Chapter 3

Assessing the Whole Person

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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?

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)?

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

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