Discharge planning

A summary of the Department of Health’s guidance
Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care
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Introduction
Being admitted to hospital can be frightening. In addition to the physical ill-health or trauma that triggered admission, hospital environments can be daunting and confusing, particularly for people who are ill, frail or vulnerable. Patients have consistently reported feeling ‘anxious, insignificant and powerless’ (Department of Health (DH) 2010).

Care transfer is an essential part of care management in any setting and it bestows responsibilities on organisations, systems and individuals. Smooth and effective care transfer ensures that health and social care systems are proactive in supporting individuals, their families and carers. It also ensures that resources are used effectively.

Timely care transfer requires clinicians and others to plan, inform and negotiate to ensure a smooth transition for individuals and their families. Underpinning this is the need for early identification of discharge/transfer dates including pre-admission planning, effective communication between individuals and across settings, good clinical management plans and the alignment of services to ensure continuity of care.

Although nursing roles are distinct in different services, the role of the nurse in liaising with patients, families and colleagues is central in achieving smooth transitions of care across service interfaces. The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (Nursing and Midwifery Council 2008) highlights the responsibility of nurses to:

- Listen to people in their care and respond to their needs and preferences.
- Share with people in a way they can understand the information they want and need to know about their health and care.
- Share information with colleagues and keep them informed.
- Work effectively as part of a team.
- Ensure that patient consent is gained before intervention.
- Act as advocate for patients.

Ready to go? Department of Health (England) guidance
The DH has issued comprehensive guidance on planning the discharge and transfer of patients from hospital and intermediate care (DH 2010). Accompanying the guidance is a package of resources that can be adapted for local needs. This essential guide aims to offer practitioners ideas to help support improvements in how they manage hospital discharge of individuals and transfer of care between settings. Service examples are also provided.

The ten operating principles
- Start early to anticipate problems, plan for discharge and agree an expected discharge date.
- A person-centred approach treats individuals with dignity and respect and meets their diverse or unique needs to secure the best outcomes possible.
Care planning process is co-ordinated effectively to dovetail processes.
Communication creates strong productive relationships between practitioners, patients and carers.
The multidisciplinary team (MDT) works collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharge/transfers.
Social services are involved, where appropriate, and the requirements for the assessment notification and discharge notification are met.
 Patients and carers are involved at all stages of discharge planning, given good information and helped to make care planning choices.
 Patients who do not have capacity to make decisions are given their rights under the Mental Capacity Act 2005.
 Carers are offered an assessment to identify any services they may need to support them in their caring role, if appropriate.
 Eligibility for NHS continuing health care is assessed, where appropriate.

**Person-centred care and patient empowerment**

Fundamental to effective care transfer is understanding patients in their normal situations. Through assessment, their individual needs and

**BOX 1**

**Person-centred care and patient empowerment**

In the enhanced recovery programme for colorectal surgery at Torbay hospital, staff talk with patients in detail about their operation, what will happen afterwards and what to expect when they go home. Before admission, the enhanced recovery nurse (ERN) spends approximately an hour with patients and carers in their homes to prepare them for the hospitalisation experience. Patients are given a booklet that includes a shopping list of items to buy before admission and foods to enhance their recovery on return home. An expected discharge date is put into the patient’s diary.

The enhanced recovery integrated care pathway contains milestones for patients, who assess their progress daily. They are empowered to take responsibility for their own care, for example in reminding staff that their urinary catheter is scheduled for removal on a specific day. Patients take responsibility for walking a defined distance each day. A yellow line has been painted on the floor so that the distance can be measured and the ‘hospital friends’ purchased epidural pumps and rucksacks so that patients can walk without dragging drip stands.
Patients take responsibility for eating and drinking what they need to aid recovery, for example supplementary protein drinks.

When patients go home they receive telephone follow up every day for three to four days or can call if they require anything. Surgeons are prepared to allow patients to go home knowing they are receiving follow up. There is a clinic in the outpatient suite where patients can see a colorectal surgeon or ERN and, because problems can be identified early, the readmission rate is low. When the programme started, length of hospital stay was ten to 14 days. It is now between six and a half and seven days.

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 priorities can be identified, along with the treatment, advice and services that could offer the most effective support. A common assessment framework for adults is being developed (DH 2009a), which aims to deliver a better experience for those who use health and social care services by supporting a proportionate, but thorough, and more person-centred assessment of need and care.

Good communication is essential to ensure that practitioners’ knowledge and clinical skills are used to best effect. Using terminology familiar to the patient, it is important that the right questions are asked so that the details of the patient’s lifestyle in the months leading up to his or her hospital admission are clear.

Information should be provided in a manner that takes account of the person’s ability to understand and it is important to check his or her understanding. Always explain to patients and their carers how they are to be involved in decisions, remembering that they are experts in how they feel and what it is like to live with, or care for, someone with a particular condition or disability. (Tips for communicating with patients and families are offered in Passing the Baton (National Leadership and Innovation Agency for Healthcare 2008.)

From the start it is important to recognise the role of a carer, and to be aware that patients and carers may have different needs. People should feel empowered to the maximum possible extent to manage their care, rehabilitation and transfer (Box 1).

Person-centred care and patient empowerment are particularly important for individuals who have a physical impairment, dementia, learning disability or a mental health need. Practitioners are obliged to ensure that patients are fully aware of their circumstances and able to give informed consent, in that they must have sufficient information, and understand that information, to be able to make specific decisions pertinent to transfer. If the patient does not have mental capacity, their rights and staff obligations under the Mental Capacity Act 2005 will need to be put into operation.

Hospital discharge/transfer systems present particular problems for people with dementia, including lack of access to support such as physical rehabilitation or intermediate care services (Nuffield Institute for Health 2002) and, where delayed discharge has been a problem, about half of those affected are people with dementia (National Audit Office 2007).

People with dementia commonly stay longer in hospital than people with the same medical condition who do not have a dementia. The longer people with dementia are in hospital, the worse the effects on their dementia and physical health; antipsychotic drugs are also more likely to be used. More than one third of people with dementia who go into hospital from living in their own homes are discharged into a care home setting (Alzheimer’s Society 2009). The National Dementia Strategy (DH 2009b) emphasises that people with dementia generally benefit from the full range of services including rehabilitation and intermediate care (Box 2).

Other vulnerable people include those who are homeless, living in insecure or temporary accommodation, living in prison or seeking asylum. Most homeless people have poorer health than others in the community. They may have difficulty
accessing primary care, which means they do not seek treatment until the problem is at an advanced stage. Once admitted, they can present a complex medical and social picture, requiring partnership working with the local authority, primary care trust, voluntary sector and housing organisations. Every hospital should have an admission and discharge protocol for homeless people. (See Department for Communities and Local Government/DH 2006.)

Any vulnerable person believed to be at risk of abuse should be protected from harm and investigations conducted in line with legal protection of vulnerable adult procedures under the Mental Capacity Act 2005 and national guidance (DH 2000 (under review)). (A useful factsheet is available at www.devon.gov.uk/index/socialcarehealth/adult-protection.htm)

Ready to go? The ten steps
The DH (2010) identified ten steps in the discharge/transfer process. These are explained in the following sections.

Step 1: start planning for discharge or transfer before or on admission
It is important that the planning of care transfer is embedded into everyday practice; starting with an initial assessment, ensuring that systems and

BOX 2

Transfer of care for people with dementia

The home treatment service (HTS) in Eastern and Coastal Kent was set up to provide specialist mental health intermediate care for people with a dementia. Consistent with the aims of intermediate care, the HTS works with complex transitions, particularly where a breakdown in the care situation is imminent. At its core, much of the HTS work is about carefully assessing and addressing a whole set of needs, which are often distressing, severe and multiple. The aim is to bring about the most positive outcome for clients, their families and/or paid carers with a minimum of disruption and distress. This includes reducing unnecessary moves, particularly to a mental health hospital, and minimising distress should such moves be required.

Placement of the client at the centre of decision making and intervention is paramount. The intention is to enable people to live in the least restrictive and/or most appropriate setting, preferably one of their choosing. This service differs from traditional intermediate care in that the HTS is for those whose primary problems relate to the dementia itself, not to physical health issues. The service is characterised by:

- Person-centred, time-limited interventions for up to 12 weeks.
- Flexible, multiprofessional and intensive involvement.
- Creative risk management.
- Close working with relatives and staff.

The HTS works alongside health and social care services, reviewing their input and enabling clients to receive additional services as required.

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For information about the systematic evaluation of the service (Culverwell et al 2010) contact Alisoun Milne, senior lecturer in social gerontology, Tizard centre, University of Kent. A.J.Milne@kent.ac.uk
processes are in place to support safe and timely transfer, and that all practitioners are clear about their role and contribution to this process.

Planning for transfer should start before admission or on admission (Box 3). It is crucially important to identify any factors that would make a patient’s discharge or transfer problematic so that action can be taken early to plan care. Where specialist teams are not in operation, the responsibility for the assessment and planning of discharge/transfers must rest with the ward team. Discharge/transfer is frequently delayed when the individual’s preferred accommodation is not available (Godden et al 2009). While it is reasonable for a person to exercise choice at a vulnerable time in their life, the DH guidance is clear that, as long as an interim placement meets the needs of the individual, it is acceptable for a person to move from an acute hospital to an interim placement until the permanent choice becomes available (DH 2005).

**BOX 3**

**Planning for discharge/transfer of care across sectors**

Care between hospital and a care home or other independent provider should be a seamless process that is integrated and works in partnership with statutory health and social care organisations to deliver the best outcomes for each individual client. This is achieved through the initial assessment when the person moves into the care home, which identifies the person’s preferences on hospital admission and where the most appropriate care would best be delivered when the need occurs.

Wherever possible, assessment and care planning should be a partnership arrangement between clients, their families and significant care agencies. With the person’s informed consent, assessments are shared with his or her key stakeholders, such as family members, GP and social worker. When individuals are unable to give consent, advocate support is offered.

When a hospital admission occurs this partnership working should be apparent, with the care home being seen as a catalyst to supporting an accelerated discharge. On admission, hospital staff should be made aware of the client’s wishes regarding care delivery. Wherever possible, and as soon after admission as possible, an expected discharge date should be communicated to clients, their families and the care home. Working in partnership the hospital and care home can support the necessary enhanced package of care to expedite the transfer to the care home.

To support this proactive approach to care transfer there is telephone follow up to monitor the client's outcomes following discharge.

To further support older people’s timely discharges from hospital we advocate an ‘assertive in reach team’ to identify people with complex needs associated with older age who would benefit from being assessed, treated and cared for away from the ‘high end’ activity often experienced in secondary care settings. The independent sector is a natural resource for this type of focused client-centred work. We can enhance partnership approaches to people’s care and assist in meeting many critical health and social care outcomes.

*Further information from Tracie North, director of operations & quality, Cornwall Care, Truro Tracie.North@cornwallcare.org*
Step 2: identify whether the patient has simple or complex discharge/transfer planning needs, involving the patient and carer

Once the initial assessment has been completed, the assessor will need to evaluate whether this is a complex transfer or discharge. For most patients, about 80 per cent, discharge planning is relatively straightforward, or ‘simple’. The remaining 20 per cent will have more complex needs and ward staff may need support from health and social care colleagues with specialist understanding of the local community services. Most complex transfers can be managed effectively by the core MDT. Identifying complexities early in the patient journey ensures that complications are foreseen and overcome.

Some people with chronic illness and their carers become expert in managing long-term conditions. In such cases home care arrangements can usually be set up quickly once the patient is clinically fit for transfer. Involving the people who provided the care plan before admission, such as a care manager, community matron or community mental health practitioner, can help this process (Box 4).

Occasionally someone who is approaching the end of their life may be admitted inappropriately. In such cases, where they do not wish to die in hospital, care plans should be put in place to enable them to transfer quickly so that they can die with dignity in the place of their choice (DH 2008). Many of these patients will already be on an end of life care pathway in the community, such as the Liverpool Care Pathway (Marie Curie Palliative Care Institute 2007), and will have a key worker who can advise on this.

Most patients leaving hospital will not be eligible for NHS continuing healthcare funding. However, patients who do have complex health needs are eligible to have those needs considered against this criteria (DH 2007c).

Step 3: develop a clinical management plan within 24 hours of admission

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

**BOX 4**

**Distinguishing between simple and complex needs**

Simple ongoing care needs do not require complex planning and delivery, for example if the patient:
- Does not require or want any social care services on discharge.
- Requires straightforward community nurse services on discharge – for example, dressings, suture removal, continence assessment.
- Is independent or has a carer.

Complex ongoing health and social care needs require detailed assessment, planning and delivery by a multiprofessional team and multiagency working. Indicators could be, for example:
- If an assessment tool, for example Barthel Activities of Daily Living Index (Mahoney and Barthel 1965), indicates high dependency.
- If, before hospital admission, the patient was already in receipt of community nursing or social care services.
- If the patient requires assessment for nursing equipment (for example, pressure-relieving, syringe drivers), ongoing rehabilitation at home, is terminally ill and wishes to die at home, or if the home is environmentally unsafe.

A comprehensive list of considerations is offered in Ready to go? (DH 2010). See also DH (2007).
Identification of the problem.
Goals for treatment activities to achieve outcomes.
Methods for achieving the goals.
Estimated time to meet the goal.
Diagnostic tests, therapy and other interventions.

Multidisciplinary team assessment should be co-ordinated effectively to ensure that everyone understands their role and is working to the same time frame and outcome. It can be helpful to agree local standards for response times for referral to radiology, pathology and other services such as mental health. Good interdepartmental co-operation is essential to achieve the most efficient options.

Medication should be reviewed on admission, a medicine care plan put in place and compliance training undertaken. (DH 2003 contains useful information on medicines management.)

While early and proactive planning is essential, it is important not to prejudge the eventual outcomes for the patient before full potential is achieved. Rehabilitation and recuperation should always be explored and enacted before any life changing decisions are made. Some localities have developed specialist rehabilitation teams (Box 5).

Step 4: co-ordinate the discharge/transfer process through effective leadership and handover of responsibilities at ward level
Effective co-ordination can make a significant difference to the speed and quality of the patient journey. Making the connections, enabling the procedures to involve people and prompting the resources required to care for the patient in the future must be integral to the care planning process at ward level. The productive ward programme (NHS Institute for Innovation and Improvement (NHSIII) 2007-2010a) offers useful techniques to improve discharge co-ordination.

Because individual staff members are not available every day, it is important to ensure that one person takes responsibility, is accountable for leading the care planning process each day and has all the information available to them. Ward handovers can be used to report back and identify the person to whom the lead will be handed over. It is important to keep documentation up to date and in one place so that everyone can contribute to the plan. Patient boards can improve communication between practitioners. For complex transfers of care the patient will have a number of problems that require systematic co-ordination across the wider multidisciplinary team.

Step 5: set an expected date of discharge/transfer within 24-48 hours of admission and discuss with the patient and carer
Most patients want to know how long they are likely to stay in hospital. They want information about their treatment and when they are likely to be discharged. This helps them to achieve their goals and plan for their own transfer. The exceptions to this are intensive care and high dependency units where setting an expected discharge date (EDD) should be delayed until the patient is transferred to the ward.

Predicting length of stay can be undertaken in two ways. It can be based on actual performance in the ward or unit, or on benchmarking information. It is essential that
the ward or unit understands and uses the system to give a valid and sustainable approach. The DH discharge guidance (2003) states that: ‘Estimating date of discharge is based on the expected time required for tests and interventions to be completed, the integrated care pathway and the time it is likely to take for the patient to be clinically stable and fit for discharge.’

For simple discharges an EDD should be set within 24 hours and communicated to the patient and all staff in contact with the patient.

Any tests that are not urgent could be undertaken as an outpatient. Ideally this EDD should be displayed in a prominent position. The EDD should be proactively managed against the treatment plan on a daily basis and any changes communicated to the patient (Box 6).

For complex cases it is more difficult to anticipate length of stay and detailed multidisciplinary assessment and planning will be required but, in most cases, an EDD can be set within 48 hours. Frail older people with multiple pathology should always have access to

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**BOX 5**

**Clinical management and rehabilitation**

The NHS Camden provider services stroke Reds (Reach early discharge scheme) team works in the Camden Reach community rehabilitation team to offer an early stroke discharge pathway. The main aim of the jointly commissioned service (NHS Camden and the Borough of Camden) is to ensure that stroke survivors who are appropriate for early discharge are able to go home early with support and intensive rehabilitation and therapy from the team to the level that patients would receive on a stroke unit.

This in-reach model incorporates participation in weekly ward rounds and team members are contactable via telephone, email or the Camden Reach single point of access. In a few hours they can complete an access visit, organise equipment, set up a package of care and, once the patient is home, provide rehabilitation and care for six weeks. In addition to the interdisciplinary rehabilitation input, a pool of ten enabling carers can provide up to three calls a day and night/day sitting service if needed.

A six-week package of care and intensive therapy can considerably reduce long-term dependency as early evaluation shows that only 27 per cent of clients require ongoing social services, with an average package of care comprising just over two hours per week in total.

Stroke Reds also complete full multidisciplinary six-month reviews aiming to capture quality of life changes, identify any change that would trigger a referral for further rehabilitation or advise on stroke clubs, community services or communication groups.

On average our team reduces inpatient stays by about nine bed days across acute and inpatient stroke units, with the average discharge occurring at day 12. Early evaluation shows that it is potentially more cost effective for patients to go home with us than to stay on stroke units. A key to our success is that all our therapists have years of experience working in stroke rehabilitation, we have a track record of providing seamless transfer of care and belong to a well resourced and fully functioning community rehabilitation team.

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multidisciplinary expertise. Some may need 24-48 hours to settle into their new environment before a true picture can be assessed and a realistic EDD set. This may also be the case for a patient who transfers to other departments or units for rehabilitation.

Step 6: each day review the clinical management plan with the patient, take the necessary actions and update progress towards the discharge/transfer date

It is important to identify likely problems in a patient’s care pathway and to take proactive action to prevent these arising. If the clinical management plan is reviewed each day with the patient, necessary actions can be taken to progress towards the discharge or transfer date.

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

Integrated care pathways exist for the most common conditions and these should be used where available to enable practitioners to anticipate and plan. Patients and carers should be involved so that they can make informed decisions that deliver a personalised care pathway and maximise their independence (Box 1).

**BOX 6**

**Setting an expected date of discharge**

Trusts on the orthopaedic rapid improvement programme (NHSIII 2007-2010b) have made significant improvements in their fractured neck of femur (#NOF) pathways, for example:

- Criteria for the expected discharge date (EDD) were devised in one trust by a physiotherapy team and, in another, by a ward sister based on her orthopaedics experience.
- EDDs are written on the front of the #NOF pathway and are given to patients on admission assessment. If delays occur, the EDD can be altered. Phased introduction of the EDD allows time for training. The percentage of people with an EDD, and whether they are discharged before or after this, are recorded and reviewed in weekly meetings.
- A letter has been designed to give patients and carers clearer understanding of what to expect during their stay and the discharge options. They are now better informed and this also helps to prevent delayed discharges that arise when people are confused about the services they should be receiving.
- A fast-track system has been devised to take patients through the emergency department to the trauma ward and, due to the newly organised daily trauma list, there is an increased chance of surgery within 24 hours.
- One team has increased the rate of patients seen before surgery by a geriatrician from 30 per cent to 80 per cent, and increased the patients being mobilised 12-18 hours after surgery from 73 per cent to 100 per cent. Early mobilisation greatly improves recovery rate and also helps achieve the EDD.

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Document the risk management plan in accordance with the local risk management policy. Once the full assessment of needs and risks has been identified, the potential discharge care options can be considered. Explore all options in care pathways, for example people with dementia should, where appropriate, be offered the full range of services including rehabilitation and intermediate care (DH 2009b).

Step 8: plan discharges and transfers to take place over seven days that deliver continuity of care for the patient
Length of stay varies according to the day of the week that patients are admitted (Godden et al 2009). Planning discharges/transfers should take place over seven days and service adjustments, such as those described in boxes 1 and 6, can help to reduce length of stay.

Step 9: use a discharge check list 24-48 hours before transfer
Discharge checklists can help to enhance effective liaison between the patient and his or her carer and family, members of the core MDT, multiagency services and community providers. They communicate what actions have been taken and what remains to be done. They can also be used throughout the patient's stay.

The transfer plan should be checked 24-48 hours before transfer of care. Written information should be prepared in advance and treatment, medication, dressings and equipment should be prepared ready for transfer with the patient. Following transfer, the documentation should be filed in the patient notes as a record of the discharge planning process. Sending a copy with the patient should also be considered. (A checklist is provided in the Ready to go? resource pack (DH 2010).)

Step 10: make decisions to discharge/transfer patients each day
Decisions to discharge and transfer patients should be reviewed each day. The DH (2004) advises that:
‘While overall legal responsibility for a patient’s care remains with their senior medical practitioner... the consultant can delegate responsibility to an appropriately qualified health professional. When a task is delegated the consultant/lead clinician assumes responsibility for delegating appropriately. The person to whom the responsibility is delegated takes on a commitment and responsibility for carrying out the task in a responsible, accountable, reasonable and logical manner in keeping with their own professional code of conduct.’

Nurses can take responsibility for initiating transfers, especially when the transfers are uncomplicated. (A matrix of competencies is included on the memory stick in the resource pack.)

A key concept is ‘clinical stability’, that being the degree of medical acuteness of the patient’s condition as reflected by specific needs for ‘hospital-type’ assessment and treatment. This generally relates to having abnormal physiological vital signs and needing something done about it quickly. In attempting to describe which patients need to be in hospital and which do not, a variety of tools have been used including the appropriateness (of being in hospital) evaluation protocol (Tsang and Severs 1995). Typically, a patient regarded as ‘appropriate’ will have needs for a daily medical assessment and treatment decisions, for example variable doses of medication. The patient may also have intensive needs for nursing or therapy care, and whether these require the patient to be in hospital depends on the facilities of the potential alternative venues of treatment. The concept of ‘stability’ focuses on what the needs of the patient are likely to be tomorrow, the next day or next week. (Guidance on the definitions of ‘clinical readiness’ and ‘safe to transfer’ are included in the resource pack.)

To prevent delayed discharges, the NHS has a statutory responsibility under the Community Care (Delayed Discharges) Act 2003 to alert social services if the patient is likely to need community care services on leaving hospital. Patients must be made aware of this and give their permission for a referral to be made.

**Improving your practice**

The key to making small and continuous improvement in practice is having the courage and opportunity to question the way things are done. Once issues are identified, people need to feel that it is safe to critique constructively existing practice. The goal should not be to solve all the problems in one go, but to try to find consensus on a particular issue and act on it. No matter how small each change is, this can start to gain momentum and the trust of everyone concerned. Training needs should be identified. (Lees and Emmerson (2006) offer a training needs analysis tool.)

Communication is key and it is always important to check that what is communicated is the same as what has been understood. Monitoring the effectiveness of team communication can improve the patient’s experience and develop better working relationships. Many areas are now developing specialist teams (Box 7).

**Further information**


The DH Prevention Package for Older People Resources (2009d) is a suite of downloadable resources available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146)
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