Doncaster
Metropolitan Borough Council

NHS
Doncaster
Clinical Commissioning Group

Themes from part 1

of Intermediate Care Study.

(October 2015)

Overarching category	Sub-category (and examples)	Further sub- category (and examples)
1. POOR COMMUNICATION		
	1.1. Records are inaccurate: *Discharge dates wrong* *Discharge destination not correct.* *Notes not updated with death.* *Discharge summaries are incomplete or inaccurate.*	
	1.2. Information is not easily accessible: *Records are written that are then not routinely available to other teams.* *Records are not available to all services.* *Notes held in several places and in different systems.* *Copy of assessment not shared in records.* *Notes from Falls service not available on S1.*	
	1.3 Information is not shared proactively: *DNAR not shared.* *Copy of assessment not shared in records.* *Care plans not shared with all services who support patient e.g. ambulance service.* *Alcohol liaison services do not routinely share records.* *Community services not communicating effectively.*	
	1.4. GPs do not receive the up to date information they need: *Information on pattern of falls not shared with GP.* *Results of scan not sent to GP.* *No discharge letter sent to GP* *GP not aware of referral to Positive Steps. And no discharge summary received.*	

Overarching category	Sub-category	Further sub-category
2. QUALITY OF CARE IS AFFECTED		
	2.1. Referrals are delayed: *Referral not made until day of discharge then not picked up by team (3 weeks).* *Referral for falls assessment delayed.* *Other professionals not making referrals – sending back to GP.* *Delay to referral to MMH rehab.* *Delays to access Positive steps.*	
	2.2. Discharge is delayed: *Discharge delayed by 23 days because patient was slept out.* *Patient could have been discharged earlier.* *Discharged delayed for several weeks as home visit required.* *Discharge delayed due to wait for NOMAD.*	
	2.3. Inappropriate referrals are made: *What else would FALLS clinic been able to offer after all input patient had received?* *Referred to MMH rehab but not appropriate for rehab.* *Referrals unchallenged.*	
	2.4. Adverse impact on patient	**2.4. 1. Social care needs are not met:** *Housing and family situation not made clear in records.* *Housing services needs integrating.* *Social care needs not accounted for.* *Needs a social worker appointing.*

		2.4.2. Psychological needs are not met: *MH team not involved.* *Emotional needs overlooked.* *Psychological needs overlooked and now a significant problem.* *Anxiety not addressed.* *Patient would have benefitted from psychological therapy but not received.*
	2.5. Adverse impact on processes of care	**2.5.1. Care is not co-ordinated or planned:** *Pharmacy not involved so unable to ensure dressings / meds available.* *Duplication of services e.g. referrals to OT.* *Care planning for EOL needed.* *Care coordination would have been beneficial for patient.* *Would benefit from an advanced care plan.* *Care only provided reactively not proactively.*
		2.5.2. Opportunities missed: *Telehealth could have benefitted patient but not offered.* *RAPT could have picked up patient but missed as only 58.* *Direct access to ECP instead of calling ambulance.* *GP can no longer access care offered in Sheffield.*

Overarching category	Sub-category	Further sub-category
2. QUALITY OF CARE IS AFFECTED		
	2.6. Unnecessary stay in hospital: *Care could have been given in community not as inpatient.* *Urology investigations could have been done as outpatient.* *Frailty assessment could have been done at home.* *Could have had anaemia investigated as outpatient.* *Patient could have been managed at home.*	
3. SYSTEM WORKING WELL		
	Whole system worked for patient. *Early Stroke Discharge Team worked well.* *Telehealth worked well to reduce admissions.* *Social Prescribing worked well.* *Discharge plan from respiratory ward worked well.*	