Clinical Skills Programme
Discharge Planning
Clinical Skills Programme

Discharge Planning

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<tbody>
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Discharge planning

Section 1

Rationale for programme

Effective discharge planning not only impacts the quality of the individual patient’s health care experience/journey but also has a major impact upon the overall management of patient flow and in the optimisation of bed capacity. Poor discharge planning can result in re-admission to hospital, increased patient/carer distress, increased workload for primary and secondary care settings, inefficient use of beds and longer waiting times.

In addition, effective discharge planning is a skill that is rarely updated through ongoing education and training and the quality and standard of discharge planning within the practice setting is inconsistent.

Though nurses have long been pivotal in the co-ordination, preparation and organising of patient discharge, they have not traditionally been the key decision-maker. Medical staff currently hold authority to discharge patients from the hospital setting through deeming them ‘medically fit’ for discharge. They do however rely heavily on nursing and allied health professional assessment and information to support this decision in terms of functional ability and psychosocial status. The shifting boundaries in health care has enabled registered nurses to respond to the drive for comprehensive, modern health care services through advancing their roles to improve the quality of care for service users. Delegated authority for discharging patients from the hospital setting to suitably qualified nurses in collaboration with the multi disciplinary team, can facilitate a proactive approach to discharge planning promoting timely discharge and reduce delays for patients advancing current discharge practice.

This document contains theoretical information to enable practitioners to enhance their knowledge, identify good practice and enable effective, safe, timely discharge practice. Learning outcomes are provided together with an assessment of core knowledge skills.

The programme aims to:

**Inform and clarify issues related to discharge practice**
- Standardise and improve current discharge practice
- Achieve timely and effective discharge for service users
- Formalise the professional’s role in ensuring a proactive approach to discharge planning
- Ensure that patients and carers are involved in discharge planning and receive appropriate information regards their anticipated length of stay in hospital facilitating forward planning.
How to use this programme:
The programme contains practical and theoretical guidance relating to the management of patients requiring discharge planning.

The practitioner will read through the contents of the pack, undertaking the recommended reading. The practitioner will then work through the activities provided which assess their knowledge and practice on discharge planning in their clinical area.

An essential requisite for the programme is that the reader has access to and is familiar with:


b) NHS Highland, Highland Council, Argyll and Bute Council (2010) Partnership Policy document: Joint Admission Transfer and Discharge Policy.

c) NHS Highland, Highland Council, Argyll and Bute Council (2010) Partnership Procedures Guidance for Joint Admission, Transfer and Discharge Policy


Roles and Responsibilities for Education:

- Line managers should ensure that education packs are given at induction and completed satisfactorily and that best practice is carried out in relation to discharge planning
- Each practitioner has a responsibility to integrate this skill into their daily practice for the benefit of patients in their care and maintain his/her standards of discharge planning through regular review and updating.
• On successful completion of the programme, each registered practitioner will be accountable and responsible for maintaining his/her own practice.

• Completed records for nursing staff training will be held within each area by the Senior Charge Nurse/Line Manager

Assessment includes:

• Activities are included throughout the pack to facilitate critical review of current practice in relation to best practice identified in the learning pack. Your mentor will assess these activities.
• Theoretical assessment of admission, transfer discharge practice
• Successful completion of this study guide

Registered practitioners who have completed this study guide can act as an assessor. The Senior Charge Nurse / line manager retains responsibility for holding records of completion of the programme.

Links to KSF dimensions and levels:

Core 1 Communication, level 3
Core 5, Quality, level 2
HWB2, Assessment and care planning to meet health and well being needs, level2
Learning Outcomes

On completion of this programme, the practitioner will be able to: -

1. Demonstrate knowledge and understanding of National and Local drivers relating to best practice in discharge planning included in the reading list.

2. Discuss the Nurses role in relation to admission, transfer, discharge planning taking cognisance of:
   a) Medico-legal aspects.
   b) Principles and practice of record keeping.
   c) Best practice in relation to safe and effective admission, transfer and discharge management.
   d) Describe the process and rational of expected date of discharge and/or criteria for discharge.
   e) Discuss the co-ordination of the multidisciplinary team actions.
   f) Discuss the process of involving patients and carers in the discharge planning process.

3. Describe the roles and responsibilities of the multidisciplinary team in the discharge planning process.
   a) Registered nurses
   b) Medical staff
   c) Occupational Therapist
   d) Physiotherapist
   e) Pharmacy
   f) Ambulance service
   g) Community nursing staff
   h) Dietician
   i) Speech and language therapy
   j) Social work
   k) Care home sector
   l) Continence service

4. Demonstrate an awareness of the process of referral and criteria to the following services: -
   a) Occupational therapy
   b) Physiotherapy
   c) Social work department
   d) Community/specialist nursing service
   e) Ambulance service
   f) Speech and language therapy
   g) Dietician
   h) Care Home sector
   i) Continence service
5. Demonstrate effective documentation of discharge planning including:
   a) Evidence of patient/carer involvement
   b) Evidence of involvement of multidisciplinary team
   c) Evidence of appropriate use of multidisciplinary acute record of care, including discharge planning meeting documentation
   d) Patient discharge information sheets
   e) Nursing transfer letters
   f) documentation

6. Demonstrate the skills required to devise and implement an admission transfer discharge outcome pathway by:
   a) Interpreting the patients condition and assessing their needs in relation to admission, transfer, discharge
   b) Demonstrating application of policies, protocols and care pathways
   c) Assessing the patients physical, psychological, functional and social status in relation to discharge planning & suitability for discharge
   d) Demonstrating ability to use advanced clinical decision making skills and work collaboratively with the multi-professional/multi-agency team recognising need for onward referral/advice when patient presents with complex or problem issues affecting discharge

7. Demonstrate ability to complete the discharge process through nurse-led discharge by:
   a) Demonstrating knowledge and understanding of the patient’s physiological, functional and social assessment of suitability for discharge
   b) Demonstrating knowledge and understanding of the patient’s medical condition and apply critical thinking and reasoning to potential risks/problems taking appropriate action before proceeding to discharge

8. Define and describe anticipatory care, telecare, self management and re-ablement
Section 2 Medico-Legal Aspects

The registered practitioner must be fully cognisant with his/her legal responsibilities in relation to their role, role expansion and the duty of care owed to patients.

Accountability requires each registered practitioner to explain and justify her actions and clinical decisions. This means that you are answerable for your actions and omissions or departure from good professional practice, regardless of advice or direction from another professional (NMC 2008; GMC 2004; HPC).

Standard expectations include a good standard of care which encompasses competence; being honest and trustworthy; respecting patients’ dignity and privacy; and making the patients the priority.

In law there are four areas whereby the practitioner may be called to account for her actions / decisions these include:

- Accountability via civil Law
- Accountability via criminal law
- Professional accountability to NMC / GMC / HPC / SSSC
- Accountability to employer

Each registered practitioner must be fully cognisant of his/her legal responsibilities in relation to role and the duty of care owed to patients.

Activity one

Before proceeding, read your relevant professional code (NMC 2008; GMC 2004; or equivalent)

What aspects of your code of conduct can you apply to the carrying out of discharge planning?

________________________________________________________________________

________________________________________________________________________

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NB Practitioners must acknowledge their limitations and work within the limits of their competence. Supervision by a competent practitioner must take place until the required knowledge and skill is reached.

As a registered practitioner you are personally accountable for obtaining consent before you give any treatment or care, this includes discharge planning and sharing of information.
Consent can be expressed or implied, that is given verbally, in writing or inferred by conduct (acquiescence by a person who understands what will be undertaken), depending on the clinical situation, the treatment or procedure and the degree of risk involved.

There are 3 major requirements to establish legally valid consent to treatment:

1. The patient is legally competent to give informed consent.
2. Expression of free will by patient.
3. Consent is based on adequate information.

**Activity two**

A patient you are looking after does not appear to have the capacity to consent to discharge planning. Discuss your actions.

**Adults with Incapacity Act (Scotland) 2000**

This act was introduced to permit decisions to be made on behalf of adults who are incapable of making decisions themselves. According to the Act, incapable means incapable of acting; making decisions; communicating decisions; understanding decisions; retaining the memory of decisions.

Inability to communicate does not include deficits which can be corrected, for example, the use of a hearing aid, or the attendance of an interpreter. In order to comply with the Act, practitioners must ensure the intervention is necessary, beneficial to the patient and must be the minimum necessary to achieve the purpose. Practitioners must also take account of the patient’s and nearest relatives’ wishes and feelings as far as is practicable to do so. The patient should be encouraged to use any skills they do have. Further information can be obtained by visiting [www.scotland.gov.uk](http://www.scotland.gov.uk). Type “adults with incapacity” into the search and select part 5 of the Act.
Documentation:
Harris (2003) reminds us that:
“If a clinical examination is not recorded, it must be assumed that it did not happen”.

(Dimond, 2005a)

The importance of clear and unambiguous documentation can not be over emphasised. Accurate documentation not only provides practitioners with evidence of their actions in a court of law, it is also essential for effective patient care.

Activity three

The article by Dimond (2005a) “Exploring common deficiencies that occur in record keeping” provides case examples to highlight the importance of documentation from a legal and patient care perspective. Read the article and identify if there have been any difficulties in your clinical area due to poor documentation.

There are some good practice points for record keeping which are relevant to all health and social care practitioners:
• Ensure entries are accurate and legible
• Write up notes as soon as possible after the event (contemporaneously)
• Be accurately dated, timed and signed
• Do not include jargon or abbreviations
• Never include offensive, subjective statements
• Photocopies should be clear, therefore it is good practice to write in black indelible ink.

Reference:

Section 3 Principles of Discharge Planning

‘Discharge from hospital is a process and not an isolated event. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individual concerned and their carers should be involved at all stages and kept fully informed by regular reviews and updates of the care plan. Discharge planning should start prior to admission for planned admissions and as soon as possible for other admission’ (DOH, 2003)

Activity four
Reflect upon your current discharge practice in relation to the above quotation. Describe your current strengths, and discuss the areas for improvement?

Effective discharge planning has a major impact upon the quality of the individual patient’s health care experience and to improving the management of bed capacity within the hospital setting. Optimising discharge planning is essential to facilitate the patient’s recovery both physically and mentally and to support patients and carers in preparing for going home. Planning for discharge must take place at the earliest opportunity and must involve both patients and carers in the decision making process.

Activity five
Reflect on any issues/incidents/near misses relating to the discharge of patients from your area. Discuss what have you learnt from your reflection?
The engagement and active participation of individuals and their carers (with patient consent) as equal partners is central to the delivery of care and in the planning of a successful discharge.

**Activity six**
Discuss why it is important to consider discharge planning at the earliest opportunity.

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**Activity seven**
Describe the process and rationale for using a planned date of discharge (PDD).

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**Activity eight**
Discuss how you can actively involve patients and carers at an early stage in the discharge planning process, to shift the focus to a more collaborative approach. Then describe how you would document this?
It is cited in the literature that simple discharges account for up to 80% of discharges from hospital (Achieving timely, ‘simple’ discharge from hospital, A toolkit for the multidisciplinary team, 2004). Improving discharge planning in this large group of patients can have a major impact upon the overall bed availability and of course on unnecessary waits/delays for these patients.

**Activity nine**
List factors that cause delays in discharge planning for patients within your area

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<th>Factor 1</th>
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Process mapping allows you to stand back and consider the steps involved in an aspect of care/treatment. It involves recording all the steps in a process and reviewing which of these add value and which are unnecessary duplicate or delay the process.

**Activity ten**
Process map/audit one patient discharge in your area of practice.
Consider time of discharge, day of discharge, types of delays, use of planned discharge date (PDD) etc. Discuss your findings.

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<th>Action 1</th>
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<th>Action 3</th>
<th>Action 4</th>
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Activity eleven
Process map / audit one complex patient discharge in your area of practice. Consider time of discharge, day of discharge, types of delays, use of planned discharge date (PDD) etc. Discuss your findings.

Discharge planning is a multidisciplinary process, which can include numerous professionals, patient, family / carers. Involving all the relevant people is essential for successful discharge. Understanding individual roles and responsibilities within the discharge planning process is also fundamental to securing safe and effective discharge.

Activity twelve
Describe how you would apply these principles to practice when undertaking a straightforward discharge.

Activity thirteen
Following discussion with members of the multidisciplinary team re discharge planning, describe their roles and responsibilities in the process of discharge planning in your area: -

a) Registered Nurses
b) Social work
c) Pharmacy
d) Occupational therapy

<table>
<thead>
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<th>e) Physiotherapy</th>
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<tr>
<td>f) Speech and language therapy</td>
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<td>g) Continence service</td>
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<td>h) Community nursing service</td>
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<td>i) Dietician</td>
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<tr>
<td>j) Medical staff</td>
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<tr>
<td>k) Ambulance service</td>
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<tr>
<td>l) telecare</td>
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**Activity fourteen**

In collaboration with the following team members list the criteria and the referral process in your area:

<table>
<thead>
<tr>
<th>a) Physiotherapy</th>
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<td>b) Occupational therapy</td>
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<td>c) Ambulance service</td>
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<td>d) Community nursing service</td>
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<td>e) Dietician</td>
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<td>h) Social work</td>
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<tr>
<td>i) Continence service</td>
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<td>j) telecare</td>
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Activity fifteen
Discuss the key principles incorporated in this document.

Activity sixteen
Define a delayed discharge and describe the actions you must take when you identify a delayed discharge.

Activity seventeen
Describe the current record keeping system used for documenting discharge planning. Demonstrate how the involvement of the multidisciplinary team is documented.
Activity eighteen
Describe the action you would take when planning a discharge for a homeless individual and the key individuals to contact to facilitate this process.

See reference at end of section

Activity nineteen
Complete a discharge pathway; you may wish to use the following reflective model to assist your critical analysis of the process. Discuss the discharges with your mentor. One of the complex discharges should include the learner planning, facilitating and documenting a discharge-planning meeting.

What happened?

What were you thinking and feeling?

What was good and bad about the experience?
<table>
<thead>
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<th>What will you do next time?</th>
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**Activity twenty**

Describe what steps you would take before discharging a client who resides in sheltered housing accommodation, detailing who you would contact in this situation and why:

NB It is important that the warden/carer/family is informed of the discharge back to sheltered accommodation/home especially during the winter months thus ensuring that water and heating are on for their return. Following a lengthy stay in hospital, finance services should be informed to ensure that benefits are recalculated and re-started.
Section 4 The Nurse’s role in Discharge planning

Achieving effective and timely discharge from hospital is a fundamental principle in the management of patient flow and in optimising bed capacity. In improving and ensuring timely discharge from hospital the NHS modernisation Agency (2004) suggest that nursing teams should proactively manage the discharge process and initiate simple discharges.

Straightforward or simple discharges, which can incorporate up to 80% of discharges from hospital, include those patients that:

- Will be discharged to their own home or place of residence
- Have simple ongoing care needs that do not require complex planning and delivery
- No longer require acute care
- Have a predicted length of stay
- Can be discharged directly from A&E / Wards or assessment units and community hospitals.

Though nursing staff have long been pivotal in the co-ordination, preparation and organising of patient discharge, traditionally, medical staff have held the authority to discharge patients through deeming them ‘medically fit’ for discharge. They have however, relied heavily on nursing and allied health professional assessment of the patient’s psychosocial status and functional ability. Straightforward discharges can be delayed when the decision is dependent upon the availability of medical personnel or ward round times. In addition, discharge planning tasks such as ordering of discharge drugs often does not take place until the medical decision is made. Delegated authority to suitable competent registered nursing staff who are available 24 hours per day, seven days per week gives flexibility to discharge planning and enables the nurse to complete the process streamlining care and advancing current discharge practice.

Activity twenty one

Discuss the responsibilities of the registered nurse in relation to the admission transfer discharge policy:
As a registered nurse you are expected to assume responsibility and accountability for your actions and decisions relating to nurse led discharge to the same standard as a medical practitioner.

**Activity twenty-two**
Describe the principles you would apply and the actions you would take prior to discharging a patient from hospital.

**Activity twenty three**
You are in the process of discharging a patient from hospital. You have concerns that all assessments have not been completed and the bed is required today for an admission. What happens next?

**Self Management**
There is a range of descriptions, definitions and language used to describe what self management is but that they all encompass similar concepts and notions about the terms self care and self management and are often used interchangeably. Within the UK, England refers to self care while in Scotland we refer to self management programmes. To enable some clarity across Scotland, the LTCAS (2008) tried to define the 2 terms:
Self care is what each person does on a daily basis. This is often compromised for a person living their life with long term conditions. Self management is the process each person develops to manage their conditions.

Self management is the successful outcome of the person and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long term condition.

**Some common experiences of patients are**

- Not enough involvement in decision
- No-one to talk to about anxieties and concerns
- Tests and/or treatments not clearly explained
- Insufficient information for family/friends
- Insufficient information about recovery

(Source: Coulter, A, Picker Institute, 2005)

**Activity twenty four**

How can you actively support patients/clients to be more involved in decision making about their care from an early stage in their admission?

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**Activity twenty five**

Consider who holds the power in the ward environment and record how that can affect the relationship between the patient and the staff.
Activity twenty six
Reflect on a recent consultation you had with a health professional. How much of the consultation and information given do you remember and do you feel you were able to ask all the questions you needed to feel fully informed?

Re-ablement
The objective of re-ablement is, through the use for timely and focused intensive interventions;

- To maximise users long term independence, choice and quality of life
- To appropriately minimise ongoing support required, and thereby, minimise the whole cost of care
- Helping people “to do” rather than doing “to do for” people
- Outcome focused with defined maximum duration
- Assessment for ongoing packages cannot be delivered by a one off assessment but requires observation over a defined period

This approach has to be embedded across all hospital and community care and should start on admission and follow through after discharge

Evidence is that this approach makes significant differences to outcomes for people and to the efficiency of the service as well as having a benefit on their health needs. This links very well with the whole concept of “Shifting the Balance of Care”

Visit the links below to review some of the evidence relating to re-ablement


Activity twenty seven

Reflect on a recent patient/client in the ward and consider how a re-enablement approach by the whole team may have changed the outcome for that person. How much of a ‘doing for’ rather than a ‘doing to’ approach was actively promoted?

Anticipatory/advanced care planning

Anticipatory care planning is a process of discussion and reflection about personal choice, values and preferences for future treatment in the context of an anticipated deterioration in the person's condition. This is important, particularly for those with multiple, complex needs who are at highest risk of emergency admission and/or readmission to specialist services. Anticipatory care and self-management are key aspects to improving the management of people living with long term conditions.

The need for anticipatory care planning is supported by both health and social care, and embodied in the Scottish Government’s Performance Assessment Framework. Targets have been identified for the NHS through the HEAT targets, and local government and partnership targets, actions and indicators are summarised in local Single outcome Agreements. Key targets areas include focus on prevention of admission to hospital, prevention and reduction in delayed discharges, reduction in length of stay in hospital, increasing the number of people able to live at home and delivery of interventions related to smoking, reducing alcohol consumption and to healthy weight. More information on HEAT targets and community outcome indicators can be found on the NHS intranet and also on your local council website.

Anticipatory/Advanced care plans have a vital role in the management of people with more complex and multiple conditions or at end of life. But ultimately anticipatory care is more about an approach than the tools that are used and this approach should be embedded into all stages of the illness or disability.

For the more complex case, an anticipatory care alert form is put in place and shared with GP, the patient, Community team, social work, the out of hours service and NHS 24. This alert contains some core information to aid the decision making about the admission of patients to hospital, should their condition deteriorate. It can be completed by any health or social care professional and must be completed in collaboration with the patient. In this respect it is a process of discussion and reflection about personal choice, values and preferences for
future treatment agreed prior to a crisis event occurring, and anticipating what actions could and should be put in place.
The other key difference is that the alert form is available though a web based database to the out of hours doctor. This doctor can see at a glance what medications the patient is on, what the treatment plan is, if there are any emergency medications in the house such as steroids and what other plans have put in place as regards care.
By identifying these key areas at point of contact a readmission may be avoided as well as potential disruption to home care services.
When someone is admitted with an ACP it can be used to assist in the discharge planning process. Someone who has frequent admissions can be identified as suitable for an ACP by involving the community team in the process prior to discharge
People with more complex needs will also require a shared assessment with social work to be completed as well. It is vital that a multi disciplinary approach is taken when working in an anticipatory way with people with more complex needs to ensure that all needs of the person are discussed.
This work sits alongside the Advanced Care Planning for palliative care patients and the Gold Service Framework. Living and Dying Well - A National Action plan for palliative care. (SGHD, 2008b)

**Activity twenty eight**
Describe how an anticipatory approach can be used in the ward environment to support the discharge process and prevent delayed discharge

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**Telecare**
The following definitions of Telecare and Telehealth were taken from the Shared Vocabulary agreed and published by the Scottish Government.
“Telecare is the remote or enhanced delivery of health and social services to people in their own home by means of telecommunications and computerised systems. Telecare usually refers to equipment and detectors that provide continuous, automatic and remote monitoring of care needs emergencies and lifestyle changes, using information and communication technology (ICT) to trigger human responses, or shut down equipment to prevent hazards.”
You can find out more about Telecare by clicking on the link below
http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/
Activity twenty nine
Find out what the referral criteria are and how to refer clients for Telecare in your area:

Improving the standards of discharge planning can have a significant impact upon the patient’s healthcare experience. Registered practitioners play a major part in expanding their practice and roles to improve the quality of discharge planning. We hope this programme provides the foundation for practitioners to take forward innovative discharge practice within your area.
Admission transfer Discharge planning

Section 5 Record of Completion of Programme

All staff must complete and return this slip to their Senior Charge Nurse / line manager.

Full Name: ____________________

Job Title: ________________  Clinical Area: ________________

<table>
<thead>
<tr>
<th>Completion of theoretical assessments / activities</th>
<th>Signature (Practitioner)</th>
<th>Signature (Assessor)</th>
<th>Date</th>
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<tbody>
<tr>
<td>Attended facilitated discussion on discharge</td>
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<td>Been assessed in practice</td>
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<td>Competent to carry out discharge planning</td>
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<td>Competent to carry out nurse led discharge</td>
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It is the responsibility of Senior Charge Nurses/Managers to photocopy this form and to keep a copy of this at ward level whilst giving a copy to the staff member for their own portfolio.
References


b) NHS Highland, Highland Council, Argyll and Bute Council (2010) Partnership Policy document: Joint Admission Transfer and Discharge Policy.

c) NHS Highland, Highland Council, Argyll and Bute Council (2010) Partnership Procedures Guidance for Joint Admission, Transfer and Discharge Policy


