Appendix 1 - Accounts of hospital discharges back to PCC Sheltered Housing schemes that went well and hospital discharges that could have gone better

Summary of events	Outcome & Residents / Scheme Manager comments
X arrived home in the evening on the 10/04/13. The family had told us when they went to see X that night X had a fall. We went to see X in the morning; X was upset and could not stand. X wanted to go to the toilet we helped X onto the commode but it was a struggle, we made X a cup of tea and toast and phoned the GP. The GP phoned X and spoke to her friend to say that she would not be coming out to see X. I phoned the GP up and said that GP needs to come out and could they see staff. GP phoned me and advised that they were taking X back into Hospital. X was relieved to go back into hospital. X became very ill then sadly passed away.	I would question why X was discharged home without support and care set up and in place to support X's discharge.
X came home on 18-6-2013 at 4.30pm, we were notified about that X was coming home and X was told by the ward sister that X would have a carer that evening and a morning and evening call starting the next day. X didn't have a carer that night, I phoned the next day, was told PRRT should have seen her, I phoned them, they knew nothing about it. I called the hospital again they said they would make the referral. There were no visits at all on the 19-6-2013, I phoned again on the 20-6-2013 and told ASC that X was extremely distressed about what was happening. Care started later that day. Scheme staff helped X until the care started.	This was very frustrating as I felt I was being pushed from pillar to post and all I wanted was to get X the care she had been promised on discharge.

X had a very successful discharge from hospital. A Social Worker rang to say X would be home on the 25th February 2013 about tea-time. It enabled us to ring the meal provider, the community nurses to dress X's leg and X's care agency. Family were informed and a friend was going to visit to check on X. As X had suffered a stroke X was sent home with a thickener for food/drink. Family were also able to buy a liquidizer and suitable foods and we were aware of X's needs because the Social Worker had briefed us.We were also informed that X would receive care 4x a day and what that consisted of and 3x week the Stroke Team would visit.	Good communication and involving scheme staff allowed this to be a very smooth, efficient discharge and our resident received excellent care from all involved.
Admitted to hospital on 20.06.13 and was discharged on 26.06.13. I rang the hospital (ward E3) and advised staff that X had no family support and that they needed to contact me to let me know when X would be discharged so that I could ensure that I was in the scheme and get any shopping, meds etc that X may need and arrange frequent visits to ensure that X was ok. I was not advised of X discharge and it was by luck that I saw X in the building. X had no food in the flat and could not walk far at all. I took X to the shops in a wheelchair as X could not have got to the shops unassisted and visited frequently until X recovered.	If I had not have seen X, X would have been at home without food, a drink or visits to ensure X's wellbeing. This may have resulted in X being readmitted from either falling or dehydration. The hospital should have contacted me as requested.
3/1/13 Admitted to hospital via ambulance and treated for lung infection, discharged 29/1/13 and arrived home at 7pm with family. O.T visited X's flat prior to his discharge, PRRT in place for his return to help with poor mobility.	Everyone arrived as they should and the transition was a good one for our resident.

Discharged on 07/08/12 - Home at 14:30X broke upper arm falling out of bed on 06/08/12, X was sent home by ambulance car without any checks on home situation or prior warning to scheme staff.X had no chair to sit in as X had only moved in to the scheme on the day X broke arm, X was upset and confused.We had no idea what if any care had been arranged until staff contacted the Hospital.	It would have been helpful if Hospital staff or O/T had spoken to scheme staff to find out the home situation and advised us of arrangements for care package prior to discharge.
X was admitted with heart and lung problems on 15/03/13 X was sent home in a Taxi on a walking frame, the driver dropped X's bag outside the main door and left X, X had no key to get in. No info was given to scheme staff prior to discharge, no home situation check and no care package arranged. Seven days later X fell and broke collar bone in four places.	It would have been helpful if Hospital staff or O/T had spoken to scheme staff to find out the home situation and advised us of arrangements for care package prior to discharge.
18.5.13 Admitted to hospital via ambulance, 19.5.13 sent home with PRRT in place to support. First visit from PRRT on the 19th resulted in X being taken back into hospital as they felt X couldn't cope in own home at that time. No rehab placement was available so X was taken back to QA, before being transferred to Spinnaker ward at St Marys shortly after. We were called by the discharge nurse 5.6.13 to tell us X would be home the following afternoon, X actually arrived home around 15:30 7.6.13. PRRT was put in place but was cancelled by X as they were coming to get X up but arriving between 10/11am, by which time X had got up, been out and back again.	X felt that had a rehab placement been offered before the first discharge X wouldn't have had to be re admitted to hospital.