SOCIAL POLICY RESEARCH FOR CORNWALL

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Bed-blocking: blaming it all on care services is buck-passing

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Your March 10 article 'Seven hospital wards are full with patients now fit to be discharged' quotes the Chief Executive of the Royal Cornwall Hospitals NHS Trust as saying that the hold-up is happening because 'the majority of the people waiting to be discharged are waiting for residential care home beds or domiciliary packages of care in their own homes'. We're evidently meant to understand that it's mainly the fault of the inadequate social care system in Cornwall.

There is more to this story than meets the eye.

If we ask how it is decided that a patient is 'medically fit for discharge', we find something very odd. Hospitals have been given a rulebook to follow with a list of eleven 'criteria to reside'. So for a patient to be allowed to stay in hospital following treatment they must require oxygen therapy or intravenous fluids or medication, for example, or have undergone lower limb surgery less than 48 hours ago. [For the complete list, see Appendix 1.]

If they are followed strictly, these criteria do not allow clinicians to make their own judgement as to whether a patient should be kept in for observation to check that they are recovering satisfactorily, or to make allowances for a patient who is frail or has a complex of conditions, or to allow for a patient's poor mental health, or to ensure that arrangements are in place for speedily readmitting a discharged patient if they take a turn for the worse.

Experienced clinicians may feel confident enough to trust their own judgement over keeping a patient in – they know that 'medically fit for discharge' does not necessarily mean fit to go somewhere else – but others may not, especially if they are under pressure from the hospital's executive team to free up beds.

Hospital executives seem keen to pass the buck to social services, but we need to ask what happens to patients who are indeed stuck in hospital while waiting for a place in a residential care home or for a package of care to support them in their own home.

Are they actively helped to get themselves and their lives back together? Or are they parked in whatever beds happen to be available dotted around the hospital? If they are labelled medically fit for discharge they are unlikely to be top of the list for attention from the clinicians who originally treated them. We know that some are incarcerated in a bed where they lose autonomy, muscle strength and perhaps even the will to live. It wouldn't be surprising if their relatives feel they can't cope with them at home. [See the four patient stories in Appendix 2.]

The Royal Cornwall Hospital at Treliske is tackling this issue with its new *Wheal Vor* ward dedicated to preparing patients to leave, but is one ward enough? And what are the community hospitals doing? It would be good to hear from some chief executives that they are taking active steps to help 'stuck' patients, and not just passing the buck to stressed social services to do this. If integrated care is to mean anything it must mean them playing their part along the whole pathway through NHS care that patients take.

Appendix 1: Criteria to Reside

from Hospital Discharge and Community Support: Policy and Operating Model, p.35

Annex A: criteria to reside – maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made:

- Requiring ITU or HDU care?
- Requiring oxygen therapy/NIV?
- Requiring intravenous fluids?
- NEWS2 > 3? (clinical judgement required in persons with AF and/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic?
- Acute functional impairment in excess of home/community care provision?
- Last hours of life?
- Requiring intravenous medication > b.d. (including analgesia)?
- Undergone lower limb surgery within 48 hours?
- Undergone thorax-abdominal/pelvic surgery with 72 hours?
- Within 24 hours of an invasive procedure? (with attendant risk of acute life-threatening deterioration

Clinical exceptions will occur but must be warranted and justified.

Appendix 2: Trapped in hospital: four patient stories

These stories are reproduced from HOW TO LOOK AFTER YOURSELF IN HOSPITAL (second edition) , published on this website, where the original sources are cited.

Mike, aged 89

Mike was enjoying an early evening at home when he tripped over the edge of a rug and hit his head on the side of a cupboard. He remained conscious and was able to get to the phone to call 999. He was seen swiftly in A&E and was found to have no serious injuries, just some bruising.

The medical team decided to admit Mike overnight for observation, as a precaution, simply to be sure he was safe to go home. A day or two passed, during which time some tests were carried out. They all confirmed that there had been no serious or lasting damage and no underlying cause for the fall. He had simply tripped.

10 days later, Mike was still in his hospital bed. By this time he had lost a good deal of mobility, so an assessment by the physiotherapy team was arranged. The physiotherapists felt that Mike really needed assessment by the occupational therapists, and also by the social work team. All of these assessments took further time to arrange, and the days turned into weeks.

Based on the assessments, a recommendation was made for 24-hour residential care and that is where Mike was placed.

The occupational therapist (OT) who conducted Mike's assessment felt very strongly that had the physiotherapists, the OTs and the social care team all worked together as a single unit from the outset, this scenario might have been avoided. They could have worked in parallel rather than in series, thereby dramatically reducing the time it all took.

[The] opinion of the OT and the other teams involved was that, had they worked more effectively together, Mike could have gone home, with reablement support for his mobility issues.

* * *

Jane, aged 85

Whilst cleaning her kitchen, Jane, who has had insulin-dependent diabetes for 59 years, slipped on the wet floor and fell. Jane was enjoying living independently with the support of a care package to help monitor and control her diabetes. She was seen in A&E and admitted for observation and monitoring of her diabetic control.

10 days later, Jane was declared medically fit. She was keen to go home.

There was then a series of delays with discharge, as a result of some internal communication processes not working as well as they should. Three weeks following her fall, Jane developed a severe hospital-acquired infection. Two months after admission to hospital, Jane was discharged – to a residential home.

Had Jane's discharge been managed more effectively and rapidly, she would have been less likely to suffer a hospital-acquired infection and far more likely to have been discharged to her own home and independent life – as she had wanted.

* * *

Jean, aged 90

Another example of decline, this time in a community setting, is provided by the Embrace Care project in Cornwall.

Day 0: Jean, an elderly woman with a history of falls, has a fall at home. After a very short stay in the acute hospital, she is discharged to a community hospital.

Day 1: At this point Jean is able to use the commode, is washing herself (with some support to reach her feet), cleaning her teeth, brushing her hair, and is moving around. She says she wants to return home when she is discharged from hospital. A search begins for support at home to enable her to do this.

Day 60: After many attempts to source a support package in the community have failed, Jean is told she will have to be moved into an intermediate care setting while a long term support package is found. She spends the following two days in bed.

Day 62: Jean starts to require full support to wash herself.

Day 74: A support package has been found to allow Jean to return home. However, her needs have increased and her physiotherapist suggests that the support package is now not sufficient, and it is refused.

Day 78: A checklist is completed and Jean again expresses her desire to return home.

Day 89: Jean is moved into a temporary bed in a care home.

Day 185: Still in the temporary bed in the care home, Jean dies.

* * *

Ann, age unknown

The fourth patient story is an anonymized account of two visits a week apart in July 2019 to an elderly woman patient in the Royal Cornwall Hospital at Treliske, near Truro. The visitor was from Healthwatch Cornwall. On the first visit the patient was engaging and engaged:

[Ann says] ‘I have good and bad days. It feels like I’ve been in hospital a long time – too long. ... I have no idea when I’m leaving. The doctors haven’t spoken to me about leaving here yet. I’m worried about money. It’s not always possible to get what you want. I’m from a large family and wish I could be with them now. But I’m quite happy here on the ward. The food is good and I’m well looked after.’

[The visitor says] ‘We visited Ann again seven days later. It was like visiting a different patient. Last week she was engaging and although [she] clearly had a level of cognitive impairment, she had a degree of understanding and seemed happy and talkative. Today she seemed unhappy and distressed and kept repeating that she wanted to go home.’

* * *

These four cases all date from the pre-coronavirus era. As we have seen, acute hospitals are now keen to see you leave as soon as possible. But if the result is that, like Jean, you are moved to a community hospital, you may have much the same experience as Mike, Jane and Ann with time-consuming administrative procedures but in a community setting instead.