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Gwent Research, Innovation and Improvement Communication Hub (RIICH)

Learning and Improvement Network 3: Seamless Care

Case Study 1: Adult Care Homes – hospital discharges and resilience of the workforce

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1 Summary

1.1 Case Study Overview in Brief

Care Homes have been disproportionately affected by COVID-19 in every aspect – on a human scale, with a high proportion of residents becoming ill and dying, and the effect coping with this has on the work force, through to the business impact, with day-to-day operation changed.

The speed and efficacy of Hospital discharge processes have become crucial to both hospitals as well as Care Homes. The pressure on hospitals to free up beds requires a fast, efficient and streamlined process. The change in personnel allowed to take part in the discharge process has been limited within hospitals (for COVID safety reasons), with an impact on the extent and quality of information passed to Care Homes.

Care Homes have largely closed their doors to all external visitors, including external staff and specialists, volunteers and students. The future of the workforce is of concern if students cannot complete their placements and achieve their qualifications. The quality of life for staff at work in Care Homes will also impact on the retention of the workforce long-term.

1.2 What did people tell us? – Summary

Care Homes find the information given to them about new patients can be inaccurate or incomplete. It can result in residents arriving at Care Homes that are not appropriate for that resident's needs, or a lack of information for the Care Home about what treatment that resident has had, or ongoing needs for that person.

There is a real need and desire from Care Homes to work in collaboration with hospitals for a more cohesive discharge process. A lack of resource and pressures in dealing with the pandemic seems to have been a barrier in hospitals for developing better processes so far.

Care Homes that operate across the Gwent region have to cope with the differences in forms, email systems and processes across the five Local Authorities. A more joined-up, unified approach would be welcomed by Care Homes affected by this.

Care Homes are – understandably – risk averse. They feel safer having a ban on anyone coming into the Home who is not a permanent member of staff or bank staff. They are not willing at the moment to allow student placements.

Health and Social Care courses have not been given the same focus or status as student nurses and student medics, with most courses suspending placements. There is concern that the future workforce will be affected, with current students not qualifying (dropping out of courses or switching careers) and future recruitment suffering – it has always been difficult to recruit to this sector.

1.3 Moving forwards – Strategic Priorities

Partnership working with hospitals is vital – it needs to involve relevant hospital staff *and* Care Homes. Meetings with hospital staff are needed.

A Hub system may be of benefit, where each hospital has a team who collate the information – this could streamline the information and check for quality.

Training for hospital staff is needed, providing them with an understanding of what information is required, and why, by Care Homes. Reminder notices and brief instructions could be useful.

A cohesive approach across the five Local Authorities would be of benefit to Care Homes who operate across the Gwent region – having a unified set of forms and one Email system would be welcomed.

A Careers Library is being developed with ABUHB – including the diverse range of careers within a Care Home would be useful. Developing a video of 'A day in the life of a care home' across the staff roles could attract more young people to work in the sector.

Model risk assessments may be of benefit for Care Homes, giving them (and their staff, residents, and residents' families) the confidence to allow them to be more flexible and responsive to the COVID pandemic – when appropriate, they could then permit external visitors and students.

Model risk assessments may be useful for other sectors too, such as ancillary staff from other organisations, charities, volunteers and educational settings. This would help reassure and guide organisations on what needs to be considered for working in or visiting Care Homes under the current circumstances.

2 Rationale and context

LIN Case Studies Pandemic note

When this work on case studies was started it was thought that the Covid crisis may have peaked in the first half of 2020 and that therefore any lessons identified would be in a context of reflection and reconstruction. However as we enter winter it is now clear that the pandemic has entered a second phase and the case study lessons

identified are presented to assist supportive improvement in the most difficult of circumstances

Since COVID-19 arrived in Wales at the end of February 2020, Adult Care Homes have faced unprecedented challenges in protecting, supporting and caring for their residents. They are particularly vulnerable to outbreaks of COVID-19 and have been disproportionately affected because of the mortality risk it brings for older adults, particularly those with dementia.

Care homes have been (and still are) scrutinised by numerous working groups and reviews, with the aim of helping their continued operation and protection of our society's oldest and most vulnerable adults. Organisations are still responding to the ongoing crisis, and staff across Health and Social Care have responded above and beyond their normal roles to improve the situation – the success of which is evidenced by the lower infection rate in Care Homes so far in 'wave 2'. Efforts to review and improve have not stopped, and work is ongoing to make processes as robust and collaborative as possible.

With the likelihood that COVID-19 will be with us for quite some time, it is important to look at how organisations can live *with* COVID-19, rather than pinning all hopes on a vaccine or social distancing measures to eliminate it. This case study aims to provide examples of the latest situation for Care Homes in relation to hospital discharge processes and the resilience of the future workforce in Care Homes, in order to inform possible areas to follow up, investigate or develop.

3 What happened with hospital discharges?

At the start of the pandemic in March and April, there was a push to free up hospitals beds to provide capacity for the expected rise in COVID admissions. Residents were discharged to a Care Home without a COVID test – in line with national advice and policy at that time.

It was decided that a regional Gwent-wide approach should be adopted in responding to the pandemic, unless there was a specific reason that a local response would be better.

At the beginning of October, the Healthcare Inspectorate Wales and Care Inspectorate Wales shared their reflections ahead of the winter period, on how health and social care services in Wales have responded to COVID-19. Regarding hospital discharge, they noted:

- *"The importance of a rights-based approach… their families and or advocates are involved in decision make."*
- *"Recognising that providers are partners in care, especially in relation to hospital discharge, as are family members for many people. Acknowledging successful discharge occurs with coordinated communication, essential timely discharge planning and the receipt of detailed and timely discharge information."*

Huge improvements and changes have been made overall, and Care Homes have acknowledged the enormous efforts that numerous staff have made to cope with the

pandemic, and to make Care Homes a safer environment, protected as far as possible from the effects of COVID-19.

There is a great deal of understanding and acceptance from Care Homes on the pressures that hospitals and Social Care staff face – but the following highlights some issues mentioned and are possible areas for further investigation.

3.1 Hospital discharge process pre COVID-19

To discharge a patient from hospital to a Care Home, a comprehensive set of assessments are carried out by numerous professionals, but tailored to the needs of that patient. The usual people involved in the hospital discharge process could include:

- Discharge liaison nurse
- Hospital discharge assistant (Discharge coordinators) / Patient Flow Coordinators
- Ward manager or lead nurse on the ward
- Social worker
- Family

Assessments are carried out to confirm the patient's needs, but these may also include 20+ other staff, such as Occupational Therapists, Physiotherapists, etc. All of these people need to liaise to collect and collate the information - there is no hierarchy or 'final sign-off' process, although theoretically Health are responsible for each discharge. In theory, the patient and family then have 14 days in which to visit and choose a Care Home, along with that Care Home's manager (or representative) carrying out an assessment in the hospital to confirm that their Home can give the appropriate care to that person.

This whole process can take at least 2 to 3 weeks. During this time, the patient is in hospital or a step-down bed, if it's available.

3.2 Hospital discharge process during COVID-19

During the pandemic, hospitals have had to minimise the number of staff present on wards, which resulted in a lot of staff being taken out of the discharge process as they were not on the wards. From a Home First point of view, this led to a more controlled process as there were less people involved, which, for them, improved the flow of communications.

A Hub was set up at the Royal Gwent Hospital, coordinated by Home First, during the first lockdown. This has since been disbanded, with mixed views from staff regarding this. It provided a single point of contact for hospitals and Care Homes, and meant the information could be collated in one team for the Care Homes. Staff acknowledge there were some issues with roles and responsibilities that needed to be resolved, but had it continued it is possible these could have been addressed.

Care Homes have commented they like being able to speak to the relevant staff carrying out the assessments, so if a Hub system was ever adopted, it may be beneficial to include Care Homes in reviewing the processes.

The choice policy 'kicks in' after the assessments have been completed – but that is currently suspended in ABUHB. Care Homes have closed their doors to visitors, which means they can no longer visit patients, and patients and families cannot visit Care Homes.

Care Homes are now reliant on the information that is collected for them – although hospital-based staff attempt to collect the relevant information for them, there has been no formal replacement for the additional information Care Homes would usually collect, which can often result in missing information Care Homes would find extremely useful for transitioning a new resident.

> *"It is more difficult to manage when we cannot send out one of own staff to do the assessment. Have to take the information you're given and sometimes that isn't as accurate as it ought to be."*

Once they have arrived at a Care Home, residents are isolated in their room for 14 days even if a COVID-19 test comes back negative. With dementia patients it can be extremely difficult to get them to understand and comply – often impossible. This poses a danger for other residents and staff. Care Homes would like the rapid test available to help reduce this:

> *"If we have the rapid 90 minute test, that isolation period could be shortened to 48 hours. Reduce isolation…. Homes as well as hospitals need the rapid test."*

Before COVID-19 happened, a link with the Behavioural Support Team had been established, and Care Homes were starting to get help from them. Since the pandemic started, this team has either been scaled back or redeployed elsewhere, when in fact, their expertise would be hugely useful to Care Homes when they have to operate under the current restrictions.

3.3 COVID-19 testing and hospital discharge

There have been mixed experiences for Care Homes in relation to testing processes and hospital discharge. Pressures on hospitals to free up beds, and issues with the availability of tests (or laboratory availability) can cause problems in the continuity and consistency of care.

From early in the pandemic, all patients discharged from hospitals to Care Homes should have a COVID-19 test with a negative result before leaving hospital:

> *"It was improving slightly, but it's sometimes a battle. [The hospital] will tell you, you don't need to have a COVID test, and we say 'no we've got to have a test and need a negative result', but it doesn't go down well. We still have trouble with discharge letters and getting the COVID result written down – [the hospital] will give it to us over the phone"*

> *"They [hospitals] don't follow the guidance on discharge and testing"*

There was the occasional example of unsafe discharges that must have been distressing for the patient. These are escalated to the Corporate Governance Team:

"So our managers go through the guidance properly, through a checklist, and the hospital discharge staff don't ask why we're checking this. It ends up with a strong disagreement between the discharge staff and Care Home managers about what the discharge procedure is. We've had residents discharged and ending up in the car park. One resident had a blank piece of paper with 'COVID negative' hand written on it, and that was her discharge note."

The results from rapid tests are also sometimes delayed. Normally this would be a swab test, with the patient ready for discharge, and the results returned within an hour. However, a patient can remain in hospital for a relatively long time after the test, with the hospital still wishing to discharge them. Several Care Homes gave examples of patients remaining in hospital for 3 or 4 days after their rapid test, without the hospital willing to carry out another. The SOP requires that a test is done within 48 hours of a patient being discharge – Care Homes say this is not recent enough to the day and time of discharge, whilst hospitals argue that this is not long enough.

There is also a different approach adopted for Care Home residents who are treated in hospital but not admitted (and therefore, not discharged) and those who are admitted to a ward:

"We've asked for 90 min tests (rapid tests) if we send a resident to A&E. If after 4 to 5 hours of assessment, they will take a 90 minute rapid test to check which ward they are to go on. If they [the hospital] send them back to us, they don't get a test. Why do they need a test if they're staying in hospital, but not if they're coming back to us? It's one rule for them and another for us."

3.4 A joined-up approach with hospitals

The rules on isolation for Care Homes and hospitals are different. This is understandable in the main, given the different environments, but can cause problems for Care Homes:

"The system can work, if you get step-up-step-down units in place, and follow the discharge guidelines, but we know they don't follow the guidance – even when [residents are] sent to units, we find out from families that they've visited, so we know they're not isolated. The local Health Board have got to follow the guidance.... Need to consider this for the second wave, step up/ step down, sometimes care homes need to send direct from the care home into these wards."

There can be practical issues for Care Homes in isolating COVID-19 positive residents, particularly those with dementia, and protecting their other residents:

"Really hospitals should be taking COVID positive residents so we can protect our other residents. It's especially important at the moment, as care homes can no longer get COVID insurance cover."

Regular visits back and forth to hospital, can have serious consequences – despite increasing the risk of contracting COVID-19 through contact with more staff, a short visit does not require a formal 'hospital discharge' process, and with that, no COVID test:

> *"We had a case where one lady in her 60s needed dialysis 4 times a week. Her needs were so great she should have been transferred to one of these facilities [step-up-step-down unit], because she had to be transferred 3-4 times a week. She caught COVID and died."*

The care home felt that if she had stayed in the safety of the unit, she would have come into contact with less people and this may have provided a greater level of protection.

3.5 Collaborative working

A SOP has been agreed and signed off between the 5 Local Authorities and ABUHB regarding hospital discharge. However, although this has made huge strides in unifying the process, in practice, there is not a fully consistent approach across the ABUHB for hospital discharge. For Care Homes who take in residents from across the region, this can cause problems that range from mild niggles through to significant impacts on the speed and quality of a patients' discharge from hospital. Differences include:

- Different forms for completion of assessments
- Three different email systems across the five Local Authorities, in addition to the NHS system
- Inconsistency from wards and members of staff in different hospitals

The paperwork is different across the Local Authorities - although the overall content is the same, the quality can vary, and this could (in part) be improved by having a uniform set of paperwork across Gwent. One Care Home cited the Caerphilly Unified Assessment, and the Aneurin Bevan Hospital Discharge Assessment, as good documents.

The three different email systems set up across the five Local Authorities specifically for dealing with COVID-19 communications means that Care Homes have three different passwords, plus the NHS system. No alerts are set up, so they need to log in to check whether they have received information from the hospitals – a seemingly minor issue, but when Care Home managers have such increased workloads, this can feel like an unnecessary, uncoordinated process where Care Homes have not been considered and are just on the receiving end.

NHS Digital and other organisations have put considerable effort into encouraging the use of 'NHS Mail' and the unifying Email system for secure communication between NHS bodies and Care Homes. As all local Authorities have access to using NHS Mail a solution of all stakeholders (Care Homes, NHS hospitals and Local Authorities) using one Email system already exists.

At the moment, care homes feel that the hospital discharge guidance is developed without them and then they are informed what it is they need to do. Their view is that if they are involved, the process could run more smoothly. If care home representatives *have* been involved in its development, this could be publicised to emphasise the efforts made for collaborative working.

> *"…[there are] faults within the guidance... It would have been nice for care homes to have been involved in developing the guidance."*

It has been acknowledged that care homes need to be included as a key partner in the discharge from hospital process, and there have been disagreements between Care Home staff and hospital staff about the details needed within the discharge information:

> *"…we've been asking for 2 months to have a meeting with A&E staff – we know they have their problems so let's have a meeting so we know each other's point of view and sort out the policy between us, but we can't get those meetings arranged"*

This Care Home recently reported that things have got a bit better, but meetings have been promised but not yet happened, which they feel are still needed.

There can be limited understanding in hospitals about how a Care Home operates. This can lead to misunderstanding and frustration for both the hospital as well as the Care Homes. There seems to be a barrier in getting the information to the hospital staff about:

- What it's like to work in a Care Home
- The limitations on Care Home staff's time (e.g. the Care Home nurse may not be able to speak to the hospital when they phone – especially if they are the only nurse on duty in the Care Home)
- What information Care Homes need about the patient
- The limitations for Care Homes in isolating residents, especially those with dementia
- The lack of insurance for Care Homes now that COVID is excluded, and the impact this can have on it as a business and the service it provides, and the role that Care Homes then need hospitals to take
- What a safe discharge looks like for Care Homes

It would be beneficial to both Care Homes as well as hospitals if ABUHB could facilitate meetings both, to build relationships and understanding of each other's needs and requirements.

4 Workforce resilience – what's happened with volunteers, the Third sector and work experience placements?

4.1 Visiting professionals and volunteers

Care Homes have largely closed their doors to external visitors and staff since the start of the pandemic. Many Care Homes managers said they 'had to' or had been directed to by national guidance. However, "there has never been a complete block on people visiting a Care Home. It comes back to what is defined as 'essential'."

Residents and staff can feel safer if the Care Home is 'locked down', with no visitors or ancillary staff allowed, including those who provide activities and expertise, such as hairdressers, podiatrists, and early on in the pandemic even GPs did not come into some Care Homes. However, the impact on residents' quality of life can be very negative, and this is not sustainable long-term.

Some Care Homes use volunteers a great deal, mainly for providing activities and supporting residents with their interests. The Third sector also provides important expertise for Care Homes. Students on work placement or work experience in Care Homes are also important for the future sustainability of the workforce.

All this stopped with the pandemic, which has meant extra pressure on staff. One Care Home said:

> *"Sadly, one consequence [of COVID-19] is a reduction in resident numbers. [Care Home name] is down by 20%, [Care Home name] by 50%. Whereas before we would have cut staffing numbers, we haven't done that, so staff have picked up the slack. So we have extra time to spend with residents. If it wasn't for extra [financial] support the government has given then we would have had to cut staff. Financial support has prevented an adverse effect."*

This additional support will end at some point, and business continuity is already being investigated in the Care Home Failure Response Plan. The impact and role of volunteers, the Third sector, and student placements should also be considered within this [IS IT ALREADY?].

Care Homes often have a specific role with a staff member getting in touch with the local community and local organisations who may want to come into the home. Due to cut backs, some Care Homes have reported this role disappearing, with the loss of links to the local community.

4.2 Work experience placements and the future workforce

A consortium was set up in 2018 covering the Gwent region brings together ABUHB, Local Authorities, private providers, the Third sector and Coleg Gwent, among others. It has been very effective, gained new members, and is now refocusing, having looked initially at issues that included the changing curriculum as new Health and Social Care qualifications are developed, recruitment and retention.

Since the pandemic began, Care Homes have closed their doors to students, colleges and universities have stopped placements, and ABUHB have also not allowed placements.

There has been a substantial amount of help given to HE and University students, but less focus on FE students. Health and Social Care students have not been given the same status as student nurses or medics. Without completing their placements, these students will not be able to complete their qualifications. ABUHB is now working with Coleg Gwent, looking at the strategy for placements for these students.

> *"I think this will have quite a big impact [on care homes in the future]… depends how long we're kept in lockdown… if people don't get the work placement practice, they don't know the job"*

> *"…students are the future workforce and stopping them gaining experience in this sector will lead to further shortages. We are already overworked and stretched trying to look after service users so we need to act now"*

This academic year is the main issue so far. For a Level 3 course, students need to achieve 100 hours of placements in their first year and 100-150 in their second year. Coleg Gwent had put back the start of these to October 2020, but these are now delayed further. It is vital that students get this hands-on experience, in order to have a good appreciation of the role and understand what is required in practice. Students need this to see that it is a role which involves compassion, care and values, and some of the key benefits for staff too, such as flexible working hours, training and achieving a genuine connection with residents and having a positive impact on their lives.

A career bank is being developed with ABUHB, which could prove hugely influential in recruitment to careers in Care Homes, which has always been an issue:

> *"What we could do with care homes, we could look at getting 3D videos done, like a tour of a Care Home. We know what the career path is. The image of Care Home working is not the best. Everyone seems to say they want to work in hospitals. Care homes are never portrayed as being glamourous – it's end of life, palliative care. Need to change that image."*

Retention of students within the sector is vital – recruiting the right people in the first place, and creating a working environment within which they want to stay is important long-term:

> *"Currently there are a lot of vacancies in care but not many are applying or once they gain employment they are not staying, this is scary. Unless they increase the pay and conditions this will go on for a while."*

The image is not helped by the media and news – there is not much about people choosing to go to a Care Home and enjoying life there. There is much to be done on improving the image of careers in Care Homes, especially with young people. One care home hopes the government's Kickstart scheme will make a difference: *"…future workforce needs to come from young people who want to get involved in social care".*

The range of careers within Care Homes also needs to be promoted. For example, it is not 'just' Care Assistants, but also Physiotherapists, Play Therapists, Chefs, Gardeners, Care Home Managers, Accountants, Nurses, etc. Currently, the variety does not come across to students.

There may be 'virtual' options for some students too – it might be possible to ask some residents to have a videoconference with them, and discuss what life is like for them in the Care Home:

> *"Some of the patients like being consulted on these matters, who would probably have creative ways to support the students to understand the needs of individuals and the role of the carer and more sensitive stuff about delivering care, whilst not being directly hands on."*

4.3 Risk

Understandably, a risk averse approach has been used so far in relation to allowing external people into Care Homes. It will require a great deal of effort to reassure

residents, staff (who are often in older age groups themselves) and families about the safety of opening up Care Homes again. It may be worth looking at creating model risk assessments for care homes, Third sector providers, volunteers, ancillary staff, schools and colleges to facilitate a safe and managed approach to reopening the doors of Care Homes, and for work experience placements to go ahead.

Lockdown for Care Homes long-term may not be a realistic sustainable approach, and it could be useful to encourage a transition from risk avoidance to safe risk management.

5 What this means for the future

There are a number of issues that could be investigated further regarding hospital discharge:

- Formalised collection of information by staff at the hospital that the Care Home would normally collect when assessing the patient at the hospital
- More collaboration (or publicising of collaboration) with Care Homes to develop hospital discharge processes
- Promotion of collaborative working between hospitals and Care Homes – facilitate regular meetings between hospitals and Care Homes
- More publicising and training within hospitals and for social care staff about the importance of the discharge information, to reduce missing information / chasing up for information, and to reduce disagreements between Care Homes and hospitals on the detail needed for discharge
- Investigate streamlining collation of the information, and re-instigation of Hub teams as the norm (not 'just' for the pandemic)
- More consistency across Gwent, regarding email systems, processes, forms, guidance and testing
- Rapid testing that has a maximum turnaround time before another test is required
- The introduction of COVID tests for patients who need to regularly attend hospital
- Re-establish links with the Behavioural Support Teams
- Consult with residents regarding their hospital discharge process

Looking at the future of the workforce, it may be worth investigating the following areas:

- Showcasing the variety of careers within care homes, using 3D tours, and looking at 'A day in the life' of a Care Home
- Raising the profile of the importance of work placements for Health and Social Care students, emphasising the importance for the future stability of businesses
- Drafting model risk assessments for care homes, schools and colleges, to facilitate the reintroduction of work placements
- Drafting model risk assessments for care homes to promote and encourage the use of ancillary staff, such as hair dressers, podiatrists, volunteers, and Third sector providers, to improve the quality of life for residents
- Continue emphasising to Care Homes that they can open their doors to visitors – the definition of what is deemed an 'essential visitor' can be broadened

- Provide a guide for creative ideas for meaningful activities for residents, given reduced visitors
- Fostering a culture of safe risk management, rather than long-term risk avoidance
- Consult with residents regarding activities and visiting professionals
- Ask residents to have videoconferences with students, as part of their training

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