

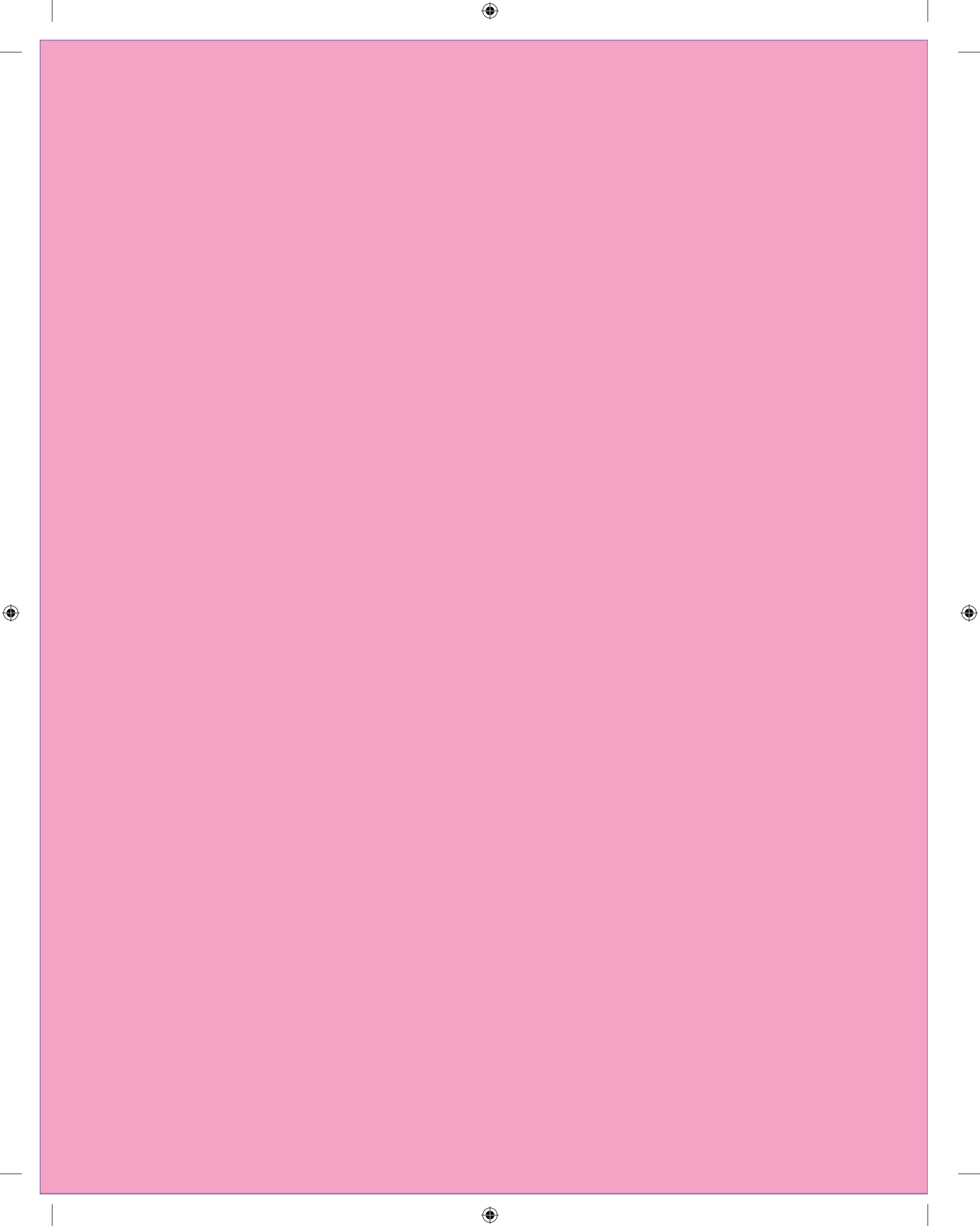
Part One

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Assessment and discharge

2



By reading this chapter and undertaking the learning activities within it, you should be able to:

- 1 Demonstrate a critical understanding of the principles and structure of nursing assessment, so that such frameworks and tools can be used to identify patient problems/nursing diagnoses and monitor the effectiveness of care.
- 2 Construct a comprehensive nursing care plan for a patient that includes clear identification of the patient's problems, measurable outcomes and realistic nursing interventions.
- 3 Identify the key considerations when planning a discharge for a patient from hospital to the community to ensure the patient receives safe and effective ongoing care.

Overview

10

This chapter will give an overview of a patient's care from assessment through to discharge.

Assessment forms an integral part of patient care and is considered to be the first step in the process of individualized nursing care. It provides information that is critical to the development of a plan of action that enhances personal health status.

Assessment decreases the potential for, or the severity of, chronic conditions and helps the individual to gain control over their health through self-care (RCN 2004). Early and continued assessments are vital to the success of the management of patient care. It is critical that nurses have the ability to assess patients and document their findings in a systematic way.

Discharge planning is key to ensuring that patients return to the community with the appropriate care to support them and their carers at home. The process can also reduce hospital length of stay and unplanned readmission to hospital, and improve the co-ordination of services following discharge from hospital (Shepperd et al. 2013).

The nurse's ability to assess the needs of the patient and carer (Atwal 2002) is central to a good discharge.

Inpatient assessment and the process of care

DEFINITION

Assessment is the systematic and continuous collection, organization, validation and documentation of information (Berman et al. 2010). It is a deliberate and interactive process that underpins every aspect of nursing care (Heaven and Maguire 1996). It is the process by which the nurse and patient together identify needs and concerns. It is seen as the cornerstone of individualized care, a way in which the uniqueness of each patient can be recognized and considered in the care process (Holt 1995).

RELATED THEORY

Principles of assessment

The purpose of the nursing assessment is to get a complete picture of the patient and how they can be helped. An effective assessment will provide the nurse with information on the patient's background, lifestyle, family history and the presence of illness or injury (Crouch and Meurier 2005). The nursing assessment should focus on the patient's response to a health need rather than disease process and pathology (Wilkinson 2007). The process of assessment requires nurses to make accurate and relevant observations, to gather, validate and organize data and to make judgements to determine care and treatment needs. It should have physical, psychological, spiritual, social and cultural dimensions, and it is vital that these are explored with the person being assessed. The patient's perspective of their level of daily activity functioning (Horton 2002) and their educational needs is essential to help maximize their understanding and self-care abilities (Alfaro-LeFevre 2014). It is only after making observations of the person and involving them in the process that the nurse can validate their perceptions and make appropriate clinical judgements.

Effective patient assessment is integral to the safety, continuity and quality of patient care, and fulfils the nurse's legal and professional obligations in practice. The main principles of assessment are outlined in Box 2.1.

Structure of assessment

Structuring patient assessment is vital to monitoring the success of care and detecting the emergence of new problems. There are many conceptual frameworks or nursing models, such as



Box 2.1 Principles of assessment

- 1 Patient assessment is patient focused, being governed by the notion of an individual's actual, potential and perceived needs.
- 2 It provides baseline information on which to plan the interventions and outcomes of care to be achieved.
- 3 It facilitates evaluation of the care given and is a dimension of care that influences a patient's outcome and potential survival.
- 4 It is a dynamic process that starts when problems or symptoms develop, and continues throughout the care process, accommodating continual changes in the patient's condition and circumstances.
- 5 It is essentially an interactive process in which the patient actively participates.
- 6 Optimal functioning, quality of life and the promotion of independence should be primary concerns.
- 7 The process includes observation, data collection, clinical judgement and validation of perceptions.
- 8 Data used for the assessment process are collected from several sources by a variety of methods, depending on the healthcare setting.
- 9 To be effective, the process must be structured and clearly documented.

Source: Adapted from Alfaro-LeFevre (2014), NMC (2008), Teytelman (2002), White (2003).

Roper's Activities of Daily Living (Roper et al. 2000), Orem's self-care model (Orem et al. 2001) or Gordon's Functional Health Patterns Framework (Gordon 1994). There remains, however, much debate about the effectiveness of such models for assessment in practice, some arguing that individualized care can be compromised by fitting patients into a rigid or complex structure (Kearney 2001, McCrae 2012). Nurses therefore need to take a pragmatic approach and utilize assessment frameworks that are appropriate to their particular area of practice. This is particularly relevant in today's rapidly changing healthcare climate where nurses are taking on increasingly advanced roles, working across boundaries and setting up new services to meet patients' needs (DH 2006a).

Nursing models can serve as a guide to the overall approach to care within a given healthcare environment and therefore provide a focus for the clinical judgements and decision-making processes that result from the process of assessment. During any patient assessment, nurses engage in a series of cognitive, behavioural and practical steps but do not always recognize them as discrete decision-making entities (Ford and McCormack 1999). Nursing models give novice practitioners a structure with which to identify these processes and to reflect on their practice in order to develop the analytical, problem-solving and judgement skills needed to provide an effective patient assessment.

Nursing models have been developed according to different ways of perceiving the main focus of nursing. These include adaptation models (e.g. Roy 1984), self-care models (e.g. Orem et al. 2001) and activities of daily living models (e.g. Murphy et al. 2000). Each model represents a different view of the relationship between four key elements of nursing: health, person, environment and nursing. It is important that the appropriate model is used to ensure that the focus of assessment data collected is effective for particular areas of practice (Alfaro-LeFevre 2014, Murphy et al. 2000). Nurses must also be aware of the rationale for implementing a particular model since the choice will determine the nature of patient care in their day-to-day work. The approach should be sensitive enough



Box 2.2 Gordon's functional health patterns

- Health perception – health management
- Nutrition – metabolic
- Elimination
- Activity – exercise
- Sleep – rest
- Cognitive – perceptual
- Self-perception – self-concept
- Coping – stress tolerance
- Role – relationship
- Sexuality – reproductivity
- Value – belief

Source: Gordon (1994). Reproduced with permission from Elsevier.

to discriminate between different clinical needs and flexible enough to be updated on a regular basis (Allen 1998, Smith and Richardson 1996).

The framework of choice at the Royal Marsden Hospital is based on Gordon's Functional Health Patterns (Gordon 1994; Box 2.2). The framework facilitates an assessment that focuses on patients' and families' problems and functional status and applies clinical cues to interpret deviations from the patient's usual patterns (Johnson 2000). The model is applicable to all levels of care, allowing all problem areas to be identified. The information derived from the patient's initial functional health patterns is crucial for interpreting both the patient's and their family's pattern of response to the disease and treatment.

EVIDENCE-BASED APPROACHES

Collecting data

Data collection is the process of gathering information about the patient's health needs. This information is collected by means of interview, observation and physical examination and consists of both objective and subjective data. Objective data are measurable and can be detected by someone other than the patient. They

include vital signs, physical signs and symptoms, and laboratory results. Subjective data, on the other hand, are based on what the patient perceives and may include descriptions of their concerns, support network, their awareness and knowledge of their abilities/disabilities, their understanding of their illness and their attitude to and readiness for learning (Wilkinson 2007). Nurses working in different settings rely on different observational and physical data. A variety of methods have been developed to facilitate nurses in eliciting both objective and subjective assessment data on the assumption that, if assessment is not accurate, all other nursing activity will also be inaccurate.

Studies of patient assessment by nurses are few but they indicate that discrepancies between the nurses' perceptions and those of their patients are common (Brown et al. 2001, Lauri et al. 1997, McDonald et al. 1999, Parsaie et al. 2000). Communication is therefore key for, as Suhonen et al. (2000) suggest, 'there are two actors in individual care, the patient and the nurse' (p.1254). Gaining insight into the patient's preferences and individualized needs is facilitated by meaningful interaction and depends both on the patient's willingness and capability in participating in the process and the nurse's interviewing skills. The initial assessment interview not only allows the nurse to obtain baseline information about the patient, but also facilitates the establishment of a therapeutic relationship (Crumbie 2006). Patients may find it difficult to disclose some problems and these may only be identified once the nurse-patient relationship develops and the patient trusts that the nurse's assessment reflects concern for their well-being.

While the patient is the primary source of information, data may be elicited from a variety of other secondary sources including family and friends, other healthcare professionals and the patient's medical records (Kozier 2012, Walsh et al. 2007).

Assessment interviews

An assessment interview needs structure to progress logically in order to facilitate the nurse's thinking (an example of such a structure can be found in Box 2.3) and to make the patient feel comfortable in telling their story. It can be perceived as being in three phases: the introductory, working and end phases (Crumbie 2006).

It is important at the beginning to build a rapport with the patient. It is vital that the nurse demonstrates interest and respect



Box 2.3 Carrying out a patient assessment using functional health patterns

Pattern	Assessment and data collection are focused on
Health perception – management	<ul style="list-style-type: none"> • The person's perceived level of health and well-being, and on the practices they use for maintaining health. • Habits that may be detrimental to health are also evaluated. • Actual or potential problems related to safety and health management may be identified as well as needs for modifications in the home or for continued care in the home.
Nutrition and metabolism	<ul style="list-style-type: none"> • The pattern of food and fluid consumption relative to metabolic need. • Actual or potential problems related to fluid balance, tissue integrity. • Problems with the gastrointestinal system.
Elimination	<ul style="list-style-type: none"> • Excretory patterns (bowel, bladder, skin). • Excretory problems such as incontinence, constipation, diarrhoea and urinary retention may be identified.
Activity and exercise	<ul style="list-style-type: none"> • The activities of daily living requiring energy expenditure, including self-care activities, exercise and leisure activities. • The status of major body systems involved with activity and exercise is evaluated, including the respiratory, cardiovascular and musculoskeletal systems.
Sleep and rest	<ul style="list-style-type: none"> • The person's sleep, rest and relaxation practices. • Dysfunctional sleep patterns, fatigue, and responses to sleep deprivation may be identified.

(continued)



Box 2.3 Carrying out a patient assessment using functional health patterns (continued)

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Pattern	Assessment and data collection are focused on
Cognitive and perceptual ability	<ul style="list-style-type: none"> The ability to comprehend and use information. The sensory and neurological functions.
Perception/concept of self	<ul style="list-style-type: none"> The person's attitudes toward self, including identity, body image and sense of self-worth. The person's level of self-esteem and response to threats to their self-concept may be identified.
Stress and coping	<ul style="list-style-type: none"> The person's perception of stress and its effects on their coping strategies. Support systems are evaluated, and symptoms of stress are noted. The effectiveness of a person's coping strategies in terms of stress tolerance may be further evaluated.
Roles and relationships	<ul style="list-style-type: none"> The person's roles in the world and relationships with others. Satisfaction with roles, role strain or dysfunctional relationships may be further evaluated.
Sexuality and reproduction	<ul style="list-style-type: none"> The person's satisfaction or dissatisfaction with sexuality patterns and reproductive functions. Concerns with sexuality may be identified.
Values and belief	<ul style="list-style-type: none"> The person's values, beliefs (including spiritual beliefs) and goals that guide their choices or decisions.

Source: Adapted from Gordon (1994). Reproduced with permission from Elsevier.

in the patient from the very start of the interview. Some of the questions asked are likely to be of a searching and intimate nature, which may be difficult for the patient to disclose. The nurse should emphasize the confidential nature of the discussion and take steps to reduce anxiety and ensure privacy since the patient may modify their words and behaviour depending on the environment. Taking steps to establish trust and develop the relationship early will set the scene for effective and accurate information exchange (Aldridge et al. 2005, Silverman et al. 2013).

In the middle working phase, various techniques can be employed to assist with the flow of information. Open questions are useful to identify broad information that can then be explored more specifically with focused questions to determine the nature and extent of the problem. Other helpful techniques include restating what has been said to clarify certain issues, using verbal and non-verbal cues to encourage the patient, verbalizing the implied meaning, using silence and summarizing (Kozier 2012, Silverman et al. 2013). It is important to recognize that there may be times when it is not possible to obtain vital information directly from the patient; they may be too distressed, unconscious or unable to speak clearly, if at all. In such situations, appropriate details should be taken from relatives or friends and recorded as such. Effort should equally be made to overcome language or cultural barriers by the use of interpreters.

The end phase involves a further summary of the important points and an explanation of any referrals made. In order to gain the patient's perspective on the priorities of care and to emphasise the continuing interest in their needs, a final question asking about their concerns can be used (Alfaro-LeFevre 2014). Examples include: 'Tell me the most important things I can help you with', 'Is there anything else you would like to tell me?', 'Is there anything that we haven't covered that still concerns you?' or 'If there are any changes or you have any questions, do let me know'. Box 2.4 provides a summary of the types of assessment.

LEGAL AND PROFESSIONAL ISSUES

The NHS *Knowledge and Skills Framework* (DH 2004a) states that the specific dimensions of 'assessment and care planning to meet people's health and wellbeing needs' and 'assessment and treatment planning related to the structure and function of physiological and psychological systems' are core to nursing

posts in all settings. In undertaking this work, staff will need to be aware of their legal obligations and responsibilities, the rights of the different people involved, and the diversity of the people they are working with.

Nurses have an obligation to record details of any assessments and reviews undertaken, and provide clear evidence of the



Box 2.4 Types of patient assessment

Mini assessment

A snapshot view of the patient based on a quick visual and physical assessment. Consider patient's ABC (airway, breathing and circulation), then assess mental status, overall appearance, level of consciousness and vital signs before focusing on the patient's main problem.

Comprehensive assessment

An in-depth assessment of the patient's health status, physical examination, risk factors, psychological and social aspects of the patient's health that usually takes place on admission or transfer to a hospital or healthcare agency. It will take into account the patient's previous health status prior to admission.

Focused assessment

An assessment of a specific condition, problem, identified risks or assessment of care; for example, continence assessment, nutritional assessment, neurological assessment following a head injury, assessment for day care, outpatient consultation for a specific condition.

Ongoing assessment

Continuous assessment of the patient's health status accompanied by monitoring and observation of specific problems identified in a mini, comprehensive or focused assessment.

Source: Ahern and Philpot (2002), Holmes (2003), White (2003).

arrangements that have been made for future and ongoing care (NMC 2010). This should also include details of information given about care and treatment.

PRE-PROCEDURAL CONSIDERATIONS

Assessment tools

The use of assessment tools enables a standardized approach to obtaining specific patient data. This can facilitate the documentation of change over time and the evaluation of clinical interventions and nursing care (O'Connor and Eggert 1994). Perhaps more importantly, assessment tools encourage patients to engage in their care and provide a vehicle for communication to allow nurses to follow patients' experiences more effectively.

Assessment tools in clinical practice can be used to assess the patient's general needs, for example the supportive care needs survey (Bonevski et al. 2000), or to assess a specific problem, for example the oral assessment guide (Eilers et al. 1988). The choice of tool depends on the clinical setting although in general, the aim of using an assessment tool is to link the assessment of clinical variables with measurement of clinical interventions (Frank-Stromborg and Olsen 2004). To be useful in clinical practice, an assessment tool must be simple, acceptable to patients, have a clear and interpretable scoring system and demonstrate reliability and validity (Brown et al. 2001).

More tools are used in practice to assess treatment-related symptoms than other aspects of care, possibly because these symptoms are predictable and of a physical nature and are therefore easier to measure. The most visible symptoms are not always those that cause most distress (Holmes and Eburn 1989); however, an acknowledgement of the patient's subjective experience is therefore an important element in the development of assessment tools (McClement et al. 1997, Rhodes et al. 2000).

The use of patient self-assessment tools appears to facilitate the process of assessment in a number of ways. It enables patients to indicate their subjective experience more easily, gives them an increased sense of participation (Kearney 2001) and prevents them from being distanced from the process by nurses rating their symptoms and concerns (Brown et al. 2001). Many

authors have demonstrated the advantages of increasing patient participation in assessment by the use of patient self-assessment questionnaires (Rhodes et al. 2000).

The methods used to facilitate patient assessment are important adjuncts to assessing patients in clinical practice. There is a danger that too much focus can be placed on the framework, system or tool that prevents nurses thinking about the significance of the information that they are gathering from the patient (Harris et al. 1998). Rather than following assessment structures and prompts rigidly, it is essential that nurses utilize their critical thinking and clinical judgement throughout the process in order to continually develop their skills in eliciting information about patients' concerns and using this to inform care planning (Edwards and Miller 2001).

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Learning Activity 2.1

Learning in practice: Patient assessment

- Make a list of all the different assessment tools you have observed being used in practice.
- Have a look at the types of patient assessment listed in Box 2.4 and classify each assessment as either a mini, comprehensive, focused or ongoing assessment.
- If there are any that you are not sure about, discuss with a colleague or your mentor.

Principles of an effective nursing assessment

The admitting nurse is responsible for ensuring that an initial assessment is completed when the patient is admitted. The patient's needs identified following this process then need to be documented in their care plan.

Box 2.5 discusses each area of assessment, indicating points for consideration and suggesting questions that may be helpful to ask the patient as part of the assessment process.



Box 2.5 Points for consideration and suggested questions for use during the assessment process

1 Cognitive and perceptual ability

Communication

The nurse needs to assess the level of sensory functioning with or without aids/support such as hearing aid(s), speech aid(s), glasses/contact lenses, and the patient's capacity to use and maintain aids/support correctly. Furthermore, it is important to assess whether there are or might be any potential language or cultural barriers during this part of the assessment. Knowing the norm within the culture will facilitate understanding and lessen miscommunication (Galanti 2000).

- How good are the patient's hearing and eyesight?
- Is the patient able to express their views and wishes using appropriate verbal and non-verbal methods of communication in a manner that is understandable by most people?
- Are there any potential language or cultural barriers to communicating with the patient?

Information

During this part of the assessment, the nurse will assess the patient's ability to comprehend the present environment without showing levels of distress. This will help to establish whether there are any barriers to the patient understanding their condition and treatment. It may help them to be in a position to give informed consent.

- Is the patient able and ready to understand any information about their forthcoming treatment and care? Are there any barriers to learning?
- Is the patient able to communicate an understanding of their condition, plan of care and potential outcomes/responses?
- Will he or she be able to give informed consent?

Neurological

It is important to assess the patient's ability to reason logically and decisively, and determine that he or she is able to communicate in a contextually coherent manner.

- Is the patient alert and orientated to time, place and person?

(continued)

**Box 2.5 Points for consideration and suggested questions for use during the assessment process (continued)****14****Pain**

To provide optimal patient care, the assessor needs to have appropriate knowledge of the patient's pain and an ability to identify the pain type and location. Assessment of a patient's experience of pain is a crucial component in providing effective pain management. Dimond (2002) asserts that it is unacceptable for patients to experience unmanaged pain or for nurses to have inadequate knowledge about pain. Pain should be measured using an assessment tool that identifies the quantity and/or quality of one or more of the dimensions of the patient's experience of pain.

Assessment should also observe for signs of neuropathic pain, including descriptions such as shooting, burning, stabbing, allodynia (pain associated with gentle touch) (Australian and New Zealand College of Anaesthetists 2005, Jensen et al. 2003, Rowbotham and Macintyre 2003).

- Is the patient pain free at rest and/or on movement?
- Is the pain a primary complaint or a secondary complaint associated with another condition?
- What is the location of the pain and does it radiate?
- When did it begin and what circumstances are associated with it?
- How intense is the pain, at rest and on movement?
- What makes the pain worse and what helps to relieve it?
- How long does the pain last, for example, continuous, intermittent?
- Ask the patient to describe the character of pain using quality/sensory descriptors, for example, sharp, throbbing, burning.

For further details regarding pain assessment, see Chapter 8: Patient comfort and end-of-life care.

2 Activity and exercise**Respiratory**

Respiratory pattern monitoring addresses the patient's breathing pattern, rate and depth.

- Does the patient have any difficulty breathing?
- Is there any noise when they are breathing such as wheezing?
- Does breathing cause them pain?
- How deep or shallow is their breathing?
- Is their breathing symmetrical?
- Does the patient have any underlying respiratory problems such as chronic obstructive pulmonary disease, emphysema, tuberculosis, bronchitis, asthma or any other airway disease?

In this section it is also important to assess and monitor smoking habits. It is helpful to document the smoking habit in the format of pack-years. A *pack-year* is a term used to describe the number of cigarettes a person has smoked over time. One pack-year is defined as 20 manufactured cigarettes (one pack) smoked per day for 1 year. At this point in the assessment, it would be a good opportunity, if appropriate, to discuss smoking cessation. A recent meta-analysis indicates that if interventions are given by nurses to their patients with regard to smoking cessation the benefits are greater (Rice and Stead 2008). For further details see Chapter 9: Respiratory care.

Cardiovascular

A basic assessment is carried out and vital signs such as pulse (rhythm, rate and intensity) and blood pressure should be noted. Details of cardiac history should be taken for this part of the assessment. Medical conditions and previous surgery should be noted.

- Does the patient take any cardiac medication?
- Does he/she have a pacemaker?

Physical abilities, personal hygiene/mobility/toileting, independence with activities of daily living

The aim during this part of the nursing assessment is to establish the level of assistance required by the person to tackle activities of daily living such as walking and steps/stairs. An awareness of obstacles to safe mobility and dangers to personal safety is an important factor and part of the assessment.

- Is the patient able to stand, walk and go to the toilet?
- Is the patient able to move up and down, roll and turn in bed?
- Does the patient need any equipment to mobilize?
- Has the patient good motor power in their arms and legs?
- Does the patient have any history of falling?

The nurse should also evaluate the patient's ability to meet personal hygiene, including oral hygiene, needs. This should include the patient's ability to make arrangements to preserve standards of hygiene and the ability to dress appropriately for climate, environment and their own standards of self-identity.

- Can the patient take care of their own personal hygiene needs independently or do they need assistance?
- What type of assistance do they need: help with mobility or fine motor movements such as doing up buttons or shaving?

It might be necessary to complete a separate manual handling risk assessment – see Chapter 6: Moving and positioning.

3 Elimination**Gastrointestinal**

During this part of the assessment it is important to determine a baseline with regard to independence.

- Is the patient able to attend to their elimination needs independently and is he/she continent?
- What are the patient's normal bowel habits? Are bowel movements within the patient's own normal pattern and consistency?

- Does the patient have any underlying medical conditions such as Crohn's disease or irritable bowel syndrome?
- Does the patient have diarrhoea or is he/she prone to or have constipation?
- How does this affect the patient?

For further discussion see Chapter 5: Elimination.

Genitourinary

The assessment is focused on the patient's baseline observations with regard to urinary continence/incontinence. It is also important to note whether there is any penile or vaginal discharge or bleeding.

- Does the patient have a urinary catheter *in situ*? If so, list the type and size. Furthermore, note the date the catheter was inserted and/or removed. Urinalysis results should also be noted here.
- How often does the patient need to urinate? (Frequency)
- How immediate is the need to urinate? (Urgency)
- Do they wake in the night to urinate? (Nocturia)
- Are they able to maintain control over their bladder at all times? (Incontinence – inability to hold urine)

For further discussion see Chapter 5: Elimination.

4 Nutrition

Oral care

As part of the inpatient admission assessment, the nurse should obtain an oral health history that includes oral hygiene beliefs, practices and current state of oral health. During this assessment it is important to be aware of treatments and medications that affect the oral health of the patient.

- If deemed appropriate, use an oral assessment tool to perform the initial and ongoing oral assessment.

During the admission it is important to note the condition of the patient's mouth.

- Lips – pink, moist, intact.
- Gums – pink, no signs of infection or bleeding.
- Teeth – dentures, bridge, crowns, caps.

For full oral assessment, see Chapter 8: Patient comfort and end-of-life care.:

Hydration

An in-depth assessment of hydration and nutritional status will provide the information needed for nursing interventions aimed at maximizing wellness and identifying problems for treatment. The assessment should ascertain whether the patient has any difficulty eating or drinking. During the assessment the nurse should observe signs of dehydration, for example dry mouth, dry skin, thirst or whether the patient shows any signs of altered mental state.

- Is the patient able to drink adequately? If not, please explain why not.
- How much and what does the patient drink?
- Note the patient's alcohol intake in the format of units per week and the caffeine intake measured in number of cups per day.

Nutrition

A detailed diet history provides insight into a patient's baseline nutritional status. Assessment includes questions regarding chewing or swallowing problems, avoidance of eating related to abdominal pain, changes in appetite, taste or intake, as well as use of a special diet or nutritional supplements. A review of past medical history should identify any relevant conditions and highlight increased metabolic needs, altered gastrointestinal function and the patient's capacity to absorb nutrients.

- What is the patient's usual daily food intake?
- Do they have a good appetite?
- Are they able to swallow/chew the food – any dysphagia?
- Is there anything they don't or can't eat?
- Have they experienced any recent weight changes or taste changes?
- Are they able to eat independently?

(Arrowsmith 1999, BAPEN and Malnutrition Advisory Group 2000, DH 2005)

For further information, see Chapter 7: Nutrition, fluid balance and blood transfusion.

Nausea and vomiting

During this part of the assessment you want to ascertain whether the patient has any history of nausea and/or vomiting. Nausea and vomiting can cause dehydration, electrolyte imbalance and nutritional deficiencies (Marek 2003), and can also affect a patient's psychosocial well-being. They may become withdrawn, isolated and unable to perform their usual activities of daily living.

Assessment should address questions such as:

- Does the patient feel nauseous?
- Is the patient vomiting? If so, what is the frequency, volume, content and timing?
- Does nausea precede vomiting?
- Does vomiting relieve nausea?
- When did the symptoms start? Did they coincide with changes in therapy or medication?
- Does anything make the symptoms better?
- Does anything make the symptoms worse?
- What is the effect of any current or past antiemetic therapy including dose, frequency, duration, effect, route of administration?
- What is the condition of the patient's oral cavity?

(Adapted from Perdue 2005). For further discussion see Chapter 5: Elimination.

(continued)

**Box 2.5 Points for consideration and suggested questions for use during the assessment process (continued)****16****5 Skin**

A detailed assessment of a patient's skin may provide clues to diagnosis, management and nursing care of the existing problem. A careful skin assessment can alert the nurse to cutaneous problems as well as systemic diseases. In addition, a great deal can be observed in a person's face, which may give insight to his or her state of mind.

- Does the patient have any sore places on their skin?
- Does the patient have any dry or red areas?

Furthermore, it is necessary to assess whether the patient has any wounds and/or pressure sores. If so, you would need to complete a further wound assessment. For further information see Chapter 15: Wound management.

6 Controlling body temperature

This assessment is carried out to establish baseline temperature and determine if the temperature is within normal range, and whether there might be intrinsic or extrinsic factors for altered body temperature. It is important to note whether any changes in temperature are in response to specific therapies (e.g. antipyretic medication, immunosuppressive therapies, invasive procedures or infection (Bickley et al. 2013)). White blood count should be recorded to determine whether it is within normal limits. See Chapter 11: Observations.

- Is the patient feeling excessively hot or cold?
- Have they been shivering or sweating excessively?

7 Sleep and rest

This part of the assessment is performed to find out sleep and rest patterns and reasons for variation. Description of sleep patterns, routines and interventions applied to achieve a comfortable sleep should be documented. The nurse should also include the presence of emotional and/or physical problems that may interfere with sleep.

- Does the patient have enough energy for desired daily activities?
- Does the patient tire easily?
- Has he/she any difficulty falling asleep or staying asleep?
- Does he/she feel rested after sleep?
- Does he/she sleep during the day?
- Does he/she take any aids to help them sleep?
- What are the patient's normal hours for going to bed and waking?

8 Stress and coping

Assessment is focused on the patient's perception of stress and on his or her coping strategies. Support systems should be evaluated and symptoms of stress should be noted. It includes the individual's reserve or capacity to resist challenge to self-integrity, and modes of handling stress. The effectiveness of a person's coping strategies in terms of stress tolerances may be further evaluated (adapted from Gordon 1994).

- What are the things in the patient's life that are stressful?
- What do they do when they are stressed?
- How do they know they are stressed?
- Is there anything they do to help them cope when life gets stressful?
- Is there anybody who they go to for support?

9 Roles and relationships

The aim is to establish the patient's own perception of the roles and responsibilities in their current life situation. The patient's role in the world and their relationships with others are important to understand. Assessment in this area includes finding out about the patient's perception of the major roles and responsibilities they have in life, satisfaction or disturbances in family, work or social relationships. An assessment of home life should be undertaken which should include how they will cope at home post discharge from hospital and how those at home will cope while they are in hospital, for example dependants, children or animals, and if there are any financial worries.

- Who is at home?
- Are there any dependants (include children, pets, anybody else they care for)?
- What responsibilities does the patient have for the day-to-day running of the home?
- What will happen if they are not there?
- Do they have any concerns about home while they are in hospital?
- Are there any financial issues related to their hospital stay?
- Will there be any issues related to employment or study while they are in hospital?

10 Perception/concept of self**Body image/self-esteem**

Body image is highly personal, abstract and difficult to describe. The rationale for this section is to assess the patient's level of understanding and general perception of self. This includes their attitudes about self, perception of abilities (cognitive, affective or physical), body image, identity, general sense of worth and general emotional pattern. An assessment of body posture and movement, eye contact, voice and speech patterns should also be included.

- How do you describe yourself?
- How do you feel about yourself most of the time?

- Has it changed since your diagnosis?
- Have there been changes in the way you feel about yourself or your body?

11 Sexuality and reproduction

Understanding sexuality as the patient's perceptions of their own body image, family roles and functions, relationships and sexual function can help the assessor to improve assessment and diagnosis of actual or potential alterations in sexual behaviour and activity.

Assessment in this area is vital and should include relevant feelings about the patient's own body, their need for touch, interest in sexual activity, how they communicate their sexual needs to a partner, if they have one, and the ability to engage in satisfying sexual activities.

This may also be an opportunity to explore with the patient issues related to future reproduction if this is relevant to the admission. Below are a few examples of questions that can be used.

- Are you currently in a relationship?
- Has your condition had an impact on the way you and your partner feel about each other?
- Has your condition had an impact on the physical expression of your feelings?
- Has your treatment or current problem had any effect on your interest in being intimate with your partner?

12 Values and beliefs

Religious, spiritual and cultural beliefs

The aim is to assess the patient's spiritual, religious and cultural needs to provide culturally and spiritually specific care while concurrently providing a forum to explore spiritual strengths that might be used to prevent problems or cope with difficulties. Assessment is focused on the patient's values and beliefs, including spiritual beliefs, or on the goals that guide his or her choices or decisions. A patient's experience of their stay in hospital may be influenced by their religious beliefs or other strongly held principles, cultural background or ethnic origin. It is important for nurses to have knowledge and understanding of the diverse cultures of their patients and take their different practices into account.

- Are there any spiritual/cultural beliefs that are important to you?
- Do you have any specific dietary needs related to your religious, spiritual or cultural beliefs?
- Do you have any specific personal care needs related to your religious, spiritual or cultural beliefs (i.e. washing rituals, dress)?

13 Health perception and management

Relevant medical conditions, side-effects/complications of treatment

Assessment of the patient's perceived pattern of health and well-being and how health is managed should be documented here. Any relevant history of previous health problems, including side-effects of medication, should be noted. Examples of other useful information that should be documented are compliance with medication regimen, use of health promotion activities such as regular exercise and if the patient has annual check-ups.

- What does the patient know about their condition and planned treatment?
- How would they describe their own current overall level of fitness?
- What do they do to keep well: exercise, diet, annual check-ups or screening?

POST-PROCEDURAL CONSIDERATIONS

Decision making and nursing diagnosis

The purpose of collecting information through the process of assessment is to enable the nurse to make a series of clinical judgements, which are known in some circumstances as nursing diagnoses, and subsequently decisions about the nursing care each individual needs. The decision-making process is based upon the clues observed, analysed and interpreted and it has been suggested that expert nurses assess the situation as a whole and make judgements and decisions intuitively (Hedberg and Satterlund Larsson 2003, King and Clark 2002, Peden-McAlpine and Clark 2002), reflecting Benner's (1984) renowned novice-to-expert theory. However, others argue that all nurses use a logical process of clinical reasoning in order to identify patients' needs for nursing care and that, while this becomes more automatic with experience, it should always be possible for a nurse to explain how they arrive at a decision about an individual within their care (Gordon 1994, Putzier and Padrick 1984, Rolfe 1999). A further notion is that of a continuum, where our ability to make clinical judgements about our patients lies on a spectrum, with intuition at one end and linear, logical decisions (based on clinical trials, for example) at the other (Cader et al. 2005, Thompson 1999). Factors that may influence the process of decision making include time, complexity of the judgement or decision to be made, as well as the knowledge, experience and attitude of the individual nurse.

Nursing diagnosis is a term which describes both a clinical judgement that is made about an individual's response to health or illness, and the process of decision making that leads to that judgement. The importance of thorough assessment within this process cannot be overestimated. The gathering of comprehensive and appropriate data from patients, including the meanings attributed to events by the patient, is associated with greater diagnostic accuracy and thus more timely and effective intervention (Alfaro-LeFevre 2014, Gordon 1994, Hunter 1998).

The concept of a 'nursing diagnosis' has historically generated much debate within the nursing literature. It is therefore important to clarify the difference between a nursing diagnosis and a patient problem or care need. 'Patient problems' or 'needs' are common terms used within nursing to facilitate communication about nursing care (Hogston 1997). As patient problems/needs may involve solutions or treatments from disciplines other than nursing, the concept of a 'patient problem' is similar to but broader than a nursing diagnosis. Nursing diagnoses describe problems that may be dealt with by nursing expertise (Leih and Salentijn 1994).

The term 'nursing diagnosis' also refers to a standardized nursing language, to describe patients' needs for nursing care, that originated in America over 30 years ago and has now been developed, adapted and translated for use in numerous other countries. The language of nursing diagnosis provides a classification of over 200 terms (NANDA-I 2008), representing judgements that are commonly made with patients/clients about

phenomena of concern to nurses, enabling more consistent communication and documentation of nursing care.

Most significantly, the use of common language enables nurses to clearly and consistently express what they do for patients and why, making the contribution of different nursing roles clearly visible within the multidisciplinary care pathway (Delaney 2001, Elfrink et al. 2001, Grobe 1996, Moen et al. 1999). Secondly, an increasingly important reason for trying to structure nursing terms in a systematic way has been the need to create and analyse nursing information in a meaningful way for electronic care records (Clark 1999, Westbrook 2000). The term 'nursing diagnosis' is not commonly used within the UK as no definitive classifications or common languages are in general use; however, for the aforementioned reasons, the adaptation and implementation of standard nursing languages within clinical practice in the UK are being explored (Chambers 1998, Lyte and Jones 2001, Westbrook 2000).

Planning and implementing care

Nursing diagnoses provide a focus for planning and implementing effective and evidence-based care. This process consists of identifying nursing-sensitive patient outcomes and determining appropriate interventions (Alfaro-LeFevre 2014, Shaw 1998, White 2003).

- To determine the immediate priorities and recognize whether patient problems require nursing care or whether a referral should be made to someone else.
- To identify the anticipated outcome for the patient, noting what the patient will be able to do and within what time frame. The use of 'measurable' verbs that describe patient behaviour or what the patient says facilitates the evaluation of patient outcomes (Box 2.6).
- To determine the nursing interventions, that is, what nursing actions will prevent or manage the patient's problems so that the patient's outcomes may be achieved.
- To record the care plan for the patient which may be written or individualized from a standardized/core care plan or a computerized care plan.

Outcomes should be patient focused and realistic, stating how the outcomes or goals are to be achieved and when the outcomes should be evaluated. Patient-focused outcomes centre on the desired results of nursing care, that is, the impact of care on the patient, rather than on what the nurse does. Outcomes may be short, intermediate or long term, enabling the nurse to identify the patient's health status and progress (stability, improvement or deterioration) over time. Setting realistic outcomes and interventions requires the nurse to distinguish between nursing

diagnoses that are life-threatening or an immediate risk to the patient's safety and those that may be dealt with at a later stage. Identifying which nursing diagnoses/problems contribute to other problems (for example, difficulty breathing will contribute to the patient's ability to mobilize) will make the problem a higher priority. By dealing with the breathing difficulties, the patient's ability to mobilize will be improved.

The formulation of nursing interventions is dependent on adequate information collection and accurate clinical judgement during patient assessment. As a result, specific patient outcomes may be derived and appropriate nursing interventions undertaken to assist the patient to achieve those outcomes (Hardwick 1998). Nursing interventions should be specific to help the patient achieve the outcome and should be evidence based. When determining what interventions may be appropriate in relation to a patient's problem, it may be helpful to clarify the potential benefit to the patient after an intervention has been performed, as this will help to ensure its appropriateness.

It is important to continue to assess the patient on an ongoing basis whilst implementing the care planned. Assessing the patient's current status prior to implementing care will enable the nurse to check whether the patient has developed any new problems that require immediate action. During and after providing any nursing action, the nurse should assess and reassess the patient's response to care. The nurse will then be able to determine whether changes to the patient's care plan should be made immediately or at a later stage. If there are any patient care needs that require immediate action, for example consultation or referral to a doctor, recording the actions taken is essential. Involving the patient and their family or friends will promote the patient's well-being and self-care abilities. The use of clinical documentation in nurse handover will help to ensure that the care plans are up to date and relevant (Alfaro-LeFevre 2014, White 2003).

Learning Activity 2.2 Case study: Developing an individualized care plan

Core care plans and care pathways are being used increasingly to plan and deliver patient care. (Why is this?) However, patients will inevitably have problems or health needs (nursing diagnoses) for which there is not a core care plan, so it is vitally important that nurses are able to develop comprehensive and individualized care plans for patients no matter what their condition.

Try doing this activity with a friend.

Read the following case study:

Anna is a 27-year-old woman who was admitted to the ward with abdominal pain via the Emergency Department. She is currently nil by mouth and on intravenous fluids. She is very anxious about her mum, who is wheelchair bound and currently being looked after by a family friend; Anna is her main carer at home.

Develop a care plan for Anna to include the following:

- Nursing diagnoses (what are her problems or health needs?)
- Outcomes (what would you realistically hope to achieve for each of her nursing diagnoses?)
- Nursing interventions (what actions do the nursing team need to take to help achieve these outcomes?)

See end of chapter for answers.



Box 2.6 Examples of measurable and non-measurable verbs for use in outcome statements

Measurable verbs (use these to be specific)

- State; verbalize; communicate; list; describe; identify
- Demonstrate; perform
- Will lose; will gain; has an absence of
- Walk; stand; sit

Non-measurable verbs (do not use)

- Know
- Understand
- Think
- Feel

Source: Alfaro-LeFevre (2014). Reproduced with permission from Lippincott Williams & Wilkins.

Evaluating care

Effective evaluation of care requires the nurse to critically analyse the patient's health status to determine whether the patient's condition is stable, has deteriorated or improved. Seeking the patient's and family's views in the evaluation process will facilitate decision making. By evaluating the patient's outcomes, the nurse is able to decide whether changes need to be made to the care planned. Evaluation of care should take place in a structured manner and on a regular basis by a Registered Nurse. The frequency of evaluation depends on the clinical environment within which the individual is being cared for as well as the nature of the nursing diagnosis (problem) to which the care relates.

- What are the patient's self-care abilities?
- Is the patient able to do what you expected?
- If not, why not?
- Has something changed?
- Are you missing something?
- Are there new care priorities?

These questions will help to clarify the patient's progress (Alfaro-LeFevre 2014, White 2003). It is helpful to consider what is observed and measurable to indicate that the patient has achieved the outcome.

Documenting

Nurses have a professional responsibility to ensure that healthcare records provide an accurate account of treatment, care planning

and delivery, and are viewed as a tool of communication within the team. There should be 'clear evidence of the care planned, the decisions made, the care delivered and the information shared' (NMC 2010) (Box 2.7). The content and quality of record keeping are a measure of standards of practice relating to the skills and judgement of the nurse (NMC 2010).

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Learning Activity 2.3

Learning in practice: Record keeping

When you are in your clinical area, find out whether there are record keeping guidelines and how these are used and monitored.

Hint: Ask about a documentation audit. How is this done? How often?

Much of the record keeping that we do is mandatory for each patient on every admission to hospital.

- What would you do if you noticed a patient did not have a required assessment (for example, a pressure ulcer risk assessment) carried out as part of their admission?
- Who would you discuss this with?

For further information and guidance on record keeping, refer to NMC (2010) *Record Keeping: Guidance for Nurses and Midwives*.



Box 2.7 The Royal Marsden Hospital Guidelines for Nursing Documentation (2011) (adopted in line with NMC (2010) Record keeping)

General principles

- 1 Records should be written legibly in black ink in such a way that they cannot be erased and are readable when photocopied.
- 2 Entries should be factual, consistent, accurate and not contain jargon, abbreviations or meaningless phrases (e.g. 'observations fine').
- 3 Each entry must include the date and time (using the 24-hour clock).
- 4 Each entry must be followed by a signature and the name printed as well as:
 - the job role (e.g. staff nurse or clinical nurse specialist)
 - if a nurse is a temporary employee (i.e. an agency nurse), the name of the agency must be included under the signature.
- 5 If an error is made, this should be scored out with a single line and the correction written alongside with date, time and initials. Correction fluid should not be used at any time.
- 6 All assessments and entries made by student nurses must be countersigned by a Registered Nurse.
- 7 Healthcare assistants:
 - can write on fluid balance and food intake charts
 - must not write on prescription charts, assessment sheets or care plans.

Assessment and care planning

- 1 The first written assessment and the identification of the patient's immediate needs must begin within 4 hours of admission. This must include any allergies or infection risks of the patient and the contact details of the next of kin.
- 2 The following must be completed within 24 hours of admission and updated as appropriate:
 - completion of nutritional, oral, pressure sore and manual handling risk assessments
 - other relevant assessment tools, for example pain and wound assessment.
- 3 All sections of the nursing admission assessment must be completed at some point during the patient's hospital stay with the identification of the patient's care needs. If it is not relevant or if it is inappropriate to assess certain functional health patterns, for example the patient is unconscious, then indicate the reasons accordingly.

The ongoing nursing assessment should identify whether the patient's condition is stable, has deteriorated or improved.
- 4 Care plans should be written wherever possible with the involvement of the patient, in terms that they can understand, and include:
 - patient-focused, measurable, realistic and achievable goals
 - nursing interventions reflecting best practice
 - relevant core care plans that are individualized, signed, dated and timed.
- 5 Update the care plan with altered or additional interventions as appropriate.
- 6 The nursing documentation must be referred to at shift handover so it needs to be kept up to date.

(continued)

**Box 2.7 The Royal Marsden Hospital Guidelines for Nursing Documentation (2011) (adopted in line with NMC (2010) Record keeping) (continued)**

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Principles of assessment

Assessment should be a systematic, deliberate and interactive process that underpins every aspect of nursing care (Heaven and Maguire, 1996).

Assessment should be seen as a continuous process (Cancer Action Team 2007).

Structure of assessment

The structure of a patient assessment should take into consideration the specialty and care setting and also the purpose of the assessment.

When caring for individuals with cancer, assessment should be carried out at key points during the cancer pathway and dimensions of assessment should include background information and assessment preferences, physical needs, social and occupational needs, psychological well-being and spiritual well-being (Cancer Action Team 2007).

Functional health patterns provide a comprehensive framework for assessment, which can be adapted for use within a variety of clinical specialties and care settings (Gordon 1994).

Methods of assessment

Methods of assessment should elicit both subjective and objective assessment data.

An assessment interview must be well structured and progress logically in order to facilitate the nurse's thinking and to make the patient feel comfortable in telling their story.

Specific assessment tools should be used, where appropriate, to enable nurses to monitor particular aspects of care, such as symptom management (e.g. pain, fatigue), over time. This will help to evaluate the effectiveness of nursing interventions while often providing an opportunity for patients to become more involved in their care (O'Connor and Eggert 1994).

Decision making and nursing diagnosis

Nurses should be encouraged to provide a rationale for their clinical judgements and decision making within their clinical practice (NMC 2008).

The language of nursing diagnosis is a tool that can be used to make clinical judgements more explicit and enable more consistent communication and documentation of nursing care (Clark 1999, Westbrook 2000).

Planning and implementing care

When planning care, it is vital that nurses recognize whether patient problems require nursing care or whether a referral should be made to someone else.

When a nursing diagnosis has been made, the anticipated outcome for the patient must be identified in a manner which is specific, achievable and measurable (NMC 2008).

Nursing interventions should be determined in order to address the nursing diagnosis and achieve the desired outcomes (Gordon 1994).

Evaluating care

Nursing care should be evaluated using measurable outcomes on a regular basis and interventions adjusted accordingly (see Box 2.8).

Progress towards achieving outcomes should be recorded in a concise and precise manner. Using a method such as charting by exception can facilitate this (Murphy 2003).

Documenting and communicating care

The content and quality of record keeping are a measure of standards of practice relating to the skills and judgement of the nurse (NMC 2010).

In addition to the written record of care, the important role that the nursing shift report, or 'handover', plays in the communication and continuation of patient care should be considered, particularly when considering the role of electronic records.

Observation**DEFINITION**

Observation is the conscious, deliberate use of the physical senses to gather data from the patient and the environment. It occurs whenever the nurse is in contact with the patient. At each patient contact, it is important to try and develop a sequence of observations. These might include the following.

- 1 As you enter the room, observe the patient for signs of distress, e.g. pallor, laboured breathing, and behaviours indicating pain or emotional distress.

- 2 Scan for safety hazards, e.g. are there spills on the floor?
- 3 Look at the equipment, e.g. urinary catheter, intravenous pumps, oxygen, monitors.
- 4 Scan the room – who is there and how do these people interact with the patient?
- 5 Observe the patient more closely for data such as skin temperature, breath sounds, drainage/dressing odours, condition of dressings, drains, need for repositioning (Wilkinson 2007).

Accurate measurements of your patient's vital signs provide crucial information about body functions (see Chapter 11: Observations).

Discharge planning

DEFINITION

Discharge planning is defined by Rorden and Taft (1990) as 'a process made up of several steps or phases whose immediate goal is to anticipate changes in patient care needs and whose long-term goal is to ensure continuity of health care'. Discharge planning should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting and include the multidisciplinary team, the patient and their carers. Furthermore, it involves building on, or adding to, any assessments undertaken prior to admission (DH 2003).

INTRODUCTION

Discharge planning is a routine feature of health systems in many countries (Shepperd et al. 2013). The evidence suggests that a structured discharge plan tailored to the individual is best practice (Shepperd et al. 2013); therefore, effective, safe discharge planning needs to be patient and carer focused. There is consistent evidence to suggest that best practice in hospital discharge involves multidisciplinary teamwork throughout the process (Borrill et al. 2000). The multidisciplinary approach, where all staff have a clear understanding of their roles and responsibilities, will also help to prevent inappropriate readmissions and delayed discharges (Stewart 2000). This approach also promotes the highest possible level of independence for the patient, their partner and family by encouraging appropriate self-care activities.

Ineffective discharge planning has been shown to have detrimental effects on a patient's psychological and physical well-being and their illness experience (Cook 2001, Kissane and Zaider 2010, Lees 2013). Planning care, providing adequate information and involving patients, families and healthcare professionals will keep disruption to a minimum.

To achieve the best quality of life for patients and carers, there needs to be effective co-ordination in terms of care planning and delivery of that care over time (Day et al. 2009, NMC 2009, Øvretveit 1993). Discharge co-ordinators are, in general, health or social care professionals who have both hospital and community experience. Their role is to advise, help with planning, and assist the co-ordination of the differing care providers that the patient may need when leaving hospital, particularly when the nursing and care needs are complex. For complex discharges, it is helpful if a key worker, for example the discharge co-ordinator, is appointed to manage the discharge and, where appropriate, for family meetings/case conferences to take place and include the patient/carer, multidisciplinary team and primary healthcare team (PHCT) and representatives (Department of Evaluation in Healthcare Organisations 2001).

Patients with additional needs

There are groups of patients who may have additional needs on discharge and the approach taken may have to be tailored to meet these additional needs. If, for example, the patient has dementia or a learning disability, the approach to their discharge plan may need to be adjusted. If, for example, the patient has been assessed as lacking capacity to make a decision about where they live then the principles of the Mental Capacity Act (2005) must be employed to ensure the family and carers are involved. Where the patient is assessed as lacking capacity and has no relatives or friends and so is 'unbefriended' as defined by the Mental Capacity Act (2005), a referral should be made to the local Independent Mental Capacity Advocacy Service (Mental Capacity Act 2005). There is a concern that where a person has a degree of cognitive impairment, there will be an assumption that they cannot return home or that they need care. These assumptions should be challenged and decisions made on the basis of an assessment, including a mental capacity assessment. The assessment should

evidence that the principles of the Mental Capacity Act (2005) have been applied.

For patients who may have additional needs on discharge, it is worth exploring what support services may be available and to identify what services were in place prior to admission. For example, if the person has a learning disability they may have a learning disability nurse in the community; involving them in the patient's discharge would ensure a safer transition for the patient and enable access to a professional who has knowledge and expertise in the field of learning disabilities but also in the needs of the patient.

Discharge processes (DH 2004b) endorse the value of co-ordination in a climate of shorter hospital stays and timely patient discharge. Poor discharge planning may result in patients remaining in hospital for longer than is necessary. Research has demonstrated that a high level of communication between the professionals planning the discharge and the providers of services outside the hospital setting is an effective mode of preventing readmission (Shepperd et al. 2013). McKenna et al. (2000) suggest that an indicator of poor discharge practice is poor communication amongst the multidisciplinary team (MDT), and between the hospital and community. For patients with complex needs, see Box 2.8 for additional support and guidance for decision making and planning. This should be used in conjunction with the discharge checklist (Figure 2.1).

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Learning Activity 2.4

Scenario: Discharge planning

You are caring for a patient who is known to have dementia. What particular issues should you consider prior to discharge?

- 1 Does the patient lack capacity?
- 2 Does he/she have family/carers who should be involved in their care decisions?
- 3 Is it appropriate for him/her to return to their previous living arrangements?
- 4 If the patient lacks capacity and the answer to questions 2 and 3 is 'no', who should you get involved in their care?
- 5 What other support services might you want to get involved in his/her discharge?

See end of chapter for answers.



Learning Activity 2.5

Learning in practice: Complex discharge planning

Identify a patient who requires complex discharge planning. Review the discharge documentation for the patient and compare with the 'guide to arranging a complex discharge home' (see Box 2.8).

- Have all these steps been followed for your patient?
- Is there anything missing?
- What can you do to help?

Discuss this activity with a friend or your mentor to see if there is anything that could be done differently for this or future patients who have complex needs on discharge from hospital to home.



Box 2.8 Guide to arranging a complex discharge home

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NB: This is not an exhaustive list and MUST BE DISCUSSED with the complex discharge co-ordinator/specialist sister, discharge planning, palliative care

Complex discharge definition

- A large package of care involving different agencies.
- The patient's needs have changed since admission, with different services requiring co-ordination.
- The family/carer requires intensive input into discharge planning considerations (e.g. psychological interventions):
 - patients who are entitled to NHS Continuing Healthcare and who require a package of care on discharge
 - patients for repatriation.

1 Comprehensive assessment by nurse on admission and document care accordingly

(a) Provisional discharge date set.	<ul style="list-style-type: none"> • This will only be an approximate date, depending on care needs, equipment, and so on. • It should be reviewed regularly with multidisciplinary team. • Discharge should not be arranged for a Friday or weekend.
(b) Referrals to relevant members of multidisciplinary team.	For example, occupational therapist, physiotherapist, social services.
(c) Referral to community health services (in liaison with multidisciplinary team).	For example, community nurse (who may be able to arrange for night sitters), community palliative care team.
(d) Request equipment from community nurse and discuss with family.	For example, hoist, hospital bed, pressure-relieving mattress/cushion, commode, nebulizer.
If oxygen is required , medical team to complete Home Oxygen Ordering Form (HOOFF) and Home Oxygen Consent Form (HOCF) for oxygen cylinders and concentrators at home. Fax to relevant oxygen supplier.	

2 Discuss at ward multidisciplinary meeting, arrange family meeting/case conference as required, and invite all appropriate healthcare professionals, including community staff

(a) Appoint discharge co-ordinator at the multidisciplinary meeting.	<ul style="list-style-type: none"> • To act as co-ordinator for referrals and point of contact for any discharge concerns. • To plan and prepare the family meeting/case conference and to arrange a chairperson and minute-taker for the meeting. • Patient's named nurse to liaise with discharge co-ordinator.
(b) Formulate a discharge plan at meeting.	<ul style="list-style-type: none"> • At the meeting, formulate a discharge plan in conjunction with patient, carers, and all hospital and community personnel involved and agree a discharge date; an occupational therapist home visit may be required.
(c) Ascertain discharge address.	<ul style="list-style-type: none"> • Liaise with services accordingly. • It is important to agree who will care for patient/where the patient will be cared for, for example ground/first floor. • Ascertain type of accommodation patient lives in so that the equipment ordered will fit in appropriately. • NB: If not returning to own home, a GP will be required to take patient on as a temporary resident.
(d) Confirm PROVISIONAL discharge date.	<ul style="list-style-type: none"> • This will depend on when community services and equipment can be arranged. • This must be agreed with the patient and family/informal carer/s.

3 Ascertain whether community nurse is able to undertake any necessary clinical procedures in accordance with their local trust policy, for example care of skin-tunnelled catheters. Consider alternative arrangements if necessary

(a) Confirm equipment agreed and delivery date.	<ul style="list-style-type: none"> • NB: Family must be informed of delivery date and also requested to contact ward to inform that this has been received.
(b) Confirm start date for care.	<ul style="list-style-type: none"> • For example, social services/community nurse/community palliative care.

(c) Confirm with patient/family agreed discharge date.

- Liaise with complex discharge co-ordinator for Community Services Arrangements Form.
- Check community services are able to enter patient's home as necessary.

4 Forty-eight hours prior to discharge, fax and telephone community nurse with Community Care Referral Form and discuss any special needs of patient, for example syringe driver, oxygen, wound care, intravenous therapy, methicillin-resistant *Staphylococcus aureus* or other infection status. Give written information and instructions

- a Arrange transport and assess need for escort/oxygen during transport.
- b Ongoing review.
- c If NO change within 24 hours of discharge, confirm that:
 - patient is medically fit for discharge
 - all community services are in place as agreed
 - patient has drugs to take out (TTO) and next appointment
 - access to home, heating and food are checked.
- Should be in place for any change in patient's condition/treatment plan.
- If there is a change, notify/liaise with multidisciplinary team and community services.
- Ensure patient has drugs TTO with written and verbal instructions.
- Next in/outpatient appointment as required.
- Check arrangements for patient to get into home (front door key), heating, food and someone there to welcome them home, as appropriate.

5 Hospital equipment, for example syringe drivers: ensure clearly marked and arrangements made for return

6 After discharge, follow-up phone call to patient by ward nurse/complex discharge co-ordinator as agreed to ensure all is well

The ten steps to discharge planning

The DH has identified ten steps to discharge planning to assist with the planning of discharge and transfer from hospital and intermediate care (DH 2010).

- 1 Start planning for discharge or transfer before or on admission.
- 2 Identify whether the patient has simple or complex discharge and transfer needs, involving the patient or 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 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 personalized care pathway and maximize their independence.
- 8 Plan discharges and transfers to take place over 7 days to deliver continuity of care for the patients.
- 9 Use a discharge checklist 24–48 hours before transfer.
- 10 Make decisions to discharge and transfer patients each day.

EVIDENCE-BASED APPROACHES

Single Assessment Process

The Single Assessment Process (SAP) is a key part of the *National Service Framework for Older People* (DH 2001), but is not used comprehensively in the UK. The SAP is designed to replace fragmented assessments carried out by different agencies with one seamless procedure (Hunter 1998). It is based on the recognition that many older people have wide-ranging welfare needs and that agencies need to work together to ensure that assessment and subsequent care planning are effective and co-ordinated, and that

care is holistic and centres on the whole person (Lymbery 2005). This standard aims to ensure that the NHS and social care services treat older people as individuals and enable them to make choices about their own care, by producing a comprehensive 'individualized care plan' that will set out their full needs and entitlements (Taylor 2012). The SAP aims to make sure older people's needs are assessed thoroughly and accurately, but without procedures being needlessly duplicated by different agencies, and that information is shared appropriately between health and social care agencies.

LEGAL AND PROFESSIONAL ISSUES

There is a requirement in discharge planning for nurses to share information about patients with health and social care providers in the community and, in doing so, there needs to be consideration regarding consent to share information and using safe procedures to ensure information is only shared with those who require it. Failing to apply good information governance processes could result in information being shared inappropriately and the breaching of a patient's right to confidentiality. Patients need to consent to their information being shared and, where the patient lacks capacity to share information, then sharing needs to be considered in the patient's 'best interest' based on a mental capacity best interest assessment (Mental Capacity Act 2005, p.3).

PRE-PROCEDURAL CONSIDERATIONS

It is essential that nurses are aware of their organization's discharge procedures, policies and protocols. If a patient is to be admitted for an elective procedure and has attended pre-assessment, discharge needs should be identified at this point to allow effective planning and potential services notified in advance of any admission. This is even more pertinent where patients are being admitted for a short length of stay. These discussions with patients and their families can also help them to determine what they may need on discharge and to plan accordingly.

The role of informal carers

Engaging and involving patients and informal carers, family member or friends who provide care in an unpaid capacity as

Patient's Name:..... Hospital No.:.....

**Complex Discharge Planning Sheet**

Document the patient & carer involvement in discharge decisions and any change of discharge date or arrangements

SIGNATURE WHEN ACTIONED			COMMENTS	
Discussed / agreed discharge date & arrangements e.g. Is heating organized? Is access sorted e.g. keys available / steps considered?	Patient informed	Sig	Provisional discharge date:.....	
		Date/Time		
	Carer informed	Sig	Agreed discharge date:.....	
		Date/Time		
Equipment Access INTRANET for information about Discharge - Community Liaison <ul style="list-style-type: none"> Discharge checklists for specific needs Home equipment 	Not applicable	Sig	<i>Consider whether the patient needs: bed, hoist, mattress, commode, oxygen, nebulizer, syringe drivers at home</i>	
		Date/Time		
	<ul style="list-style-type: none"> Specify equipment & document in the discharge planning progress notes the arrangements as appropriate. Obtain or print relevant discharge checklist(s) and complete as part of the patient's documentation 			
Take home medication/ equipment	Medication ordered	Sig		
		Date/Time		
	Nutritional supplements ordered	Sig		
		Date/Time		
	Dressings ordered	Sig		
		Date/Time		
	Appliances ordered e.g. stoma & continence aids	Sig		
		Date/Time		
	Medication explained & given to patient	Sig		
		Date/Time		
	Patient's own medication returned including controlled drugs	Sig		
		Date/Time		
Ability to self medicate If NOT ABLE , name the person who will prompt or give medication post discharge	Able	Sig	Is a dosette box required? Yes <input type="checkbox"/> <i>Note arrangements in discharge planning progress notes</i> Named person: Self medication chart provided Yes <input type="checkbox"/>	
		Date/Time		
	Not able	Sig		
		Date/Time		
Follow up appointment Note Check if any investigations are required e.g. EDTA, X-ray or scans	Ordered	Sig	Sick note given <input type="checkbox"/> N/A <input type="checkbox"/>	
		Date/Time		
	Given to patient	Sig		
		Date/Time		
	No follow up	Sig		
		Date/Time		
Transport - specify on transport form if : <ul style="list-style-type: none"> Walker Chair Stretcher Oxygen Escort 	Not required	Sig	Date of transport booking: Booking reference no: 'Do not attempt resuscitation' letter completed by medical staff for ambulance staff provided Yes <input type="checkbox"/>	
		Date/Time		
	Required	Sig		
		Date/Time		
	Booked	Sig		
		Date/Time		
Property / valuables (including key to access home)	Returned to patient	Sig		
		Date/Time		
	Not applicable	Sig		
		Date/Time		

Figure 2.1 Complex discharge planning sheet.

Communication & written information to: Community nurse; Community Palliative Care Team, Hospice Home Care Team <ul style="list-style-type: none"> Document in the discharge planning progress notes the nature of communication with others and action required or taken Note whether Community Referral form(s) or Hospice form faxed and/or given to the patient 			
Community nurse	Referral not required	Sig	Comments Copy of Referral form given to patient Yes <input type="checkbox"/>
		Date/Time	
	Referral required	Sig	
		Date/Time	
	Date of referral	Sig	
		Date/Time	
	Referral form faxed	Sig	
		Date/Time	
Date of first visit agreed with community staff Yes <input type="checkbox"/> No <input type="checkbox"/> Not specified <input type="checkbox"/>		Sig Date/Time	
Community Palliative Care Team / Hospice Home Care Team	Referral not required	Sig	Comments Copy of Referral form given to patient Yes <input type="checkbox"/>
		Date/Time	
	Referral required	Sig	
		Date/Time	
	Date of referral	Sig	
		Date/Time	
	Referral form faxed	Sig	
		Date/Time	
Date of first visit agreed with community staff Yes <input type="checkbox"/> No <input type="checkbox"/> Not specified <input type="checkbox"/>		Sig Date/Time	
Other e.g. Marie Curie Nurse, Stoma Nurse, Continence Advisor,			Comments Copy of Referral form given to patient Yes <input type="checkbox"/>
Specify:	Referral required	Sig	
		Date/Time	
	Date of referral	Sig	
		Date/Time	
Referral form faxed	Sig		
	Date/Time		
Date of first visit agreed with community staff Yes <input type="checkbox"/> No <input type="checkbox"/> Not specified <input type="checkbox"/>		Sig Date/Time	
Communication & written information to Community Social Services <ul style="list-style-type: none"> Clarify if section 2 and 5 notification forms required or whether the patient requires information, advice and/or carer's assessment by hospital social services (complete RMH Social Services Trigger Form) Be aware whether Community Care (Delayed Discharge) Act 2003 section 2 or section 5 notification sent to community social services. If section 5 notification sent - ensure section 5 confirmation received from community social services prior to discharging the patient. Document in the discharge planning progress notes the nature of communication with others and action required or taken 			
Community Social Services	Referral not required	Sig	Comments
		Date/Time	
	Required	Sig	
		Date/Time	

Figure 2.1 (Continued)

equal partners is central to successful discharge planning (DH 2003, Holzhausen et al. 2001). The Picker Report, an independent patient survey, identified that 16% of patients questioned reported that they did not feel involved in their discharge (Garrett and Boyd 2008). The hospital discharge process is also a critical time for informal carers, placing an increasing burden of care on them (Bauer et al. 2009, Higginson and Costantini 2008), yet Holzhausen et al. (2001) suggest they do not feel involved in the discharge process. It may be the first time they have been confronted with the reality of their role, the effect it may have on their relationship with the person needing care, their family and their employment (Hill et al. 2001). Research suggests that if carers are unsupported, this can result in early readmission of

the patient (Holzhausen et al. 2001). It is therefore important to involve carers as partners in the discharge planning process.

The Carers (Equal Opportunities) Act 2004 was implemented to support carers in a practical way by providing information, helping carers to remain at work and to care for themselves. Under the Act, carers are entitled to their own assessment and many support services can be provided, including respite, at no charge. Carers are often unaware that they are entitled to an assessment and may be able to access care and support as a carer. It is important that carers are made aware of this and part of this might be as simple as letting them know that the role they play with their family member is that of a carer: many people would see themselves as a wife, husband or daughter rather than a carer.

It is important to recognize that in some families, children may take on a caring role and their needs may go unrecognized (Naked Flame Research 2004). Informing community health and social care providers that there are young carers involved, with prior consent from the parents, may enable the young carers to access additional support services (CarersUK 2012, Naked Flame Research 2004). Young carers may struggle with the responsibilities of providing care to parents and their function can frequently go unrecognized, making the young carer feel isolated and distressed.

Throughout discharge planning, carers' needs should be recognized and acknowledged. Carers may have different needs from patients and there may be conflicting opinions about how the patient's care needs can be met. It is not uncommon for patients to report that their informal carer is willing to provide all care but the carer is not in agreement with this. Healthcare professionals should allow carers sufficient time and provide appropriate information to enable them to make decisions. They should also provide written information on the discharge plan and ensure adequate support is in place before discharge takes place (DH 2010). This will promote a successful and seamless transfer from hospital to home.

The discharge planning process and the primary/secondary care interface

The discharge planning process can be initiated by any member of the PHCT or social services staff in the patient's home, prior to admission, in pre-admission clinics or on hospital admission (Huber and McClelland 2003). Importance is attached to developing a primary care-led NHS, reinforced by the government's White Paper *The New NHS: Modern, Dependable* (DH 1998). The focus on quality, patient-centred care and services closer to where people live will be dependent on primary, secondary and tertiary professionals working together (Davis 1998).

However, it is important to note that the Community Care (Delayed Discharges) Act (DH 2003) introduced a system of reimbursement to NHS bodies from social services departments for delays caused by the failure of social services departments to provide timely assessment and/or services for a patient being discharged from an acute hospital bed. An awareness of the process and required timescales is essential to ensure that a patient's discharge is not delayed because social services have had insufficient time to respond to a request for an assessment.

The discharge planning process takes into account a patient's physical, psychological, social, cultural, economic and environmental needs. It involves not only patients but also families, friends, informal carers, the hospital multidisciplinary team and the community health/social services teams (Maramba et al. 2004, Salantera et al. 2003), with the emphasis on health and social services departments working jointly. However, a new emphasis is being placed on personalized care in the community, with patients purchasing and managing their own care package (Darzi 2008). Giving patients greater control and choice over the services they need requires the professionals to ensure that they have provided information regarding all the possible alternatives for care open to the patient and their carers (Darzi 2008).

As well as patient experience, discharge planning is considered a factor in reducing the length of hospital stay, which has a financial impact for the NHS (DH 2004b, Bull and Roberts 2001, Mardis and Brownson 2003, Nazarko 1998). Given the huge cost of inpatient care, it is important to ensure that procedures are in place, and complied with, to facilitate patients being discharged at the earliest opportunity. However, the notion of a seamless service may be idealistic because of increasing time constraints and the complex care needs of high-dependency patients (Smith 1996).

A significant proportion of patients, 3–11%, return to hospital within 28 days because of complications that have arisen as a consequence of their health. Readmission rates can be reduced through the health assessments and planning that take place in hospital (NHS Institute for Innovation and Improvement 2014). This reinforces the fact that good discharge planning can not only support



Box 2.9 Discharge against medical advice form

Name:

Hospital No:

Address:

I wish to discharge myself against medical advice and accept full responsibility for my actions.

Signed:

Date:

Time:

Statement to be signed by the Doctor

I have discussed with the patient the medical reasons why he/she should remain in the hospital.

Signed:

This form should be filed with the patient's medical records

NB: If concerned about support in the community for the patient, contact social services, the complex discharge co-ordinator or the on-call sister in charge out of hours for advice.

a better experience for the patient and their carers on discharge but could in fact prevent further unnecessary admissions to hospital.

Occasionally the discharge process may not proceed as planned; a discharge may be delayed for a number of reasons and a system should be in place to record this. Patients may take their own discharge against medical advice and this should be documented accordingly (Box 2.9). When patients are assessed as requiring care or equipment but decline these, this does not negate the nurse's duty to ensure a discharge is safe. A discussion should take place with the patient and carer to assess how they intend to manage without the required care/equipment in place. It is crucial that the community services are aware of assessed needs that are not being met through patient choice or lack of resources. It is critical that the community teams who will be supporting the patient when they return home are notified and where possible this should be in writing, such as sending them a copy of the 'Discharge against medical advice' form (see Box 2.9 and Box 2.10).

When patients are informed by their medical teams that there are no further treatment options and advised that their prognosis may be poor, they may decide they want to go home urgently and plans would need to be set up at short notice.

Voluntary services

In many areas voluntary sector providers have begun to forge ways to deliver efficient, high-quality, patient-centred care. Evidence suggests that partnerships between the NHS and voluntary sectors have the potential to address a number of priorities, including prevention and shifting treatment, care and support into the community (Addicott 2013). Therefore, it is worth exploring what voluntary services are available locally that could support patients in the return to the community, ranging from practical support such as small home improvements to befriending services.

Reablement and intermediate care

The provision of reablement or enablement and intermediate care packages constitutes what are known as 'supported discharges'. The aim is to support the patient in making the transfer from hospital to community, thereby avoiding lengthy



Box 2.10 Patients taking discharge against medical advice

Nursing staff responsibility

If a patient wishes to take their own discharge, the ward sister/co-ordinator should contact:

- a member of the medical team
- the manager on call
- the complex discharge co-ordinator.

The complex discharge co-ordinator will inform social services if appropriate. Out of hours, following a risk assessment, the manager on call will contact the local social services department, if appropriate, and inform the hospital social services department the following day.

Medical staff responsibility

The doctor, following consultation with the patient, should complete the appropriate form prior to the patient leaving the hospital. The form must be signed by the patient and the doctor and filed in the medical notes. The doctor must immediately contact the patient's GP.

stays for rehabilitation in an acute hospital bed (DH 2010). This may be a short stay in a residential rehabilitation unit or community hospital. This can also be provided in the patient's own home with additional services such as occupational therapy and physiotherapy being provided to support a personal care package. These services are normally short term and are likely to be reviewed within 6 weeks of discharge.

Reablement or enablement has been defined as 'services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living. The focus is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves' (DH 2010). Reablement or enablement focuses on dressing, using the stairs, washing and preparing meals. In some areas reablement or enablement may include social reintegration to support social activities. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive.

The *National Service Framework for Older People* (DH 2001) signalled the development of intermediate care as one of the major initiatives for services in the future. It is recognized that, if at all possible, older people are best cared for at home. To aid the transition period from hospital to home, intermediate care teams may provide a period of intensive care/rehabilitation following a hospital stay, which may take place in a care home or in the individual's own home. It is likely to be limited to a maximum of 6 weeks but there are local variations in practice. Intermediate care needs to have a person-centred approach, involving patients and carers in all aspects of assessment, goal setting and discharge planning. Its success depends on local knowledge of the service and interagency collaboration (Hancock 2003). There is growing evidence suggesting that intermediate care initiatives reduce admissions to acute hospitals and residential/nursing home placements (DH 2010, Foundation Trust Network 2012).

Social services care – Sections 2 and 5

If a patient does not meet the criteria for reablement, enablement or intermediate care, they may still receive assistance with personal care and domestic tasks through social services. However, it must be made clear to the patient and/or their family that they will be financially assessed and as a result may be charged for the service. In some local authorities, if the patient is assessed as 'self-funding', social services may only then offer a signposting services to private care providers. Where a patient is assessed as requiring care from social services to enable them to return

home, then the trust should notify the local authority using the Community Care and Delayed Discharge Act processes.

The local authority will require a Section 2 no later than 72 hours prior to discharge but this should be done at the earliest opportunity. When the patient has been assessed and is ready for discharge, a Section 5 notification should be sent to the local authority at least 24 hours before discharge. How the local authority responds to the Section 2 may depend on what local arrangements are in place. Many local authorities have a social worker or social work department within the trust to facilitate the setting up of care packages for discharge. Other authorities may require additional assessments such as occupational therapy or medical reports to enable them to set up the care. It is not uncommon for local authorities to request an NHS Continuing Healthcare checklist to be completed as part of the process to assess if the patient might be entitled to NHS Continuing Healthcare funding.

NHS Continuing Healthcare

NHS Continuing Healthcare funding exists to support people with complex healthcare needs. It is provided to support the care that people need over an extended period of time as a result of disability, accident or illness, to address both physical and mental health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings, for example, from a care home to care in people's own homes. NHS Continuing Healthcare is a package of care arranged and funded solely by the NHS. It should be awarded when it is established (through a comprehensive multidisciplinary assessment) that an individual's primary care need is a health need. There has been inconsistency in applying the criteria nationally (House of Commons Health Committee 2005), resulting in the Department of Health producing a *National Framework for NHS Continuing Healthcare* (DH 2009).

In November 2012 new national tools for NHS Continuing Healthcare were launched. These replace any previous tools, including the fast-track assessment for patients who have a rapidly deteriorating condition and a checklist to identify if a patient should be assessed using the full assessment. There is a legal obligation to inform patients of their right to be assessed for NHS Continuing Healthcare funding. There is an online resource booklet (www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet) informing patients of their rights and outlining the process (DH 2012). Patients who may be entitled to funding through this process could be paying unnecessarily for their care through social services as they will have been financially assessed or could be funding their own care. An important element of the new tools is the requirement for a signed consent rather than presumed consent (DH 2012).

Discharge to a care or nursing home

Discharging a patient to a care or nursing home requires careful thought as giving up their own home is one of the most traumatic events that a person has to consider. The impact on a patient and their carer may be significant, particularly where the person lives with a partner or family member and this would be a loss for both of them. A thorough multidisciplinary assessment is essential, taking into account the individual needs of the patient and their family or carer and exploring all the options before deciding on a care/nursing home. It is really important that carers are supported throughout this process. In most cases the family or carer will be the person who is looking for a care home placement. This can be quite a daunting process and it is worth providing a list of questions and things to look for when assessing a care or nursing home (Table 2.1).

Nursing and care home placements can be delayed while waiting for funding to be approved or waiting for a suitable bed to become available and it may therefore be necessary to consider an interim placement (DH 2003). It is important that the patient and carers are aware that there may be time limits on the stay in hospital so they will be required to find a suitable placement within an agreed timescale. Many hospitals have a policy to support staff where patients and their carers are delaying the process of arranging a nursing home placement.

Table 2.1 Questions and things to look for when assessing a care or nursing home

Questions	
First impressions	<ul style="list-style-type: none"> • Is the home easy for family and friends to visit, particularly those who have to rely on public transport? • Does the home have its own transport? • Is the main area accessible for disabilities, e.g. wheelchairs, poor sighted, hard of hearing? • Do the staff answer the door promptly? • Do the staff appear friendly and welcoming? • Does there appear to be a number of staff on duty? • Do the residents look well cared for and clean? • Is there an up-to-date registration certificate on display? <p>It is usual to sign a visitors' book on arrival.</p>
The accommodation	<ul style="list-style-type: none"> • Is the home/room clean and fresh? • Are the rooms single or shared? • Do the rooms have ensuite facilities? • Can you bring your own furniture and personal belongings? • Where are the nearest toilets, are they accessible? • Is there a telephone in the room and/or mobile phone reception? • Is there a wifi connection/is there a charge for this? • Are there quiet areas to sit in? • What are the meal times? • Is there a choice of meals/diets? • Is there a laundry service on site?
Personal needs	<ul style="list-style-type: none"> • How often do the hairdresser, dentist, chiropody, religious support, GP visit? • Does a resident change GP if they move from the local area? • Where are medications stored? • Can I get a newspaper? • What activities can I join in or hobbies to continue? • Does the home arrange outings? • Are there quiet areas for family/friends to visit? • Can they stay for meals? • Is there an overnight room where they can stay?
Finances and contracts	<ul style="list-style-type: none"> • What are the fees? • What services do the fees include, e.g. chiropody, hairdresser, etc.? • What are the terms and conditions? • Is there a reduction if the patient is admitted to hospital or goes on holiday? • What is the notice period/terminating contract? • When is the room available from?
Nursing needs	<ul style="list-style-type: none"> • How many qualified nursing staff are on duty day and night (in a nursing home)? • How often do qualified nursing staff review a resident (in a nursing home)? • How often does the community nursing team visit and review residents in the care home? • What is the daily care routine? • If the patient has very specific nursing needs, how will they be managed? Refer to the list given by the ward staff on the patient's specific health care needs. • How often do the community palliative care team visit the home? • How often is the GP or doctor in the home? • Although a difficult thing to consider, are they able to support patients to remain in the home for end-of-life care?

In 2007 there were important changes in the funding arrangements for adults requiring registered nursing care in nursing homes in England (DH 2013). All adults needing the skills and knowledge of a Registered Nurse to meet all or certain elements of their care needs have that care paid for by the NHS. The amount of funding, paid directly to the nursing home, is dependent on a comprehensive assessment of the patient's care needs by a Registered Nurse, who will usually be employed by the local Clinical Commissioning Group. NHS-funded nursing care was originally provided via payment 'bands', which relate to the level of nursing care required. However, the National Framework (DH 2006b), which came into effect in October 2007, replaced the banding system with a weekly rate for NHS-funded nursing care.

Equipment to facilitate a patient's discharge

Patients will frequently require equipment to enable them to return home. The equipment needs of each patient should be assessed at

pre-admission and throughout their stay. From a nursing perspective, patients may require additional equipment such as oxygen, which should be prescribed using the appropriate national Home Oxygen Order Forms part A and B. However, in some hospitals this task is completed by a specialist respiratory nurse. It is useful to know how the local procedures work and how to access oxygen for patients at home. Consideration also needs to be given to the monitoring and reviewing of the patient on oxygen once at home.

Specialist ongoing care provisions for patients at home

Patients may require additional provisions to be put in place to facilitate a safe and timely discharge. Patients may be returning home having had interventions that mean they need specialist nursing input. There will be locally agreed policies and procedures in the community about what can be provided, therefore it is important to confirm that the individual patient's nursing needs can be met before discharge.

Nutritional needs on discharge

In some cases, patients may be receiving nutritional supplements via feeding tubes, known as enteral feeding. The common routes for enteral feeding in the community are:

- radiologically inserted gastrostomy (RIG)
- percutaneous endoscopically placed gastrostomy (PEG)
- jejunostomy
- nasogastric.

Community nurses and dieticians should be contacted in advance of a patient returning home with supportive feeding *in situ* to ascertain what information and support they need to facilitate the patient's safe and timely discharge.

Pumps and drains

For wound healing, in some cases patients may be discharged with drains or pumps *in situ*. It is important to confirm that the Clinical Commissioning Group will fund the equipment before discharge. The patient should be supplied with at least 1 week's supply of dressings, allowing the community nurse time to order additional supplies. This timescale may vary depending on local agreements between acute trust and community health providers.

Medication

Before a patient is discharged, the nurse needs to ensure that the patient and, where appropriate, the carer are competent to self-administer medication at home. In some areas tablet dispensers are provided, particularly for those who have difficulty opening containers. If carers/community nurses are involved, local policies need to be adhered to. A medicines administration record (MAR chart) should be given on discharge, clearly stating the name of the drug, dose and frequency and any other special instructions. Special considerations are required for medications prescribed for pumps and drivers, e.g. for patients who require end-of-life care of symptom management.

Patients with particular care needs on discharge

It is important to recognize that some patients may have additional needs that they have not considered themselves whilst in hospital (Box 2.11). If, for example, the patient lives alone or is very frail, simple tasks such as shopping for basic provisions may be very difficult. Consequently, some shopping may need to be done prior to discharge. The patient may have a family member, friend or neighbour who can do this but the patient may assume this task is going to be done when it has not been, thus leaving the patient at home with no basic provisions and no means of getting them. It is therefore really important to talk to the patient about how they might manage these tasks on discharge and consider other means of support such as Age UK or a local voluntary service.

For patients who are frail and at risk of falls, ensuring that they know that the community pendant alarm systems can be installed may provide the patient and family with some reassurance. Further information regarding these alarms and the local providers is usually held by the local authority.

Housing and impact on discharge

On discharge, consideration may need to be given to patient accommodation, such as the suitability of the accommodation and equipment needs, for example, if the patient's property is in a poor state or there are issues in relation to hoarding. A domiciliary visit may be required to ensure the property is habitable; this may need to be done by or with social services. It is also possible that prior to admission patients were homeless or they have become homeless during the admission. The patient may need to be supported to access accommodation through the local authority homelessness team. As part of the process, the patient will need to provide evidence of eligibility for social housing.

Issues of access to patient accommodation may impact on discharge plans. For example, the patient was mobile prior to



Box 2.11 Patients with particular care needs on discharge

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- Live alone.
- Are frail and/or elderly.
- Have care needs which place a high demand on carers.
- Have a limited prognosis.
- Have serious illnesses and will be returning to hospital for further treatments.
- Have continuing disability.
- Have learning difficulties.
- Have mental illness or dementia.
- Have dependants.
- Have limited financial resources.
- Are homeless or live in poor housing.
- Do not have English as their first language.
- Have been in hospital for an 'extended stay'.
- Require aids/equipment at home.

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admission and lives in third-floor accommodation with no lift, but is no longer mobile. However, the patient may still be discharged back to their property whilst the housing department reviews the accommodation and provides suitable alternative accommodation at a later date. Where the patient is a home owner, the housing department may be less likely to intervene and it may be down to the patient and their family to address this.

PRIOR TO DISCHARGE

It is important to continue to review the discharge needs of a patient up until the day of their discharge. There are certain issues that need to be addressed for all patients, such as transport to enable them to return home and that medications to take home have been ordered and are ready for discharge. For patients with more complex needs, it may be useful to use a discharge checklist; this can be commenced on the patient's admission and monitored throughout the patient's hospital stay (see Figure 2.1).

DISCHARGE AT THE END OF LIFE

The *End of Life Care Strategy* (DH 2008) requires that an assessment is made of the patient's preferred place of care and how and where they wish to be cared for at the end of life. Some patients may already have an advance care plan, within which will be recorded these wishes as well as any advance decision they have made about their end-of-life care. For some patients, these conversations may need to take place to ensure that they and their families are given the opportunity to make informed decisions about their wishes. It is important that these conversations are realistic and that patients and their families are aware of the services and potential gaps that might arise once the person is at home. For instance, if the patient believes that community nurses can be with them at any time day or night when a crisis occurs, this may set up the patient, family and community healthcare providers to fail.

The condition of a person nearing the end of life may change rapidly, so it is essential that choices are made and community services are accessed without delay. There may be occasions when a patient is reaching the end of life and the decision is made that their preferred place of care/death is home. Then every effort must be made to ensure that all practicable steps are taken to allow that to happen (Vaartio et al. 2006). Such discharges are often complex and multifactorial and require a multidisciplinary team to be flexible and responsive. It is important in the first instance to contact relevant community teams to highlight the need for a rapid response to any referrals being made. Community nursing, the community palliative care team and, where available, the community matron should be notified at the earliest opportunity. A fast-track NHS Continuing Healthcare funding application may

need to be submitted to access funding for the care provision. The patient may also require essential equipment to enable them to return home, such as a profiling bed, commode or hoist; again, these should be ordered at the first opportunity.

Once care and equipment are in place and discharge is proceeding, ensure that a medical review takes place and that

the GP, community nurses and community palliative care team are provided with a copy of the discharge summary (Figure 2.2). Telephone contact with the GP prior to discharge is essential to ensure they visit the patient at home.

The patient should be reviewed just prior to discharge by the medical team and any changes in their clinical condition or needs

Name:

Hospital No:



Patients Being Discharged Home for Urgent Palliative Care Checklist for Discharge

This form should be used to assist with planning an urgent discharge home for a patient with terminal care needs. It should be used in conjunction with the Discharge Policy.

Sign and date to confirm when arranged and equipment given. Document relevant information in the discharge planning section of the nursing documentation. Document if item or care is not applicable.

Appoint a designated discharge lead:

Name:..... Designation:..... Contact No:.....

	Date & Time	Signature, Print Name & Job Title
Patient / Family Issues		
Meeting with patient/family to discuss:- patient's condition and prognosis		
Plan agreed and discussed with patient and carers. Explain the level of care that will be provided in the community. Ensure an understanding that there will not be 24 hour nursing presence.		
Communication with Community Nurse and Community Palliative Care Team		
Discuss with patient/family: <ul style="list-style-type: none"> • Patient and family needs • The role of each service and the timing and frequency of visits • Community Service cover at night (to support family) e.g. Marie Curie or other local services • The need to complete the Continuing Care Application Form, if necessary. • Liaise with complex discharge co-ordinator if advice or fast tracking needed. 		
Agreed planned date and time of community nurses first visit.....		
Agreed planned date and time of community palliative care team first visit.....		
Night nursing service Start date.....		
Communication with GP and Community Palliative Care Medical Team- Medical Responsibilities (Hospital medical team to organize – the nurse to confirm when arranged)		
Registrar to discuss patient's condition with GP and request home visit on day of discharge for death certification purposes. Agreed date and time of visit.....		
Oxygen: HOOF and HOCF completed and faxed to relevant company. Company to arrange delivery date and time with family. [Fax copies to GP for information only]		
Medical summary faxed to GP <input type="checkbox"/> copy with patient <input type="checkbox"/>		
Registrar or Specialist Nurse to discuss with the Community Palliative Care team the patient's needs and proposed plan of care		
Adequate supply of drugs prescribed for discharge (TTOs) including crisis drugs e.g. s/c morphine, midazolam.		
Authorization for drugs to be administered by community nurses. Please refer to Subcutaneous Drugs policy and		

Figure 2.2 Checklist for patients being discharged home for urgent palliative care.

complete the discharge checklist for the McKinley T34 syringe pump.		
Prescription sheet of authorisation for drugs to be administered by community nurses. Faxed to Community Nurse and GP		
'Do Not Attempt Resuscitation' letter for Ambulance Crew		

Equipment - confirm delivery of equipment		
Electric, profiling hospital bed		
Pressure relieving equipment		
Commode/urinal/bed-pan		
Hoist/ slings/ sliding sheets		
Other, please state e.g. McKinley T34.....		
Provide 4 days supply of:		
Dressings		
Sharps bin		
Continence aids		
Transport (confirm by ticking appropriate boxes) CHECK OTHER DISCHARGE DOCUMENTATION		
Escort (family/nurse)		
Family informed and aware that the patient may not survive the transfer journey and that the ambulance crew will not attempt resuscitation		
Written information and documentation		
Community Care Referral form completed and faxed for the attention of.....		
Community Care Referral form and medical summary given to patient or relative (specify)		
Community Palliative Care Team form completed and faxed for the attention of.....		
Patient/carer given list of contact numbers of community services (including night service)		
Medication list, stating reasons for drugs, given and explained to patient/ relative		
Confirm with the Hospital Consultant/Complex Discharge-Co-ordinator whether a bed should be held for this patient for 24hrs only (unless in exceptional circumstances following discussion with the Complex Discharge Co-ordinator)		

Signature/print name of designated ward based discharge lead:.....

Date/Time.....

File this form in the patient's records on discharge.

Figure 2.2 (Continued)

should be shared with the community healthcare providers. It may even be necessary to review the decision and to have open and honest conversations with the patient and their family about what to expect in the coming hours, days or weeks.

POST-PROCEDURAL CONSIDERATIONS

A discharge delay is when a patient remains in hospital beyond the date agreed between the multidisciplinary team and beyond

the time when they are medically fit to be discharged (DH 2003). For every patient who is 'delayed', NHS trusts are required to report the delay to their commissioners. It is the responsibility of the health authorities, in collaboration with local authorities, to monitor and address any issues that result in delays in the transfer of patients from an acute bed to their home or community bed, such as care home or rehabilitation bed. Trusts closely monitor bed activity and reporting varies from weekly to daily in winter months.

Key points

- Assessment tools can be used to assess patients' general needs or to assess a specific problem.
- A comprehensive and systematic assessment is the key to planning and providing individualized patient care.
- Nurses have a professional responsibility to ensure that healthcare records provide an accurate account of the care process and are viewed as a tool of communication within the team.
- Effective discharge planning involving the multidisciplinary team helps to prevent inappropriate readmissions and delayed discharges while promoting the highest level of independence for the patient.
- When planning discharges, nurses are required to share information about patients with health and social care providers in the community. Principles of information governance must be adhered to, with care being taken to ensure that information is only shared as required and with the patients consent.

Now Test Yourself

This section provides a range of exercises/activities to further test your learning. For additional exercises visit www.wiley.com/go/websitenamegoeshere.

Learning Activity 2.6 Learning exercises and reflecting on practice

- 1 Within your clinical area, find the opportunity to either observe or carry out a patient admission assessment. Considering what you now know about that patient, go through the assessment questions in Box 2.5 and identify any 'gaps' in the patient assessment. What aspects of the assessment were not covered? Why?
 - A Carer's (Equal Opportunities) Act (2004)
 - B Mental Capacity Act (2005)
 - C Health and Social Care Act (2012)
 - D All of the above
- 2 If a patient has been assessed as lacking capacity to make their own decisions, what government legislation or 'act' should be referred to?
 - A Carer's (Equal Opportunities) Act (2004)
 - B Mental Capacity Act (2005)
 - C Health and Social Care Act (2012)
 - D All of the above
- 3 How many steps to discharge planning were identified by the Department of Health (DH 2010)?
 - A 5 steps
 - B 8 steps
 - C 10 steps
 - D 12 steps
- 4 The single assessment process was introduced as part of the *National Service Framework for Older People* (DH 2001) in order to improve care for this group of patients
 - A True
 - B False
- 5 Under the Carer's (Equal Opportunities) Act (2004) what are carers entitled to?
 - A Their own assessment
 - B Financial support
 - C Respite care
 - D All of the above
- 6 What is the main aim of the *End of Life Care Strategy* (DH 2008)?

See end of chapter for answers.

Learning Activity 2.7 Learning for practice

After studying this chapter, list five key points you have learnt about assessment and discharge planning that you will be able to apply to your clinical practice.



For further learning exercises visit www.wiley.com/go/websitenamegoeshere

Answers

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Learning Activity 2.2 Case study: Developing an individualized care plan

Core care plans and care pathways are being used increasingly to plan and deliver patient care. (Why is this?) However, patients will inevitably have problems or health needs (nursing diagnoses) for which there is not a core care plan, so it is vitally important that nurses are able to develop comprehensive and individualized care plans for patients no matter what their condition.

Try doing this activity with a friend.

Read the following case study:

Anna is a 27-year-old woman who was admitted to the ward with abdominal pain via the Emergency Department. She is currently nil by mouth and on intravenous fluids. She is very anxious about her mum, who is wheelchair bound and currently being looked after by a family friend; Anna is her main carer at home.

Develop a care plan for Anna to include the following:

- Nursing diagnoses (what are her problems or health needs?)
- Outcomes (what would you realistically hope to achieve for each of her nursing diagnoses?)
- Nursing interventions (what actions do the nursing team need to take to help achieve these outcomes?)

Example care plans

Anxiety related to being unable to care for her mother

For Anna to feel reassured that her mother is being looked after:

- 1 Allow time for Anna to discuss her home situation.
- 2 Support Anna to be able to speak with her mother over the phone.
- 3 Be flexible with visiting times to allow her mother to visit 'out of hours' if required.

Acute pain related to unknown cause

For Anna to state she is comfortable with pain score less than 3 (pain scale 0–10):

- 1 Assess pain hourly using a pain assessment chart.
- 2 Administer prescribed analgesia and monitor effect.
- 3 Provide Anna with information and support for any investigations she may have.

Risk for fluid deficit: nil by mouth

For Anna to state she does not feel dehydrated and to be in a slight positive fluid balance:

- 1 Administer prescribed IV fluids.
- 2 Maintain an accurate fluid balance chart.
- 3 Encourage Anna to rinse her mouth regularly.

Learning Activity 2.4 Scenario: Discharge planning

You are caring for a patient who is known to have dementia. What particular issues should you consider prior to discharge?

- 1 Does the patient lack capacity?
- 2 Does he/she have family/carers who should be involved in their care decisions?
- 3 Is it appropriate for him/her to return to their previous living arrangements?

- 4 If the patient lacks capacity and the answer to questions 2 and 3 is 'no', who should you get involved in their care? **Local Independent Mental Capacity Advocacy Service (Mental Capacity Act, 2005)**
- 5 What other support services might you want to get involved in his/her discharge? **For example: the hospital discharge team, social services, the mental health team?**

Learning Activity 2.6 Learning exercises and reflecting on practice

- 1 Within your clinical area, find the opportunity to either observe or carry out a patient admission assessment. Considering what you now know about that patient, go through the assessment questions in Box 2.5 and identify any 'gaps' in the patient assessment. What aspects of the assessment were not covered? Why?
- 2 If a patient has been assessed as lacking capacity to make their own decisions, what government legislation or 'act' should be referred to?
 - A Carer's (Equal Opportunities) Act (2004)
 - B **Mental Capacity Act (2005)**
 - C Health and Social Care Act (2012)
 - D All of the above
- 3 How many steps to discharge planning were identified by the Department of Health (DH 2010)?
 - A 5 steps
 - B 8 steps
 - C **10 steps**
 - D 12 steps
- 4 The single assessment process was introduced as part of the *National Service Framework for Older People* (DH 2001) in order to improve care for this group of patients.
 - A **True**
 - B False
- 5 Under the Carers (Equal Opportunities) Act (2004) what are carers entitled to?
 - A Their own assessment
 - B Financial support
 - C Respite care
 - D **All of the above**
- 6 What is the main aim of the *End of Life Care Strategy* (DH 2008)?
 - A **Identify a patient's preferred place of care.**
 - B An assessment is used to identify how and where patients wish to be cared for at the end of life.

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