The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

Review of Discharge Arrangements from Acute Hospitals

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Assurance, Challenge and Improvement in Health and Social Care

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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on RQIA's website at www.rqia.org.uk

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Executive Summary

Discharge from hospital should be a process and not an isolated event (DOH 2003). It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individual concerned and their carer(s) should be involved at all stages, and kept fully informed by regular reviews and updates of the care plan.

Patients who are discharged from hospital, will be discharged back into the care of the general practitioner (GP) with whom they are registered. Essential information about the patient's stay in hospital, that allows the GP to continue the patient's care and management following discharge, is sent by the hospital to the patient's GP, in the form of an immediate discharge summary.

In June 2011, the GAIN guideline – Guideline on Regional Immediate Discharge Documentation for Patients being discharged from Secondary into Primary Care was published. It sets out the information that should be included in an immediate discharge summary, sent from secondary to primary care.

In its 2012-2015 review programme, RQIA has included this review, to assess the use of the GAIN guideline, but also include an assessment of discharge processes in acute hospitals, and how they might impact on patient flow throughout these hospitals.

A number of good initiatives were happening in the trusts, both in terms of the discharge process, but also in trying to prevent admission to an acute setting in the first place. All trusts had developed a number of ambulatory pathways in order to try to prevent patients having to go through the Emergency Department, and so lessen the pressure on this part of the hospital.

Findings indicate that all trusts now have processes in place to comply with the majority of fields required by the guideline. A large number of discharge summaries are typed, but there are some that are handwritten, and these can create difficulties for GPs in terms of accuracy and legibility. The majority of immediate discharge summaries are sent home with patients. The Southern Trust is the only trust that e-mails most of its discharge summaries direct to GPs, though a number of trusts make it available on Patient Centre. Patient Centre is the acute hospital document management system linked to the patient administration system.

Regarding the discharge process, the review team considers that there should be a small group of clinicians and managers with sufficient seniority to oversee the process and ensure that all pieces of the patient journey fit together as seamlessly as possible. The systems, as they stand at the moment, have oversight of the separate parts, but there didn't appear to be the required oversight linking the entire process together.

RQIA considers that one of the most vital factors to facilitate effective discharge, was the availability of real time information regarding each part of the patient journey, and the input of all staff; medical, nursing, social work, AHP and pharmacy. The Southern Trust had the most developed IT system, supplying accurate information on all patients and also information regarding necessary multidisciplinary input.

Early discharge and early multidisciplinary input are a crucial part of the process. Early community social work input was an important factor in a successful discharge, especially in those complex discharges where patients needed a variety of packages and equipment. The review team considered that direct pharmacy input into wards, leads to a smoother, more efficient discharge. It also helps to eliminate errors in the prescriptions that are written by junior doctors.

The review team considered that trusts should work towards a system that provides for discharges to happen throughout a seven day working week.

Dealing with care homes was an area reported by all trusts as potentially leading to delays in discharge. It was clear to the review team that within those areas where there was an effective forum with care homes, there were fewer problems and all trusts need to have effective forums for this purpose.

Transport was an issue for all trusts in relation to discharge. The review team was aware of the difficulties faced by NIAS (Northern Ireland Ambulance Service) and also was aware of the fact that transport is an issue that can cause problems for emergency departments. The review team considers that trusts should work with NIAS and commissioners to create a system that better supports transport, for those people being discharged from acute hospitals**.**

Repatriation of patients to other trusts was brought forward to the review team as a potential cause of delayed discharge by a number of trusts. This was considered to be more of a problem for the Belfast Trust, which operates as a tertiary centre for a number of services.

Patient stories supported evidence gained through other parts of the review, in that two of the main reasons patients were kept waiting were due to delays in the production of the discharge letter and discharge medication. Patients also felt that, though communication was generally good, they were not sufficiently involved in the discharge process and trusts must consider this in the future.

The report makes 20 recommendations for improvement in discharge arrangements through the work of this review.

1.0 Introduction

Discharge from hospital should be a process and not an isolated event (DOH 2003)[1]. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individual concerned and their carer(s) should be involved at all stages, and kept fully informed by regular reviews and updates of the care plan.

Planning for hospital discharge should start prior to admission for planned admissions, and as soon as possible for all other admissions. This involves building on, or adding to, any assessments undertaken prior to admission.

Effective and timely discharge requires the availability of alternative, and appropriate, care options to meet continuing health and social care needs.

Many of the delays that occur when discharging patients are predictable and relate to communication and coordination between acute and community care. Others are concerned with internal hospital systems. This underlines the importance of starting discharge planning at the earliest opportunity following admission, in order to plan for, and resolve problems before they impact on patient care and length of stay.

Guidance to patients and carers, on the correct use of medication, managing chronic conditions and the effective use of medical equipment, will improve the transition from hospital to home.

The key principles for effective discharge and transfer of care are that;

- unnecessary admissions are avoided and effective discharge is facilitated by a whole system approach
- the engagement and active participation of individuals and their carer(s), as equal partners, is central to the delivery of care and in planning of a successful discharge
- discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across primary, hospital and social care services
- staff should work within a framework of integrated multidisciplinary and multi-agency team working, to manage all aspects of the discharge process
- effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately, and individuals achieve their optimal outcome

Problems concerning hospital discharge arise for a number of reasons. These include discharges that;

- occur too soon
- are delayed
- are poorly managed from the patient/carer perspective

[1] Department of Health (2003). Discharge from hospital: pathway, process and practice. London: Department of Health.

Some of the factors that contribute to poor quality discharges are;

- the timing of ward rounds
- the wait for diagnostic test results
- delay in referring for social services support
- organisation and management of medication
- availability of transport
- coordination of hospital and community based services
- capacity and resource issues
- limited availability of transitional and rehabilitation places
- placement difficulties associated with care homes
- availability of a home care provider
- patient /carer/involvement/choice
- lack of engagement with patients/carers in decisions about their care
- limited availability and choice of care options
- ordering or availability of community equipment
- ability of community staff to respond to rehabilitation needs, including timeliness of response or level of input available

To ensure an effective discharge process, strong leadership is required at all levels across the whole range of services that are involved at organisational level; multidisciplinary team level; and within individual wards and departments. With strong senior leadership, it is easier to manage tensions, deal with problems and deliver solutions.

Robust discharge policies and procedures should be developed, implemented and regularly evaluated for effectiveness. Staff roles within the discharge process should be clearly defined, and staff should be resourced to measure their individual and team performance, with a view to improving performance and quality of discharge.

Patients and carers must be regarded as equal partners in the discharge process as their engagement is essential to a successful outcome. Multidisciplinary team working is critically important, within the acute hospital setting and between hospital and community.

Good communication is also a prerequisite for a well-coordinated patient journey from admission through to discharge. Staff involved in the discharge/transfer process frequently have conflicting pressures and priorities involving targets, professions, patients, carers and relatives. Good communication at all levels will help to ensure effective partnership working, leading to a more effective discharge process.

Good communication is also the basis for a successful patient-centred approach, which recognises the important contribution which can be made by both patients and carers. In the past, carers have reported that they often feel powerless, anxious and insignificant. They wish to have consistent information delivered in an honest and

sympathetic way, which gives them confidence in the system, and allows a degree of control over what is happening[2].

For those people who are in receipt of packages of support prior to admission, there is an opportunity to anticipate and pre-plan for likely problem areas. It is important to involve social services at an early stage, and key workers should be fully involved in the process, to help hospital practitioners meet the specific needs of these individuals and also support carers.

The decision that a patient is medically fit for discharge can only be made by the patient's medical consultant (or by someone to whom the consultant has delegated his/her authority) or by another doctor who is responsible for the care of the patient.

Patients who have both health and social care needs must only be discharged when they are clinically fit, a decision made by the multidisciplinary team after consideration of all relevant factors. These include the relative safety of remaining in hospital compared to an alternative preferred place of care, and the patient and carer views of associated risks.

The NHS Plan
In the NHS plan[3], the Chief Nursing Officer for England identified 10 key roles for nurses; one being 'to admit and discharge patients for specific conditions using agreed protocols'.

The Northern Ireland Nurse Led Discharge and In Reach Report[4] of 2006 identified the benefits of nurse led discharge as being;

- contributing to the reform and modernisation agenda
- improving the quality of discharge planning
- improving the patient experience by involving patients in their discharge planning, achieving a more timely discharge
- appropriate utilisation of nursing and other professional skills
- achievement of increased value for money and effective patient care

The report noted that there was evidence of varying levels of nurse led discharge across Northern Ireland, and made a series of recommendations that would assist the implementation of nurse led discharge on a regional basis.

Ready to Go – Planning the discharge and transfer of patients from hospital and intermediate care (DOH 2010)[5] sets out ten steps towards achieving safe and timely discharge.

[2] Preston C et al (1999). Left in Limbo: patient's views on care across the primary/secondary care interface. Quality in Health Care 8:16-21
[3] Department of Health (2000) The NHS plan: a plan for investment, a plan for reform. London: Department of Health.
[4] Nurse Led Discharge and In Reach Report. April 2006 NMAG.
[5] Department of Health (2010). Ready to go: Planning the discharge of patients from hospital and intermediate care. London: Department of Health

The 10 Steps	
1.	**Start planning for discharge or transfer before or on admission.**
2.	**Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.**
3.	**Develop a clinical management plan for every patient within 24 hours of admission.**
4.	**Coordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.**
5.	**Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.**
6.	**Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.**
7.	**Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.**
8.	**Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.**
9.	**Use a discharge checklist 24–48 hours prior to transfer.**
10.	**Make decisions to discharge and transfer patients each day.**

Once an initial assessment has been completed, the assessor will need to evaluate whether this is a simple or complex transfer or discharge. For the majority of patients (about 80 per cent), discharge planning is relatively straightforward – these are usually referred to as simple discharges. These patients:

- will usually return to their own home; and
- have simple ongoing care needs which do not require complex planning and delivery

The other 20 per cent of patients will have more complex needs. Ward staff may need support from health and social care colleagues, who have more specialist knowledge and understanding of the local community services and choices available.

The majority of complex transfers can be managed effectively. However, a very small number of these patients, if delayed, have a disproportionately high impact on bed occupancy. Identifying complexities early in the patient journey ensures that complications are foreseen and overcome.

The Ready to Go (DoH 2010) guidance sets out some ways the organisation can contribute to an effective discharge process;

1. Monitor and evaluate the causes, length and types of delays that follow the patient through the system. This should include the wider aspects of patient flows, such as discharge co-ordination and multi-agency cases.
2. Carry out a simple hourly flow diagnosis to understand patient flows in and out of hospital.

3. Ensure that the discharge policy is up to date with regional policy and legislation, and includes inter-agency agreements on joint working protocols (including for the homeless, people in prison and asylum seekers).
4. Provide written information for patients so that they have clear guidance on what to expect, and what is expected of them while they are in hospital.
5. Schedule ward rounds in a way that allows, at least daily, a senior clinical review of all patients in acute hospitals.
6. Ensure that all tests and treatments continue seven days a week and results made available seven days a week.

Carers and Discharge – a carers' guide to hospital discharge (DHSSPSNI 2010)[6] states that: 'when patients leave hospital without appropriate plans being put in place, there is a real risk that this could result in re-admission to hospital. It is important that you feel prepared for the patient returning home and that plans include information about how you will be supported once the patient leaves hospital or intermediate care. The following checklist will help you to ensure that all appropriate arrangements are in place for a safe and timely discharge and to support you in the caring role'. It provides a checklist as to what should be in place prior to a patient's discharge.

Medicines management also plays an important role in preparing patients and their carers for transfer/discharge and has an impact on the recovery/maintenance of their condition. The use of medication is increasing, which is particularly evident in the older age group who may suffer from a number of chronic conditions. The risk of adverse drug interactions increases with additional medication and a number of hospital admissions and readmissions are due to adverse reactions to medicines or incorrect medicine taking.

While a patient is in hospital, it is likely that a familiar medication pattern will be altered. In order to take the prescribed medicines as intended, the patient and/or their carer needs to understand the rationale for the medication regime as well as physically manage to take the medicines. It is also important that the GP receives an accurate record of prescribed medicines on discharge (medicines reconciliation) detailing reasons for changes.

DHSSPS Targets

DHSSPS monitors information on the proportion of patients remaining in hospital after the time they were deemed medically fit for discharge. A Ministerial target has been set for the effective discharge of patients from an acute hospital setting. From April 2013;

- 90 per cent of complex discharges from an acute hospital should take place within 48 hours with no complex discharge taking more than seven days.

- All non -complex discharges from an acute hospital should occur within six hours of the patient being assessed as medically fit for discharge.

[6] Carers and Discharge – a carer's guide to hospital discharge. DHSSPSNI 2010

2.0 Context for the Review

2.1 Discharge Documentation

When patients leave hospital without appropriate plans being put in place there is a real risk that this could result in readmission. It is important that plans include information about how the patient will be supported once they leave hospital or intermediate care. Accurate and detailed discharge information is essential for an effective discharge process.

The preparation and sharing of accurate and timely records of care and treatment are central aspects of good clinical practice. The principles of Good Medical Practice[7] set out by the General Medical Council (GMC) therefore apply in the provision of discharge documents.

Patients who are discharged from hospital will be discharged back into the care of the general practitioner (GP) with whom they are registered. Essential information about the patient's stay in hospital that allows the GP to continue the patient's care and management following discharge is sent by the hospital to the patient's GP, in the form of an immediate discharge summary.

Clear and complete documentation in a patient's health record is directly related to the quality of care they receive. Detailed and accurate documentation helps to reduce negative outcomes, by ensuring that all clinical staff have access to the information they need to deliver an appropriate level of care.

Effective communication between primary and secondary care is vital to ensure a smooth and seamless transition of care between both sectors. Current hospital practice seeks to reduce inpatient stay to a minimum length of time and there is a need for clear information to be provided when the patient returns to primary care.

The information conveyed at the time of discharge from hospital has always been an important element of communication between secondary and primary care. There is some evidence that the standard of discharge information is very variable.

A 2008 national survey by the NHS Alliance[8] reported that patients in England are regularly put at risk because some hospitals delay sending essential information to GPs when patients are discharged. It found that;

- 58 per cent of GPs said that the clinical care of patients had been compromised in the past year because discharge information was delayed
- 39 per cent said that patient safety had been put at risk in the past year

Doctors reported that it was not just late information that was the problem, but also inadequate detail. Sometimes details such as the patient's name may be missing from the discharge summary, along with the diagnosis, treatment provided, medication and follow up details. In one case, a discharge summary was provided

[7] www.gmc-uk.org/guidance/good_medical_practice.asp
[8] A Very Present Danger. A national survey into information provided by hospitals to GPs when patients are discharged. NHS Alliance 2008.

but it failed to mention that the patient had just spent a week in intensive care following a stroke and a heart attack.

In 2009, audits carried out by the regional prescribing teams of the Health and Social Care Boards in Northern Ireland[9] presented the following results.

On admission;

- 28 per cent of notes had a medication omission
- 34 per cent had a dose or frequency mismatch
- 2 per cent included a medication which had been discontinued
- 44 per cent had allergy information omitted (6 per cent of these patients had a documented allergy)

On discharge;

- 21 per cent of GPs received information within 2 days
- 30 per cent of GPs received information within 4 days
- 75 per cent of GPs received information within 7 days
- 38 per cent of discharge prescriptions had a discrepancy

In 2002, the Royal College of Physicians audited 149 case notes in five hospitals in England and Wales. Of 87 printed discharge summaries present in the notes;

- 17 per cent had no diagnosis
- 19 per cent had no procedure
- 21 per cent had no follow up arrangements
- 75 per cent provided the GP with no information on what the patient had been told

The content, structure and production (particularly the timeliness) of discharge documents have long been a cause for concern. Improving the quality and timeliness of discharge documents can lead to improvements in patient safety, by improving the process of transition from hospital to GP care.

In order to try to address these issues, a minimum dataset for the immediate discharge document was published by the Scottish Intercollegiate Guidelines Network (SIGN) in 1996 (SIGN 5) and revised and updated by SIGN in 2003 (SIGN 65). In June 2012, SIGN issued another version, SIGN 128 – The SIGN discharge document[10].

The Academy of Medical Royal Colleges developed a set of standards for the clinical structure and content of patient records, which include a section on immediate discharge summaries. These were updated in 2013[11].

[9] Northern Prescribing Forum Interface Sub-Committee; Audit of hospital discharge prescriptions. September 2009.
[10] Scottish Intercollegiate Guidelines Network (SIGN). The SIGN discharge document. SIGN 128
[11] http://www.rcplondon.ac.uk/sites/default/files/standards-for-the-clinical-structure-and-content-of-patient-records.pdf

In Northern Ireland, a workshop involving key stakeholders was held on 1 December 2008 to explore issues involving discharge information, examine good practice from other areas, and make recommendations for improvement.

The recommendation from the workshop was that a regional working group should be established by GAIN, with representation from both primary and secondary care, to define a Northern Ireland standard dataset in terms of immediate discharge documentation.

2.2 GAIN Guideline

In June 2011, the GAIN guideline, "Guideline on Regional Immediate Discharge Documentation for Patients being Discharged from Secondary into Primary Care" was published. It sets out the information that should be included in an immediate discharge summary sent from secondary to primary care.

As a minimum the summary should include;
• reason for hospitalisation
• treatment received while in hospital
• discharge diagnosis
• comprehensive and reconciled medication list
• active problems at discharge
• prognosis
• follow up arrangements
• carer information
• dates of admission and discharge
• details of doctors involved with the patient's care
• information on drugs stopped and started in hospital with reasons for this

It was planned that RQIA, in its 2012-2015 review programme, would include a review assessing the use of the guideline.

Subsequent to this, on Wednesday 8 January 2014 a major incident was declared at the Royal Victoria Hospital, due to a backlog of patients at the Accident and Emergency Department (ED).

At one stage 42 people were waiting on trolleys. Extra staff were drafted in to address the situation; a number of patients were placed in a theatre recovery area and fracture clinic and a day procedure unit was reopened. On the evening of 8 January 2014 ambulances were diverted to the Ulster Hospital for several hours. The major incident was declared over just before midnight.

On 30 January 2014, RQIA was asked by the Minister for Health, Social Services and Public Safety to carry out an inspection of the Emergency Department and Acute Medical Ward of the Royal Victoria Hospital at the earliest opportunity.

A preliminary report was provided to the Minister in the week commencing 10 February 2014.

Following on from this, on 17 February 2014, the Minister asked RQIA to carry out a review of unscheduled care

It was recognised that problems in Emergency Departments in acute hospitals are multifactorial and include issues with patient flow throughout the hospital. Issues with delayed discharge for patients can lead to delays in the availability for new patients being admitted to a hospital.

It was decided to widen the scope of the discharge review to include an assessment of discharge processes in acute hospitals, and how they might impact on patient flow throughout these hospitals. The review would also include the assessment of the use of the GAIN guidelines.

3.0 Terms of Reference

1 To describe the current systems and procedures in place, which ensure the safety, quality and effectiveness of the arrangements for discharge of inpatients from acute hospitals, in accordance with the principles of the GAIN guideline. To include;

- both simple and complex discharges, which may involve elderly people and those with long term conditions, and all levels between, and transfers between hospitals
- use of the GAIN guideline on immediate discharge documentation or an equivalent and also interaction with Northern Ireland Single Assessment Tool (NISAT)
- whether such discharges were made at an appropriate time of day
- whether all relevant processes and arrangements were in place
- the effectiveness of communication and partnership working

2 To review the relevant governance arrangements in place for discharge of patients from hospital and transfer of patients between hospitals– to include complaints/incidents around discharges and delayed discharges.

3 To collect information on the experiences of patients, carers and relatives in relation to discharge from acute hospitals.

4 To collect information on the views of primary and community care practitioners regarding the effectiveness of communications in relation to patient discharge. To include;

- quality and timeliness of discharge information being received by GPs
- views of allied health professionals (AHPs)
- views of social services
- views of nursing staff
- views of pharmacy staff

5 To make recommendations for improvement.

4.0 Methodology

Key stages of the review:

1 HSC trusts were asked through a questionnaire to;
- provide information regarding the implementation of the gain guideline on regional immediate discharge documentation for patients being discharged from secondary into primary care
- outline their discharge policy and process and any challenges or areas of good practice they could identify

2 Through Integrated Care Partnerships, a questionnaire was sent to all General Medical Practitioners, seeking their views as to the quality and timeliness of immediate discharge summaries they were receiving.

3 Trusts were asked through a specific pharmacy questionnaire to;
- rate progress on implementation of key elements of moving patients' medicines safely – guidance on discharge and transfer planning[12]
- provide documentary evidence supporting the information provided and submit a concise description of the current pharmacy input into the medicines discharge process

4 Meetings were held with;
- junior medical staff
- senior trust staff with responsibility for discharge within their trust
- social services staff
- pharmacy staff

5 Telephone interviews and focus groups were held with service users who had experience of being discharged from an acute hospital setting.

Hospitals included in the review were;
- Royal Victoria Hospital (RVH)
- Belfast City Hospital (BCH)
- Mater Hospital (MIH)
- Craigavon Hospital (CAH)
- Daisy Hill Hospital (DHH)
- Altnagelvin Hospital (ALT)
- South West Acute Hospital (SWAH)
- Antrim Area Hospital (AAH)
- Causeway Hospital (CAU)
- Ulster Hospital Dundonald (UHD)

[12] Moving Patients, Moving Medicines, Moving Safely – Guidance on Discharge and Transfer Planning. Royal Pharmaceutical Society of Great Britain 2005.

5.0 Findings

5.1 GAIN Guideline

The GAIN guideline – Guidelines on regional immediate discharge documentation for patients being discharged from secondary into primary care was published in June 2011.

All trusts have processes in place for receipt of GAIN guidelines. These were updated in the Southern Trust in 2012 and in the Northern Trust in 2013.

There is no standardised process for dissemination of GAIN guidelines. Depending on the guideline, it may be accompanied by a letter from the Chief Medical Officer or may be disseminated by other means. This guideline was not issued with an accompanying letter, but instead was issued by e-mail to trust nursing staff. As a consequence the guideline was not disseminated widely within trusts and its use was initially limited.

On 19 March 2013, the Director of Public Health, on behalf of the Public Health Agency (PHA), wrote to trusts requesting an update position on the use of the guideline. A number of staff from all trusts reported to the review team that the receipt of the letter was the first time that they were aware of the existence of the guideline. The PHA letter asked trusts to;

- advise if they were content that the trust's current arrangements reflected the guideline
- if not, outline the actions the trust plans to take to implement the guidance

Following receipt of the above letter from the Director of Public Health, the Belfast, Northern and South Eastern Trusts each appointed a senior individual to lead on implementation of the guideline. The Southern Trust was unable to ascertain a definite implementation plan for the guideline, and the Western Trust reported that they had not nominated an individual to lead any implementation process. However, all trusts had established working groups, and carried out a number of pieces of work to ensure that the principles contained in the guideline were being followed.

In response to the letter, each trust provided evidence of actions to be taken to ensure implementation of the guidance.

In terms of acute hospitals, the Belfast Trust reported that;

- the trust was examining how discharge letters might be incorporated into Patient Centre to make them available on the Electronic Care Record (ECR)
- the trust was building consensus on development of two Belfast Trust templates – a psychiatry template and a non-psychiatry template
- the trust would consider electronic transmission but advised that this was not in the immediate future
- a regional approach would be helpful

The Northern Trust reported that;

- immediate discharge summaries on Patient Centre were currently being rolled out across the directorates
- the immediate discharge summaries contained in excess of 90 per cent of the dataset outlined within the GAIN guideline
- there was a high level of GP satisfaction
- full roll out to be completed by August 2013
- GPs should receive the immediate discharge summaries directly

The South Eastern Trust reported that;

- within the medical directorate, an electronic discharge document is already generated via Patient Centre, and although not transferrable electronically it is available in the ECR
- a copy of the immediate discharge document is given to the patient
- the final verified version is posted to the GP
- handwritten discharge letters are rarely used within the medical directorate but are generally used in the surgical directorate

The Southern Trust reported that;

- in 2012 the trust had developed a program called the Electronic Correspondence Module, which allowed the creation of an electronic discharge summary, which could then be sent to GPs
- the trust was planning to extend the facility to allow for e-mailing of the discharge summary to GPs. If this is not possible it should be posted directly to the GP

The Western Trust reported that;

- overall the trust was partially compliant with the guideline
- in all clinical areas, on discharge, the patient is given a copy of the immediate discharge letter to pass on to their GP
- following discharge, consultants are able to verify the letter and if required, revisions of the letter are posted out to the GP. GPs can view the verified letter on Patient Centre but this does not happen in most GP practices

Although not always specifically following the GAIN guidance, all trusts mostly comply with the majority of requirements and fields contained within the guideline. For example, the Southern Trust reported that their Electronic Correspondence Module meets the requirements of the guideline and the Western Trust reported that the guideline was implemented through Patient Centre and the Northern Ireland ECR which covers almost all of the requirements of the guideline.

Trusts reported that responsibility for completion of the immediate discharge summary rests most often with junior medical staff, with support from senior medical staff and nursing staff.

Three trusts reported that immediate discharge summaries were sent to General Medical Practitioners within 24 hours. The exceptions were the Belfast and South Eastern Trusts. All trusts reported that immediate discharge summaries are typed, with exception of certain areas of the Belfast Trust, and most commonly they are

sent with the patient or a family member, to pass on to their GP. Exceptions are the Southern Trust which e-mails the discharge summary direct to the GP and the South Eastern Trust where some are sent electronically and some are sent with the patient/family member.

A number of trusts reported that the immediate discharge summary is made available to GPs by using the ECR. The Belfast Trust is carrying out a pilot notification system whereby the GP is informed that their patient has been admitted to hospital, and also when they are being discharged, so that they can access the discharge summary on the ECR.

All trusts reported that they have well established forums to meet with GPs in their area, where issues such as the quality of immediate discharge summaries can be discussed. No trusts reported any complaints arising being brought to these forums regarding the quality of discharge summaries.

A focus group was held in each trust with a group of junior doctors. They confirmed that Foundation Year 1 Doctors (FY1) were mainly responsible for the completion of the immediate discharge summary. Occasionally there would be input from more senior medical staff.

No junior doctors had any awareness of the existence of the GAIN guideline. However, in most trusts, letters were completed using an electronic Patient Centre proforma which maps onto the domains covered by the guideline. The Belfast City and Mater hospitals did not use the Patient Centre system, but used a comparable system that also mapped to the domains contained in the guideline.

Junior doctors reported that in most cases the discharge letter is started and completed at the time of discharge, and not populated early in a patient's stay which would speed up, and help with the accuracy of the final product. The summary is completed by a junior doctor who might not necessarily be aware of the patient and may not have been involved in their care.

Good practice would be that the discharge summary is populated throughout the patient's stay in hospital, as this will lead to more efficient production of the discharge summary, and lessen the possibility of errors. Care should also be taken throughout the patient stay to accurately record all important data, which will ultimately be required for the discharge summary, such as the reason for any medication changes.

Recommendation 1.
An immediate discharge summary should begin as soon as a patient is admitted to hospital, and be populated gradually throughout the patient journey.

Trusts were asked if the quality of immediate discharge summaries was audited.

The Belfast trust reported that periodic intervention audits on the quality of discharge prescriptions are carried out, and in 2013 a project was undertaken, looking at the accuracy of the prescribing information that was transferred to GPs. No audits were

carried out in the Northern, Southern or South Eastern trusts. In Southern Trust pharmacy carry out audit activity of the pharmacy aspect of the Electronic Correspondence Module programme to ensure safety and quality.

In June 2011, in the Western Trust, 100 discharge summaries were compared with the GAIN guideline. It identified that;

- the vast majority were created by FY1s
- 10 per cent had an incorrect primary diagnosis
- medical information was generally good but rehabilitation information was often omitted
- there were implications for coding and peer comparisons across the region

As a result of this audit, recommendations were made to increase training for FY1s, to ensure that senior clinicians clarify for junior staff the exact diagnosis and review plans, and to look at the possibility of piloting a discharge summary sheet to be prepared at the discharge ward round.

The junior doctor focus group also highlighted the need for a more robust induction process in relation to preparation of immediate discharge summaries. They also highlighted the lack of appreciation among junior doctors of the importance of the immediate discharge summary and the discharge process in improving the quality of patient care.

Recommendation 2.
Junior doctor induction should be more robust in relation to discharge summaries, and should emphasise the importance of the discharge process on patient care and patient flow throughout the hospital.

5.2 Survey of General Practitioners

Following the publication of Transforming Your Care (TYC)[13], Integrated Care Partnerships (ICPs) were established in Northern Ireland, to be a key enabler for service improvement in health and social care.

ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors.

17 ICPs have been established in Northern Ireland;

- four in the Belfast area
- four in the Northern area
- four in the South Eastern Area
- three in the Southern area
- two in the Western area

The review team considered that it was important to seek the views of GPs directly, regarding the quality of immediate discharge summaries they were receiving and any difficulties they had encountered. Following discussion with ICP leads, agreement was reached to send a short questionnaire to every GP in Northern Ireland, through the ICPs, which asked a number of questions about the quality and timeliness of immediate discharge summaries. A copy of the questionnaire is included as Appendix 1 and a complete set of results is included as Appendix 2 to the report.

Findings

Overall the return rate was 37 per cent with the rate per area as follows;

Table 1 Percentage return per ICP area.

Area	Percentage return
Belfast	**53**
Northern	**39**
South Eastern	**24**
Southern	**29**
Western	**30**

The following information is aggregated for each ICP area, to present overall principles and it should be noted that this aggregated information contains data from hospitals outside that particular ICP area.

Source of discharge summaries

GPs in the Belfast area most commonly received discharge summaries from the Royal Victoria (RVH), Belfast City (BCH) and the Mater Hospitals, with a smaller number from the Ulster Hospital and a few from Lagan Valley.

[13] Transforming Your Care (A Review of Health and Social Care in Northern Ireland) DHSSPS, 2011.

GPs in the Northern area most commonly received discharge summaries from Antrim Area and Causeway Hospitals, but a number were also received from the RVH and Mater Hospitals.

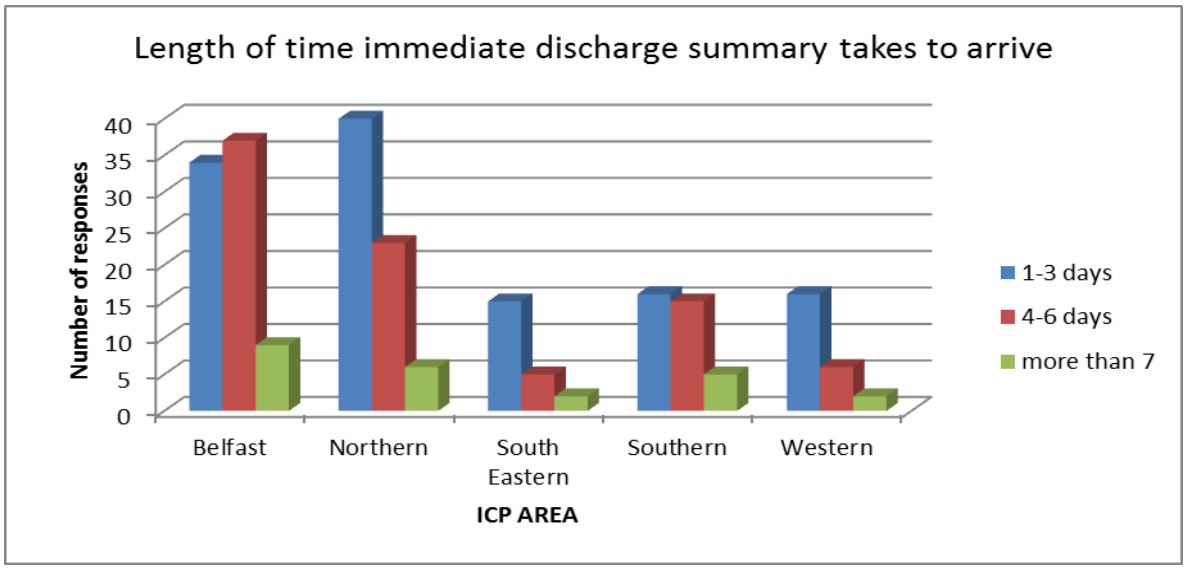
GPs in the South Eastern area most commonly received discharge summaries from the Ulster Hospital, but also received a number from RVH and BCH.

The majority of discharge summaries in the Southern Area were received from Craigavon Area and Daisy Hill Hospitals, with a small number from RVH and BCH.

In the Western area Altnagelvin and South West Acute Hospitals were the most common sources for immediate discharge summaries, with a small number being received from RVH and Antrim Area Hospitals.

Timeliness of receipt of discharge summary

In the majority of areas, responses indicated that the immediate discharge summary arrived at the practice within 1-3 days. However in the Belfast and Southern areas a number of GPs reported that the discharge summary reached their practice within a 4-6 day timeframe. In all areas some GPs reported it took more than 7 days to receive.

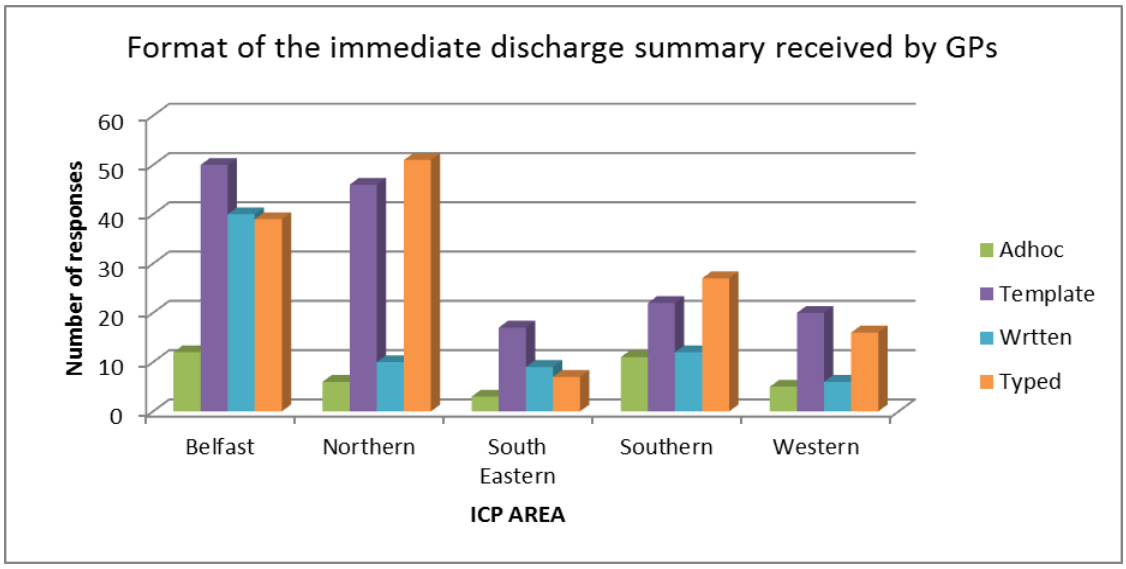


Graph 1

Format of discharge summary

In the Northern, Western and Southern areas, the great majority of discharge summaries received were typed, with only a small number handwritten. GPs in the Belfast and South Eastern areas reported that a larger number of discharge summaries were handwritten. The questionnaire did not distinguish between specialties within the hospitals and it is possible that a number of these were from the ED department.

GPs considered that handwritten discharge summaries are not appropriate as often the handwriting was illegible and medication information was particularly difficult to decipher, which was a risk to patient safety.

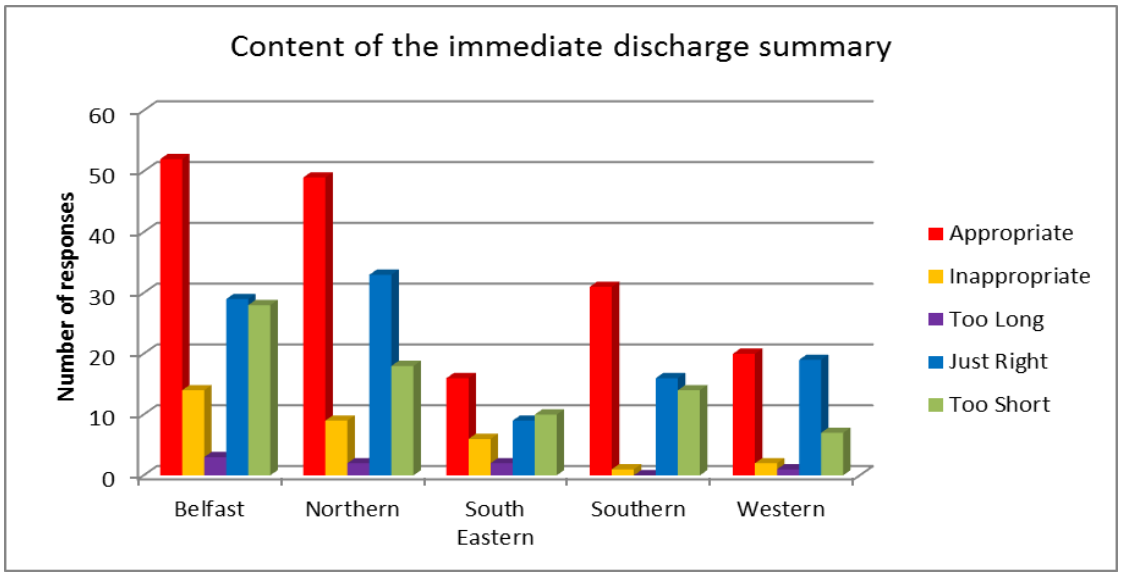


Graph 2

Content of discharge summary

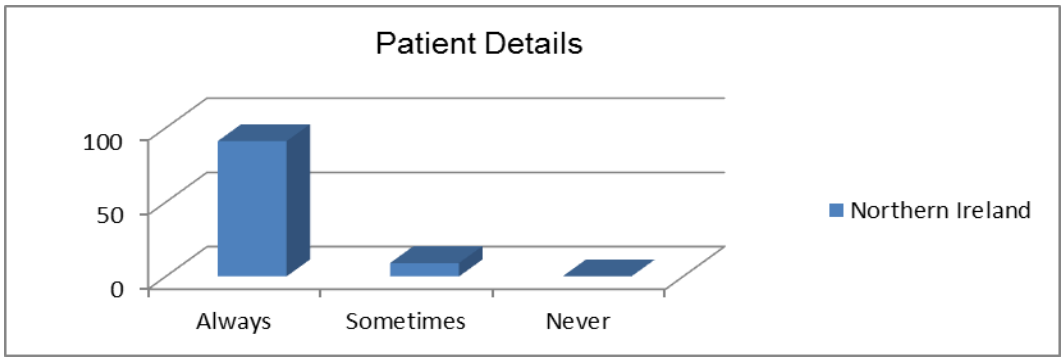
In all areas, the majority of GPs reported that the content of the immediate discharge summary was appropriate. A very small number considered the discharge summary to be too long, with a slightly larger number considering the content to be too short.

When asked in the questionnaire to comment on the most common problems associated with content the overwhelming majority related to medication. Frequently a patient's medication regime is changed while in hospital, but these changes may not be accurately reflected in the discharge summary. Within this cohort of patients, inadequate, inaccurate or incomplete information with regard to Warfarin was the most commonly reported problem.

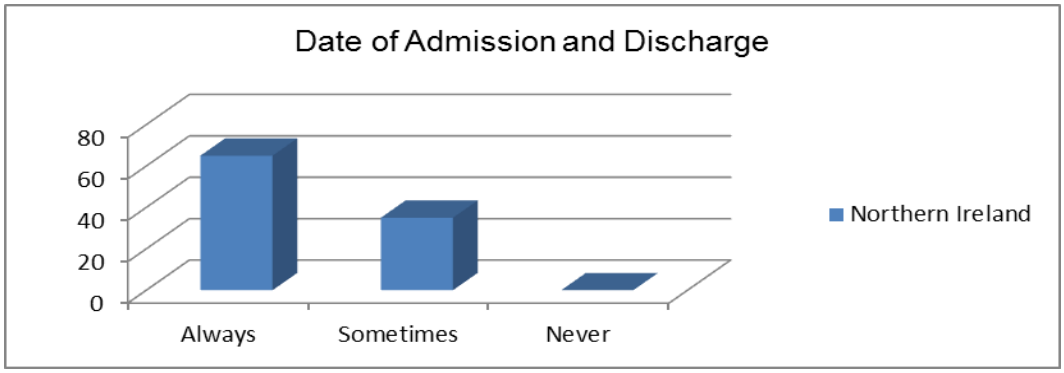


Graph 3

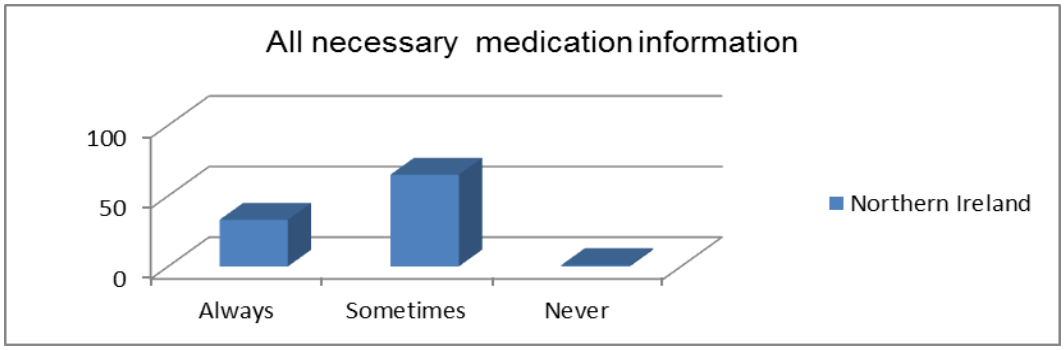
Results from across Northern Ireland showing the percentage of GPs that believed the following are included in an immediate discharge summary received by their practice.



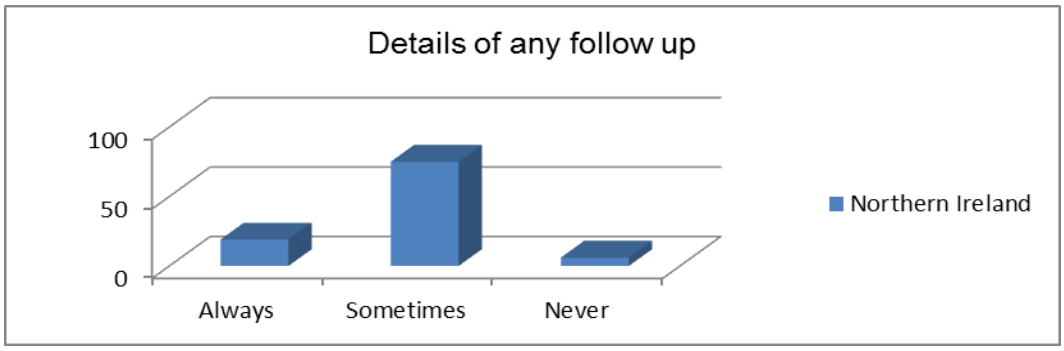
Graph 4



Graph 5



Graph 6



Graph 7

Delivery of discharge summary

The vast majority of discharge summaries are received by the practice either by post or delivered by the patient. GPs considered this to be an area for further consideration, as it led to considerable delays in information getting to them and in some cases the information did not reach them at all. The preference expressed by the majority of GPs, was for electronic transmission of the discharge summary. This could either be via the Electronic Care Record or by e-mail.

Conclusions

Generally the impression provided by GPs was that the situation regarding immediate discharge summaries was improving. The timeliness and general content of the summaries had improved and the major problem with content related to medication information.

GPs considered that all summaries should be typed and that consideration should be given to a method of electronic transmission.

The review team considered that there is a need to ensure that the HSC system is working consistently and that all HSC trusts are utilising electronic collection and recording of information. This will avoid possible handwritten mistakes. Relying on handwritten summaries or that the patient takes the record to their GP is no longer acceptable. Trusts should also work closely with their local GP practices to ensure they are aware that a patient has been in hospital and also that they have been discharged, to allow for appropriate management and follow up.

Recommendation 3.
Trusts should fully implement electronic production and transmission of immediate discharge summaries and ensure that no hand written summaries are produced.

5.3 Discharge Process

5.3.1 Leadership and Planning

Strong managerial and professional leadership is required at all levels to oversee the discharge process. There should be a shared commitment to making the system work. With strong leadership it is easier to manage the tensions that arise within the hospital system, and ensure that patients and carers receive the service that they expect. It is also important to have an effective escalation policy that is responsive, and sensitive enough to deal with problems which may arise with the discharge process, in real time.

All trusts have discharge policies in place which appear robust, have a multidisciplinary approach and take account of the DHSSPS Carers' Guide to Hospital Discharge,[14] which sets out what carers should expect in relation to the discharge from hospital of the person for whom they are caring.

All trusts reported that they have a patient flow/discharge coordinator(s) (or equivalent) in post in their acute hospitals, and that both the in-hours and out of hours periods are covered.

Not all trusts however have a senior level group in place with responsibility for the oversight of discharge planning processes within their hospitals.

The Belfast Trust reported that in its hospitals a discharge planning and coordination group has recently been established under the direction of the Director of Nursing and User Experience. The purpose of the group has been agreed and terms of reference are being developed.

The Southern Trust reported that, on a daily basis, operational management of discharge planning in their hospitals is overseen by an Assistant Director of the week, which rotates across acute assistant directors. They are supported by the head of patient flow and operational heads of service for allied health professionals (AHPs), with input from other heads of service as necessary. A senior leadership group chaired by the Directors of Acute and Older People's and Primary Care Services including heads of service for social work and AHPs meets monthly, monitors trends and identifies any lessons to be learned.

The Western Trust reported that it has in place an acute reform group which has, as one of its functions, review of the patient journey including discharge planning. The review team considered that this group was very large and it would be difficult to be responsive to problems with the discharge process as they arose.

The Northern and South Eastern trusts had no single senior group with responsibility for oversight of the discharge process. Although the South Eastern Trust reported that a number of staff, including the emergency care reform manager, patient flow

[14] Carers and Discharge. A carer's guide to hospital discharge. DHSSPS. August 2010.

coordinators and a number of assistant directors were available when concerns needed to be escalated.

All trusts have procedures in place for immediate escalation of issues in relation to discharge; however during focus group meetings it emerged that there was variability as to how effective or sensitive these procedures were in practice.

Recommendation 4.
All trusts should establish a senior multidisciplinary group to oversee the discharge process, and resolve systems issues which hinder effective discharge. All trusts should also establish effective escalation procedures that are sufficiently sensitive and operate in real time.

All trust boards receive information in relation to compliance with discharge targets and any other issues in relation to discharge.

All trusts have robust systems in place for dealing with complaints and incidents in relation to discharge. A number of themes emerged from complaints;

- communication
- waiting for medication
- timing of discharge
- discharge letter information
- inadequate care package in place
- patient/family choice

5.3.2 Compliance with DHSSPS Targets

From April 2013 DHSSPS asked trusts to ensure that 90 per cent of complex discharges from an acute hospital take place within 48 hours with no complex discharge taking more than 7 days.

Trusts were asked by RQIA to provide figures as to how many delayed discharges had gone beyond seven days in the last 12 months.

Table 1 – numbers of delayed discharges beyond 7 days

Trust	No of delayed discharges beyond 7 days
Belfast Trust	278
Northern Trust	80
Southern Trust	8
South Eastern Trust	349
Western trust	241

Trusts were asked to identify if any trends had been identified in relation to the above figures and the trusts reported the following issues.

Belfast Trust

- contracts for transport
- access to social services
- repatriation of patients to other trusts

Northern Trust

- provision of equipment in complex discharges
- medication changes
- transport arrangements via the Northern Ireland Ambulance Service (NIAS)
- lack of availability of care packages / lack of carers in certain areas

Southern Trust

- No trends as very few delayed discharges

South Eastern Trust

- transport arrangements via NIAS
- repatriation of patients to other trusts
- lack of availability of care packages

Western Trust

- financial pressures
- lack of nursing home/residential home/EMI (Elderly Mentally Infirm) places
- lack of carers in remote areas
- timely assessments for care home managers
- timely assessments from mental health and learning disability programmes of care
- impact of weekly panel decisions

These were identified by Altnagelvin hospital. The South West Acute Hospital added the following;

- limited social work input
- limited rehabilitation services in the community
- equipment

5.3.3 Estimated Date of Discharge (EDD)

Most patients want to know how long they are likely to stay in hospital, to be provided with information about their treatment and when they are likely to be discharged. The estimated date of discharge is the estimated date when it is expected that the patient will be ready to be safely discharged from acute care, to their normal or new place of residence, or transferred to a non-acute setting for ongoing care. The setting and regular review of estimated date of discharge also helps a hospital to plan and understand its capacity at all times.

The EDD;

- should be set early in the patient journey
- helps to plan and understand available capacity at all times
- helps the multidisciplinary team to proactively plan and action a patient's discharge from the start of their admission

- aids communication with patient and families – helps them to be involved in the process and helps families plan for discharge as well
- helps with patient experience by monitoring the number of patients going home on their agreed date
- non clinical delays are signalled when the EDD is reached but the patient remains in hospital

If these steps are in place, this should lead to;

- a more efficient patient journey
- possible reduced length of stay

Discussions with trust staff and evidence from junior doctor focus groups indicated that there was variable use of the EDD across hospitals and specialities. It seemed that not all staff agreed as to its usefulness as a tool to aid the flow of patients through a hospital.

Recommendation 5.
Estimated date of discharge to be set within 24 hours of admission and used appropriately.

5.3.4 Facilitation of Early Discharge

One of the features of an efficient discharge process is that discharges take place as early in the day as possible. This facilitates effective multidisciplinary input and allows for;

- early identification of those patients who are medically fit to go home or be transferred elsewhere
- production of a timely discharge summary
- provision of accurate medication information
- early arrangement of transport
- appropriate social services input

Any delays in the decision making process that establishes that a patient is ready for discharge, can mean a further delay involving one or more of the above processes, which may result in a discharge being delayed for a number of hours, or even until the next day.

Ward rounds should be structured in such a way that patients who are ready for discharge should be prioritised in order to lessen the chance of further delays involving any of the other processes around discharge.

The junior doctor focus group indicated that most discharges take place in the afternoon, and there is no prioritisation or traffic light system to ensure that patients who are ready for discharge are seen early in the ward round. It is understood that those patients who are most ill need to be seen first, but those ready for discharge could be moved up the list.

Trust pharmacy returns indicated the time of day that a prescription is received by a hospital pharmacy is a major factor in determining the timescale for ward delivery of

discharge medicines. Responses highlighted late receipt of prescriptions or simultaneous receipts from a number of wards as a major problem. For example, an audit carried out in the Ulster Hospital showed that only 55 per cent of prescriptions were received in the pharmacy by 1pm; by 5pm the figure was 91 per cent. An audit carried out by the RVH showed a similar picture, with 58 per cent received by 1pm and 91 per cent by 5pm.

Facilitating early prescriptions to hospital pharmacies will also help to discharge patients, which will remove a potential source of delay.

Recommendation 6.
Ward rounds should be structured to initially prioritise patients with greatest clinical need, followed by those who are deemed ready for discharge.

5.3.5 Nurse Facilitated Discharge

On the day of discharge, or transfer of a patient, a decision needs to be made that the patient is actually ready to leave the acute setting. Historically, such decisions have been made by the consultant responsible for the patient's care, but this can potentially lead to delays in the system. Nurse facilitated discharge is one of the ways this potential delay can be removed from the system, by allowing a member of the nursing team to assess the patient, liaise with the multidisciplinary team, and plan a timely discharge based on an agreed clinical management plan.

All trusts reported that they used nurse facilitated discharge to a greater or lesser degree. Two trusts, Southern and South Eastern felt they already used nurse facilitated discharge to its full potential, while the Belfast, Northern and Western trusts felt there was the potential to increase their use of nurse facilitated discharge.

Recommendation 7.
Trusts should continue to explore the potential for maximisation of nurse facilitated discharge.

5.3.6 Multidisciplinary Working

Early Input of Social Work and Allied Health Professional (AHP) Staff

Effective multidisciplinary working is an essential component of any discharge process, and early involvement of social work and AHP staff will help to prevent delays in the process. An early assessment should be made as to whether staff are dealing with a simple or complex discharge or transfer. For the majority of patients, discharge planning should be relatively straightforward, and they will usually return to their own home and have simple ongoing needs, which do not require complex planning and delivery. However the remainder of the patients will have more complex needs. Ward staff need to work with social services colleagues, to ensure early decisions are made, which are in the best interests of the patient.

Dealing with complex discharges often involving elderly patients with a range of conditions and needs, underlines the importance of starting discharge planning at an

early stage following admission, in order to plan for and resolve problems before they impact on the length of a patient's stay.

All trusts in their questionnaire returns provided information on how they considered multidisciplinary input is provided, and also how community services are linked into the discharge process.

The review team considers that early multidisciplinary input is one of the key factors of a successful discharge. During focus groups it was clear that all trusts were aware of the importance of early multidisciplinary intervention but were at different levels in respect of how successful they had been.

The review team considered that the Southern Trust has developed a very robust system in the form of its daily multidisciplinary whiteboard meetings at ward level and the introduction of the Southern Trust information hub, which alerts community services once a patient has been admitted to hospital. This allows discharge planning to begin at a very early stage in a patient journey. Junior doctor focus groups did not note any potential delays in the discharge process with regard to multidisciplinary input.

The Belfast Trust also seems to have a strong multidisciplinary focus at ward level, with community in-reach social work teams, occupational therapy and physiotherapy input at an early stage. The trust has developed a Community Information System known as the Hub, a rapid response social services system which is a method for the acute system to access community rehabilitation services. The trust reports a 93 per cent response within 48 hours for rehabilitation services. Junior doctor focus groups reported that multidisciplinary working mostly functioned well, but noted that in the Belfast City Hospital (BCH) it may take several days for patients to be seen by AHPs.

The South Eastern Trust is aware of the advantages of early social work involvement but the review team was informed that due to capacity issues, social workers were often not involved until a patient was considered to be fit for discharge. Junior doctor focus groups noted that physiotherapists and occupational therapists in the trusts were proactive in seeing patients. Multidisciplinary team meetings were ad hoc but effective. They identified lack of social work input as a factor that was leading to significant delays in discharge of patients with complex needs.

In the Northern Trust, each day, community teams identify patients on admission. They will then identify key social workers if present, and obtain information regarding main carers, family members etc. to allow the discharge process to be instituted at an early stage. However junior doctor focus groups identified social work input in Antrim Area Hospital as a potential source of delayed discharge, as due to capacity issues, patients would only be seen if 'end of acute admission' was documented in medical notes.

In Causeway Hospital however junior doctors considered that social work input occurred early in the admission process.

The Western Trust has a referral management system which attempts to provide early social work input. The review team was informed that the social work team usually responds within 24 hours and definitely by 48 hours. However the team was also informed that sometimes referral to community services may take up to four days. The review team was informed of some capacity issues for occupational therapy. The trust has set up a panel to allocate resources/funding for complex discharges requiring continuing care in the community. However, the panel only meets weekly and the review team considered this to be a potential source of delayed discharges. Junior doctor focus groups reported that physiotherapy and occupational therapy input was good. They felt that social work input into the discharge process was very helpful, but felt that more input was needed to provide help with complex discharges.

In discussions with social work staff two other issues were discussed:

- provision of intermediate care facilities for those patients no longer needing acute care but not yet ready to go home
- all trusts reported this as a potential source of delayed discharge, especially in the South Eastern Trust where one of the facilities they use is situated in the Belfast Trust and staff reported that it was sometimes difficult to get placements

The use of the Northern Ireland Single Assessment Tool (NISAT) was also discussed, and the review team considered that its use varied throughout trusts.

In the Belfast Trust the consensus was that a single assessment was desirable and a positive way forward. However NISAT had not replaced the duplication of other assessments (by AHPs and social workers) and that NISAT results in extra workloads.

In the Northern Trust the CM 2000 system has been developed to hold patient information and care workers' availability. A pilot of e-NISAT is being carried out in Causeway Hospital, allowing patient information to pass into the acute sector.

In the South Eastern Trust NISAT is seen as a positive development by AHPs and social workers. However feedback from staff indicates that duplication remains in relation to recording of information, as no other assessments have been removed or reduced.

In the Southern Trust there is a strong desire to have an information system which develops effective shared information for GPs, AHPs and social workers to aid discharge. Although desirable, NISAT is not seen by staff as being suitable for short stay patients.

In the Western Trust staff feel that the throughput of patients in an acute hospital is too fast for NISAT to work effectively. While Waterside Hospital occupational therapists are using the specialist summary of the NISAT documentation, they are not completing this as part of the e-NISAT assessment tool. Recent discussions indicate that this could be improved upon. The Waterside Hospital only deals with rehabilitation and sub-acute patients.

The review ream considers that complex discharges are likely to require multidisciplinary input, including specialist assessments and that the implementation of e-NISAT should continue to be examined as a vehicle for improving discharge procedures.

Recommendation 8.
To facilitate discharge, all trusts should develop systems that allow early multidisciplinary and community services input to include continuing development of e-NISAT.

5.3.7 Care Homes

All trusts informed the review team of difficulties in relation to discharge of patients from the acute sector to the care home sector. These difficulties had been managed to a greater or lesser degree within different trusts, and contribute to delayed discharges. Issues included;

- limited access to nursing homes particularly EMI provision
- care homes will not accept patients after a certain time of day
- care home managers have to carry out an assessment of a patient before they will take them back into their care. The manager may not be available when the patient is ready for discharge
- nursing homes may not accept patients at weekends
- some homes may not take back more than one or two patients in any one day
- patient choice of homes
- end of life care

All trusts have established forums with care homes in their area to discuss any issues that arise, including issues around discharge from hospital. In general the review team was made aware that trusts understood the importance of senior managers within the trust meeting regularly with care home providers. However, greater regional emphasis should be given to the need for providers to engage at the interface with the acute sector, in order to ensure a more timely response.

In the Northern Trust, due to effective communication and partnership working, a number of homes had become much more flexible about the timing and number of patients they were willing to accept. These homes also accepted the trust's nursing assessment and did not insist on carrying out a pre-admission visit. The Northern Trust and the northern sector of the Western Trust particularly identified the lack of EMI provision as a potential cause of delayed discharge. In the Southern Trust a Care Home Support Team has been established.

Recommendation 9.
Trusts should explore methods of making their care home forums more effective, and developing closer partnership working with care home providers, so that hospital discharge and other concerns are addressed in a mutually supportive way.

Delays in discharge relate to patient choice, when a patient or their family has identified a preferred post hospital placement that is not immediately available. The patient remains in hospital awaiting a place in the preferred option, even though

other options may be available. Such delays relate primarily to patients awaiting a place in their residential care or nursing home of choice, and can be considerable if not managed properly.

There will be times when a patient's preferred choice of residential care or nursing home is not immediately available. Trusts have to balance the right of the patient to go to a placement of their choice, against the need to avoid delays in discharge, by providing an interim placement until the patient's first choice becomes available. All trusts had policies or processes in place for dealing with patient choice as part of discharge, and also policies for dealing with complications arising from patient choice. The review team considered that this was an area that created difficulties for all trusts and these polices were sometimes not as effective as they could be. Staff expressed a desire for support from clinical colleagues and senior teams within trusts to explain to families and carers the need for interim solutions when their desired placement was not available.

Recommendation 10.
All trusts should re-examine the effectiveness of their policies for dealing with patient choice and difficult discharges, and evaluate the input of the multidisciplinary team into the process.

In discussions with the review team, a number of trusts raised the possibility of running a public awareness campaign to explain the functioning of an acute hospital, and the pressures that an acute hospital is operating under. It could also explain the difficulties that exercising patients' and carers' rights may cause in terms of delays to discharge, and subsequent difficulties this may cause in another part of the hospital. Finally it would promote the need to make realistic choices. The review team agreed that this was a reasonable suggestion.

Recommendation 11.
Consideration should be given to developing a public awareness campaign, explaining the functioning of an acute hospital and the pressures under which it operates.

A number of trusts raised an issue with the review team regarding palliative care and end of life care. It was felt that a number of patients were being admitted to an acute setting from a care home, when their preference and that of their families would have been to remain in the home.

The Western Trust has employed a community geriatrician who has developed a training initiative involving nursing homes, designed to prevent admission to acute hospitals. This also includes training in palliative care, to prevent those at the end of their life being admitted to an acute setting. An initiative has also been developed in conjunction with Integrated Care Partnerships where Foyle Hospice is providing end of life care training across nursing homes in the area.

The Southern Trust has provided specific training in palliative care for nursing homes in order to ensure safe and effective end of life care in nursing homes.

All trusts provided examples of training and development in end of life care; however it was acknowledged that this had to be ongoing.

The review team considered this was an area that required good communication between GPs, Out of Hours GP Services, acute hospitals and nursing homes. It is an area that perhaps could be explored in conjunction with Integrated Care Partnerships.

Recommendation 12.
Trusts should examine ways of supporting safe and effective end of life care in nursing homes, by developing staff skills and confidence, to allow residents to end their life in a familiar environment, with carers they and their family know.

5.3.8 Information Technology (IT)

The review team considers that one of the main building blocks of an effective discharge process is the availability of accurate, real-time information which can only be supplied by an appropriate IT system. This enables more effective multidisciplinary working and reduces the possibility of delays in discharge.

All trusts have different systems, delivering different levels of information to facilitate discharge processes.

The Belfast Trust in collaboration with the NHS Greater Manchester Commissioning Support Unit produces a daily predictive analysis report which provides information in relation to ED performance against four and 12 hour targets, numbers of attendances and admissions and also numbers of discharges. This gives an overall snapshot of the picture in the trust but does not supply information on individual patients. The trust patient flow system provides information on the live bed state within the trust hospitals, which is used to generate a site status report, which is shared with clinicians and senior management four times a day.

The Ulster Hospital Dundonald in the South Eastern Trust has an Electronic Patient Management System (EPMS). This provides staff with information about patients arriving in the ED through to their admission to wards. Junior doctors have access to information on the system about investigations that are required, and can record that they have been actioned.

In the Northern Trust, information is available via Quickview Solver, a whiteboard flow system, and bed capacity can also be monitored using their open ward electronic bed management system.

The Southern Trust has a system known as IMMIX Flow; an electronic whiteboard system which is utilised by all staff and is visible in all areas of the hospital, ensuring that the bed state can be clearly seen in live time by all trust staff. The system is fed from the Patient Administration System (PAS) and provides real time information on the status of all patients in the hospital. It contains their estimated date of discharge, has a note of whether the patient needs input from social work, AHPs or pharmacy and also will flag up if this has not been carried out. It provides information on numbers of patients awaiting admission from the ED, and also the number of

patients awaiting discharge. It will provide a list of patients for all consultant staff, help in the allocation of tasks to junior staff, and is utilised to ensure a more sufficient handover process.

The review team was informed that the Western Trust is implementing the IMMIX Flow System for its own use.

The review team considers that the Southern Trust seems to have a very effective IT system which in conjunction with its community hub provides the basis for an effective discharge process.

Recommendation 13.
All trusts should have an effective IT system, supplying appropriate real time information that leads to a more efficient discharge process.

5.3.9 Seven Day Hospital Working

Social Services and AHPs

Many hospitals try to manage weekend capacity by discharging large numbers of patients on a Friday. Discharge numbers then fall dramatically until Monday morning or more frequently Monday afternoon. This is not the most effective strategy as it often takes several days for the mismatch between admissions and discharges, built up over the weekend, to resolve. This has predictable consequences in terms of pressure on beds.

All trusts were aware of the need to even out the flow of discharges over the entire week, and the need to work towards a seven day working system. All trusts were at different levels in regard to working towards this goal.

In the Belfast trust, on the RVH site, hospital social work provides a limited weekend service, usually four hours per day on Saturdays, Sundays and bank holidays. Hospital social work is not available out of hours in the Mater or BCH except during bank holidays. A hospital social worker can restart or increase an existing package of care, or commission a simple package. They can also access step down beds in a care home. The trust is presently considering what AHP services would be necessary to deliver a seven day service.

In the Northern Trust, there is social services availability at weekends. There is one physiotherapist and one occupational therapist available; however they have to prioritise their workload so discharge may not be seen as a top priority. The trust feels that it is still some way from providing a seven day service. The trust is however using a member of staff to act as a weekend discharge doctor. This doctor may be a staff grade or a registrar. This helps to smooth out the flow of patients being discharged from the hospital. No new care packages can be instigated at weekends.

The Southern Trust does not in general have any social services or AHP weekend cover with regard to discharges. There is however targeted seven day working by physiotherapy staff to facilitate enhanced recovery and early discharge. Staff also

informed the review team that, with their information system and community hub, weekend discharges can be planned for early, and then facilitated by nursing staff utilising the Southern Trust OOH Protocol for re-start of services.

The South Eastern Trust provides a limited amount of weekend social work and AHP cover which the trust feels has contributed towards evening outpatient flows. A pilot project has secured funding for a social worker which ensures limited social work cover from Friday 2pm until Sunday. As yet, there is no funding for extra AHP staff.

Western Trust hospitals do not have any social services or AHP provision at weekends. Discharges that require social services support are not facilitated, unless there is an emergency response required e.g. mental health assessment for possible detention.

Pharmacy

Historically, hospital pharmacies have been funded to provide a weekday service, generally between 8:30am and 5pm, plus a limited service at weekends and on public holidays (typically 2-3 hours on Saturdays/public holidays and in some cases Sundays, for the dispensing of discharge prescriptions and new inpatient medicines). One trust reported that the weekend services was funded by re-alignment of existing Monday to Friday services. Trust returns indicated that considerable efforts have been made to extend these hours over recent years, on a recurrent or ad-hoc basis.

Antrim Area Hospital dispensary now stays open until 7pm Monday to Friday, and also provides services on Saturdays, Sundays and public holidays.

The RVH and BCH pharmacies are open until 9pm on weekdays and from 9am to 5pm at weekends. This model has been in place since September 2013. The RVH and BCH extended hours service provides a pharmacy service for all of the Belfast Trust. The extended hours service in the Belfast Trust is currently not funded, and an investment proposal template has been submitted to the local commissioning group in relation to this.

The Ulster Hospital dispensary is open until 5pm Monday to Friday with a lock up team staying beyond 5pm to finish any remaining discharge prescriptions. The dispensary is also open on all public holidays with the exception of Christmas day and open 8.30 – 12pm on Saturdays. A Sunday service has been operated over the last two winters (10am to 2pm) to facilitate Sunday discharges.

Altnagelvin pharmacy is open until 6pm on weekdays and from 10am until 2pm on Saturdays. SWAH pharmacy opens Saturdays, 11am to 1pm.

This extended provision has facilitated patient discharges outside normal pharmacy opening hours, but falls short of a full seven-day service on most sites.

Recommendation 14.
All trusts should develop a system that provides for discharges to happen throughout a seven-day working week.

5.3.10 Transport

Transport provision for those patients who require it, was raised by all trusts as an issue that could potentially cause delays in discharge. The review team was informed that on a number of occasions a booking is made with the Northern Ireland Ambulance Service (NIAS) to provide transport for a patient being discharged from an acute hospital, which is then cancelled at short notice. This may lead to a patient being discharged very late in the day or in fact having to spend another night in a hospital bed. A number of trusts have developed alternatives to the use of NIAS transport and have contracted with organisations such as the Red Cross, or are providing their own means of transport. Often these services are provided by non-recurrent funding and are not long-term solutions to the problem.

The review team recognises that there are many calls on a finite resource in terms of ambulance provision. It also recognises that it is a very complicated situation when considering emergency admissions, non-emergency admissions and GP urgent admissions, as well as trying to provide a service to facilitate hospital discharges and also providing transport for a significant number of patients who are attending outpatient clinics. The timings of these events also means that the greatest pressure on the service tends to occur at the same time as most discharges are taking place i.e. in late afternoon.

The review team feels that this is an area that could be looked at regionally. Trusts could work with NIAS to look at the flows of patients from all of these areas, in order to make it easier for NIAS to prioritise their workload and perhaps carry out some remodelling of their system, to facilitate discharges from acute hospitals.

Recommendation 15.
Trusts should work with NIAS and commissioners to create a system that better supports transport for those people being discharged from acute hospitals.

5.3.11 Repatriation of Patients to Other Trusts

Although brought forward as an issue to the review team by a number of trusts, the review team considered this to be more of a problem for the Belfast Trust, which operates as a tertiary centre for a number of services.

Belfast Trust staff reported to the review team that as well as being a tertiary centre, changes in other trusts have affected the trust catchment area, leading to an extended catchment area, especially at weekends. The result of this is a number of patients from other trusts needing to be transferred back to these trusts. Trust staff also reported that all trusts have different discharge pathways with regard to the level of assessment and documentation required. This especially applies to those patients with complex needs who will have a more complicated discharge procedure, and sometimes leads to considerable delays in discharge. To help to address this, the Belfast Trust has employed a Discharge Expeditor who works with other trusts to support the discharge of these patients into the most appropriate pathway.

In the review team's opinion this was an area that could be looked at regionally, with consideration given to development of regional documentation for this purpose and also a single point of contact in each trust.

Recommendation 16.
A regional group should be set up to develop a more effective process for repatriation of patients back to another trust.

5.3.12 Provision of Discharge Medication

Virtually all hospital patients receive medicines during their in-patient stay. Many of them will have been taking prescription or non-prescription medicines prior to admission. Most will leave with discharge medication and recommendations for future treatment.

Hospital discharges are frequently complex in terms of medicines management, due to a number of factors such as;

- a large number of medicines being taken
- significant medication changes during the inpatient stay
- a medication such as warfarin which requires monitoring
- a condition such as renal impairment which could affect the clearance from the body of some drugs
- controlled drugs such as strong opioids

A stay in hospital, with associated changes in medication may significantly increase the risk of discrepancies occurring after discharge, due to inaccuracies in the prescription, or misunderstandings by the patient.

The majority of these discrepancies are likely to be minor, but potentially they can have serious consequences, such as reduced symptom control, treatment failure, over dosage, or adverse reactions/inter- actions. These consequences can lead to further demands on primary or secondary care services, including re-admission to hospital.

For this part of the review, trusts were asked to complete a specific pharmacy questionnaire and provide documentary evidence to validate their responses. A member of the review team met with the five Trust Pharmacy and Medicines Management leads collectively to obtain more detailed comments. Visits were carried out to six hospitals to observe the pharmacy service in operation.

A full copy of the pharmacy and medicines management report is included as Appendix 3 to this report.

The potential contribution of pharmacists to the medicines discharge process, needs to be considered in the context of practice developments which have been instrumental in shaping the current pattern of pharmacy services.

In 2005, an integrated medicines management/ clinical pharmacy model was rolled out across Northern Ireland. This model involves a team of ward based pharmacists

and technicians reconciling medication on admission, during the patient stay and at discharge. In 2012 the service was reviewed by DHSSPS, and the report indicated that there was considerable variation in the numbers of wards that had pharmacists delivering an integrated medicines management service. A number of wards in all hospitals did not have a pharmacist to directly input into medicines reconciliation on discharge.

Findings from this part of the RQIA review indicated that the pharmacy service has a clear vision of what is required to ensure quality and safety in the medicines management process, and there has been considerable progress in making the required changes in equipment, systems and culture. However, there was found to be considerable variation in the rate of implementation of the integrated medicines management model across hospitals and across wards/specialities. Only about half of the beds had an appropriate service model in place, and staffing levels on these wards were not always sufficient to deal with the workload.

Responses from the trusts indicated that there were three main models of pharmacy input;

1) Fully integrated medicines management and one stop dispensing service - In this model, pharmacy support is available on the ward during all or most of the working week. There is active communication regarding discharge planning between medical, nursing and pharmacy staff. The pharmacist prepares or reviews the discharge medicines list which forms part of the immediate discharge letter. Where a one stop dispensing service is also available the discharge prescription is dispensed by the ward based pharmacy team. Some excellent examples of integrated working were observed in coronary care and renal wards.

2) Wards with a clinical pharmacy service but no integrated medicines management service – In this case the provision of the clinical pharmacy service may be limited and subject to occasional suspension if pharmacy resources are stretched. In most circumstances the pharmacist reconciles the medicines on discharge and the discharge prescription is taken to the main pharmacy to be dispensed.

3) Wards with no clinical pharmacy service – pharmacy support is generally limited to advice on request or when resources permit. Discharge prescriptions are prepared by the doctor and sent to the main pharmacy for dispensing.

Discussions with ward staff indicated that communication and cooperation with pharmacy staff is greatly enhanced where the fully integrated medicines management and one-stop-dispensing model is in place. It facilitates early planning for discharge, reduces the chances of prescription error and speeds up the dispensing of discharge medicines.

In discussions with trust staff, and also with pharmacy staff, it emerged that errors in discharge scripts were a potential cause of delayed discharge. Up to 60 per cent of discharge scripts completed by junior doctors contained errors, and had to be

returned for correction, often requiring the doctor to go to the pharmacy. The doctor involved may have gone off duty and this added to the potential for delayed discharge.

Junior doctors in their focus group were very supportive of integrated working with pharmacists on their wards, as it helped to improve the quality of the overall discharge process, as medications were correct from the start.

Trust returns and focus groups confirmed that the extent of medicines review and reconciliation at discharge depended on the operational model that was in place.

The RVH, BCH, and Mater hospitals commented that the clinical check may be undertaken at the dispensary, where there is no clinical pharmacist service to that ward.

The Ulster Hospital said that for wards with no clinical pharmacy service, discharge prescriptions are clinically checked in the dispensary prior to dispensing. In Craigavon and Daisy Hill hospitals the discharge medication is reviewed by the prescriber who writes the discharge prescription. If there is a clinical pharmacist for that ward, they will also review the discharge medication.

In the Northern Trust, patients' medicines are reviewed and reconciled by ward based pharmacists prior to discharge.

In Altnagelvin and South West Acute Hospitals, medications are reviewed where a clinical pharmacy service is available, and otherwise screened in the dispensary.

In Antrim hospital, pharmacists now prepare the medication list of the immediate discharge summary, either as a pharmacist independent prescriber following an agreed treatment plan or following a trust protocol. The final list is uploaded to Patient Centre thus providing a seamless service.

Time taken to check prescriptions and prepare discharge medication was also seen as a potential source of delay in the discharge process, particularly where there is no one-stop ward dispensing system and prescriptions have to be sent to the main pharmacy. Turnaround times of under two hours were generally reported in these cases, but transit arrangements could add substantially to this in some places. Therefore to ensure that discharge medications are available at a certain time, prescriptions need to be in the pharmacy two hours before that time. This again emphasises the need for planning for discharges to take place earlier in the day. Trust staff again confirmed that preparation times for discharge medications are much less of an issue where ward based pharmacy teams are in place.

The review team considered that the integrated medicines management and one stop dispensing services contribute to improving the accuracy of discharge medication, as well as increasing the efficiency of the discharge process.

The other main issue for the review team was the number of errors in discharge prescriptions prepared by junior doctors, both in terms of patient safety and also the potential to delay discharge. All hospitals had a system to pick up and correct the

errors, but the time taken for this to happen could adversely affect the discharge process. An integrated medicines management model would help to prevent these errors, but in the interim the review team considered that medicines management should be an integral part of junior doctor training and induction.

Recommendation 17.
Trusts should continue to develop integrated medicines management models with clinical pharmacy input at ward level.

Recommendation 18.
Trusts should provide structured prescribing and medicines management training for junior doctors as part of their induction.

6.0 Engagement with Service Users

In April 2014, three focus groups and 15 one-to-one telephone interviews were carried out throughout five health and social care trusts in Northern Ireland. In total, 24 patients (or their carer) engaged in this part of the review; 13 were female and 11 were male.

The interviews and focus groups covered five health and social care trusts, with four participants from the Belfast, Western and Southern Trusts. Six participants were from the South Eastern Trust and two were from the Northern Trust, as shown below (Diagram 1):

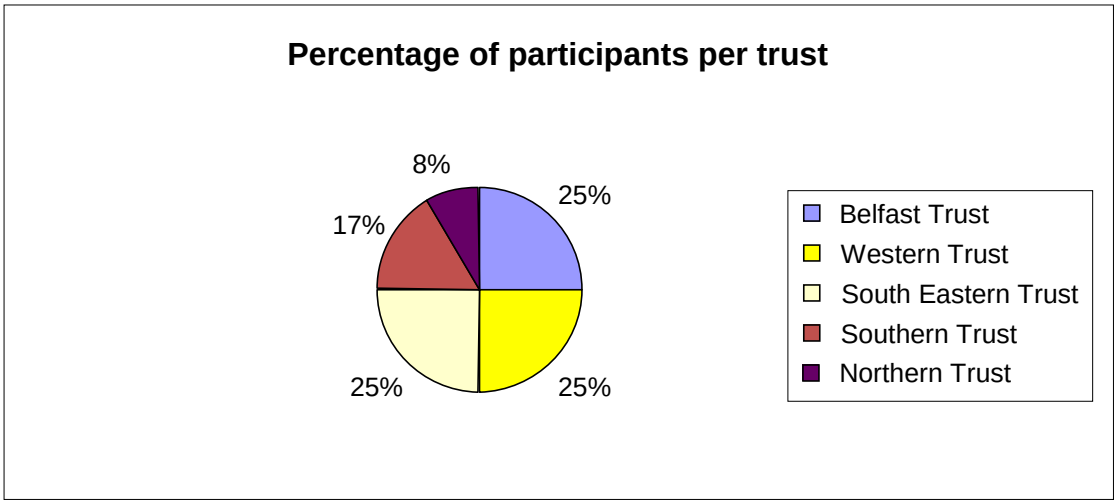


Diagram 1 – Breakdown of participants by Health and Social Care Trust

Participants had been involved in a range of simple and complex discharges.

Patients (or their carer) were asked about their own experience of hospital discharge. In particular, they were asked about:

1. the discharge process (timeframes/reasons for delays/discharge letter).
2. communication around the discharge process.
3. what happened after they went home (implementation of care packages/equipment/medication).
4. what they would like to change.

A full copy of the report is attached as Appendix 4 to this report.

6.1 Belfast Trust

One focus group (three patients) and two one-to-one interviews were carried out in the Belfast Trust. A total of five patients (or their carer) took part in the process.

The Discharge Process

Most patients reported having to wait for over seven hours between the time they were told they were being discharged and the time they were actually discharged.

Two patients reported having no issues with the process even though they had to wait for an extra couple of hours.

Two participants reported having to wait one extra day or more to be discharged and in one case the delay was due to having to wait for an ambulance.

The same participant who was a carer gave an example of a previous discharge when the organisation of a complex discharge package delayed the discharge of her mother by over a week;
"*One day we were told she was going home, then she wasn't, then she was. It kept changing, then they don't work at weekends. That held it up even more because the whole place seems to die at the weekend."*

Participants reported that the length of time between being told they would be discharged and the actual discharge time had a negative impact on patients, leading to increased uncertainty and confusion;
"I suppose it's the uncertainty, for her, she has dementia, so obviously the confusion, strange people, strange place"
"It was horrible, mummy's dementia at that stage wasn't as bad as it is now, when she got home she was in total confusion, it took her a month before…..and it basically went down after that, not that I am saying that it was the cause but she went down, as a result she had to go to a nursing home."

Participants reported several reasons for delays in discharge which included waiting for a discharge letter, sorting out care packages and medication and waiting for an ambulance.

Patients were aware of the problems surrounding care packages, especially complex care packages. In addition, discharges occurring at the weekend seemed to be subject to further delay because of a lack of staff.

Communication

Although one of the patients was very positive about communication around the discharge process, the general feeling was that they would prefer to be told they were being discharged just before the actual discharge, rather than leaving several hours between the two events.

Post Discharge

For patients and carers the discharge process does not end when they leave hospital. Two participants reported not having access to a social worker after they were discharged. They didn't know why that was the case and didn't ask anyone about it.

One patient was sent home without his medication and another mentioned how her husband was sent home without the equipment he needed (special shoe).
"[name] was sent home without his medication. I had to give him old stuff that I had in the house….A district nurse gave us the medication a few days later.

There was nothing arranged to bring him home … I feel he should have been into rehabilitation or something just for a wee while longer."

What would they change?

A couple of patients did not suggest any improvements, as they were very happy with the discharge process. Others suggested that;

- the discharge letter should be sent direct to the GP.
- staff should be better prepared (re medication) ahead of the discharge.
- more staff working at weekends would improve the discharge process.
- having more coordination between the different staff involved in the discharge process would improve the whole experience.

6.2 Northern Trust

Two patients from the Northern Trust took part in a one-to-one interview.

Discharge Process

The two participants reported delays in discharge of five and a half hours and one day. The main reasons for the delays were waiting for medication and discharge letter. One patient, although she felt that she had had quite a long wait could not pinpoint exactly who or what was to blame for the delay;
"There's something missing there, don't ask me what, but there's something missing between the time that the doctor tells you that you are well enough to go home and you actually get there. There's something missing whether it's in the admin bit or whether it's to do with the doctor's writing of the discharge note. I'm not sure".

One of the participants felt that the delay meant that they were wasting a bed which someone could have used.
"It takes from 11am until 7pm to get a doctor to discharge him plus his medicine. It seems an awful waste of a bed, it's a full day that he's lying in a bed that somebody else could be in."

Communication

One participant reported that they had received little written information on the discharge process. Therefore her input into the process was non-existent. However, she reported that nursing staff had been very helpful, and the other participant reported that staff explained to her how to use the equipment she would need at home.

Post Discharge

Neither participant needed a care package, and no issues were reported.

What would they change?

One patient reported that she would like to see everything in place before being told she was being discharged. The other patient did not understand why it took the

doctor so long to sign the discharge letter, and felt that if they were told the reason it might make the delay more bearable.

6.3 South Eastern Trust

Six patients from the South Eastern Trust took part in one -to-one or telephone interviews.

The discharge process

A majority of the participants reported no delay, or a delay of 2-3 hours, between the time when they were told they were being discharged and the time of the actual discharge. The main reason for any delay in the process was waiting for medication to come from the pharmacy.
"there was a delay in the drugs coming down to me"

Another participant reported waiting for eight hours because of medication. Although he waited for three hours another patient felt he was "pushed out" of hospital.
"it felt a bit rushed to be honest that this decision was taken so suddenly…I had been quite ill with a high temperature….it was a bit of a shock…it seemed to me that they wanted me out of there….it wasn't as if they said to me if we get you out of antibiotics then you will be able to go home, no-one suggested that ….it was stop the IV and then go home, It seemed like a surprise, it did seem like there was a general clear out."

When asked if he had mentioned this to anyone he said he hadn't as he felt the nurses had done a great job.

All participants were given a discharge letter to give to their GP. The patients went home either with relatives or by ambulance; one participant who went by ambulance reported a delay in the process.

Communication

All participants were very positive about the communication around the discharge process. They were kept informed of the reasons for any delays and the process was explained to them.

As a general rule, although staff explained the discharge process to the patients, most reported that they had no input into the process themselves. The communication was mainly verbal. No written information was handed out.

Post Discharge

Participants were positive about their return home. Having said that, most of them had simple discharges that did not need care packages.

What would they change?

Most participants agreed that having everything ready (including discharge letter and medication) before asking the relative to come and collect them would improve the discharge process. They felt that having more information earlier would improve the service.

6.4 Southern Trust

One focus group (4 participants) was carried out in the Southern Trust.

The discharge process

Two of the patients reported long delays in getting discharged (between 7 and 10 hours) and felt strongly about it.
"In terms of the plans that are in place around discharge I have to say I've had quite a negative experience, in the timeframes of discharge. Given that on Friday I was informed at 9am that I would be discharged and not being able to leave hospital until 7pm, quite frankly I don't think it is acceptable in the 21st century health service, that it takes so long to get something from pharmacy".

The main reported reasons for delay were waiting to see a doctor and waiting for the discharge letter.

"The doctor came around on a Sunday at lunchtime to tell me I could go home…..5pm came and the nurse said the doctor in the main hospital would not come over, that was her word, would not come over to sign the discharge letter. It was me and an older lady… then at 7:30pm, a different nurse came and said – if we let you home, can you guarantee you will come back tomorrow to get the discharge letter. I was only too happy to go home.

The patient came back the next day and had to wait a further two hours to get his discharge letter.

One of the consequences of having to wait to be discharged was that some patients became stressed and anxious as they felt they *"just wanted to go home".*

Organising transport was also an issue made more difficult by the delay in being discharged. Participants also had issues with being discharged late in the evening, especially to nursing homes as this impacted on the patient, relatives and the home.

Communication

Participants expressed mixed views about the communication they received as part of the discharge process. One patient found the communication to be clear and very useful but others felt there was not enough.
"What about listening to the voice of the parents? We didn't have any say in our son's care….he wasn't comfortable in the ward, it wasn't a good place for my son to be and I knew instinctively that he would have improved better if he had got home,

the stress levels would have decreased if I had been able to air my views but I was shut down".

A participant, who was the wife and carer of a patient, felt that she was excluded from the discharge process, as the doctor asked her to leave when he wanted to discuss something with her husband.

Post Discharge

The patient who had gone home with no letter was anxious in case something happened, as he had not been told anything. One patient found that the discharge letter was lacking information on medication dosage. In addition she had been told an inappropriate dosage by a nurse. As a result she had rung her local pharmacist who advised her of the appropriate dosage, adding to the stress and worry of looking after her son.

What would they change?

There was a definite feeling from participants that there was a need for clear timeframes around discharges which they did not feel were in place.

It was also suggested that the different departments (pharmacy, medical and nursing staff) needed to better collaborate with each other.
"Collaboration is the key factor. I think that it would be helpful for the department to put in place as they have in A&E clear timeframes around discharge…..I think four hours is reasonable.

6.5 Western Trust

One focus group (3 patients) and four one-to-one interviews were carried out in the Western Trust.

The discharge process

A number of participants reported only minor delays of a couple of hours due to having to wait for medication. One participant waited three days (over a weekend) to be discharged. She wasn't sure why she had to wait but speculated that it was due to discharges not happening at a weekend.
"It was too late on the Friday to be discharged so then I was told that it would be Monday morning".

One next of kin raised the issue of the implication of being discharged to a nursing home. As places in nursing homes are limited it was felt that this created bed blockage in the hospitals.

Communication

Most participants were very positive about the communication around the discharge process. They all received either written or verbal advice on the process itself. Staff kept patients/next of kin informed of the process.

"They kept me informed all the time, the different assessments that were being done".
"I had a talk with the pharmacist as well about his medication".

Post Discharge

Some of the patients were given equipment (i.e. Zimmer frame, stairlift). Mostly there were no issues, but there was a minor delay when staff forgot to give one patient a Zimmer frame.

What they would change?

Most participants were mostly content with the discharge process but some mentioned that they should not have to wait so long for a discharge letter.

6.6 Conclusions

On being interviewed as part of this review, delays in being discharged from hospital were reported by a number of participants or their carers. Delays ranged from between two hours and a number of days. The main reasons quoted were waiting for a discharge letter from the doctor and waiting for medication. There was a definite lack of understanding from patients regarding the reasons for delays in producing discharge letters.

Overall, patients and carers were positive about communication around discharge, even though they had little or no input into the process.

Some issues were reported by participants regarding help provided after discharge, including faulty/missing equipment and lack of help.

Patients and carers believed that several steps could be taken to improve the discharge process including

- doctors signing the discharge letter when they visit the patient.
- more collaboration between the different staff involved in the discharge process.
- having everything such as care packages and medication organised before telling patients they are going to be discharged.

Recommendation 19.
Trusts should ensure that there is good collaboration between all departments to facilitate the discharge process.

Recommendation 20.
Trusts should ensure that the discharge process is transparent for patients and carers, and that patients and carers are fully engaged in the process.

7.0 Good Initiatives

A number of good initiatives had been developed by trusts, both in terms of the discharge process but also in trying to prevent admission to an acute setting in the first place. All trusts had developed a number of ambulatory pathways in order to try to prevent those patients having to go through the Emergency Department, and so lessen the pressure on this part of the hospital.

The Belfast Trust has developed a rapid access neurology clinic, and a service improvement team has been appointed to review current pathways and support future initiatives.

The Belfast Trust has also developed a dedicated assessment area for all unscheduled surgical admissions in RVH and created a Programmed Treatment Unit which manages patients with such conditions as Iron Deficient Anaemia, Congestive Cardiac Disease, Chronic Hepatobiliary Disease and Blood Transfusion.

Antrim Area Hospital has developed an acute assessment service for GPs to have their patients assessed by senior medical staff, without the need to go through the Emergency Department.

The Southern Trust has developed a number of ambulatory pathways for example head injury, DVT and chest pain.

The South Eastern Trust, in The Ulster Hospital Dundonald, has developed a system that includes diagnosis, treatment and rehabilitation of patients who under a more traditional model would have required admission to hospital.

Altnagelvin and South West Acute hospitals have developed ambulatory pathways for conditions such as DVT, stroke, cellulitis and seizures. In Altnagelvin the Older People's Assessment and Liaison Service (OPAL) responds to patients over the age of 75 years.

A number of trusts have developed rapid response teams, which are designed to support patients who are medically stable enough to be treated in their own homes. They can also provide support to nursing homes, especially out of hours, again to help prevent admission to an acute setting.

The Southern Trust has developed a robust process for setting the estimated date of discharge and the increase in compliance, and the two way flow of information between Acute Services and Older People and Primary Care Services, has been a significant development in the trust.

In the Northern Trust, notable initiatives were felt to be the appointment of a discharge doctor with responsibility for facilitating weekend discharge, an effective forum with care homes in their area, and in Causeway Hospital Surgical Department families can book a 15 minute appointment with a surgical sister in order to anticipate discharge issues, and facilitate communication.

The South Eastern Trust's respiratory team provides training for practice nurses, to minimise the need for admission, and clinical nurse specialist teams have been developed to facilitate discharge. The South Eastern and Southern trusts have also established a project to enhance patient flow by working with an improvement and change specialist team (Alamac). The project aims to help the trust to understand and improve flows of patients and to enhance their predictive skills using activity data from the previous day to predict the activity for the current day and improve flow.

The main initiatives in the Southern Trust have been the development of their IT IMMIX electronic flow system and information hub (which ensures good coordination of communication across acute and older people primary care services in relation to the over 65 population and effective utilisation of services), which the review team considers have been instrumental in providing the building blocks for an effective discharge process. In addition, the Southern Trust geriatric liaison team input to the Emergency Department to turn around patients and prevent admission, and links to the new Rapid Response Service for older people to facilitate a Hospital at Home Service and prevent admission. The COPD team also assesses patients in the Emergency Department and links directly with the Community Respiratory team to prevent admission and improve patient care.

In the Western Trust, it is hoped that creation of a community geriatric post will provide in-reach services to nursing homes, thus preventing admission. Subacute beds have been provided in the Waterside Hospital which facilitate discharge for those patients who no longer require acute care, but are not quite ready to go home, and the trust has adopted the IMMIX electronic Flow system.

8.0 Conclusions

The GAIN guideline Guideline on Regional Immediate Discharge Documentation for Patients being Discharged from Secondary into Primary Care, was published in June 2011. However most trusts reported they were not aware of its existence at organisational level, until 19 March 2013, on receipt of a letter from the Regional Director of the PHA, asking trusts to set out how they met the requirements set out in the guideline.

All trusts now have processes in place to comply with the majority of fields required by the guideline. The majority of discharge summaries are typed, but there are some that are handwritten, and these can cause difficulties for GPs in terms of accuracy and legibility. The majority of immediate discharge summaries are sent home with patients. The Southern Trust is the only trust that e-mails the majority of its discharge summaries direct to GPs, though a number of trusts make it available on Patient Centre. In this case the GP needs to be aware that their patient was in hospital in the first place and that they are now being discharged.

The discharge summary, in the majority of cases is produced by a junior doctor who may not have been involved in the patient's care, and is trying to put together a coherent picture from the hospital record.

All trusts are aware of the need to begin to populate the discharge summary when the patient is admitted, and then to build it up throughout the patient journey. This will make the junior doctor's task much easier on discharge. All trusts are aware of the need to work towards electronic transmission of the immediate discharge summary, and are aware of the risks attached with sending the summary home with patients, making it their responsibility to pass it on to their GP.

A typed, electronically transmitted immediate discharge summary that meets all the requirements of the GAIN guideline is the only discharge correspondence that is necessary. The review team considers there is then no need for the follow up discharge letter that arrives with the GP a number of weeks after the patient has been discharged. In circumstances where Intermediate Care or a placement outside the patient's home area is required, there is a need for the discharge summary to go to the GP who will provide an immediate response to the patient, as well as to the patient's own GP.

The review team was aware of the importance of the patient journey throughout the hospital, and the influence that a part of that journey might have on the rest of its components. There is now an awareness of the influence that delay in discharge might have on the front door of the hospital, and the inability to move patients through the system.

The review team considered that there were a number of factors in the discharge process that were crucial to facilitating an efficient and effective discharge, and a number of them were interlinked. There should be a small group of sufficient seniority to oversee the discharge process and ensure that all pieces of the patient journey fit together as seamlessly as possible. The systems, as they stand at the

moment, have oversight of the separate parts, but there didn't seem to be the required oversight linking the entire process together.

One of the most vital factors was the availability of real time information regarding each part of the patient journey, and the input of all staff; medical, nursing, social work, AHP and pharmacy. The Southern Trust had the best developed IT system, supplying accurate information on all patients and also information regarding necessary multidisciplinary input.

Early discharge and early multidisciplinary input were also considered to be a crucial part of the process. Early ward rounds and prioritisation of those patients who were ready for discharge meant that other parts of the process, such as production of discharge medication could happen earlier. This meant that pharmacies were not under such pressure receiving a large number of prescriptions at unsuitable times. The review team also considered that direct pharmacy input into wards, leads to a smoother, more efficient discharge. It helps to eliminate a large number of errors in the prescriptions that are written by junior doctors.

Early community social work input was an important factor in a successful discharge, especially in those complex discharges where patients needed a variety of packages and equipment. This was also the case for AHPs. Social work and AHP presence was limited at weekends in most trusts, leading to few discharges happening at weekends, immediately adding pressure early in the new week. Nurse led discharge was also an area which some trusts felt needed further development.

Dealing with care homes was an area reported by all trusts as potentially leading to delays in discharge. It was clear to the review team that those areas where there was an effective forum with care homes, there were fewer problems and all trusts need to have effective forums in their area.

Repatriation of patients to other trusts was a problem for all trusts and especially for the Belfast Trust, as it was a tertiary centre for a number of conditions. This was an area that in the opinion of the review team could be taken forward regionally. Transport was also a problem for all trusts. The review team was aware of the difficulties faced by NIAS and also was aware of the fact that transport is an issue that can cause problems for emergency departments. When looking at transport as a whole, discharge should also be considered.

Gathering the views of patients and carers who had been through the discharge process was important to the review team. Patient stories supported evidence gained through other parts of the review, in that two of the main reasons they were kept waiting were due to delays in the production of the discharge letter and discharge medication. Patients also felt that though communication was generally good, they did not feel that they were sufficiently involved in the process and trusts must consider this in the future.

The patient journey through a hospital can be a complicated one, and delayed discharge can be very frustrating for both patients and staff. Delays can be caused in a number of areas, and it is important that the discharge process as a whole is considered, and not just its component parts taken in isolation. Even small delays in

discharge can have a profound effect on a system that is constantly working to near full capacity, so preventing these delays should be a priority for all trusts.

9.0 Summary of Recommendations

Recommendation 1.
An immediate discharge summary should begin as soon as a patient is admitted to hospital, and be populated gradually throughout the patient journey.

Recommendation 2.
Junior doctor induction should be more robust in relation to discharge summaries, and should emphasise the importance of discharge process on patient care and patient flow throughout the hospital.

Recommendation 3.
Trusts should fully implement electronic production and transmission of immediate discharge summaries and ensure that no hand written summaries are produced.

Recommendation 4.
All trusts should establish a senior multidisciplinary group to oversee the discharge process, and resolve systems issues which hinder effective discharge. All trusts should also establish effective escalation procedures that are sufficiently sensitive and operate in real time.

Recommendation 5.
Estimated date of discharge to be set within 24 hours of admission and used appropriately.

Recommendation 6.
Ward rounds should be structured to initially prioritise patients with greatest clinical need, followed by those who are deemed ready for discharge.

Recommendation 7.
Trusts should continue to explore the potential for maximisation of nurse facilitated discharge.

Recommendation 8.
To facilitate discharge, all trusts should develop systems that allow early multidisciplinary and community services input to include continuing development of e-NISAT.

Recommendation 9.
Trusts should explore methods of making their care home forums more effective, and developing closer partnership working with care home providers, so that hospital discharge and other concerns are addressed in a mutually supportive way.

Recommendation10.
All trusts should re-examine the effectiveness of their policies for dealing with patient choice and difficult discharges, and evaluate the input of the multidisciplinary team into the process.

Recommendation 11.

Consideration should be given to developing a public awareness campaign, explaining the functioning of an acute hospital and the pressures under which it operates.

Recommendation 12.
Trusts should examine ways of supporting safe and effective end of life care in nursing homes, by developing staff skills and confidence, to allow residents to end their life in a familiar environment, with carers they and their family know.

Recommendation 13.
All trusts should have an effective IT system supplying appropriate real time information that leads to a more efficient discharge process.

Recommendation 14.
All trusts should develop a system that provides for discharges to happen throughout a seven day working week.

Recommendation 15.
Trusts should work with NIAS and commissioners to create a system that better supports transport for those people being discharged from acute hospitals.

Recommendation 16.
A regional group should be set up to develop a more effective process for repatriation of patients back to another trust.

Recommendation 17.
Trusts should continue to develop integrated medicines management models with clinical pharmacy input at ward level

Recommendation 18.
Trusts should provide structured prescribing and medicines management training for junior doctors as part of their induction.

Recommendation 19.
Trusts should ensure that there is good collaboration between all departments to facilitate the discharge process.

Recommendation 20.
Trusts should ensure that the discharge process is transparent for patients and carers, and that patients and carers are fully engaged in the process.

Appendix 1 GP Survey Proforma

One response per practice, please.

The Regulation and Quality Improvement Authority	GP Survey on the quality of discharge summaries across Northern Ireland	Immediate Discharge Summary The document produced on the day of discharging the patient from the hospital.

Name of Practice	
In which Trust area is your practice located?	
Which hospitals do you most commonly refer to?	
Approximately how many immediate discharge summaries* per month does your practice receive? (*not the discharge letter)	
What is the most common method of receiving a discharge summary	Patient ☐ Email ☐ Post ☐ fax ☐
Does the quality of the discharge documentation differ by hospital?	**Yes** ☐ **No** ☐

Please name the two hospitals that send the most discharge summaries to your practice, and complete the questions below for both.	Hospital 1 name…	Hospital 2 name…
How soon after the patients' discharge does the immediate discharge summary arrive with your practice?	1-3days ☐ 4-6 ☐ more than 7 ☐	1-3days ☐ 4-6 ☐ more than 7 ☐
Format Q1	Adhoc ☐ or Template ☐	Adhoc ☐ or Template ☐
Q2	Written ☐ or Typed ☐	Written ☐ or Typed ☐
Content Q1	Appropriate ☐ Inappropriate ☐	Appropriate ☐ Inappropriate ☐
Q2	Too long ☐ Just right ☐ Too short ☐	Too long ☐ Just right ☐ Too short ☐

Are the following pieces of information included?	**Always**	**Sometimes**	**Never**	**Always**	**Sometimes**	**Never**
Patient Details	☐	☐	☐	☐	☐	☐
Date of Admission/Discharge	☐	☐	☐	☐	☐	☐
Diagnosis/clinical details/investigations	☐	☐	☐	☐	☐	☐
Consultant Details	☐	☐	☐	☐	☐	☐
Which wards the patient was in	☐	☐	☐	☐	☐	☐
All necessary medication information	☐	☐	☐	☐	☐	☐
Details of any follow up	☐	☐	☐	☐	☐	☐
Details of person completing the summary	☐	☐	☐	☐	☐	☐

Please click over a box or type in an X. The larger cells will accept free text.

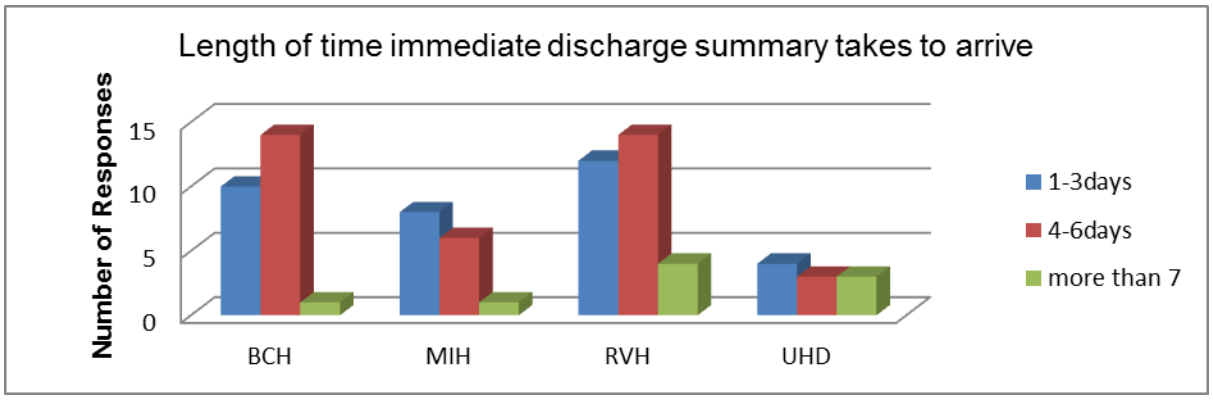
One response per practice, please.

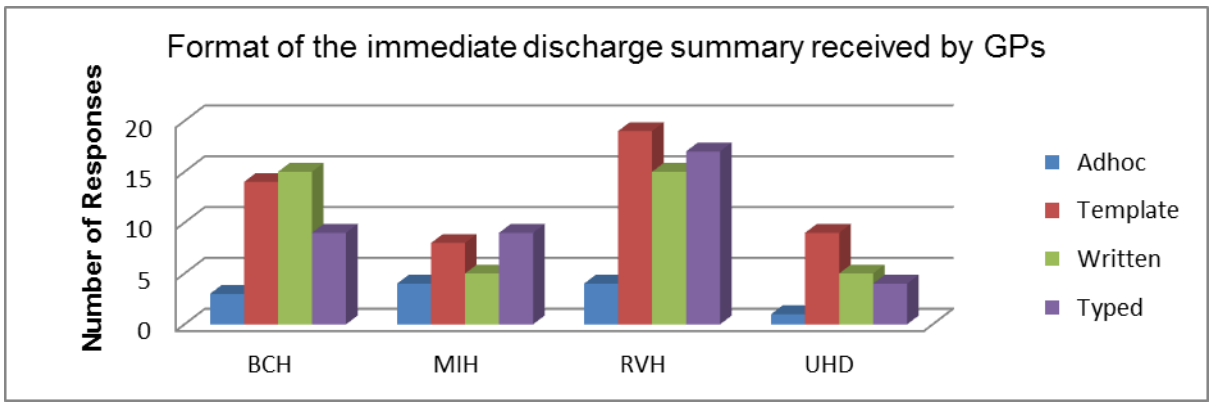
In your opinion have any patients been harmed a result of incomplete/delayed immediate discharge summary?	**Yes** ☐ **No** ☐
Please give a short summary	
In your opinion have any near misses resulted from incomplete/delayed immediate discharge summary?	**Yes** ☐ **No** ☐
Please give a short summary	

Any other comments you wish to make about discharge arrangements?	

Please click over a box or type in an X. The larger cells will accept free text.

Appendix 2 Results of GP Survey
Appendix 2.1 Full Results of the GP Survey for Belfast ICP Area





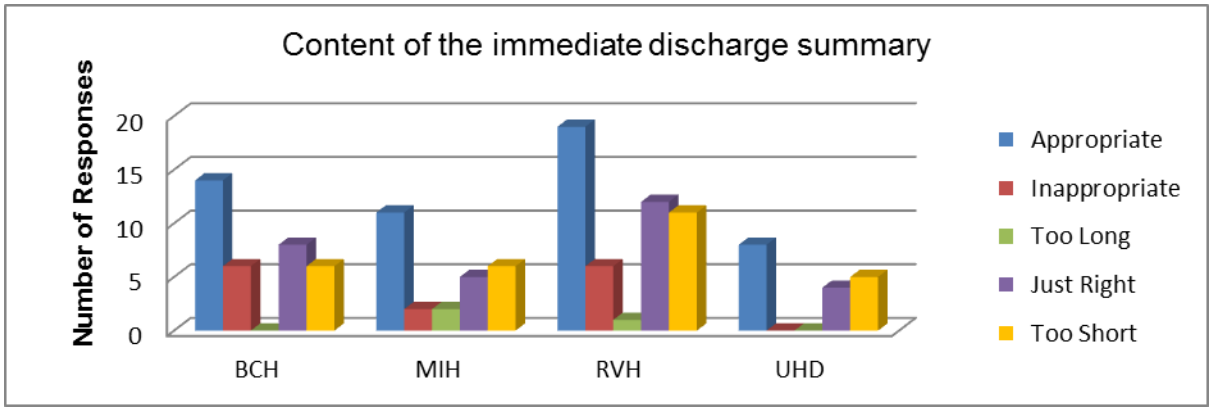
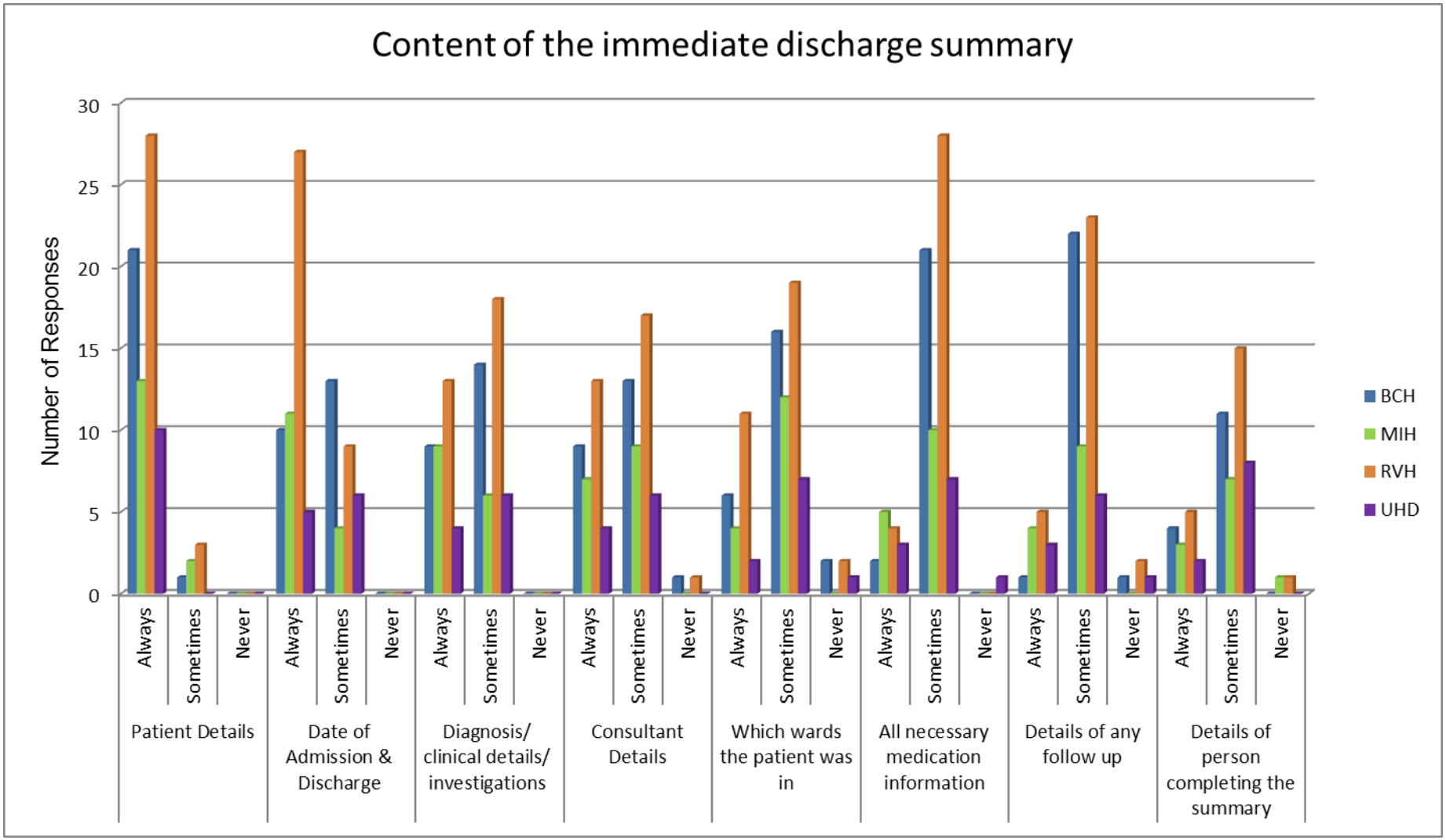


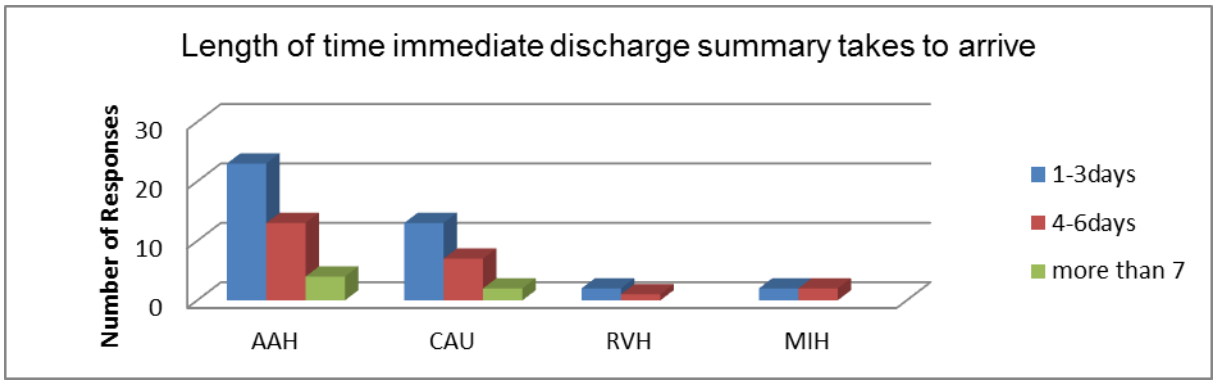
Table of Data from general practices' surveyed in the Belfast ICP

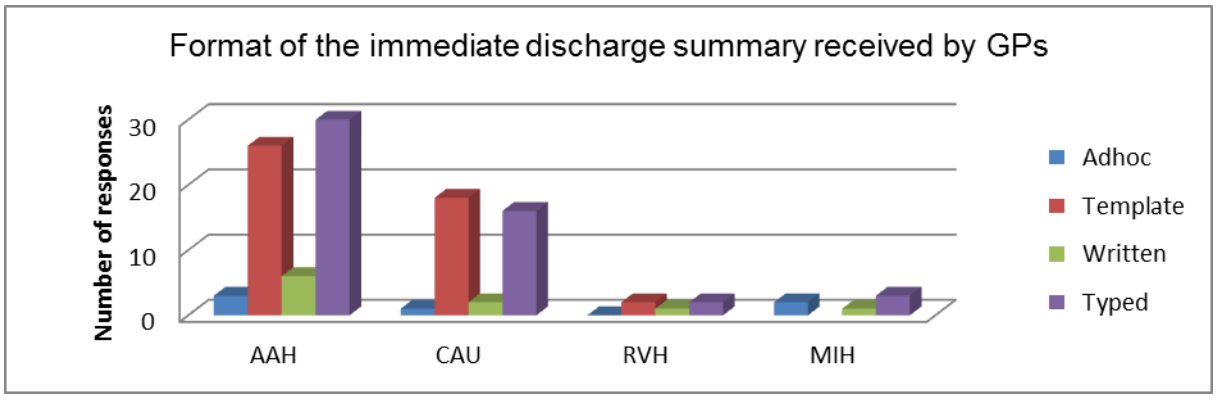
Hospital	BCH	RVH	MIH	UHD	LVH
Which hospitals do you most commonly refer to?	**28**	**35**	**18**	**14**	**3**

Range	0-20	21-40	41-60	61-80	81+
Approximately how many immediate discharge summaries per month does your practice receive?	**12**	**3**	**4**	**5**	**1**
What is the most common method of receiving a discharge summary	Patient **(29)**	Email **(10)**	Post **(9)**	Fax **(0)**	
Does the quality of the discharge documentation differ by hospital?	YES **(24)**	NO **(18)**			


Content of the immediate discharge summary
Number of Responses
30
25
20
15
10
5
0
Always
Sometimes
Never
Patient Details
Date of Admission & Discharge
Diagnosis/ clinical details/ investigations
Consultant Details
Which wards the patient was in
All necessary medication information
Details of any follow up
Details of person completing the summary
BCH
MIH
RVH
UHD

Appendix 2.2 Full Results of the GP Survey for Northern ICP Area





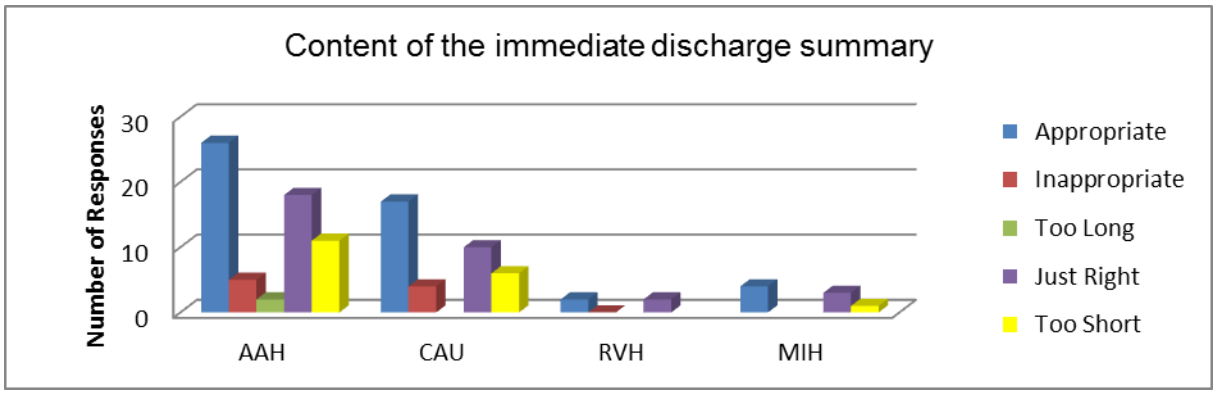
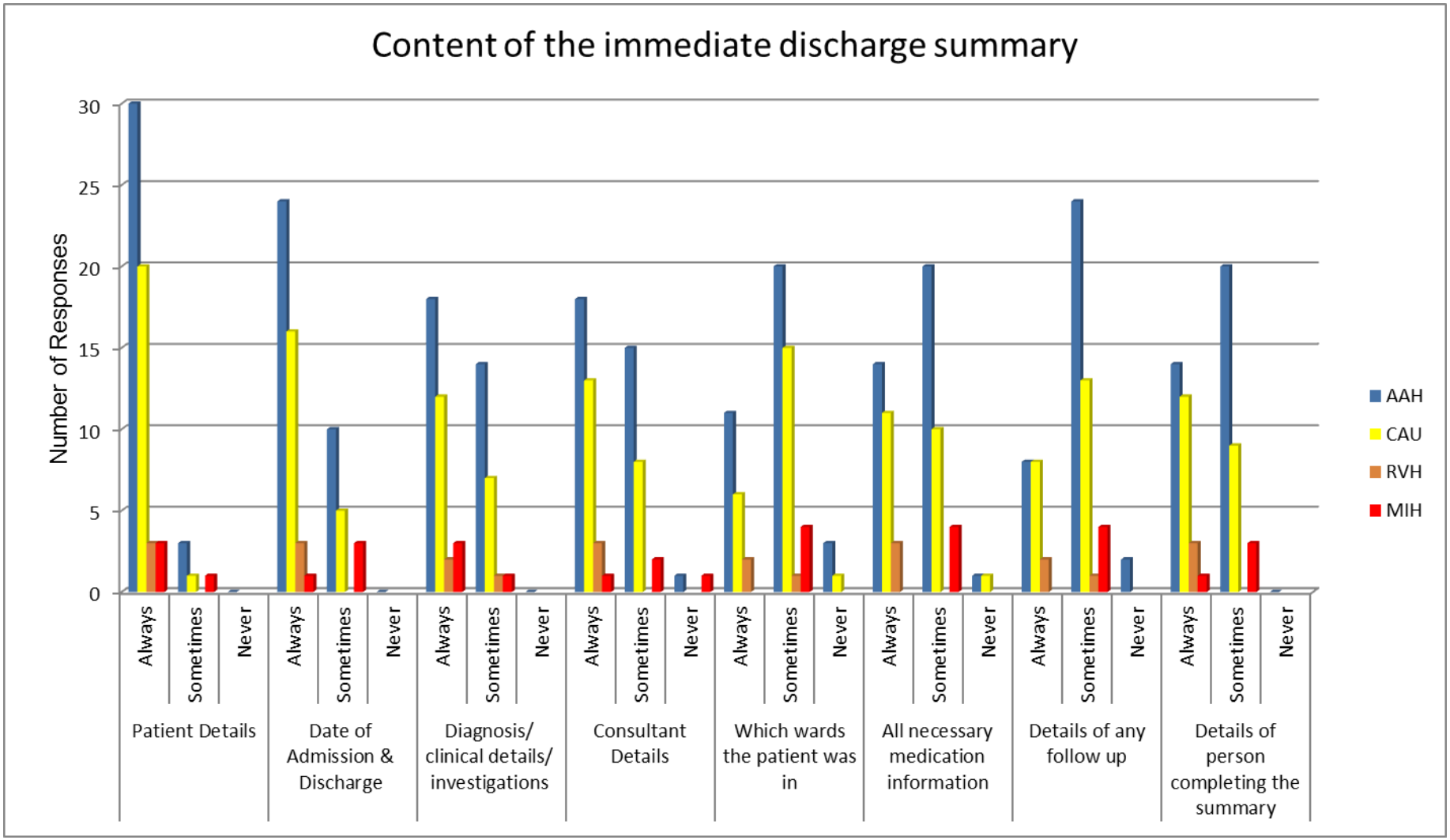


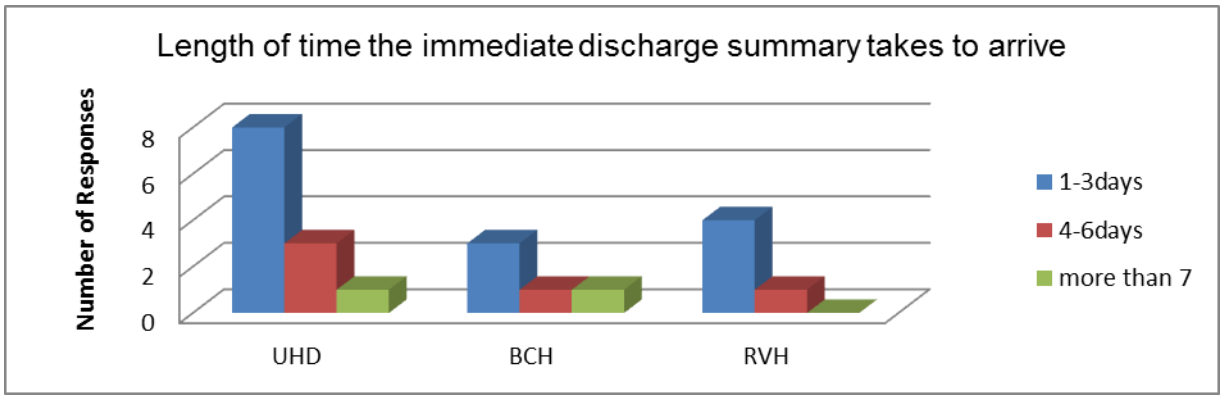
Table of Data from general practices' surveyed in the Northern ICP

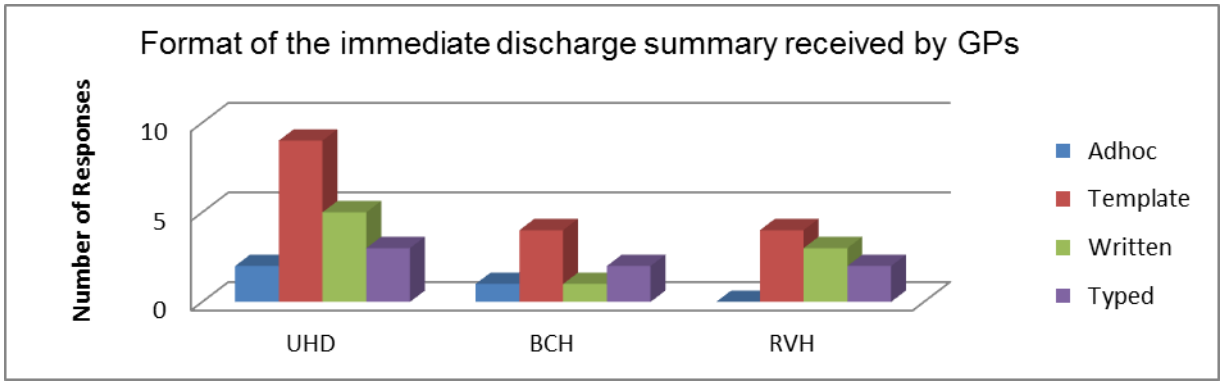
Hospital	AAH	CAU	RVH	MIH	BCH
Which hospitals do you most commonly refer to?	**34**	**26**	**8**	**5**	**8**

Range	0-20	21-40	41-60	61-80	81+
Approximately how many immediate discharge summaries per month does your practice receive?	**10**	**8**	**3**	**1**	**5**
What is the most common method of receiving a discharge summary	Patient **(19)**	Email **(0)**	Post **(27)**	Fax **(0)**	
Does the quality of the discharge documentation differ by hospital?	YES **(22)**	NO **(13)**			


Content of the immediate discharge summary
Number of Responses
30
25
20
15
10
5
0
Always
Sometimes
Never
Patient Details
Date of Admission & Discharge
Diagnosis/ clinical details/ investigations
Consultant Details
Which wards the patient was in
All necessary medication information
Details of any follow up
Details of person completing the summary
AAH
CAU
RVH
MIH

Appendix 2.3 Full Results of the GP Survey for South Eastern ICP Area





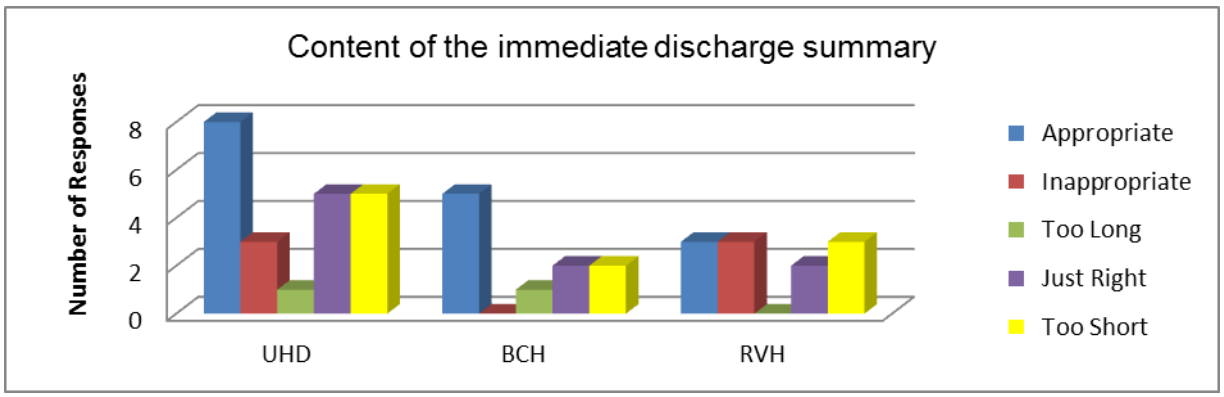
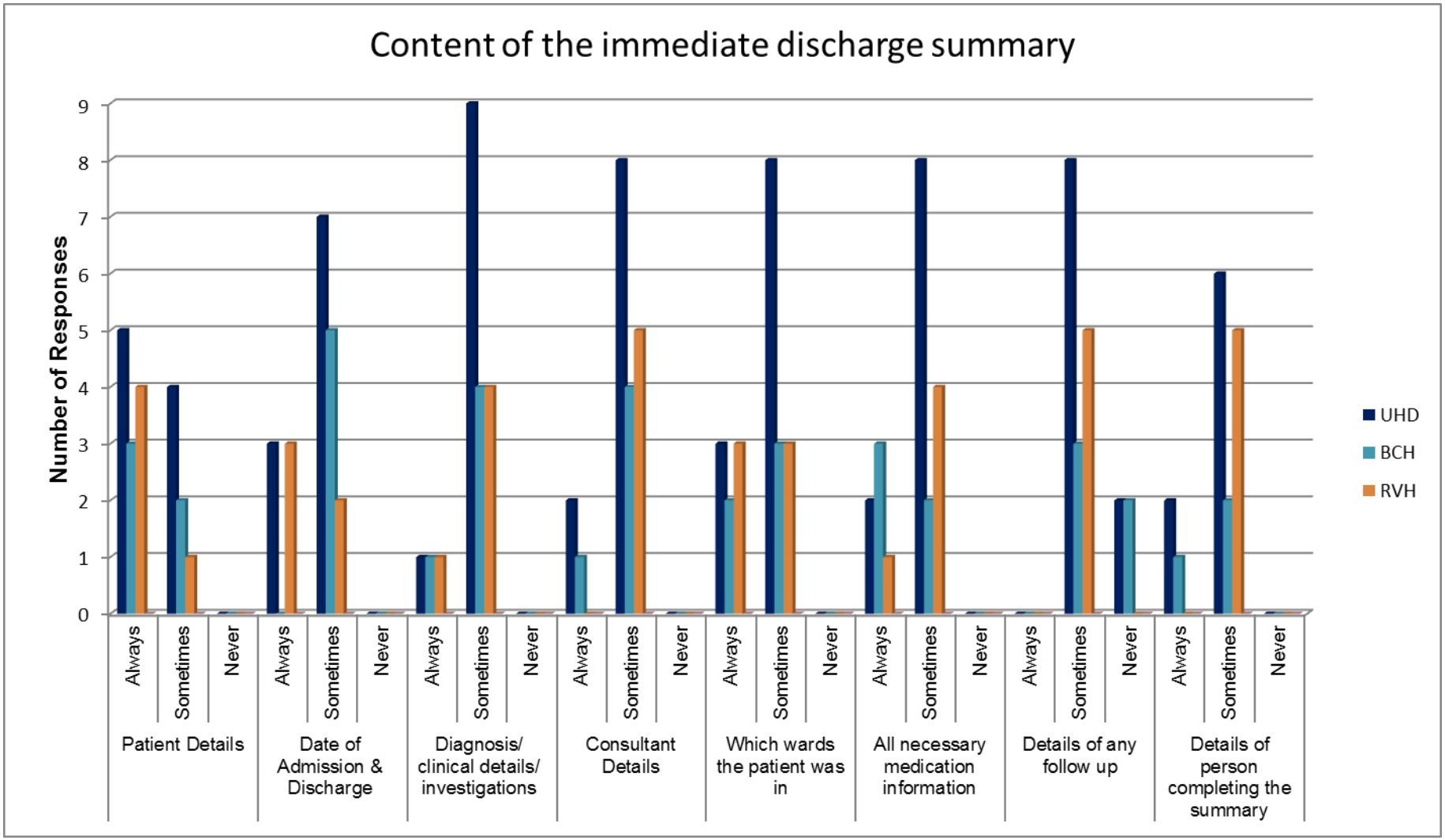


Table of Data from general practices' surveyed in the South Eastern ICP

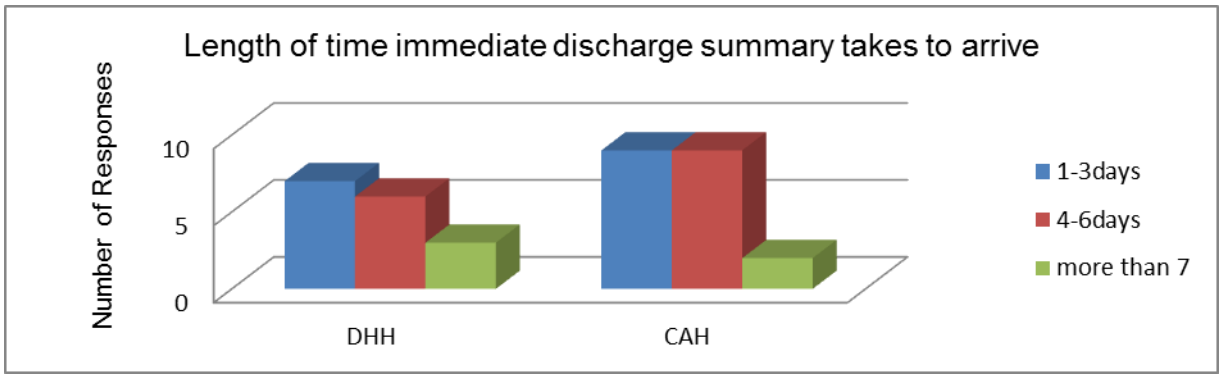
Hospital	UHD	BCH	RVH	LVH	Downe
Which hospitals do you most commonly refer to?	**9**	**6**	**6**	**3**	**2**

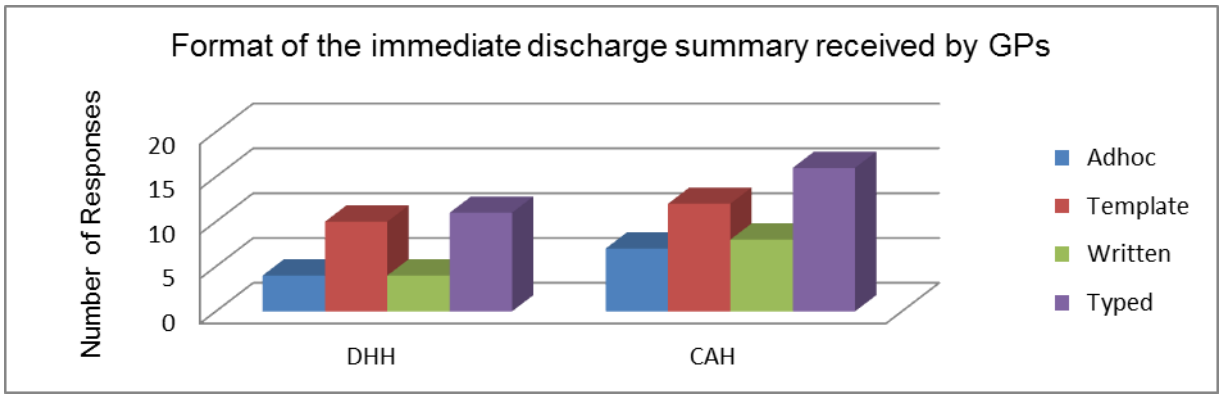
Range	0-20	21-40	41-60	61-80	81+
Approximately how many immediate discharge summaries per month does your practice receive?	**5**	**0**	**1**	**0**	**4**

What is the most common method of receiving a discharge summary	Patient **(12)**	Email **(0)**	Post **(3)**	Fax **(0)**
Does the quality of the discharge documentation differ by hospital?	YES **(9)**	NO **(5)**		


Content of the immediate discharge summary
Number of Responses
0
1
2
3
4
5
6
7
8
9
Always
Sometimes
Never
Patient Details
Date of Admission & Discharge
Diagnosis/ clinical details/ investigations
Consultant Details
Which wards the patient was in
All necessary medication information
Details of any follow up
Details of person completing the summary
UHD
BCH
RVH

Appendix 2.4 Full Results of the GP Survey for Southern ICP Area





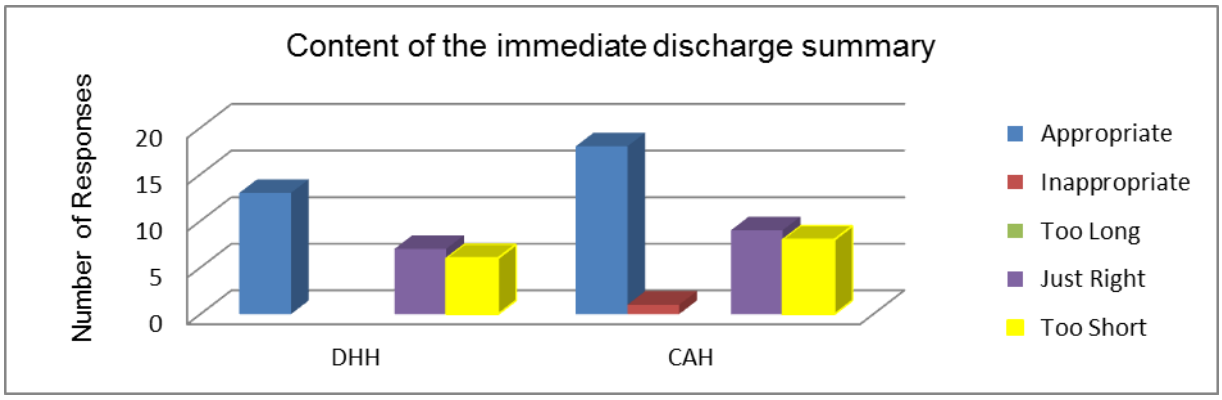
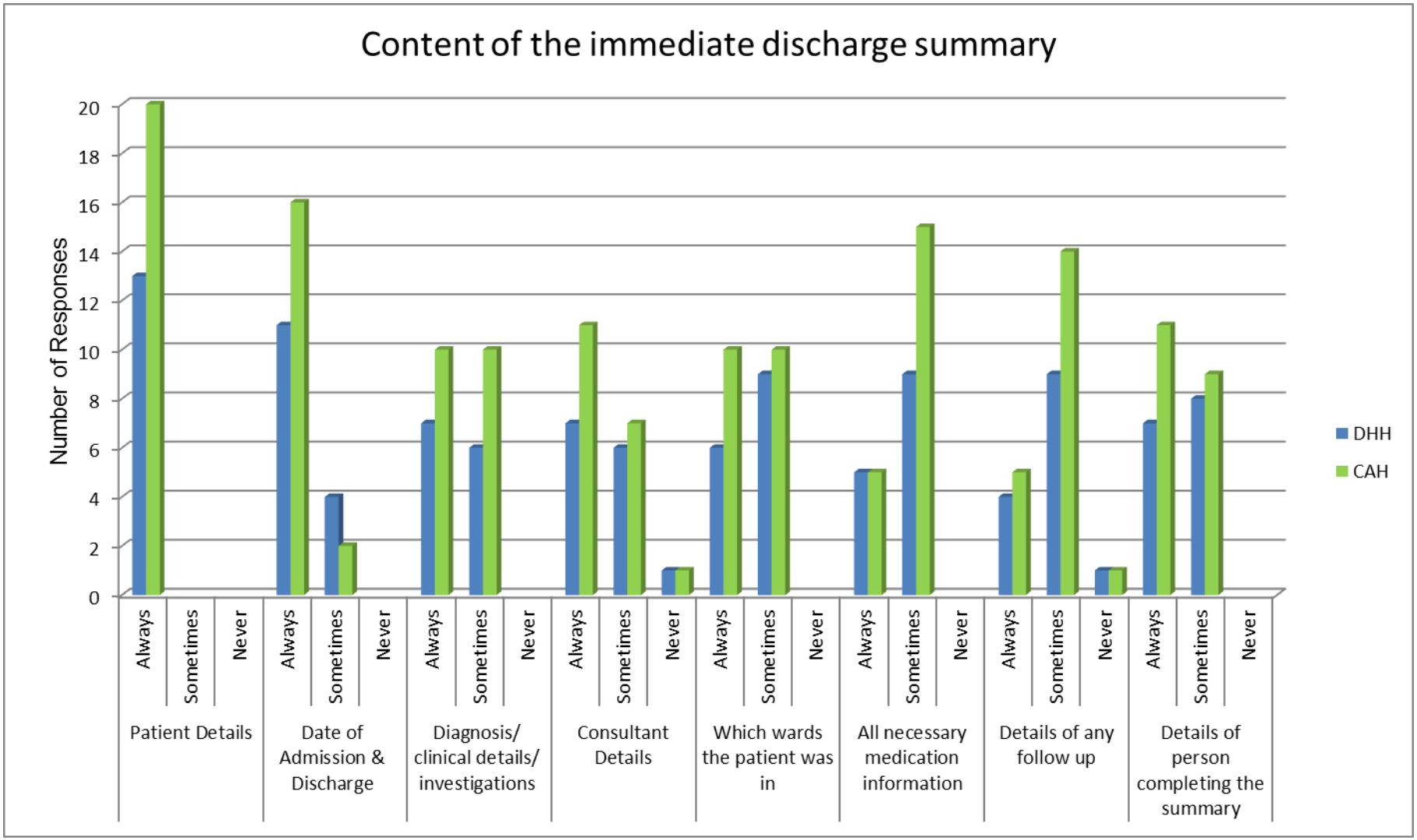


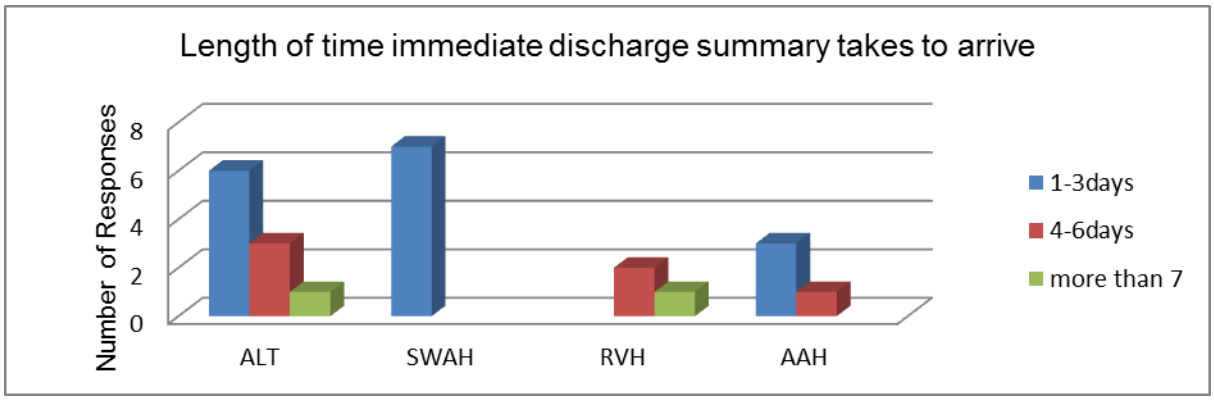
Table of Data from general practices' surveyed in the Southern ICP

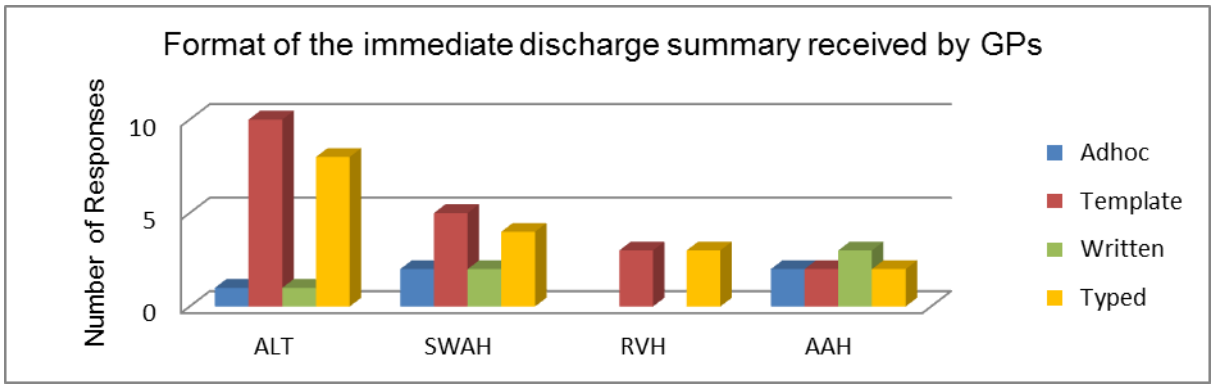
Hospital	DHH	CAH	STH	RVH	BCH
Which hospitals do you most commonly refer to?	**15**	**15**	**3**	**3**	**2**

Range	0-20	21-40	41-60	61-80	80+
Approximately how many immediate discharge summaries per month does your practice receive?	**6**	**4**	**2**	**1**	**3**
What is the most common method of receiving a discharge summary	Patient **(17)**	Email **(0)**	Post **(8)**	Fax **(0)**	
Does the quality of the discharge documentation differ by hospital?	YES **(5)**	NO **(16)**			


Content of the immediate discharge summary
Number of Responses
0
2
4
6
8
10
12
14
16
18
20
Always
Sometimes
Never
Patient Details
Date of Admission & Discharge
Diagnosis/ clinical details/ investigations
Consultant Details
Which wards the patient was in
All necessary medication information
Details of any follow up
Details of person completing the summary
DHH
CAH

Appendix 2.5 Full Results of the GP Survey for Western ICP Area





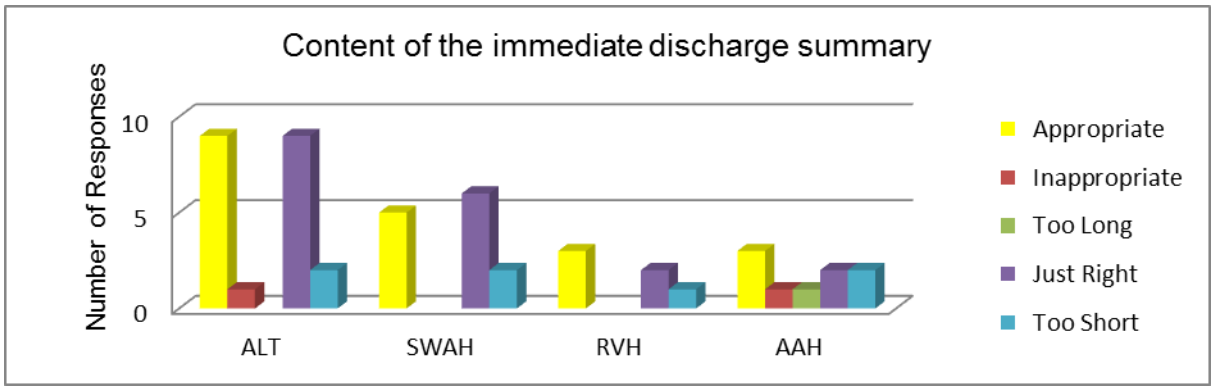
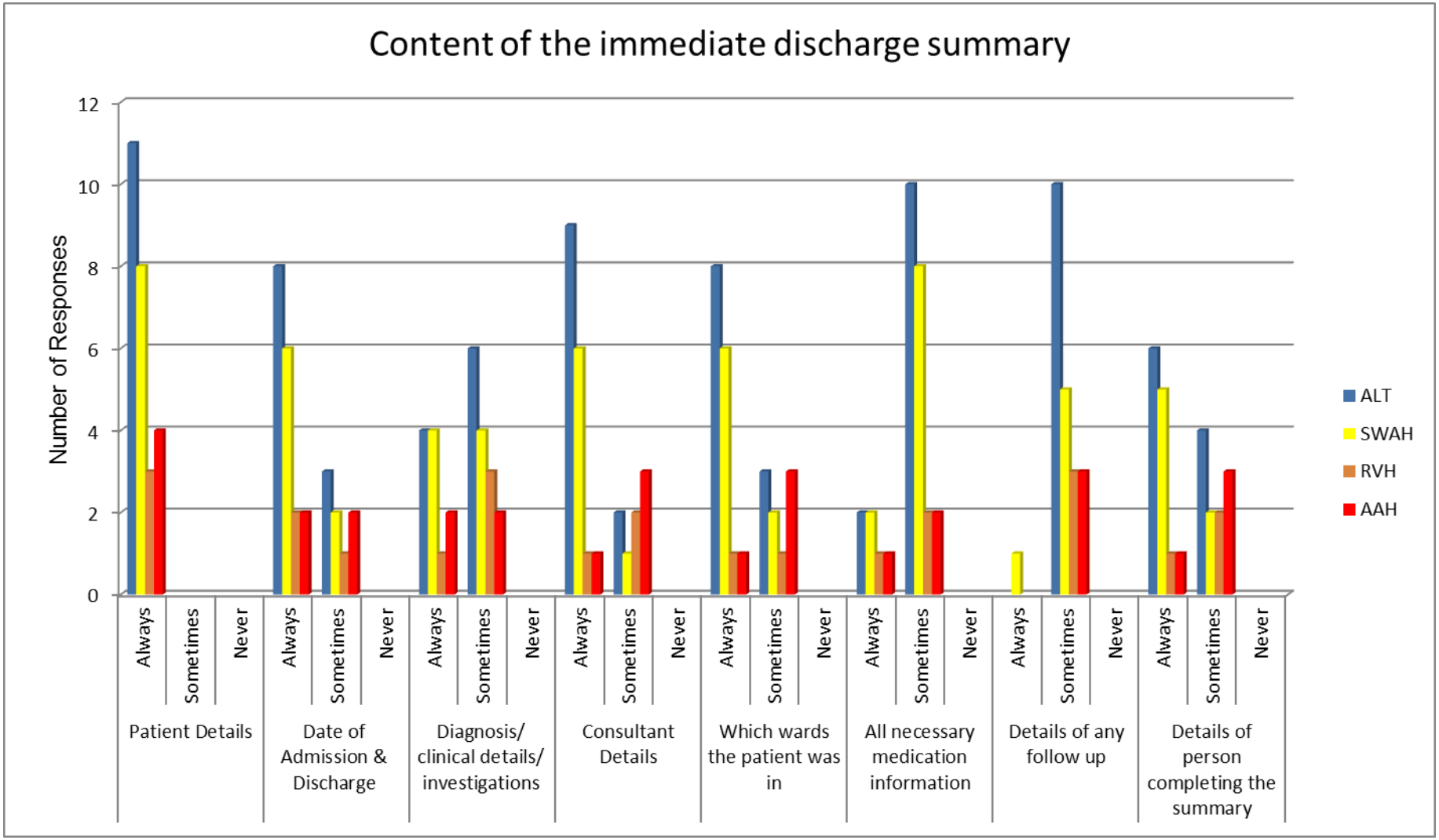


Table of Data from general practices' surveyed in the Western ICP

Hospital	ALT	SWAH	RVH	AAH
Which hospitals do you most commonly refer to?	**11**	**7**	**3**	**2**

Range	0-20	21-40	41-60	61-80	81+
Approximately how many immediate discharge summaries per month does your practice receive?	**5**	**3**	**0**	**3**	**3**
What is the most common method of receiving a discharge summary	Patient **(12)**	Email **(1)**	Post **(3)**	Fax **(0)**	
Does the quality of the discharge documentation differ by hospital?	YES **(7)**	NO **(7)**			


Content of the immediate discharge summary
Number of Responses
12
10
8
6
4
2
0
Always
Sometimes
Never
Patient Details
Date of Admission & Discharge
Diagnosis/ clinical details/ investigations
Consultant Details
Which wards the patient was in
All necessary medication information
Details of any follow up
Details of person completing the summary
ALT
SWAH
RVH
AAH

Appendix 3 Pharmacy Report

Medicines and Pharmacy Discharge Issues

Background

This part of the review considers the arrangements in place for the effective management of discharge medicines and the associated transfer of information, with a focus on both the accuracy of the data and the efficiency of the hospital processes.

The issues associated with medicines at discharge reflect the main themes which have been identified in relation to the wider discharge processes. However, they merit particular consideration within this review because medicines are the most common therapeutic intervention in the healthcare system, with a potential for both significant benefits and adverse consequences. There have also been major developments in medicines management in the hospital sector over recent years, although progress on implementation is variable and there are still settings where only a basic level of service is available.

Medicines at the Hospital/Community Interface

Virtually all hospital patients receive medicines during their in-patient stay. Many of them will have been taking prescription or non-prescription medicines prior to admission. Most will leave with discharge medication and recommendations for future treatment.

At the time of admission, there can often be discrepancies between:

- GP (prescribing) records / Electronic Care Record (ECR)
- community pharmacy (dispensing) records
- care home records (where applicable)
- medicines (if any) brought into hospital by the patient, and
- the patient's account of what they have actually been taking

Such discrepancies are not surprising, in view of the different ways in which medicines are named (e.g. brand/generic) or formulated (e.g. single drug/drug combination, standard tablet/sustained release) and the variety of dosages, administration methods and devices in use. Several thousand pack permutations are in common use; less common items account for many more thousands.

Under some circumstances, a stay in hospital with changes in medication may increase the risk of discrepancies occurring after discharge due to inaccuracies in the prescription, lack of written clarity on the reasons for the changes or misunderstandings by the patient. Post-discharge delays in updating records and transcription issues can also be a factor.

The majority of these discrepancies are likely to be relatively minor, but sometimes they can have serious consequences such as reduced symptom control, treatment failure, over-dosage or adverse reactions/inter-actions.

These consequences can lead to further demands on primary or secondary care services, including re-admission to hospital.

There are also clinical, logistical and cross-sector organisational issues associated with the supply of medicines and the communication of accurate information at the time of discharge. Delays in sending the prescription to the hospital pharmacy or peaks in prescription numbers at certain times of the day, together with competing pressures in the dispensary/ward-based satellite dispensary can extend the time required to obtain medicines and hold up the discharge process (although significantly less with the satellite system). The need for pharmacy interventions to resolve queries with some discharge prescriptions adds to delays. Problems can also arise when patients are discharged outside normal pharmacy opening hours.

Some changes in hospital practice such as the increasing use of patients' own medicines and One Stop Dispensing (see later) may require updating of regional agreements between primary and secondary care practitioners. The recent introduction of the Northern Ireland Medicines Formulary provides a framework for enhanced cooperation across the sectors on medicines issues, including discharge arrangements.

Gain Guidelines on Discharge Medicines

The core recommendations in the 2011 GAIN guidelines echoed earlier reports[15] in highlighting the importance of:

- reconciling medication profiles as soon as possible after admission
- tracking all medication changes throughout the in-patient stay
- ensuring that medication profiles are reviewed and updated prior to discharge
- counselling the patient, and
- communicating the medicines information promptly to the GP and community pharmacist (the key recipients of this information) and other appropriate primary care practitioners, giving the reason for any medication changes, directions on the continuation or duration of each item and any further specialist advice.

A 2005 report on Discharge and Transfer Planning, *Moving Patients, Moving Medicines, Moving Safely*[16], emphasised the need to adopt a whole systems approach in seeking to ensure achievement of the above. It provided practical guidance to help minimise the medicines risks for patients at the interface, through multidisciplinary working and re-engineering of processes. It also advocated greater utilisation of pharmacists' knowledge and skills in this team approach (in the context of a reported 8 per cent error rate with pharmacists and 32 per cent for doctors).

[15] Scottish Inter-collegiate Network (SIGN). (2003). SIGN 65: The Immediate Discharge Document.

[16] Royal Pharmaceutical Society of Great Britain, Guild of Hospital Pharmacists, Pharmaceutical Services Negotiating Committee, Primary Care Pharmacists' Association. (2005). Moving Patients, Moving Medicines, Moving Safely – Guidance on Discharge and Transfer Planning. (Royal Pharmaceutical Society of Great Britain)

Patient Safety Guidance issued jointly by NICE and the National Patient Safety Agency in 2008[17] provided further support for increased involvement of pharmacists in medicines reconciliation (reported error rate 19 per 100 admissions for pharmacists versus 44 per 100 admissions for doctors).

Clinical Pharmacy and Medicines Management

The potential contribution of pharmacists to the medicines discharge process needs to be considered in the context of the innovative practice developments which have occurred over the last fifteen years. These have been instrumental in shaping the current pattern of pharmacy services.

Clinical Pharmacy relates to the safe, effective and economic use of medicines as part of the 'patient care journey'. It is practised in a multidisciplinary healthcare team and is directed at achieving specific patient treatment goals. Clinical Pharmacy Standards for Northern Ireland were published in 2009[18] and updated in 2013. These provide a description of the individual components of clinical pharmacy services and are used as a tool for assessing the quality and volume of service provision in a healthcare setting.

Medicines Management in hospitals was defined by the Audit Commission in 2001 as encompassing "the entire way that that medicines are selected, procured, delivered, prescribed, administered and reviewed, to optimise the contribution that medicines can make to producing informed and desired outcomes of patient care"[19].

Medicines Management (which is now being superseded by the term Medicines Optimisation) has also been described more simply as "the right medicine for the right patient at the right time".

The clinical pharmacy and medicines management concepts were crystallised in a more tangible form with the development in Northern Ireland of the **Integrated Medicines Management (IMM)** model, which allows measurement of resource inputs and the resulting service outputs. In 2000, a randomised controlled study was carried out in one trust site to evaluate the potential of a proposed IMM service. The service involved a team of pharmacists and technicians implementing three different levels of medication reconciliation/monitoring - on admission, during the patient stay and at discharge.

This and other early studies demonstrated a number of benefits from IMM[20,21,22], which included:

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[17] National Institute for Health and Clinical Excellence, National Patient Safety Agency. (2007). Technical Patient Safety Solutions for medicines reconciliation on admission of adults to hospital. (Alert Reference NICE/NPSA/2007/PS G001).

[18] Department of Health, Social Services and Public Safety. (2009, updated 2013). Northern Ireland Clinical Pharmacy Standards.

[19] Audit Commission. (2001). A Spoonful of Sugar: Medicines Management in NHS Hospitals.

[20] Scullin C, Scott MG, Hogg A, McElnay JC. An innovative approach to integrated medicines management. Journal of Evaluation in Clinical Practice 2007; 13: 781 – 788.

- improved accuracy of medication histories
- decreased medicines administration error rates
- improved medication appropriateness
- faster discharge process
- reduced length of stay
- reduced readmission rates, and
- substantial non cash-releasing efficiencies

This model of medicines management has been recognised Europe-wide under the European Partnership Programme where this example of best practice was awarded 3 star status, the only such one related to medicines[23].

On this evidence, the IMM/clinical pharmacy service was rolled out across all the trusts, beginning in 2005, as part of the Pharmaceutical Effectiveness Programme. The service was reviewed by the DHSSPS in 2012[24] and a key finding in the report was that 80 per cent of all trust sites had pharmacists and/or technicians delivering IMM services. However, only 46 per cent of wards and 52 per cent of the beds which were considered suitable for IMM were receiving the service on the basis of the funding available. The service was largely limited to weekdays, although all pharmacies did provide a basic pharmaceutical service over the weekend.

The report also highlighted major differences in the number of WTE pharmacists and pharmacy technicians associated with the delivery of IMM/clinical pharmacy services across the main hospitals and trusts. Whilst the Belfast Trust had the highest number of both pharmacist and technical staff, the highest numbers of clinically based staff were at Antrim Hospital (the original development site for the service), followed by Craigavon, Altnagelvin, Ulster, BCH and the RVH. All the other hospitals had lower numbers.

Information from the RVH states that 50 per cent of wards have a clinical pharmacist. However, each pharmacist covers 1 – 2 wards and the level of service provided is said to be determined by the number of beds, length of stay and complexity. Significantly, only one or two pharmacy technicians are based at ward level in the hospital, while other sites have ward-based teams in which the ratio of technicians to pharmacists generally ranges from 1:3 to 1:1.

A number of hospitals reported that recruitment of technicians is a significant problem.

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[21] Burnett KM, Scott MG, Fleming GF, Clark CM, McElnay JC. Effects of an integrated medicines management programme on medication appropriateness in hospitalized patients. Am J Health Syst Pharm 2009 May 1;66(9):854-9.

[22] Scullin C, Hogg A, Lou R, Scott MG, McElnay JC. Integrated medicines management – can routine implementation improve quality? Journal of Evaluation in Clinical Practice 2012; 18(4) 807-15.

[23] Excellent Innovation for Ageing: A European Guide. European Commission 2014.

[24] Department of Health, Social Services and Public Safety. (2012). Review of Integrated Medicines Management in HSC Trusts - Final Report.

Medicines Reconciliation
The Northern Ireland Clinical Pharmacy Standards[18] includes a standard for Medicines History Taking and Reconciliation. Medicines reconciliation, when carried out by a health care professional with the appropriate product knowledge and clinical experience, can be a time-consuming process, but is vital to ensure that the patient is taking the appropriate medicine safely and effectively.

The standard requires at least two sources of medicines information to be used. These may include GP records and information from the patient. When a source other than the patient or inspection of his/her own drugs is used a written copy of the medicine history should be obtained. When this is not possible the information may be obtained verbally.

The person carrying out the process may therefore have to refer to both paper-based and computer records (ECR). A patient interview may be carried out, with inspection of any medicines brought in. Phone calls may also be necessary to obtain information from community pharmacists and other sources.

When medicines reconciliation is carried out at discharge, checks must be made to ensure that all changes are accurately recorded, along with the reasons. Relevant additional information may be required, such as laboratory test results. This may require reference to paper-based or electronic hospital records.

Audits have shown that the number of discrepancies detected and corrected is greater when more than one source of medication information is available. This does increase the length of time taken to reconcile the data, but this is time well spent given the consequences of failing to undertake this process.

Simple and Complex Discharges
From the medicines management perspective, an example of a simple discharge would be where a patient with no regular medication has a surgical procedure and then leaves on a standard course of treatment with oral antibiotics and/or analgesics. However such situations are probably in the minority since added factors like the following can make the discharge more complex:

- a large number of ongoing medicines
- significant medication changes during the inpatient stay
- a medication such as warfarin which requires ongoing monitoring
- a condition such as renal impairment which could affect the clearance from the body of some drugs
- number of co-morbidities
- specialist medicines which require a shared care arrangement
- controlled drugs such as strong opioids
- a patient history of problems with medicines adherence (also referred to as compliance or concordance); this can be intentional or unintentional

- a need for additional counselling, aids or support, or supply of medication in a Monitored Dosage System (MDS) (see later for discussion)

Where ward resources to carry out medicines reconciliation or related tasks are limited, it may be necessary to prioritise the patients who will receive these services but it is evident from the above that identification of those with complex needs may be difficult. In some cases an individual patient's needs may only become apparent through the reconciliation process.

Re-Engineering Hospital Systems

Another related development has been the introduction of One Stop Dispensing (OSD)[16], consisting of five main elements:

1. medication history taking / reconciliation
2. use of Patients' Own Drugs (PODs)
3. lockable bedside cabinets
4. dispensing hospital medication labelled with administration instructions for each patient
5. counselling patients at discharge (now prior to discharge to facilitate re-ablement)

The documented benefits of OSD are better management of patients' medication during the inpatient stay and a streamlined medicines discharge process, direct from the ward[25,26]. The OSD system is a further development of the IMM model, with this enhancement facilitating the ultimate goal of full medicines optimisation.

Legacy Systems

The roll-out of IMM and OSD has been prioritised in accordance with the amount of funding available and the suitability/needs of each type of ward or specialty. Where new systems have not yet been introduced the service model can vary, but it typically consists of:

- stock medicines being held in ward cupboards (generally checked and topped up by a pharmacy assistant, often managed by a designated pharmacy technician).
- medicines in current use being administered from a lockable trolley.

A limited clinical pharmacy service may be provided, depending on daily availability of pharmacists.

Rationale for this part of the Review

The developments in clinical pharmacy services to wards over recent years are well-documented, as described above. However, pharmacists are only

[25] Lou R, Scullin C, McElnay JC, Hogg A, Scott MG, Currie A. One stop dispensing and discharge prescription time. Hospital Pharmacy Europe 2012 issue 65. 43-46.

[26] Hogg A, Scullin C, Lou R, Currie A, Scott MG, McElnay JC. Do patient bedside medicine lockers result in a safer and faster medicine administration round?. European Journal of hospital Pharmacy 2012; 19: 525-528.

one of the contributors to medicines management during a patient stay and at discharge. Medical and nursing staff have the primary responsibility for patient care at ward level and are the key members of the discharge planning team, with specific professional and legal responsibilities. As previously evidenced, the pharmacy team has significant input in respect of the medicines component of discharge.

Each profession brings particular knowledge and skills to help in optimising patient care, and the best outcomes are likely to be achieved if respective roles and procedures are well-defined and understood. Effective communication and integrated working are also essential.

Information about the extent to which hospital staff do work together in this way is limited, so this review assesses the arrangements for patient discharge in this context. It aims to provide assurance that these arrangements are robust and adhered to by all staff involved.

Terms of Reference (ToR)
In respect of medicines management, some of the main themes (in italics) cited in the first and fourth terms of reference for this review are particularly relevant i.e.

First ToR
To describe the current *systems and procedures* in place which ensure the *safety, quality and effectiveness* of the arrangements for discharge of inpatients from acute hospitals in accordance with principles of the GAIN guidelines. To include:

- both *simple and complex discharges*
- use of the GAIN guideline on *immediate discharge documentation*
- whether such discharges were made at an *appropriate time of day*
- whether all relevant *processes and arrangements* were in place
- the effectiveness of *communication and partnership working*

Fourth ToR
To collect information on the *views of primary and community care practitioners* regarding the effectiveness of communications in relation to patient discharge.

Methodology
Relevant information was obtained through the following methodologies:
1. Two of the questions in the main trust questionnaire asked if there were documented procedures in each ward/specialty describing the medicines management arrangements prior to and at discharge, including pharmacy aspects both during and outside normal opening hours.
2. Using a self-assessment questionnaire, trusts were asked to rate progress on implementing a range of *Key Elements of a Successful Medicines Discharge Service*. These elements were based on recommendations in *Moving Patients' Medicines Safely – Guidance on Discharge and Transfer Planning*[16].

3. Trusts were also asked to provide documentary evidence in support of their ratings and to submit a concise description of the current pharmacy input to the medicines discharge process and the main constraints on future development.
4. A member of the review team (DM) met the five trust pharmacy and medicines management heads collectively to obtain more detailed comments. He also visited six main hospitals to observe the pharmacy service in operation.
5. Junior medical staff were asked, in the course of focus group meetings with review team members, to comment on their experience of the medicines discharge process and the underpinning ward procedures.
6. Focus group responses were sought at a community pharmacists' education and training event, to obtain some feedback on their experience of the discharge process from the medicines perspective.

Findings

Context

The 2012 IMM Report from the DHSSPSNI[24] showed the percentage of patients admitted to an IMM ward during a selected period who had their medicines reconciled on admission or discharge.

On average across the trusts 77 per cent had their medicines reconciled on admission. However, there was considerable variation between trusts, with the figure ranging from 89 per cent in NHSCT to 67 per cent in the BHSCT.

Fewer patients had their medicines reconciled on discharge, with the average being 53 per cent. Again there was considerable variation between trusts, from a high of 70 per cent in the WHSCT to a low of 37 per cent in the BHSCT.

A number of respondents to the pharmacy self-assessment questionnaire provided local trust or hospital data on pharmacy discharge activity which complemented these broad figures. The figures were not presented in a standardised format (see comment later), but they did help to provide a context for this part of the review.

For example, the Western Trust provided clinical pharmacy activity data for three hospitals, which had been collected on a standardised five-trust template during the same selected week in January 2014. Over this period, 410 patients at Altnagelvin Hospital were admitted to wards with a clinical pharmacy service (out of a total 623 excluding day cases, ward attenders, renal dialysis and maternity). Medicines reconciliation was undertaken for 81 per cent of these patients (49 per cent within 24 hours). Of these patients, 72 per cent required pharmacist interventions to deal with discrepancies or other issues.

There were 375 discharges in the same week from Altnagelvin wards with a clinical pharmacy service (out of a total 570 excluding day cases, ward attenders, renal dialysis and maternity). Medicines reconciliation was carried

out for 63 per cent of these patients, 99 per cent of whom required interventions.

Broadly similar percentages were reported for the South West Acute Hospital.

Ward-based pharmacy input is therefore very effective in identifying and resolving medicines management issues. In the BHSCT the proportion of patients admitted to wards with a full clinical pharmacy service is, on average, much lower. However, audits have demonstrated that the clinical checks made in the main pharmacy when dispensing the discharge prescriptions can also identify and deal with many issues. For example, a recent audit of 326 discharge prescriptions in the RVH found that 58 per cent of them needed some form of intervention or clarification. A range of sources were utilised in order to resolve the queries, the most common being nursing or medical staff, dispensary records, ECS/ECR or the ward pharmacist.

Comparable intervention rates have been reported in other audits. The clinical importance of this activity is clearly evident when the findings are extrapolated to the hundreds of thousands of discharge prescription items dispensed annually across the service.

Systems and Procedures

The submissions from trusts, together with the site visits, enabled the review team to make an assessment of the current state of medicines management up to and including discharge in the various hospitals. The overall picture was of a service with a clear vision of what is needed to ensure safety, quality and effectiveness in the process, along with evidence of considerable progress in making the required changes in equipment, systems and culture. However, there was found to be considerable variation in the rate of implementation across hospitals and wards/specialties, leading to a spectrum of service models in some sites. While there were many examples of excellent practice, only about half of the beds had an appropriate service model in place and staffing levels on these wards were not always sufficient to cope with the clinical workload.

On the positive side, there was evidence of extensive re-engineering of the physical environment and equipment to help cope with the increasing service pressures and improve efficiency. For example, all of the major hospital pharmacies have installed high-density medicines storage modules with computer-controlled robotic arms to facilitate the secure management, retrieval and labelling of packs.

Ward medicines storage systems in some older hospitals have been modernised to improve the efficiency of the monitoring and re-stocking process. A range of benefits have been demonstrated from this change, including reduced wastage and improved stock availability on the ward, with a resulting reduction in delayed or missed doses. This approach has been incorporated into new facilities as opportunities have arisen.

The most extensive changes in medicines management have been at ward level, with the introduction of satellite based dispensaries thereby enabling rapid resolution of medicines issues. Bedside lockers with electronic access and oversight have also been installed in many units to improve the efficiency of medicines administration and to facilitate the One Stop Dispensing (OSD) and clinical pharmacy/IMM initiatives which were described earlier.

These developments coincided with major innovations in information technology which facilitated the recording of data, improved both internal and external communications and helped to promote integrated practice.

Since there may be very different ways of working between areas where modernisation has occurred and those with legacy systems, procedural guidelines need to reflect local circumstances. Provision also needs to be made for the necessary awareness-raising and training. To help determine whether this has been done, two questions were included in the main questionnaire which was sent to trusts. The first asked if there were documented procedures on each ward/specialty describing the operation of the in-hours pharmacy service in relation to the management of patients' medicines, up to and including discharge. All of the responses indicated that

there were specific sections in the trust's Medicines Code or Policy detailing the arrangements.

The second question asked if there was written guidance on how to access pharmacy services outside normal working hours when discharge medicines are required. Again, all trusts said that there were sections in their policies regarding action to be taken when the pharmacy is closed. Copies of the relevant guidance were submitted or references given to the specific sections.

Awareness and practical issues relating to these procedures were explored further in the focus groups with junior doctors.

Processes and Arrangements

The next step, and the main thrust of this part of the review, was to assess progress in each hospital towards implementing the Key Elements of a Successful Discharge Medicines Service. As previously described, these elements were identified by a 2005 working group on moving patients' medicines safely[16]. The report of the group recommended that the elements be used as the basis for a self-assessment tool by hospital pharmacy managers, using a traffic light self-assessment system.

Although this report was produced by pharmacy organisations, the listed elements of success were predicated on good team-working between medical, nursing and pharmacy staff. A whole-systems approach was therefore adopted, taking account of underpinning medicines management initiatives which could contribute to optimising the process.

For the purpose of this review, it was necessary to update some of the elements to include recent innovations and also to customise them for the local context, particularly in respect of the GAIN guideline on Immediate Discharge Documentation. Accordingly, the questionnaire that was issued to trusts listed twenty seven elements of success, encompassing ten main process areas. These were:

- communication, Integrated Working and Planning for Discharge
- reconciling Medicines on Admission
- patients' Own Drugs
- reconciling Medicines Prior to Discharge
- writing Prescriptions & Obtaining Medicines
- self-Administration of Medicines
- counselling and Information
- compliance Aids & Post-discharge Medicines Management Support
- discharge Medicine Summary
- electronic Transfer of Information

In addition to completing and returning the questionnaire, trusts were asked to provide supplementary information and documented evidence to support their green, amber or red ratings. They were also asked to include a concise description of the local pharmacy support for the medicines discharge process

and to comment on opportunities and constraints regarding future developments. A considerable amount of information was obtained from these sources, supplemented later by visits to each of the major hospitals to observe the pharmacy systems in operation.

Since it would not be practical to include a detailed account of all this data in the body of this report, the following section summarises the review team' s understanding of the current operational situation, drawing on all the information received. It is presented in terms of the ten main process areas listed above. In each case the relevant key elements of success are stated.

Communication, Integrated Working and Planning for Discharge
Key Success Elements:
1. Planning for discharge or transfer starts at admission, including communication between pharmacy and ward staff, and
2. Communication mechanisms are also in place to ensure safe and timely arrangements for medicines supply and transfer of information at discharge.
3. For transfers between wards or hospitals, the receiving facility is advised of all prescribed medication including any post-admission changes, and can access the necessary medicines.

The responses from trusts indicated that the level of communication and integrated working between pharmacists and the members of the ward team is dependent on the service model in place for each ward or specialty. For example, the BCH rated these elements as amber. The response said that where a clinical pharmacy service is in operation (pharmacist/technician), good communication exists between ward staff and pharmacy staff for planned discharges but not necessarily from admission.

Altnagelvin said that on wards with a clinical pharmacy service there is direct communication between ward staff and pharmacy staff. Clinical audit has shown that this does not routinely start at the point of admission.

The responses and the hospital visits confirmed that there is a spectrum of service models across the trusts but in essence there are three main scenarios:

1. **Full Integrated Medicines Management (IMM) and One Stop Dispensing (OSD) Service.**
The main features of this model generally include the following:

- Pharmacy and technician support is available on the ward during all or most of the working week. This is provided by assigned staff who are integrated into the ward nursing and medical team. The pharmacist is responsible for a range of designated clinical procedures and provides professional advice. The technician may be accredited, after additional training, to carry out some clinical technical functions in accordance with documented procedures.
- There is active communication regarding discharge planning between medical, nursing and pharmacy staff, with daily ward meetings and a communication diary at ward level.

- If the level of dedicated pharmacy team time is limited or outside working hours the contingency arrangement is that ward staff will undertake those functions for some patients, prioritising where necessary.
- Medicines reconciliation is carried out on admission to hospital, transfer within clinical areas and discharge from secondary care to primary care, in accordance with a medicines reconciliation policy which highlights the responsibilities of medical, nursing and pharmacy staff.
- This activity is audited against regional and national (NICE) standards. The audit standards include timescales by which the first medicines reconciliation should be completed and the medicines discharge planning process should be initiated.
- The pharmacist monitors the prescription chart (kardex) during the inpatient stay and makes clinical interventions where appropriate. (In the Northern Trust clinical pharmacy technicians with specific training will screen kardexes and refer to the pharmacist as appropriate).
- Information is gathered on a software package Electronic Pharmacy Intervention System (EPICS) which records the number of clinical pharmacist interventions and a rating of their clinical significance.
- The pharmacist prescribes (Northern Trust), prepares or reviews the discharge medicines list which forms part of the Immediate Discharge Sheet/Letter.
- The pharmacist/pharmacy technician counsels the patient and communicates where necessary with the patient's community pharmacy or GP to ensure continuity of treatment.
- Where a One Stop Dispensing system is in place, the discharge prescription is generally dispensed by the ward-based pharmacy team during normal opening hours. It may have to be dispensed from the main pharmacy if it includes specialist products or Controlled Drugs.
- At weekends, discharge prescriptions may be dispensed from the main pharmacy or, if unavoidable, by ward staff or the on-call pharmacist.

Some excellent examples of integrated working in accordance with this model were observed on the pharmacy visits. They included medical, coronary care and renal wards, as well as a medical admissions unit.

2. Wards with a clinical pharmacy service but no IMM/OSD service.
In this model the provision of the clinical pharmacy service may be limited and subject to occasional suspension if pharmacy resources are stretched. However**,** in most circumstances the pharmacist undertakes medicines reconciliation as per above and counsels the patient. Prescription chart monitoring is undertaken subject to available resources. The prescription is sent to the main pharmacy to be dispensed.

3. Wards with no clinical pharmacy service.
In this scenario pharmacy support is generally limited to stock management by a pharmacy assistant or technician and advice by a pharmacist on request or when resources permit. Discharge prescriptions are prepared by the doctor and sent to the main pharmacy for dispensing.

There are local variations in the procedure for dispensing prescriptions in the main pharmacy, but the most common system starts with the signed form being sent to the pharmacy by pneumatic tube or hand-delivery. On receipt in the dispensary the prescription is allocated a unique batch number for tracking and a bar-coded label is attached. This allows each prescription to be tracked using a software package, so that pharmacy and ward staff can view its status.

Before dispensing, the prescription is clinically checked by a pharmacist. The initial check is to identify any problems which are evident from the prescription itself, such as dosage errors, items which should have been discontinued, potential interactions or failure to meet legal requirements. In some cases the ward may send the prescription chart to aid this process and to help identify discrepancies relating to changes during the inpatient stay.

The most significant recent innovation is access to relevant parts of the Electronic Care Record (ECR) in the dispensary. This provides another source of information for validation and may include additional information such as relevant laboratory results. However the dispensary pharmacist still does not have a full clinical picture for the patient, so the clinical check is less robust than it would be by a pharmacist at ward level. Another practical disadvantage of this model is that where problems are identified ward staff may be asked to send a new amended prescription, so the process starts again. This adds to the time required before the ward receives the medicines, particularly if the doctor is not immediately available to re-write the prescription.

Observation of the dispensary processes in a number of sites showed that the working environment is often very pressurised, particularly where floor space is limited or there are other constraints. In the RVH for example, the dispensing robots are older models which have limited capacity and require frequent topping up. Replacement will require significant funding and also internal re-structuring to accommodate larger storage units.

In relation to the first two key elements of success for this process area, there was a consensus amongst pharmacy respondents that communication and cooperation with ward staff is greatly enhanced where the full IMM/OSD model is in place. This facilitates early planning in respect of medicines and reduces the chances of errors at a later stage. However, their impression was that ward discharge planning does not always appear to commence at admission and that subsequent events can change the anticipated outcome. They emphasised the importance of obtaining a reconciled medicines list at the earliest opportunity and of contemporaneously documenting any medication changes during the stay, together with the reasons for them.

One trust said that steps need to be in place to ensure the final verification of the discharge document. They had experienced incidents where the final prescriber did not pick up changes in medicines which had been made after the start of the document, due to the unverified document being visible on ECR before final sign-off. For this reason, it was important to avoid multiple partially started discharge prescriptions for the same patient.

Recommendation – An immediate discharge summary should begin as soon as a patient is admitted to hospital, and be populated gradually throughout the patient journey.

Junior doctors at the focus group meetings were very supportive of integrated working with pharmacists on the wards. They said that the availability of pharmacists improves the quality of the overall discharge process as medications are correct from the start. Where no pharmacist is present, a high proportion of the discharge prescriptions may have to be returned for correction, often requiring the doctor to go to the pharmacy and potentially delaying some discharges.

Anecdotal reports indicated a high level of support from nurses for a clinical pharmacy presence on their wards. Where they had experience of the full IMM/OSD service they regarded the pharmacist as an integral and valued member of the ward team.

Recommendation - trusts should continue to develop integrated medicines management models with clinical pharmacy input at ward level.

In relation to medicines arrangements when patients are transferred between wards or hospitals, most trusts rated their assessment green or amber. However, comments from junior doctors (see later) indicated that care issues could often arise from transfers, particularly when patients were “outliers”.

Reconciling Medicines on Admission
Key Success Elements:
1. Medicines reconciliation by a pharmacist is available following all admissions (with a trained accredited technician facilitating this task by collating the drug history, the first stage of the medicines reconciliation process, as part of a One-Stop Dispensing System where implemented).
2. Information from GP and community pharmacy records is routinely used to supplement patient information and facilitate reconciliation of data.

The relevant Clinical Pharmacy Standard for this activity requires that medicines reconciliation is documented/verified by a pharmacist as soon as possible after admission to hospital, ideally within 24 hours. Trained accredited technicians facilitate this task by collating the drug history, the first stage of the medicines reconciliation process. Medicines reconciliation should include all current and recently prescribed and over-the-counter medicines (the latter may include herbal, homeopathic and Chinese remedies). Any

clinical trial, shared care or unlicensed medicines should be recorded, along with any known previous adverse drug reactions, allergies or medicines adherence issues.

As described previously, several sources may need to be used to obtain a reliable record and this process can be time-consuming. The time required to complete this activity per patient on various types of ward was recorded in operational conditions over a period and the figures listed in the 2013 Clinical Pharmacy Standards report. For General Medicine the average was 28.0 minutes. For Surgical wards (including Trauma & Orthopaedics) and Gynae wards it was 25.5 minutes. Where an initial basic history was obtained by a pharmacy technician from an electronic source the time required was generally about five minutes.

On the self-assessment returns most trusts reported that at least two sources were normally used to obtain and reconcile the history - most often GP records via ECS/ECR and usually the patient. Community pharmacists were generally only contacted if queries were raised. It was not generally considered necessary or efficient to consult multiple sources.

There are no timing figures for medicines history taking and reconciliation where a clinical pharmacy service is not available and it is done by ward staff.

On the trust returns, four hospitals rated the first key element green, and the remainder amber, for medical, elderly and cardiac wards. Where amber was given, it was generally due to admissions out-of-hours not having access to clinical pharmacy support. However, some wards with a clinical pharmacy service fell short of this standard in-hours, due to inadequate cover in relation to the number of admissions.

Pharmacy-based medicines reconciliation was variable in surgical and other clinical areas, with a red rating from a number of hospitals.

Patients' Own Drugs

Key Success Elements:

1. Patients' own drugs (PODs) are routinely used during admission, inpatient care and discharge (as part of a One-Stop Dispensing System where implemented).

2. Lockable bedside medicine cabinets are provided where a One-Stop Dispensing System is in place.

The majority of hospitals have secure bedside lockers for medicines on many wards. However, the use of patients' own drugs (PODs) is variable, being dependent largely on the extent of IMM/OSD coverage and other limiting factors. The latter may include:

- patients or carers not bringing the medicines into the hospital
- brought-in medicines not being suitable for hospital use
- permission not being given by the patient or carer

Three hospitals indicated, with a red rating on the returns, that PODs were not used routinely in medical wards (RVH, MIH and UHD). There were also red ratings for other clinical areas, particularly at the MIH.

Most hospitals had taken active steps to encourage patients and carers to bring in medicines to assist reconciliation, even where POD systems were not in place. Carers sometimes had to take the medicines home again after inspection, due to inadequate storage space on the ward, contrary to their expectations.

Reconciling Medicines Prior to Discharge
Key Success Element:
Patients' medication is reviewed as necessary before discharge.

The responses from trusts confirmed that the extent of reconciliation carried out prior to discharge is dependent upon the provision of IMM/OSD support across each hospital, as indicated in the section on Communication, Integrated Working and Planning for Discharge.

The RVH and MIH commented that it may be done at dispensary level, where there is no clinical pharmacist service to that ward. The UHD said that for wards with no clinical pharmacy service, discharge prescriptions are clinically checked in the dispensary prior to dispensing. For surgical wards medicines charts are sent with the prescriptions to facilitate this. However, it is not possible to send charts with all prescriptions, since this has to be balanced against the risks of removing the chart from the ward and increased likelihood of omitted doses.

The CAA and DHH stated that the discharge medication is reviewed by the prescriber who writes the discharge prescription for the patient concerned. If there is a clinical pharmacist for that ward, they will also review the discharge medication if the patient is discharged on a weekday (there is no clinical ward pharmacy service at weekends).

In the Northern Trust, most patients' medicines are reviewed and reconciled by ward-based pharmacists in-hours prior to discharge.

At Altnagelvin hospital and the South West Acute Hospital (SWAH) medications are reviewed where a clinical pharmacy service is present. Out-of-hours the clinical pharmacy service is not operational, so not all patients are seen. Medicines reconciliation audits have shown that not all patients' medicines are reviewed by a pharmacist at ward level. Medicines are clinically screened in the dispensary when discharges are sent from wards with no clinical pharmacy service.

The timings for the reconciliation process from the Clinical Pharmacy Standards report give an indication of the resources needed for the monitoring of medicines during an in-patient stay. It was noted above that history taking and reconciliation at admission can take an average of almost half an hour per patient. When the time required for daily prescription chart monitoring,

discharge reconciliation and patient counselling is added, the average number of minutes required per patient stay are as follows:

	Pharmacist Time (minutes)	Technician Time (minutes)
General Medicine	102	83
Surgical wards	79.5	63.5
Gynae wards	67	51
Paediatrics	36	14
Acute Elderly Care	160	141

It is apparent from this that units with a high number of daily admissions and discharges, such as some MAUs, would require dedicated input from several pharmacists, with technician support, in order to effectively screen and manage the medicines of every potentially complex patient.

Writing Prescriptions & Obtaining Prescriptions
Key Success Element 1:
Prescriptions are sent to the pharmacy allowing sufficient time for dispensed medicines to be obtained.

In order to consider this issue, it is necessary to put it into context first by outlining hospital pharmacy arrangements for dispensing discharge medicines.

As described above, discharge medicines are generally dispensed from the main pharmacy for patients in wards, or when the IMM/OSD service is not available. In the case of the IMM/OSD model, with a satellite dispensary on the ward this step is eliminated with resultant time savings. Outside pharmacy opening hours discharge medicines may have to be supplied from ward stock by nursing staff.

Hospital pharmacies have historically been funded to provide a weekday service, typically between 8.30am and 5pm, plus a limited service at weekends and on public holidays. The returns from trusts indicated that considerable efforts have been made to extend these hours over recent years by a range of initiatives. For example, Antrim Hospital pharmacy now provides a seven-day 9am to 5pm service, with extended opening for discharge prescriptions and new inpatient medicines until 7pm on Monday to Friday. A pharmacist is available in the Emergency Department from 8am to 8pm Monday to Friday.

The RVH is open until 9pm on weekdays and from 9am to 5pm at weekends. This model has been in place since September 2013. The RVH and BCH

extended hours scheme provides a pharmacy service for all of BHSCT. The extended hours service in BHSCT is currently unfunded and an IPT has been submitted to the LCG in relation to this.

The Ulster Hospital has a local arrangement whereby a lock-up team stays after 5pm to deal with the backlog of discharge prescriptions. It has also provided Sunday opening between 10am and 2pm over the last two winters. Altnagelvin Hospital pharmacy is open until 6pm on weekdays.

Much of this additional provision is not funded recurrently. Whilst efforts are being made to maintain or increase the provision on a zero-budget basis, there is limited scope to do so since pharmacy managers have to cross-cover staff shortages and there are no bank/agency arrangements for hospital pharmacists in Northern Ireland. Additional funding will be required to allow all pharmacies to provide extended weekday and enhanced weekend services. It is understood that the HSCB has signposted its intention to fund seven-day working in pharmacy and that a business case is being developed.

Recommendation - Trusts should work towards a system that provides for discharges to happen throughout a seven day working week.

The pharmacy dispensing process now generally includes additional clinical checks, using information from ward prescription charts or the Electronic Care Record. This has enhanced accuracy and safety for the patient, but it has also increased the time taken to dispense the prescription and make the medicines available at the ward.

Whilst pharmacy access and workload is a major factor in determining the timescale for ward-delivery of discharge medicines, the other main determinant is the time-of-day at which the prescription is received from the ward. Many of the pharmacy responses highlighted late receipt of prescriptions, or simultaneous receipts from a number of wards, as a major problem. For example, an audit at the Ulster Hospital showed that only 55 per cent of all prescriptions were received in the pharmacy by 1pm; by 4pm the figure was 91 per cent.

Pharmacies generally had turnaround times of under two hours (average 83 minutes in one audit), but transit times could add substantially to this in some places. Therefore, to ensure that 50 per cent of discharge medicines are available on the ward by 1pm, the prescriptions would need to be received in the pharmacy two hours earlier i.e. 11am. The hourly figures logged in a recent RVH audit report showed that, on average over the four week period, only 24 per cent of discharge prescriptions were received in the pharmacy by 11am. There was only one occasion between March and May 2014 when the RVH pharmacy received discharge prescriptions in time to allow 50 per cent of patients to be discharged that day before 1pm.

Respondents reported that the situation varies at weekends, due to reduced medical cover and different arrangements for medical rounds and pharmacy services. For example, the RVH pharmacy stops accepting prescriptions after

4.30pm at weekends, so the Saturday/Sunday figures will differ from those for Monday to Friday. The audit above is based on a daily average.

Recommendation - Ward rounds should be structured to prioritise patients who are ready for discharge and facilitate earlier writing of discharge prescriptions.

Key Success Element 2:
Ward-based dispensing-for-discharge arrangements are in place where appropriate.

Preparation times for discharge medicines are much less of an issue where ward-based pharmacy teams are in place. This is partly because medicines are dispensed directly from the ward and also because prescriptions are less likely to contain errors which have to be corrected. One audit found that the average dispensing time was 25 minutes. Other respondents confirmed that the time saving compared to dispensing in the main pharmacy was often about one hour. One trust said that the saving could be as much as four hours.

Therefore the expansion of the IMM/OSD model to more wards would increase efficiency as well as improving patient care. Efforts are ongoing to achieve greater coverage through skill-mix changes and other means, but further resources are needed. It is understood that the Trust Heads of Pharmacy & Medicine Management have presented a paper to Chief Executives and the HSCB outlining how Gain Sharing could help bridge the gaps in service through reinvestment.

Key Success Element 3:
Amounts ordered on prescriptions are adequate for the destination of the patient.

Discharge prescriptions from the main pharmacy generally provide 28 days supply, as agreed regionally some years ago.

Discharge prescriptions from IMM/OSD wards vary because of the different inpatient systems, which may include use of patients' own drugs (PODs). Generally the supply is for up to 28 days, although it may range from 14 to 42 days, depending on circumstances. It may be necessary to update the regional agreement to reflect this situation.

The supply will be much less than 28 days for medicines dispensed in Monitored Dosage Systems. Some hospitals do not supply MDS at all. Instead they try to arrange dispensing by a local community pharmacist, in liaison with the patient's GP practice.

Outside normal working hours discharge medicines may have to be supplied from ward stock by nursing staff. Local systems vary and are detailed in ward protocols. The aim is to minimise the necessity for supply by ward staff as much as possible. However, over-labelled stock or blank labels may be made

available for this purpose. Nursing staff may also have access to trolley or cupboard stocks. Controlled drugs are not permitted and medicine supplies are generally limited to few days (between three and seven).

Key Success Element 4:
A scheme is in place under which a pharmacist takes responsibility for the writing of discharge prescriptions.

In Antrim hospital, pharmacists prepare the medication list of the Immediate Discharge Sheet (IDS), either as a Pharmacist Independent Prescriber following an agreed treatment plan, or following a trust protocol. The proforma for this list constitutes part of the Writemed software (Electronic Medicines Reconciliation System), which has been developed locally in conjunction with GPs. The final list is uploaded to Patient Centre, thus providing a seamless service. The process differs in other hospitals, where EMRS is not used and the doctor signs off the discharge prescription.

The available evidence indicates that discharge prescriptions prepared or signed by ward-based pharmacists contain fewer discrepancies or errors than those prepared by relatively inexperienced doctors without pharmacy input. Accuracy, safety and efficiency are the main objectives of the discharge medicines process, so there is a case for the pharmacist ultimately signing the prescription. However, concern has been expressed about the potential risk of de-skilling junior doctors with this approach. This issue has also been the subject of some debate in pharmacy circles.

Irrespective of who signs off the prescription, it is important that there is a clear separation of roles and responsibilities in relation to the prescribing and dispensing arrangements. The procedures should be clearly documented and quality assured.

In some situations, the pharmacy input to the medicines part of a discharge sheet may be regarded as transcribing rather than prescribing (the supply being made under the authority of the original direction to supply). It is for each trust to ensure that there is a clear governance framework for this activity that meets legislative and professional/ethical guidance.

In relation to doctor de-skilling concerns, it can be argued that there are other ways for junior doctors to develop their medicines knowledge, and the availability of a pharmacist on the ward can increase the learning opportunities.

In most hospitals junior doctors receive some training in relation to medicines management from pharmacists, although there is variation in the extent and duration of this training. BHSCT has funded a teacher practitioner pharmacist who provides practical prescribing training sessions for junior doctors and has done so for a number of years at induction. In the Northern Trust, pharmacy staff are actively involved in ongoing medical staff training. A new post has been approved to formalise and enhance this role in a structured and co-ordinated fashion, thereby addressing any de-skilling concerns.

Recommendation - Trusts should provide structured prescribing and medicines management training for junior doctors throughout their F1 and F2 training periods.

Key Success Element 5:
The pharmacist also takes responsibility for the supply of medication and the patient education/support functions outlined above (as part of a One-Stop Dispensing System where implemented).

Most respondents commented that these functions are core to the IMM/clinical pharmacy role and that they will therefore generally be provided in-hours by arrangement with the ward where this service exists. Depending on resources and time of day it may be necessary to prioritise complex cases or for ward staff to undertake this activity.

Self-Administration of Medicines
Key Success Elements:
1. *Self-administration schemes are in place.*
2. *Staff use self-administration to reinforce messages about medicines.*
3. *Patients' competency at self-administering medicines is assessed prior to discharge.*

None of the respondents reported regular medicines self-administration schemes being in place, but they did state that trust medicines codes or policies do allow such schemes for appropriate circumstances or products (such as inhalers or insulin). Some pilot schemes are underway in selected locations.

The Western Trust highlighted a self-administration pilot scheme in an intermediate care setting (see later).

In relation to assessment of patients prior to discharge, some limited schemes were reported. For example, at the RVH, one involves patients with conditions such as cystic fibrosis and pulmonary hypertension. At the BCH, patients may be assessed with regard to intravenous lines and the self-administration of EPO and insulin.

In the Northern and South Eastern trusts a pilot Medicines Adherence Support Service (MASS) is underway. A clinical screening tool is used by clinical pharmacists to assess patients' adherence before referral to the pilot pharmacist for more in-depth assessment and recommendations for solutions to help with taking medicines.

In Antrim and Causeway Hospitals pharmacy technicians have been trained to assess inhaler technique.

Other hospitals said that assessments would be carried out where specific concerns had been raised about a patient's ability to manage self-medication.

Counselling and Information

Key Success Elements:

1. There is liaison between ward and pharmacy staff about patients who will require additional support in the community, including medicines-taking support (complex needs).

2. Arrangements are in place between the ward and pharmacy to ensure that patients receive verbal counselling about their medicines prior to discharge.

3. Arrangements are in place between the ward and pharmacy to ensure that patients receive written information about their medicines prior to discharge.

Trust respondents were generally fairly positive about liaison between ward and pharmacy staff in relation to patients who may require additional support with their medicines in the community (mostly green or amber ratings).

The BCH said that details are recorded on the front of the prescription chart if a patient is using a compliance aid at home, including the name of the supplying community pharmacist.

Antrim and Causeway Hospitals said that there is liaison between pharmacy staff, nursing staff and the social worker. However, problems can arise when a monitored dosage system is recommended for a patient for the first time, for example as part of a domiciliary care package.

Other trusts commented that for liaison to be effective there needed to be a ward-based pharmacy contact person. Problems were most likely to arise outside pharmacy opening hours.

The responses indicated that verbal counselling was generally provided for patients prior to discharge (mostly green and amber ratings).

BCH said that it is a nurse-led process and that priority is given to high-risk patients and/or those with high-risk medicines. UHD reported that clinical pharmacists counsel patients upon request or where appropriate. This is not standard practice for all patients at discharge and trust policy is that nurses also go through medications with patients as part of their discharge procedure.

Antrim Hospital said that on the fifteen wards which operate OSD as part of the discharge process, pharmacists counsel patients on their medication. Similarly at Causeway patients on OSD are counselled before discharge. On other wards warfarin counselling is carried out. However, pharmacy staff are not available seven days a week in Causeway Hospital.

Other hospitals indicated that nursing and pharmacy staff identify patients who require counselling.

The responses in relation to the provision of written information for patients were more variable.

The self-assessment ratings for the RVH and MIH were red for all types of ward, except coronary care. The BCH said that Patient Information Leaflets from manufacturers are included in the take-home medicines, along with treatment cards for medicines such as anticoagulants and steroids. This is required under legislation, so other hospitals also make this information available.

At Antrim and Causeway Hospitals additional information is provided for specialist medicines, and information leaflets are available for patients explaining medications commenced following a myocardial infarction. A Medicines Record Sheet is given to patients on four or more medicines. For other patients, written information is only given if requested or assessed as necessary.

In the South Eastern Trust medication lists are hand-written by the clinical pharmacists for those patients who require them. At the Ulster Hospital a copy of the Immediate Discharge letter is given to patients on discharge, followed up by posting the final copy to the GP from the ward.

At Craigavon written information is provided for those patients on multiple medicines and/or who are considered to need help with their compliance. This happens on weekdays where there is a pharmacy team at ward level. The pharmacy team has developed a 'green card' IT system to assist with this, however, due to limited resources, it is not possible to provide one for every patient being discharged.

At Altnagelvin and the SWAH additional written information is provided for specialist medicines, e.g. warfarin and NOACs. Patients who require written information are identified by pharmacy and ward staff. Not all areas have a clinical pharmacy service and an out-of-hours service is not operational.

Compliance Aids

Key Success Element:

Arrangements are in place between the ward and pharmacy to assess patient needs for compliance aids, reminder cards, MAR charts or large print labels as necessary.

The trust responses indicated that there is considerable scope for improvement in relation to compliance aids.

BHSCT pharmacy departments do not routinely provide compliance aids. The RVH and MIH said that compliance aids are not provided unless there is a public health issue, or the patient is severely visually impaired. The BCH said that a formal assessment tool for this function is not implemented. All indicated red ratings.

Antrim and Causeway both reported that pharmacy staff had limited time to carry out full assessments and that there is no mechanism to supply an ongoing solution. However, a pilot medicines adherence project is under way.

The Ulster Hospital, Craigavon, Altnagelvin and SWAH all commented that compliance aids and medication lists should be part of the clinical pharmacist's role, but medicines charts or large print labels are not provided.

The main compliance aid provided by several hospitals is Monitored Dosage Systems (MDS), where patients have already been receiving their medicines in these devices prior to admission. MDS is a calendar-type device in which the tablets or capsules are dispensed in separate cells for each administration day and time. They are often known by their brand name (for example Medi-Dose™, Medisure™, Nomad™) or may just be called "weekly boxes". Their use has become much more common in the community over recent years. They have added to the complications of discharge planning from hospitals.

The dispensing of medicines in these devices is a time-consuming and intensive process, particularly when a large number of prescription items are involved, since the required tablets or capsules have to be popped out of their blister-strip packaging and then placed in the correct cells of the device, with appropriate labelling. This has significant workload implications for both community and hospital pharmacists when they are supplied on discharge. Where it is not hospital policy to supply in MDS, there can be considerable difficulty in ensuring continuity of medication, particularly out-of-hours and over weekends or bank holidays.

There are undoubtedly many patients for whom this system is of major benefit in helping them to manage their medication, with or without carer assistance. However, the initiation of MDS for an individual patient is an unmanaged (and probably unmanageable) event, since there are external pressures other than assessed patient need. Commercial competitive factors have encouraged, or put pressure on, community pharmacists to provide this service. Family or professional carers have also helped to create demand, since MDS can speed up the medicines administration process and reduce the onus on them to scrutinise individual tablet packs and administer the tablets in accordance with the directions on each.

As a result of these factors it is likely that some patients who are in receipt of MDS do not really require this service, while others who would benefit are not receiving it.

The disadvantages arising from the over-use of MDS include the fact that patients become passive recipients of a service when some could continue to manage their medicines in a much more pro-active way, with the right education and/or with simpler compliance aids. The benefits of this approach have been demonstrated in an intermediate care setting in the Western Trust area, where pharmacy and nursing staff have worked together to re-able patients before discharge, using self-administration of medicines as a mechanism.

Work is also under way to assess whether a system can be implemented in which an independent pharmacist decides whether or not an MDS is necessary, based on an objective assessment. Although this issue goes

beyond the immediate scope of this review, it is having an increasing impact on hospital discharge arrangements. Therefore, any initiative to introduce a more managed system should be supported.

Post-discharge Medicines Management Support
Key Success Element:
Support protocols are in place to ensure that high risk patients are able to continue their medication regimen after discharge, with the aim of preventing readmission.

The responses from trusts indicated that there are examples of good post-discharge support being given to patients with conditions requiring complex technical equipment or joint primary/secondary care arrangements. For example the BCH is involved in interface services and protocols relating to:

- Nephrology transplants
- Administration procedures for insulin, enoxaparin; syringe pump prescriptions
- Warfarin monitoring and adjustment
- Anticoagulant prescriptions and administration
- Acute to Community Medicines Code

As the regional centre for many specialised services the RVH manufactures and provides a wide range of aseptic and other complex products to patients in the community. It also has the largest outpatient dispensing service. However, the return from the RVH stated that it does not have the capacity to provide post-discharge support services as described in the key success element. Its rating was red.

Southern Trust said that specialist hospital and shared care medicines are provided by the hospitals, including all chemotherapy regimen medicines. Post discharge support is provided by the GP and at outpatient clinics. Western Trust said that clinical pharmacists liaise with relatives, community pharmacy and GPs when required. Patients receive information on specialist medicines such as insulins and warfarin. However, not all areas have a clinical pharmacy service and an out-of-hours service is not operational.

Work is under way to evaluate the benefits of clinical pharmacist support in both an intermediate care facility and in nursing homes. Two consultant pharmacists with this remit (one each for the Western and Northern trusts) were recruited with DHSSPS funding in 2011. The reports of both of these studies were published recently[27,28].

The pharmacist assumed pharmaceutical care responsibility for the patients throughout their stay and for a minimum of 30 days post-discharge. The

[27] Miller, ERF. (February 2014). The Role of the Consultant Pharmacist in the Pharmaceutical Care of Elderly Patients in Intermediate Care - Final Report. Western Health and Social Care Trust.
[28] Miller, ERF. (May 2014). The Role of the Consultant Pharmacist in the Pharmaceutical Care of Oder People in Intermediate Care (NHSCT Nursing Home Outreach Clinics) - Final Report. Northern Health and Social Care Trust.

pharmacist assessed each patient's medications on admission. Clinical interventions made on admission and throughout the stay were recorded for each patient. Although this was not set up as a randomised controlled study, the results indicated similar benefits to those which were reported in the original IMM trials. Follow-up work is ongoing to assess the impact of providing educational/re-abling support for patients admitted on Monitored Dosage Systems (40 per cent of the total). Self-administration of medicines is a key feature of this approach.

Discharge Medicine Summary

Key Success Elements:

1. Mechanisms are in place to ensure that GPs receive a discharge medication summary with the Immediate Discharge Document before repeat medication is required, for example through a Pharmacy Discharge Sheet or Care Plan Information on medicines for discharged patients complies with GAIN recommendations. It includes:

- *complete medication profile (reconciled medicines before admission and on discharge)*
- *identification of changes to medication profile, including the reason why a change has been made, and*
- *an indication of whether each of these medicines is to continue and for how long*
- *monitoring needs and discontinuation plans*

2. Information for specialist and paediatric patients includes details of drug formulation, arrangements for authorisation & supply, dose changes, licence status, plus monitoring needs and discontinuation plans

3. All information is clear and complete.

4. Mechanisms are in place to ensure that community pharmacists receive a discharge medication summary before repeat medication is required.

The discharge proforma in the Patient Centre maps into the GAIN guidelines and the data fields can be populated with all the necessary information in relation to medicines and other issues. The extent to which this is actually done and the accuracy of the inputted data is dependent on local custom and practice. There are guidelines on preparing a discharge prescription in Patient Centre.

The trust responses acknowledged that all sections of the proforma are not always completed. For example, the reasons for medication changes are not always documented and duration of treatment may be omitted.

Also, not all clinical areas use Patient Centre. Where hand-written discharge documents are used they may not be GAIN-compliant.

There can be particular problems where specialist medicines have been prescribed. The RVH said that in some instances the licence status or arrangements for authorisation/supply may not be included. Western Trust said that licence status is not routinely highlighted in a medicines discharge prescription. Information on red listed medicines is included but assurances are being developed for amber listed medicines.

Other hospitals pointed out that full information on specialist medicines may not be provided when discharges take place outside normal working hours.

When the discharge letter has been finalised it is available on the NIECR, but the reporting of this inpatient event to the GP is dependent on the patient taking a printed copy of the letter to the practice (or in some cases a copy being posted to the practice).

The provision of discharge medication information to community pharmacies varies across trusts and hospitals.

The Belfast Trust said in its response that it is not current practice for hospitals to send discharge information to community pharmacists.

In the Northern Trust patients are provided with a copy of the Medicine Record Sheet to give to their community pharmacist, although the patient may not always do so. For patients on Monitored Dosage Systems the community pharmacist and GP practice are contacted in advance to make arrangements. The discharge prescription is faxed to both on the day of discharge.

In the South Eastern Trust patients on MDS devices may be given a supply from the hospital and a copy of the immediate discharge medication page is faxed to the community pharmacy. The community pharmacist is phoned to confirm any changes.

In the Southern Trust it is not routine practice to send a copy of the hospital discharge prescription to community pharmacists. When a hospital pharmacist knows that a particular patient is receiving their medicines via a compliance aid they will phone the community pharmacy to ensure that they are aware that changes may have been made.

In Altnagelvin and the SWAH, pharmacists may contact community pharmacists to clarify medicines on admission and at discharge, for example compliance aids or unlicensed medicines. However, this does not routinely happen where a clinical pharmacy service does not exist.

Electronic Transfer of Information
Key Success Element:
Opportunities for electronic transfer of information are fully utilised.

The introduction of Patient Centre and the NIECR has transformed the way in which patient information is recorded and made accessible to authorised users in other healthcare settings. However, further development is required in order to reduce the dependence on paper copies for transfer of information to GPs, community pharmacists and other potential users. The system requires greater controls to allow electronic changes to be attributed to an individual prescriber or pharmacist, and the use of an electronic signature would enhance flow and safety. The Northern Ireland electronic prescribing

and medicines administration (EPMA) project will facilitate the achievement of this objective.

Southern Trust uses software with an electronic signature to facilitate the dispensing of medicines at discharge. However, there are still some developmental issues to be addressed.

South Eastern Trust said that Patient Centre electronic prescriptions are used in medical wards, but the system is not sufficiently robust to meet the legislative requirements of an electronic signature, so prescriptions are printed and signed at ward level before sending to pharmacy.

Northern Trust has developed Writemed software to facilitate electronic storage of the accurate medication list obtained following medicines reconciliation on admission. The medication list on discharge is prepared by the pharmacist using Writemed and uploaded onto Patient Centre. Currently in excess of 25000 records are held which will greatly facilitate future management. This software is available on tablet devices for mobile working.

UHD has utilised secure iPads at ward level to enable clinical pharmacists to wirelessly access medicines information and related clinical data, thereby reducing the need to log on to fixed PC stations.

In the future trusts could work together to further develop and roll out significant local and regional IT innovations relating to the prescribing, dispensing and management of medicines, and the sharing and transfer of medicines information.

Supporting Evidence Relating to Service Outputs and Outcomes
In addition to completing the self-assessment questionnaire, pharmacy respondents were asked to provide a description of current pharmaceutical arrangements for patient discharge at each hospital, including summary facts and figures relating to throughput, workload and compliance with agreed service standards. Details of any relevant published reports or case studies were also requested, as supporting evidence for the self-assessed ratings.

In response, a considerable amount of supporting information was submitted and reference has been made to some of it above. Published research findings from local studies have attracted considerable attention outside Northern Ireland, giving rise to international collaborative working and adoption of the IMM approach in a number of other countries. Statistical information from computer records, audits or research projects was provided in relation to a number of hospitals or trusts. It was evident from this that much effort has been devoted to quantifying and evaluating the clinical contribution of pharmacists to the discharge process.

However, when attempts were made as part of the discharge review to put together a comprehensive Northern Ireland picture from this information, or from follow-up enquiries, it proved difficult to do so because of differences in data collection or processing methodology between trusts. Basic activity data,

such as the number of discharge prescriptions dispensed from the main hospital pharmacy, or by ward-based pharmacy teams, was not available in a standardised format which would facilitate reliable aggregation. It also appeared that some potentially useful clinical information could not be easily retrieved in an aggregated form. For example, data on the number, type and clinical significance of medicines management issues identified by hospital pharmacists when patients are admitted would provide a valuable insight into the prevailing problems in the community. While this information is available in most sites it is not routinely aggregated in a common format.

A five trust approach to standardising the methodology for collecting and processing this data would maximize its value as a performance measurement tool and research resource.

Views of Junior Doctors on Pharmacy & Medicines Arrangements
Reference has already been made above, and in the main review group report, to the positive comments from junior doctors about pharmacy support at ward level. Working relationships appeared to be very good and junior doctors found it helpful to have access to pharmacy advice in relation to medicines issues.

Community Pharmacists' Views and Experiences
In order to obtain a community pharmacist perspective on hospital discharge medicines issues and information transfer, a short time for discussion was made available at a postgraduate education and training event. A focus-group approach was adopted, with participants also being requested to self-report their responses on a simple form to aid collation.

They were asked how recently they had received, or had sight of, a medicines discharge sheet from a hospital for one of their regular patients. Sixty two of the seventy attendees provided a written response.

- Fifty Three (85.5%) had seen a medicines discharge sheet within the last six weeks
- Six (9.7%) had seen one within the last six months
- Three (4.8%) had seen one longer ago

  - Thirty eight (61.3%) said that the sheet had been prepared by hospital pharmacy staff
  - Two (3.2%) said that the sheet had been prepared by hospital ward staff
  - The remainder did not know who had prepared the sheet or did not say

    - Twenty one (33.9%) said that the sheet had been brought in by a patient or carer
    - Eighteen (29.0%) said that it had been faxed or sent from a hospital pharmacy
    - One (1.6%) said that it had been faxed or sent from a nursing home
    - One (1.6%) said that it had been faxed or sent from the local GP practice

- The remainder did not know or did not say

The most common reason for the medicines sheet being sent or requested was in relation to patients who were receiving their medicines in a Monitored Dosage System. This was mentioned by twenty three pharmacists. In one case this was a requirement of a nursing home; in another it was a requirement of the home help service.

This feedback from community pharmacists may not be typical, since they were all from the Northern Trust area where hospitals have a high level of ward-based pharmacy support. Nevertheless it does illustrate the value of making available discharge medicines information to community pharmacists.

Attendees were also invited to comment on problems which they had experienced in relation to discharge medicines. Some said that it was more difficult to sort out discharge queries with Belfast Trust hospitals since they did not routinely make medicines sheets available and it was not always easy to contact a hospital pharmacist.

A number of the pharmacists gave examples of medication discrepancies which had been identified following discharge from hospital. These included omitted products and wrong dosages. One person said that while the Northern Trust medicines sheet was very useful it did not provide information on changes made in hospital or the reasons for them. Therefore it had been necessary for him to contact the hospital on a number of occasions to check whether an unexpected change or omission had been intended, or was a prescription error. He pointed out that community pharmacists are ideally placed to identify and query any unusual changes in the post-discharge medication of a regular user of their pharmacy, but this could only be done efficiently if they had full information from the hospital. This is an area which could be explored further by trusts in conjunction with the Health and Social Care Board.

Assessment of Findings

There is much to comment on that is positive or excellent and aids safe and timely discharge. This includes the following:

1. The service has a clear vision of what is needed through integrated working between ward and pharmacy staff to ensure safety, quality and effectiveness in the medicines management process.
2. There has been considerable progress in making the required changes in equipment, systems and culture.
3. There has been extensive re-engineering of the physical environment and equipment to help cope with the increasing service pressures and improve efficiency.
4. Integrated Medicines Management (IMM) and One Stop Dispensing (OSD) services have been shown to improve the accuracy of discharge medication and information, as well as increasing the efficiency of the discharge process.

5. A clinical pharmacy/IMM/OSD service is now provided to more than half of the hospital beds in Northern Ireland which are considered suitable for the service.
6. It is understood that the Department and the HSC Board have acknowledged the need for further development and expansion of this service in their strategic planning.
7. There are many excellent examples of integrated working between pharmacy and ward staff across the five trusts. They include medical, coronary care, surgical, oncology and renal wards, as well as medical admissions and intermediate care units.
8. There have also been regional and local innovations in information technology for recording, verifying and sharing clinical and medicines information. The systems are mapped to a template which complies with the GAIN recommendations.

The weaknesses of the current situation include the following:

1. There are still many wards and specialties without a clinical pharmacy or IMM/OSD service.
2. Even where full integrated systems are in place there may be insufficient pharmacy support to carry out medicines reconciliations or routine inpatient kardex review, and provide other medicines functions for all potentially complex patients.
3. There is evidence that the medicines section of the immediate discharge sheet is not always completed fully or accurately.
4. The partial implementation of integrated pharmacy support has resulted in different service models being operated across hospitals, wards and specialties, giving rise to variable standards and training and operational issues for medical and other staff.
5. There are also differences between trusts in the way in which IMM/OSD activity is recorded and monitored, making it difficult to collate figures and monitor outputs and outcomes on a regional basis.
6. Dispensary and ward-based pharmacy staff are struggling in some settings to meet the service standards for medicines reconciliation and review, supply of discharge medicines and provision of relevant information to primary care professionals.

The concerns arising from this situation include the following:

1. Some vulnerable patients in wards with no integrated service, or insufficient pharmacy resources, may not be treated with the appropriate medication. As a result, they may receive sub-optimal care or suffer adverse effects.
2. In addition to the impact on the patient, this can contribute to increased length of stay, delays at discharge, further demands on primary care services and an increased risk of re-admission.
3. Where ward and pharmacy procedures are not coordinated, discharges may be delayed due to problems with the prescription or the supply of the medication.

4. There is considerable scope for improvement in relation to medicines compliance aids, both in terms of needs assessment and provision.
5. Problems at the RVH are exacerbated by the low number of ward-based pharmacists and technicians, with safety implications for patients, and a negative impact on the efficiency of the discharge process.

Recommendations

1. An immediate discharge summary should begin as soon as a patient is admitted to hospital, and be populated gradually throughout the patient journey.
2. Trusts should continue to develop integrated medicines management models with clinical pharmacy input at ward level.
3. Trusts should work towards a system that provides for discharges to happen throughout a seven day working week.
4. Ward rounds should be structured to prioritise patients who are ready for discharge and facilitate earlier writing of discharge prescriptions.
5. Trusts should provide structured prescribing and medicines management training for junior doctors throughout their F1 and F2 training periods.

Appendix 4 Report of Service User Survey

RQIA Review of Discharge Arrangements – Patients Focus Groups
Christel McMullan

Three focus groups and 15 one-to-one telephone interviews were carried out throughout the five Health and Social Care Trusts in Northern Ireland in April 2014. In total, 24 patients (or their carer) took part in this review. Of these 24 participants, 13 were female and 11 were male.

The interviews/focus groups took part in all five Health and Social Care Trusts with four participants from the Belfast Health and Social Care Trust, Western Health and Social Care Trust and the Southern Health and Social Care Trust. Six participants were from the South Eastern Health and Social Care Trust and two were from the Northern Health and Social Care Trust, as shown below (Figure 1):

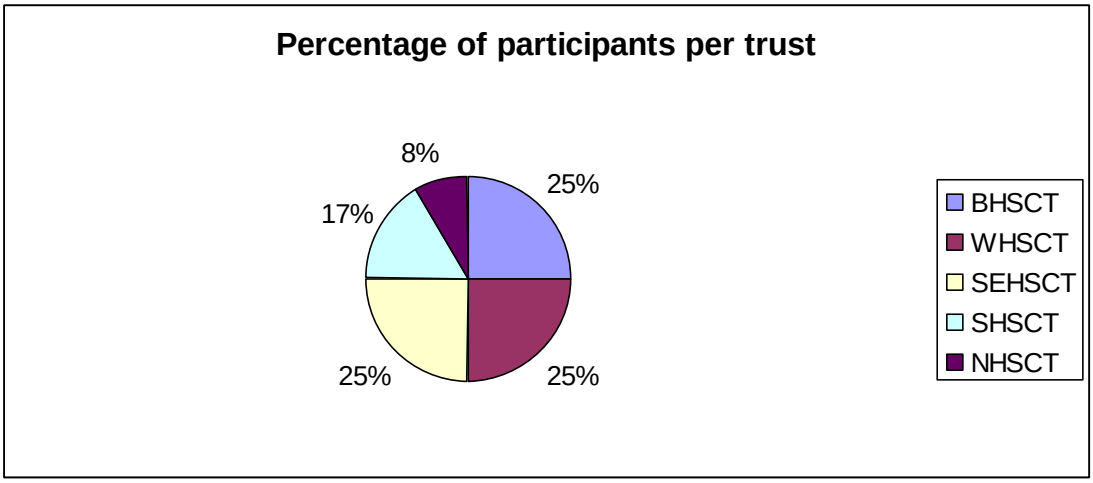

Figure 1 – Breakdown of participants by Health and Social Care Trust

There was also a range of simple and complex discharges.

Patients (or their carer) were asked about their own experience of hospital discharge. In particular, they were asked about:

1. The discharge process (timeframes/reasons for delays/discharge letter)
2. Communication around the discharge process
3. What happened after they went home (implementation of care packages/equipment/medication)
4. What they would like to change

Belfast Health and Social Care Trust

One focus group (four patients) and two one-to-one interviews were carried out in the Belfast Health and Social Care Trust. A total of six patients (or their carer) took part in the focus group/interviews.

1. The discharge process

Overall, most patients reported waiting for over seven hours between the time they were told they were being discharged and the actual time they were discharged at. Two patients reported having no issue with the discharge process, even though they had to wait a couple of hours before being allowed home:

"I really don't have any problem with it [the discharge process]"

Another two participants reported waiting one day or more to be discharged after being told they would be discharged. One particular participant reported that her mother (brought in overnight for a scan) had to wait an extra day after being told she would be discharged, due to having to wait for an ambulance:

"I was told she would be discharged that afternoon but she wasn't discharged that day, they had to keep her an extra night… I think she had to wait for an ambulance… she was able to go home but had to stay an extra night"

The same participant gave the example of a previous discharge experience when the organisation of a complex care package delayed the discharge of her mother by a week, causing her some distress:

"One day we were told she was going home, then she wasn't, then she was, it kept changing, then they don't work at weekends, that held it up even more because the whole place seems to die at the weekend"

One carer felt that the staff wanted their relative to leave the hospital, despite the fact that there were only two patients in the ward. The carer seemed confused about the reasons for discharging their relative:

"The bed manager wanted him out… but I mean it was only him and another man on the ward… I don't know where that came from"

The length of time between being told that they would be discharged and the actual discharge had a negative impact on the patients, according to some participants, including uncertainty and confusion:

"I suppose it's the uncertainty, for her, she has dementia, so obviously the confusion, strange people, strange place"

"It was horrible, mummy's dementia at that stage wasn't as bad as it was now, when she got home, she was in total confusion, it took her a month before… and it basically went down after that, not that I'm saying that it was the cause but she went down, as a result she had to go to a nursing home"

It also had a negative impact on the relative who arranged to collect the patients from hospital:

"It was very stressful because I was booking time off work because I thought she was getting home. Then she wasn't, I lost leave because of it"

Some patients reported having difficulty getting into their car as they left the hospital and believed that it was the hospital's responsibility to assist them:

"I didn't get any help on the way out. My son wheeled me to get out of the building… even getting into the car when you're weak. Even when my husband was discharged, there was no help"

Several reasons were mentioned for the delays in being discharged. They included waiting for the discharge letter, sorting out the care package and the medication, and waiting on an ambulance. One of the main reasons for the delays was waiting for the discharge letter. One particular patient mentioned some confusion around the letter which never reached her GP:

"The day they sent me home, there seemed to be a mad rush to send me home… the discharge letter went missing… it must have went missing in the house, one of the nurses must have took it… I didn't know, I was still waiting on the doctor to get back to me, I didn't know what went wrong"

Another reason for the delays was the time it took to sort out the care package, especially in the case of a complex care package.
In addition, discharges occurring at the weekend seemed to be delayed further because of a lack of staff.
The delay in obtaining the medication was another reason for the delay in being discharged. One particular patient left the hospital without their medication and had to use old medication at home:

"[name] was sent without his medication. I had to give him old stuff that I had in the house... A district nurse gave us the medication a few days later"

This particular patient believed that her discharge arrangements were left to the last minute and as a result, were insufficient and inadequate.

The participants were aware that the discharge process was easier for the patients who did not need care after being sent home and who were able to make their own way home. However, one of them had to wait for a St John ambulance to pick them up from hospital, which added to the delay:

"If you're not able-bodied, somebody else has to see that you're going home… we had to wait until 9pm for the ambulance. He went to bed at 10.30pm [feeling annoyed]"

2. Communication

Although one of the patients was very positive about communication around discharge, the general feeling was that they would prefer to be told they were

being discharged just before the actual discharge rather than leaving several hours between the two events.
One participant reported not knowing that their relative was getting discharged until the actual discharge itself. The same patient was sent home with a rash which his carer only discovered after they arrived home. No one had told them about the rash. One of the reasons which were mentioned was the pressure the staff is under.

3. After being discharged

The discharge process did not end when the patients left the hospital. Indeed, it included looking after the patients after they went home, by providing care packages, and equipment. Participants mentioned several issues regarding what happened after they went home. Two participants reported not having access to a social worker after they were discharged. They did not know why they had no access to a social worker. They did not know why that was the case and did not ask anyone about it.
A couple of participants were negative about the help they received after they went home and mentioned that not only they had to wait two weeks to get some help but they also found the care assistants to be of poor quality:

In addition, the patients also recognised the fact that there was a lack of healthcare assistants and therefore believed that the healthcare assistants did not spend enough time with the patients:

"They say in the book that they were with you for 15 or 20 minutes, in fact it was only five minutes!"

"They don't stay very long, they're short staffed. The one who came to see my husband, he was always in a rush"

One patient was sent home without their medication (although they needed medication):

"[name] was sent without his medication. I had to give him old stuff that I had in the house... A district nurse gave us the medication a few days later"

Another patient mentioned how her husband was sent home without the equipment he needed (special shoe):

"There was nothing arranged to bring him home… I feel he should have been into rehabilitation or something just for a wee while longer"
One carer felt that not having access to the appropriate help (care assistants/medication/equipment) was having a negative impact on them, as they reported being tired and not being able to go out:

"I haven't been able to go out of the house in four months, this is the first time"

4. What would they change?

A couple of patients did not suggest any improvements as they were very happy with the discharge process.

Others suggested that the discharge letter should be sent to the GP instead of handed in:

"Those letters should be sent by post directly to the GP"

In addition, it was felt that the staff should be better prepared (re medication) ahead of the discharge:

"If they knew when the person would be discharge and try and arrange things a day or two beforehand, you seem to be waiting a long time. If they say you can go home at a certain time, you can't because you won't have your medication… They just leave it to the last minute"

"They should tell you one or two days in advance that you will get discharged on such a day. It gives you time to get sorted and it gives them time also to get ready"

"One or two days would make a big difference"

One next of kin mentioned that having more staff working at the weekends would improve the discharge process.

Finally, it was believed that having more coordination between the different people involved in the discharge process would also improve the whole experience. It was felt that the different staff kept passing the buck onto others:

"There's too many departments and they don't seem to work together: 'I've done my wee bit so someone else can do that wee bit', I think it needs a bit of working together"

South Eastern Health and Social Care Trust

Six patients from the South Eastern Health and Social Care Trust took part in a one-to-one telephone interview.

1. The discharge process

A majority of the participants reported no delay or a delay of 2-3 hours between the time when they were told they were being discharged to the time of the actual discharge. The reason for this delay was waiting for their medication from Pharmacy:

"There was a delay in the drugs coming down to me"

One participant reported waiting for 8 hours because of the medication.

Another participant believed that his discharge had been a little rushed:

"I was on IV antibiotics until 12pm. It was quite a shock to find out that as soon as instantly I was off the IV I would be going home… I was told at 12.30pm that I would be going home…"

Although he mentioned waiting three hours between being told he would be discharged and when he was actually discharged, this patient felt that he had been "pushed out" of the hospital:

"It felt a bit rushed to be honest that this decision was taken so suddenly… I had been quite ill with high temperature… it was a bit of a shock… it seemed to me that they wanted us out of there… It wasn't as though they said to me if we get you out of antibiotics then you'll be able to go home, no one suggested that… it was stop the IV and then go home. It seemed like a surprise, it did seem like that there a general clear out"

When asked if he had mentioned this issue to anyone, he answered that he had not as he believed that the nurses had done a great job.

All the participants were given a discharge letter from the hospital before they were discharged, which they then gave to their GP.

The patients went home either with a relative or by ambulance. One participant who went home by ambulance reported some delay in leaving the hospital.

The delay in the discharge process had an impact on the relatives/friends who collected the patients from hospital:

"The person who came over to give me a lift, he had to wait for about an hour, there was a bit of hanging around to get out"

2. Communication

All participants were very positive about the communication around the discharge process. They were kept informed of the reasons for the delays and the process was explained to them:

"Yes everything was explained to me, they went through it all very carefully"

In some cases, the next of kin (or carer) was involved in this communication to keep them informed as well of the process:

"Yes my wife had a conversation with the medical staff, as my carer she was going to be attending a course; they took this into consideration when they were planning my discharge"

As a general rule and although the staff explained the discharge process to the patients, most of them reported that they had no input in the process itself. The communication was mainly verbal. No written information was given out.

3. After being discharged

The participants were positive about their return home. Having said that, most of them had simple discharges and did not need care packages. A couple of them were cared for by their spouse.

4. What would they change?

Most of the patients agreed that having everything ready (including discharge letter and medication), before asking the relative to come and collect them, would improve the discharge process. One of the patients admitted not knowing enough about the process itself. Therefore, they felt that having more information earlier would improve the overall service.

Northern Health and Social Care Trust

Two patients from the Northern Health and Social Care Trust took part in a one-to-one interview.

1. The discharge process

The two patients interviewed reported some delay in being discharged. One waited 5.5 hours and the other one waited a day.

The main reason for the delay was waiting for their medication and their discharge letter. One of the patients thought that the discharge process was "long-winded" but also admitted that, because she had been recently admitted to and discharged from hospital several times, she had got used to the delays. She also gave the example of another patient beside her in the ward who waited nearly two days before she went home because the staff could not find an ambulance. Although she believed that it was quite a long wait, she could not pinpoint exactly what or who was to blame for it:

"There's something missing there, don't ask me what, but there's something missing between the time the doctor tells you you're well enough to go home and you actually get there, there's something missing, whether it's in the admin bit or whether it's to do with the doctor's writing of the discharge note, I'm not sure"

Another reason for the delay was the confusion over whether or not a patient was supposed to be given a nebuliser. This patient felt that the confusion added to the delay:

"The fact that you were told that you were getting the nebuliser and then you weren't getting it meant that it delayed the getting home process"

One participant felt that this delay meant that they were wasting a bed which someone could have used:

"It takes from 11am till 7pm to get a doctor to discharge him plus his medicine, it seems an awful waste of a bed, it's a full day that he's lying in a bed and somebody else could be in it"

The impact of this delay was also felt on the relatives, as some of them had to take time off to collect them from the hospital:

"I rang my daughter and she lost time off work, and that happened before"

2. Communication

One participant admitted receiving little written information on the discharge process. Therefore, her input in the discharge process was non-existent. Having said that, she found the nursing staff to be very helpful. The other participant mentioned how the nurses explained to her how to use the equipment she needed at home.

3. After being discharged

Neither patients needed a care package after they got home and no issue was reported.

4. What would they change?

One patient mentioned that she would like to see everything in place before being told she is being discharged:

"They should have all that in place before they come and tell you that you're getting home. I know it's not easy but…"

The other patient did not understand why it took the doctor so long to sign the discharge letter, and it was felt that if the patients knew why it takes several hours to be given the letters/for the doctor to write the discharge letter, they would feel better about the delay:

"I don't know why it takes so long for all this [signing discharge letters and medication] to happen"

Western Health and Social Care Trust

One focus group (3 patients) and four one-to-one interviews were carried out in the WHSCT.

1. The discharge process

Most of the patients interviewed reported no delays in getting discharged, despite waiting for a couple of hours for their medication. However, one participant waited three days (over a weekend) to be discharged. She was not sure why she had to wait three days but speculated that it was to do that discharges did not happen at the weekend:

"It was too late on the Friday to be discharged so then I was told that it would be the Monday morning"

They were all given a discharge letter which they then passed onto their GP.

One next of kin raised the issue of the implication of being discharged to a nursing home. As places in nursing homes are limited, it was felt that this created bed blockage in the hospitals.

2. Communication

Most of the participants were very positive about the communication around the discharge process. They all received either written or verbal advice on the process itself. They found the communication useful, although one of them admitted that she knew what to do anyway. Staff kept the patients/next of kin informed of the process:

"They kept me informed all the time, the different assessments that were being done"

"I had a talk with the pharmacist as well about his medication"

"I found the communication brilliant here, unlike in the Royal, the doctor came to speak to me, made it very clear"

"I was informed when she was being discharged, as she was being discharged"

3. After being discharged

Some of the patients were given equipment (ie zimmer frame, stairlift). Although most of them reported no issue, one next-of-kin mentioned that the staff forgot to give his relative her zimmer frame, which led to some minor delays in the patient settling in the nursing home.

4. What would they change?

Most of the participants interviewed reported that they would not change anything to the discharge process.

However, some of the participants mentioned that they should not have to wait for the discharge letter for so long:

“We’re always waiting for the letter, that seems to be lasting forever, perhaps they should do something about that”

Another participant suggested that the hospital could communicate with the next of kin by text messages to keep them informed.

Southern Health and Social Care Trust

One focus group (4 participants) was carried out in the SHSCT.

1. The discharge process

Two of the patients who took part in the focus group reported long delays in getting discharged (between 7 and 10 hours) and felt strongly about it:

"In terms of the plans that are in place around discharge, I have to say I've had quite a negative experience, in the timeframes of discharge. Given that on Friday, I was informed at 9am that I would be discharged and not being able to leave hospital before 7pm, it's quite frankly I don't think acceptable in the 21st century health service, that it takes that long to get something from pharmacy"

The main reasons for the delay were waiting for the discharge letter and waiting to see the GP:

"The doctor came around on a Sunday at lunchtime to tell me I could go home… 5pm come and the nurse said the doctor in the main hospital would not come over, that was her word, would not come over to sign the discharge letter. It was me and an older lady… then at 7.30pm, a different nurse came and said 'if we let you home, can you guarantee that you will come back tomorrow to get the discharge letter?' and as this gentleman said, I was only too happy to go home"

As mentioned in the above quote, this particular patient left the hospital without a discharge letter. He was asked to come back the next day and had to wait a further two hours before being given his letter. There was the feeling that the patients did not understand why it took so long for the doctor to sign the discharge letter:

"Why does it take still take that length of time to be discharged, if you don't need medication? He was a simple discharge. Why can't he sign it there and then? It's not always the pharmacy they're waiting on to be discharged"

Furthermore, patients reported that they did not want to be in hospital any longer than they had to. They also felt that waiting after being told they would be discharged meant that they were using a bed unnecessarily:

"They're not able to get somebody off the ward who is no longer in requirement of the bed, therefore holding that bed up for somebody who needs the bed… bed managers need to liaise better with Pharmacy and pharmacy needs to be given the resources to cope with the demand"

When given the discharge letter, one of the patients found that it was incomplete and lacked information on medication dosage.

One of the consequences of having to wait to be discharged was that some patients became stressed and anxious, as they felt that they "just wanted to get home":

"I think it causes unnecessary amount of stress and anxiety because when you are in hospital and you're told you're getting out, the first thing you want to do is head towards the door"

One particular participant felt that her son would have recovered quicker if he had been allowed home earlier. The lack of clear guidelines around the waiting time in the discharge process was mentioned by one of the participants as increasing this stress.

Organising transport home was also an issue made difficult by the delay in being discharged, as patients were not sure at what time they would leave the hospital and as the relatives might have to wait for the patients to be discharged:

"Particularly in rural areas, if the patients are dependent on taxi, it's that waiting to be told you can go but then having to make sure that the taxi is here for you, obviously the taxi cannot stay on standby"

In addition, one of the participants seemed to have an issue with being discharged late at night, as she believed it was not fair on the patient himself:

"Being discharged at 9pm at night is not on, and that happened several times to my brother… because he was coming back to a home, they told him he was being discharged at 9pm but he might not have left before 11pm at night"

In the case when a patient was discharged to a nursing home, as mentioned by one participant, it was clear that being discharged late at night did not only impact on the patient, but also the relative and the nursing home:

"My brother was discharged from A&E at 11pm [to a nursing home] and I don't think that was on, that wasn't fair on him, that wasn't fair on the staff in A&E… he couldn't speak, so some member of the family had to be over there because we were his voice, the nursing home would phone to say he's coming back and someone had to be over. That's not fair on the patient and that's not fair on the nursing home, they're closed at that time and they have to open again"

Finally, all participants were very positive about the nursing staff, but noticed that they were too busy.

2. Communication

Participants were mixed about the communication they received around the discharge process. While one patient found the communication very clear and useful, the others felt that there was not enough communication.

Another participant revealed that she was not happy with the way she was told that her son was to be discharged. Indeed, the doctor was busy and waved his finger at her saying "You can go now, you can go". In addition, she believed that she was not able to have any input in her son's discharge:

"What about listening to the voice of the parents? I don't think we had any say in his care… he wasn't comfortable in the ward, it wasn't a good place for my son to be and I knew instinctively that he would have improved better if he had got home, the stress levels would have decreased, if I had been able to air my views, but I was shut down"

In addition, the issue of confidentiality during the discharge process was raised by the same participant. She felt that it lacked privacy:

"The doctor came round with a number of junior doctors… all these eyes staring at me, it was a very intimidated process, it lacked respect and privacy. The doctor was standing over me with all the junior doctors behind him and I thought it lacked privacy"

Another participant, who was the wife and carer of a patient, felt that she was excluded from the discharge process, as the doctor asked her to leave when he wanted to discuss something with her husband:

"When the doctor came in to discuss, I had to leave, I thought, being [name]'s wife, I should have been able to stay in the ward and he would have spoken to both of us. He sometimes forgets things that I could have picked up on"

3. After being discharged

The patient who went home with no letter was anxious and wary after he went home in case something happened, as he had not been told anything.

Having said that, one patient found that the discharge letter was lacking information on medication dosage. In addition, she had been told an inappropriate dosage by a nurse. As a result, the participant rang her local pharmacist who advised her on the appropriate dosage.

The participants did not need any specific equipment.

4. What would they change?

There was a definite sense that there was a need for clear timeframes around discharges, which the participants did not think were in place:

"We need to put some robust improvement plan in place, a reform around the discharge process, what timeframes are acceptable and not acceptable, and those need to be made clear to everybody, from the Chief Executive to the patients on the wards"

"I think the onus is on the trust to make people aware of the guidelines in place… it's about access to this information"

It was suggested that the different departments (pharmacy, GP, nursing staff) needed to collaborate with each other better:

"Collaboration is the key factor. I think it would be helpful for the department to put in place, as they have in A&E, very clear timeframes around discharge… if that timeframe was put up around discharge as well, it would give a target structure… I think 4 hours is reasonable"

Conclusion

Delays in getting discharged from hospital were reported by the patients (or their carers) interviewed for this review. These delays ranged between 2 hours and several days.
The main reasons for the delays were waiting for the discharge letter from the doctor and waiting on the medication from the pharmacy.
There was a definite lack of understanding from the patients regarding the reasons for the delay in the discharge letter being signed by the doctor.
Overall, the patients (or their carers) were positive about the communication around the discharge process, even though they had little input into the process itself.
Some issues were reported by the participants after they went home after their discharge, including faulty missing equipment/medication, and lack of help.
Finally, the patients (or carers) interviewed believed that several steps could be taken to improve the discharge process, including:

- the doctor signing the discharge letter when they visit the patient on the ward
- more collaboration between the different participants
- having everything (care packages/medication) organised before telling the patients they are going to be discharged

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