PASSING THE BATON

A Practical Guide to Effective Discharge Planning

Document Information

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Originator:	Change Agent Team, NLIAH
Authorisation:	Chief Executive, NLIAH
Further Information:	National Leadership & Innovation Agency for Healthcare, Innovations House, Bridgend Road, LLANHARAN CF72 9RP Telephone: 01443 233333 Facsimile: 01443 233334
Web Link:	www.nliah.wales.nhs.uk

Introduction

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Executive Summary

NHS Wales provides inpatient care to thousands of people every year. In addition there are hundreds of thousands of attendances at Accident & Emergency Departments. The profile of health policy in recent years has been to focus on reducing the delays that patients are experiencing in getting access to hospital. However, a continual theme within reviews such as the report by Derek Wanless, 'The Review of Health and Social Care in Wales 2003', emphasised how significant amounts of resources have been used caring for patients in hospital beds who ideally could and should have been discharged to a more appropriate setting for their needs.

Even though it has been estimated that 80% of all discharges are simple in nature, it is acknowledged that providing a safe and effective discharge for every person who attends our hospitals can become complicated. Practitioners have to ensure that the specific needs of every single patient are catered for, to make sure that they can leave hospital safely and on time.

Taking a proactive approach to discharge planning with every individual will have a positive impact on the causes of delayed transfers of care.

To do this effectively requires careful patient assessment, planning and the cooperation of many professionals not just from health and social care, but also from other allied agencies including commercial, charitable and voluntary organisations.

The challenges of making discharge safe, appropriate, timely and effective have been around for a long time. Changes in society's expectations means that a much more sophisticated response is now required.

Effective discharge can be dependent on many factors such as the need to make adjustments to the persons' home, determining long term funding arrangements or the identification of a suitable care setting.

The Change Agent Team (CAT) is based within the National Leadership and Innovation Agency in Healthcare (NLIAH). The overall aim of CAT is to work with health and social care professionals to improve the journey and experience of individuals throughout the care system.

In 2007, CAT published "Six Steps from DToC to EToC – A Summary Report of the National Self Assessment of Discharge Planning in Wales". This report identified that there is a weakness in the knowledge, skill and confidence of front line staff in managing the discharge of patients from hospital.

Health and social care professionals highlighted that the increasing complexity of discharge processes, actually helping patients to leave hospital, seemed to require greater and greater involvement and leadership of key specialist staff such as Discharge Liaison Nurses. Reasons for this were broadly accepted as:

- The faster pace of the Ward or A&E environment
- More performance pressures upon staff
- Increasingly complex needs of patients
- The increasing challenge of translating health and social care policy into practice

Practitioners are becoming more reliant upon specialists in discharge to make discharge happen, in cases where any Practitioner could and should be able to manage the process.

'Passing the Baton' is the result of NLIAH working directly with health and social care professionals and can be described as many things – a toolkit, a resource file, or even a general reference guide. It is designed to provide Practitioners with the basic knowledge and information they need to play a greater role in managing the patient discharge.

Whereas the learning within the Guide is intended to be useful for all Practitioners, the practical content primarily refers to adults. As such, the technical references quoted within the Guide are predominantly adult oriented. For Practitioners caring for specific groups, such as Children or Mental Health, reference should always be made to existing statutory guidance.

This Guide is not designed to be read in one sitting. It has been produced by Practitioners across Wales to provide information, advice and support on all aspects of discharge. It should be used to complement and develop local tools and operational policies already in existence.

The intention is to continue the development of the Guide beyond the initial publication, to ensure that it remains compliant with current policy. Part of this development will include the production of more detailed information on improving the effectiveness of discharge planning for specific groups.

It is always challenging to write something that will be of practical use to everyone. Some people, who read this, may not learn anything new and for them the challenge becomes putting the skills into practice, consistently. For others such as newly qualified Practitioners, the amount of information may seem overwhelming at first. However, the Guide is designed to support the development of knowledge and skill over time.

Passing the Baton Metaphor

'Passing the Baton' may seem a strange title for a document about discharge planning. The Health and Social Care Practitioners, who have written this Guide, believe that effective discharge from secondary care can be likened to the smooth flow in which relay runners pass the baton over to the next runner.

> *"In a relay race you can't just throw the baton up in the air and hope the next person catches it. You must keep a firm hold of the baton until you're absolutely sure the next person has got it."*

In this case the baton symbolises the responsibility to deliver the right care using knowledge and understanding of the patient's needs. Each athlete is responsible for carrying the baton and playing their part in the race to the best of their ability. At the right time and in the right place, the baton must be passed to the right person.

In athletics there are usually only four runners in each team, all moving at the same speed over the same distance neatly, one after another. To produce the best performance in athletics and pass the baton effectively, each athlete requires a good plan, dedication to training and the development of trust in each other. The goal is to produce synergy in the team, so that they can achieve more together, than could have been possible separately.

In health and social care there can be several teams, each moving at different speeds, over variable distances, all running at the same time. Producing a good performance will require a more sophisticated approach, better planning, more training, extra dedication and considerable amounts of mutual trust and understanding.

> *"Good discharge planning is the only way to ensure that the baton is passed safely and effectively across health and social care."*

The Welsh Assembly Government (WAG) has set out significant challenges for Health and Social Care Services in order to achieve world class standards. For example "Designed for Life" published in 2005 and "Fullfilled Lives; Supportive Communities" published in 2007. Many of the targets for each agency cannot be delivered without improving the practices and processes that enable patients to move smoothly through the hospital and wider care system.

There is an opportunity to impact upon the whole system, improving the patient journey and the patient experience by re-enforcing what needs to be done to make discharge safe and effective.

Acknowledgements

Editors

The Change Agent Team (CAT) within the National Leadership and Innovation Agency for Healthcare (NLIAH), has been responsible for facilitating the development of this Guide and providing the editorial function, bringing together the contributions into a single product:

Lynda Chandler
Lynda.chandler@nliah.wales.nhs.uk

Matt Wyatt
Matt.wyatt@nliah.wales.nhs.uk

Iain Roberts
Iain.roberts@nliah.wales.nhs.uk

Administrative support for the Community of Practice was provided by Lisa Conway.

Methodology

Producing this Guide has been a unique achievement in harnessing the knowledge and expertise of Health and Social Care Practitioners across Wales. The aim has been to produce a practical document which reflects the real-life experiences and aspirations of those on the frontline of effective discharge planning practice.

Grateful thanks are offered to the participating organisations for allowing people the time to attend workshops and for permission to share their tacit knowledge. The work has been completed 'on top of the day job' and everyone involved must be congratulated and thanked for their commitment and perseverance.

All of the individuals listed below are members of the national Discharge Planning Community of Practice (CoP). To reflect the different types of contribution that have been made, participants have been listed in three groups:

- A core group of CoP members attended most workshops and wrote elements of the Guide. These are listed as 'authors'.
- Another group of CoP members were unable to attend workshops but did provide invaluable support by commenting on drafts and sharing information, policies and relevant documents. These are listed as 'contributors'.
- The Expert Panel provided much valued external scrutiny and advice to ensure that the Guide supports the appropriate legal, regulatory and policy frameworks.

The Community of Practice is open to all health and social care Practitioners and managers who share the passion to make a difference. If you would like to join or require further information please contact the Change Agent Team.

Authors

Wayne Turner	Blaenau Gwent Social Services
Sarah Thomas	Bridgend Local Health Board
Audrey Roach	Bro Morgannwg NHS Trust
Geraldine Bizby	Bro Morgannwg NHS Trust
Mandy Edwards	Bro Morgannwg NHS Trust
Judith Viney	Cardiff Social Services
Linda Jenkins	Cardiff & Vale NHS Trust
Louise Williams	Cardiff & Vale NHS Trust
Carole Walters	Carmarthen NHS Trust
Lynne Morgan	Carmarthen NHS Trust
Jon Rees	Carmarthen Social Services

Gaby Staite	Ceredigion Health & Social Care
Janet Davies	Conwy & Denbighshire NHS Trust
Sue Fitton	North East Wales UA Partnership
Angela Michael	Gwent Healthcare NHS Trust
David Hopkins	Gwent Healthcare NHS Trust
Nicola Beerenbrock	Gwent healthcare NHS Trust
Cheryl Way	Informing Health Care
Wendy Rees	Monmouthshire Local Health Board
Sue Price	Monmouthshire Social Services
Janet Hawkridge	Neath Port Talbot Social Services
Carol James	Newport Social Services
Angela Fry	NLIAH
Gillian Jackson	NLIAH
Shari Lewis	NLIAH
Wendy Chaloner	North East Wales NHS Trust
Christina Griffith	North West Wales NHS Trust
Sharon Thomas	North West Wales NHS Trust
Christine Phillips	Pembrokeshire & Derwen NHS Trust
Iris Lee	Pembrokeshire Social Services
Hilary Mullan	Powys Local Health Board
Jane James	Swansea University
Ceri Hamilton	Velindre NHS Trust

Contributors

Joanne Beecham	Caerphilly Local Health Board
Pose Akande	Cardiff Social Services
Mary Dykes	Cardiff Social Services

Angela Williams	Cardiff & Vale NHS Trust
Debbie Murphy	Conwy & Denbighshire NHS Trust
Margaret Rennocks	NLIAH
Deb Harris	North Glamorgan NHS Trust
Meryl Swales	Pontypridd & Rhondda NHS Trust
Gill Haram	Swansea NHS Trust
Chris Hennessy	Torfaen Social Services
Vicky McCourt	Social Services Improvement Agency
Lynne Turner	Workforce Development Unit Expert Panel

Expert Panel

Neil Desmond	Welsh Local Government Association
Gaynor Williams	Welsh Assembly Government – Waiting Times & Emergency Care
Stephen Griffiths	NLIAH – Workforce Development Unit
Jean White	Welsh Assembly Government – Office of the Chief Nursing Officer
Malcolm Fisk	National Partnership Forum for Older People
Molly Hughes	Carers' Representative
Paula Martyn	Welsh Assembly Government – Continuing NHS Health Care
Rob Pickford	Care & Social Services Inspectorate for Wales
Tessa Shellens	Morgan Cole Solicitors
Trish Buchan	Powys Association of Voluntary Organisations
Vivienne Walters	University of Swansea

How to Use the Guide

This Guide could be read in one long sitting, however the format is designed to enable Practitioners to dip in and out and pick up pertinent advice as and when it is needed.

The Guide should be relevant to a broad spectrum of staff across health and social care, so the use of language has been considered carefully.

The word Practitioner has been used as a common term to denote a member of qualified staff in any profession. Similarly there are many words used to describe the people who use public services and the terms person, individual, user, citizen and patient have been used across the document in the most appropriate context.

Throughout the Guide visual symbols have been used to easily identify significant learning points:

This icon identifies an insight or quote that provides an opportunity for Practitioners to reflect on their experience and practice.

This icon identifies a direct quote or paraphrased description of the experience of a service user.

This icon identifies a Case Study a real experience of how things have worked in practice or an example of how things should work.

Structure of the Guide

The Knowledge Barometer
Read this section first! It describes four steps to help individuals and teams begin to apply the Guide in to practice.

1. Principles of Effective Discharge Planning
Six common principles upon which effective discharge planning and successful transfers of care are dependent

2. Communicating with Patients & Families
How to develop effective dialogue with the patient, their family and carers and become a more effective communicator

3. Assessing the Whole Person
How to build a detailed, full and clear understanding of every service user through individualised assessments

4. Individualised Care Options
Proactively responding to individual needs by considering creative care packages tailored to each set of circumstances

5. Legal Issues Relating to Discharge
Making the effort to get it right first time by raising awareness of the current legal rights and obligations in the provision of care
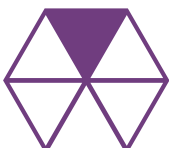
6. Passing the Baton in Practice
Putting it all together on the day and creating a framework for identifying, training and developing the necessary expertise

The previous diagram highlights the Guide's structure and colour coding. There is also an Appendix which includes a Bibliography and more detailed Subject Index.

'Passing the Baton' is structured over six chapters, each focussing on a specific aspect of discharge. Before the formal chapters begin, there is an important section of the Guide, called 'The Knowledge Barometer'.

The Knowledge Barometer

The Knowledge Barometer should be read first as it contains a four step exercise to help begin the process of improving discharge planning practices. The 'High Level Pathway' and 'Simplicity Matrix' are tools that reinforce the core principles that are integral to all elements of the Guide.

Formal Chapters

Chapter 1 sets out the 'Principles of Effective Discharge Planning', refreshing the common aims and enabling Practitioners to begin to reflect on the purpose of discharge planning. It identifies that discharge is not an isolated event at the end of a patient's stay in hospital. It is a process that starts on, or even before, admission and works best when planned collaboratively with colleagues, the patient and their family.

Chapter 2 offers tools, tips and advice for 'Communicating with Patients and Families'. This Chapter will be of value to all staff, particularly as we know that the majority of complaints from service users are triggered by poor communication. One of the most important messages in this section is to remember that good communication requires a personal approach but is a collective responsibility. Care is provided by a team that must

communicate effectively with each other, with the patient, their family and carers, and also with colleagues in other agencies and locations.

Chapter 3 focuses on 'Assessing the Whole Person' and the planning processes required to make discharge safe and effective. Very often health and social care Practitioners are focussed on dealing with the immediate clinical or social needs of the individual. This Chapter advocates taking a broader person centred approach and tools such as the 'Daily RAP' and the '4Ps' will help Practitioners to embed the principles of effective discharge planning into everyday practice.

Chapter 4 explores the need for discharge assessment and planning to take a much more creative approach, to produce 'Individualised Care Options'. There is a need to develop care packages that are tailored to support individuals in ways that enable them to maintain their health and well-being for the longer term. There is real potential for this approach to develop and inform future commissioning arrangements.

Chapter 5 works step by step through the complexities of the 'Legal Issues Relating to Discharge'. This Chapter is not designed to turn people into amateur lawyers. It has been written with a number of very readable case studies to help guide staff through some of the more challenging aspects of discharge. Discharge can seem complicated with issues such as the Mental Capacity Act, Continuing NHS Health Care, the Protection of Vulnerable Adults and the Chapter will help de-mystify these and similar issues.

Chapter 6 is devoted to the final practical steps to be taken in order to facilitate safe and effective discharge planning and actually 'Passing the Baton in Practice'. This is a very simple summary to focus the minds of Practitioners on the operational considerations that lead up to the actual discharge or transfer of care. This Chapter also includes a section that provides guidance

for Practitioners responsible for education and training. It makes recommendations for developing local education programmes within a strategic Training Framework.

Currently there is no other single resource available in NHS Wales focussed on discharge in the detail described in 'Passing the Baton'. It is a living resource, so as practice changes and improves, or health and social care policy changes, so the Guide will be updated. In the meantime, within the Guide and the accompanying resources on the CD, there are many examples of good practice, information and tools available for use and development.

"There are real consequences to dropping the baton starting with the patient and emanating out to untold people who have to pick it back up. Compensating for poor planning wastes time and energy, requires more money that we don't have and ultimately takes other Practitioners away from other patients. Nobody wins!"

The Knowledge Barometer

The Knowledge Barometer

Taking the Lead

The following quote is familiar to most people. The statement is attributed to Mahatma Ghandi and was adopted as the motto of Bombay Hospital:

> "A patient is the most important person in our hospital. He is not an interruption to our work. He is the purpose of it. He is not an outsider in our hospital. He is a part of it. We are not doing him a favour by serving him, he is doing us a favour by giving us an opportunity to do so."

Although it is not couched in today's politically correct terms, the sentiment is perhaps more true now, than it has ever been.

On any given day Practitioners are put under pressure to deliver more and more efficient care within a process-driven system of targets and professional accountabilities. It is easy to lose sight of the purpose of providing care in the first place.

'Passing the Baton' is not just another process to be applied into practice on top of everything else. The learning and development is centred on creating a set of core values and then applying some tools and techniques in a way that supports those values.

This is not as simple as 'getting back to basics', a phrase often used to remind people of a past time when things were simpler and easier to do.

"This is about getting back to values, a much more sophisticated approach that requires people to constantly visualise; why we do, what we do."

Creating your own personal view or even a collective vision of what is right, may sound like a far cry from those daily pressures of work. However, there is evidence from across the world, throughout commercial and not for profit organisations that values drive behaviour, not processes.

It has become too easy to blame 'The Process' for poor practices and hand off responsibility to someone else to improve outcomes. Improving the efficiency of processes by removing blockages or reducing waste, is undoubtedly a valuable and necessary part of continuous improvement. But it is only one part.

"Too many projects have failed to sustain their improvements, beyond the life of the project, because the people who ended up being changed never really knew why they were changing."

To truly improve and sustain that improvement, organisations, teams and individuals must be able to, first of all, identify the right things to change. To find or see the right things in everyday practice requires intimate knowledge and therefore, Practitioners are the best people to decide what should be done.

"Challenging current practice when you're in the middle of it, can seem like a difficult and often intimidating thing to do. Especially, when nothing usually happens as a result!"

Having a set of common values provides people with a benchmark to ask themselves and each other; "Does what we're doing feel right?" If it doesn't support the values it is unlikely to be right and must be explored further.

Practitioners are not the only people able to do this. Service users, their families and carers can ask the same simple question and form a view that will similarly drive their behaviour.

There are many published examples gathered through programmes of Public Participation that have shown how service user and service provider opinions are often very different. Despite this, the same evidence has also shown how the personal values that underpin these opinions are actually very similar.

"The key to all this is to getting yourself to the point where you know the right thing to do and then you take responsibility to do it right."

The Knowledge Barometer is the last step of four exercises that have been devised to relearn and reflect on, what it means to manage the care process:

1. The Complicated Questions
2. Finding Simple Answers
3. Creating Discharge Checklists
4. The Knowledge Barometer

These exercises start to explore the important values, alongside developing simple tools to improve decision making, to the point where an individual Practitioner makes a conscious decision on how to act.

'Passing the Baton: A Practical Guide to Effective Discharge Planning' in its entirety, can be used as a training and development resource. The four steps are designed and written to complement the practice advocated throughout the Guide with one principle objective:

• To help individuals and teams begin to apply the Guide in practice using the values, tools and techniques through self directed learning and reflection.

The four steps can simply be read and absorbed by an individual or used in a more structured way where teams work through the exercises together.

1. The Complicated Questions

This exercise is designed to help Practitioners to reflect on their values and their own unique contribution to care.

The first objective for anyone learning about the journey through care is to understand their own individual relationship to and impact upon, the entire system.

That can sound like a strange statement! In a journey through care that may last hours, weeks or even years, the actions or omissions of a single person over just a few minutes can make an immeasurable difference.

> *"During the many investigations I've done over the years, I've talked to hundreds of good people, skilled people, who simply didn't understand the significance of their behaviour on others and on what eventually happened."*

In terms of effective discharge planning, this level of personal understanding is crucial to ensuring that decisions are made and actions taken, in a way that recognises their individual impact upon the whole experience of the patient.

> *"Until you have a personal view of the potential impact of your involvement, it's difficult to make consistent decisions in real time, on how to go about your job."*

The single and continuous message throughout this Guide and one that should be repeated when applying the knowledge and skills into practice is:

> *"Effective discharge planning comes from many simple things done consistently"*

In teaching and learning about the practice within this Guide it is helpful to first have an open discussion about what we mean by discharge planning. Without focussing too much on hard definitions, the purpose should be to explore the relative importance of discharge planning amongst all the complicated processes that make up the modern journey through care.

The following three questions can be used to facilitate such a discussion encouraging participants to consider the wider implications of effective practice, before identifying each person's own individual contribution:

"Who is in charge of, or responsible for, planning effective discharge?"

The answer is, "you!" Everyone who contributes to the journey through care is responsible for ensuring that they personally add value:

From the patient's perspective: To identify the unique needs of each person and help to overcome anxiety, remove uncertainty and to keep things moving in the best way.

From the Practitioner's perspective: there should be a balance between simple everyday core duties by each staff group and specialist knowledge and intervention when necessary.

From the organisation's perspective: the aim should be to reduce unnecessary delays whenever possible and improve the journey by actively overcoming potential problems.

"What priority is given to discharge in the great scheme of things?"

Similar to other training programmes it is important to include and emphasise the far reaching impact of effective and ineffective systems, the statutory obligations facing organisations and how we are held to account:

From the patient's perspective: the most important work is that which directly involves them, the things that can be seen, heard, felt and remembered and subsequently where the greatest effort is required.

From the Practitioner's perspective: simple day to day operational processes are important, they must support the reality of caring for people and putting the individual at the centre rather than the paperwork or procedure.

From the organisation's perspective: effective discharge is not only about the practical flow of patients but also the qualities of behaviour and the interpersonal, professional and interagency relationships.

"What is your relationship to the patient flow and discharge processes?"

To answer this, training and development frameworks must range from simple awareness raising, through routine duties and on to expert practice. This will enable a wide variety of people to understand their connection to the system:

From the patient's perspective: training must enable staff to relate to the patient and help them to understand their own role and that of each Practitioner.

From the Practitioner's perspective: Training must be practically orientated to assist the front line process, but supported with sufficient academic reference and evidence to validate the practices.

From the organisation's perspective: understanding individual impact should reinforce professional and departmental accountability to work proactively and support colleagues within the multidisciplinary team.

2. Finding Simple Answers

This exercise is designed to help Practitioners to determine the difference between simple and complex care processes.

The previous complicated questions are inevitably difficult to encompass with definitive answers in a single session. Effective discharge planning seems to touch on such a broad spectrum of issues that everything can quickly seem too complicated.

> *"A key element in effective discharge planning is recognising the difference between simple and complex discharges early in the patient journey."*

In reality only a relatively small number of patients follow very complicated journeys with the majority of patients only requiring routine processes to be actioned. Irrespective of the level of complexity or the potential length of stay, discharge planning processes must be carried out to the same high standard.

For those patients who will require greater planning to facilitate effective discharge, once again, it is the processing of relatively routine actions, in a timely way that ensures complications are foreseen and overcome.

Differentiating between simple and complex can seem quite difficult at first glance. There are many different scenarios that could affect the relative complexity of a patient's journey. Potentially there could be many experienced people involved who each consider their input to be quite simple.

> *"I'm a Care Coordinator, responsible for linking up all sorts of professional opinion, but nothing is more important than building a rapport with the patient and their family, making sure they always feel listened to and involved."*

The following diagram shows a high level pathway for the discharge planning process.
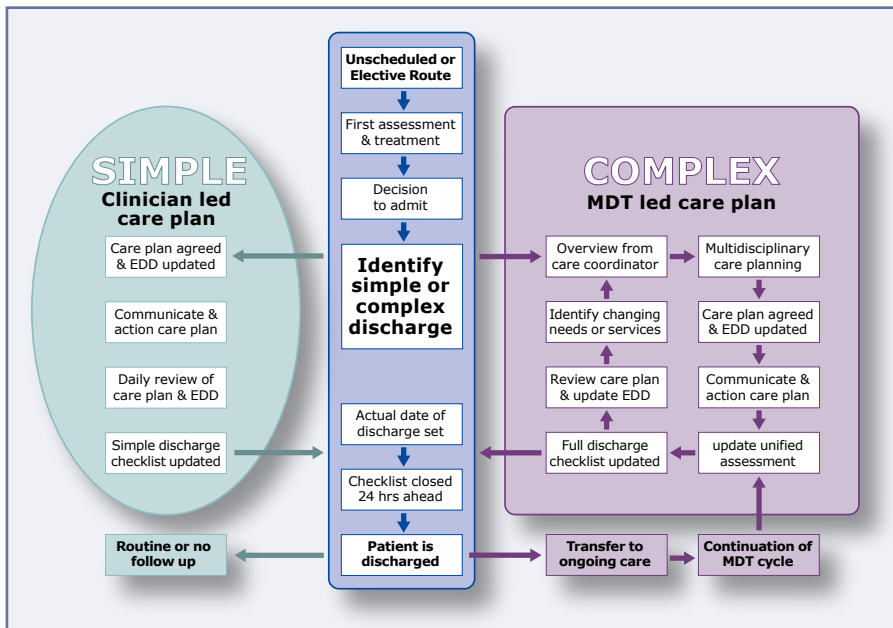
The pathway works for elective or emergency admissions. Whether derived from an elective pre-assessment or an emergency triage, the information required to make a decision to admit a patient, also enables an assessment of the potential complexity of the patient's journey.

If the discharge process is identified as potentially complex, then this should instigate the involvement of a named Care Coordinator. Although the role of a Care Coordinator can vary, their primary function is to facilitate the cycle of multidisciplinary care planning. If the discharge process is identified as simple, then the patient journey will follow a more linear care plan from diagnosis to discharge. However, as the patient journey continues there must be a clear process for recognising changes; those things that could trigger a move towards a complex discharge.
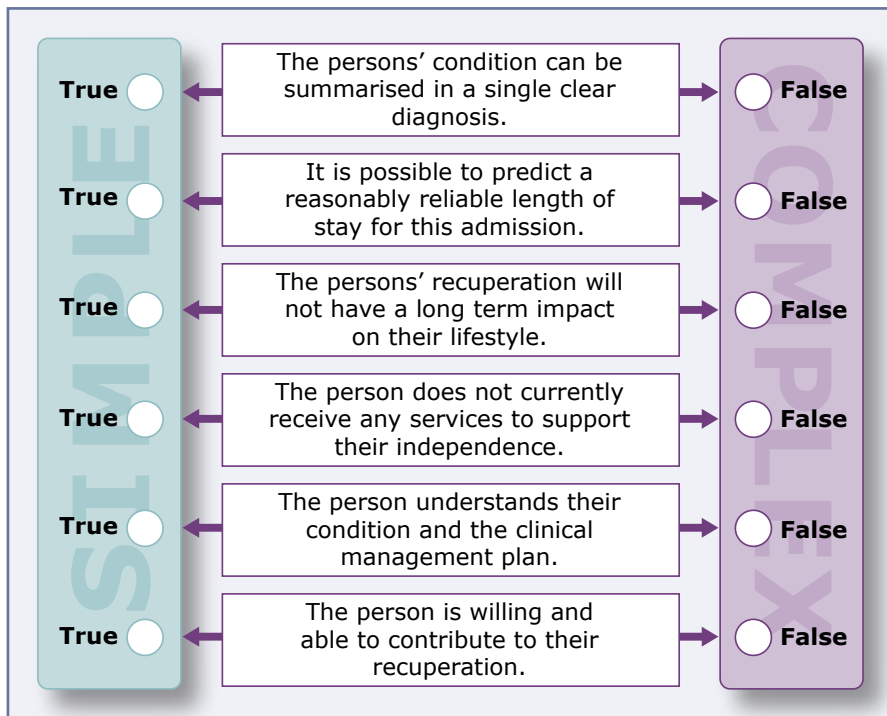
It therefore becomes important to define what is simple and what is complex so that the considerations made at the decision to admit, can be applied consistently as the patient's situation changes.

"The relative complexity of a patient's journey is not an excuse to hand off responsibility to senior or more experienced Practitioners."

The Simplicity Matrix

The following diagram contains six generic statements about the persons' individual circumstances and the Practitioner will need to determine if those statements are 'True' or 'False'. The statements are phrased in positive language towards identifying a simple journey. Therefore more 'True' answers would suggest that the discharge process is more likely to be simple, more 'False' answers and the discharge is probably going to be more complex.

SIMPLE / **COMPLEX**

True	Statement	False
True ◯	The persons' condition can be summarised in a single clear diagnosis.	◯ False
True ◯	It is possible to predict a reasonably reliable length of stay for this admission.	◯ False
True ◯	The persons' recuperation will not have a long term impact on their lifestyle.	◯ False
True ◯	The person does not currently receive any services to support their independence.	◯ False
True ◯	The person understands their condition and the clinical management plan.	◯ False
True ◯	The person is willing and able to contribute to their recuperation.	◯ False

With just a little thought these questions can be repeated at any point in the journey through care to provide a consistent assessment of the complexity.

You may want to score the questions, as clearly a score of 3 would highlight the need to observe the progress of the care plan closely. It's not really necessary and may just add confusion and alternatively the matrix could be incorporate into local documentation for reference.

3. Creating Discharge Checklists

This exercise is designed to enable Practitioners to develop local discharge checklists.

It is difficult to write one set of standardised procedures or provide reliable written instructions when each journey is unique for each patient.

However, even in the most complex journeys, there are some elements of the pathway that are common to everyone.

> *"There are endless possible scenarios that can influence the safe and effective provision of care and no process can ever outweigh or overrule the combined experience and expertise available right there, right then."*

Procedures should always be written in way that supports the active judgements made by the multidisciplinary team in real time. An established method of doing this is the checklist. It is a way of delineating core elements of a formal process, but the decision on how and when to act requires the judgement of a competent Practitioner.

As indicated in the previous pathway diagram, there is a key stage for a discharge checklist and a clear distinction between a 'simple discharge checklist' and a full or 'complex discharge checklist'.

> *"A checklist is not a complicated document; it is literally a list of important things relevant to your involvement in the overall process that can be ticked off when they are put into action."*

Each health community should develop its own discharge checklists based upon the organisational relationships and services that are available.

Encouraging teams of Practitioners to develop and implement their own checklists is a useful tool in applying this Guide into practice.
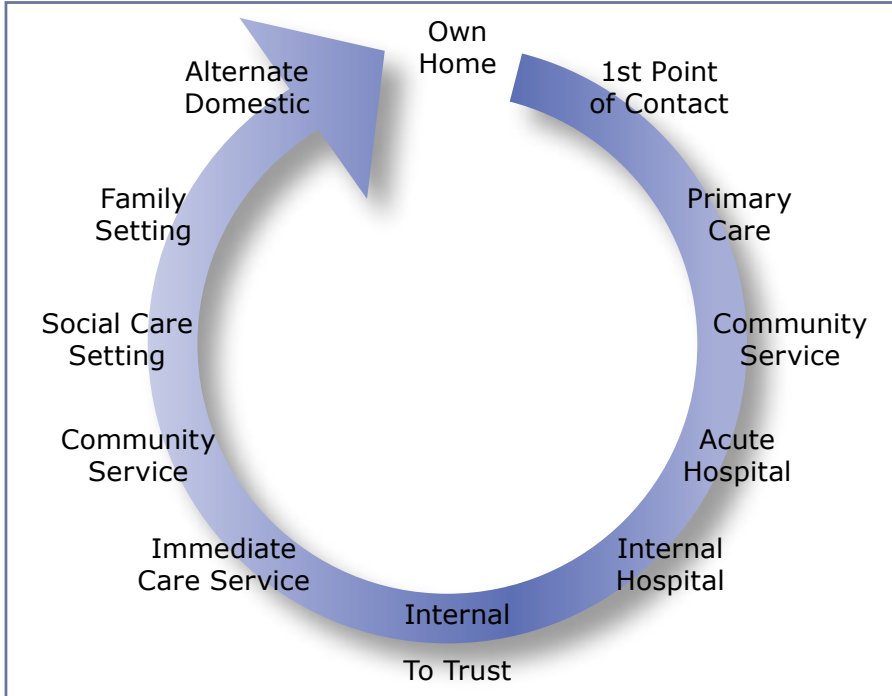
"Recognise the difference between a hand over and hand off! A hand off is when you push someone away. A hand over is like passing a baton, you've got to keep a firm hold until you're absolutely sure the next runner has got it."

Who Why How

The need for a discharge checklist to form part of the care process can become very clear, when considering the possible number of handovers in a journey through care, for example:

Own Home

Alternate Domestic

1st Point of Contact

Family Setting

Primary Care

Social Care Setting

Community Service

Community Service

Acute Hospital

Immediate Care Service

Internal Hospital

Internal

To Trust

The diagram is just a snap shot of the possible handovers that would require effective working relationships and involve transferring knowledge alongside the physical movement of the patient. Relationships, knowledge and movement are the three essential themes of a good checklist:

WHO Identify the people that must be involved to ensure that the process flows smoothly with a clear description of what is expected of them

WHY The reasons for the process to flow, including all of the relevant knowledge and experience accumulated in the process so far

HOW The logistics, or next steps in the process of what practical things need to happen, when they should happen and in which order

Who, Why and How are not headings, but more like the type of thing to consider adding to a checklist. A simple example could be for take home medication:

Appointed Pharmacist			Phil
Prescription completed and forwarded			✔
Deliver To: Ward	✔	Dis-Lounge	
Discharge date confirmed to pharmacy			✔

Potentially, different departments in the same organisation could require slightly different discharge checklists. For example, Cardiology will use different pathways and refer to different services than Orthopaedics.

Overall, the checklists should be based on a common framework and teams and organisations should be encouraged to share their knowledge and experience when developing these tools. Some practical examples of existing checklists are available in the resource pack that accompanies this Guide.

Local checklists may already be in use; sometimes they are not specifically called a 'checklist', but essentially do the same job. Read it, understand it and start by asking "Does what we're doing feel right?"

If you don't have a checklist, design a simple one and put it into practice. Do small tests to see if the checklist works and improve it, rather than try and get it perfect in one go!

4. The Knowledge Barometer

This exercise is designed to enable Practitioners to become acutely aware of their own expertise.

In following the four learning steps Practitioners will:

- Firstly consider their personal responsibility
- Secondly see a method for assessing the journey
- Thirdly create a practical way of managing the first two

The fourth part should now make perfect sense. "Six Steps from DToC to EToC" is the summary report of the National Self Assessment of Effective Discharge Planning in Wales published in 2007. This report highlights one of its key findings as the almost complete lack of any joint interdisciplinary or interagency training on effective discharge planning.

"As a result, groups of allied staff are expected to work together within systems that do not complement each other; work with people who may not fully understand each others contribution to the journey through care; and ultimately try to communicate using different forms of language and with different expectations."

The starting point to overcome this apparent disconnection is by increasing the level of mutual understanding.

> *"Without doubt, there are plenty of experienced Practitioners who have developed really broad knowledge of the care system and enjoy good working relationships with a range of people."*

The challenge then becomes, how do Practitioners tap into this expertise without overburdening those few people and how do they spread the good practice encompassed in that wealth of knowledge?

At this point, it is necessary to make a clear distinction between two different aspects of competency:

1. Knowledge and experience in professional or clinical practice, actually delivering the care
2. Knowledge and experience in managing the journey through the care system

These two things are complementary, in that you would naturally expect to gain better understanding of managerial processes as your career and practical experience develops. Managing the journey is about making the connections and enacting the procedures to involve people and prompt the resources required to care for the patient in the future.

This aspect of work is often called the Care Process and discharge planning is one of the practical methods of managing the care process.
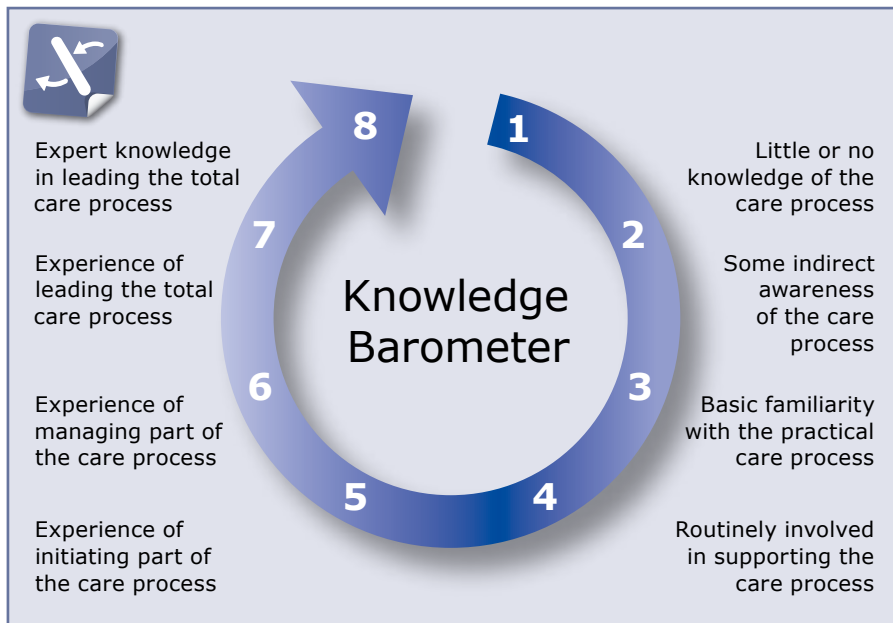
> *"You may be brilliant and provide the best care for your patient, but no matter how good you are, the patient will have a bad experience if you don't also manage the care process."*

Practitioners do not have to be experts in managing the care process, to personally deliver excellent care. But even the most experienced Practitioners will acknowledge that a different set of skills is needed to manage the care process.

> *"The idea behind developing the Knowledge Barometer was to provide a tool to help Practitioners create a personal view of whether they have the appropriate level of knowledge and experience, to effectively manage a particular journey through care."*

To create this view the Knowledge Barometer has eight levels of understanding ranging from 'None' to 'Expert'. The eight levels are based on the Training Framework described at the end of Chapter 6. These levels have simple definitions that describe the relative extent of understanding and experience of the care process.

Knowledge Barometer

Level	Description
1	Little or no knowledge of the care process
2	Some indirect awareness of the care process
3	Basic familiarity with the practical care process
4	Routinely involved in supporting the care process
5	Experience of initiating part of the care process
6	Experience of managing part of the care process
7	Experience of leading the total care process
8	Expert knowledge in leading the total care process

The barometer is about the level of understanding and is therefore not just a question of seniority.

"Just because a case may be considered as more complicated, it should not automatically follow that the case requires a more senior Practitioner."

It is possible for someone with "expert knowledge" at level 8 on the barometer, to be a junior member of staff who has gained a great deal of experience with the specific needs of a particular type of patient. Similarly a team manager may have little or no knowledge of the care process required for a rare scenario.

Subsequently, depending on the particular circumstances of the patient, Practitioners may have a different level of knowledge and experience in managing the necessary care process.

A 'Whether' Forecast

Imagine you have taken responsibility for a new patient and just completed an admission assessment. After considering all of the information available so far, you have determined that this patient has a more complex journey. It is therefore necessary to take early action on several care processes identified on the discharge checklist.

At this point you need to consider whether you have the right level of knowledge and experience to manage the total care process for this patient. Think about which description on the barometer best suits your situation and use the level as an indicator to decide:

- Whether you are able to manage the total care process without any support [Score 6,7,8]
- Whether you will need to seek additional advice or support to manage the total care process [5,6,7]

- Whether you should support the care process managed by someone with more experience [3,4,5]
- Whether you need a more experienced Practitioner to manage the total care process [1,2,3]

As you can see from the suggested scores above, it's not a hard and fast decision tool.

The value of the forecast becomes more apparent and more critical when circumstances change, processes are more complex and you end up working closer to the limits of your knowledge and skill.

Communicating with the Knowledge Barometer

The same process of assessing one's own level of understanding can be used to develop better rapport when communicating with the patient, their family and carers.

The different levels of understanding described on the Knowledge Barometer can also be applied to the patient as advocated in Chapter 2.

"This acknowledgement of the patient or carers' own level of understanding has been recognised as a key contributing factor to a successful episode of care."

Some people who have had regular experience of the care process can be a genuine asset and actively contribute to the practical journey through care. They can absorb fairly detailed information from the outset and help direct the care process.

However, people with limited knowledge would find it difficult to absorb similar levels of complex information and be less able to contribute at the beginning.

> *"I've been in three times this year, so I know the deal. Last time, one Doctor was dithering about saying all kinds of things needed to happen. Well, I felt a bit nervous, so sneaked my mobile into the toilets and phoned Phil. He's a good boy, been my social worker for years."*

It therefore becomes crucial for Practitioners to consciously acknowledge their own level of understanding, so that it is possible to similarly consider the patient. Only then, can Practitioners tailor their personal approach and ensure that the patient's information and communication needs are met.

It is important to recognise that similar to any competent Practitioner, a patient's level of understanding is not static. The Knowledge Barometer can be used to similarly gauge this change from novice through to, in some cases, expert and ensure that the interactions with the patient reflect this.

Long Term Forecast

The Knowledge Barometer has another function! It can be used by Practitioners to help inform and direct personal development plans.

Keeping a note of the Barometer conclusions will help to identify where there are opportunities for learning. Or alternatively, opportunities to create challenges to increase a Practitioners' exposure to and experience of, particular situations and care processes.

The Takeover Zone

In athletics the relay race has a special area marked out on the track. It is a 20 metre long strip known as the 'Takeover Zone' and signifies the only place where the baton can be passed from one runner to the next.

It is 20 metres long for a good reason. As a runner comes to the end of their leg of the race, they have to spot the place in advance, where they intend to pass the baton. At the same time the next runner must prepare themselves by trying to match the speed and stride of their approaching team mate. If the new runner sets off too quickly, they are likely to head off, out of the zone, without the baton. If they set off too slowly they will loose momentum and stumble into each other. Either way they'll probably drop the baton!

From this point forward the Guide follows the formal Chapters that contain the main body of recommendations for good practice. The four exercises that end with the Knowledge Barometer are the Guide's version of a Takeover Zone and should help Practitioners get up to speed as they take responsibility to grasp the next baton.

> *"The Knowledge Barometer is like advice from the coach, while you're sat in the changing room putting on you're running shoes. These are the basics but the real work happens out on the track."*

Chapter 1
Principles of Effective Discharge Planning

Principles of Effective Discharge Planning

Chapter Overview

'Passing the Baton' is underpinned by a set of core principles that are integral to all of the Chapters within it. The health and social care Practitioners who wrote this Guide identified six fundamental principles essential to achieving effective discharge planning:

1. Communication
2. Coordination
3. Collaboration
4. Consideration
5. Creativity
6. Integrity

Like much of the learning in this Guide, these principles are not new and consistently putting them into practice, will require individual commitment to working together.

The aim of this Guide is to help Practitioners embed the principles consistently into daily practice so that they become habit. Small things done consistently can, and do, have significant impact on the people who rely on safe and professional services.

Back to Values

Good **communication** creates strong, productive relationships across and between individuals and agencies whilst a commitment to **coordination** will contribute towards seamless services that foster the dovetailing of processes.

Being **collaborative** enables greater understanding and promotes mutual respect that delivers the best possible services for users and carers. These are enhanced by **consideration** of individuals' and organisations' limitations, expectations and their legal rights and obligations, contributing to satisfactory results for all.

Finding new ways to deliver services to meet the diverse needs of communities and individuals, demands **creativity** and inventiveness in partnership with commissioners and care planners. Professionals have a responsibility and duty of care to act with **integrity** in securing the best outcomes for all involved.

Whilst no doubt all Practitioners will readily agree with the principles, it is recognised that individual needs have become more complex. At the same time, pressure on beds and other resources has increased dramatically. Adoption and application of the principles will provide Practitioners with a framework to address both simple and complex discharge planning.

'Discharge from hospital: pathway, process and practice' DoH 2003 notes that:

"Discharge is a process not an isolated event"

The National Assembly for Wales Circular 2005/17 "Hospital Discharge Planning Guidance" reinforces this:

"People being discharged from hospital are entitled to expect and receive a smooth transition from one stage of care to the next. A lack of coordinated and person centred planning for discharge can lead to poor outcomes for patients, possibly jeopardising health and safety or leading to inappropriate readmission to hospital."

Good practice in discharge planning and transfers of care is underpinned by the six fundamental principles. They were developed and agreed by the Health and Social Care Practitioners in the CoP:

1. Communication

"Good communication involves having a common language and mutual understanding of the transfer of care process between everyone involved."

"This requires effective dialogue and sharing of up to date information between patients, carers, providers and commissioners"

2. Coordination

"The patient's experience is partly determined by the quality of the coordination of their care. The Unified Assessment Process provides a gateway to the patient journey."

"This journey needs to be coordinated by a named individual to ensure the continuum of care is effectively provided by the appropriate professionals and multi agency teams. This whole systems approach will require clear definition of roles and responsibilities"

3. Collaboration

"Working together to achieve a common goal requires trust, respect, joint ownership and early planning."

"Shared systems and protocols, as well as multi professional training, will help break down professional barriers and develop a culture of collaboration and joint working."

4. Consideration

"Adopt a person centred approach and recognise the wants, needs and expectations of the individual in their particular circumstance."

"Understanding the service options available locally and how to access them involves developing awareness of and effective relationships with, partner providers including the family and carers."

5. Creativity

"People who have complex
transfer of care needs
will require a flexible and
imaginative person centred
approach from all partners.
This must start with the
commissioning process
involving population needs
assessment and consideration
of best practice models,
matched to available resources
and measurable outcomes.
Staff need confidence and
support, along with robust
information about the range of
available resources in order to
develop creative solutions to
transfers of care"

6. Integrity

"Integrity is about making transfers of care everybody's business, including the patient."

"All parties must uphold the values of honesty, commitment to the process and joint accountability to ensure that the patient remains at the centre."

Chapter 2

Communicating with Patients and Families
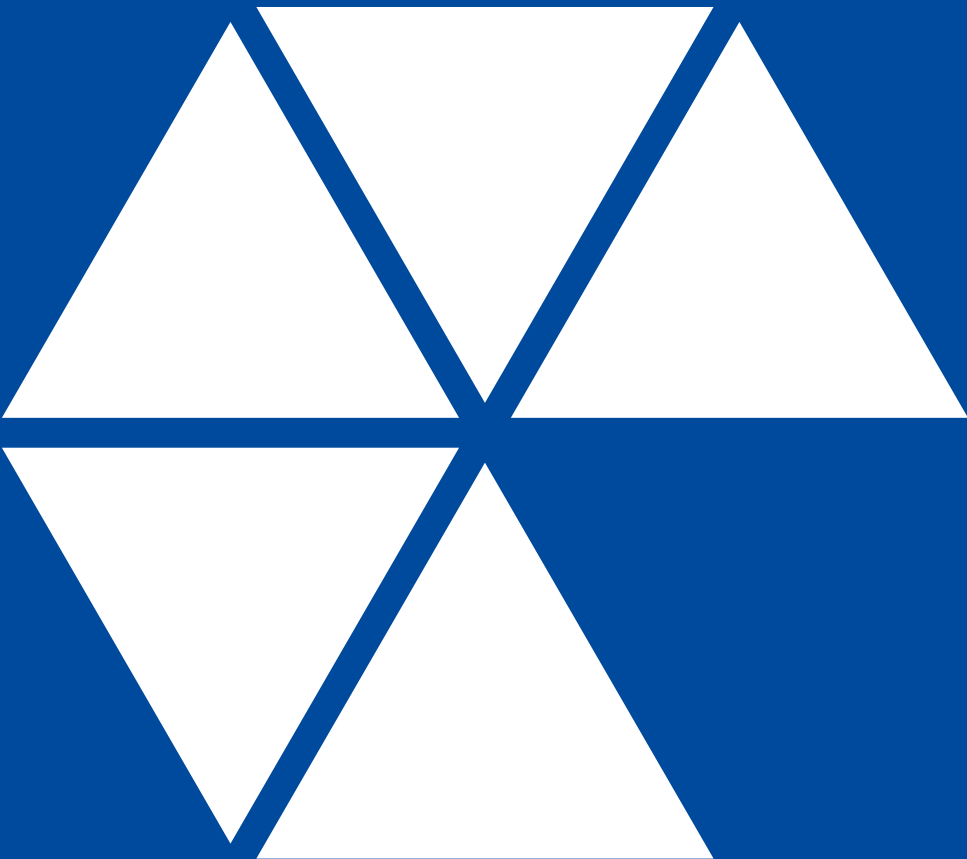
Communicating with Patients and Families

Chapter Overview

The aim of this Chapter is to emphasise that communication is the most important tool in supporting the individual's experience. Not only can good communication help the individual and their carers at a particularly frightening and confusing time, but it can also ensure that the team who are caring for the person are doing just that – working as a team with all the information they need at their disposal.

This Chapter suggests considering communication from the perspective of the patient or service user. How would you like to be spoken to? What information do you think you need?

Practitioners work in a wide variety of settings and the demands made upon them can be immense.

"If we can build up a rapport with people by being able to empathise with their predicament, fears, and concerns and have an understanding about what is of value to them, then we will have a significant positive impact upon their experience of our care services."

Having an open and positive relationship with patients, their family and carers will make the discussions required to plan the discharge productive and smooth. Tools such as the Communication Audit can help Practitioners to think about the information that is needed especially when care is provided from different care settings and other supporting organisations.

The Most Important Skill

Although communication has a specific chapter, the theme of communicating effectively is uniquely sewn in and amongst everything within this Guide, underpinning all of the ideas and recommendations.

> *"Communication is the most important human skill... up to three quarters of our waking time involves reading, writing, talking and listening... 40% of that time is spent in listening yet we are never really taught how to listen."* S. Covey

Throughout this Guide there are a variety of ideas, techniques and examples of good communication practice in relation to discharge planning. There are also examples from organisations across Wales, on the accompanying CD, of good information, written for a huge variety of circumstances, in a wide range of formats, aimed to meet the needs of diverse groups of people.

The principles of this Chapter, and indeed the Guide as a whole, reflect on and comply with 'Fundamentals of Care: Guidance for Health and Social Care Staff' which you can access via:

http://www.wales.nhs.uk/documents/booklet-e.pdf

There may seem to be a distinct separation between communicating with a patient, their family and carers and communicating with colleagues and allied professions across the multidisciplinary team.

This Chapter is written in the context of communicating with a patient, their family and carers, however, the principles of being a good communicator are completely transferable. Chapter 1, Principle 1, describes this as creating effective dialogue.

It is this ability to adapt to meet communication needs that determines how effective we are. Although there are some examples of what information to communicate, the learning and practice is focussed on how and when to communicate:

- In a way that always considers the whole person and their past and present circumstances, as well as their need for information
- At a time that helps to reduce anxiety, maintain realistic expectations and promote and enable shared decision making

Planning & Communication

"Planning in its simplest terms is merely the formation of a collective view of the future."

It is a view because it is based on what has happened so far and it is collective, because forming the view and enacting the future will inevitably involve agreement with other people.

In terms of planning for discharge, this definition seems to relate directly to what is required of the multi disciplinary team. Gather information on what has happened to the patient so far; form an agreed view of when the patient could leave hospital and enact what needs to be achieved to reach a safe and timely discharge in the future.

Understanding Expectations

One of the biggest problems identified in managing discharge is dealing with surprises towards the end of the episode of care. Many surprises are not even clinical in nature and are simply where the patient, their family and carers did not expect things to happen in the way they do.

This mismatch of expectations is the result of inconsistent or poor communication earlier in the patient's experience.

> *"A normal busy day involves working within limited resources and following organisational policies and procedures, constrained by time. Subsequently our day to day systems and processes can lead us away from some of the essential components of practice that are less easy to define and measure."*

The most common theme in formal complaints across the entire NHS is poor communication. It is therefore important that communication is seen as more than information giving. People can tell very quickly if you are distracted and not engaging with them in a meaningful way.

Aiming to understand and manage expectations is a useful objective in considering when and how to communicate. It is important to keep checking that the person has heard and understood what has been communicated.

Those aspects of a patient's experience that are considered most valuable, are grounded firmly in the compassion of frontline staff, are developed from a deep sense of respect for each other and are evident as a bond of trust when it matters most.

Obligations & Empathy

Practitioners are obliged to ensure that patients are fully aware of their circumstances and are able to give informed consent.

This means they must have enough information, and understand that information, to be able to make choices and arrive at a decision. If the patient may not have capacity then an assessment will need to be made to decide whether:

- More support is needed so that the patient can make decisions
- The patient does not have capacity and the rights and obligations under the Mental Capacity Act will be triggered (see Chapter 5)

This requirement is explicit in training and reinforced in practice. There are specific questions to ask and forms to sign and these are an important professional and legal requirement.

However, there is a side effect of this process driven interaction, especially when it is perceived by Practitioners as professionally right and therefore the right way to speak and engage with people.

It is normal on a busy day to deal with people quickly and even efficiently, but without really taking time to listen and understand their needs. With no intention to be offhand, Practitioners can easily slip into poor practice, jumping in, quickly predicting questions and almost using a set of scripted phrases or familiar responses.

"I know that lots of people come and go, but by the end of the week I could tell you what he was going to say next, no matter what the question."

In essence we have a professional obligation to ensure that we are properly understood. Yet the most effective communication methodologies suggest that to really engage with someone, you must first seek to understand the other person before trying to make yourself understood.

> *"Research has shown that the paperwork required to comply with these obligations is often used to script the conversation. The process becomes dominant and can actually result in distracting the Practitioner from properly engaging with the person in front of them."*

Understanding the other person is not just listening to their words. To fully understand someone, you must put their point of view into context. Pay attention to their frame of mind, how they are feeling, who is involved and why they happen to find themselves talking with you. Quite often these feelings are expressed or accentuated through a person's body language.

This understanding of another person from their point of view is called empathy. Once you consciously have empathy with another person you are better able to adapt yourself to meet their needs and enable them to understand you.

> The first product of communication is Empathy

There is a really simple technique for breaking your train of thought, reminding yourself not to script and reframing things in your mind to be more attentive and empathic:

STOP	Say the word "stop" in your head; stand still, preferably put down anything you're carrying, remind yourself this is important and recognise your own frame of mind.
LOOK	Say the word "look" in your head; be aware of your immediate surroundings, notice how the person may be feeling and move to respond to them; stand up or sit down, as they are.
LISTEN	Say the word "listen" in your head; don't think of answers while they are speaking, make a point of really trying to understand them by checking back with them, before answering.

If you practice this regularly, especially in busy moments, the three words will start to come naturally to you. It will take literally a few seconds to change your frame of mind, empathise with the person and be a better communicator.

Understanding Implications

The implications of good and bad communication are far reaching, like a pebble thrown into a pond the ripples can be seen long after the first splash has gone.

We know that the effects of poor communication on a person can be emotional, social and physical. In clinical governance terms ineffective communication can cause real harm in the form of events like medication error. These sorts of events have a consequence for the professionals involved as well as the organisation as a whole, giving them a high profile.

On the other hand, good communication practices have less of a profile, with most of the best outcomes going virtually unnoticed. This may sound discouraging at first, but actually helps to understand how good communication works in practice and there are no individual grand answers or universal techniques.

> *"Effective communication relies upon many simple things done consistently."*

Public and patient involvement work across the NHS has provided an element of feedback that is consistent across many groups; that patients, their family and carers are confused by the system.

This results in a lack of understanding and a feeling of a loss of control. The system therefore, appears complicated and disempowering especially when language changes and processes don't appear joined up. In truth, this feedback is echoed by a large proportion of staff.

A Vicious Circle

When the care plan doesn't follow the expected route it is even more important to communicate relentlessly:

> *"My 84 year-old Grandmother who died recently in a nursing home would have been able to live independently in her own home for much longer had communication systems been more robust when she fell and broke her hip 3 years ago on Christmas Eve. Initially she recovered well from the operation and was walking again the next day but suffered 2 falls on the ward, contracted MRSA, malnutrition for not eating for 5 days un-noticed, and her mental health declined after 16 weeks of bed-blocking due to a catalogue of delays in scans and assessments, treatments and discharge arrangements. Hospital advocacy services would have improved her informed choice on accommodation and care on discharge. There are many competent and caring staff within the health service but time again it is the information systems that let patients down."*

A Virtuous Circle

Recognising some of the simplest human needs with empathy and acting upon them in practical ways can improve the patient's experience and create trust:

"One out of 10 of the nurses showed common sense. She asked us what my mother's children's names were; she had 4, and wrote them on big piece paper and put them above the bed. She instructed all nurses to communicate using one or all names in conversation and then asked some simple questions how she liked her favourite cup of tea; her favourite food and the town she lived in. These were familiar things which enabled her to feel she was being cared for in between our visits."

Understanding Practicalities

"Information in any form is never an adequate replacement for effective dialogue."

Despite the limitations of information, considerate language, well written literature, clearly designed diagrams, simple signposting and accessible media in any format all help to complement and reinforce the dialogue.

The task of communicating effectively then becomes a process of considering how to engage with the person from a menu of tools and techniques. There are six practical steps to consider:

1. Be clear about who should be communicating what and with whom, to avoid duplication
2. Be able to relate yourself to the person and adapt your approach to suit their needs
3. Identify the best medium for supporting information using appropriate content and format. Be particularly aware of the need to adapt the type of communication method you use when dealing with people with sensory or cognitive impairment
4. Use standardised basic information but individualise it with further details specific to the person
5. Ask directly how the person would prefer to have information and identify special communication needs
6. Explain your responsibility to communicate effectively and always invite the person to ask anything, however simple

A key determinant of this effective dialogue is acknowledgement of the level of understanding of the people involved in the dialogue.

For example if you are talking to a person with a long term condition and several previous admissions to hospital, it is likely that they will have a good understanding of their circumstances and the journey ahead. The dialogue in this case could be more sophisticated than the dialogue with a person who has never been in hospital before.

Consequently over a period of time in hospital the patient, their family and carers will increase their understanding gradually and the dialogue with Practitioners should change to complement the increased understanding.

This flexibility in approach is discussed in "The Knowledge Barometer" section at the beginning of the Guide.

Setting Time Aside

Considering the potential consequence of good and bad communication on both the patient's experience and the organisation's credibility, communicating effectively is a core business and the responsibility of every member of staff.

If you have something important to communicate, reflect the importance of the dialogue by taking some time to plan what you're going to say. Agree with your colleagues to protect some time from interruption, and let the patient know that you've set aside some time to come and talk with them. Chapter 3 advocates this sort of dialogue as an everyday duty called a 'Daily RAP'.

> *"I saw my Dad in that chair and made it my mission to make sure he got home. It was all he really wanted and I made sure everyone knew it."*

Continuous Improvement

> *"Communication issues are notoriously difficult to distil down to specific improvement work as the subject touches on such a broad range of areas across all of our work."*

Monitoring the effectiveness of team communication is an essential and proven method of slowly and consistently improving the experience of the patient and developing better working relationships.

Action Not Just Words

The key to making small and continuous improvements in practice is having the courage and opportunity to question the way things are currently done.

> *"The real key to making significant improvements is not in an organisation's ability to solve its problems; it is the ability to see its problems."*

Once issues are identified, people need to feel that it is safe to constructively criticise existing practice. This is hard to do as the common response is to defend what is done now.

So that issues do not become confrontational, the goal should not be to solve all the problems in one go. Try to find consensus on a particular issue that everyone agrees on and act on it. No matter how small, this will start to gain momentum and the trust of everyone concerned.

This is an important principle that can quickly become part of the culture of a team or department. In order to find consensus you must talk to people openly and honestly in a supporting way and regularly check back with them that you all agree on the same thing.

This process is equally relevant for the relationship with the patient, their family and carers. It is a method of engaging with people so that they can be involved and share decision making. It is based on a simple test; that what was intended to be communicated is the same as what was understood.

> The last product of communication is Agreement

This does not mean that everyone has to agree intellectually with everything that has been communicated, but they do have to agree that what was said was understood.

Communication Audits

There are a number of communication audit tools available on the internet that can be found from a simple search. They are usually designed to meet a specific local need or subject of inquiry but are fairly straight forward to adapt.

The following audit tool was developed as an exercise for working teams to identify broad areas of weakness in local communication practice.

The statements are like goals that reflect good practice and, subject to a little consensus across the team, small scale improvement projects can be designed to help achieve the goal.

Communication Audit Tool

Aim to Reduce Anxiety:

☐ There is a consistent use of language and terminology across the whole clinical team and acronyms are avoided

☐ The patient experience leads the drive for improvement rather than other performance indicators

☐ Consideration is always given to how and when to communicate and then what information to give

☐ There is a clear process of escalation where needs and circumstances are becoming more complex

Recognise Cultural Differences:

☐ Ethnicity, gender, sexuality, geography, economics, social history and family structure are taken into consideration

☐ Literature is always designed to reduce the apparent complexity of health and social care system

☐ Non clinical information is communicated every time for every patient at formal handovers

☐ The patient's own language is used on reports and assessments to emphasise important issues

Overcome Operational Issues:

☐ Practitioners responsible for communicating are trained with the appropriate level of knowledge and skill

☐ Practical options are in place to provide information at all times of day throughout the episode of care

☐ Communication and supporting literature is designed to meet the needs of elective and emergency pathways

☐ Documentation is shared professionally at every opportunity and checked back with the patient

Take Personal Accountability:

☐ Communicating continuously without having to be asked is a core duty, so the patient plays an active role

☐ Staff take personal responsibility to act on information and the wishes of the patient as their advocate

☐ Standard literature and information is supplemented to meet the needs of each individual

☐ New technologies and methods are used to trigger active engagement and enable effective communication

Chapter 3

Assessing the Whole Person

Assessing the Whole Person

Chapter Overview

This Chapter will show the importance of assessing the person from a number of perspectives in order that their needs can be understood and planned for. To make discharge safe and effective for everyone will require a great deal of skill and expertise on behalf every Practitioner involved.

People who are admitted to hospital have such a broad range of needs. They could receive care for less than four hours in an A&E, or more than four months in a community hospital. In such diverse circumstances a person centred approach to assessment is required to ensure that individual needs are met. In truth, most Practitioners can assess most of the people who require our services.

The '4Ps' and the 'Daily RAP' are tools described in the Chapter that will help Practitioners to complete the assessment process and build confidence and expertise. If they are undertaken consistently, they will inform and enhance the care delivery process contributing ultimately to a smooth discharge. Over time, this will mean less reliance upon the Discharge Liaison Nurse and other specialist Practitioners. Assessments done well will help to plan for discharge, and where appropriate take remedial action to resolve issues and problems at an early stage.

Finally, discharge is a multidisciplinary process driven by team working, however rather than this being an opportunity to rely on others to facilitate the discharge, it emphasises personal accountability.

Working With Whole People

This Chapter re-visits many of the tried and tested assessment and discharge planning processes that are routinely used by Health and Social Care Practitioners. It suggests how to get the best out of these talents.

When a person is admitted to hospital, Practitioners must quite rightly focus on immediate clinical issues. However, prompt consideration of the individual as a 'whole person' is required to ensure that optimum recovery is possible and that the return home, or transfer to ongoing care, is safe.

> *"A patient is the most important person in our hospital. He is not an interruption to our work. He is the purpose of it. He is not an outsider in our hospital. He is a part of it. We are not doing him a favour by serving him, he is doing us a favour by giving us an opportunity to do so."*

Admission to hospital is an unpleasant disruption to people's normal lives. Professional priorities should focus on supporting timely return to the previous, or a new, equilibrium.

Assessment for Discharge, what is it?

Discharge planning has become a priority for the NHS and its partner organisations, with increasing requirements to demonstrate improvements in their assessment and planning processes.

The purpose of assessment is to evaluate the effect of an individual's presented need on their independence, daily functioning and quality of life, so that appropriate action can be planned.

National Assembly for Wales Circular 2005/17 states that:

"An assessment of the patient's needs by the care co-ordinator to determine actual or potential problems begins on admission or even pre-admission wherever possible. This enables continuity and co-ordination of health care on discharge."

Assessment is a continuous process that commences in the community where early proactive intervention can avoid the need for an emergency admission, or aid prompt discharge following an elective procedure. It must include the individual, their family and carers and is a process made up of several key interlinked components:

- Person Centeredness
- Early Planning
- Communicating Effectively
- Continuity of Care
- Assessing & Managing Risk

"People may not say it out loud, but hospital is frightening. I'm a grown man and it made me feel like being a kid again; not quite sure where I am or what's going to happen next ... and when can I go home?"

Person Centred Approach

Health and Social Care Practitioners must recognise that the individual and their carers are the "experts" in how they feel. Furthermore, some individuals and carers also gain expertise in living with or caring for someone with a particular long term condition.

National Assembly for Wales WHC 2002/32 states that:

"The Practitioner needs to achieve a person centred approach to assessment where the patient is an active partner. The assessment should be proportionate to need with family and carers involved as appropriate."

It is essential that any assessment and care planning process continually engages the individual and their carers and provides information in a way that helps them.

The benefits for the **Person** of effective assessment and discharge planning include:

- Understanding how the person's situation has arisen to identify and meet their needs
- Maximising independence by feeling part of the care process, to really understand and sign up to the ongoing care plan
- Experiencing care as a seamless journey not a series of unrelated activities
- Believing they have been supported and have made the right decisions about their future

The benefits for the **Carer** of effective assessment and discharge planning include:

- Feeling valued as partners in the process
- Having their contribution recognised and not taken for granted
- Being aware of their rights to have their needs identified and met

- Feeling confident about support in their continual role and getting support before it becomes a problem

More information and the rationale for Person Centred Care can be found in the National Service Framework for Older People in Wales (Welsh Assembly Government, 2006).

Estimated or Predicted Date of Discharge

Creating this joint working relationship will facilitate the setting of a predicted or estimated date of discharge (EDD).

Department of Health toolkit published in 2004 states that:

"The Estimated Date of Discharge will be proactively managed against the treatment plan, usually by the ward staff on a daily basis and changes communicated to the patient. This is vital for the patient to understand how long they are likely to be in hospital to plan for their return home."

The 'Guide to Good Practice: Emergency Care' produced by Innovations in Care (IiC) Team in 2004 and available from NLIAH, describes the use of EDD also referred to as PDD in some areas, as follows:

"EDD is based on the expected time required for tests and interventions to be completed, the integrated care pathway and the time it is likely to take for the patient to be medically/ clinically stable and fit for discharge. Decisions regarding discharge should involve patients and carers and be made following senior assessment on admission. The expected date of discharge should be documented in the patient notes/record and care plan.

Predicting Length of Stay or Planned Discharge Date:

The prediction of Length of Stay for patients enables an organisation to ensure that patients are progressing through their care pathway at a predetermined rate. This should be based upon best clinical practice and ensuring that patients progress in a structured manner through the value steps with the minimum of waits, mistakes and other wasteful inhibitors.

There are a number of ways in which predicting length of stay can be undertaken. It can be based on the actual current performance using:

- ICD 10 codes
- Health Resource Group (HRG)
- Sub specialty information systems

It can be based on benchmarked information:

- National Audit Office: Acute Hospital Portfolio www.audit-commission.gov.uk
- CHKS data subscribed bench mark information: CASPE Healthcare Knowledge Systems Limited

It is important that organisations understand the system, which will give them a predicted length of stay for each patient admitted to hospital, emergency cases as well as elective cases. The process for predicting this length of stay has to be both valid and sustainable."

Planning Assessment for Discharge

Using the person centred approach, the admitting nurse needs to identify whether the patient's discharge is likely to be simple or complex.

A method of making this decision is described within the 'The Knowledge Barometer' at the start of this Guide. In addition, if it is suspected that the patient lacks mental capacity, a further assessment is required as described in 'The Mental Capacity Act' section of Chapter 5.

The following definitions of simple and complex discharge are taken from the IiC 'Guide to Good Practice: Emergency Care':

"Simple discharge:
Patients with simple discharge needs make up about 80% of all discharges and are defined as patient who will usually be discharged to their own place of residence, or who have simple ongoing care needs not requiring complex care planning and delivery. The level of on going care required is the important factor in the relative complexity of the discharge process.

Complex discharges:
Occur where the length of stay is difficult to predict, where patients are likely to have complex on going health and social care needs requiring detailed assessment, planning and delivery by multi-professionals and multi-agency teams.

The timely assessment process commenced on admission will identify those patients who will potentially have complex discharge needs and facilitate further comprehensive assessment and planning."

Staff such as Discharge Liaison Nurses or Care Coordinator will be able to provide you with specialist advice and support with complex cases.

The function of assessment Heartfield [1996] and Allen [1998] can be summarised as follows:

- To ascertain patient, family and friends potential needs
- To provide information on which to plan interventions and thus to achieve appropriate outcome
- To document and record the relevant areas assessed, to act as a baseline for reassessment and evaluation of care given
- To act as an instrument for safety, continuity and quality of patient care
- To facilitate the structuring of knowledge for nursing practice
- To fulfil legal and professional obligations

"It is vital that Practitioners do not prejudge the eventual outcomes for the patient prior to completing the whole person assessment."

The patient has the right to be given every opportunity to meet their optimum potential, for example through rehabilitation and to have full access to the range of services for which they are eligible.

Communicating during assessment

At the heart of coordinating and planning discharge is:

- the ability to communicate accurate information from the patients and carers perspective and to ensure that their views are conveyed and understood
- the ability to share the relevant assessment information between the professionals involved in the patient's episode of care
- the ability to provide feedback to the patient, their family and carers in a way that they can understand

In order to ensure the patient receives appropriate care at home or in their new care environment further coordination with the following agencies may be required:

- GP/Practice Nurse
- District Nurse Service
- Specialist Chronic Conditions Management Teams
- Community Mental Health Teams
- Social Services
- Local Authority or Voluntary Sector Housing
- Intermediate Care Services
- Voluntary Agencies providing 'low intensity support' eg Hospital Discharge or Good Neighbour Schemes
- Care homes and independent domiciliary care providers

"Careful talk saves lives"

Coordinated, safe and timely discharge planning is based on professionals working together with the individual to develop shared outcomes and an agreed plan of care. A lack of communication and compatibility of assessments can result in a domino effect for people with complex needs:

- undergoing multiple assessments
- uncoordinated and premature discharge
- result in the patient being poorly prepared
- discharge with needs unidentified and unmet
- increased risk of readmission

The following is an example of what can go wrong if we don't all work together. It is taken from 'You can take him home now; carers' experiences of hospital discharge' (2001):

"*Admitted by ambulance to A&E, 21 February. A few tests. Go home, take antibiotics. Next day, GP visited, called 999, readmitted. Discharged 3 March contrary to my wishes. Ambulance again to go to A&E. Longer stay and recuperation at local cottage hospital. Home 25 March. 21 May during routine check up at surgery, ambulance called to go to A&E. Discharged too soon, on 4 June. On 7 June called 999 again, back on oxygen on the way to hospital. This went on until I learned about the hospital discharge drill at my carers' forum. I refused to take her home. After the right discharge procedure, help was arranged at home, the patient improved much more quickly and a better recovery than ever before.*"

Managing Medication

This is a common area where miscommunication can directly lead to an adverse effect on the patient's condition.

A typical scenario is where the patient is admitted with one set of prescribed medication, which is changed during their hospital stay.

It is vital that these changes are properly communicated to the patient, their family and carers and that the new routine is fully understood. There are a number of high profile cases where failure to do so has led to catastrophic results.

A relevant case study has been included later in this chapter.

Continuity of assessment

In undertaking individualised assessment it is recommended that professionals consider the '4Ps' principle:

1 Previous   The patient's general circumstances, lifestyle and events leading up to the admission

2 Present   The patient's current condition and how they are dealing with the changes

3 Predict   The factors likely to impact on completing a successful discharge for this patient

4 Prevent   The actions required to overcome problems and prepare the patient for discharge

Creating an individualised assessment is the best way to fully understand the patient. It is more than answering a set of predetermined questions and is therefore, difficult to complete in one go.

Whereas a great deal of information can be gathered at the first assessment, building a picture of the whole person will require an ongoing approach. Over time, the picture will gain additional detail and should reflect changes in the patient's circumstances or condition.

Using the analogy of passing a baton, imagine the day of discharge is like the Olympic Final of a Relay Race. To successfully carry the baton across the finish line in a good time, each team of athletes must work as a single seamless system. In athletics, a good performance on the day is achieved through relentless preparation and developing the necessary skills and tactics.

Using the '4Ps' is like developing the race tactics. It requires an in-depth understanding of physical and emotional strengths and weaknesses, deciding in advance how to run the race on the day and taking responsibility to maximise the chances of success by putting the plan into practice. Think of it as all the things you need to know, to produce your best performance.

The table below contains a sample of simple questions under the '4Ps' that should form part of an individualised assessment. The things you need to know! The lists are not exhaustive and in practice the questions must be relevant to the individual.

The table has been formatted with extra space so that Practitioners' can add in any additional questions that are particularly relevant to their own area of practice.

Principle	Example questions
PREVIOUS What were the circumstances prior to admission?	Do they live alone? What was their mobility status? Do they sleep upstairs? Are there stair rails in the home? Is there a toilet downstairs? Are there carers at home or close by? Are they a carer? Do they have any pets? Do they self medicate? Can they cook for themselves? What was the contact with health and social care prior to admission? Were they deemed to have capacity to make choices and decisions? Is their ability and safety awareness consistent? How do they feel they are coping in their usual situation? Is their admission for a new condition or was it an exacerbation of an existing problem?

3.14

Principle	Example questions
PRESENT What has happened now to cause admission?	What is mobility status?
	Do they need help with washing and dressing?
	What is wound status?
	Can they still self medicate?
	Have they fallen and if so why?
	Has there been any change in mental capacity?
	Has nutritional risk been formally assessed?
	If the patient has a long term condition that has been jointly managed with secondary care – is that consultant aware that the patient has been admitted?

Principle	Example questions
PREDICT Identify risk factors that impact on discharge	How will they manage stairs? How will they manage shopping? How will they prepare meals? Will they need assistance with food preparation/eating? Are there environmental factors to cause falls? Will they be able to self medicate? What is the expected level of recovery compared to before? Is any support required likely to be for the short or long term? Is any deterioration in mental capacity likely to be short-term (e.g. resulting from infection) or longer-term (e.g. diagnosis of dementia)?

3.16

Principle	Example questions
PREVENTION Act to minimise risk on discharge	Have appropriate referrals been made?
	Has assistive technology been considered?
	Adaptations or equipment arranged?
	Have nutritional needs been met?
	Carer assessment completed?
	Care plan agreed & communicated?
	Has the multidisciplinary team fulfilled its obligations under the Mental Capacity Act?

'4Ps' in Practice

"Mr Thomas is an 82 year old widowed gentleman, admitted following a fall. He sustained a fractured neck of femur and has undergone surgery."

Previous

What were his circumstances before admission?

Mr Thomas normally lives alone in a three-bedroom terraced house, that was home to his family and which he does not want to leave. He has a son who lives away and a daughter who lives locally and provides informal support whilst balancing a full-time job and family of her own. Until now, Mr Thomas has been fiercely independent, and has continued to sleep and use the bathroom upstairs, even though he has experienced increasing difficulty managing the stairs. He exercises regularly with his small terrier dog and normally does his own shopping. His only previous contact with health and social care services has been with his GP surgery. He is on medication for his arthritis and carries a GTN spray for occasional angina. There is no indication that Mr Thomas lacks the mental capacity to make his own choices.

Present

What has happened to cause hospital admission?

Mr Thomas slipped on an icy path whilst walking his dog. His wound is healing well following surgery on his fractured femur and his pain is well-controlled, but he is frustrated by being in hospital. He is able to wash with a bowl at his bedside, but his mobility is severely limited and he needs assistance to shower and go to the toilet. He has become quiet and withdrawn and has

confided to his nurse that he is worried about his ability to keep his beloved dog and about being a burden to his family. He has become increasingly withdrawn and is not eating well.

Predict

Identify risk factors impacting on discharge:

Physically, Mr Thomas was in reasonable good health prior to his fall and was able to cope in his own environment. His ability to cope on discharge will depend on his level of recovery and his motivation. It is evident that the incident has been a great shock to him and he is anxious about his future. In order to achieve the best possible outcome for Mr Thomas, health and social care staff will need to work together in a timely fashion to restore his confidence, to promote his independence and to prevent a downward spiral of depression and increasing physical vulnerability.

The exact risk on discharge is therefore difficult to predict prior to rehabilitation. However, the early assessment information will have alerted Practitioners to the fact that this could be a complex discharge and that the following areas will need discussion and planning:

- The bedroom and toilet are upstairs and even if a reasonably full recovery is achieved, managing the stairs will continue to be problematic. To prevent further risk of falls Mr Thomas, his family and the MDT could consider fitting a stair lift or stair rails or moving sleeping and bathroom arrangements downstairs. Although this must be balanced with the need to maintain activity and increase strength
- Mr Thomas is likely to require support, in the short term at least, with shopping, meal preparation, fetching prescriptions etc
- His dog is an important part of his life and consideration will need to be given as how he can continue to manage to exercise or care for him

Prevent

Minimise risks on discharge:

In order to maximise Mr Thomas's potential for recovery and continued independence, it will be essential to commence rehabilitation as soon as he is medically fit to do so. Timely referral to the MDT will help to address his anxieties regarding resumption of his life at home.

Possible care options to minimise risk on discharge, whilst abiding by Mr Thomas's choices and desire for independence include:

- Adaptations either to enable him to continue to use his upstairs rooms or to bring the facilities onto the ground floor
- Comprehensive assessment of home environment for falls risks
- Support from the intermediate care Reablement Team to restore confidence and continue rehabilitation post discharge
- Assistive technology, including personal alarm and falls detection
- Social care package if required for ongoing assistance with personal care
- Informal support from daughter with shopping etc subject to carers assessment if desired
- Voluntary agency support eg to exercise dog
- Day hospital follow up

Impact of '4Ps'

'4Ps' is an aide memoir that enables you to gradually build a holistic picture of the individual's unique circumstances.

This information will directly inform the discharge planning process ensuring that issues are identified and acted upon in a timely way.

"All clinical areas have some form of admission documentation does yours comply with the 4P's Principle?"

Early identification of a potentially complex discharge can trigger the Unified Assessment and Care Management Process.

'4Ps' will help to manage this process and ensure that the subsequent assessments are carried out at the appropriate stage of treatment and recovery, when the patient's needs, can be accurately assessed.

If transferred either to another ward or hospital, for example for rehabilitation, the same information collated to produce the assessment must be shared with the receiving area or professional to avoid duplication.

Some organisations have developed Integrated Care Pathways that include a framework for discharge planning to assist in ensuring the appropriate steps are taken in a timely fashion.

Assessment information might also indicate the need to commence other pathways which should be actioned by the MDT and linked into care planning and the discharge process.

Assessment & Management of Risk

Identification and management of risk is central to any decision making that surrounds care planning and future care options.

When managing risk in relation to hospital discharge consideration should be given to four factors:

Health & Safety

- Risk to the person's health and safety – consider risk of falls, self harm, ability to manage medication
- Risk to the safety of others – consider safety awareness and behaviour, consider manual handling, behaviour, home environment
- Clinical risks; communication to ensure clarity and accuracy of take home medication & prescription, robust communication of treatment plans to primary or intermediate care services and follow up appointments

Ability to Carry out Daily Routine:
- Physical mobility
- Ability to carry out daily living tasks safely for self and for others
- Requirement for supporting equipment

Capacity for Involvement:
- Strength of social network
- Relationships with family friends
- Work related issues

Autonomy:
- Does the individual have the capacity to make choices and decisions?
- Can they make their wishes and views known, make choices, or do they need help to do so? Does the person have the skills and equipment to be as independent as possible?
- What is their level of self-motivation and initiation?

Risk Record

Relevant evidence needs to be gathered and documented to identify risks in order to reduce or alleviate them and therefore further consideration should be given to:

- Timescale
- Likelihood and Consequence
- Severity and Impact
- Intensity and Complexity

The assessment of the presenting needs and circumstances of people in hospital must involve patients in a meaningful way. Where patients cannot represent themselves, the next of kin, carers, relatives or an advocate must be involved.

Independent advocates may enable views different from the carers to be heard. They can help the patient understand the process, explain the choices and act as intermediaries when conflicts of opinion arise.

Whilst the value of independent advocacy is recognised within the National Service Framework for Older People, such services are not universally provided. Further information can be obtained from www.accymru.org.uk.

"As professionals we are bound to act in the patient's best interests. In your experience have patients been persuaded to enter long-term care as a result of clinical 'risk-aversion'? Is this acting in their best interests?"

The construction and negotiation of risk management requires multidisciplinary team involvement in order to ensure that all the different perspectives are considered and that a way forward is agreed between all those concerned.

The effective management of risk is an obligation throughout all aspects of health and social care work. Specific areas of risk encountered when planning for discharge include:

Medicines Management

A significant risk associated with medicines is mainly due to the potential for error in the information transfer process between the hospital and the new care setting or home.

Risk can be exacerbated by:

- Omissions and errors on the discharge summaries from the hospital
- Delays in the hospital sending the discharge summary to the GP practice
- Delays in acting on discharge information at a practice
- Patients being unclear or ill-informed about their new medicine regimen once they're discharged for example, patients using previous medications as well as new medicines to take away

Failure to manage these risks can result in patient harm and readmission, as highlighted in the following case study:

"District Nurse received a referral to visit and assess a patient who had been discharged from the local hospital. On arrival the family expressed concern that the patient was very drowsy and was difficult to manage. Further questioning resulted in the family producing a large bag of medication which had been prescribed on discharge. As well as the "usual tablets" being offered for examination! It soon became apparent that the patient was taking Nitrazepam and Mogadon and Diazepam and Valium as well as a cocktail of other drugs. The patient and family had understood when and how to take the tablets prescribed by the consultant and were concordant. However, unfortunately they also did not want to offend their long standing GP and were also continuing to take the tablets he had been prescribing for sometime. Diplomacy and communication skills were required to unravel the situation, ensure patient safety and maintain trust and clinical relationships."

Equipment provision

Identified equipment needs to be in place in time for discharge and in full working order. This may involve checking that previously provided equipment remains appropriate and safe to use. Users, including the patient, their informal carers and professionals from health and social care, need to be trained in the use of any new equipment, prior to discharge.

Assistive technology products such as community alarms, falls detectors, pressure pads, gas alerts, can also form a vital part of a care package aimed at maintaining independence in a person's own home. They are provided subject to professional assessment,

installation and maintenance and may involve some cost to the individual – so you will need to factor in time for planning prior to discharge.

Accommodation Issues

Ensure there is safe access to the property with consideration to environmental factors such as outside steps and obstructions.

Ensure ability to manage stairs if required, access to toilet and bedroom, ability to use the phone, location of property and ability to access facilities such as transport.

Also check that home security is attended to and access is properly organised for example, that they have keys to get in to the house.

Discharge of Homeless People

Guidance is currently under development which will assist agencies when a homeless person, or person from a specific vulnerable group at risk of moving frequently, is discharged from a hospital setting. The guidance will aim to provide a joined up approach from health and housing to ensure that a patient is not discharged to an unsafe environment, insecure housing or homelessness.

From this guidance, a working example of a protocol will be developed which might then be tailored for local use. It is expected that the protocol will be piloted in different areas in Wales and re-drafted as necessary. There will be the usual external consultation on the guidance.

Key issues to consider in preventing inappropriate discharge are:

- Working in partnership with the person so that they are empowered through joint decision making; are less likely to self-discharge and are not unduly anxious about losing their accommodation while in hospital
- Identifying a patient at risk of insecure housing or homelessness on admission to hospital
- Planning for discharge from the time of admission, not at the time of discharge
- Training on homelessness issues for health staff
- Identifying a link nurse in Emergency Care Units to promote liaison between health and other agencies
- Robust links in place between health services and housing or homelessness services for ease of joint planning and service provision
- Liaison with key health professionals previously involved with a patient's care before discharge so that follow-up is seamless. This is particularly important if the person is discharged to a hostel setting or other temporary accommodation, so that they are not lost to follow up
- Having a directory of services available to support a person leaving hospital, for example access to drug and alcohol services

It is not acceptable to simply discharge a homeless person with instructions to attend their local housing office. Adequate provision must be in place for someone recovering from a hospital admission. If the measures detailed above are implemented, it will help prevent the following type of scenarios.

"A young homeless man, living on the streets, was admitted to hospital following a knife assault. His abdominal wounds were stitched up and when he was ready for discharge he gave a friend's address where he was to stay. After a few days the sofa-surfing arrangement with his friend broke down and he was back living rough. Although the wound needed checking, follow up was difficult as he had no GP and no secure address."

"A young homeless man, previously detained under the Mental Health Act (1983) was due to be discharged in the near future. He took his own discharge before there was time to arrange any community follow up. This resulted in him having no accommodation to go to, no prescription for his medicines and no plan to manage his on-going mental health needs in place. He was planning to rough sleep but was found by a homelessness worker in a confused state that evening."

Care & Support

Ensure that the person has the appropriate level and type of support to maintain their safety on discharge. This will require timely referrals being made to community services taking account of service response times and availability, for example, district nurses, community psychiatric nurses, social services, information to GP.

In order for the discharge to be safe contingencies must be in place where services are unable to respond at the appropriate time – it should not be assumed that families and friends can and will fill any gaps.

Needs of the Carer

Where informal carers are being asked, or offering, to provide support ensure that they fully understand what this will entail and are willing and able to provide the support.

It should never be assumed that the carer is able or willing to continue or assume the role. As part of the assessment process it is essential to consider:

- What was the previous situation regarding the provision of informal care (who, how, when)?
- Was it working well for both parties?
- Has anything changed eg has the patient's condition deteriorated or have the physical, emotional or social circumstances of the carer changed?
- Does the carer clearly understand the responsibilities they are taking on?

Carers should be offered an assessment by a social worker in order to identify their needs as a carer and to see what support they can be offered to fulfil this role.

Further information for carers, including the document "Looking after someone: a guide to carers' rights & benefits 2007/2008" can be accessed from Carers UK at www.carersuk.org or telephone 0808 8087777.

There may also be a local carers group and Discharge Liaison Nurses or Social Work Teams that will be able to provide contact details. The following are examples of bad and good carer experiences, taken from the Carers Association document "You can take him home now" (2001):

> *A poor experience; "My father-in-law is aged and lives alone. He was discharged from hospital despite being in pain and still bleeding. I am his sole carer but I also care for my own mother. I was told that even if I refused to look after him he would still be discharged because a) they wanted the bed, b) they felt there was nothing more they could do, c) of course you must realise how short of money we are."*

> *A good experience; "The experience was brilliant. I attended a meeting of nurses, OTs and social services at the hospital where a care plan for my wife's return was agreed, plus home visits. She was not discharged until the complete plan was in place."*

Social Network

To avoid the risk of isolation, ensure that the patient is enabled to continue links with their social network: family, friends, regular visitors and neighbours etc.

Nutritional needs

Adequate nutrition is an essential part of recovery. If the patient can prepare food themselves, ensure that they can, for example, access the kitchen, reach into the fridge, open jars or tins and use a kettle. Are they able to go shopping or get help provided by family, friends or carers?

For those people who have been assessed as not being able to reliably prepare their own meals, appropriate support services such as Meals on Wheels must be provided.

Given that food supplements can be prescribed in the same way as medication, instructions may be included on the discharge summary for the GP to action. This must be managed appropriately on discharge to ensure continuity. Whilst as an inpatient, food supplements may be appropriate, every effort should be made to return to a normal diet.

Care Coordination

The role of the Care Coordinator is pivotal to ensuring continuity and consistency in the assessment and care planning process.

The Care Coordinator during a hospital admission will often be a named or lead nurse, but this does not have to be the case. The role can be undertaken by the professional with the largest contribution to the discharge process. This could also therefore be a Discharge Liaison Nurse, Social Worker, Physiotherapist, Occupational Therapist or other allied health professional.

The person acting as Care Coordinator can change as the patient progresses through the journey of care.

Some patients will already have a community-based Care Coordinator, such as a social worker or specialist Chronic Condition Nurse, who should be involved in providing information and support to the patient and hospital team throughout the individual's care pathway.

In some cases it may be appropriate that they continue to be the Care Coordinator during an inpatient episode of care, particularly for short or planned admissions. It is important on admission and discharge that the role of Care Coordinator is clarified and passed on where necessary.

The Care Coordinator should act as the patient's guide, ensuring timely referrals and completing the detailed arrangements for transfer or discharge.

Even though all members of the MDT do not work over seven days, effective communication and continuity is essential to ensure that progress is maintained.

"Effective shift handover procedures must be implemented so that the Practitioner can safely pass the baton for continued discharge planning."

The challenge for the ward staff is to ensure that discharge planning is a coordinated and proactive seven day a week process in which, the ward team understand how to involve the patient and their carer in care decisions.

The Department of Health Toolkit published in 2004 states:

"Patients need to sense they are moving forward and feel involved in all decisions about their clinical, rehabilitative and social care needs and carers feel valued, supported and part of the process."

Regular multidisciplinary or multi agency team meetings should:

- Monitor the patient's plan of care and achievement of desired outcomes
- Identify any problems impacting on the expected date of discharge
- Ensure that actions are identified and attributed to members of the team

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Multidisciplinary Team Meetings

The usefulness of multidisciplinary meetings, or case conferences, often depends on how effectively they are chaired. Some organisations have already developed local guidance and supporting documentation to manage these meetings. The following handy hints will help Practitioners build their experience and confidence to chair meetings.

Case conferences in particular, can be emotive or even stressful events and care needs to be taken to ensure that issues can be properly resolved. This includes using simple techniques such as comfort breaks and using colleagues to de-escalate any tension.

Responsibilities of the Chair:

Any member of the MDT can chair the meeting, although it does require someone with sufficient knowledge and experience of the care process. Less experienced Practitioners seeking to develop their skill can chair the meetings with support from a more experienced participant.

Duties:

- Ensure sufficient time has been allocated to deal with the issues and keep the meeting focussed
- Ensure that the patient and carer's viewpoints are voiced and listened to. If they are unable, or do not wish to attend and give consent, arrange for an advocate to be present. If the Mental Capacity Act applies, make sure you comply with those requirements (see Chapter 5)
- Ensure each professional viewpoint is considered
- Ensure that the meeting follows a structured format
- Ensure that at the end of each patient discussion, a clear plan of action is evident
- Ensure each action is allocated to a specific individual

- Ensure a consensus decision is reached regarding patient treatment plans and future care arrangements
- Ensure that the MDT has considered eligibility for Continuing NHS Healthcare funding and NHS funded nursing care. Clearly document the rationale for decisions made in accordance with Welsh Health Circulars WHC (2004)54 & WHC (2004)024

Responsibilities of the Note-taker:

It is difficult to both participate and take notes during a meeting. The accurate recording and documentation of the discussion and the decisions reached is important for the communication and continuity of patient care and to support safe and timely discharge.

The notes are a formal document to demonstrate that the team has appropriately discharged its legal and professional obligations. The records should reflect the contribution of each professional and the agreed action that is determined following the multidisciplinary discussion.

Duties:

- Accurately record the contributions of each team member and the agreed actions
- Summarise the agreed actions
- Ensure that the documentation can be easily understood by individuals who were not present at the case conference
- Distribute the final document to all represented parties, including the patient, carer and advocate

Responsibilities of Professionals

A successful meeting can only be achieved if every participant is properly prepared and willing to contribute in a constructive and mutually respectful way, putting the patient's best interests first.

Duties:

- Have up to date information for all your caseload and those of your colleagues, if appropriate
- Ensure actions agreed previously have been followed through
- Ensure you have spoken with patients and their carer's and that their views are supported or represented at the case conference
- Be clear on your own actions for each patient and ensure follow through
- Ensure adequate support for colleagues new to the case conference process

A Daily RAP

If the '4Ps' can be thought of as developing the race tactics, then the 'Daily RAP' represents the day to day preparation of training for the race. Similarly the 'Daily RAP' is a physical activity that includes checking that the goals are achievable and the tactics include everything you need to know.

The 'Daily RAP' is a simple and specific face to face interaction with the patient for a few minutes everyday. It will ensure that the individualised assessment is up to date; new information can be added; and an opportunity to check that the discharge process is progressing as planned.

It requires basic observational clinical skills, an effective dialogue with the patient and carer and a personal drive to achieve the best experience for your patient.

A Daily RAP

REVIEW

- Ask the patient, "how do they feel?"
- Is the patient responding to treatment?
- How is the patient's general condition?
- Has there been any change in mental capacity?
- Is patient meeting their outcomes and goals?
- Is the expected date of discharge accurate?

ACTION

- Talk to patient and carer about progress
- Monitor and evaluate care plan
- Identify actions required to make progress
- Assessment of mental capacity if required
- Liaise with multidisciplinary team
- Review expected discharge date

PROGRESS

- Advocate on behalf of patient and carer
- Check pathway milestones are being achieved
- Chase up outstanding actions
- Check obligations under Mental Capacity Act
- Escalate problems and expedite solutions
- Update discharge checklist

Chapter 4

Individualised Care Options
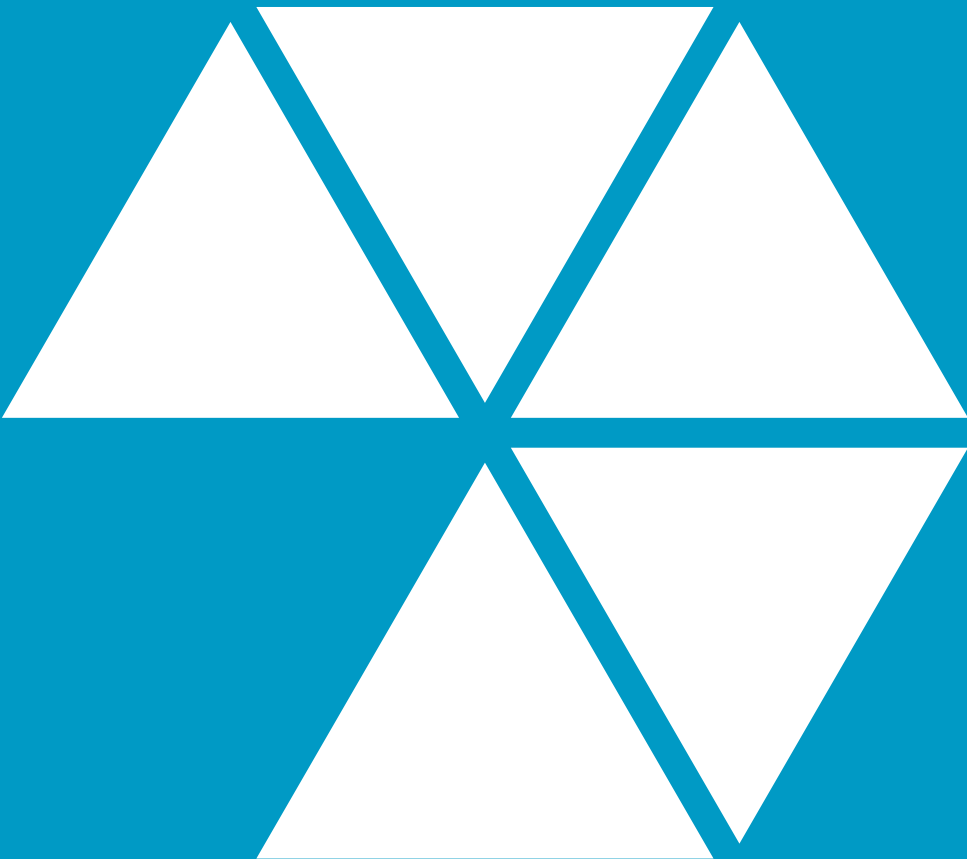
Individualised Care Options

Chapter Overview

For a person with complex needs an individualised care package can only be designed following a thorough and timely assessment of the whole person which must involve their family and carers.

Appropriate choices can only be made when there is effective dialogue and empathy with the person. Even with excellent communication skills, choices will depend upon having sufficient knowledge of the variety of local services available.

The list of locally available options must contain a description of the services, together with the eligibility criteria and potential costs, for which the person may be liable. Although discharge planning is a process, it needs to be individualised to support people to make informed choices:

- Individuals, families and carers need to understand how and when discharge arrangements are going to take place so that they can be involved in planning
- Staff need to involve other professionals across the MDT so that they have sufficient time to assess the patient and make appropriate arrangements
- Information about creative care options needs to be comprehensive, accessible and up to date. This is easier to achieve if it is centrally coordinated
- Staff and patients need to have information about eligibility criteria, referral protocols and capacity in order to be able to access alternative care options

Creating Individual Solutions

The social model of health encourages people to take accountability for their own wellbeing. However to achieve this, individuals need good information about the choices that are available to them and support from professionals on how to access them.

> *"Not everyone wants to go out to Bingo, day-care, luncheon clubs or special interest groups."*

This Chapter explores the need for discharge assessment and planning to take a much more creative approach to the development of care packages. The purpose is to tailor responses to individual needs in such a way that they are empowered to maintain their health and well-being for the longer term. This involves:

- Managing expectations
- A full range of choices
- Accessing care options
- Identifying other enablers

Care options can only be determined following a thorough assessment of need. It is important that specific care options are not discussed or considered too early in the process and that any discussions do not pre-judge the assessment process.

Managing Expectations

It is important to manage the expectations of all parties with regard to:

- The practical discharge process
- The outcomes that can be planned for
- The service options that may be available
- How and when information will be communicated
- Voicing concerns

The expectations need to be understood from the following three perspectives.

1. Individuals

Individuals must feel fully included in the discharge planning process, and to know that their pathway is planned around their specific needs.

The care plan should be shared with them and they should be encouraged to ask questions, especially if the expected care or timescales vary from the plan.

It is essential that health and social care Practitioners use the assessment process to help individuals to:

- Identify any personal risks to their health and well being
- Jointly formulate plans that minimise and manage those risks
- Have mutually transparent discussions about the realistic care options available

"Not having time is not an excuse. Five minutes spent asking the right questions now can save weeks of delay and distress for everyone."

Research has shown health and social care services can sometimes decrease independence both on admission to hospital and when providing community care. Increased dependency will have a negative impact on the individual's physical and emotional well-being.

It must be clearly communicated at an early stage that the aim of the care provided is to restore the individual to their maximum potential. This will help to manage expectations and is particularly important when the care plan includes transfer to a rehabilitation facility or intensive Reablement at home.

2. Family and Carers

As described in Chapter 3, it is essential that family members and carers are consulted with on admission and at the beginning of the assessment process. If the patient does not have mental capacity, then any further consultation will need to comply with the Mental Capacity Act, as described in Chapter 5.

Carers Groups often report that they feel frustrated that they are not listened to and that essential information such as medication administration is lost. This carries obvious risks both from a patient safety perspective and with regard to effective discharge planning.

The use of EDD as described earlier, also allows families and carers to plan ahead and be able to support the individual when they come home from hospital.

Practical examples include:

- Booking time off work to take their relative home in the morning, rather than relying on ambulance or voluntary transport later in the day
- Getting shopping in
- Making sure the home is warm

It is important not to make assumptions regarding what care and support will be provided by family members or neighbours.

"Simple checks can save distress and prevent possible readmission later."

It may be the case that a crisis in informal social support has led to the hospital admission. In which case, early identification of these issues will assist in managing the expectations of all those involved and facilitate timely discharge.

Practitioners need to explain that the service provided will be dependent on:

- Full assessment of need undertaken at an appropriate time in the individual's journey, for example following a period of rehabilitation
- Meeting appropriate eligibility criteria for service provision

"Don't forget that funding for social care is provided subject to eligibility criteria being met and is means-tested; individuals should be forewarned that this is the case."

This can be a stressful time for patients and carers that are unfamiliar with the care system:

> *"You may have to repeat information and check understanding.Written information sheets are helpful to supplement verbal dialogue but should not replace it."*

3. Practitioners

It is important that appropriate members of the MDT are involved in discharge planning as early as possible.

Some patient needs will be predictable, while others will be dependent on the impact of treatment and the recovery that takes place during the hospitals stay. Practitioners should recognise these possible changes and avoid discussing specific services options in detail, too far in advance

Patients and carers are often provided with different answers to their queries depending on which professional they speak to. This in turn leads to confusion, anxiety and loss of confidence in the health and social care system, which is a significant contributory factor of delayed transfers of care.

As increasing numbers of individuals are admitted with existing community-based support for their long term conditions, it is vital that prompt and effective communication is established in accordance with local information sharing protocols.

Professionals who may already be involved in delivering care could include:

- GP
- Practice Nurse
- District Nurse
- Specialist Nurse eg for Chronic Conditions
- Social worker
- Community-based Therapist
- Domiciliary Care Agency
- Voluntary agencies
- Consultant

If the individual has an existing Care Coordinator, they may continue to manage liaison between the other agencies involved.

If the individual has been admitted from a care home, the Registered Manager will be a key link in the assessment and care planning process. Early liaison will also help identify any issues that may impact on discharge from hospital, for example:

- Increased frailty requiring assessment for NHS-funded nursing care
- NHS Continuing Health Care funding
- Transfer to a different category of care home

"As a professional working in hospital, your ultimate aim is to get your patients well and back to their optimum level of health and independence as quickly as possible."

A Full Range of Choices

To promote independence and support individuals at home in their community, NHS Trusts, Local Authorities and Local Health Boards have developed a range of intermediate and long-term care solutions.

The table below provides some examples of the types of services that may be available in your area to support individuals to minimise and manage risks to their health and social well-being.

"It's better to ask advice about these sorts of services than miss an opportunity. Speak to your local teams."

This is not an exhaustive compendium and each locality will have a unique range of choices, some of which may be subject to means testing.

Examples of Care Options

Need	Providers	Type of support offered
Benefits and allowances	Social services, voluntary sector e.g. Citizen's Advice or Age Concern	Advice on eligibility and how to apply. Support with form filling
Direct payments	Local authorities	Receipt of direct payment of funds so that the individual can employ there own carers/create their own care package
Housing issues	Local authorities Housing associations	Advice and support on dealing with accommodation issues, including housing benefit and larger adaptations
Extra care housing schemes	Local authorities Housing associations Private sector	Provision of supported living accommodation/sheltered housing, that can be an alternative to care home placement with a comprehensive care package
Small household repairs/adaptations	Voluntary sector and local authorities	'Care and Repair'-type services. 'Man in a Van' to fit equipment essential for discharge e.g. handrails

Need	Providers	Type of support offered
Remote support at home using telecare	Social services Private sector	'Assistive technology' e.g. personal alarm systems, fall detection, dementia care packages
Homelessness	As above plus voluntary sector and LHBs Trusts	Advice and support on specific issues facing those who are homeless or at risk of becoming so Counselling, practical help. Outreach clinics/direct support
Short-term low level support checking service on discharge	Voluntary Sector	Hospital Discharge Schemes. Usually maximum of 5 days e.g. checking house is warm, shopping, organising prescriptions, help with meal preparation or light personal care
Supported Recovery and Reablement	Social Services LHBs	Intensive time-limited support (usually 6 weeks) from multi-disciplinary team

Need	Providers	Type of support offered
Intensive clinical intervention	NHS Trusts/LHBs	Rapid Response Teams to access rapid diagnostics and/or to provide specific clinical intervention e.g. IV antibiotic administration, DVT treatment Community mental health/crisis intervention teams
Clinical monitoring	NHS Trusts LHBs GPs	Telemedicine: remote supervision of vital signs etc District nurse or specialist nurse visits/ community mental health teams GP/practice nurse clinics
Practical social & emotional support for living with a chronic condition	Voluntary agencies LHBs GPs	Support groups, practical advice, and internet Expert Patient programmes Specialist nurse input Counselling
Coping with bereavement	Voluntary sector	Practical advice and emotional support

Need	Providers	Type of support offered
Nutrition and Diet	Social services Voluntary sector Domiciliary care agencies	'Meals on Wheels', Frozen meals delivery, luncheon clubs, day centres Support with shopping/ food preparation
Medication compliance	Community pharmacies Social services Domiciliary care providers	Collection/ordering and delivery of repeat prescriptions Medication reviews Advice on administration, including use of Dosette boxes etc Supervision of medication compliance as part of a care package
Help with domestic chores low level social support	Voluntary and private sector	Cleaning, "washing the nets", ironing, shopping, and gardening
Care of pets	Voluntary and private sector	Pet-sitting or fostering, dog walking etc

Access to Care Options

Across Wales, it is evident that different types of services are provided in different localities. This can cause difficulties for staff working in hospitals that receive patients from many different areas, if information about these services is not easy to access or constantly kept up to date.

Details of intermediate care services are published on most Local Health Board websites and in local directories of services. In some areas, details are also available on NHS Direct and work is in progress to create a single national database.

In the meantime, it is recommended therefore that the most useful local information is collated centrally, perhaps by the Discharge Liaison Nurses or Hospital Social Work Team. These groups of staff usually act as the key point of contact for up to date local information, including details of eligibility criteria and contact points.

Clinical Follow Up

If the patient requires ongoing clinical review following discharge from hospital, clear information must be given verbally and in writing to confirm the arrangements for this.

Clinical reviews can be undertaken in a variety of settings including:

- Outpatient clinics
- GP clinics
- Day hospitals

Information on discharge will need to include:

- Date, time and location of appointment
- Reason for appointment
- What the patient needs to bring with them for example letters, specimens, medication
- Specific instructions for any investigations
- Transport arrangements if required

The patient may need to modify their normal routine or behaviours following their stay in hospital for example:

- New diet or nutritional supplements
- Restrictions on alcohol intake
- Giving up smoking
- Undertaking an exercise plan
- Change to medication and possible effects

Furthermore, some follow up services will be arranged on discharge to be provided at the person's place of residence, such as district nursing.
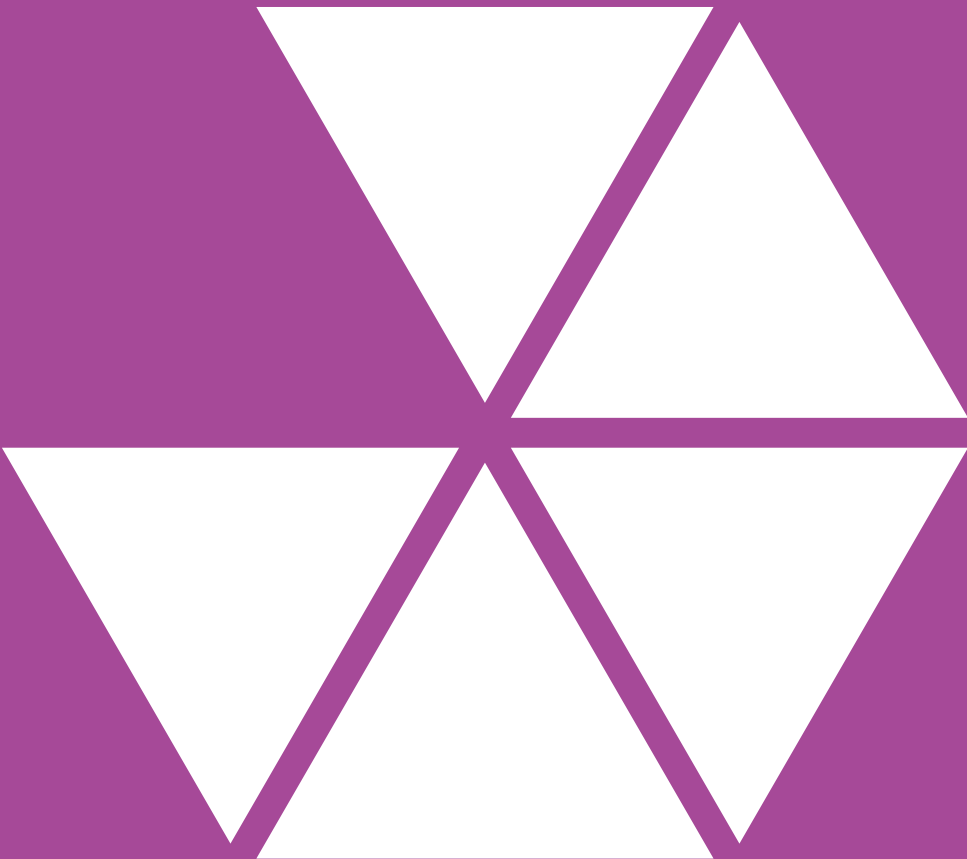
Patients, their family and carers must be provided with clear, easy to read information to take home with them, plus contact details of support services, in case of further query.

Chapter 5
Legal Issues Relating to Discharge

Legal Issues Relating to Discharge

Chapter Overview

Managing legal responsibility is a complicated area of practice that can feel disconnected from the process of delivering care on a day to day basis.

> *"The legal complexities of discharge can be perceived as too difficult for all but the most experienced Practitioners."*

However, this Chapter is designed to increase Practitioners awareness of all the legal issues, so that the subject becomes less intimidating.

An important section of this Chapter discusses the protection of vulnerable people and the obligations under the Mental Capacity Act. In particular it addresses the responsibilities that all health and social care Practitioners have with regard to protecting patients and what to do when they have concerns.

Continuing NHS Health Care is currently a subject of particular significance, so there is a section that focuses on explaining and summarising the key obligations and processes within existing guidance.

Right First Time

Frontline Practitioners involved in the assessment, planning and delivery of care, may be wondering why this section is included in the Guide.

"Don't panic! We're not trying to turn you into a mini lawyer."

An increasing number of lengthy delayed discharges are being caused by legal disputes between patients, their families and the various statutory bodies.

As a general principle discharge planning has to be robust and compliant with the legal obligations of NHS and Social Care organisations, to reduce the threat of legal challenge but more importantly, to ensure that everyone's right to appropriate care is respected.

Practitioners need to be mindful of the different legal frameworks that health and social care providers are obliged to work to, for example, social care is means tested whereas healthcare is free at the point of delivery.

As the Wales Audit Office Report: 'Tackling delayed transfers of care across the whole system' (2007) states:

"The problem of delayed transfers of care often arises at the interface between health and social care services, where different budgetary and organisational accountabilities and systems can act as a barrier to whole systems working focused on the needs of the citizen."

Analysis of high profile legal cases and review by the Ombudsman tell us that many disputes could be avoided or resolved long before court, if they had been handled differently.

"If you manage and document the discharge process effectively, you hopefully won't get to this point!"

The aim of this section is to set out the key learning points which will help Practitioners spot and resolve potential disputes before they get out of hand and to give the essential information regarding:

- Human Rights
- Patient Choice
- Mental Capacity
- Protection of Vulnerable Adults
- NHS Continuing Health Care funding

Prior to exploring the legal technicalities seven essential themes have been identified to underpin good practice.

Essentials underpinning good practice

Key Essential One

Legal disputes are distressing for all concerned

Legal disputes are distressing, time consuming and costly for all concerned, but particularly for patients and their families who already have to cope with changed circumstances as a result of illness or injury. No Practitioner wants to make a difficult time even worse for the people receiving care. Appropriate professional responses can avoid the deterioration in relationships that can lead to legal dispute.

Key Essential Two

Remember the person at the centre

From the person's perspective any health event impacts on their day to day functioning for example, 'I've broken my leg and that now means I can't get to the shops'. We know that for healing to take place, the person must have rest and good nutrition but shopping would be viewed as a social care need – or would it?

Navigating the health and social care system can be complex for the Practitioners who work in it; for patients, their family and carers it can be simply baffling.

To make matters worse, delays in discharge can occur where Local Health Boards and Local Authorities are in dispute with each other over who pays for what part of a care package or placement. Such an experience can leave the patient feeling isolated, vulnerable and frustrated.

Professionals need to make sure that they provide enough information, support and advocacy to patients and carers as they navigate their way through the care system.

Chapter 2 provides further information on 'Communicating with Patients and Families'.

Key Essential Three

Communicate, Communicate, Communicate

One of the greatest causes of escalating dispute is poor communication. Communication can be poor as in 'non-existent' or poor as in 'the quality of the interaction'. This is discussed in detail in Chapter 2.

> *"Although there may be many reasons that contribute to 'non-existent' communication, are there really any excuses for such failure?"*

Hospital admission is a bewildering process and communication is an essential part of care delivery. Practitioners cannot choose to opt out, however difficult this may be at times.

Even at inevitable times of staff shortages, arrangements must be made to ensure that someone is available to deal with patient and carer queries. Practitioners should therefore endeavour to provide prompt and accurate answers and if in doubt seek the appropriate advice.

> *"Communication can be as simple as saying, I'm sorry but I don't know the answer, and taking responsibility to find out and feed back."*

At times of heightened anxiety there is always the potential for human beings to act irrationally. The frightened and frustrated relative may think they are being assertive in order to get the best deal for their loved one. This may appear to be aggressive and demanding. The rushed and tired Practitioner may feel overwrought or out of their depth. This may appear to be sharp and dismissive. It is easy to see how such situations can quickly degenerate.

Every Practitioner has a duty to ensure that information is provided in an appropriate format, is explained, and to confirm that the recipient understands what has been shared with them.

The ability to recognise and manage potential conflict comes with experience, but even the most skilled and experienced Practitioner needs to know where to find back up when things start to escalate.

Key Essential Four

Understand and Adhere to your Discharge Policy and Processes

All NHS Trusts in Wales have agreed discharge policies with their partner agencies, which include escalation processes for managing potentially problematic discharges.

> *"Make sure that you familiarise yourself with your local policy and that you know which senior manager needs to be informed when you become aware that a dispute or challenge is brewing."*

Intervention by a senior manager or member of the Executive Team at this stage may still be sufficient to resolve the situation. If not, at least the appropriate people in your organisation have been alerted and will support you through a difficult process.

There will also be local agreements between health and social care agencies regarding, for example, response times to referrals and joint arrangements for specific circumstances. If in doubt, refer to your policy or seek advice from your local expert Practitioner.

Key Essential Five

Don't Prejudge Outcomes

Part of the frustration of being a patient is the loss of a sense of personal control when professionals suddenly seem to hold a great deal of power over your future.

Disputes with patients and families can occur where Practitioners prejudge assessment outcomes. Albeit with the best of intentions patients, their family and carers can as a result, feel pressurised towards accepting discharge destinations such as a care home.

Key Essential Six

Manage Expectations From the Beginning

Patients and carers arrive in hospital with increasingly high expectations of what will be provided for them on discharge. Information is gleaned from various media sources, the internet and social contacts. However, such information may not be given in context or based on meeting specific individual needs.

Many patients and carers have described their role in discharge planning as 'playing a game where you don't know the rules'. Effective dialogue between Practitioners and the patient and carers at an early stage can help to overcome any potential mismatch in expectations.

Some areas have local Advocacy Services that will be able to provide additional support for patients and their families to engage with the discharge process.

The following example is taken from the experience of a carer at a focus group held in South Wales, whose relative was waiting for a placement in a care home of their choice. They became labelled as a 'bed blocker' and interaction with staff deteriorated.

> *"It got to the point where every day I would dread going into the ward. It was particularly bad on the days when the Consultant did his ward round. I always felt that they were cross with me that they felt I should be doing more to get Mum out of hospital. But what could I do?"*

Whatever pressure professionals are under, patients and their carers should not be made to feel that delayed discharges are their fault.

There will be a locally agreed 'Choice Policy' that needs to be adhered to. Practitioners must work together to provide patients and carers the information they need, verbal and written, so that they can comply.

> *"Respect people's rights and you can reasonably expect them to accept their responsibilities."*

Key Essential Seven

Document and Communicate Individualised and Rationalised Decisions

Many disputes for example, regarding NHS Continuing Health Care funding, are upheld because the multidisciplinary team has failed to demonstrate that they have undertaken a full and fair assessment or failed to record the rationale upon which decisions have been made.

Discharge decision making for patients with complex care needs must, as a rule:

- Be undertaken in partnership with the patient and their carers
- Follow a comprehensive multidisciplinary assessment
- Be discussed at a case conference with all relevant parties present and all risks identified, discussed and a plan for managing them agreed
- Be documented on the appropriate Decision Making Record
- Be communicated appropriately and explained verbally and in writing. For example, copies of the Summary Assessment, notes of case conference and Decision Making Record to be provided to patient, care co-ordinator and care home if applicable

"Don't forget! Always ascertain mental capacity when you seek patient consent for any action or information sharing."

Human Rights Legislation

The Human Rights Act was passed in 1998. Its purpose is to support a culture of respect for everyone's human rights – making them a feature of everyday life. Principles such as dignity, equality, respect, fairness and autonomy are used by individuals and groups to negotiate improved public services and by public service providers to improve the quality of their services.

The Human Rights Act underpins the interpretation of all other legal obligations of NHS and Social Care organisations. Human Rights principles can be used to promote better care for individuals in their day to day living.

Rights protected by the Human Rights Act

All the Human Rights Act Articles are listed in the reference section with the core rights in respect to discharge planning listed below:

- The right to life (Article 2)
- The right not to be tortured or treated in an inhuman or degrading way (Article 3)
- The right to liberty (Article 5)
- The right to respect for private and family life, home and correspondence (Article 8)
- The right not to be discriminated against in relation to any of the rights contained in the European Convention (Article 14)

The following three case studies are taken from 'The Human Rights Act – Changing Lives' – The British Institute of Human Rights:

Case Study 1

"Older couple split up by local authority after 65 years of marriage. A husband and wife had lived together for over 65 years. He was unable to walk unaided and relied on his wife to help him move around. She was blind and used her husband as her eyes. They were separated after he fell ill and was moved into a residential care home. She asked to come with him but was told by the local authority that she did not fit the criteria. Speaking to the media, she said "We have never been separated in all our years and for it to happen now, when we need each other so much, is so upsetting. I am lost without him – we were a partnership." A public campaign launched by the family, supported by the media and various human rights experts and older people's organisations, argued that the local authority had breached the couple's right to respect for family life (Article 8)."

Outcome

The authority agreed to reverse its decision and offered the wife a subsidised place so that she could join her husband in the care home.

Case Study 2

"An older woman was staying in hospital following a number of strokes. She had been interned as a Japanese prisoner of war during the Second World War and suffered a range of trauma related mental health problems. She was observed re-enacting various behaviours from this period including washing her clothes with rocks and hanging them to dry on hospital fences. Against her wishes, the hospital sought to discharge her and move her into residential care on cost grounds. Her Advocate was

concerned that being in an institution was what was causing this regression. He used human rights language to argue that she should not be placed in residential care and that she be allowed to return home in accordance with her wishes."

Outcome

Funding was secured to support her care at home.

Case Study 3

"A disabled woman was told by her occupational therapy department that she needed a special ('profile') bed. She was unable to leave her bed and this new arrangement would allow carers to give her bed baths. She requested a double bed so that she could continue to sleep next to her husband. The authority refused her request even though she offered to pay the difference in cost between a single and double bed. A stalemate ensued for eighteen months until the woman was advised by the disability law centre to invoke her right to respectful and private family life."

Outcome

Within three hours of putting this argument to the authority it found enough money to buy the whole of her profile double bed.

The right to respect for private and family life is not an absolute human right. Instead it is a qualified right, meaning that it may have to be interfered with in order to take account of the rights of other individuals and or the wider community. This means that financial difficulties are a relevant consideration.

However, for any interference with this right to be justified, including financial grounds, it must be lawful, necessary and proportionate. A proportionate response to a problem is one that is appropriate and not excessive in the circumstances. Other qualified rights include the right to freedom of thought, conscience and religion and freedom of expression.

Home of Choice

Paragraph 20 of the WAO report "Tackling delayed transfers of care across the whole system" (2007) states that:

> "Patient choice of a residential or nursing home remains a major cause of delayed transfers of care - while it is entirely reasonable for people to exercise choice at an extremely difficult and vulnerable time in their lives, choice issues have a significant impact across the whole system. The inconsistent management of patient choice in individual localities and across Trust areas, and confusion about how best to handle delays arising from choice, exacerbates its impact. Very high care home occupancy levels make it difficult to operate a realistic choice policy for those for whom a care home placement is the most appropriate option."

NHS Trusts and Social Services Departments are required to have in place a policy to address arrangements for the discharge of patients who are in need of long term care, 'Cypher Smith letter of February 2002'. The policy takes into account the National Assistance Act 1948 (choice of accommodation) Directions 1993 and WHC 2004/066.

The policy applies to:

- Patients for whom an agreed multidisciplinary assessment has identified that discharge from hospital is appropriate but who require residential or nursing home care. The placement may be funded by Social Services, the NHS or the patient, dependent on the outcome of clinical and financial assessments
- Patients who have identified a home of choice at which no bed is currently available
- Patients who have stated that they are unwilling for their transfer of care to occur until a bed is available in a home of their choice

5.14

- Patients for whom an interim placement has been identified which meets their assessed physical and mental health needs

The Choice Directive HSG(95)8/LAC(95)5. "NHS Responsibility for meeting Continuing Health Care Needs" states that:

"…when a patient has been assessed as needing nursing or residential placement, the patient has the right to choose (within any limits of cost and assessed needs), which home he or she moves to so long as it does not cost more than the NHS and the Local Authority Social Services would normally pay for such accommodation and care."

However, where a place in the chosen home is currently unavailable and is unlikely to be available in the near future it may be necessary for the patient transfer to another home until a place is available. The guidance also comments that where patients have been assessed as not needing NHS inpatient care, they do not have the right to occupy indefinitely an NHS bed.

Practitioners need to:

- Be aware of the guidance
- Adhere to your local choice policy and escalation procedures

Also there are alternative care options to care home placement as described in Chapter 4 and the patient must be satisfied that these have been fully explored.

Case Study

Mrs Davies is an 84 year old lady who was admitted to hospital with congestive cardiac failure (CCF). She was confused on admission and although this settled as her medical condition improved, her family reported their concern that she had been increasingly forgetful prior to admission.

Further investigation produced a diagnosis of early stages of vascular dementia. Following a suitable recovery period and completion of a Unified Assessment the MDT, with Mrs Davies and her family, agreed that she needed placement in a nursing home that is also registered for providing care to patients with dementia.

Only two homes in the area are registered to provide both nursing and dementia care. Mrs Davies and her family visited the two care homes; they liked the first but there is currently no vacancy and a substantial waiting list. They did not like the second home and are adamant that she should not go there. They have found a third nursing home which they like and which has a vacancy, but it is not registered to care for people with dementia.

The family and staff at the hospital do not feel that Mrs Davies' dementia is an issue with regards to her care and that she should go to the home of her choice, particularly as she no longer needs to be in hospital and the third home has a vacancy.

What Happens Next?

Firstly Mrs Davies must be considered as an individual person with specific needs and wants. Although she has a diagnosis of dementia there has been no questioning of her mental capacity in relation to choosing her future place of care. Under the Mental Capacity Act there is a presumption of capacity unless there is an appropriate assessment that states otherwise. Therefore, there is a duty of care to do our best to accommodate her right to choose her care home.

There is also a statutory obligation to ensure that her care home placement is able to meet her assessed need. She has congestive cardiac failure which will need careful monitoring and treatment, and which may put her at risk of further complications for example, decreased mobility, pressure sore formation and malnutrition. It is assumed that all care options have been considered and that it has been agreed that a nursing home placement, rather than community based health and social care package, is the best option for her.

Mrs Davies' confusion increases when her CCF is poorly controlled and so there is a risk that this will recur in the future. In addition, we know that dementia is a progressive disease and her needs in relation to this will increase over time.

From the social and psychological perspective it is important for Mrs Davies that she is placed close to her family and that she is in an environment in which she and they feel is comfortable and safe.

The care home that is most obviously registered to meet her needs does not currently have a vacancy and it would not be appropriate to keep Mrs Davies in hospital until a placement becomes available.

She does not wish to go to the second option, which means that the MDT, in collaboration with Mrs Davies and the care home manager, needs to decide if the third option nursing home can safely meet her needs.

As Mrs Davies' primary need is physical, it may be the case that it will be acceptable for her to transfer to the third choice nursing home, with additional advice and support for her dementia care needs from the appropriate community older people's mental health team.

> *"The Care Coordinator will need to ensure that any discussions comply with the local Choice Policy."*

If Mrs Davies is transferred to the third choice nursing home, she will need active care co-ordination to facilitate transfer to the first choice home, if she so wishes, when a place becomes available.

Throughout the process, Mrs Davies and her family will need to be kept fully informed, verbally and in writing of the discussions and progress being made.

Mental Capacity

What is it and why is it important for managing the discharge process?

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make their own decisions.

The Act sets out who can take decisions, in which situations and how they go about doing so. A Code of Practice has also been issued and this section should be read in conjunction with that Code. Web links are provided at the end of this section.

> *"Health and social care professionals have a legal duty to have regard to the Code when working with or caring for adults who may lack capacity to make their own decisions."*

In accordance with the Act, "a person who lacks capacity" means a person who lacks capacity to make a particular decision or to take a particular action for them at the time the decision or action needs to be taken. This means that capacity is decision specific so that:

- a person may lack capacity to make some decisions for him or herself, but will have capacity to make other decisions
- further, a person who lacks capacity to make a decision for him or herself at a certain time may be able to make that decision at a later stage or
- while some people may always lack capacity to make some types of decisions, others may learn new skills which enable them to gain capacity and to subsequently make decisions for themselves

5.19

Anyone assessing someone's capacity to make a decision is required to use the following two stage test of capacity:

- Does the person have an impairment of mind or brain, or is there some sort of disturbance affecting the way their mind or brain work?
- Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

In deciding whether the person is unable to make the decision, then the questions to consider are:

- Does the person have a general understanding of what decision they need to make and why?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to the decision?
- Can the person communicate their decision? In this context would the services of a professional eg a speech and language therapist, be helpful?

"The Act sets out five principles which are values that underpin the legal requirements and which should "inform" any decision making made by a health or social care professional on behalf of anyone without capacity."

These principles are explained in detail within the Code. In particular there is a "presumption of capacity" which means that it should be assumed that any adult (over 16) has full legal capacity to make decisions for themselves unless it can be shown that they lack the capacity to make the decision at the time the decision needs to be made. The principles also require

that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision making process.

In accordance with the principles, if a person lacks capacity, then actions or decisions can be made on their behalf if they are in the person's best interests. Best interest decisions are usually reached following consultation with the person who lacks capacity, other professionals, anyone previously named by the person as someone to be consulted, close relatives, friends or others who take an interest, the donee of a Lasting Power of Attorney or any deputy appointed by the Court of Protection.

The Act explains at section 4 how to work out what the best interests are of the person concerned. It sets out a check list of common factors that must always be considered by the professional concerned.

Why do you need to know about it?

The intention of the Act is to:
- Assist and support people who may lack capacity
- Discourage anyone who is involved in caring for someone who lacks capacity to be overly restrictive or controlling
- Balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves

In making any discharge decision involving any person, it is therefore fundamental to decide in the first instance whether or not that person has the capacity to decide and make choices and to determine the extent to which the person should be supported and who should be involved in making a best interests decision.

All health and social care settings should therefore have a copy of the Act and the Code of Practice on site for your reference. All professionals, such as doctors, social workers, and paid carers, must have regard to the guidance in the Code of Practice when they are supporting someone who lacks capacity.

What does it mean to you?

Any Practitioner may be required to assess whether someone has the capacity to make a particular decision. Health and Social Care bodies have been advised to develop an assessment tool and process for this purpose and to ensure that staff are trained to use it. The process and the decision must be recorded.

What does it mean to other Practitioners?

Sometimes the decision needing to be made is more serious or complex, for example when consent is needed for treatment or examination. In such decisions there may be a need for a more thorough assessment, perhaps by involving a doctor or another health care professional for example, a psychologist.

What does it mean to patients and carers?

The law expects people to be supported as far as possible to make their own decisions and assumptions must not be made about a person's capacity because of age, appearance, their behaviour or any condition they may have. If there is a reasonable belief that someone lacks capacity, their ability to make particular decisions must be assessed and they must receive all the support available to help them to make a decision. Even if the person lacks mental capacity, their wishes and opinions must be taken into account when considering what is in their best interests.

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The Act recognises that people have a right to set out some decisions in advance or let people know what they would like to happen to them if they lose the capacity to make decisions. This is called an Advance Decision. The Act also gives people the right to appoint someone else to make financial and specific health and welfare decisions for them in the future, this is called a Lasting Power of Attorney.

If a person, who lacks mental capacity to make certain important decisions, has no one else to support him/her in that decision making; for example, by way of family or friends then an Independent Mental Capacity Advocate (IMCA) must be involved in order to ensure that such decisions are made in the person's best interests.

An IMCA must be instructed, and then consulted, whenever:

- An NHS body is proposing to provide serious medical treatment
- An NHS body or local authority is proposing to arrange accommodation, or a change of accommodation in hospital, or a care home
- The person will stay in hospital longer than 28 days
- They will stay in the care home for more than 8 weeks

An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- Care reviews where no one else is available to be consulted
- Adult protection cases, whether or not family, friends or others are involved

What happens where there is a dispute about whether any action is in a person's best interests?

Reference can and should be made to the Court of Protection which has the power to determine the decision making. Before reference to the Court however, the Code expects that attempts will have be made to resolve the dispute either by mediation or some other form of alternative dispute resolution, Chapter 15 should be referred to in the case of any dispute.

Further information:

A series of information booklets are available. These can be viewed electronically and downloaded for free by going to:

www.justice.gov.uk/guidance/mca-info-booklets.htm

The Mental Capacity Act can be viewed by going to:

www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1

The Code of Practice can be viewed and downloaded for free by going to:

www.justice.gov.uk/guidance/mca-code-of-practice.htm

Protection of Vulnerable Adults

Protection of Vulnerable Adults (POVA) in the context of discharge planning

In the course of planning hospital discharge any incident relating to identification of potential or suspected abuse must be taken into account and an investigation process conducted in line with locally agreed POVA policies and procedures. Practitioners must be familiar with local policy, and know who to refer to in the first instance should it be suspected that the patient is vulnerable to abuse.

A POVA disclosure or referral may be triggered via a complaint, previous concerns expressed prior to a patient's hospital admission, or following direct observation by staff or third parties, of an incident of abuse which occurs during a stay in any care setting.

"Across Wales compliance with agreed practice has demanded ongoing multi-agency staff training programmes to sustain this cultural change which recognises the responsibilities of all."

Creating safe care or support for vulnerable people involves a holistic approach which is centred upon the needs of the cared for, or supported person. It also recognises that this will only be achieved through effective recruitment, induction, support, training and management of staff.

Background

In July 2000, WAG produced a guidance document entitled "In Safe Hands". This guidance called for the development and implementation of multi-agency policies and procedures to protect and support vulnerable adults from abuse and inappropriate care. Across Wales all agencies and organisations involved in the care, support and protection of vulnerable adults were tasked with this responsibility in order to ensure effective interagency working and high standards of care, safety and protection for vulnerable adults. This work was taken forward by four regional adult protection forums across Wales based in Dyfed Powys, North Wales, Pan Gwent and South Wales.

An update to "In Safe Hands" was issued by the Welsh Assembly Government in 2003. It contained:

- Financial guidance – general principles about managing other people's money and specific guidance for care homes and supported accommodation
- Adult protection monitoring – to adopt a consistent monitoring and reporting model
- Care Standards Inspectorate for Wales – procedure for responding to the alleged abuse of vulnerable adults in regulated settings

These requirements have been further reinforced by the 'National Service Framework for Older People in Wales' (2006) which set out a programme of action to deliver higher quality services for older people.

> *"There will be a local policy available to all Practitioners which you will be expected to adhere to. If you suspect abuse you must inform your line manager without delay."*

The Role of Adult Protection

Adult protection aims to provide the services and protective support systems to the people in our society who are deemed to be the most vulnerable. This group of people may need extra help and support in maintaining their own safety.

Although all adults can be assaulted, harmed and exploited in many ways, adults with significant disability, difficulties, frailty or ill health are particularly vulnerable to abuse due to their dependency on others. The Law Commission publication, 'Who Decides - Making decisions on behalf of mentally incapacitated adults' [1997] states the following definition that:

> "A person who is 18 years of age or over, and who is or may be in need of community care services, by reason of mental or other disability, age or illness and who is or may be unable to care for him or herself against significant harm or serious exploitation."

What is Abuse?

The term abuse can be subject to a wide interpretation. The following provide the basis from which to develop practice.

"Abuse is a violation of an individual's human and civil rights by any other person or persons" SWAP Forum Policy 2001

The charitable organisation Action on Elder Abuse, describe abuse as:

"A single or repeated act or omission, occurring within a personal or other close relationship where there is an expectation of trust, which causes harm to a vulnerable adult as defined above."

Who abuses Vulnerable Adults?

Abuse of vulnerable people has taken place across a wide variety of settings. They may be abused by their own family members, paid carers at home, in day, residential or nursing home or health settings.

They may be abused by another vulnerable adult within a service setting, such as a supported living situation, or even by strangers who target them because of their obvious vulnerability; a common feature is often that the perpetrator abuses a position of power over the vulnerable person.

Why are Vulnerable People abused?

Risk factors that increase the possibility of abuse include the social isolation of the vulnerable person, with a history of poor relationships between the abuser and the victim. Research suggests that the abusers will often have their own difficulties, mental health issues, drug, alcohol dependence etc. In care settings abuse is sometimes identified as a factor where there are inadequate staffing levels, staff are poorly trained, poorly supervised and have little support from management.

Categories of Abuse

The following categories are identified by the "In Safe Hands" guidance published in 2000:

- **Physical abuse** – includes hitting, slapping, pushing, kicking, misuse of medication, undue restraint or inappropriate sanctions
- **Sexual abuse** – includes rape and sexual assault or sexual acts to which the vulnerable adult has not or could not consent and/or was pressured into consenting
- **Psychological abuse** – includes threats of harm or abandonment, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks
- **Financial abuse** – includes theft, fraud, pressure around will, property, or inheritance, misuse or misappropriation of benefits
- **Neglect or acts of omission** – failure to access medical care or services, negligent in the face of risk-taking, failure to give prescribed medication, poor nutrition or lack of heating

What is the multi-agency process for the Protection of Vulnerable Adults?

- Anyone, anywhere who is concerned about the possible abuse or exploitation of a vulnerable adult should alert Social Services, Health or the Police to their concerns, in accordance with the local policy

- Adult abuse is everyone's business regardless of occupation, role or position

- At the point that a concern is raised it may be necessary to gather more information, identify the needs and wishes of the vulnerable person and taken any urgent action needed to keep them safe. A referral form (VA1) is usually completed as the first part of the process

- Designated Lead Managers across all agencies including POVA Co-ordinators should be listed and identified to staff as responsible for taking a lead role within the POVA process

- All processes are subject to adherence to the scales and monitoring and review procedures

- A Strategy Discussion or Strategy Meeting may need to be organised in order to plan any investigative process and to identity the roles and remit of the investigating officers. Whether the alleged abuse is a criminal act will also be clarified. If this is the case the Police take ownership of the investigation and the POVA process is then suspended until the conclusion of the criminal investigation. An action plan may also be developed in order to protect the vulnerable person from continued or potential harm. An Adult Protection Case Conference will be held at the conclusion of the investigation

Roles and Responsibilities of Key Agencies will be explicit within agreed local multi-agency policies and protocols. These will include the following agencies:

- Local Authorities
- Social Services Authorities
- Local Health Boards
- Health Providers
- General Practitioners and Primary Care
- NHS Trusts and Secondary Health Care Providers
- Private Health Care Providers
- National Public Health Services
- Care Standards Inspectorate for Wales
- Independent and Voluntary Sector
- Police Services
- National Probation Service
- Crown Prosecution Service
- Housing Support Organisations
- Victim Support Organisations
- Wales Ambulance Services NHS Trust
- Department of Work and Pensions

The POVA list

The POVA List came into force in 2004. The Department of Health operates this on behalf of England and Wales and it has two main parts:

- It establishes a list of people who have harmed a vulnerable adult or placed a vulnerable adult at risk of harm. An individual on the list is not allowed to work in a care position with vulnerable adults
- It requires employers to refer people for inclusion on the list and to make pre employment checks against the list
- If concerns have been raised regarding a qualified Health or Social Care Practitioner, there is an expectation that the claims will have been formally investigated by the relevant professional body, prior to referral to the POVA list

"Good Practice requires that vulnerable adults understand the nature and effects of the alleged abuse and the choices and possible outcomes facing them."

Case Study

"Mrs. A. aged 68 years was admitted to an acute medical ward to have Warfarin for an arterial fibrillation. She is epileptic, has frequent falls and is on medication for her blood."

At the time of discharge ward staff noted that she was becoming very anxious and seemed reluctant to return home.

The discharge liaison nurse was advised by the patient's son and his partner that they were very worried about the treatment Mrs. A. received from her husband. An allegation of both verbal and financial abuse as well as neglect in terms of supporting her management of medication was made.

It was reported that Mrs. A. who is "slow" and illiterate was under the control of her husband who managed all the financial income which he used for betting and alcohol. He had only visited his wife once whilst in hospital. There was no indication of physical abuse but blood tests in hospital indicated that Mrs. A was not taking correct dosage of medication.

The Discharge Liaison Nurse in consultation with her line manager completed a POVA VA1 referral form and Social Services co-ordinated a multi-agency strategy discussion and meeting at which the Police and Health were represented. More information was gathered from the family.

Outcome

Mrs. A. had mental capacity and did not want the Police to take any action. In putting in place a safe discharge Mrs. A. agreed to be discharged to her son's home whilst submitting an application as an individual for sheltered housing. Social work support and follow-up was agreed to monitor Mrs. A's future care and an adult protection plan agreed. The husband did not choose to oppose these plans.

Continuing NHS Health Care

"What is it?"

Welsh Health Circular (2004)54 'NHS Responsibilities for Meeting Continuing NHS Health Care Needs: Guidance 2004 states that:

> "In certain circumstances where, following a thorough assessment of needs, a person's overall health needs are judged to be so significant, the NHS will manage and pay for all the care they need. This is known as 'continuing NHS health care' status."

During 2008 WAG intend to issue a new National Framework for Continuing NHS Health Care and a Decision Making Tool, which aims to provide a more consistent approach across health and social care throughout Wales. At the time of publication of this Guide the Framework was still in its draft stage.

The new Framework will supersede the guidance issued in the Welsh Health Circulars of 2004 and 2006 that are referenced within this Guide. However, it is worth noting that the new Framework will reflect the Grogan Judgement (2005) by describing Continuing NHS Health Care as follows:

> "Where, following a thorough assessment of all needs, a person's **primary need is judged to be a health need**, responsibility for providing them with all care services they are assessed as requiring, including, wherever appropriate, care home accommodation, will rest with the NHS in accordance with sections 1 and 3 of the NHS (Wales) Act 2006."

Why is it important?

Reliable and transparent decision making processes are important for all parties involved in assessment of eligibility for Continuing NHS Health Care.

For users, the significance of receiving Continuing NHS Health Care may be substantial in regard to their income and capital assets, which will not be subject to means testing. Care managers, on behalf of users, will want to ensure appropriate advice and advocacy is available where this is necessary.

The new Framework will also state that:

> "Social Security and other benefits (e.g. Independent Living Fund) available to support the individual's living costs may be affected. Therefore, the impact of benefit changes on care arrangements must be discussed with the service user before care and funding arrangements are finalised."

The Local Authority has no statutory remit to provide services that are deemed the responsibility of the NHS.

"All citizens have an equal right to consideration and assessment for Continuing NHS Health Care Funding."

Continuing NHS Health Care Eligibility Criteria

Eligible individuals must have been assessed as having significant physical or mental health needs that are likely to have resulted from illness, an accident or a disability.

The following characteristics may, in combination or alone, demonstrate a primary health care need, because of the quality and or quantity of care required to meet the individual's needs:

- **Nature:** the type of needs and the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them
- **Intensity:** both the extent ('quantity' or level) and severity (degree) of the needs, including the need for sustained care ('continuity')
- **Complexity:** how the needs arise and interact with each other leading to an increase in the amount of skill needed to monitor and manage the care
- **Unpredictability:** the degree to which needs fluctuate, creating difficulty in managing needs and the level of risk to the person's health if adequate and timely care is not provided

The new Framework will include a Decision Making Tool which is designed to ensure that the full range of factors which have a bearing on an individual's eligibility are taken into account in making this decision. The English version of the Tool is already in use and can be accessed via the Department of Health website http://www.doh.gov.uk.

It is vital that the multidisciplinary team's decision on eligibility for continuing NHS health care is recorded as appropriate in:

- The patient's clinical records
- The patient's Personal Care Plan
- The formal record of the MDT meeting

The patient and their family or carers must be informed in writing of the decision and the reasoning behind it.

Assessment

The topic is covered in detail in Chapter 3: Assessing the Whole Person.

A key message in the new Framework is that:

'decision making must be based on the outcome of an appropriate multi-agency assessment process, by staff who know the individual, utilising a range of appropriate validated assessment tools, including the clinical opinion of the consultant or GP who has responsibility for the patient. The approach to assessment must be holistic and person centred'.

The following circumstances are examples of triggers for an NHS Practitioner to consider whether an individual might meet the eligibility criteria for Continuing NHS Health Care:

- During contact, overview or specialist assessment
- On admission to hospital
- When any transfer of care is being considered
- At a significant change in their needs
- At the time of review of funded nursing care
- Request from the individual, family or carer

Following completion of a comprehensive assessment the MDT can consider four broad alternatives:

1. Continuing NHS Health Care Package

The Coughlan Judgement (c1998) and the Health Service Ombudsman Special Report (2003) emphasised that decisions about the respective responsibilities of the NHS and local authorities for the provision of health and social care must be made on the basis of a careful assessment of the facts in each individual case.

When an individual has been assessed as eligible for continuing NHS healthcare the NHS will fund the full package of health and personal care. As described above, the patient will need to be made aware that this may involve a change to their existing care package and benefits.

Where Continuing NHS Health Care has been agreed, an NHS Practitioner will be designated as the individual's Care Coordinator. Care may be provided in a variety of settings, for example in the person's own home, in a hospice, a care home or a hospital. In addition the Care Coordinator will review the individual's needs on a regular basis as specified in the care plan.

> *"Care needs can change and there is potential for someone to move in and out of eligibility for continuing NHS Health Care."*

In most instances Continuing NHS Health Care will be funded by the Local Health Board, with some specialist care funded by Health Commission Wales.

The Local Authority will continue to fulfil its responsibilities including for example its role in participating in multi-agency assessment and review, assessment and support for carers and the meeting of housing or educational needs.

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2. Combined Health & Social Care Package

This describes the situation where care packages are funded and provided by both the NHS and the Local Authority. These are provided to people whose needs are not primarily health needs but who require increased levels of support at home or in a care home.

The healthcare element of the joint package, for which the NHS is responsible, incorporates registered nursing services and is known as NHS Funded Nursing Care.

Other healthcare services, for example access to a General Practitioner or other NHS specialists, are free at the point of delivery. The social care elements of a joint package of care are means tested and there may be a charge for some or all of these services. In this situation a social worker or a health care professional may be designated as the individual's Care Coordinator.

Individual's receiving care in care homes with nursing needs will be assessed by the Local Health Board to determine the extent of their need for care by a registered nurse. The care home will receive payment from the Local Health Board to provide NHS funded nursing care.

3. Social Care Package

This describes the situation where a person has been assessed in accordance with the NHS and Community Care Act 1990 and is deemed to have social care needs. In this situation it is likely that a social care professional will be designated as the individual's Care Coordinator.

Social care is commissioned by Local Authorities. The individual may have to pay for social care services depending upon their personal financial circumstances. Eligibility for social care services will be based upon the Local Authority's Community Care Eligibility Framework and Criteria in accordance with the Welsh Assembly Government publication, 'Fair Access to Care' (2002).

In this situation healthcare needs will be met through the general primary care services with access to secondary and specialist services as required.

4. Routine Healthcare Provision

This describes the situation where an individual requires on going care to meet their health needs, with no specific social care requirements. This is free at the point of delivery.

Rights to Request Review

A patient or his or her representative has the right to ask the Local Health Board to review the decision making process, which has occurred in relation to eligibility for Continuing NHS Health Care or NHS Funded Nursing Care before discharge from hospital, or before any decision on a long-term care package is finalised, whatever the patient's location.

Chapter 6

PASSING THE BATON
in Practice
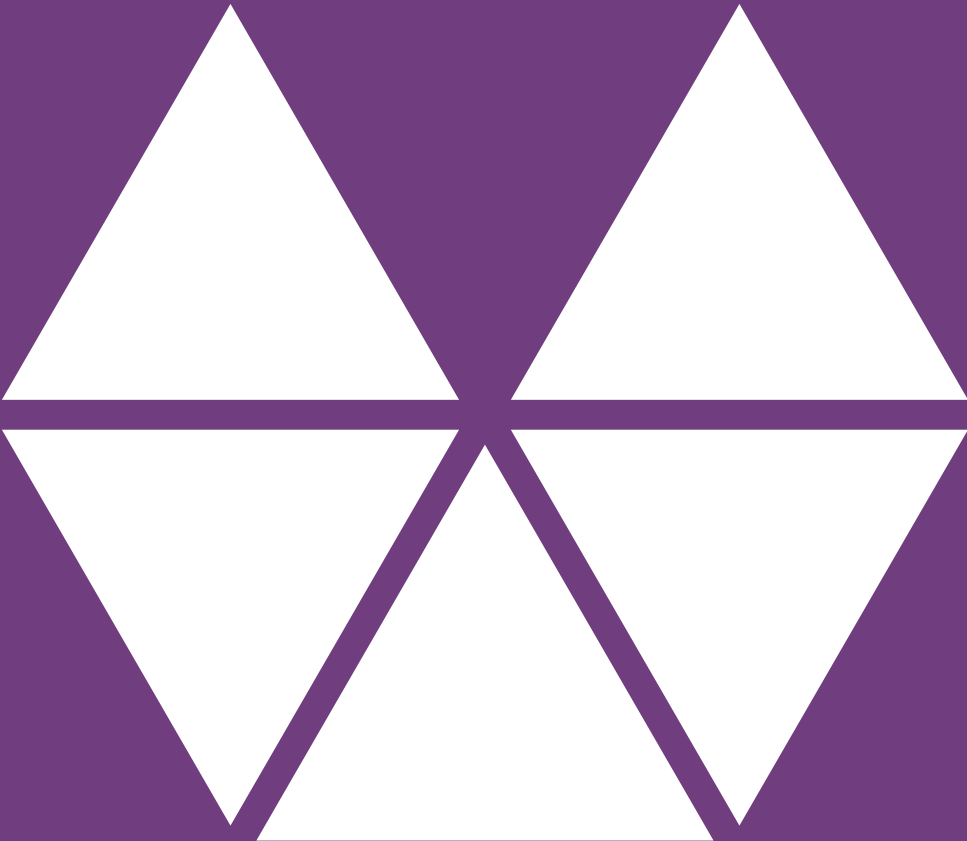
PASSING THE BATON
in Practice

Chapter Overview

This Chapter provides a final summary of the practical application of the Guide, the actual process of discharging or transferring the patient.

> *"Having developed rapport with the patient while undertaking their individualised assessment, you have been able to agree a unique package of care that will enable an early discharge from hospital. The rest is easy!"*

Also included is information for educators which describes a Training Framework that will be developed further during the ongoing implementation of 'Passing the Baton' across Wales.

A whole person approach has been advocated throughout this Guide as the best way to ensure that individual needs are understood. This approach is equally relevant to the way Practitioners are trained and developed.

Training programmes must include specific content that encourages talent and reflects on personal values to ensure that the knowledge and skills gained can be fully applied into practice.

Making a real and sustainable improvement will require as many people as possible to embrace the change. Creating a social movement is an evidenced methodology as discussed in the last section entitled 'A Test of Endurance'.

The Anchor Leg

In an ideal situation, the whole journey through care and the discharge process will be working exactly to plan. In which case, this last stage should be easy:

Practitioners will have:

- Developed an individualised care plan based on the specific needs the individual
- Adhered to locally agreed discharge policies and procedures
- Met any and all legal and professional responsibilities

As a result, there will be:

- An accurate understanding of the individual's discharge needs and wants
- A plan of care to meet those needs and wants agreed by everyone involved
- An agreed date of discharge

Many departments already use checklists at this point while others have developed a Discharge Integrated Care Pathway. Examples of these tools are available in the resource pack accompanying this Guide.

The local guidance will need to have included the following eight day of discharge issues:

1. Timescale

Maintaining attention to detail is essential in the period leading up to discharge. It is difficult to set a specific timescale for this last stage as lengths of stay and levels of complexity for each individual vary so significantly.

For longer lengths of stay, it is reasonable to expect final arrangements to be confirmed 48 hours before the actual discharge. Often, simple logistical arrangements such as hospital transport require this level of notice.

One thing is certain; prior to formally confirming all the discharge arrangements, Practitioners must speak to the individual, their family and carers first, to check that the EDD is reasonable and that there are no obvious reasons to avoid a particular date of discharge.

The remaining steps assume that an actual date of discharge has been agreed and confirmed.

2. Protocol or Practitioner-led Discharge

Traditionally, decisions to discharge from hospital have been made almost exclusively on the Ward Round. As a result, discharges can occur late in the day and rarely at weekends or Bank Holidays.

Improved multidisciplinary ways of working mean that other professional Practitioners can safely make the final decision to discharge, subject to protocols agreed specifically for individual patients.

Whilst some NHS Trusts have developed pre-printed proforma, others work by writing clear instructions in collaborative patient notes. Regardless of the format used, agreed instructions for protocol-led discharge will include the following as a minimum:

- Consensus that protocol led discharge is appropriate for the particular patient
- The proposed date and time of discharge
- The lead clinician signs off the protocol for the individual patient concerned
- The agreed clinical parameters that will constitute medical fitness for discharge for example, vital signs within normal limits is clearly documented
- The designation and grade of the Practitioner with delegated responsibility for making the decision to discharge
- Confirmation that all planned discharge arrangements are in place
- The person responsible for discharging the patient ensures all communication requirements are met
- The discharging Practitioner's contact information is available in case of query

3. Transport:

Ensure that you have asked the patient about their transport needs for discharge at least two days prior to their EDD. In most cases relatives, carers or friends will be more than happy to help if they are given adequate notice.

- Follow your local protocol for ordering transport and give as much notice as possible
- If the patient does qualify for transport, consider the use of voluntary transport in the first instance, as many Trusts have contracts with agencies such as St John's Ambulance. Any potential costs to patients must be explained in advance

> *"Only offer ambulance transport home or to onward place of care where there is a clinical need for it. This is a limited resource which we all have a duty to use to maximum effect."*

- Ensure that you communicate any particular requirements, such as transportation of Zimmer frames or bulky luggage
- Any specific clinical instructions for the individuals care in transport together with requirements for their physical movement such as a chair or trolley

4. Medication To Take Home (TTH)

There are continued reports of short but frequent delays in discharge caused by poor coordination of TTH medication. This is often because prescriptions are not written until after the ward round on the day of discharge.

> *"Such delays are frustrating for patients and carers and in the vast majority of cases totally avoidable."*

- If working to an EDD, the TTHs should be written no later than the day before. In some Trusts ward-based pharmacists are able to transcribe TTH prescriptions on behalf of the clinicians

- If there are changes made to current medication on the final medical review for example warfarin dosage, the TTH should be written immediately to allow time for dispensing and collection

- As already addressed as part of the assessment and discharge planning process, confirm that your patient understands their medication regime and is able to comply with it

- Provide written information to support verbal discussion about the medication regime which includes a clear description of potential side effects

- If supervision or support with medication compliance is needed, double-check that appropriate arrangements are in place

- Ensure that any intravenous cannulae that are no longer required are safely removed

- Ensure that arrangements are in place for submission of repeat prescription requests and the collection or delivery of medicines

5. Home Environment:

Everyday activities can be taken for granted, so sending someone home without thinking about with their immediate needs can cause a loss of confidence. There are a few straight forward points to consider so that the journey home is made smooth:

- Confirm that all required equipment has been delivered, installed and the relevant personnel trained to use it
- Ensure all home adaptations have been fully completed and signed off as safe
- The individual has been made aware of any adaptations and received appropriate training, preferably through an accompanied home visit with a suitable Practitioner prior to discharge
- Check that the accommodation will be adequately heated ready for the patient's arrival home
- Check there is adequate provision of food and means of preparation
- Check that the patient or whoever accompanying or meeting them on discharge has a key to access the property

6. Ongoing Care Setting:

Similarly if the person is not returning to their usual or previous home environment, consideration must be given to any new requirements:

- Full details of the new setting and its location and transport links are available
- The patient, their family or carers have visited the new setting prior to discharge
- Access and physical transport arrangements have been confirmed with the receiving department
- The contact name and details of the person charged with receiving the handover are confirmed
- Any specific domestic or personal care requirements are catered for

7. Information Sharing on Discharge:

All MDT decisions, including those regarding the assessment of eligibility for Continuing NHS Health Care or NHS Funded Nursing Care must be recorded in the patient's notes and documented in the discharge information. A copy should also be provided for the patient and carer.

A comprehensive assessment must be documented and shared, subject to consent and local protocols, with those who will be providing care on discharge.

The Care Coordinator should be responsible for the formal handover upon discharge. At this point the Care Coordinator role may be passed on, for example, from named nurse to community-based social worker.

Where an ongoing care plan is required, it will need to be agreed with the individual, their carer or advocate and provided in writing including clinical follow up arrangements such as an out-patient appointment.

GPs report failures in continuity of treatment, which can lead to errors or avoidable readmission, due to poor or untimely communication of essential information on discharge.

Although some health communities have developed a local means of prompt electronic transfer of discharge information, others still have to rely on traditional summaries.

The Practitioner overseeing the discharge process needs to ensure that the GP Practice receives legible information within 24 hours of discharge to include:

- Diagnosis
- Inpatient investigations and treatment
- Changes to existing medication
- Follow up
- Discharge arrangements

If it is usual practice to send this information with the patient, Practitioners must ensure that they have the means to deliver it to their GP surgery within the same timeframe.

8. Use of Discharge Lounges

Many Trusts have designated Discharge Lounges, usually staffed by nurses, to which patients can safely be transferred in the morning of the day of discharge.

If all the measures advocated in this Guide have been implemented there should be little need for such facilities. However, at present the effective use of the Discharge Lounge can significantly assist in maintaining patient flow throughout the hospital.

Most patients are happy to be transferred to the Discharge Lounge, if the rationale for doing so is explained to them. However, many nurses still instinctively feel that the best place for the patient to wait for discharge is on the ward.

Patient information provided on admission should state that as a matter of routine patients who are medically fit will be transferred to the Discharge Lounge before 10am on the morning of their discharge.

In Hospitals where Discharge Lounges are routinely use, it is good practice to inform allied departments that the patient will be leaving the hospital via the discharge lounge. This can provide an opportunity to coordinate activities such as delivering TTHs through the Discharge Lounge.

Discharge Lounges should provide a pleasant and comfortable experience for patients looking forward to going home. Many examples in Wales provide:

- Comfortable seating
- Tea and coffee making facilities
- Snacks or warm meals
- Reading materials and TV
- An accessible pick up point for relatives, voluntary or ambulance transport
- An opportunity for final reassurance or discussion with competent and compassionate staff

Information for Trainers

This guide is aimed at frontline Practitioners, who already have a great deal of knowledge and skill. To ensure that there is recognition of the range of expertise required in discharge planning it needs to sit within a larger structure and this is described as a Training Framework.

The Training Framework is a more strategic view of what is necessary to deliver effective discharge planning and will be developed further as part of the ongoing implementation of 'Passing the Baton'.

Potentially this will involve the creation of formally accredited programmes of education in patient flow and managing the journey through care.

"The objective is to provide expert Practitioners and educators with a framework to develop more specific local training plans and resources."

The use of Expert Practitioners is essential to the delivery of ongoing training and education in discharge planning. Although nursing is the largest staff group, these 'Champions' for discharge planning will be needed in a range of professions.

To underpin this and support development in practice, undergraduate programmes will need to strengthen the curriculum with more explicit application of the knowledge and skills necessary to manage the care process.

These two approaches represent two arms of a single integrated plan to improve discharge planning through training.

For both arms of training, organisations will also need to consider what opportunities are available to deliver this training in a joined up, inter professional and inter agency programme of shared learning and development.

"Integration is increasingly the way services are delivered in the real world, just look at the expansion of intermediate care and it's inevitably going to increase in the future."

It is clear that there are many training and development programmes going on separately in many partner organisations. Local training leads have developed bespoke programmes, presentations and teaching resources within the formal staff development plans of each organisation.

Subsequently for those organisations who want to deliver shared learning, it is more of a logistical issue than one of needing additional funding. The aim is to create a complimentary programme of trainers and champions collaborating within a systematised approach to continuous improvement.

Elements of Training

If Practitioners actively use the knowledge Barometer they will naturally identify gaps in their knowledge and skill. The challenge for educators and training departments becomes how to respond to that need for development.

Every health and social care community will need to tailor their programme to encompass the particular organisational relationships and services active within their catchment.

To deal with the issues of locality while ensuring that good practice is implemented consistently, each programme must be based around a common core of knowledge, skills, tools and techniques. 'Passing the Baton' represents this basic level of common principles and their practical application.

Management of the expectations of the patient, their family and carers is part of the knowledge base along with practical ability to deliver care and activate the organisation's processes. Consequently a large part of the competency should be based around professional and interpersonal communication skills.

Throughout the Guide, the interaction with the patient and carers is emphasised as critical to managing expectations. As a result an essential of effective practice is ensuring that the sophistication of the dialogue is congruent with the complexity of the patient journey and the level of understanding of the Practitioners, the patient, carers and wider family.

> *"We must be aware of evolving patient and carer expertise and as a Practitioner correspond to the increasing need for involvement, as well as knowledge and information."*

Intellectual need is only one part of what has to be covered in the training programme. The content must also reinforce recognition of emotional needs and cover aspects of both cultural and social diversity.

The practical content of a training programme therefore needs to cover a broad spectrum of issues:

- Understanding your own and other's roles in delivering care and managing the care process
- Knowledge of the practical skills in the care process across several organisational partners

- Skills in applying the knowledge consistently on a routine day to day basis
- Communicating effectively with people who have a diverse range of needs and expectations
- Impact of effective care processes to create systematised information, learning and improvement
- Recognition that equity and diversity goes beyond ethnicity to social, cultural and legal obligations

These traditional areas of learning and their practical application need to be combined in a way that extends beyond technical ability.

The Chapters dealing with principles, communication and assessment each advocate taking a whole person, holistic view connecting to the patient and their family with compassion. This whole person approach requires Practitioners to develop a range of empathic skills to recognise a person's needs in mind, body, heart and spirit.

> *"It really saddens me that we seem to have lost something so essential… training in these aspects of personal values and their legitimacy in modern practice has to become much more explicit."*

If organisations want Practitioners to deal with 'whole people', then they need to be developed as 'whole people' themselves. The training programme must encompass personal development and reflective practice processes that help each Practitioner to understand their own mind, body, heart and spirit.

The Expert Model

The following diagram is a useful model to consider how to apply whole person thinking to a training and development programme. The Expert Model has four internal characteristics and four external requirements that combine to create 'Expertise'.
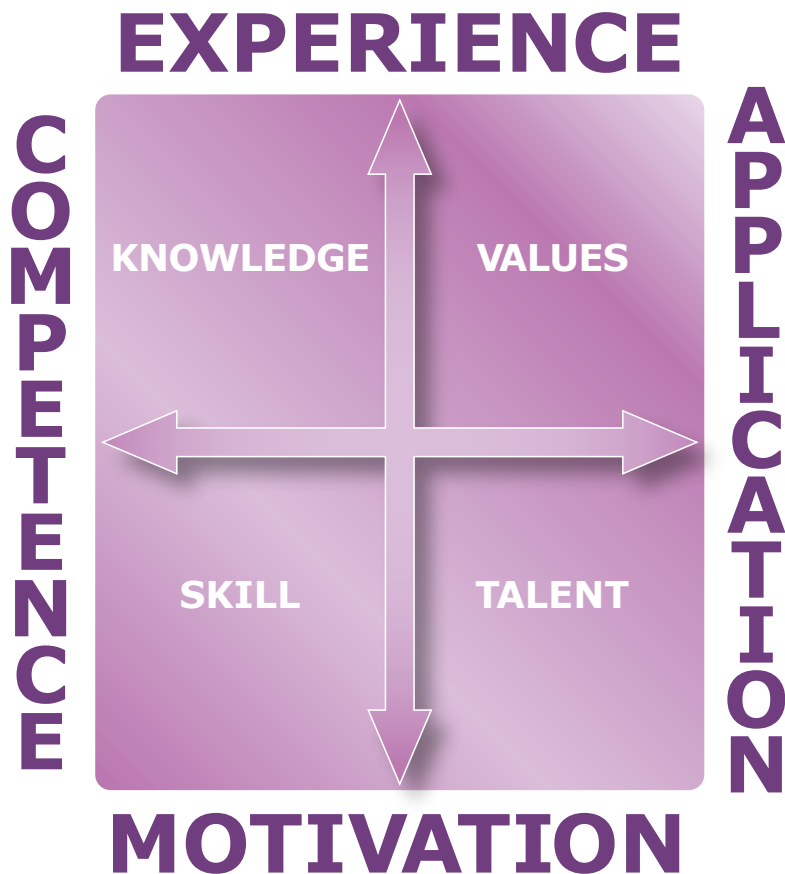
The left side represents 'Competence' and the practical training elements of Knowledge and Skill the mind and the body. Competence alone is not enough, despite its recent focus, as it means "only just". Without continuous evidence of practice it's just a small step from incompetence.

6.15

The right side refers to the 'Application' of that knowledge and skill. The innate talent that a person has and the values they hold in acting upon that talent. It is the heart and spirit of a person and the manifestation of the empathy that connects them to other people.

When considering the vision of being able to deal with the whole person across a diverse community, the training and professional development frameworks must be explicit in the education and development of all four characteristics; Knowledge, Skill, Talent and Values and reflect how they change over time.

"At the start of a career you have talent and some skill and the 'Motivation' to deploy those capacities. As your career progresses with appropriate support, you gain greater knowledge and greater confidence in your ability to act on that knowledge. This is essentially 'Experience'. If you can maintain the connection between your experiences and your personal values you gain greater insight into your own sense of purpose. The Practitioner becomes powerful and compassionate, someone who others will see to physically represent high moral understanding and be able to influence people on many levels, dealing with the whole person."

A Framework for Development

Across the range of undergraduate education programmes, there are several academic modules and practical placements that are aimed at acquiring knowledge and skill in the care process. Some have specific discharge planning objectives.

However, it is not routine to offer practical placements with experts in managing the patient journey. The placements with specialist nurses tend to be around recognised disease pathways. Some wards do have designated link nurses for discharge planning and other similar care processes, but their input is generally not formally recognised within the competency framework.

There is an issue to overcome in connecting up inter-professionally to educate and train people involved in more complicated processes with a common language and knowledge base. In particular for advanced roles where care processes like discharge planning or care coordination are the primary purposes of the job.

There is a clear need to further explore the development of accredited training or perhaps a post graduate qualification in subjects that encompass managing the patient journey, care pathways or operational healthcare dynamics.

At the other end of the scale, education must also extend to patients, their family and carers. There is potential to develop new support programmes and qualifications that are aimed at priority groups such as new carers, alongside general awareness and signposting.

> *"Every LHB must have a Carer's Strategy and services that link with Health Social Care & Wellbeing Plans, with access to support services and education."*

The framework needs to identify individuals and the correlating level, content and type of training in relation to their role or exposure to processes in practice.

The Training Framework has been developed to describe the people, requirements and structure of training across 8 levels of expertise split into 4 categories:

- General Awareness
- Standard Practitioner
- Enhanced Practitioner
- Expert Practitioner

Although this Guide is aimed at front line health and social care staff identified as 'Standard Practitioner' on the Framework, a complimentary programme of education and training needs to be developed to spread consistent knowledge across the entire care process.

With regard to Level 1 on the Framework, part of the ongoing development and implementation of 'Passing the Baton' will be the production of a training video. It will be aimed at raising basic awareness of the care process and how services users, their family and carers, together with support staff across public services can contribute to the journey through care.

General Awareness
Level 1

Role	All citizens
	Staff from voluntary, independent and public services associated to but with little or no experience of the hospital process
Exposure to & Complexity of Discharge Process	No routine or day to day involvement with the patient journey
Application of Training	The All Wales National Effective Discharge Planning Awareness Video
Content	Knowledge – A common language for what discharge planning involves and why it's important to get home as quickly and safely as possible
	Skill – Provision of basic advice and signposting on what to expect
	Values – Empathy for the staff and patients involved in delivering and receiving a complex service

General Awareness
Level 2

Role	All health and social care staff for general employee awareness The patient, their family and carers involving a long term condition
Exposure to & Complexity of Discharge Process	General non clinical or indirect involvement in the discharge process and no requirement to deal with situations beyond normal indirect remit
Application of Training	Corporate Induction and organisational mandatory refresher training
Content	Knowledge – Your role and relationship to the patients journey Skill – To ask questions pertinent to facilitating effective discharge Values - Ability to recognise the potential disempowering effect of hospital settings

Standard Practitioner
Level 3

Role	Junior clinical staff, support staff and carers involved in the day to day delivery of care
Exposure to & Complexity of Discharge Process	Mostly dealing with simple discharges and provision of information for patients and carers and basic awareness to communicate on discharge
Application of Training	Departmental Mandatory training on a rolling basis
Content	Knowledge – Ongoing variation in the understanding and information needs of patients and carers Skill - Recognition of triggers that escalate discharge complexity Values – Ability to engage with patients and carers to reduce anxiety

Standard Practitioner
Level 4

Role	Staff directly involved in the management of the patient pathway
Exposure to & Complexity of Discharge Process	Mostly dealing with uncomplicated discharge and the provision of patient information and regular need for a formal clinical handover
Application of Training	Departmental Mandatory training on a rolling basis Self directed and departmental learning through audit and review
Content	Knowledge – Operational understanding of hospital processes related to effective discharge Skill – Active recognition and management of patients and carer expectations of the discharge process Values – Ability to explore and identify patient's emotional needs and offer explicit advice or service

Enhanced Practitioner
Level 5

Role	Experienced clinical staff and operational leaders with responsibility for other staff and allocation of day to day resources
Exposure to & Complexity of Discharge Process	Regular management and overview of patients who routinely require post discharge management and support from one or more agencies
Application of Training	Internal organisational training and development workshops linked to findings of local audit and review
Content	Knowledge – Care coordination and management of multidisciplinary team meetings and case conferences
	Skill – Advanced clinical assessment, planning and reporting
	Values – Ability to advocate on behalf of patient and initiate action to meet individual needs

Enhanced Practitioner
Level 6

Role	Specialised Practitioners, link nurses, care coordinators and other patient liaison staff
Exposure to & Complexity of Discharge Process	Overview of multiple patients on specific or complex clinical care pathways routinely involving multidisciplinary follow up post discharge
Application of Training	Externally facilitated workshops linked to health community improvement plans
Content	Knowledge – interagency working and the development of local professional partnerships

Skill – chairing of multidisciplinary team meetings and case conferences

Values – Ability to individually tailor discharge planning processes |

Expert Practitioner
Level 7

Role	Senior clinical and managerial staff with broad organisational responsibilities for assessment and escalation of risk
Exposure to & Complexity of Discharge Process	Dealing with operational resources and management authority to enable effective discharge for patients who require new or additional interagency services
Application of Training	Professionally accredited training module linked to formal CPD
Content	Knowledge – Development of systematic and organisational improvement in patient flows

Skill – Maintaining a physical overview of the environment and dependencies of care

Values – Ability to relate policy and strategy to the hands on delivery of compassionate care |

Expert Practitioner
Level 8

Role	Expert Practitioners and managers with a primary role or responsibility for discharge planning and dealing with complex care coordination
Exposure to & Complexity of Discharge Process	Operational case management of multiple patients with complex needs that require an individualised package of care in place prior to discharge
Application of Training	Formal post graduate qualification in a patient flow or clinical pathway methodology
Content	Knowledge – Whole system approach to delivering effective transfers of care Skill – to motivate, advocate and educate individuals and influence organisational processes Values – Ability to lead in the service of others

When considering a programme for Practitioners at a particular level, the whole framework can be related directly to the broad communication requirements identified within the knowledge and skills framework used in healthcare:

Category 1	Communicate with a limited range of people on day-to-day matters
Category 2	Regularly communicate with a range of people on a range of matters
Category 3	Develop and maintain communication with people about difficult matters and in difficult situations
Category 4	Develop and maintain communication with people on complex matters in complex situations

This can then translate into practical teaching opportunities:

- Champion led education sessions with opportunities for multidisciplinary and agency reflective practice
- General presentations on discharge processes, DToCs, simple versus complex pathways
- Workshops to develop checklists with triggers to identify common complicating factors with awareness and drop in sessions run by specialist Practitioners
- Ongoing novice programme for newly qualified staff on all aspects of discharge planning and the care process
- Rolling programme of update session on the role of specialist patient flow teams
- In house formal training programme delivered by champions and specialist Practitioners on relevant changes to policy and practice
- Supervised involvement in MDT to gain experience in coordinating meetings and care planning
- Full technical training plan on discharge planning using 'Passing the Baton' as a workbook

A Test of Endurance

Let's be honest, implementing the contents of this Guide isn't going to be easy. What change ever is?

> *"To take the athletics analogy one step further, embedding these principles into everyday working practices in hospitals, social work departments and community services across Wales, will require the combination of the expertise of the relay team with the psychological traits of the marathon runner."*

Characteristics cited as essential to 'going the distance' include:

- Discipline
- Dedication
- Determination
- Persistence

The working environment for all Health and Social Care Practitioners is challenging because of the pressures of workload and the perceived increasing complexity of the individuals who require their services. This Guide is about the response and approach of Health and Social Care Practitioners to those pressures.

Having a rational agreement that this is how we should do things, will not be sufficient to ensure that consistent standards are maintained during times of pressure. As the old adage goes:

> *"Change happens in the heart not the head."*

In all its content, this Guide has appealed to the inherent ethos and values of health and Social Care Practitioners and the known desire to do the best job possible.

In order to achieve and sustain improvements in discharge planning practice, all readers of this Guide will need to become change agents themselves, forming a social movement that actually makes it uncomfortable to do anything else.

Bate et al (2005) describe six groups of factors that influence the mobilisation of collective action or social movement:

Rational:	"I understand why this is worth doing"
Emotional:	"It feels right"
Social:	"My organisation supports it"
Behavioural:	"My professional practice and that of my colleagues is underpinned by it"
Organisational:	"Our policies and operational processes enable me to do it"
Leadership:	"Employees and managers at all levels of the organisation agree it is a priority and give me space to do it"

In this context, it is clear that everyone has a responsibility to drive the improvement in practice and that all contributions, from whatever level in the organisation, are equally valid. This principle has underpinned the development of the Guide so far, harnessing:

- the support of executives and managers
- the skills and expertise of Practitioners from a variety of professions and agencies
- the advice of experts

> *"At present, prevailing strategies rely largely on outmoded theories of control and standardisation of work. More modern, and much more effective, theories of production seek to harness the imagination and participation of the workforce in reinventing the system."* Berwick, 2003

'Passing the Baton' has never been envisaged as being the silver bullet that will solve all the problems encountered when discharging patients from an acute hospital setting. It became clear during its development that the key to success is not a 'big bang' but to do relatively small things correctly and consistently.

> *"Movements are more likely to fine-tune reality than to give rise to the brave new world."* Palmer, 1997

The messages in the Guide are not new and they are not rocket science. Rather, the Guide should be seen as catalyst around which enthusiasts can gather their efforts in order to mainstream change and improve practice.

> *"Roll out and implementation will seek to maintain momentum by supporting a federated NHS improvement movement."* Bate et al, 2005

This will involve the setting up of local and national networks via the Community of Practice, which will support practical training, problem solving, feedback mechanisms and further development.

The Guide is designed to be a living and evolving document. The authors actively encourage you to use the feedback mechanisms provided and engage in its development and most of all, to join them in the journey to really make a difference to patients' experiences.

"You can't wait for inspiration...

... you have to go after it with a club."

Jack London

Appendices

Appendices

Subject Index

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Local Information

Local Information

This Section of the Guide has been included for Practitioners to be able to insert pertinent local information to support the application of the guide in their place of work.

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