**Premature discharge from hospital**
June 2020

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## Introduction

This is a report of a qualitative survey that explored unsafe, premature discharge from hospital.

The Patients Association has regularly heard from helpline callers that patients believed that they had been discharged too early from hospital, and that as a result they had either suffered harm or been at risk of harm.

For the purposes of this report, we were therefore not concerned with looking for information about times when a person was discharged from hospital and problems arose because of a lack of support from social care services or local health services. A large amount of research has already been conducted into those situations.

Far less research has been done on *premature discharges* from hospital – that is, discharges that simply happened too early – even though we hear about this regularly from callers to our helpline.

A premature discharge in this sense means that it happened before a patient was well enough to leave hospital without imminently experiencing further problems arising from the health condition they had been hospitalised for.

## 1. Unsafe discharge: background and key research

### i. Healthwatch England

Healthwatch has carried out substantial work on issues around discharge from hospital during the 2010s, and continues to work actively on the subject. Its reports and briefings include:

- Safely Home - what happens when people leave hospital and care settings (2015)[1]

[1] https://www.healthwatch.co.uk/report/2015-07-21/safely-home-what-happens-when-people-leave-hospital-and-care-settings

- What happens when people leave hospital and other care settings?[2]
- What do the numbers say about emergency readmissions to hospital?[3]
- Emergency readmissions: What's changed one year on?[4]

Healthwatch's work has particularly led it to focus on the issue of emergency hospital readmissions. Overall it argues that many could be avoided if the right care were made available when patients are discharged.

**ii. British Red Cross – In and Out of Hospital**

The British Red Cross's report, published in 2018, looked particularly at the experiences of older and vulnerable people, and found, "a bleak picture of the stress the system is under [where] all too often, we see vulnerable people having to reach a crisis point before they receive support."[5]

This report argued that opportunities were being missed which could prevent deteriorating health or problems recurring post-discharge. Furthermore, it was clear that hospitals did not have the mechanisms to notice and appropriately address multiple readmissions.

**iii. Parliamentary and Health Service Ombudsman - A report of investigations into unsafe discharge from hospital (2016)[6]**

This report highlighted four key issues around unsafe discharge:

i) Patients being discharged before they are clinically ready to leave hospital
ii) Patients not being assessed or consulted properly before their discharge
iii) Relatives and carers not being told their loved one has been discharged
iv) Patients being discharged with no home care in place or being kept in hospital due to poor co-ordination across services

The report highlighted the trauma and distress caused by unsafe discharges and the avoidable suffering this could lead to for both patients and their carers.

[2] https://www.healthwatch.co.uk/report/2017-10-05/what-happens-when-people-leave-hospital-and-other-care-settings
[3] https://www.healthwatch.co.uk/report/2017-10-05/what-do-numbers-say-about-emergency-readmissions-hospital
[4] https://www.healthwatch.co.uk/report/2018-11-14/emergency-readmissions-whats-changed-one-year
[5] https://www.redcross.org.uk/about-us/news-and-media/media-centre/press-releases/press-release-repeat-visits-to-accident-and-emergency
[6] https://www.ombudsman.org.uk/publications/report-investigations-unsafe-discharge-hospital

It recognised that there are structural and systemic factors preventing good discharge planning, and that these could not be fixed immediately. Recommendations focused on improving joint working of health and social care services, but also on exploring how to improve people's experience of leaving hospital.

## 2. Methodology

### i. About the survey

We set out to explore discharges that are unsafe because they are made prematurely in respect of the patient's health, rather than in respect of the support available to patients outside hospital.

We asked people to complete our survey if they thought that their experience, or the experience of someone close to them, matches the description of an unsafe, premature discharge. The survey was conducted online over a six week period, and asked mainly for qualitative answers in which respondents described their experiences or those of people close to them (see Appendix for the full questionnaire). It was promoted through our weekly email newsletter and social media channels.

Since the survey closed, the NHS has responded to the coronavirus pandemic by discharging large numbers of patients from hospital in order to free up beds, and delaying large amounts of elective surgery and other treatment. A period in which it has to 'catch up' with this delayed treatment and manage admissions in a new way is therefore beginning. These survey results offer a snapshot of premature discharge in the pre-coronavirus NHS.

### ii. About the sample

There were a total of 98 respondents to the survey. Of these, 15 did not give enough information about what happened to them or their loved one to be included in the analysis.

The remaining 83 responses were analysed and classified according to the main reason for the unsafe discharge having taken place. Of the 83, 44 of the respondents were identified as relating clearly to circumstances that appear, on the basis of the information presented by the respondents, to represent premature and unsafe discharges. Of those 44, more than half (28) were cases where the patient was re-admitted to hospital.

Tables 1 and 2 outline who the respondents were in relation to the events at issue (for instance, were they the patient or a relative), and how they know about what happened.

**Table 1. Respondents to the survey**

| Respondent | Number |
|---|---|
| Patient | 16 |
| Close relative | 24 |
| Friends or distant relative (relationship stated in answers) | 4 |

**Table 2. Who was present when these events took place? Were you / they present throughout / present for much of what happened / mostly heard through other people?**

| **Present throughout** | **Total: 28** |
|---|---|
| Patient | 16 |
| Close relative | 12 |
| Friend / distant relative | - |
| **Present for much of what happened** | **Total: 11** |
| Patient | - |
| Close relative | 11 |
| Friend / distant relative | - |
| **Mostly heard through other people** | **Total: 5** |
| Patient | - |
| Close relative | 1 |
| Friend / distant relative | 4 |

Overwhelmingly, respondents were present for all or most of what happened, so we can be confident that what respondents told us essentially represents first-hand testimony. The main exception is the small number of respondents who were neither the patient nor a close relative, who mostly heard about events second-hand.

**Table 3. Year in which the premature discharge took place**

| | |
|---|---|
| 2019 | 11 |
| 2018 | 8 |
| 2017 | 7 |
| 2016 | 4 |
| 2015 | 1 |
| 2014 | 5 |
| 2013 or earlier | 8 |

The experiences reported in the survey are overwhelmingly recent, with a plurality taking place in 2019. We therefore feel confident in accepting the

results as meaningful testimony about the performance of the NHS in the period prior to the coronavirus pandemic.

**Table 4. Clinical reason for initial admission.**

| | Patient readmitted (28) | Patient not readmitted (16) |
|---|---|---|
| Respiratory | 6 | - |
| Cardiovascular | 5 | 3 |
| Multiple | 4 | 1 |
| Mental health | 3 | 3 |
| Cancer | 2 | - |
| Gastroenterology | 2 | - |
| Orthopaedics | 1 | 5 |
| Urology | 1 | 2 |
| Endocrinology | 1 | 1 |
| Hepatology | 1 | - |
| Obs & Gyn | 1 | - |
| Infectious diseases | - | 1 |
| Post-operative (spec unclear) | 1 | - |

Table 4 shows both the number of respondents who reported that the discharge results in readmission, and the broad area of the health issue that prompted the initial admission.

There was a wide variety of clinical conditions involved in the cases reported by respondents. Accordingly we have no reason to conclude, on the basis of this small sample, that any particular specialty or disease area is particularly prone to the problems identified here.

**Table 5. Length of time until readmission**

| Time to readmission | Number |
|---|---|
| Same/ next day | 13 |
| 2-3 days | 5 |
| 4-7 days | 4 |
| 8 days to 2 weeks | 3 |
| 15 days - 1 month | - |
| 1 month - 2 months | 1 |
| 2 months - 6 months | 1 |
| > 6 months | 1 |

The readmissions that were described to us were usually rapid, with 13 taking place on the same day as discharge. A much smaller number ended up back in hospital after a week or more at home.

## 3. Results

**Table 6. Immediate and longer term effects of the incident – readmitted patients**

| Effect | Number |
|---|---|
| Original health condition continued to be a serious problem | 25 |
| Increased health problems, including long-term deterioration | 13 |
| Long-term dis/stress to carer/s | 12 |
| Serious deterioration in condition | 9 |
| Anxiety / distress to the patient | 9 |
| Death | 8 |
| Additional emergency care arranged | 4 |
| Additional care required from family/ others (non-professional) | 4 |

Table 6 presents a thematic analysis of respondents' answers to questions eight and ten, which asked them what happened during the incident and after it, specifically for the cases that involved readmission to hospital. It summarises a set of mostly terrible experiences for patients and those close to them, with the illness they were hospitalised for either the same or made worse, more care needed, and some patients not surviving.

**Table 7. Immediate and longer term effects of the incident – non-readmitted patients**

| Effect | Number |
|---|---|
| Increased health problems, including long-term deterioration | 14 |
| Original health condition continued to be a serious problem | 11 |
| Additional emergency care arranged | 7 |
| Additional care required from family/ others (non-professional) | 6 |
| Long-term dis/stress to carer/s | 4 |
| Serious additional medical condition | 2 |
| Poor rehab | 2 |
| Death (including 1 suicide) | 2 |

The range of themes reported to us by patients who were not readmitted following their discharge was broadly similar to those expressed by those who were.

**Patients told us: the consequences of premature discharge**

*Mum said the doctor had stood over her and told her she had to go home as they needed the bed. Mum's Parkinson's medication had been mixed up while she was in hospital and she didn't feel well enough to go for at least another day or two.*

*I was told there was nothing wrong and discharged at 3am to get home despite still being in agony.*

*I do not live in London where my daughter was hospitalised. I had arranged to come to see her on the ward as judging by the way she spoke to me on the phone, she was still unwell. I was very surprised to hear a nurse tell her she could go out for the afternoon with me. I had a very challenging few hours with my daughter which I reported on when I returned her to the ward. To my surprise I got a phone call the next day saying my daughter was being discharged despite my explaining I didn't live near her and I strongly felt she was still unwell. I was told to pick her up later that day. I expressed my concerns to the staff but there was no changing their minds.*

*A friend collected the patient (age 92 who lives alone with support from carers) from hospital. No help was given for provision of wheelchair etc. They struggled to transfer the patient to the car, and from the car on arrival home. The patient was transferred to a chair from the wheelchair with difficulty, exhausted and complaining of light-headedness. Later carers called an ambulance as the patient was unable to stand from the chair.*

*Mum knew she was not well enough to go home; her temperature was still unstable and she said she just felt really poorly. She was discharged on oral antibiotics home by herself, with family support. Both my sister and I advocated for mum (I am a nurse) as we completely agreed with her, but despite some very strong interactions with staff the discharge went ahead. We took leave to care for mum but she deteriorated fairly quickly at home.*

*I was discharged and given Oramorph 10mm 4 times a day. That evening I retired to bed around 10pm. At 3.30pm the following day my wife could not wake me. Ambulance paramedics could not awaken me and I was taken to the hospital - I was in a coma for 5 days.*

*I was in hospital due to a paracetamol overdose. I was told by a doctor I was being discharged but the next day I got a call from the doctor saying they just checked my blood tests and my liver level was too high and I needed to come back to the hospital.*

*He died. Formal complaint made. Hospital apologised. No compensation.*

*My Grandmother was discharged to a care home, unable to walk or get out of bed, as the hospital wanted the bed and to reduce patient numbers over Easter. She had a chest infection, which when we enquired about it we were told was just the reaction to the anaesthetic, but it was clear she was still unwell. She was rushed back to hospital three days later and died of sepsis three days after readmittance, a week after she had been discharged.*

*Devastated and feeling suicidal after his death. Unable to go through the complaints procedure.*

*At the time of discharge the patient was hallucinating, unable to stand (had previously had a serious fall in hospital requiring CT scan) and had very low blood pressure and heart rate. The junior doctor had failed to ask for cardiology input despite my multiple requests (Dad was on an understaffed neurology ward but had long standing heart failure and prior digoxin toxicity). We were waiting for discharge meds for a number of hours and I had already expressed concerns to nurses that I could not move Dad safely. I was unable to get Dad up, his legs gave way and a nurse present was unable to measure his heart rate and blood pressure. She summoned the junior doctor who had discharged him and they reversed their decision.*

*I had a stroke and was refused MRI at the time. They sent me home the next day, incontinent and unable to use my arm.*

*On discharge from hospital my mother could not manage cooking or other self care, and no provisions had been made. She also had a swollen leg which was diagnosed as a DVT after the GP was called.*

*Near the end of his life I had to rush him to hospital since he could not breathe. He was comfortable in hospital, however after less than a week consultant sent him home with breathing equipment (a staff nurse said to me at the time he should not be going home). He was supposed to go back a week later to see the consultant, but no consultant was available, only a nurse who drained fluid and indicated to him he was dying and to go home and ring family. I was in tears and said he needed to be in hospital. She then tried to call hospices to no avail and just sent us packing. He died within a couple of days.*

*She was discharged on the Friday, but by Saturday evening my wife was being sick and in a lot of pain. At A&E if it had not have been for a nurse pushing the junior doctor into the correct procedure then I think my wife would have been in a lot more trouble. A surgeon attended and examined my wife, and instructed that she be readmitted.*

*Mother refused to go into hospital again*

*My mother was reasonably well on admission, but suffering reduced consciousness at discharge (I asked about this at the time, but was told it was a temporary side-effect and everything was OK). After spending the weekend at home, she was sent back by the family as an emergency on the Monday evening as she was falling into a stupor. She was again sent home by ambulance in the early hours of the next morning, barely conscious and so unable to stand; yet staff insisted she was fine and I was at fault for wasting their time, but should have her GP re-admit her in the morning. One nurse did mutter under her breath that they did not have any beds. She passed away three weeks later owing to kidney failure.*

*Both my husband and I were very stressed. I ended up with pneumonia and heart failure which could have been avoided if I hadn't been discharged early.*

*The effects were not long term but my husband spent a week in extreme discomfort and some distress. He was 82 at the time.*

The serious consequences of discharging mental health patients prematurely emerged as a theme from some patient testimony.

*I was discharged whilst still actively suicidal the morning after admission, despite the fact that when my admission was decided it was supposed to be for three days. Immediately afterwards I walked to a bridge and tried to jump off it. I was held on to by a police officer and then taken back to hospital by police.*

*I was being told if I did not agree to stay voluntarily then my section 2 would be extended to a section 3. Overnight that changed to discharge (all beds had been full without turnover). Over the course of about three days there was a discharge procession of patient after patient (basically all the patients that didn't have psychosis) carrying their bags out, having been told that they were leaving when days or sometimes hours before they had had meetings to discuss how much longer they would still need to be admitted for (usually more than one week).*

*The patient was in utter distress[.] Staff asked for me to help with calming him, I rushed up there (miles away) to find that I had missed him by minutes. Hours later he was released from a police station cell, with a former headteacher interceding for him. He then collapsed at my place after attempting to run out onto the street, with no proper clothing, not knowing where he was or what was happening to him. I have never seen anything so distressing. He was totally unsafe.*

*The issues at that time also caused me to resign from my job because I was so distressed and suicidal without appropriate support. I didn't complain because I knew I couldn't prove the truth around how I was discharged.*

**Table 8. What do you believe led to the unsafe discharge?**

| | |
|---|---|
| Lack of beds | 18 |
| Staff errors | 12 |
| Patient – misperceptions of | 8 |
| Don't know | 6 |

Patients may not always be in a position to understand the decision to discharge: it should of course always be explained to them and made with them, but in these instances of unsafe discharge, often taking place despite the concerns of the patient and/or their families, we already know that this process has overwhelmingly not operated as it should have done. Nonetheless, we wanted to hear what patients perceived to be the reasons for the decision.

The reasons broadly fall into two categories: issues with the system that meant there was a lack of beds; and errors by doctors, either clinical or more specifically in the sense that they misunderstood the patient's condition, situation or preferences. This included the feeling that doctors mistook concerns raised by the patient about a disability for an uncooperative attitude, saw patients as 'too old', or failed to investigate symptoms properly. A theme also emerged of discharges being accelerated to accommodate weekends and Bank Holidays.

**Patients told us: reasons for the premature discharge**

*They told me regarding the MDT meeting: "you either come now or we're discharging you!" I didn't go immediately as no reasonable adjustments had been made for my disability, so I was accordingly discharged for 'refusing to engage'. No assessment was made of my mental state at the time - that didn't come into their decision.*

*Quote from the discharge co-ordinator: "we are very busy, we have people needing beds, you are in a nursing home, if you refuse to accept we will raise a safeguarding alert against you."*

*We believe it was because they needed the bed.*

*They wanted the bed and to reduce patient numbers over the Easter Bank Holiday.*

*Discharge was on a Bank Holiday weekend. The decisions were made very quickly.*

*He was old. They wanted to be rid of him.*

*Prejudice: they thought I was having a panic attack.*

*Probably poor communication on the ward or between the ward and the surgical staff.*

*Pressure on beds. I refused to accept the discharge as he had been hospitalised three times in three months. I had to fight several health professionals to get an NHS assessment to prevent further admissions associated with UTI and a catheter. NHS funding was finally granted and my 98 year old dad has been spared further hospital admissions because he now gets nursing care. The consultant was oblivious to his duty to ensure a safe discharge.*

*They had no knowledge of chronic pain and disbelieved me.*

*Winter bed pressure. Lack of communication with next of kin who had stated concerns during admission.*

*Sending people home because they were closing the ward for the weekend.*

**Table 9. Was any formal complaint / similar process launched?**

| | |
|---|---|
| **Yes** | 12 |
| **No** | 11 |
| Not stated | 20 |
| Don't know | 1 |

**Appendix: Survey questions**

1. When did the unsafe discharge take place? [Month/ Year]
2. Who was discharged unsafely from hospital? [Me/ A close relative/ Friend or distant relative]
3. What relationship is the person who was discharged to you? Were you present when these events took place? Were you present throughout / present for much of what happened/ mostly heard through other people?
4. What had you, or the person you're telling us about, been in hospital for?
5. After the discharge, did you or the person you're telling us about have to be re-admitted to hospital to get further treatment for the same medical issue?
6. How soon after the initial discharge did the re-admission happen? It's OK to give an approximate answer if you can't remember exactly.
7. Was it premature, unsafe?
8. Please tell us briefly what happened at the time of your / the patient's discharge and immediately afterwards.
9. Did you/the patient have an idea of what caused the hospital to make the unsafe discharge?
10. What were the long-term effects of the incident on you / the patient and family / friends? Was any formal complaint or similar process pursued and, if so, what happened?
11. [If you are happy for us to contact you to ask for further information, or permission to include details in the report that could identify you, please provide your name and email address and/or phone number below. We won't publish any information that could identify you if we don't have this permission.]