NHS
The Mid Yorkshire Hospitals
NHS Trust

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4188/17/SJ/CC - 10/18

Mr K McLoughlin
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Dear Mr McLoughlin

Re Inquest touching Eileen Cooke (deceased) – Regulation 28 Report to Prevent Future Deaths

Following our correspondence on this matter I am providing a response to assure you that the Trust has a robust process for the safe discharge of elderly patients.

The Mid Yorkshire Trust is a large multi-site acute trust serving the population of Wakefield and North Kirklees. Frail elderly patients may be discharged from Pinderfields, Pontefract or Dewsbury and District Hospitals. The majority of discharges from the medical department occur from the older person's wards – Ward 41, 42, 43 at Pinderfields and Ward 2, 9 and 11 at Dewsbury Hospitals.

The Trust defines frailty in the following way:

F	**Falls** (not alcohol related) **or new reduced mobility**
R	**Repeat** Hospital attendances >= 3 in last 12 months and/or **Rated** as at least moderate Frailty in the community
A	**Acute** confusion (Delirium) or **Chronic Confusion** (incl. Dementia)
I	New **INCONTINENCE (urinary/faecal)**
L	**Lives** in residential or nursing home
T	**Treatment** for Parkinson's
Y	**Years** >=80 years old

Wherever possible frail elderly patients are admitted to one of the Acute Care of the Elderly (ACE) Units. This ensures that a holistic approach is taken and a comprehensive geriatric assessment completed. When frail patients are admitted to other areas the care of the elderly department does offer consultations to help guide clinical care and discharge planning.

There are a number of possibilities for the discharge for frail older patients with most being discharged back to their usual place of residence. All patients who have had a deterioration in their mobility are reassessed by therapists. Frail older patients, regardless of their location as an inpatient, have access to occupational therapy assessments and if necessary physiotherapy. These therapy assessments allow patients and their relatives to obtain valuable information about other support available to them in the community.

Therapy assessments along with those made by nursing and medical staff may reveal that a person requires more support. This may be a new or increased package of care, require placement in an interim bed or care home. Others require a further period of rehabilitation, to improve their mobility and general health which may be delivered from a respite placement. Those patients returning to 24 hour care in residential or nursing homes do not require an occupational therapy review (which looks at community needs on discharge) but do have a physiotherapy review if their mobility is not altered. The therapy reviews are not required if the patient is bed bound but they are followed up in the community. When concerns about care home placements are raised then teams ensure that there are no outstanding safeguarding issues which do not need addressing to keep patients safe.

For all older patients, there are a number of community services which may need to be accessed:

a) District nurses for wound dressings, monitoring or follow up review for example to check lying/ standing blood pressures
b) Tissue viability nurses
c) Vascular nurses for those who have wounds which have a vascular origin
d) Diabetes nurses
e) Community pharmacists – They can look at medications and their delivery for those who are discharged who have a history of no or poor compliance

Discharge plans for frail older patients are discussed with patients themselves and often their family or next of kin. In those who lack capacity to make decisions for themselves, discharge plans are discussed with relatives especially those who have Power of Attorney over health and well-being. The Trust has a safeguarding adult team to support clinical teams in their decisions and discussion if required.

On the two ACE Units, there is a dedicated multidisciplinary/ multiagency team named the Rapid Elderly Assessment Care Team (REACT) – the Trust was one of the Phase One Sites for the Future Hospitals Programme at the Royal College of Physicians which supported the expansion of the service.

The team at Dewsbury and District Hospital is slightly different as the Clinical Commissioning Group have a Hospital Avoidance Team which supports discharges which occur within 5 days. The teams at both hospitals have close links with community providers and use various community services to ensure discharge is safe for patients following an acute admission. AgeUK Wakefield often take patients home and also now have an advice hub within Pinderfields Hospital were advice on

their services can be obtained. This can be accessed by all in patients and their relatives whether they are on the elderly care wards or other wards in the hospital. The REACT service is aimed at the first 72 hours of a patient's admission.

Each of our Care of the Elderly wards has access to therapy teams who attend daily board rounds which occur on a Monday to Friday. Treatment and prospective discharge plans are discussed. This allows issues to be raised and concern addressed: such as how someone is going to manage at home or whether further information or time is needed. At these daily board rounds and safety huddles, therapists, nurses, doctors and discharge coordinators are present. Each of our care of the elderly wards has a dedicated discharge coordinator, who helps to facilitate safe and timely discharges of frail older patients. Once a patient is deemed medically fit, the therapists work to establish the baseline and whether a patient's current needs have changed. In some this can be established quickly, in others especially those with cognitive issues, assessments may be reliant on engagement of the patient and family in the discharge process. The options for discharge do vary and the most appropriate decision is made in consultation with those concerned. If during the discharge process, things change such as the patient becomes unwell then discharge plans are put on hold and their clinical condition and suitability for discharge is reassessed.

In instances where our frail elderly patients are being cared for out with the elderly care areas, the Care of the Elderly Department offers a consultation option to help manage patients with complex needs or support with discharge plans. Although we would prioritise an elderly care bed for these patients, the complexities of some conditions necessitate their care being delivered in a specialist area. The team will also support best interest decisions.

If a patient is returning to a care home, discussions take place with the care home to see if their needs can still be met. This would be standard practice for those who are bedbound due to frailty. If necessary, such conversations are followed up by a visit from the care home staff to the ward.

The Trust is committed to improving our liaison with care homes and where possible, the disruption of an admission to hospital for their patients. There are currently two clinicians who outreach into the local care homes visiting the care homes, often after a patient has been discharged, to talk through advanced care planning or to review patients so they do not have to attend a clinic at the hospital. They have set up a dedicated email for communication and each home will have a named geriatrician that they can access. Both these geriatricians have knowledge of the management of moderate/ severe frailty and have set up good liaison with the neurophysiologist who manages contractures in the Trust to ensure patients with severe/ moderate frailty with contractures can be seen.

Patient and family feedback is a really important way in which the Trust learns and improves. REACT actively seeks this feedback by working closely with their patient representatives gaining feedback prior to discharge and post discharge with follow up phone calls. The patient representatives contact patients who have been discharged obtaining feedback on the discharge process and whether services were

provided as planned on discharge. The majority of responses have been positive. Where we establish discharge plans have not fully satisfactory then the team strive to ensure that improvements in the discharge process are made and shared.

I hope that this provides the information that you require.

Yours sincerely

Karen Shore

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