Appendix 4 - Anonymised views of frontline care sector workers

On Committee's request, an email was sent to front line workers in Cardiff Council, inviting their anonymised views on the hospital discharge process for those with care needs.

The email sought the frontline workers specific views on what works well in the process, and areas for improvement.

The below provides the comments received:

Working Well:

"I have seen an improvement having one point of access to the Integrated Discharge Hub team, as this has given clear triage pathways and has enabled the right people to come through for a reablement service"

Areas for Improvement:

Better hospital transport:

Aiming for timely discharges as assessments can take some time to complete depending on the complexities.

Discussions with patients and Families or support networks on if able to support the individual overnight so assessment could be completed early the next morning – this will save on transport costs if family are able to collect from ward.

Home assessment visits by ward OT's:

When assessing a patient using equipment such as hoists or profiling beds, there used to be home assessments that took place with the patient in their own home. This identified the best equipment to prescribe based on the environment and took into consideration space and accessibility for carers providing care.

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Alternatives to care:

Thinking outside the box, is there any technology, equipment or other services that could provide the support a carer could, i.e Meals on Wheels, Wiltshire Farm Foods, Telecare, Alexa etc. Trolley to transport food and drink from room to room, perch stool to enable a patient to sit at the kitchen counter and make their own drinks and snacks.

Medication:

It would assist if the ward staff were to think how medication was managed before admission, is it appropriate to change to alternative dispensing methods or better to stick to what they know and have managed. Can family or friends assist, were they assisting before admission, what has changed.

Ward Views:

Be less risk averse from a ward level, It may be that a patient requires 4 x daily assistance, but this does not mean that when home they would not have some reablement potential and the calls could be reduced from 4 to less or even none with a good reablement approach from Health and Social care and the right support networks around them. (I understand this will not be the case at all times)

Level of care required:

Currently there are no care constraints but when they do arise think about the level of care that is being requested, again looking at alternatives and ensuring that everything has been taken into consideration such as for an example if a request to support a patient with medication is required does the medicines regime fit with the care calls being requested if not rationalise the regime with the Ward Dr and Pharmacy.

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Communication:

Open and honest communication, if someone has a prognosis of a terminal illness it is not always appropriate to send to a reablement team knowing that within maybe a couple of weeks they must move to another agency.

Take the patients word for it. If there is no doubt in relation to the capacity of a patient and they advise they don't want care when they go home, and you know this is an informed decision as they have been advised of all identified risks. Arrange the discharge, if anything then fails it would be picked up by either the GP or the First Point Of Contact Social work team in the community. (Give them the contact numbers for this service).

The below information was received in specific relation to the D2RA pathway:

The premise of D2RA is that the patient is assessed by either an Occupational Therapist (OT), Social Worker (SW) or Social Work Resource Assistant (SWRA) on the ward, with a view to providing a temporary care package, a review then conducted in their own home environment post-discharge with a view to providing a permanent care package.

The following comments for each process are below:

Allocation*: each case is triaged at the Integrated Discharge Hub (IDH) at UHW – from an OT perspective we have an Occupational Therapy Assistant (OTA) working in the triage office – this has worked really well as the OTAs can in-reach onto the wards for further information. This may be further enhanced if an OT was in triage, to provide advice and support on manual handling/equipment/adaptations issues. Particularly from working in an NHS environment it is vital that Multi-Disciplinary Teams communicate and collaborate in this way. What is important is that all professions will view the patient from a different perspective, thus offering patient-centred care.*

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Unfortunately, the triage team have recently been moved into the main First Point of Contact (FPOC) room, and they have to share one phone between four of them. Although this may appear minor, in their role it is vital that all equipment needs are in place as a matter of urgency. At present the current office environment at UHW is not conducive to allowing everyone to work to their full potential. The office is overcrowded, and can be noisy at times, particularly if a sensitive phone call for example would need to be conducted. FPOC/OT at County Hall work well, if this was replicated in a hospital environment, then this would only enhance working outcomes.

As the D2RA project is new, we appreciate that there are processes which are evolving and need to be resolved accordingly. For example, we are currently working with team managers to finely tune the allocation process, so after the triage stage to OT or SW – some patients require more manual needs over social issues and vice versa.

Assessment: *the allocated member of staff would receive the allocation via a joint Teams notification and within 24 hours they attend the ward (at present this could be UHW, UHL or St David's Hospital). The patient is spoken to, assessed, ward staff are consulted, ward notes perused and updated as necessary.*
This has worked well – Cardiff Council (CC) staff being able to in-reach onto the ward and again communicate and collaborate with NHS staff has been extremely successful.

There are several requirements needed to be made by NHS staff for the IDH team to commence D2RA pathway, it is felt these need to be listed below and comments made as some of these processes can delay a discharge:

Equipment*: all equipment needs to be in situ at the home environment – this is usually the responsibility of the ward OT/staff, prior to referral being made to IDH. However, there can be delays with this for various reasons. For example, a referral being received on a Monday, OT visits ward to assess patient on Tuesday, however only part-equipment delivered to home address. A decision needs to be made as to*

whether the patient needs to then be re-referred and go through the whole process again, or by Community Occupational Therapist (COT), OT and ward OT liaising with each other and D2RA co-ordinator, a temporary hold on the referral for one day, delivery of the final piece of equipment on Thursday means the patient can then be discharged Friday. This would not appear to be a smooth D2RA process 'on paper' however by collaborative working this has saved the patient being in hospital for another week and not having to be re-referred.

Medication: *a necessity for discharge via the D2RA pathway is that the patient can either self-medicate, family support is available to give medications or medications are in blister packs. Very often blister packs are difficult to get hold of in the community, which then causes a delay in discharge via this pathway. By resolving pharmacy supply of blister packs a huge amount of time and money could be saved.*

On numerous occasions CC staff have to reiterate to NHS staff that the above processes need to be in place in order for the patient to be D2RA suitable, this is not a complaint or a criticism as this could be resolved by presentations or information being made to NHS staff in order to clarify the pathway.

Interim care package: *the relevant process is followed on CareFirst, the D2RA care co-ordinator would commence their work and it is usually within 72 hours that the patient is discharged from hospital to their home environment, and a temporary care package is started for the patient. As the patient has been assessed on the ward and information gained to support the assessment the care package can be supported by this early intervention. For example, very often third sector support and CC referrals are made at this stage.*

Review visit: *the initial allocated worker (namely OT, SW or SWRA) would attend the patient's home to review the care package. This is the stage that differs according to profession for example, OT would usually visit 7-10 days post-discharge, SW 3 days post-discharge. The OTs arrange to meet the care agency at the property so they are able to observe the care provided. This allows for any amendments to be made, for example timing of calls or any equipment needs required.*

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We feel strongly about the D2RA project and how this can aid a safe, timely and cost-effective discharge. It is appreciated that all professions will have a different perspective, however the end goal is the same, namely the patient/citizen. This is an excellent example of collaborative working.