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**Improving the patient experience of transition from hospital to home following stroke:
A service evaluation.**

Abstract.

Background: Returning home from hospital after a stroke can be a challenging time. There is often a need for patients to be discharged quickly therefore a poor discharge experience for patients and their carers is consistently reported. Individuals can feel anxious and unsupported during this period.

Aim: To conduct a service evaluation in a regional stroke service to explore the experiences of patients being discharged home from the Acute Stroke Unit with support from the Early Supported Discharge Service.

Methods: Specific elements of a previously validated questionnaire were completed by 9 participants. The service evaluation built on previous research and expanded the data by including patients with communication or cognitive difficulties.

Findings: Patients had a positive experience of discharge home from hospital. Most patients received the information they needed and felt involved in discharge decisions. However, one third of patients experienced a delay due to waiting for medication and the need for greater psychological support was identified.

Conclusions: A collaborative approach involving patients and professionals is suggested to bring about improvements to stroke discharge services. Patients should be offered appropriate psychological support and medication should be available as soon as discharge is proposed. Any subsequent study would be improved by recruitment of a larger number of participants; particularly from more diverse ethnic groups who are currently underrepresented, and the option of online or hard copy questionnaire distribution.

Background:

More than 100,000 strokes occur each year in the UK and most people will require a hospital stay (Stroke Association, 2018). Over the past 30 years, the total number of National Health Service (NHS) hospital beds in England has more than halved while the number of patients treated has increased significantly (The King's Fund, 2020). In many hospitals there is a need for patients to be discharged as soon as clinically possible due to limited bed capacity (British Medical Association, 2020).

The NHS Long Term Plan (NHS, 2019) proposes a target of 90% of stroke patients receiving care on a specialist stroke unit. It is therefore necessary for stroke patients to be discharged in a timely way so that there are beds available to ensure subsequent patients receive the treatment they need. Additionally, extended hospital stays can have a negative impact due to the increased risks of hospital acquired infection, reduced clinical outcomes and increased exposure to harmful events (NICE, 2014; NHS Improvement, 2017). Discharge from hospital is therefore a common occurrence which benefits both the organisation and the individual patient. However, this can be an unsettling time in the patient's journey. The Royal College of Physicians (2023) recognises that the transition from hospital to home is a stressful period for stroke patients and their families, with people reporting feeling anxious and unsupported (RCP, 2023).

The Adult Inpatient Survey conducted nationally by the Care Quality Commission (CQC, 2019), found that patients consistently report a poor discharge experience, particularly in relation to the quality of information given and time waiting for discharge. This is perhaps unsurprising, given the aforementioned pressure for hospital beds resulting in less time to prepare patients and involve them fully in decisions about discharge. Additionally, there are well documented issues with nurse staffing and skill mix in the UK. Appropriate nurse staffing levels have been shown to be associated with improved physical outcomes as well

as greater patient satisfaction. When nurses are busy, they are less likely to talk to patients, comforting and educating them (NIHR 2019).

Whilst some stroke patients can spend weeks in a rehabilitation setting, many are discharged directly home from an acute stroke unit (ASU), particularly patients who are able to continue their rehabilitation at home with support from an early supported discharge (ESD) team (Rodgers and Price, 2017; Stroke Association, 2020c). Although many studies have been undertaken on the stroke patients' experience, these have tended to focus on other aspects of patient care or have tended to be of a longer time-frame post discharge (months or years); little is known about the initial patient experience of discharge directly home from hospital (Connolly and Mahoney, 2018).

The previous research conducted highlights various issues. Studies have identified the emotional and psychological impact of stroke including shock (Connolly and Mahoney, 2018), vivid memory of the acute stage (Simeone *et al.* 2015) and other mental health factors such as depression, changes in sense of self, uncertainty and adjustment. Patients have also reported feeling like a bother, a burden to family members and dependent on others (Simeone *et al.* 2015 & Santos *et al.* 2015).

In order to inform the discharge process and ensure better support for people after stroke, greater emphasis is needed on including the views and perceptions of patients and carers (Ellis-Hill *et al.* 2009 & Gustafsson and Bootle 2013). For instance, the Healthcare Quality Improvement Partnership (2018) recommended gaining greater insight into the patient experience and involving patients and carers' in discharge planning. Similarly, Connolly and Mahoney (2018) advocated for an individualised patient-centred plan for discharge. Each patient has their own needs, so Connolly and Mahoney (2018) suggest healthcare professionals create individualised plans regardless of stroke severity, as even if physical and cognitive deficits are minimal, patients can have difficulty adjusting to life when they return home

There are links between perceived stress in stroke patients and their functional independence (Santos *et al.* 2015). Almborg *et al.* (2010) found a strong relationship between mood and quality of life. Therefore, services should be provided to help stroke patients cope with life changes. Patients would benefit from interventions that psychologically prepare them for the transition home, alongside interventions to help family and friends connect with the person following stroke (Simeone *et al.* 2015 & Rittman *et al.* (2007). These could include practicing skills at home prior to discharge and giving patients the right information, rehabilitation, training and support. Gustafsson *et al.* (2014) recommend helping patients to have more realistic expectations to improve the experience. Connolly and Mahoney (2018) suggest future research to explore racial and ethnic diversity in relation to the patient experience particularly with participants from less resourced environments. However, Rhoda *et al.* (2015) conducted a study in Rwanda, South Africa and Tanzania which found stroke patients experience similar challenges and barriers to patients in high income countries, despite differences in the availability of resources.

The studies discussed in the literature review each had a different emphasis. Additionally, research was carried out in countries which might not have the same standards and procedures for stroke care as the UK. Therefore, all of these issues were taken into consideration when designing this service evaluation.

Service evaluation:

Clearly, there is evidence of a need for improvement in discharge processes in order to give patients a more positive experience (CQC, 2019). The NHS constitution and NICE (2012) states that providers should actively encourage and welcome feedback on healthcare experiences and use this to improve services (Department of Health and Social Care, 2015).

The Early Supported Discharge service in which one of the authors works, has regular discharge review meetings involving staff from ASU and ESD. The purpose is to evaluate previous discharges in order to make changes to improve the discharge process and patient

experience. In response to patient and family feedback relating to uncertain expectations, changes have been implemented over recent years:

- New leaflets were produced with information on discharge arrangements.
- Referral forms and processes between teams were updated, increasing communication.
- The ASU staff inform ESD where there is a particularly complex discharge planned, in order to plan for this together.
- ESD team members may visit the patient on the ward when it is identified that this may alleviate a patient's anxiety.

No formal evaluation had been carried out into the effectiveness of these changes and the impact on the patient's discharge experience. Hence this service review was designed to gain patient feedback and to improve the service delivered.

Aims

A service evaluation was carried out in one unit with the aims of gaining an understanding of the patients' experience of discharge, evaluating process modifications and to identify key areas to focus on for further improvement.

Methods

A descriptive design was used to gather quantitative and qualitative information on the patient experience. A mixed method approach allows the researcher to utilise the advantages of each research approach whilst avoiding the weaknesses associated with each (Polit and Beck, 2017).

Ethics:

The NHS Health Research Authority (HRA, 2018) questionnaire was completed which confirmed that the study would not be considered research by the NHS. However, permission was granted from the Stroke Clinical Lead, the Matron for Stroke, the Patient

Experience Team and the Research and Development Office. The project was registered with the Audit Department and issues such as coercion and cognitive limitations (presented below) were discussed and resolved among the clinical teams and Research and Development Office.

Questionnaire:

Questionnaires were used instead of interviews due to time constraints. Paper questionnaires were used as this format was already in use in the Trust to gain patient feedback and there was limited time to set up an electronic version. Questionnaires can have a low response rate and if using a postal survey, can be expensive (Polit and Beck, 2017). Therefore, the questionnaires were distributed and collected by the ESD team on visits they would already be carrying out as part of their service. It is acknowledged that coercion and positive bias could exist with this approach, but all efforts were made to minimise this (Aveyard, 2019). This included a statement on the patient information sheet reassuring participants that their care would not be affected whatever their decision. It should also be remembered that patients were effectively discharged from the ASU at the time the questionnaires were handed out.

The validated questionnaire used was the 'Leaving Hospital' section of the Care Quality Commission Adult Inpatient Survey (CQC, 2019). Permission was received from the CQC. The CQC Stroke Questionnaire (2004) was considered, however this focused on the provision of stroke prevention information and was not felt to be comprehensive enough to fully address the research question. The Adult Inpatient Survey addressed the aims of the service evaluation, had the required reliability and validity and had been widely used previously (CQC, 2019). The adapted questionnaire was piloted with 3 patients to ensure the intended meaning was understood. It included 17 quantitative questions (details of which can be found in Table 3) and 3 qualitative questions (below).

- Was there anything particularly good about your experience of leaving hospital?

- Was there anything that could have improved your experience of leaving hospital?
- Do you have any other comments?

Each quantitative response was categorised with a numerical descriptor with 1 indicating the highest level of satisfaction and 4 being the lowest. As part of the piloting process the distribution of the questionnaires should also have been considered. This may have identified some of the distribution difficulties experienced later (discussed in the limitations section).

Sample:

The sample population were patients who have had a stroke and been discharged home directly from the ASU. See Table 1 for inclusion criteria.

Inclusion Criteria
Adults >18 years
Stroke Diagnosis (Ischaemic or haemorrhagic)
Discharged from the Acute Stroke Unit.
Discharged Home.
Receiving Early Supported Discharge.

Table1: Inclusion criteria

Unlike much of the previous research discussed above, patients were not automatically excluded from participating if they had cognitive or language impairments. This was a conscious decision as one-third of people have problems with speaking, reading, writing and

understanding following stroke, therefore this is a large part of the stroke population and their experiences are important (Stroke Association 2020a). If a patient was able to complete the questionnaire with help, they were given the opportunity to participate. A speech and language therapist was available to provide assistance for patients with communication difficulties.

Previous studies (Rittman et al., 2007; Almborg *et al.*, 2008) used the Mini-Mental State Exam (MMSE) to assess cognition. This was devised for patients with dementia and has been shown to have limitations for use with stroke patients (Mancuso *et al.*, 2018) however given the age of the studies, an alternative was not available to them. More recently, the Oxford Cognitive Screen (OCS) (Demeyere *et al.*, 2015) was developed to be an aphasia and neglect friendly tool to screen for cognitive deficits after stroke. The OCS is routinely used on the ASU where the sample was recruited from and therefore was used to establish if the patient had impairments that would impact on their ability to participate or if support was required for completing the questionnaire. If there were concerns, an occupational therapist would help those with a cognitive deficit.

Data Collection:

All patients that met the inclusion criteria were invited to participate during January and February 2020 and questionnaires were distributed by the ESD team.

Demographic information was collected to help with the analysis of the results. These included details such as gender, age and ethnicity as well as issues which may impact on how the person was managing at home, such as living alone. Information on functional ability was gathered using the Barthel Index (Mahoney and Barthel, 1965).

In the setting where the service evaluation was carried out, some of the recommendations discussed in the literature review were already in place - such as aiming to involve patients and their carer's in discharge planning and providing information to patients to manage their expectations about the discharge process and support available. This was evaluated by

asking patients if they felt involved in their discharge and received the information they needed. Interventions such as taking patients home to practice are not generally practical on the ASU due to time constraints and the average length of stay being less than one week, although could be considered for some patients. ESD was in place to help with the transition from hospital to home and part of the selection criteria was that all participants received ESD. Participants were asked about support received on discharge and part of the **service review** was to see if this was felt to be adequate or if greater or different support was needed to enhance experiences of discharge home.

Analysis:

The data analysis technique used for the quantitative data was descriptive statistics. The statistics clearly describe the main results (Aveyard 2019). Details of the descriptives can be found in table 2. The qualitative data obtained from the open questions was recorded in a spreadsheet and was analysed using thematic analysis. This is process in which the researcher uses six steps to become familiar with the data, identify key components of the data (codes) and group it into categories or 'themes' which become the results (Braun and Clarke, 2006). **This process was undertaken by JH using an inductive, semantic approach which involved highlighting areas of text using different colours to correspond with different codes which were then formed into themes.**

Findings:

Thirty-five patients were discharged home from the ASU receiving ESD between January and February 2020. Twenty-six questionnaires were distributed, 10 were completed giving a response rate of 38%. However, when collating the data, it was discovered that 1 patient had been discharged to a nursing home rather than home therefore their questionnaire was not included in the final analysis. This left 9 questionnaires. This is a small sample size (Polit and Beck 2017) **which might be partially explained by the fact that Coronavirus was starting to be discussed in healthcare and by the public. This may have distracted attention from the study.**

Seventeen completed questionnaires would have been preferable for meaningful analysis resulting in high quality data. However, the demographic information gathered helped in establishing if the respondents were representative of the selected sample (Polit and Beck 2017).

Most participants (8/9) filled in the questionnaire themselves with one participant completing it with a friend. Three participants did not complete all the demographic questions and 2 did not complete the qualitative questions. Why these questions were not completed is unknown.

The results can be seen in table 2.

Gender	25% Male 75% Female	In the UK more women have strokes compared to men (Stroke Association, 2020d)
Age range	51 - 93 years old	
Living Arrangements	43% Living alone 43% With spouse/partner 14% With son/daughter	
Religion	43% No religion 57% Christian	For comparison, the 2011 Census data for the county showed 60.2% were Christian and 27.9% had no religion (Office for National Statistics (ONS), 2018)
Ethnicity	100% White English/Welsh/Scottish/ N Irish/British	For comparison, the 2011 Census data for the county showed that 91% of residents were white (ONS, 2018)
Sexuality	100% Heterosexual/straight	For comparison, the 2011 Census data for the county showed that 94.6% of the UK population aged 16 years and over identified as heterosexual or straight (ONS, 2018).

Table 2: Demographics

Three respondents stated they had physical or mental health conditions, disabilities or illnesses that had lasted or were expected to last for 12 months or more, including problems related to old age.

- 1 reported blindness

- 1 reported cancer

- 1 stated that they had “bipolar, severe depression and brain disease”

Two of these participants reported that these conditions did not reduce their ability to carry out daily activities with the other participant reporting their ability was a little reduced

- 66.6% of participants reported no other condition, disabilities or illnesses.

Responses for each question of the questionnaire are shown in the following tables and text.

	Yes, definitely	Yes, to some extent	No	No response
Did you feel involved in the decisions about your discharge from hospital? (R:9)	6	2	1	0
Did hospital staff take your family or home situation into account when planning your discharge? (R:9)	6	1	2	0
Were you given enough notice about when you were going to be discharged? (R:9)	7	2	0	0
Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital? (R:9)	7	0	1	1
After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? (R:9)	7	2	0	0
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? (R:9)	7	2	0	0
Were you told how to take your medication in a way you could understand? (R:9)	7	2	0	0
Were you given clear written or printed information about your medicines? (R:9)	6	1	1	1
Did a member of staff tell you about medication side effects to watch for when you went home? (R:3)	2	1	0	6
When you left hospital, were you told what would happen next with your care? (R:9)	6	3	0	0

	Yes	No	Reason
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On the day you left hospital, was your discharge delayed for any reason? (R:9)	3	6	All 3 cited waiting for medications. The delay was between 2 and 4 hours.
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	Yes, definitely	Yes, to some extent	No	No, It was not necessary	Don't know/Can't remember
Did a member of staff tell you about any danger signals you should watch for after you went home? (R:9)	2	5	1	1	
Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you? (R:9)	3	4		2	
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (R:9)	8				1
Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital? (R:8)	4			4	
Did hospital staff discuss with you whether you	6		1	2	

may need any further health or social care services after leaving hospital? (R:8)			"I would have liked them to"		
After being discharged, was the care and support you expected available when you needed it? (R:9)	8		1 "I did not expect further support after discharge"		

Table 3: Quantitative Results

Qualitative Data: Seven out of 9 participants completed the open questions for the qualitative section of the questionnaire.

Final themes are shown below:

Good experiences of care	Limitations of care	Suggestions for improvement
Punctual discharge Patients were informed and knowledgeable about their care prior to discharge Support post discharge very good Immediate support available Friendliness of ESD and therapy teams Excellent follow-up care Good access to therapy Caring team	"No idea what was happening"	ESD should be available for patients being discharged to nursing homes. Improved access to psychological and emotional support.

Table 4: Thematic analysis results

From the qualitative data, the discharge experiences of stroke patients can be summarised by the words of one participant:

“Overall, (a) professional, caring, experience throughout!”

Patients had a varied experience of information received prior to discharge, ranging from:

“...knowing all I needed to know at that time!” to, “no idea what was happening”.

The patient who did not know what was happening (Participant 1) had a particularly unfortunate time of being moved to another room and then a different ward due to needs of other patients:

“First evening was ok. The second night I was woken up at 8am + moved to a single room ~ original had monitor equipment that was needed. At midnight woke up and moved to Ward WX - Ward YZ bed urgently needed. Staff from Ward YZ had difficulty finding me next day.”

Patients' comments indicated a positive experience of support on discharge with particular mention of the physiotherapist and occupational therapist. Follow-up support was described as being “immediate”, “very good” and “excellent”.

There were suggestions for improvement. One participant felt that the ESD service should be available for people discharged to nursing homes. The ESD service is available in nursing homes therefore this suggestion is already being addressed. Another participant identified the need for psychological and emotional support.

The experiences of patients of discharge home from hospital following stroke can be summed up as mainly positive. This is underlined by the frequency distribution, with 76% of responses categorised as 1, the highest level of positive response. All participants were informed, to some extent, what would happen next with their care. Participants mostly reported that they were given clear information about their medication, its purpose and that side effects were explained to them. Family, friends and carers were given the information they needed, and most patients were told who to contact if they felt worried about their condition or treatment after they left hospital. Follow-up was described by participants as being very good, immediate, excellent and friendly.

However, some actions were identified which would improve the patient experience. This included keeping patients informed about discharge plans, avoiding moving patients to different locations and ensuring access to psychological support. It is recognised that most people experience emotional changes following stroke (Stroke Association, 2020b). National guidelines state psychological support services following stroke should be comprehensive and include access to a specialist clinical psychologist, as part of the multidisciplinary team (NICE, 2016; RCP, 2023). Patients receiving mood and cognition screening before leaving hospital are increasing however there is still a need for improved psychological support (SSNAP, 2019).

Most participants reported that they were involved in discharge decisions to some extent however one participant reported not feeling involved and this was the same patient who had been moved to a different ward. If patients do need to be moved it is important that they still feel involved in decision making. Another participant reported not being given the information about what to do or not do after leaving hospital or information about danger signals to watch for after going home. The same participant also did not know or was unable to recall if they had been told, who to contact if they were worried about their condition or treatment. All other participants received this information, but there is room for improvement to ensure that every patient is given and is able to access the information they need.

The findings of the service evaluation can be compared to the results from the Adult Inpatient Survey (CQC, 2019). Data from the Inpatient Survey indicated that information given to patients to deal with their condition was lower than expected with 40% of respondents saying that they were not given written or printed information about what they should or should not do after leaving the hospital and 37% of respondents reported they were not told about danger signals to watch for after they went home. Twenty-five percent said they were not told who to contact if they were worried about their condition or treatment after they left the hospital (CQC, 2019). Generic information on leaving hospital is readily available from many websites

alongside information from individual hospitals. However, this relies on patients having access to the internet and searching for the information they require.

The experience of participants in the service evaluation did not reflect the findings from the Inpatient Survey for information received, with study patients having a more positive experience. The RCP (2023) recommend that before transfer from hospital to home, stroke patients are provided with a named point of contact for information and advice as well as written information about their diagnosis, medication and management plan. Given the anxiety stroke patients experience on transitioning between hospital and home, it is important that patients receive this valuable information. Unplanned readmission to hospital is linked with patients not being involved in decision making and not receiving written discharge instructions (Kemp et al., 2017). The Stroke Association (2019) has information on leaving hospital. The setting where the service evaluation was carried out has packs available which contain a range of Stroke Association leaflets and these are routinely given to patient, tailored for individual patient needs.

The Inpatient Survey found that 41% of respondents experienced a delayed discharge in comparison with 33% of participants in the service evaluation. For both, the main reason for a delayed discharge was to wait for medicines. This is a clear area for improvement. Despite many initiatives to address discharge medication issues, it has been difficult for organisations to make lasting changes. One of issues is slow completion of the discharge prescription (NHS Improvement, 2017). This is not a new issue. Hall (2004) recommended that it be written the day before discharge so there would be no delay in getting the tablets from the pharmacy. Participants in the service evaluation waited between 2 and 4 hours however the wait can be much longer. Once a patient is told they can go home they may expect to be discharged immediately and could have a negative experience if they have to wait. Delays should be anticipated by hospital staff and communicated with patients in order to manage their expectations.

Discharge delays have a negative impact on patients and are costly for the hospital (NHS Improvement, 2017). The service evaluations focus on the day of discharge meant that areas identified for improvement could be realistically addressed within the stroke service. Delays due to other factors such as waiting for care or equipment would involve working with other agencies to bring about change. In order to fully understand the patient experience, it may have been useful to explore a longer post-discharge time frame.

Previous surveys (CQC, 2019) have shown that there has been an increase in the demand for services and a reduction of hospital beds due to a growing ageing population. However, despite the current service evaluation experiencing such pressures, this did not significantly impact on patient experience as participants reported having a largely positive experience. Most participants responded “yes, definitely” or “yes, to some extent” when asked if they felt involved in discharge decisions with only one participant reporting they had not felt involved. Despite the high satisfaction levels, it is acknowledged that further developments could be made to improve the experience of discharge in the setting in which the service evaluation was carried out and systems could be put in place to ensure every patient feels involved in their discharge. The literature review also identified this. Supporting patients to be actively involved in their own care and treatment can improve outcomes and the patient experience as well as having the potential to bring financial savings to the NHS (NHS, 2020). It is a key part of the NHS Long Term Plan (2019) and RCP (2023) guidelines.

The need for increased patient involvement and its associated benefits is widely recognised and methods exist to bring about change. Some interventions are straightforward, such as staff discussing goals and needs with the patient (Almborg et al., 2008) however these can be challenging to implement in the pressured environment of the acute hospital (NHS, 2019, The King’s Fund, 2020). Ellis-Hill et al. (2009) suggested that health professionals should put greater emphasis on the ideas and expectations of patients and carers to inform the discharge and formulate a patient centred plan (Connolly and Mahoney 2018). Alongside involving individual patients in their own discharge, there could be more inclusion of the perceptions

and views of patients and carers to inform and improve the whole discharge process. Focus groups are one way to increase patient and public engagement to bring about improvements (NHS Improvement, 2016).

Limitations: The main themes that emerged from the literature review were related to emotional and psychological impacts of stroke and the need for psychological support. However, the service evaluation did not specifically address how patients *felt* about their discharge home, instead focusing on physical issues. There was no exploration of the impact of events such as delays. Patient interviews would be a preferred method to explore psychological and emotional factors.

The demographic of the convenience sample was not ethnically diverse. Future research could explore the relationship between ethnicity and the patient experience of discharge home.

The sample size was small however discharge procedures and support changed significantly due to Coronavirus, therefore the discharge experiences of patients going home in March would have been different to those discharged home in January and February and not an accurate reflection of patients' usual experiences.

There were some issues with the distribution and collection of the questionnaires. These included:

- Questionnaires were collected in person. This may have caused patients to feel coerced into participating, despite the written statement at the top of the questionnaire which was reinforced verbally at distribution with patients reassured declining would not have an impact on subsequent therapy.
- Questionnaires were collected when the ESD team were visiting the patient as part of their rehabilitation, however it was not foreseen that some patients would not require ESD input.
- The piloting stage was too short to identify issues with questionnaire distribution.
- The data collection period was too short but this was unavoidable.

- One staff member had not given a patient a questionnaire, stating that this was “due to a language barrier”. Although from overseas, the patient did speak English and their notes stated this.
- Another patient initially returned home then moved to another area with a different ESD service.
- One patient with communication difficulties was not included as the speech and language therapist who had planned to assist the patient felt that it was not in her best interests due her high anxiety levels.

Conclusions:

This service evaluation has explored the experiences of stroke patients being discharged home from hospital. Due to pressure for hospital beds patients need to be discharged home in a timely way (NICE, 2014; NHS Improvement, 2017). However, the transition between hospital and home can be stressful for stroke patients and their families (RCP, 2023).

The results are encouraging for the stroke service and the good practice discussed in the introduction will continue alongside addressing areas for improvement in psychological care and timely provision of medications. With changes implemented to address the limitations of this study, the service evaluation could be repeated to ensure that standards have been maintained and to establish if further improvements have had an impact on patient experience.

The existing knowledge base has been expanded by including patients who had cognitive and communication difficulties. In addition, a stroke specific cognitive screen was employed. Future research could investigate the experiences of younger patients and those from different racial and ethnic backgrounds. It is hoped that this service evaluation will contribute to future patients having a more positive experience of discharge home following stroke.

Key words: *patient experience, discharge, stroke*

Keypoints:

- To improve the patient experience of discharge home from hospital the following areas need to be addressed - Increasing psychological support, ensuring patient involvement, reducing medication delays.
- Patients' psychological needs could be addressed by ensuring staff receive training on psychological problems and are given the skills to manage them. This education should be based on national guidelines for psychological support and could also include sign-posting to stroke support groups and referring patients to a psychological service for assessment and intervention.
- Patients should be involved in developing services. The highest level of engagement would be through a co-design partnership enabling patients and professionals to collaboratively design and evaluate services.
- Delays due to waiting for medication could be addressed by prescriptions being written and sent to the pharmacy earlier. Realistic timeframes should be communicated to patients to manage expectations.
- Despite Early Supported Discharge Services, discharge may not always be without problems. Vigilance is required to ensure adequate interventions are provided to help patients and carers to cope with life changes

Reflective Questions:

- Do you recognise similar issues occurring in your workplace related to discharge? If so, how might you change practices to address them?
- What barriers and facilitators can you identify to making practice changes?
- How will you evaluate the impact of the changes implemented?

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