EVALUATING DISCHARGE TO ASSESS

PATIENT, FAMILY AND INFORMAL CARER PERSPECTIVE A SCOPING REVIEW (FEB 2023)

CONTENTS

ABSTRACT

Aim: To find and synthesize evidence focusing on the patient, family and informal carer perspective of the Discharge to Assess model which was nationalised in March 2020. *Method:* A total of 13 pieces of literature were identified (1 academic, 12 grey) via searches conducted using PubMed, Google Scholar, Google, Open Grey, Government and NHS, the Cochrane database, Healthwatch library and Carers' organisations. Arksey and O'Malley's 5 stage framework was applied to the final pool to assist in the scoping process.

Findings: 3 main themes became apparent: Communication, Carers and Unmet Needs. *Conclusion:* There is room for improvement in the implementation of Discharge to Assess, and a need for more academic research to enhance current understanding of the patient, family and Carer experience.

1. INTRODUCTION

Funding from NHS England for a new Discharge to Assess (D2A) programme was commenced by the government during wave 1 of COVID-19 (HM Government, 2020). The funding was introduced as a mechanism for improving the appropriateness of long-term care needs following discharge from acute care, with up to 4-weeks of post-discharge care costs covered by the NHS. It aims to reduce acute length of stay (LOS) by moving the point of detailed assessment for ongoing care from the acute hospital into the community with the funding allowing for a full assessment 4-6 weeks post discharge. The prompt discharge of patients is clinically safer while enabling capacity for planned and unplanned admissions. It allows for a period of rehabilitation prior to the assessment of long-term needs and for that assessment to take place within a more suitable environment than an acute hospital ward.

This scoping review forms part of the 'Evaluating Discharge to Assess pathways in Kent, Surrey and Sussex' project, which aims to a) Evaluate the impacts, capacity, processes and barriers across primary, community, Voluntary, Community & Social Enterprise (VCSE) sector, and social care and other stakeholders b) Evaluate the experiences and outcomes of service users and informal carers and c) Develop outcome and process measures as part of the evaluation for use in ongoing monitoring and management of the pathway. The project centres on individuals that are discharged from hospital on pathways 1 or 2 of D2A, with the pathways classified as the following: 1 - 'Support required to recover at home or Rehabilitation' or 2 - 'Short term care in a 24-hour bedded setting'.

The research question for the review is 'What do we know about the current form of Discharge to Assess from the perspective of patients, family members and informal carers?'

2. METHOD

Scoping reviews provide a rigorous and transparent method of determining the scope, coverage and volume of the available subject literature (Munn et al., 2018). Unlike systematic reviews, scoping reviews do not typically involve an assessment of the quality of the literature, and, unlike narrative or literature reviews, do require analytical reinterpretation of the literature (Levac et al., 2010).

Arksey and O'Malley's (2005) methodological framework describes the following 5 stages that were carried out within this scoping review. Identifying the research question, identifying relevant studies, study selection, charting the data and then collating, summarising and reporting the results. The following inclusion and exclusion criteria were applied to literature in order to obtain the final pool.

INCLUSION CRITERIA

- Literature reporting on the perspectives of patients, or family, informal carers and advocates of patients.
- Patient was discharged from NHS acute hospital services since March 2020, when national Discharge to Assess guidance was implemented, until the present.

- Literature discussing Discharge to Assess directly, or a discharge process with similar criteria to D2A pathways 1 and 2 (patients are discharged either home or to temporary accommodation with further assessment and support expected).

EXCLUSION CRITERIA

- Literature published or research conducted pre-March 2020.
- Literature with no division between pre- and post- March 2020 discharges.
- Duplicates - Literature with evidence already included in another piece of literature.
- Research exploring the views of people that have not experienced discharge.
- Research specifically focused on D2A pathways 0 (discharged home without further support) or 3 (discharged to a care home)
- Blog posts and Review forum entries, inclusion of which was not possible due to time constraints.

SEARCH LOCATIONS

Search locations and search terms were developed collaboratively within the D2A project team, with collective experience of working alongside, and within, health and social care exploited to shape both areas.

After initial searches of PubMed and the Cochrane database revealed a lack of relevant academic literature, searches concentrated on grey literature. The following grey literature locations were included within the search strategy. Open Grey, the Healthwatch Library, Carers UK and Carers Trust websites, Gov.uk publications and archives, Department of Health, NHS (including www.evidence.nhs.uk), Google Scholar and Google itself (Initially using the pdf filter filetype:pdf).

Table 1. Search terms

OR	AND
Discharge to assess	patient
home first	service user
step down	Carer(s)
hospital at home	family
early discharge	relatives
virtual ward	

Academic literature were screened by title and abstract initially, with the intention of screening by the full body of text as a second step. However, so few studies passed the initial screening that completion of the second stage was minimal. Grey literature were screened by the full body of the text immediately after discovery, as structure across papers varied more broadly. Reference lists were searched for relevant papers.

It was not possible to narrow the available literature according to the use of the Discharge to Assess process, as opposed to other discharge processes. Nor was it possible to divide evidence by D2A pathway when multiple pathways were discussed. However, where feasible, the literature was viewed with a focus on findings relating to D2A pathway 1 and 2. Themes were extracted from the final literature pool using NVivo.

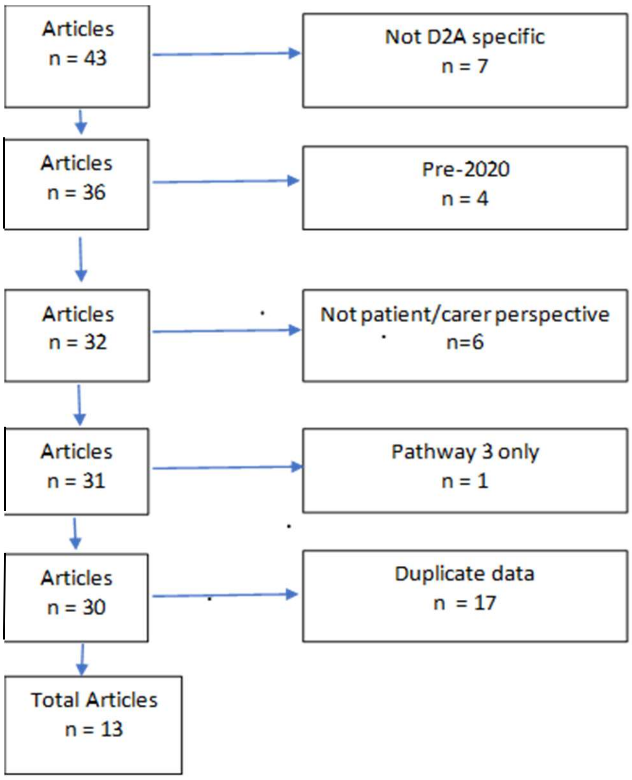

Figure 1. Inclusion flow diagram

Table 2. Final pool - Authors, methods and participant numbers

Reporting Organisation	Method	Number of participants
Carers UK	Survey	25% of 1,950 from England experienced discharge as a carer
Healthwatch Bedfordshire	Survey and comments	166 survey responses and 74 comments were recorded, from patients, service users and their families
Healthwatch Cambridgeshire and Peterborough	Telephone questionnaire	35 patients or relatives
Healthwatch Camden	1-to-1 in-depth interviews	28 patients, 14 Discharge to Assess **and 14 Rapid Response*
Healthwatch Cumbria	Case studies	5 patients, 11 unpaid carers and 2 independent advocates (with 3 patient cases)
Healthwatch East Sussex	Web based survey	36 respondents, 72.2% discharged individuals and 27.8% carers
Healthwatch Leeds	Survey	203 responses. 161 (79%) from discharged individuals and 42 (21%) from family members
Healthwatch and British Red Cross	National survey	529 responses. 352 discharged individuals and 177 unpaid or *paid* carers **unable to distinguish in all areas*
Sussex NHS Commissioners & Healthwatch in Sussex	Semi-structured telephone interviews	45 interviewees
Healthwatch Telford and Wrekin and Healthwatch Shropshire	Survey **open to all types of discharge*	50 people, including patients, carers, friends or relatives and paid care workers
Action for Carers and Healthwatch Surrey	Questionnaire and depth interviews	78 and 12 carers, respectively **only 6 experienced D2A pathway*
Healthwatch Stockton and Tees	Survey	10 patients and 5 family/carers
Smith et al. (2022)	Interviews	10 interviews with family members, and 6 with older people.

4. RESULTS

Three main themes emerged as central to the application of the Discharge to Assess guidance are from the perspective of patients, family and informal carers:

Communication,

Carers

Unmet Needs.

4.1 COMMUNICATION

Communication was a key point of discussion in all 13 papers of the final literature pool.

4.1.1 A LACK OF DISCHARGE INFORMATION

A principle of the D2A model is written as follows in the NHS quick guide to D2A "Ensure the person and their family receive clear information about their care within the acute setting including what will happen on discharge and who to contact if there are any problems after discharge."

Therefore, all patients should have received information on the D2A process. However, several papers describe patients receiving no information about the new process at all (2,3,8,10,12). A small number of patients that were given information still found the process difficult to understand (4,6).

Participant findings reported in the following papers also suggest that patients and carers often received insufficient information about the follow-up support they would receive after they left hospital (2,3,4,8,10,12). Missing information included the hospital's plan for discharge (6), whether a home visit would be received (3,12) - although it is unclear whether a visit was due, which services would be received (2), clarity over the purpose of each home-visit and how the services work together (4) and discharge location, with reasoning for the decision made (7). In one paper, 43% of participants said they didn't feel prepared for discharge having not been informed it was going to happen (7). For some patients, a lack of clear information about what was to happen next caused anxiety (4,8).

In one paper, poor communication regarding discharge was found to be reported more frequently by people discharged to their own home (7).

4.1.2 INVOLVEMENT IN DECISIONS

The evidence suggests a common theme in discharge planning, where patients and carers were not consulted or involved in discharge planning (1,6). Patients described feeling as though they were not being listened to (5) and expressed dissatisfaction at their level of involvement (7). In one paper, participants were asked if they felt they could raise any concerns about the discharge process and nearly half felt that they could not (2).

Planning for post-discharge was similarly influenced by a lack of collaborative discussion. For some, discharge was experienced as medical needs assessment, with little consideration of social care requirements (7,13). For others, conversation about post-discharge support from health or social care did not occur before leaving hospital (10). Patients felt a lack of control over the services they would receive (4).

Discussion with independent advocates revealed a perception that professionals can be reluctant to consider the views of the patient once they have made a judgement on what they think is in the patient's best interest, and a belief that patients should be made clearly aware of their rights and options throughout the process (5).

4.1.3 DISCHARGE PAPERWORK

Experiences of discharge paperwork varied. Some patients described having never received discharge paperwork (2,7,9). One paper describes occurrences of service providers taking and keeping discharge paperwork, including contact numbers (4). For those that did receive discharge paperwork, the quality varied greatly in terms of both substance and accuracy (9).

Feedback indicates a shortfall in advice for patients about caring for themselves after leaving the hospital (6). People reported that they were unsure of how to manage their condition following discharge (9), with uncertainty surrounding how to administer medication (8). For some patients, the information they did receive was unhelpful (4,6,9). Problems with the information included incomplete care plans, missing discharge dates (4) and no details of who to contact in a medical emergency (9). These patients required information on how to manage symptoms and physical conditions and information pertaining to equipment and household adaptions usage (in addition to verbal handovers). Others described needing discharge letters, relevant contact details and instructions for after-care (7).

D2A guidance states that patients should be given information on available community support services, such as voluntary sector support, but many patients did not receive this information (65.7% - 3,9).

4.1.4 CONTACT DETAILS

The evidence suggests that, upon discharge, many patients, family and carers were not given the details of who to contact with follow up questions, queries or emergencies (1,2,3,4,6,7,8,9,10,11,12). In one paper, numbers of people without paperwork were higher for people who were deaf or had a hearing impairment (25%) (7).

As a result of this missing information, some people lacked confidence in managing their condition at home (8). Authors of one paper asked participants what they would do in an emergency, in the absence of written contact details, and respondents often said they would contact their GP (9). Likewise, some discharge information instructed people to contact their GP or to go to A&E (6).

In one report, several examples were given where, despite contact information being received, telephone calls had not been answered or the patient did not know which on the list of names and numbers to ring. (9) It has been suggested that a single point of contact would be useful, particularly for those with multiple pre-existing conditions, repeat admission or for those experiencing confusion (4).

4.1.4 PLAIN LANGUAGE AND ADAPTABILITY

In some cases, information given to patients and carers was inappropriate and contained jargon (4) and abbreviated terms (6) which were not understood. The authors suggest that those conveying information should avoid confusion or misunderstanding by targeting language to suit its intended audience and taking action to explain medical terminology in complete but simple terms.

One paper (7) looked specifically at communication through the lens of The Accessible Information Standard, a legal requirement which sets out “a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.” NHS staff should be asking patients, family and carers whether they have any communication needs, but only 14% of their respondents described this occurring. One carer outlines a situation wherein the patient was presumed to be living with dementia when she had a hearing problem (11).

Similarly, in another paper (8) patients with disabilities, including those who were blind, deaf or had learning disabilities, described experiencing communication-related difficulties in understanding issues around their discharge. Family members were unable to advocate on their behalf, leading them with feelings of anxiety.

Patients describe important information being conveyed verbally, with no accompanying paperwork. This caused problems with recall (1,3,4) and a risk to health (1).

4.1.5 INTERDISCIPLINARY COMMUNICATION

The communication between health and social care staff appears to have a direct impact on both the overall experience and support received by patients, family and carers (2,3,5). At times, differing professionals gave patients conflicting advice (3,5,11) leading to confusion and feelings in the patient of being unheard (5).

Poor communication also had an impact on other services, with teams being sent to a patient’s home before they had been discharged (2) and a district nurse not attending to a patient as a referral had not been received (10).

4.2 CARERS

Carers UK estimate that 1 in 5 adults in the UK are currently providing informal care. 11 of 13 papers in the final pool describe direct engagement with carers to examine D2A from their point of view.

4.2.1 IDENTIFYING A CARER AND CARER ASSESSMENT

The work of informal carers is crucial to the successful implementation of the current health and social care system. Within D2A, carers have been confronted with several obstacles, the first of which is often based in achieving recognition from health care professionals for the carer’s role in the patient experience.

As part of the D2A process, carers should receive a carers assessment to see if they personally would benefit from any support. The high proportion of carers that disagreed when asked if they'd had a carers assessment suggests that either they were not assessed or were not involved in their own assessment (10%-1,5,10%-7). In one paper, as many as 74% had no contact from a social worker, who are usually responsible for conducting the assessments (11). Under some circumstances, a carers assessment and any resulting additional support may have allayed the concerns of a patient (10).

Timely identification of those performing caring duties and consideration of carers as 'partners in care' may improve the patient and carer experience and improve outcomes for both.

4.2.2 CARER INFORMATION EXCHANGE

Covid-19 conditions may have exacerbated communication difficulties (13). Obstacles for carers were apparent. Whilst some families felt they were supported to communicate with their relative (8), others struggled (6). Reasons for difficulties include ward relocations, the phone being engaged or unanswered, and unreturned calls (6).

In one paper, as many as 57% experienced poor communication between the hospital ward and carer, many of whom had no previous experience of discharge, leading to compromised decision making and stress for the carer (11). Families reported mixed experiences of communication with hospitals about their relative's health (8). At times, carers struggled to gain access to important information (1,6,12), with some carers experiencing difficulties in making contact (8) and others failing to make contact at all (1). Carers receiving details of a nominated/available point of contact was viewed positively by patients (6).

Frequently, carers were not consulted about, or involved with, discharge (1 – 56% of carers,6,7 – 38%, 8 – 47%,10 – 55%, 11 – 56%) and felt that they were being 'bypassed' (5). Not knowing what to expect caused frustration for carers (5). Some carers felt that a lack of opportunity afforded to discuss the patients' needs and usual care routines led to avoidable mistakes and a worsening condition for their family member (10,11). Others felt that their expert knowledge about the patient and their complex conditions was not respected or utilised (1).

Struggling to advocate for the patients they know well left some carers feeling helpless (2). Many people, particularly relatives, highlighted 'communication' or 'more information' as being an important aspect of hospital stays which they feel needs to be improved (2). When practical problems arose, it was suggested that communication broke down further (6).

A case study in one paper emphasises the importance of sharing discharge paperwork with carers (1). In this situation, the patient had been given a treatment information leaflet which was not found by the carer until it was too late to be of use.

4.2.3 PERSONAL WILLINGNESS AND CAPABILITY TO CARE

As described in one paper, "while the hospital discharge policy references the need to inform carers when discharging patients from hospital, it falls short of taking into account carers' own needs and circumstances, which can lead to poor care for patients and challenging circumstances for carers at home." (11)

Further to not receiving a carers assessment, a proportion of carers felt that their ability and willingness to care were not explored by health and social care staff at all, and that comments outlining personal perspective were not given due consideration (1,5,10,11,12). Findings from a survey by Carers UK (1) indicate the large numbers of carers that may be impacted, with 66% of respondents disagreeing or strongly disagreeing when asked if they felt listened to about their ability and willingness to care at discharge. Reported in the paper with the largest sample size (8), 53% of carers felt that their caring responsibilities were not considered during the discharge process.

For some, transitioning to adopt a carer role or experiencing an increase in caring duties was not felt to be a choice; they had to become the default care giver when insufficient or inadequate support was provided for a family member (5).

Another common finding within the literature pool is that many did not feel fully prepared to perform caring duties post-patient discharge (1,3,5,10,11). In one paper, 60% of respondents felt this was due to a lack of available support services (1). In another, interviewees felt frustration at not being able to navigate the social care system (13). For some carers, communication during the discharge process was so lacking that the needs of the person they were planning to care for were unexpected or even unknown (3,5,10,11).

4.2.4 MANAGING EXPECTATIONS

As previously discussed, family members and carers have felt detached from discharge plans for the patient (6). In terms of the impact felt by patients, family and carers, one paper reported on Carer frustration at not knowing what the patient could expect (4). In the Healthwatch and British Red Cross Survey, 3 people describe unexpected delays in discharge which, at least one, found ‘incredibly stressful’ (8).

Family members believed that managing their and their relative's expectations was important at discharge and that transparent communication would help facilitate the D2A process. For example, setting an expected date for discharge to work towards (13). Therefore, clear explanation of D2A and ongoing communication with patients and carers to keep them up to date regarding progress towards discharge may aid in feelings of preparedness (as discussed in the next section).

4.3 UNMET NEEDS

All papers in the final pool reported on unmet needs, which in many cases are similar to those experienced with discharge before D2A was implemented.

4.3.1 DISCHARGE PREPAREDNESS

Patients, family members and carers frequently said they hadn’t felt prepared for discharge (3,5,6,7,8,9,10,11,12). Reasons given include having not been informed discharge was going to happen (7), discharge feeling rushed (3,6,8), discharge happening with very short notice (3,5,7), poor communication from staff (3,8), not feeling (or being) physically ready (9,11), concerns over transport or support available post-discharge (9), lack of equipment (10), failed discharge/readmission (10) and feeling unprepared for ‘coping’ at home (6,8). Concerns over coping at home were particularly pertinent for those living alone (6). Reported feelings of preparedness were also lower at night (8).

Groups that were more likely to believe they had been discharged too soon included people that had undergone a surgical procedure (2) and people that felt they had a worse experience of leaving hospital than they had experienced previously (8**).**

Some family members described experiencing anxiety about discharge when COVID measures were in place because they had been unable to assess the patients discharge readiness personally and had formed the impression that staff were in a hurry to discharge (13).

4.3.2 DISCHARGE DELAY

In March 2020, a key tenet of D2A was the requirement for patients to be discharged within two hours of being declared medically fit to leave hospital. In an updated policy implemented August 2020, this target was relaxed slightly, however, much of the literature describes delays in terms of the original timeframe. Many people experienced wait times of over 2 hours (2,7,8,10,12,13) and a number waited for over 24 hours (2,6,10).

Similar to carers, patients also experienced a lack of communication surrounding discharge delays (8). Where there was communication, reasons given for delayed discharge include waiting for: transport (2,6,7,13), doctor confirmation (2,10), medication (10,12,13), care plan/package (2,6,7), additional adaptations at home (6,7), delayed treatment, delayed social worker contact, deterioration of health whilst in hospital, and Covid (7).

Older people describe feeling frustrated at waiting to leave hospital, especially if they were dressed and their bags were packed (13) as would be the case in a D2A discharge lounge. Family members were more likely than patients to say that the patient had been in hospital for too long and some believed that staying longer than needed could impact on a patient's mental and physical health (7).

4.3.3 NIGHT DISCHARGE

As part of the Discharge to Assess process, patients may be discharged from hospital at any time of day or night. Whilst there were people that had a positive experience when discharged during the night (3) it seems the timing presents a unique set of challenges. The main areas highlighted in the literature were communication shortfalls (10,11), transport issues (with staff less likely to ask whether transport was required – 64% compared with 43 in the daytime) and difficulty accessing out-of-hours support (11).

4.3.4 TRANSPORT

Five pieces of literature discussed problems around transport upon discharge (3,6,7,8,12). Under D2A instructions, patients should be asked whether they have access to transport to take them to their next location from hospital, so that transport may be arranged for those with no alternative option. Within the evidence, it emerged that many patients were not asked this question (as many as 44% (8) and as few as 20% (3)).

This finding is particularly significant within D2A as a lack of transport is likely to lead to delayed discharge. Waiting for transport was given as a reason for a delay in four papers (3,6,7,8), highlighting the importance of staff enquiring regarding need and booking transport as early as is convenient. Several interviewees described long waits for patient transport and the lack of an organized system of allocating people to vehicles (13).

In one paper the issue of not being asked about transport requirements appeared more pronounced at night, with 64% of people discharged at night not having been asked if they needed transport (8).

Poor communication with carers also negatively impacted transport arrangements. 67% said they were asked whether they needed any help with organising transport home, whereas only 45% of family members said that transport home had been discussed (7).

4.3.5 EQUIPMENT

A lack of appropriate equipment and instruction on how to use it properly is a common and previously well-established problem with discharge more generally, and D2A appears to follow the same pattern. This can create a difficult situation for both patients and carers (3,5,6,8).

The shortfall may begin during assessment, with as few as 6% of assessments containing discussion of equipment and mobility aids (6, also 8). In some cases where equipment discussion did occur, equipment never arrived (5). For others the equipment that did arrive was not suitable (3), or the discharged person and carer were not advised on proper usage (3,9).

A carer respondent in the Healthwatch Cumbria paper described a situation in which a family member was unable to leave their bed for two whole weeks when their equipment needs were not met, showing the potential serious consequences for incorrect or missing items (5).

4.3.6 MEDICATION

In the literature pool, waiting for medication is frequently given as a reason for a delay in discharge (2,3,7,8), with a lack of medication frequently given as the cause for breaching the initial D2A two-hour optimal discharge window.

Medication issues reportedly affected feelings of preparedness for discharge (5, for carer; 7, for patient). There were patients (and carers) that experienced a longer wait and still left hospital without their medication (8). Others returned home after receiving prescriptions which remained unfulfilled several days after discharge (3,9).

As previously mentioned, insufficient information has led to problems for patients and carers post-discharge (3,5,6,8). The importance of communicating medication management information, with written instructions, is particularly pertinent and a factor of care which patients and carers reportedly struggling without (3,6,8). Uniquely within the literature pool, one patient moved to a residential rehabilitation service where a missing drug chart led to a delay in pain medication administration (5).

4.3.7 FOLLOW-UP ISITS AND ASSESSMENT

There are discussions within the evidence regarding the lack of a post-discharge D2A professional follow-up visit. However, as it is noted within the same literature, it is not clear which patients should expect a visit due to pathway allocation and variations in application, so it is impossible to tell how many were truly omitted. The numbers of assessments reported hold little value when viewed alone. However, it is of note that, in the largest sample, 88% of people that had unmet care needs did not receive a visit (8, see also 3,10). This may be due to incorrect pathway allocation, a missed assessment, unsuitability of D2A services or something else. Also, some patients received late follow-up visits (3) potentially leaving needs unmet for an additional day.

The most common topics discussed during assessment included queries about general wellbeing (58%) and whether others were able to offer support (8). The results of the assessment were not always fed back to the patient or carer, leaving uncertainty (5).

Quality of the assessments was of concern to relatives, particularly as assessments influence the level of support a patient will receive (5). It was felt that the practice of conducting a one-off assessment with a patient post-discharge and in their own home, falls short in accuracy when the person is living with a diagnosis (such as dementia) that causes ability to fluctuate day-to-day. Late assessments were a concern (5).

Expectations were also not met in relation to other follow-up services, such as hospital appointments, GP appointments and diagnosis or test results, referrals for further treatment and referrals to other services (9).

4.3.8 INSUFFICIENT LEVEL OF CARE

As with follow-up visits and assessments, the inconsistency and confusion surrounding the D2A pathways makes gauging the cause of unmet needs challenging (1,38). If patients were placed on pathway 0 when they in fact required some professional input post discharge, they would be left with unmet needs. Patients and carers do not appear to have been consulted with regarding their level of need as part of standard practice (1,10).

Some patients (2) and family/carers (1,13) felt that insufficient support was provided to protect the health and wellbeing of both the patient and carer after discharge (1,5,10). For some participants, the support offered arrived later than advised or never materialised (3,5). Family members described a system that felt “fractured”, with a lack of joined up working in primary and community care, and funding levels or staffing potentially to blame (13).

Ongoing concerns include physical symptoms, such as pain (6) and discomfort, conflicting information and advice from health professionals (leading to anxiety over the appropriateness of the course of treatment being received), a lack of contact with health services and limited clarity on future treatment and symptom management (9).

Unmet needs were found to be more common amongst those with a disability (45%) or a long-term condition (20%), aged between 50-80+ (74%) and for those living alone (25%) (8). Patients discharged to their own home were less likely to report that the care and support they received was adequate than those that were discharged to residential settings (7). Better access to care and physiotherapy was given as one reason for this discrepancy.

4.3.9 RE-ADMISSION

Whilst readmission for some patients may be unavoidable, for others it occurs when shortfalls in the discharge process have led to an unexpected return to acute hospital services (Blunt et al., 2015). For some, it was believed that being discharged too soon led to readmission (2,10). This was echoed within the academic research, where insufficient support, leading to readmission, with more serious medical conditions was considered a major concern (13). Within the evidence, falls was the most consistently reported reason for readmission (2,6), suggesting a potential pattern of unmet need.

4.3.10 CONFUSION AND COGNITIVE IMPAIRMENT

An inability to understand the discharge process caused ‘significant anxiety’ (4) and distress (particularly for those with dementia, although not exclusively so) (11). Several people experienced disorientation in their care journey, finding it difficult to know when they had gone into hospital and when discharged and how long they had been in hospital (6). The author(s) state that aspects of the hospital experience had caused the disorientation; these were not people that lived with any form of cognitive impairment day-to-day.

Family members of older people with dementia and/or visual impairments wanted to support their relative but felt they were not always listened to or trusted by staff to provide support (13), or that the level of communication could be improved upon (13).

The importance of mental capacity assessments was highlighted both by independent advocates, when describing their role in ensuring the needs of the patient are kept at the centre of the decision-making process (5) and by a carer that felt that their relative should not have been allowed to make an important decision without familial support (6).

5. DISCUSSION AND CONCLUSIONS

The three main themes underline areas where shortfalls have occurred, and improvements can be made, within the D2A process.

In terms of communication, the use of clear verbal and written information may be critical in a variety of situations where a patient or carer might not hear, initially understand, or remember information given verbally. This is particularly important when describing what to expect of D2A, diagnosis and treatment and discharge summaries. Patients and carers value the contact details of people and organisations that can offer information and support. Preference for single points of contact to help coordinate services is evident. Patients and carers need to be offered the opportunity for involvement in decisions around their care and have their rights clearly explained.

Maintaining interdisciplinary dialogue should be built and maintained to avoid confusion and inconsistent messaging.

Carers benefit from early recognition, assessment and ongoing communication. Findings suggest an individual's willingness and capability to care should be considered before discharge, if informal care is likely to be relied upon. Planned discharge dates and regular updates help manage expectations. Treating informal carers as partners in care involves respecting carer knowledge of a patient and their medical history as well as providing carers with adequate information (in verbal and written format), contact numbers and equipment for safe and effective care.

Many unmet needs were reported across the literature pool. D2A centers around speedy discharge and clear expectations should be set early during hospital admission regarding likely short notice and, conversely, potential delays. Ongoing communication can ease frustration and anxiety for patients, family and carers. Transport, equipment, medication and night discharge provided sticking points in the discharge journey, which emphasis on a consistent approach should address. In some instances, levels of care were found to be too low, possibly leading to readmission. Unmet needs were found to be more likely in patients over 50, or in those living with a disability or long-term condition. The discharge process sometimes appears more complicated in patients with multiple requirements, such as for those diagnosed with dementia. However, patients who do not regularly experience any cognitive impairment also sometimes struggled to understand what was happening. Perceived shortfalls in the D2A process commonly led to feelings of confusion, anxiety and distress.

The scoping review has several limitations. First, time constraints affected capacity to search for academic literature. Initial searches produced large quantities of studies with limited relevance to the review question. Second, it was difficult to separate results from those that had experienced Discharge to Assess in the form implemented in 2020, to other discharge processes. Third, separation of findings by D2A pathway and a strict focus on pathways 1 and 2 was not possible.

More research is needed into the requirements of patients, family and carers involved in the discharge process, from their own perspective. Larger scale, peer-reviewed research would be particularly useful for a more in-depth understanding of what works well and what doesn't.

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