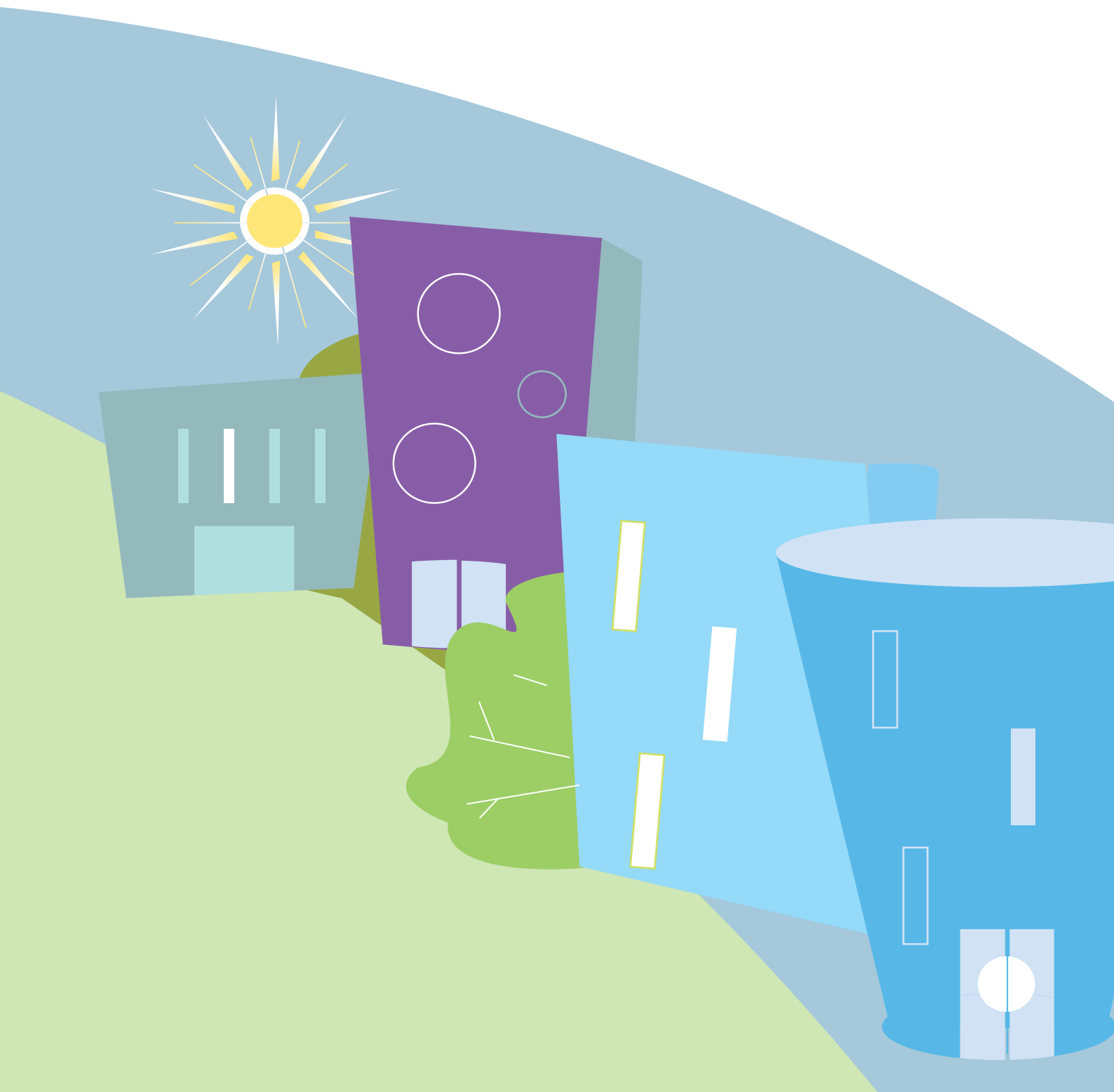


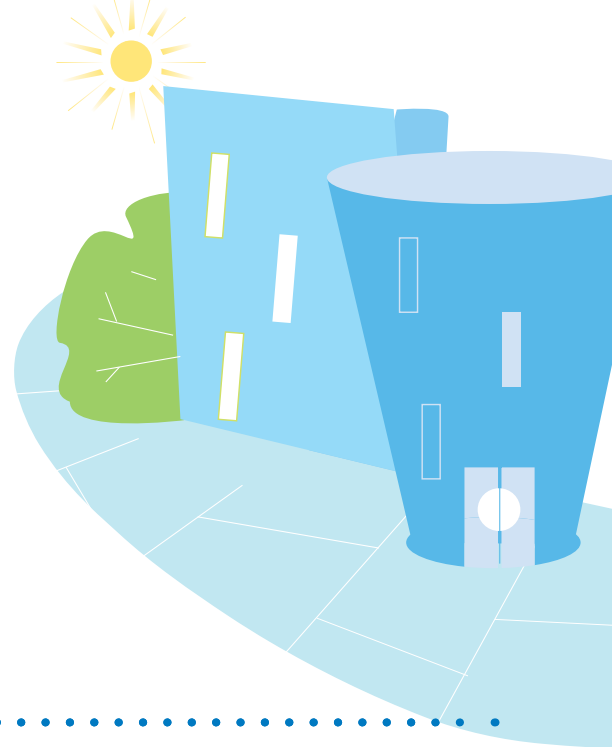
Ready to go?

Planning the discharge and the transfer of
patients from hospital and intermediate care



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Prevention Package for older people

This downloadable resource is part of a suite available to support local delivery of the Department of Health's Prevention Package for older people. It may be read as a stand-alone document or as part of a series.

The Prevention Package forms the Department of Health's main contribution to the Government's new Ageing Strategy "Building a Society for all ages" which builds on the vision originally set out in the Department for Work and Pensions' *Opportunity Age* strategy published in 2005.

The Prevention Package resources are designed to encourage and support primary care trusts, strategic health authorities and local authorities in prioritising and commissioning services that support the health, well-being and independence of older people. The resources should also help clinicians, practitioners and managers who want to improve the effectiveness of their services.

The full suite of resources is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103146





Summary

Purpose

Discharge or care transfer is an essential part of care management in any setting. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home or transfer to another setting. It also ensures that systems are using resources efficiently. This practical resource provides practitioners and organisations with advice to support improvements in how they manage the discharge of individuals and transfer of care between settings.

Outcome improvements

This resource builds on and updates established practice and previous practice guides. The need for timely discharge and care transfer requires clinicians and others to plan, communicate, negotiate and ensure a smooth transition for individuals and their families. Underpinning this is the need for:

- effective communication with individuals and across settings;
- alignment of services to ensure continuity of care;
- efficient systems and processes to support discharge and care transfer;
- clear clinical management plans;

- early identification of discharge or transfer date;
- identified named lead co-ordinator;
- organisational review and audit; and
- seven-day-a-week proactive discharge planning.

The 10 steps set out the essential steps in discharge and transfer planning, supported by 10 operating principles. The key messages are: Check it out, ask the patient and make it happen.

Further support

Accompanying this guide are further supportive practice materials and exemplars to assist clinicians and others to improve practice. These are available from www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/Preventionpackage.

Introduction

This guide has been developed to help health and social care practitioners working in acute and community hospitals and intermediate care services to improve their own discharge and transfer processes and practices. It includes key messages for health and social care organisations to ensure that practitioners have the tools they need to achieve good practice.

Most people spend a very short period of their lives in hospital; their discharge follows a fairly predictable pattern and they usually return home. The development of high-level clinical care and intermediate care in the community now enables more people with disabilities and long-term illnesses to remain in their own homes. For those people already in the care system, or for those who will need ongoing support when they leave hospital, admission and discharge processes are now more characteristic of a 'transfer of care' process. It is continuity of the right care in the right place that is important for these people.

Achieving safe and timely discharge or transfer from hospital is a complex activity. The pressure to discharge or transfer patients and release beds, together with a trend towards shorter lengths of stay, means

that there is less time for assessment and discharge or transfer planning.

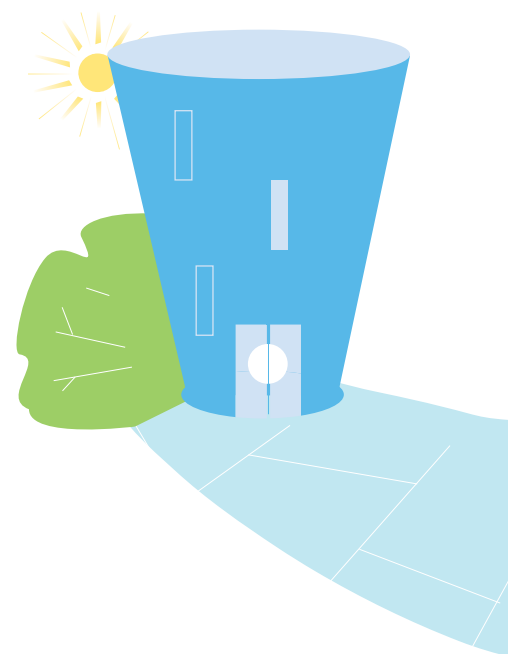
Why is discharge and transfer planning so important?

Premature discharge can leave the patient:

- with some unmet needs;
- poorly prepared for home;
- with the likelihood of readmission; or
- using inappropriate or more costly social care services (such as intensive home care or residential care).

A protracted length of stay increases the risk of:

- infection;
- depression/low mood;
- boredom;
- frustration;
- loss of independence and confidence; and
- NHS resources being used inappropriately.



How to use this guide

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This guide puts forward 10 key steps to achieving safe and timely discharge. These steps are based on the good practice previously identified and evaluated by practitioners.^{1,2,3} A pocket guide to the 10 steps is provided as an aide-memoire, and relevant websites and references can also be found throughout the document. A memory stick is included in the pack, and any checklists and forms included on it are in Word format for local adaptation if required.

The best place to start is to reflect on your own organisation's effectiveness in comparison with the processes and principles described in Chapter 1, and then to go through Step 1 in more detail. By this point you should have a clearer picture of your own practice and how, by making some small changes, you could improve outcomes. Use this guide as a reference document to help you easily access the advice and information you need to make the changes.

Chapter 1 introduces the 10 steps. The steps are intended to be viewed alongside the 10 key principles that underpin the way

practitioners work together and work with patients and their families. Practitioners cannot work effectively without the support of their organisation, the primary care trust and any local authority partners. This chapter includes a checklist to help organisations review their policies and processes, and take action where necessary.

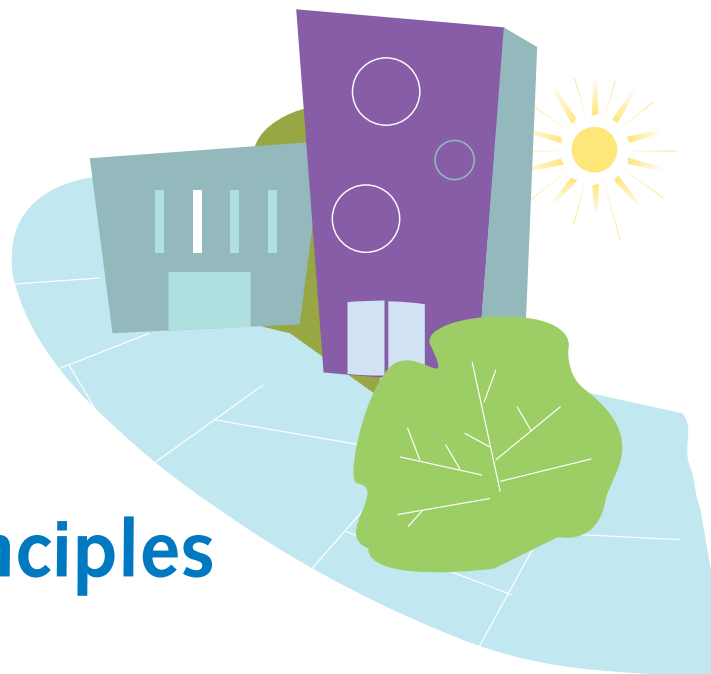
Chapter 2 incorporates the 10 steps and key principles, headlining the actions necessary to ensure that each step achieves the best outcomes for patients, carers, practitioners, the organisation and its partners.

Chapter 3 reflects on the discharge or transfer process from the patient and carer perspective – to help practitioners understand what works well and why misunderstandings occur. It offers some tools and tips to help practitioners and the multidisciplinary team (MDT) evaluate their communication with patients and their families, and within the team.

1 DH (2003) *Discharge from hospital: Pathway, process and practice*. DH.

2 Welsh Assembly Government (2008) *Passing the baton: A practical guide to effective discharge planning*. Welsh Assembly Government.

3 DH (2004) *Achieving timely 'simple' discharge from hospital*. DH.



Chapter 1:

Key practices and principles

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The 10 steps

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.



Operating principles

1. Discharge and transfer planning starts early to anticipate problems, put appropriate support in place and agree an expected discharge date.
2. A person-centred approach treats individuals with dignity and respect, and meets their diverse or unique needs to secure the best outcomes possible.
3. The care planning process is co-ordinated effectively.
4. Communication creates strong and productive relationships between practitioners, patients and carers.
5. The MDT works collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharges and transfers.
6. Social care are involved, where appropriate, and the requirements for the assessment notification and discharge notification are met. NHS bodies are required to make two notifications to social care departments in order to trigger a claim for reimbursement. The first (assessment notification – Section 2) gives notice of the patient's possible need for services on discharge. Following this notification, social care departments have a minimum period of three days to carry out an assessment and arrange services. The second (discharge notification – Section 5) gives notice of the day on which it is proposed that the patient is discharged. Reimbursement liability commences on the day after the minimum three-day period (Section 2) or the day after the proposed discharge date (Section 5) – whichever is the later.
7. Patients and carers are involved at all stages of discharge planning, given good information and helped to make care planning decisions and choices.
8. Patients who do not have capacity to make decisions are given their rights and obligations under the Mental Capacity Act.⁴
9. Carers are offered an assessment to identify any services they may need to support them in their caring role, if appropriate.
10. A person's eligibility for NHS continuing healthcare is assessed where appropriate.



4 Ministry of Justice (2005) *Mental Capacity Act*. Office of Public Sector Information. www.opsi.gov.uk/Acts/acts2005/pdf/uk

What the organisation can do to support the process

1. Monitor and evaluate the causes, length and types of delays that follow the patient through the system. This should include the wider aspects of patient flows such as discharge co-ordination and multi-agency cases.
2. Review the reimbursement notification procedure to ensure that timescales are sufficiently flexible around assessment and timely completion of Section 2 and 5 notifications.⁵
3. Carry out a simple hourly flow diagnosis to understand patient flows in and out of hospital.
4. Ensure that the discharge policy is up to date with policy and legislation, and includes inter-agency agreements on joint working protocols (including for the homeless, people in prison and asylum seekers).
5. Provide written information for patients so that they have clear guidance on what to expect and what is expected of them while they are in hospital.
6. Schedule ward rounds in a way that allows, at least daily, a senior clinical review of all patients in acute hospitals.
7. Ensure that all tests and treatments continue seven days a week.
8. Support nurses and allied health professionals to take on more responsibility for the discharge process, including the decision to discharge based on the agreed clinical management plan.
9. Ensure that mechanisms are in place for assessing the needs and preferences of those who are approaching the end of their life and do not wish to die in hospital.⁶ End-of-life care has been defined as 'care that helps those with an advanced, progressive and incurable illness to live as well as possible until they die'.⁷
10. Agree a corporate approach to discharge practice training, to include all wards, departments and teams, and provide practitioners with a training and development plan to enable them to take on more responsibility for discharge planning.

5 Hubbard et al (2008) *Reimbursement in practice: The last piece of the jigsaw?* University of Stirling, University of Leeds, King's College London.

6 DH (2008) *End of life care strategy: Promoting high quality care for all adults at the end of life*. DH.

7 Ibid.



Chapter 2: Implementing the 10 steps

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Step 1 Start planning for discharge or transfer before or on admission

*"Discharge is a process and not an isolated event at the end of the patient's stay."*⁸

It is crucially important to identify any factors that would make a patient's discharge or transfer problematic, so that action can be taken early to plan care. Failure to do this at the point of initial or admission assessment will have consequences for the patient's transfer later in the care planning process. Responsibility for the assessment and planning of discharge and transfer of care must rest with the ward team.

1. Is the planning of discharge and transfer embedded into everyday ward practice, starting with the initial assessment?
2. Are systems and processes in place to support safe and timely discharge?

Small issues that are missed early on can cause big problems later. Make sure that information gathered includes contact numbers for relatives and details of existing care packages, and that arrangements for

clothes, keys and transport for going home are discussed and agreed.

3. Are practitioners clear about their role and contribution to the process?

A number of tools and techniques are available to help ward staff review their practice. The NHS Institute for Innovation and Improvement's *Releasing time to care* productive ward programme includes a module on admission and discharge planning.⁹

A Department of Health toolkit is available, including a developmental health check progress tool to help you establish how close you are to implementing safe and timely discharge.¹⁰ A matrix of training competencies for timely discharge to help practitioners assess their level of discharge practice is available on the memory stick accompanying this guidance and available at www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/Preventionpackage. The competences can be amended or added to according to the environment in which they are intended to

8 DH (2003) *Discharge from hospital: Pathway, process and practice*. DH.

9 NHS Institute for Innovation and Improvement productive ward programme: www.institute.nhs.uk/productiveward.

10 DH (2004) *Achieving timely 'simple' discharge from hospital*. DH.

be used. The memory stick also refers to a discharge training needs analysis tool¹¹ which can be used at the ward or individual level.

4. Begin planning for discharge or transfer of care on day one for all unplanned admissions – and before admission for elective admissions – to identify potential discharge and transfer challenges. For non-elective acute admissions, the post-take ward round is a good place to start.

Nurses act as the patient's advocates. They should be present on ward rounds to ensure continuity of information communicated to the ward team afterwards.¹²

5. For planned admissions, a systematic approach as part of the pre-admission assessment (including documenting functional abilities, the existing care plan and home environment) will flag up potential discharge and transfer problems.

6. This means using a person-centred approach to understand what the person's usual situation is. Consider who else needs to contribute to the assessment.

Assessment is about putting together information on a person's needs and circumstances, making sense of that information in order to identify needs, and agreeing what advice, support or treatment to provide. The common assessment framework (CAF)¹³ for adults sets out to deliver a better experience for those who use health and social care services by

supporting a proportionate, but thorough, and more person-centred assessment of need and care.

7. Make every effort to protect from interruptions the time spent undertaking the assessment. Patients appreciate being welcomed and given clear and concise information. Taking an interest in their concerns reduces their frustration and anxiety, and sets the scene for their whole inpatient experience.

The initial assessment is a good opportunity to underline expectations about a person's stay in hospital. Remind them to bring in clothes and medication, and help them think about transport home and moving on from the acute setting as soon as they are well enough.

8. Good communication is the way to ensure that your knowledge and clinical skills are used to best effect. Use language and terminology that are familiar to the patient and are culturally sensitive. Always check their understanding.

9. It is essential that the right questions are asked so that details of the patient's lifestyle in the three months leading up to their admission are clear.

10. Always provide information and support in a way that takes account of the patient's ability to understand and absorb information. A good way to start is to ask them what they expect from their admission.

11 Lees, L. and Emmerson, K. (2006) 'Identifying discharge practice training needs.' *Nursing Standard*, Vol 20 No 29, pp 47–51.

12 Lees, L. et al (2006) 'Using post-take ward rounds to facilitate simple discharge.' *Nursing Times* Vol 102 No 18, pp 28–30.

13 DH (2009) *Common assessment framework for adults: A consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning*. DH.

Always explain to patients and their carers what to expect and how they are to be involved in decisions, remembering that they are experts in how they feel and what it is like to live, or care for someone, with a particular condition or disability.

11. If the patient has other problems such as dementia, a physical impairment, a learning disability or mental health needs, the assessor should talk to people who normally care for them to ascertain their usual level of functioning and what help they normally need.

Admission to hospital can be a particularly frightening and confusing time for people. Effective communication is the most important tool a practitioner has. The practical guide *Passing the baton*¹⁴ provides practitioners with useful advice on how to review their own communication skills and build empathy with patients and their families. Excerpts are included in Chapter 3 of this guidance.

The Department of Health has also produced best practice guidance on assessing older people with complex needs.¹⁵

12. Practitioners are obliged to ensure that the patient is fully aware of their circumstances and able to give informed consent.

This means that they must have enough information, and understand that information, to be able to make choices and arrive at a decision. If the patient does not

have capacity to make specific decisions pertinent to transfer, an assessment will need to be made to decide whether:

- more support is needed so that the patient can make decisions; or
- the patient does not have capacity, and rights and obligations under the Mental Capacity Act¹⁶ will need to be triggered.

There may also be implications for the patient of the Mental Capacity Act Deprivation of Liberty safeguards legislation.

13. Many patients with a long-term condition will have a complex case manager in the community responsible for providing them with a high level of clinical support.

These relatively new roles, often called community matrons, are predominantly undertaken by nurses who function at an advanced level of practice. They should be involved right from the start, as they should act as the patient's key worker to facilitate transfer from hospital. The aim is to get patients back to a 'self-care' level in the community as soon as possible to minimise disruption to them and their family.

14. Occasionally someone who is approaching the end of their life may be admitted inappropriately. In such cases, where they do not wish to die in hospital, care plans should be put in place to enable them to transfer quickly so that they can die with dignity in the place of their choice.

14 Welsh Assembly Government (2008) *Passing the baton: A practical guide to effective discharge planning*. Welsh Assembly Government.

15 DH (2007) *Urgent care pathways for older people with complex needs: Best practice guidance*. DH.

16 Ministry of Justice (2005) *Mental Capacity Act*. Office of Public Sector Information.

Many of these patients will already be on an end-of-life care pathway in the community, such as the Liverpool Care Pathway,¹⁷ and will have a key worker who can advise on their care pathway.

15. Remember the essential and valuable contribution made by families and community-based services to the assessment process.

Contact telephone numbers and names of key individuals should be obtained as early in the admission process as possible. These details are often overlooked, causing distress and delay in the discharge process.

16. Don't assume that a person's carer will necessarily be able to, or want to, continue in a caring role. Patients and their carers may have different needs and aspirations. Check the accuracy of information you are given from the patient about their relative's willingness and ability to care.

Carers have a right to their own assessment and to any services they may need to support them in their caring role. It is important to remember that young people may also be providing a major part of a parent's care.¹⁸

17. Identify whether a patient is at risk of homelessness or whether they are living in insecure or temporary accommodation. Also consider the specific needs of prisoners.

Most homeless people – in particular rough sleepers or those with a chaotic lifestyle – have poorer health than the rest of the

community. People living in temporary or insecure accommodation may have difficulty accessing primary care, which means that they do not seek treatment until their problem is at an advanced stage. Once admitted, they can present a complex medical and social picture.¹⁹

18. Once the relevant information has been recorded, it should be kept in one place for easy access. This can be a paper or electronic record, and colour coding helps. Consider introducing patient-held records, as these have been found to improve a patient's understanding of and involvement in their care planning. Information should be updated at each admission; often paper and electronic copies differ in the detail.

Step 2 Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision

Once the initial assessment has been completed, the assessor will need to evaluate whether this is a simple or complex transfer or discharge. For the majority of patients (about 80%), discharge planning is relatively straightforward – these are usually referred to as simple discharges. The Department of Health toolkit²⁰ describes these as patients who:

- will usually return to their own home; and
- have simple ongoing care needs which do not require complex planning and delivery.

17 Liverpool Care Pathway: www.mcpcil.org.uk/liverpool-care-pathway.

18 Home Office (2004) *Carers (Equal Opportunities) Act*. Office of Public Sector Information.

19 Department for Communities and Local Government (2006) *Hospital admission and discharge: People who are homeless living in temporary or insecure accommodation*. DCLG.

20 DH (2004) *Achieving timely 'simple' discharge from hospital*. DH.

The other 20% of patients will have more complex needs. Ward staff may need support from health and social care colleagues who have more specialist knowledge and understanding of the local community services and choices available. The majority of complex transfers can be managed effectively by the core MDT. However, a very small number of these patients, if delayed, have a very high impact on bed occupancy. Identifying complexities early in the patient journey ensures that complications are foreseen and overcome. An example of simple and complex discharges developed by Ipswich Hospital and Suffolk County Council can be found on the memory stick accompanying this guidance.

Do not confuse the needs of a patient who has complex clinical needs with those of a patient who has complex transfer of care needs.

Many patients and carers are becoming expert in managing long-term chronic conditions and often provide care that is equivalent to that provided by a registered nurse. In such cases, the home care arrangements can usually be set up quickly once the patient is clinically well enough and safe for transfer. Involving the people who provided the care plan prior to admission (such as a complex case manager, care manager, community matron or community mental health practitioner) can facilitate this process.

The following 'four Ps' model from the Welsh Assembly Government's discharge planning guide *Passing the baton*²¹ provides a four-step approach to help practitioners evaluate the assessment information, and the potential complexity of discharge and transfer arrangements. It illustrates the critical link between the early assessment of potential problems, risk assessment and management.

1. Previous	The patient's general circumstances, worries, concerns and lifestyle, and events leading up to the admission. The patient's and carer's worries and concerns about how he or she is coping.
2. Present	The likely impact of the admission on their current circumstances.
3. Predict	Risk factors that might have an impact on discharge.
4. Prevent	The actions required to overcome problems and prepare the patient for discharge.

Once this information is available, the potential risk areas and likely changes to the patient's everyday life will be clearer. And once the patient's immediate clinical needs are under control, the MDT will be able to assess the risks associated with a transfer of care and the actions needed to overcome the risks.

21 Welsh Assembly Government (2008) *Passing the baton: A practical guide to effective discharge planning*. Welsh Assembly Government.

Figure 1. The discharge and transfer planning process for simple and complex discharges

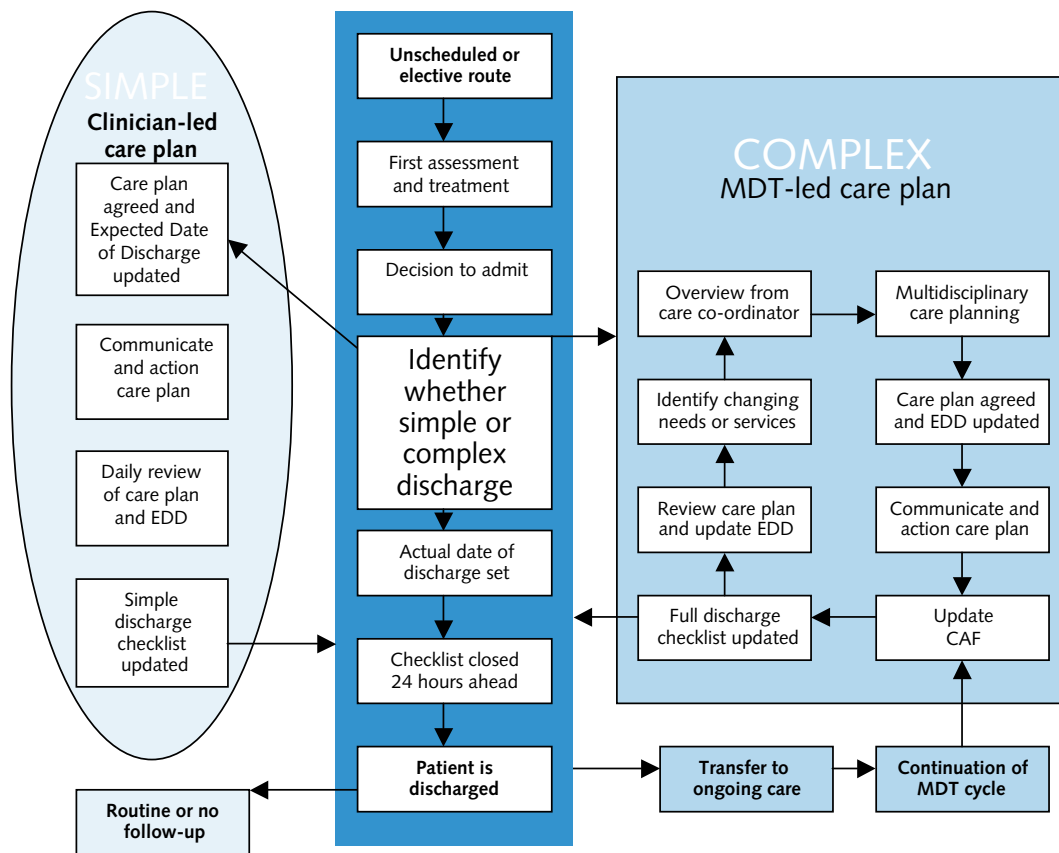


Figure 1 shows a high-level pathway for the discharge and transfer planning process, adapted from *Passing the baton*.

Step 3 Develop a clinical management plan for every patient within 24 hours of admission

Once the admission assessment has been completed, a clinical management plan should set out the goals for each patient.

Clinical management plans usually include:

- identification of the problem;
- goals for treatment activities to achieve outcomes;
- methods for achieving these goals; and
- estimated time to meet the goals.

It is essential that these goals and aspirations are developed and agreed with the patient and their carer, if they are able to participate. Patients may have very different aspirations from practitioners, and they are sometimes surprisingly simple. It is important to explore these as soon as possible with the patient to clarify expectations and motivation. Some hospitals are using post-take ward round management plans to agree goals.

1. Always clarify goals and expectations with the patient and their family.

A mismatch of expectations is often the result of poor communication early in the process.

2. Plan diagnostic tests, therapy and other interventions to avoid delays in treatment.

3. Identify any tests and therapy that could be provided in an outpatient setting if necessary.
4. Agree local standards for response times for referral to radiology, pathology and other services such as mental health. A great deal of inter-departmental co-operation is essential to achieve the most efficient options.
5. Co-ordinate MDT assessments and the management of risk effectively to ensure that everyone understands their role and is working to the same timeframe and outcome.
6. Don't prejudge the eventual outcomes for the patient before the patient has achieved their full potential. Rehabilitation and recuperation should always be explored and enacted before any life-changing decisions are made.²²
7. There is evidence that too many older people inappropriately enter long-term residential care direct from an acute hospital. Such decisions should not be made in an acute hospital other than in very exceptional circumstances.²³

Step 4 Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level

Effective co-ordination can make a significant difference to the speed and quality of the patient journey.²⁴ Ward

practitioners are becoming increasingly reliant on specialist discharge teams in cases where they should be able to manage the process themselves. Making the connections, enacting the procedures to involve people and prompting the resources required to care for the patient in the future must be integral to the care planning process at ward level. The productive ward programme²⁵ includes useful techniques to improve discharge co-ordination.

Given the changing work environment, it is unrealistic to expect one person to be available each day to co-ordinate care. It is therefore important to find a practical solution to achieve leadership of the process that fits in with your working environment.

1. Ensure that one person takes responsibility and is accountable for leading the care planning process each day, and that they have all the information available to them.
2. Manage the process so that all concerned understand their roles and responsibilities, so that their skills and knowledge are used to best effect.
3. Ensure that uninterrupted time is dedicated to the planning of discharges and transfers of care. For most patients, this will be relatively short; for others, longer will be required to complete a review and follow up concerns.

22 DH (2009) *Intermediate care – Building on the best*. DH.

23 DH (2009) *Intermediate care – Halfway home: Updated guidance for the NHS and local authorities*. DH.

24 DH (2003) *Discharge from hospital: Pathway, process and practice*. DH.

25 Ibid.

4. Use the ward handover to report back and identify who the lead will be handed over to.
5. Involve patients and carers in all stages of care planning.
6. Ensure that documentation is kept up to date and in one place, and that everyone contributes to one plan.
7. Consider whether the use of patient boards could improve communication between practitioners.²⁶
8. Focus on short- and long-term care planning outcomes.
9. Remember that it is the co-ordination of a number of simple actions that can make a big difference to the success or failure of a patient journey.
10. For more complex transfers of care, the patient will have a number of problems that require systematic co-ordination across the wider MDT.

Step 5 Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer

Most patients want to know how long they are likely to stay in hospital, and to be provided with information about their treatment and when they are likely to be discharged. This helps them achieve their goals and plan for their own transfer. The exceptions to this are intensive care and high-dependency units, where setting an

expected date should be delayed until the patient is transferred to the ward.

Predicting a patient's length of stay can be undertaken in two ways. It can be based on actual performance in the ward or unit, or on benchmarking information. It is essential that the ward or unit understands and uses the adopted system to give a valid and sustainable approach. The Department of Health's discharge guidance²⁷ states that:

"Estimated date of discharge 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 clinically stable and fit for discharge."

Decisions regarding discharge should involve patients and carers, and should be made following an assessment at pre-admission, at the outpatient appointment or on admission in an emergency.

1. For simple discharges, an expected date of discharge or transfer (EDD) should be set within 24 hours, based on the predicted length of stay. This should then be communicated to the patient and to all staff in contact with the patient.

2. Remember to identify any tests that are not urgent and can be undertaken as an outpatient.

Ideally, the EDD should be displayed in a prominent position for all to see. In many cases of elective admission, the EDD can be set before admission. The EDD should be

²⁶ Lees, L. and Delpino, R. (2007) 'Facilitating an effective discharge from hospital.' *Nursing Times*, Vol 103 No 29, pp 30–31.

²⁷ DH (2004) *Achieving timely 'simple' discharge from hospital*. DH.

proactively reviewed against the treatment plan (usually by ward staff) on a daily basis, and any changes should be communicated to the patient.

3. For complex cases, it is more difficult to anticipate the length of stay and may take a little longer, requiring detailed assessment and care planning by the MDT. In most cases, though, an EDD can be set within 48 hours.

4. For frail older people with multiple pathology in particular, it is imperative to set out goals for the MDT and, where appropriate, the patient's family. In principle, the patient should always have access to the expertise of the MDT – wherever they are treated.

Other patients with multiple pathology may need 24–48 hours to settle into their new environment before a true picture can be assessed and a realistic EDD set. This may also be the case for a patient who transfers to other departments or units for rehabilitation.

5. Ensure that everyone involved in the patient's care is aware of the anticipated timing and works towards the discharge deadline.

6. Clarify who has authority to change the EDD after consultation with the senior doctor.

7. Display the EDD in a prominent position and document it in the clinical management plan.

Some wards choose to post boards above each patient's bed to predict the discharge date and set a deadline for practitioners. Each board includes a discharge checklist so that everyone can see whether the patient is likely to be ready for transfer on the planned dates. Using patient boards in a similar way has been found to improve communication between practitioners.^{28,29}

Pointers for setting an expected date of discharge

- S** **Set** the EDD according to the patient's condition and diagnosis.
- T** **Tests** and investigations – base the EDD on the anticipated results of tests and investigations, and only change the EDD if the results are not as expected.
- A** **Achievable** but challenging – base the EDD on how long it should take to get results and assessments, not on how long it actually takes in practice (this enables organisations to identify any constraints).
- R** **Routine** – the MDT must set the EDD as part of the routine admissions assessment for every patient, and must regularly review it.
- T** **Timely** – the EDD must be set within 48 hours of admission to the acute setting, or at a pre-admissions assessment, and within four days for community settings.

28 Lees, L. and Delpino, R. (2007) 'Facilitating an effective discharge from hospital.' *Nursing Times*, Vol 103 No 29, pp 30–31.

29 Lees, L. (2008) 'Estimating patients' discharge dates: Applied leadership.' *Nursing Management*, Vol 15 No 3, pp 30–35.

Step 6 Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date

It is essential that the patient's response to treatment and their condition are reviewed daily and the likely impact on the expected date of transfer reviewed and documented.

*Passing the baton*³⁰ suggests the following.

1. A simple face-to-face discussion with the patient, for a few minutes each day, ensures that any individualised assessment is up to date, new information is added and the discharge or transfer process is progressing.
2. Progress should be reported at ward handover and any actions taken as required. These should be noted in the clinical management plan.

The RAP (Review – Action – Progress) format was developed by practitioners for this purpose.

The Review – Action – Progress (RAP)

Review

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

Action

- Talk to the patient and their carer about progress.
- Monitor and evaluate the care plan.
- Identify any actions required to make progress.
- Assess mental capacity if required.
- Liaise with the MDT.
- Review the expected discharge date.

Progress

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

³⁰ Welsh Assembly Government (2008) *Passing the baton: A practical guide to effective discharge planning*. Welsh Assembly Government.

Step 7 Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence

The majority of people leaving hospital have straightforward needs such as clinical follow-up, medication and any equipment needed to support their independence at home. Others will have more complex needs and will require ongoing rehabilitation or a complete review of their care arrangements.

1. Use integrated care pathways for the most common conditions to enable practitioners to anticipate and plan for needs and risks.
2. Manage patient and carer expectations by involving them at all stages of decision-making. Fewer problems and surprises come to light at the end of an episode of care when communication works well. A mismatch of expectations between the patient, carer and MDT is the result of inconsistent or poor communication earlier in the process.
3. Remember that patients and their carers are the experts in how they feel and what it is like to live with, or care for someone with, a particular condition or disability. Listen to their concerns and give consideration to their past and present circumstances and aspirations. Pay attention to their frame of mind, how they are feeling and who else might be involved.
4. Ensure that the patient is fully aware of their circumstances and able to give

informed consent. Where the patient cannot represent themselves, the next of kin, carer, relative or an independent mental capacity advocate (IMCA) must be involved. Their role is to represent the patient's interests, and to challenge any decision that does not appear to be in the best interest of the patient.³¹

5. Establish whether the patient has a complex case manager in the community to act as key worker for discharge planning. Their role includes supporting earlier discharge from hospital where possible.
6. Involve health and social care discharge planning teams for patients with complex transfer needs. These teams act as a resource to facilitate transfer from hospital.
7. Ensure that patients, carers and the MDT agree what needs to be happening to achieve a safe and timely discharge or transfer of care, and who needs to do what by when.
8. Offer the carer an assessment to identify any services they may need to support them in their caring role. This may be completed following the patient's discharge from hospital.
9. Ensure that any incidents relating to potential or suspected abuse of vulnerable adults are taken into account and an investigation conducted in line with local policies and procedures on the protection of vulnerable adults and the Mental Capacity Act.^{32,33} A useful factsheet (factsheet 12) about safeguarding adults can be found at www.devon.gov.uk/factsheets.

31 Ministry of Justice (2005) *Mental Capacity Act*. Office of Public Sector Information.

32 Ibid.

33 DH (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. DH and Home Office.

10. Undertake risk assessment and management. Practitioners need to understand the risks from both the patient's and the carer's perspective. What may seem an unacceptable risk to a practitioner may be completely acceptable to the patient if it enables them to meet their own goals.

11. Explore all options to ameliorate or minimise risk. Provide information in a way that empowers patients and carers to make an informed choice. Ultimately, if patients have the capacity to make a decision, the decision is theirs.

12. Always consider rehabilitation and enablement as the first options. Too many older people enter residential and nursing homes direct from acute care.³⁴

All too often, older people are encouraged to make a permanent decision to enter a care home before they have reached their full potential. Unfortunately, this is often the only option considered for many people with dementia. They are more likely to have a prolonged length of stay in hospital due to difficulties in finding suitable placements. The National Dementia Strategy suggests that many people with dementia could benefit from periods of intermediate care to optimise recovery after illness or injury.³⁵

13. Document the risk management plan in accordance with the local risk management policy. Once a full assessment of needs and risks has been made, the potential discharge care options can be considered.

Developing personalised care

Lord Darzi's NHS next stage review describes how:

*"Patients increasingly aspire to greater control and choice over the services they receive. I have seen how greater control can be offered to patients by ensuring that they have excellent information about the care options available to them and then by sharing decisions between patients and clinicians, leading to a personalised care plan tailored to the patient and agreed with them and their carers."*³⁶

*Putting People First*³⁷ sets out the strategic aims for adult social care. It reinforces the need for health and social care organisations to work closely together to promote choice and independence for people. Hospital discharge arrangements have been identified as a key area where health and social care should be integrated at the point of assessment, using person-centred planning to provide a unified approach to care delivery.

14. Provide enough relevant information and advice to people to enable them to act in their own best interest.

15. Ensure that patients do not remain in an acute setting when appropriate care can be delivered closer to their own home.

It is important to keep checking that the person has heard and understood the information, and been given an opportunity

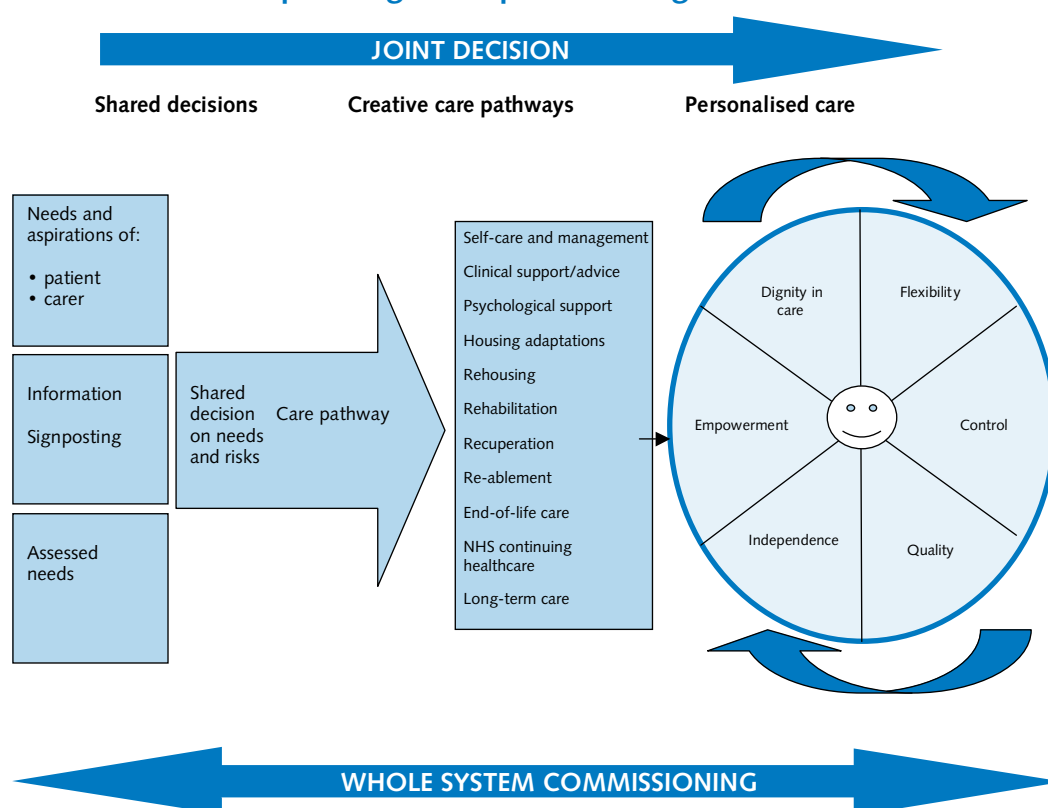
34 DH (2009) *Intermediate care – Halfway home: Updated guidance for the NHS and local authorities*. DH.

35 DH (2009) *Living well with dementia: A National Dementia Strategy*. DH.

36 Lord Darzi (2008) *Our NHS, our future: Next stage review*. DH.

37 DH (2007) *Putting People First: A shared vision and commitment to the transformation of adult social care*. DH.

Figure 2. Personalised care planning in hospital discharge



to put forward their point of view. Families and carers are becoming experts in delivering care; they know what help they need and want to have control over their own lives.

16. Personalise discharge and transfer of care, making creative use of locally available options to maximise choice and independence for each person – the right care in the right place at the right time.

NHS continuing healthcare

The majority of patients leaving hospital will not have needs that suggest eligibility for NHS continuing healthcare. However, patients who do have complex health needs are eligible to have their needs considered against the criteria.

17. In relation to hospital discharge, the NHS is required to assess a person's eligibility for NHS continuing healthcare before social services are notified of their case. A person's informed consent must be obtained before the assessment process is carried out.

Eligibility for NHS continuing healthcare is based on an individual's assessed health needs. In order to inform consistent decision-making on a person's eligibility, the *National Framework for NHS Continuing Healthcare* was introduced in October 2007 and revised in July 2009.³⁸ The framework includes three tools, described below and provided on the memory stick that accompanies this guidance, to support decision-making.

38 DH (2007) *The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*. DH (revised July 2009).

- **Fast-track tool** specifically for people who have a rapidly deteriorating condition that may be entering the terminal phase. In the hospital situation they may need to be transferred quickly to meet their needs.
- **NHS continuing healthcare needs checklist** to support practitioners in identifying people who may be eligible. The descriptions in the tool are based on the mid-level of a hierarchy of needs, described in the decision support tool (see below). The process should be completed by a member of the ward team who knows the patient well and has a basic understanding of the levels of need in the decision support tool. This will enable them to understand whether the patient's level of need falls above or below the referral criteria for a full assessment. Patients requiring a full consideration of their eligibility should be referred according to the local referral protocol. In most situations, this will be to a member of the discharge planning team.
- **Decision support tool (DST)** designed to ensure that the full range of factors that have a bearing on the person's eligibility are taken into account in making a decision. This should be completed following a full assessment of need and risk by the MDT. The patient's needs should be evaluated and a level of need apportioned. Completion of the DST should be co-ordinated by a clinician who has specialist knowledge of the NHS eligibility criteria and with the agreement of the MDT. A recommendation should then be made on the person's eligibility for NHS continuing healthcare.

18. Ward practitioners involved in the screening process should have a basic understanding of the criteria for NHS continuing healthcare in order to complete the screening process effectively. Without this understanding, inappropriate referrals are more likely: patient expectations might be raised inappropriately and discharge planning could be delayed.

Patients who are not eligible for NHS continuing healthcare and who enter a nursing home are eligible for an assessment for NHS-funded nursing care. This is a standard weekly payment made directly to the nursing home to meet the cost of the care from a registered nurse. There is also provision for continence aids, as required. The cost of accommodation and personal care is subject to a means test by the local authority.

The Community Care (Delayed Discharges etc) Act 2003

The NHS has a statutory responsibility to alert social care if a patient is likely to need community care services on leaving hospital. However, a patient must be made aware of this and must give their permission for a referral to be made.

19. Where appropriate, and in agreement with the patient, a Section 2 notification should be made according to the local agreement. If the patient is clear that they do not want social care involved, the patient becomes responsible for arranging their own onward care.

20. A Section 5 notification should be made once a discharge date has been confirmed.

The choice directions guidance³⁹

Discharge or transfer from hospital is frequently delayed when an individual's preferred accommodation is not available. While it is entirely reasonable for a person to exercise choice at an extremely difficult and vulnerable time in their lives, the guidance makes it clear that, as long as an interim placement meets the needs of the individual, it is acceptable for a person to move from an acute hospital to an interim placement until the permanent or alternative choice becomes available. It is important that consistent messages and information are given to patients and carers by all staff about the likely length of stay in hospital, and the need to move on to more appropriate care when they are ready to do so. This will avoid misunderstandings and surprises later in the process.

21. Practitioners involved in discharge planning should be aware of the NHS trust's policy on implementing the directive on choice of accommodation to guide staff.

Discharge of patients who are homeless, living in temporary or insecure accommodation, living in prison or who are asylum seekers

For many of these people, admission to hospital presents an opportunity to deal with underlying medical, social and mental health problems, and to address accommodation needs. Every hospital should have an admission and discharge protocol specifically for people with these

needs. The complex nature of the problems requires partnership working with the primary care trust, local authority, voluntary sector and housing organisations. *Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation* provides useful guidance on developing a joint protocol for admission and discharge.⁴⁰

Step 8 Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient

The 2004 DH toolkit⁴¹ identified some variation in the length of stay of patients linked to the day of the week of their admission (see Figure 3). Any mismatch between demand and capacity is normally temporary, and discharges catch up with admissions at some point. But this mismatch, however temporary, can be quite extreme. There can also be wide variation in the day of the week on which discharges take place, with the peak being on Friday and discharges then slowing to a trickle until Monday. It may take several days for the mismatch between admissions and discharges to even itself out.

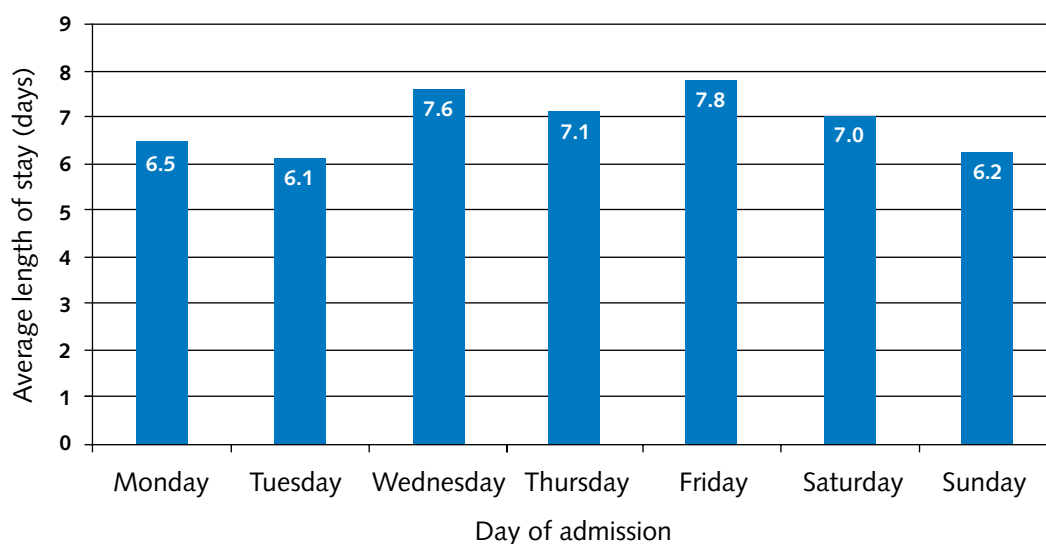
1. Ensure that people know how long they can expect to be in hospital and the time of day they can expect to be discharged, so that they can make the necessary arrangements.

39 LAC (2001) 29: Charges for residential accommodation. www.dh.gov.uk/en/PublicationsandStatistics.

40 Communities and Local Government, DH, Homeless Link and NHS The London Network for Nurses and Midwives (2006) *Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation*. CLG.

41 DH (2004) *Achieving timely 'simple' discharge from hospital*. DH.

Figure 3. Typical trust example: Average length of stay for medical patients by day of admission



The majority of patients who have a simple discharge will be able to make arrangements that can be put in place quickly, so that they can be discharged on any day each week. The more complex discharge arrangements will require some lead-in time to organise and confirm care provision.

2. Ensure that patients, carers and everyone involved in the discharge plan are kept informed of any changes.
3. Integrate the planning of discharges and transfers into ward handovers.
4. Display discharge and transfer information prominently either by using a whiteboard or by linking patient boards to discharge planning.⁴²

However well planned a discharge is, some patients and carers may have unforeseen problems that require a change of plan. A proactive approach ensures that actions are

taken every day of the week to progress the care pathway (Step 6). It is essential that the steps described earlier in this section continue over seven days each week, and in addition that the following actions are integrated into the patient's care pathway.

- Nurses, therapists and allied health professionals take on more responsibility for initiating discharge (Step 10).
 - Diagnostic tests and interventions are planned to avoid delays in treatment. Consider whether non-urgent tests can be completed as an outpatient.
 - Agreements are put in place for rapid access to specialist mental health and learning disability assessment.
 - Medication is reviewed on admission, a medication care plan is put in place and compliance training is undertaken.
- Discharge from hospital: Pathway, process and practice* contains useful

⁴² Lees, L. and Delpino, R. (2007) 'Facilitating an effective discharge from hospital'. *Nursing Times*, Vol 103 No 29, pp 30–31.

information on medicines management – this extract is provided on the memory stick accompanying this guidance.

- Patients who could be discharged or transferred early are seen first (before ward rounds or reviews).
- Regular senior reviews take place outside the ward round and include the prescription of 'treatment to take out' on the day prior to transfer.
- Decisions that the patient is clinically stable and safe for discharge are made each day.
- Discharges and transfers are not delayed due to ward rounds, drug rounds or other routine activities.
- Where available, discharge lounges and other accommodation complexes should be used to transfer patients early in the day if they need to wait for transport or other discharge and transfer items.

Step 9 Use a discharge checklist 24–48 hours prior to transfer

1. Check the transfer plan 24–48 hours before the transfer of care takes place.

The responsible practitioner must ensure that the discharge or transfer of care plan is satisfactory before the actual discharge takes place. This involves checking that the necessary actions have taken place 24–48 hours prior to the discharge date. A checklist can be used throughout the patient's stay to record actions as they take place.

2. In the case of a complex transfer of care, the responsible practitioner must ensure that the specific timing and organisation of services will provide continuity of care.

This requires effective liaison between the patient and carer and their family, members of the core MDT, multi-agency services, community providers and the independent sector, as appropriate. Written information regarding care and treatment, medication, dressings and equipment should be prepared in advance, ready for transfer with the patient.

3. Use a transfer folder and checklist to collect and disseminate relevant information to ensure that plans are clearly visible and to avoid misunderstandings.

Any changes or exceptions should be communicated to the relevant agencies as soon as practicable and documented accordingly. If discharge plans are changed and dates altered, it is important to alert the care agencies and confirm the new arrangements as soon as possible.

4. File the transfer documentation in the patient notes following transfer as a record of the discharge planning process, and consider sending a copy home with the patient.

There are many good examples of checklists that could be adapted for local use, and a basic one is provided on the accompanying memory stick. Consider colour coding for easy identification.⁴³

43 Lees, L. (2006) 'Not just another sheet of paper: discharge checklists'. *The Communicator* – RCN discharge planning and continuing care forum, summer 2006, pp 4–5.

Step 10 Make decisions to discharge and transfer patients each day

On the day of discharge or transfer, a decision needs to be made that the patient is ready for discharge or transfer. Historically, such decisions have been made by the consultant responsible for the patient's care and are made on the basis that the patient no longer needs 24-hour access to consultant-led medical care. One of the most significant internal factors delaying a patient's transfer is the timing of the consultant's decision to discharge or transfer.

Guidance on the definitions of 'clinical readiness' and 'safe to transfer' is included on the accompanying memory stick and can also be found on the DH website at: www.dhcarenetworks.org/ageingstrategy.

1. Nurses and allied health professionals should take on more responsibility for initiating transfers, especially for simple transfers.

The NHS Plan⁴⁴ identified that one of the 10 key roles for nurses was 'to admit and transfer patients for specific conditions using agreed protocols'. The DH toolkit⁴⁵ provides information and case studies to take this forward and states that:

"The overall legal responsibility for a patient's care remains with their senior medical practitioner... The consultant can delegate responsibility to an appropriately qualified health professional. When a task is delegated, the consultant/lead clinician assumes responsibility for delegating

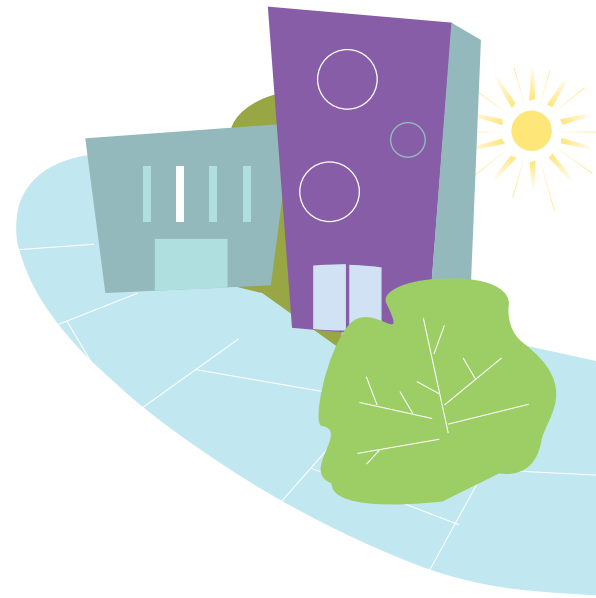
appropriately. The person to whom the responsibility is delegated takes on a commitment and responsibility for carrying out the task in a responsible, accountable, reasonable and logical manner in keeping with their own professional code of conduct.

"The consultant/lead clinician should always make sure that the person taking on the responsibility has the appropriate knowledge and skills. Where nurses and allied health professionals are taking on responsibility, clear competencies and training should be developed for staff."

The DH toolkit includes a matrix on training competencies which is also available on the memory stick.

44 DH (2000) *The NHS Plan: A plan for investment, a plan for reform*. DH.

45 DH (2004) *Achieving timely 'simple' discharge from hospital*. DH.



Chapter 3: Involving patients and carers

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This chapter reflects on the discharge and transfer process from the patient's and carer's perspectives to help practitioners understand what works well and why misunderstandings occur. Recent research has shown that there is still much to do to improve the experience of planning for, and moving from, hospital care. The challenge for practitioners is how they balance the tension between pressures in the system and their wish to provide person-centred care and treat patients with dignity.⁴⁶

Admission to hospital can be a particularly frightening and confusing time for people. Patients have consistently reported feeling 'anxious, insignificant and powerless'. Often, communication by practitioners with patients and carers is about informing them of decisions about their care. It is about creating a relationship where patients and their carers feel that things are happening around them but not with them.⁴⁷ Conversely, good relationships with practitioners enable patients and carers to put their points across and feel involved in decisions.

*"For family carers, the discharge process was often very stressful and at points they felt a sense of both powerlessness and of having to fight to achieve what they considered would be best for their relatives."*⁴⁸

If, in addition to physical ill health or trauma, someone is admitted with a learning disability or mental ill health, and/or who appears to be confused, the change of environment and the nature of acute hospitals can quickly lead to a loss of independence or possibly to the development of behaviour that causes distress to other patients.

Communication – getting it right

1. Well-developed interpersonal skills are essential if a trusting, collaborative and professional relationship is to be established. It is important that the patient feels understood from the outset and able to discuss what they perceive as their real concerns and worries.

46 Hubbard et al (2008) *Reimbursement in practice: The last piece of the jigsaw?* University of Stirling, University of Leeds, King's College London.

47 DH (2003) *Discharge from hospital: Pathway, process and practice*. DH.

48 Hubbard et al (2008) *Reimbursement in practice: The last piece of the jigsaw?* University of Stirling, University of Leeds, King's College London.

2. Good communication is the way to ensure that your knowledge and clinical skills are used to greatest effect. Use language and terminology that is familiar to the patient and is culturally sensitive. Always check their understanding.

Asking a patient how they like to be addressed (and ensuring that this is passed on) shows sensitivity and respect. Also, when undertaking an assessment, ask what is meaningful to them. This is especially important for older people, as practitioners can be unaware that an older person has a rich life history and is probably terrified that their sense of who they are is about to be denied. When these important points are omitted, patients may be labelled as difficult and uncooperative when they perceive themselves to be in conflict with those responsible for their care.

3. Ensure that the patient is fully aware of their circumstances and able to give informed consent. Where the patient cannot represent themselves, the next of kin, carer, relative or an independent mental capacity advocate (IMCA) must be involved. An IMCA's role is to represent the patient's interest, and to challenge any decision that does not appear to be in the best interest of the patient.⁴⁹

4. Show compassion – this helps patients to develop a closer bond of trust and respect with practitioners.⁵⁰

It is normal on a busy day to deal with people quickly and efficiently. Over time, we become accustomed to our own environment and immune to distractions.

Remember that the patient is in an unfamiliar environment and relies on the practitioner to choose the place and timing of any interaction.

5. Simple considerations such as these can make a big difference to the success or failure of talking to a patient:

- Body language
- Spoken word (use of non-jargon)
- Surroundings
- Noise levels
- Privacy
- Distractions
- Comfort of the patient
- Language or communication difficulties.

6. Ensure continuity of information. Every effort must be made to ensure consistency and continuity of information from different people.

7. The provision of information and discharge folders can be helpful. The patient and carer can have their own record of events and future plans, enabling them to look through the information at their own pace, ask questions and raise their concerns.

But too much information can be confusing and it may be more appropriate to provide some information in other languages, on audio tapes or in large print, Braille or British Sign Language. For some patients, it will be necessary to involve an advocate or interpreter to provide further assistance.

49 Ministry of Justice (2005) *Mental Capacity Act*. Office of Public Sector Information.

50 Welsh Assembly Government (2008) *Passing the baton: A practical guide to effective discharge planning*. Welsh Assembly Government.

Carers – getting it right for them

1. Recognise the role of the carer from the start of the discharge or transfer process to ensure that all of the stages of the care pathway are well managed.

A carer may have been in a caring role for many years and may have built up an expert knowledge of the needs of the cared-for. For others, this will be their first experience of a serious health issue and yet, on discharge, you may need their help to care for the person in the community. Carers should be involved in decision-making from the beginning so that they are better able to inform you and provide better care.

2. It is also important to check what information you are given by the patient about their relative's willingness and ability to care. Patients and their carers may have different needs, so do not assume that a carer will necessarily be able or willing to continue in a caring role. It is important to remember that young people may also provide a major part of a parent's care.

Some patients say that they will be cared for by their relatives, and yet the relative is unable to do so. When this happens, it may lead to crisis planning if it becomes apparent that the family member cannot care for the patient – because of work, living a distance away or other family commitments.

3. Check with the person concerned if there is any expectation that a relative or close friend will provide care.
4. Carers have a right to an assessment and to any services that they may need to support them in their caring role. The results of this assessment may mean more care for

the person they are caring for, care delivered in a different way or services just for the carer themselves.

The Disabled Persons Act of 1986 places a duty on local authorities to take a carer's ability to care into account when deciding what services to provide to a disabled person. It is important to find solutions that work for the family or network of other carers as a whole.

Understanding expectations



1. Planning for discharge requires the forming of an agreement and a decision with the patient and their family about what needs to happen to achieve a safe and timely discharge. This should include their responsibilities for delivering the care plan. The plan should be kept under daily review as the discharge date approaches.
2. When communication works well, it should be possible to establish a working relationship with the patient and their family. This does not necessarily imply agreement, but all concerned should be able to work together to find creative solutions.
3. A mismatch of expectations is usually the result of inconsistent or poor communication earlier in the patient's experience. Fewer problems and surprises come to light at the end of an episode of care when communication works well.
4. Provide enough relevant information and advice to people to enable them to act in their own best interest.

Practical tools and techniques

This section is taken from the Welsh Assembly Government's 2008 publication *Passing the baton*.⁵¹ It offers some tools and tips to help individual practitioners and the MDT to evaluate their communication with patients and carers and within the team.

Stop, look, listen

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

STOP  LOOK  LISTEN	Say the word 'stop' in your head. Stand still, preferably put down anything you're carrying, remind yourself that this is important and recognise your own frame of mind.
	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.
	Say the word 'listen' in your head. Don't think of answers while the person is speaking, make a point of really trying to understand them by checking back with them before answering.

Understanding practicalities

Considerate language, well-written literature, clearly designed diagrams, simple signposting and accessible media in any format all help to complement and reinforce 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 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 impairments.
4. Use standardised basic information but individualise it with further details that are specific to the person.
5. Ask directly how the person would prefer to have information provided to them, and identify any special communication needs.
6. Explain your responsibility to communicate effectively and always invite the person to ask anything, however simple.

⁵¹ Welsh Assembly Government (2008) *Passing the baton: A practical guide to effective discharge planning*. Welsh Assembly Government.

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. The dialogue with practitioners should change according to this increased understanding.

Setting time aside

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

If you have something important to communicate, take 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.

Continuous improvement

Monitoring the effectiveness of team communication is an essential and proven method of slowly and consistently improving the experience of the patient and of 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. 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 then act on it. No matter how small the issue, momentum will start to build and the trust of everyone concerned will grow.

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

The 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 communicated is the same as what was understood.

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

Communication audit tool

Reduce anxiety

- ☐ There is consistent use of language and terminology across the whole clinical team and acronyms are avoided
- ☐ The patient and carer experience (rather than other performance indicators) leads the drive for improvement
- ☐ Consideration is always given to how and when to communicate, and then to what information to give
- ☐ There is a clear process of escalation where needs and circumstances are becoming more complex

Overcome operational issues

- ☐ Practitioners who are 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 the day throughout the hospital stay
- ☐ Communication and supporting literature are designed to meet the needs of elective and emergency pathways
- ☐ Documentation is shared professionally at every opportunity and checked with the patient

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 the health and social care system
- ☐ Non-clinical information is communicated every time for every patient at formal handovers
- ☐ The patient's and/or the carer's own language is used on reports and assessments to emphasise important issues

Take personal responsibility

- ☐ Communicating continuously without having to be asked is a core duty, to enable the patient to play an active role
- ☐ As their advocate, staff take personal responsibility for acting on information and on the wishes of the patient
- ☐ Standard literature and information is supplemented to meet the need of each individual
- ☐ New technologies and methods are used to trigger active engagement and to enable effective communication



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