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Premises visited: Discharge Lounge Hull Royal Infirmary Hull	Date of Visit: 28.11.2016	HW Reference: HWERY 20161128
	Duration of visit: 1.5 hours	
	HWERY Representatives: Mrs Pam Wakelam Michelle Harvey	Staff met during visit: Manager Staff nurse Healthcare Assistants (HCA)

PURPOSE OF VISIT

1. To gather patients' experience of being discharged from hospital.

2. To give an external perspective on the discharge lounge environment/experience for patients.

INTRODUCTION

The 'Discharge Lounge' (DL) is situated on the ground floor of the hospital next to the foyer and A/E department. This provides ease of access for admission and discharge and also for ambulance access to facilitate many of the discharges.

Externally the hospital has undergone a programme of external renovation over the last year or so.

Internally the unit is bright and airy with simple décor but lacks colour and vibrancy and appears quite clinical.

The unit has facilities for 20 chairs and 4 beds. Three staff were on duty, one registered nurse and two health care assistants.

The patients coming to the unit are on the way home or to another health care facility e.g. Castle Hill hospital. They are given arm chairs to sit on or beds to lie in depending on need.

According to the staff, when asked, the process is that the patients are booked in to the unit from the various wards/departments via a computer program and a communication form is completed advising the staff on matters such as medication, ambulances booked etc.

During our visit we noted approximately 10 patients going through the unit, the lounge was visibly busy and staff were welcoming.

ENVIRONMENT AND ACCESSIBILITY

Disabled access is easy as the unit is on the ground floor. Although disabled access is not an issue, there is no designated area for wheelchair users to be seated and one patient was frequently moved around to allow access to a stock room by the staff.

There is no hearing loop though the staff nurse advised me they used to have one.

Toilets are provided outside the unit and patients who need assistance are taken by the nursing staff. Baby changing facilities are provided in one of these areas. There is a sign for toilets but it is not clear that these facilitates are situated outside the unit.

A water fountain is provided plus a trolley with water jug and juices for people to serve themselves. Tea and coffee is also available on request to the nursing staff and is made in a small kitchen off the unit. The staff nurse advised me they felt they would benefit from a boiler being installed to avoid boiling kettles which is time consuming.

Papers and magazines are provided. However there were no information leaflets in evidence (other than a couple of posters on the walls) and although the box was available for patients and families to post their comments etc. there were no forms or pens provided to complete them.

There was no payphone available within the Discharge Lounge.

SAFETY

There were no apparent safety problems. The unit is quite spacious and free from hazards.

A 'Resuscitation trolley' was provided for clinical emergencies.

Hand gel was provided for control of infection purposes

POLICIES, PROCEDURES AND CARE PLAN

The policy for the admission of patients to the unit seemed to be a problem. During our time in the unit three patients arrived from the 'Emergency Admissions Unit' (EAU) unannounced. They had been told to walk down to the unit to await their relatives etc. Fortunately the unit was not full and the staff dealt efficiently with the unexpected, however, there was no paper work and no call to advise on the care required, if any.

Only one relative was present during our visit - they are of course welcome to be with their relative while awaiting transport.

PATIENT EXPERIENCE

We spoke to seven patients during our visit to the unit. All of the patients we spoke to expressed overall happiness with the care received while an in-patient, four however felt that the discharge process had been rushed and that they did not have enough information, or the information given had been conflicting between different staff members.

Note: Two of the seven patients left on transport before the questionnaire could be completed in full.

Three patients had experiences of being moved at least once to another ward during their stay. Three also felt they had not had an opportunity to discuss discharge plans or their own concerns/worries.

Four patients had been advised of the discharge that day, and one the previous day. One did not remember and one felt the day had been changed numerous times (this may of course have been for been for clinical reasons.)

All of those questioned advised that they had not been given a time for discharge other than morning or afternoon. Some were waiting for medications; one patient spoken to identified this as a reason for waiting. It was also noted that the patients' drugs were given to the ambulance staff when taking the patients home rather than to the patient directly: one patient was observed to find this confusing.

There seemed to be an overall frustration with the discharge process amongst those we spoke to.

Average length of stay in the DL is reported by the manager to be about three hours and discussions held with patients supported this.

Some patients felt that the stay in hospital had achieved nothing in relation to understand their medical problem and they were going home with no answers so wondered why they were being discharged. It is noted that most of the patients were elderly and may have been a little confused however it was a common theme amongst those spoken to.

PRIVACY, DIGNITY AND RESPECT

The bed area had curtains around the beds but otherwise there was limited provision for private conversations with patients and families. The reception desk had no confidential area and was manned by the nursing staff when they were free.

STAFF

The staff nurse felt that there was no requirement for special training for the roles in the unit and she felt her nurse training was satisfactory.

LEADERSHIP

The manager met us when we arrived but had to leave after introducing us to the unit staff. The staff nurse in charge was also part of the nursing team. We were therefore unable to assess the overall leadership of the unit.

EFFECTIVENESS

Clearly the fact that the unit exists helps in the freeing up of beds in the hospital for the next admission. Patients questioned however felt a little abandoned and had limited understanding of why they had been sent there.

Staff members were attentive as far as they could be, given there was only three of them and they had to move patients around as well as deal with admissions and discharges so often two of them physically in attendance.

The concept of the unit is good but some processes need addressing re admission and possibly mediations.

RECOMMENDATIONS

- Ensure all the hospital wards/units understand the process of admission to the discharge lounge to prevent surprise arrivals
- Consider the need for information leaflets in the unit
- Consider reinstating the Hearing Loop.
- Review procedures for communication between patients and staff regarding the purpose of the unit and the reason they are transferred there.
- Medication delays were noted as a problem by one patient – consider reviewing the potential causes of delay and put in place measures to effectively communicate these causes to patients who are waiting to go home.
- Seek to reduce length of stay

CONCLUSION

The concept of DL's is good and if processes are followed should provide a smooth transition for patients and free up much needed beds in the hospital; however perceived long waits are experienced in the unit which causes distress to some who just want to get home. Communication between ward staff and the patients seems to be a problem generally according to those available for us to speak to.

Signed on behalf of HWERY		Date: