

Reducing delayed transfers of care (DToc) in older people: a qualitative study of barriers and facilitators to shorter hospital stays

Visual summary



Qualitative study



What is the problem?

Older patients who come into hospital often remain in hospital even after their medical problem has been dealt with. These delays can cause harm to patients through loss of their independence, and contribute to hospitals being full.

Why did we do this research?

A national Discharge to Assess policy has been introduced, encouraging hospitals to get patients home quicker. We wanted to find out what patient and family views were on shorter hospital stays and to develop recommendations to help reduce delays.

How did we do the research?

We analysed 371 stories on the Care Opinion website¹, posted by older people (aged 70+) or their families. And, we interviewed 16 older people (aged 75+) and family members about their recent experience of hospital care and discharge by telephone.

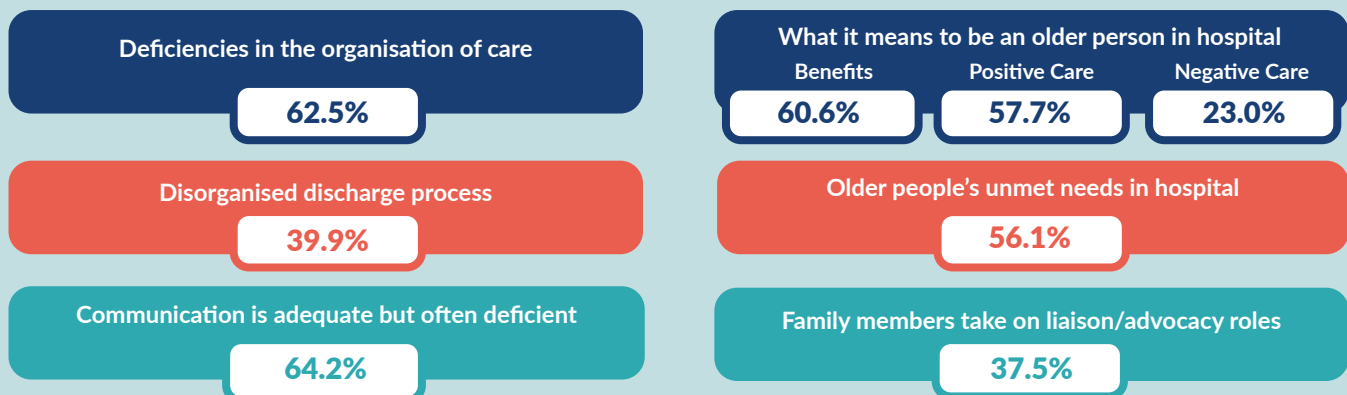
Findings Key themes identified from interviews

Thoughts and feelings about being in hospital and decisions at time of discharge

<p>1 Older people and families appreciate rationale for shorter hospital stays</p>	<p>3 Unwarranted variation and lack of confidence in care</p>	<p>5 Family and older people unprepared for ongoing care needs</p>
<p>2 Communication systems seem designed to fail</p>	<p>4 Hospital discharge process caused frustration and anxiety</p>	<p>6 Factors affecting implementation of 'Discharge to Assess'</p>
<p><i>"One of the biggest things I remember was the noise, some of it was mechanical, some of it was just people talking across the width of the ward, shouting at each other"</i> Older person</p>	<p><i>"It wasn't consistent, it wasn't reliable, it felt as if you were relying on personality"</i> Family member</p>	<p><i>"I don't feel we were involved to any extent, I think we were being told what was going to happen...I would like to have had a proper meeting with, you know, a member of staff"</i> Family member</p>

Key themes identified from the on-line care stories.

Percentage of stories contributing data to each theme:



¹ <https://www.careopinion.org.uk>



Recommendations for improvement

Findings from the interviews and on-line stories were combined and organised into barriers or facilitators to shorter hospital stays, to help us develop recommendations for improving services.

Organisation of hospital discharge

- Designated single point of contact for discharge
- Discharge to a virtual ward or hospital at home
- Patient information about local social and community care options
- Standard protocol and organised patient transport system

Discharge preparation & knowledge

- Set expected discharge date that is regularly updated
- Pre-discharge family meetings to improve communication
- Written information about what to expect before, at discharge and afterwards

Information & communication

- Family liaison officers to allow clinical staff to focus on care
- Patient and family checklist of questions to ask about discharge
- Train staff in communication skills and discharge team in cooperative communication

Conclusion

Availability and quality of information and communication provided was a prominent finding. Communication is fundamental to patient-centred care, and even more important in discharge models characterised by limited assessments and quicker discharge. Interventions at the service level, and targeted patient information about what to expect before and after discharge, could help to address poor communication and support efforts to improve discharge of older people from hospital.

Further information

If you would like further information regarding this research, please visit the Improvement Science theme webpage (<https://www.arc-yh.nihr.ac.uk/what-we-do/improvement-science>) or contact the programme manager, Andria Hanbury, via YQSRAdmin@bthft.nhs.uk

