banes/pres%20to%20care%20homes.pdf>

Evidence shows that older people staying in hospital after an acute phase get worse. End of life planning is very important as it can support a person in remaining at home. Paramedics are increasingly avoiding taking people to hospital if they can find a better option. There is a role for care providers in this.

When a GP makes a call, the call is taken by a senior nurse who is aware of the alternatives to admission and can signpost the GP. Some useful terms:

- DAT            Discharge Assessment Team – they look at the options for reducing hospital stay on admission.
- DATE           Discharge and Therapeutic Evaluation – for people who will have a longer stay in hospital and meeting their needs.
- DLT/DLN       Discharge Liaison Team/Discharge Liaison Nurse - If you have any problems with communication about discharge, speak to a member of the DLT team.
- CPA            Central Point of Access – a link to discharge assessment and liaison. The CPA at the RUH is Kate Williams telephone 01225 825698.
- APL            Active Patient List – an approach for joining up hospital care for patients.

The RUH is getting better at discharge planning but has particular challenges because it straddles three provider areas, all of whom have different frameworks and rules of engagement. As these are constantly being updated, and there is a fairly high turnover of staff, it's quite a challenge to keep all the ward staff updated. The best resource we have, and the best team to contact in difficulty, is the Discharge Liaison Nurse Team, and the Central Point of Access which is their base. Any questions or queries should be directed there. Kate Williams is the CPA and the link to the discharge liaison nurses. They have a list of all the people that they are doing business with and record interventions. They will go to the ward to get accurate information, if necessary. At this time there are initiatives to try to address time of day of discharge and weekend discharge. If there is anything we can do to help you overcome your problems in getting in to assess patients, let me know, for example, providing a parking space, or even transport for managers if you cannot get to the hospital.

Q: In relation to discharge planning and communication there is an issue in respect of confidentiality: we phone up to find out how someone is, but we are not told because we are not next of kin. If someone is in our care we do need to know.

A: I will take that back and pass it onto ward managers. Meanwhile, the CPA number is normally manned all the time, you can use Kate's or Alex's number and we can tell the ward staff it's OK to talk to you.

Q: When vulnerable people leave hospital, what information is available to us? If we don't have enough information, we can't support the client.

A: Acute hospital nurses and doctors aren't always confident about learning difficulties or mental illness and don't always understand how to connect with the people who usually care for that patient. If I had a wish list, it would have on it that whoever looks after that person is there

to have a conversation about their care and that there would be someone there who is a mental health expert.

Q: If information is given to the support worker and broken down for us, we can support that client. We can't give them that information.

A: We can work on having a better connection with a clinical expert. Gemma Box is the Learning Difficulties Liaison Nurse and has an outreach function. Maybe direct communication with Gemma Box would be a good way forward..

Q: NB Wiltshire learning difficulties' team has a person-centred plan which are very important.

Q: With admissions to hospital, GPs will still ring an ambulance, even if plans are signed by the person saying what they want to do, for example, not going into hospital. This may be done without the GP seeing the patient.

Q: Not all doctors know about DNR forms.

A: The PCT should be able to influence the GPs. In future, GP commissioners will take an interest in this as they will (effectively) have to pay every time a patient comes in.

Yvonne: There is a register of end of life wishes.

Q: So many GPs work in different ways, it's about capturing them all.

A: I agree it's not acceptable that the GP didn't go and see the patient before sending him or her in to hospital.

Q: I had issues with getting my resident back from hospital! They languished in hospital for two weeks before coming back for end of life care. They had gone in for an opinion but it felt as though there may have been a judgement made that the home could not cope.

A: (CQC) There is sometimes a lack of understanding whether a care home is providing nursing care or personal care.

Yvonne: Quite often the ward thinks residential care is nursing care.

A: Even within the NH/RH bands there are differences between the services provided by different homes. Discharge Liaison Nurses are important in understanding these differences so it is vital to work through them. The nurses on the ward do not always understand the nuances of care in the community and are actively discouraged from prescribing which type of placement is needed. The rule is that ward staff must describe need, not prescribe placement. If this happens again, or if you have any concerns about delayed discharge, please ring the CPA number.

Q: What about people being discharged into the community?

A: We request the same rapid assessment and offer the same help. The same provisions apply eg with parking. I know it's difficult to park in the hospital and we can help to ensure parking is provided where needed by any care providers.

Q: I usually go in at eight in the morning, because of the parking problems, and the wards are not happy about it. There is no time for anyone to speak to you and you have to get information from forms.

A: I'm sorry about this. Nurses do understand the importance of connecting with you but in these financially difficult times resources are often short, and the nurses tend to focus on the here and now, seeing to patient's immediate needs. That means discharge planning may often

be put off until the afternoon when things are less hectic. Again, I would advise connecting with the DLNs, as they are able to give more time, and have a better understanding of your needs.

Q: I'm a domiciliary care manager. Sometimes when people are discharged, there is no equipment in place, so they might go back into hospital. Nurses don't understand we need a manual handling assessment, it's not just about health. The assessment from hospital is not always accurate enough for the care provider, and does not reflect the needs of the patient, who will often have to go back into hospital.

A: I agree we must have a proper, thorough assessment. I'm not interested in compromising on a thorough assessment. Ward staff might not understand the context in which you work, and in which the patient will be living. If you are having difficulty getting them to accept that, speak to me. The last thing we want is people going back into hospital because of the lack of a thorough assessment.

Q: There is still a lot of problems about not having a full summary of care given in hospital when people are discharged. For example patients being discharged with adequate supplies of medication.

A: I'm afraid there has been a temporary worsening of the situation, because our new computer system has made TTA prescription, and discharge summary completion, more complicated than before. The paperwork may be done too late, or discharge may be compromised in some way. We are trying to get consultants to complete both of these at the time of the discharge decision, but too often they are left for the junior doctors to do later. A TTA ('To Take Away' procedure/packs) and discharge summary are supposed to be provided when patients leave. Another project has been set up to address this. I need feedback from you if people have incomplete TTAs or discharge forms.

Q: (CQC) It is frustrating for care homes if delays are caused by lack of provision of, for example, dressings or medication.

A: I will report that back to RUH matrons.

Q: In honesty it is resulting in people not being accepted at weekends because homes know they will be receiving patients without appropriate medication. [General agreement about this point].

A: We're doing a project to try and increase weekend discharge. Maybe we can do some work on this. Your concerns are shared with other carers' groups we have met with.

Q: The wards say transport is a problem.

A: It is not a problem as long as patients are eligible. I'm afraid the ward staff are wrong. Although we ask for advanced bookings, in practice almost all discharge journeys are booked on the day, and many at the last minute. Even so, we rarely fail to get people home on the day. There has been only one failure this year. We have our own transport provider so we are protected from outside pressures. We have a discharge vehicle on a Saturday and Sunday and we can expand that if we need to. If this is raised as an issue please tell wards you will speak to me about this, and please tell me.

Q: Are you involving GPs in everything? How are they involved with the development of the discharge process?

A: The whole healthcare community is signed up to the idea that Saturday and Sunday should be treated as normal discharge days. In most acute hospitals, we still have a bit of a Monday to Friday culture because weekend services are expensive. Regular patient reviews don't happen in the same way at weekends and we recognise this can cause delays at the weekend and on Mondays too. We are trying to address this by considering advance actions on Fridays.

Q: If, for example, on a Thursday someone is identified as potentially being discharged on a Sunday, could the home not be notified of this possibility in advance?

A: I'm afraid the likelihood is that on Thursday this would not be the plan, but then there is a capacity crisis at the weekend, and the hospital teams would be looking for people to discharge. We accept this is not good, and it isn't intentional. There is a need for a better understanding of how domiciliary care works.

Q: There is a big training issue.

A: (Yvonne): There are too many assumptions made. For successful discharge, no assumptions should be made, all decisions should be based on verified facts. It works best when someone on the ward is in charge of discharge. For example people assume homes will have dressings in cupboards. They assume homes will have the medication needed. This should all be checked.

Q: All nurses should have a week in a care home.

A: (CQC): We need to cross fertilise that knowledge.

Q: Quite a lot of youngsters come as volunteers.

A: (CQC) They may not be exposed to some of the management systems.

A: We have tried to train staff formally in the classroom, but it's sometimes impossible to get away from the wards, and the subject is complex and ever-changing (as described before). So we have adopted a high profile approach for the DLNs, encouraging ward staff to ask before they act, so that each action becomes a learning opportunity. People remember better if real cases are involved. Because of this things are improving slowly, but we still need to correct mistakes when we find them. Come back to me with the name of the person you're talking to on the ward if there is an issue.

Q: All staff in Dorothy House have shadowed senior nurses at the RUH. This was very productive and good for improved understanding. It could be done for any new senior staff who want to shadow.

A: Let's work on it. I can arrange placements for staff who want to come in, and would be keen for trained nurses to spend some time with you to get a better understanding.

Yvonne: Just seeing how a care home works would be a revelation.

Ronnie: There are constructive ways that things can be taken forward.

Q: What does the hospital need providers to be able to do?

A: We need your opinion and your assessment of patients quickly. By the time the patient is ready for your assessment there may already have been serial delays in the discharge process, so the situation could be quite critical. On the admission side the information coming in with patients is good; but we don't always capture it, so keep following up.

## **Feedback from discharge discussions [post-its]**

- Communication re: prescriptions getting to pharmacy
- Investment in the beginning = saved time further on and safe appropriate discharge in the end
- Nursing staff at RUH need to **read** relevant core needs information – i.e. re complex needs – that care home staff send in with client
- Better communication needed between departments/health care professionals at RUH prior to discharge – that have been involved in care

- As major implications re lack of crucial information i.e. respiratory ward to liaise with speech and language therapist to inform them of the intention to discharge if they have been involved
- Lack of GP support community of care
- Impact of accommodating last minute discharges
- Medicine: Patient being discharged with medication in normal boxes? Dom care carers can only administer medication from pharmacy filled dosette boxes.
- Communication – difficulties with “next of kin” – only giving information to them.
- RUH to communicate with us.
- Need to better understand the need for a **positive transfer** for a client moving from hospital to care home for the first time. A bad move could result in a placement breakdown or negative response to going into care.
- Discharge information/summary. Needs to be **accurate** and complete and **available** when being discharged.
- Full discharge summary for care providers prior to discharge for assessment purposes.
- MAR sheets should be sent out with any medication and the Dom Care office should be told exactly what medication has been given to the patient on discharge.
- Parking permit for each company to use.
- Dom Care/Nursing Home/Care Home. Create a fact sheet to be given to each person in the relevant role.
- Could discharge liaison staff take over liaising with care homes over discharges? They could collate all relevant information and work in partnership with Home Managers to manage discharges well and not involve general staff on wards who all have different opinions.
- Data about care home capabilities. i.e. take someone with s/c fluids etc s/driver
- Ronnie: accurate information about services provided rather than assumptions – could develop we based Well Aware information for use by discharge teams to provide accurate picture of provision by different care providers.
- At ward level, nurse caring should be responsible for completion of discharge checklist.
- Thorough discharge checklist planning
- Information to clients: learning difficulty, elderly, PSIs. Gemma Box ✓ but consultants how can they improve their communication? Must improve communication. Information given in a simple form. All information available in an easy read form, braille deaf, blind etc
- Understanding of different support agencies for ward staff: basic description would help and how support is provided. Domiciliary, care home, and Domiciliary Residential Home, dual support/care and floating.
- Read information that comes with client. i.e. Traffic Light Forms. Experience is this is disregarded. This could aid discharge.
- Telephones. No one answers. Community have to ring again and again.
- Access to stores in RUH and meds at weekends. To facilitate discharge. i.e.
  - a specific stock managed by DLT not used ward stock.
  - A specific stock allocated for community discharges over weekend
  - caterer equipment/dressings.
- Forward planning. Advance information stops poor discharge.
- Discharge sheet for all to write in to plan together as continuation sheet is not always read when new pages are started.

## Feedback from speed networking

- Lack of information around discharge: communication

- Not having the information needed
- Management around discharge
- Patient involvement in discharge
- Vulnerable patients: awareness of implications if discharge doesn't work
- Lack of knowledge around organisations and how they run
- Lack of understanding of impact on organisations : continuity of care on other service users
- Re: appointments: need to work together so appointments not missed
  - focus on best interests of individuals
- Need for a more holistic approach
- Consideration for needs of carers

## Other Issues

- Patient care within hospital
- Referral process: understanding what paperwork/information wanted and needed
  - Portability of assessment
  - Up to date assessments
  - Contracts all specify that providers should receive written care plan information= obligation on SH Services. Need for relatives (social working role in that) to have the assessment information they need in looking for care homes. (Consider carers needs)
  - Community ward? N.B. Work in North Somerset
- Development of directory of care: information about organisation and information required?

## Close

Yvonne: Contracts state that we will provide you with written care planning assessment information and purchase orders. You should get that before you take the person. It is more difficult if you have a self funding person and the ward is liaising with the provider. Having your own money doesn't preclude assessment. There is pressure on elderly relatives who don't understand the system. My suggestion is that they could use a nursing home, North Somerset is starting to do that and have called them community wards. In North Somerset, there is a maximum of 12 weeks, for example, to wait for equipment to go into people's homes.

Alex: Normally a social worker selects the appropriate care and advises which homes the family should consider (there are rules about this, of course). Ward staff don't normally have that role, although it might be the DLN sometimes, if the patient is self-funding. A directory of care might be useful as hospitals and homes vary.

## Evaluation

### What was the most significant outcome of the event for you?

That at last somebody will listen to the problem of discharge.  
Alex Massey.

### Do you have any suggestions regarding topics/speakers for future meetings?

Need open forums to network and discuss any current issues.  
Networking for the physical and sensory side of Health and Social Care, where can we find some resources that maybe are hard to come by? Where do we go for particular things?

### Are there any other comments you would like to make?

Could have been longer.  
None at this time.

Content	Average mark (out of 5)
Understanding of subject at start	3.5
Understanding of subject at end	4.0
<b>Sessions</b>	
Speakers	4.0
Other elements	3.0
<b>Organisation</b>	
Pre-event information	3.5
Facilitation	4.0
Organisation on day	4.0
<b>Venue</b>	
Access	4.5
Refreshments	4.5
Standard of room	3.5