The Care Home Handbook

Edited by
Graham Mulley, Clive Bowman,
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WILEY Blackwell

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Forewords

I was asked to write the foreword for *The Care Home Handbook* when I was Chief Executive Officer of Australia's Aged Care Standards and Accreditation Agency Ltd. This was the organisation in Australia charged with responsibility for promoting quality in residential aged care through the Australian government's accreditation scheme and industry education. In my role I had the opportunity to observe residential and nursing care and the methods of evaluation of those services in Australia and other countries.

My contact was Dr Clive Bowman, who was then the international medical director with Bupa. Clive, whom I have known for many years and whose passion for aged care is well known, assured me the Handbook would be comprehensive and user friendly.

He was correct. This Handbook is an easy to read guide that in becoming easy to read has not sacrificed the key messages. It can be taken as the 'how to' guide to residential and nursing aged care from beginning to end. It is comprehensive and focuses on applied practice. The inclusion of referenced material enables further exploration by the reader who wishes to pursue a particular interest. To my knowledge, no other such comprehensive book is available.

Ageing is a global phenomenon. In the next generation, more than 25% of people around the globe will be over 65 years of age and with that will be an increased demand for services for elderly people.

While the rates of ageing vary from country to country, the demand will be significant enough to render any debate about the actual numbers as moot.

As the world's population ages there will be increasing demand for services for older people. The increasing percentage of the population aged over 85 years and the migration of children away from their parents as they seek jobs and a better life will create an increased demand for residential care where older people live with other older people in institutions variously known as care homes, nursing homes and hostels.

Residents of these institutions will have increasing complex care needs which cannot be provided in their home. Arguably, some nursing homes will take on the characteristics of a sub acute hospital for a cohort of residents with high care needs and the nursing home (their home) is their preferred place to die.

It is these institutions that provide one of the ways for the younger generations to pay their debt to their forefathers and mothers by ensuring they have the best life possible and that rather than consider the nursing home as 'God's waiting room', it is a place where older citizens can live life to the fullest and in a way they choose.

The general public knows very little about aged care. Staff rarely know much before they commence their first role in aged care. The ratio of tertiary qualified staff to personal care workers in care homes is quite low compared to a hospital. Equally, opportunities for professional interaction and professional development are a challenge for care home staff.

The aged care workforce is predominately personal care workers whose level of training is quite variable. These are the staff with the most frequent interaction with residents and who support residents with the activities of daily living – eating, dressing, going to the toilet, etc.

There are few courses in nursing or management that adequately prepare nurses and managers to contend with the diversity of activity that is required in a nursing home on a daily basis. This will range from the entry paperwork through to complaints by relatives, high level clinical services and end of life care.

The team approach has always been the basis of nursing. However, 'nursing' homes are about much more than clinical services.

The Care Home Handbook is not a nursing text. It is a book that reflects the multi-disciplinary team based approach that is necessary to achieve positive outcomes for residents from a whole of life perspective. It reports contemporary best practice in what is a very diverse endeavour.

So what can the reader learn from this Handbook? It goes a long way in filling the gap between formal training and the realities of the workplace. At the very least, it brings any formal training into the care home context.

The breadth of the book reflects the best practice approach to the management of care homes. Residents are seen as people, individuals who have not lost their

human rights on entry to their new home; who must be provided with the support to age with dignity and in the way of their choosing; and where quality of life is measured from the residents' perspective – not an externally imposed measure where management purport to know what is best for the resident.

Quality of care and services is seen as an input directed to ensuring the resident is able to enjoy the best possible quality of life, not as an end in itself.

The early chapters reflect the very important aspects of working in a care home with residents each of whom is unique. Sections on values, standards, ethics and probity reflect the underlying considerations when a resident considers their life in the home.

The latter sections contextualize the many clinical activities which are daily activities in a care home.

Good clinical care is of limited utility unless provided in a caring environment where the human rights and dignity are at the forefront of the providers' and their staff's minds.

While the content is directed towards those people working in care homes, much is relevant to people providing services to older people in the older person's own home.

It is written with UK care homes as the reference point. Many of the references are to UK legislation. A focal point is necessary to give some of the advice a context. However, based on my experiences of looking at elderly care systems in many countries, I am convinced that this focus does not detract from the book and that the advice can be readily adopted.

It also provides guidance in the established aged care systems and a benchmark for those countries where residential care is not well established.

I congratulate the editors on being able to harness the energies of such a group of expert contributors and in doing so, create a text that will be more than a significant contribution to the quality of life for older citizens.

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People's expectations of care homes are changing. Current generations of older adults have become accustomed to more independence. Many of them and their families also want more choice about the kinds of services they receive and how these are delivered. People want a more personalised approach to their care.

There is evidence emerging that many older adults who come into residential or nursing care do so at later stages in life when their needs are greater and they have become frailer. Consequently many people have multiple and complex needs that present a different set of challenges for individualised care.

There is much more scrutiny of care and greater opportunities for family and staff to report poor, unsafe and inappropriate care. This, of course, is a good thing and reinforces the desire to improve care assessment and delivery in care homes.

The Care Home Handbook provides an up to date approach to personalisation in care. It helpfully starts with the journey that a prospective resident makes into a care home and covers the emotional challenges of such an experience. Unusually for this kind of handbook, it also addresses the question of discharge which is not ordinarily covered but may well be the outcome from a care home stay.

The sections covered in the handbook are comprehensive and nothing about care home life is left untouched. Additionally, there is an external focus on engagement with working with other professionals in the health and care systems.

Each section is helpful, brief and accessible and reports the topics through the personalisation lens. This book should be used in the way the authors intended. It is not a handbook that must be read from cover to cover but rather to be used as a navigational aid when needed and relevant to the issues.

The contributing authors reflect a wide array of talents and experience linked to the care of elderly and frail people. They have, by providing brief oversight of the salient themes, assured the most up to date approaches to meeting the needs of care home residents. The opportunity to have one's practices shaped, helped and reinforced by the contributing authors is a privilege for all and one that will benefit care home residents and their families.

Alan Rosenbach
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Preface

The purpose of this handbook is to improve the care, well-being and safety of people who are resident in care homes.

Care homes provide a vital role in the support of the health and care for older people internationally. The role of the care home continues to evolve greatly from a 'housing' solution to a place where often very frail people with complex health needs live permanently or for short periods.

The practice of care in care homes largely relies on established manuals and practices from hospital and community care. Typically, these are polarised either to a very clinically-driven hospital model or one dominated by social care values. We have not been able to identify a practical, succinct handbook specifically tailored for care homes. For example, standard texts often do not address several of the Geriatric 'Giants' – such as dementia, delirium, falls, stroke or impaired mobility. Many other important elderly care topics (such as fits, visual impairment, restraint, dignity and privacy) are not given the attention that they merit.

There are other considerations: regulators, accreditation organisations and others seek demonstrations of competency and safe practice. While there are some proprietary policies and procedures, they are densely worded and voluminous and not practicable for front line clinical staff. As a result, many homes are littered with a variety of cards and notices on how best to do things.

So, in this handbook, we have attempted to distil good practice into concise chapters that champion resident-centred nursing care. The handbook is not a conventional text book, nor a substitute for formal education and training, but it is a support to good safe practice. Similarly, the chapters are not exhaustive (nor exhausting) but the contributory authors have risen to the challenge of providing short accounts that blend evidence with experience so that a reader should able to remind themselves about good practice.

In reading chapters in the editing process, we all gained new insights and believe that while most of what is presented should be familiar, there will be some new 'nuggets' of information to be gained.

The handbook's approach emphasises the importance of a holistic approach, embracing social, ethical, legal, psychological as well as clinical aspects of care. It is principally aimed at staff nurses, more senior nurses and care home managers. Nursing aides and senior carers may also profit from reading it.

We have tried to ensure that the handbook is free from jargon and hope that it will remind, inform, prompt and refresh, as well as offer guidance on when to ask for help and describe what information might be needed by professional colleagues. As editors, we believe that reducing variations in practice and emphasising the best in contemporary geriatric nursing will facilitate better communications between all health professionals involved in care homes and reduce failures.

The contributors are acknowledged experts (both academics and clinical staff, with input from many care home nurses) as well as rising stars in elderly medicine from the UK, mainland Europe, the USA, Canada, Australia and New Zealand. Nurses are co-authors, co-editors or advisors for almost every topic.

Compiling this first edition started with a modest list of topics that grew. We have aimed to produce a comprehensive guide, but as editors we anticipate there may be some omissions. We very much hope that readers will provide feedback and suggestions. Please email your comments to nursingeducation@wiley.com

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List of Abbreviations

6 Ps	Pain, Paraesthesia, Pallor, Pulselessness, Paralysis, Perishing Cold
ABC	Airway, Breathing, Circulation
ABCDE	Airway, Breathing, Circulation, Disability, Exposure
ACP	Advance Care Plan
AF	Atrial Fibrillation
AIDS	Acquired Immunodeficiency Syndrome
BMI	Body Mass Index
BPM	Beats Per Minute
BTE	Behind The Ear Hearing Aids
CAM	Confusion Assessment Method
CCF	Congestive Cardiac Failure, also known as Congestive Heart Failure
CD	Controlled Drug
CDI	*Clostridium difficile* (*C. difficile*) Infection
CHF	Chronic Heart Failure
CHLS	Care Homes Liaison Service
CJD	Creutzfeldt Jacob Disease
CLI	Critical Limb Ischaemia
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control of Substances Hazardous to Health
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CRI	Cardiac Resynchronisation Therapy
DKA	Diabetic Ketoacidosis
DNAR	Do Not Attempt Resuscitation
DVT	Deep Vein Thrombosis
ECG	Electrocardiogram
FRAT	Falls Risk Assessment Tool
GCS	Glasgow Coma Scale
GDS	Geriatric Depression Scale
GSF	Gold Standards Framework
HETF	Home Enteral Tube Feeding
HIV	Human Immunodeficiency Virus
ICD	Internal Cardiac Defibrillators
IM	Intra-muscular
IMCA	Independent Mental Capacity Advocate
ITE	In The Ear Hearing Aids
IV	Intra-venous
LCP	Liverpool Care Pathway
MAR	Medicines Administration Record
MDI	Metered Dose Inhaler
MEWS	Modified Early Warning Score
MRSA	Meticillin-Resistant *Staphylococcus aureus*
NG	Nasogastric
NICE	National Institute for Health and Clinical Excellence
NMC	National Midwifery Council
NPSA	National Patient Safety Agency
NSAID	Non-Steroidal Anti-Inflammatory Agents
OT	Occupational Therapists
PD	Parkinson's Disease
PDNS	Parkinson's Disease Specialist Nurses
PEG	Percutaneous Endoscopic Gastrostomy tubes
PFT	Pulmonary Function Tests
PPE	Personal Protective Equipment
SC	Sub-cutaneous
SLT	Speech and Language Therapist
SMART	Specific, Measureable, Agreed, Realistic, Time limited
SSRI	Selective Serotonin Reuptake Inhibitors
STI	Sexually Transmitted Infections
TB	Tuberculosis, or *tubercle bacillus*
UI	Urinary Incontinence
UTI	Urinary Tract Infection
WHO	World Health Organization

Section A

The Resident's Journey

Chapter 1

Admissions and Discharges

1.1 Admissions and discharges: principles, processes and planning

Peter Rogers

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Key points

- Moving into a care home can be a distressing time for both residents and their families.
- Particular sensitivity and emotional awareness are most important at this time of transition.
- One way of delivering consistent care that meets medical as well social and emotional needs is the Nursing Process.
- This is a systematic problem-solving approach to planning and delivering care.
- It involves assessment (both subjective and objective); diagnosis; identifying outcomes; planning; implementation; and evaluation.
- The Nursing Process necessitates accurate, up-to-date documentation.

People move into a care home for different reasons and periods of time, and with varying degrees of preparation. For some, it is a short-lived experience for convalescence, respite or palliative care. For many others, it is a long-term solution to their need for social and nursing care, which has been arrived at either after careful consideration of the options available, or suddenly, following a precipitous decline in independence.

The circumstance surrounding the admission will inevitably influence how the resident, their family and friends respond. For many, particularly those contemplating permanent residency, the journey into a care home can be an emotionally difficult one both for them and those close to them.

New long-term residents have much to feel sad and anxious about; leaving a familiar environment to join a new social group, giving up many of their possessions and coming to terms with the loss of independence the admission represents, all contribute to make the move into a care home a difficult transition for many people, whatever their age.

Relatives too often have mixed emotions. While the decision might be greeted with a sense of relief that the care needs of a loved one will be recognised and met by competent staff in a safe and comfortable environment, at the same time the move can give rise to feelings of failure, guilt and intense sadness.

Whatever the particular circumstance surrounding an admission, it is crucial that the care home staff have the emotional insight and understanding necessary to sensitively and appropriately support the new resident's transition into life in the home.

The Nursing Process

The Nursing Process is one approach to the management of effective individualised care. It involves:

- the assessment of each resident's needs,
- the planning of care interventions,
- the delivery of care interventions,
- the evaluation of the resident's response and hence the effectiveness of the care provided.

In its original form, this 'systematic problem solving approach' comprised four phases of activity: assessment, planning, implementation and evaluation. In more recent times, the desire to emphasise the importance of setting out a concise statement of a person's actual or potential problems (nursing diagnosis), and the need to clearly express the intended outcomes of care – activities which were once subsumed within assessment and planning – have resulted in the now widely recognised six-step nursing process (Figure 1.1.1); a process that serves as a

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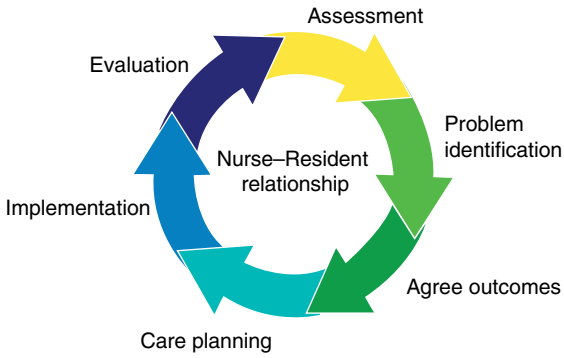

Figure 1.1.1 The six-step nursing process.

better reminder to those who use it that it is the resident or patient who is the focus of attention.

Although presented as a series of steps, the nursing process should be regarded as continuous cycle of discussion, negotiation, decision-making and review that takes place between the nurse and the resident (and at times others), in order to match care to the resident's needs and preferences.

The focus here is on the importance of assessment, the collection and interpretation of resident data as the foundation for person-centred care. However, it is important to recognise that assessment data also serve other, not necessarily complementary purposes. For example, data might be used to:

- Determine the cost of a care package and an individual's entitlement to government funded subsidies and/or financial support.
- Enable commissioners/assessors to place residents in the facilities they regard as appropriate for that person's needs.
- Provide anonymised data for public health, government and corporate planners and also academic research.

Further reading

Frauman AC, Skelly AH. 1999. Evolution of the nursing process. *Clinical Excellence for Nurse Practitioners* 3: 238–44.

Funnell R, Koutoukidis G, Lawrence K. 2009. *Tabbner's Nursing Care*, 5th edn. Elsevier, Australia, p. 72.

1.2 Assessment on admission to the care home

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Key points

- A comprehensive assessment on entry to the home will help to identify individual care needs.
- It is important to allow time for residents and their caregivers to familiarise themselves with the care home.
- A holistic assessment will include physical, psychological and social needs.
- A focused assessment can be optimised by the use of validated rating scales.
- Tips are given on the assessment of residents who are admitted for short-term care.

Whatever the particular circumstances surrounding the admission, the individual care needs of all new residents must be recognised and addressed by the nursing staff. This can only be achieved by undertaking an assessment that is sufficiently broad and appropriately detailed.

Allow time for adjustment

Whether it started before or immediately after admission, the process of familiarisation is a crucial part of the new resident's adjustment to their surroundings. This is especially true on the day of admission, when it is important not to rush into a detailed and intimate assessment of abilities and needs.

Allowing the new resident and their relatives a little time to become orientated to the new surroundings will have a positive effect on their all-important first impressions of the home and the staff. The greeting on introduction of a resident to their new home sets the tone for what is a crucial relationship; remember to smile and be friendly!

Wherever possible, new residents and their relatives should be:

- Greeted by the staff that they have already met or talked to.
- Shown around the home and introduced to a few of the staff and other residents.
- Given time to settle into their room and organise the belongings they have brought with them, and spend a little time alone with their relatives.
- Offered the chance to talk to the home manager, their named nurse or key worker about life in the home and ask to any questions they might have.
- Encouraged to take as much time as they need to reassure themselves that their loved one is settled before they leave.
- Fully informed of the visiting and telephone contact arrangements for the home.

The initial holistic assessment

The need to ensure a sufficiently broad appreciation of the new resident's needs is addressed by ensuring that the initial assessment is 'holistic' in nature, that is to say it considers the resident's physical (or biological), psychological and social needs and abilities.

The idea of a holistic approach to nursing care became established as an alternative to what is regarded by many in the profession as the paternalistic and disempowering 'medical model', which defines those who use healthcare services in terms of their problems, diagnoses and treatment needs.

The holistic approach represented below (Figure 1.2.1) recognises that a person's needs arise out of the interaction between their individual physical, psychological and social circumstances, and that by seeking to understand those interactions through the assessment process, we have a better chance of providing care that is appropriate, effective and acceptable to the recipient.

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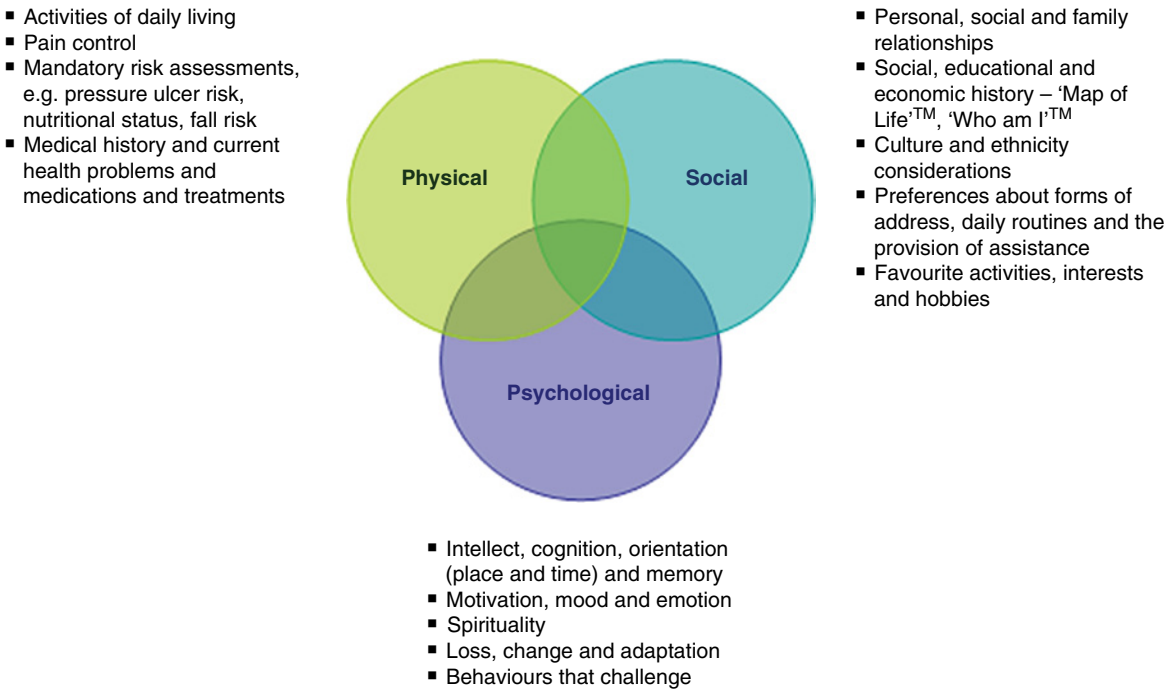

Figure 1.2.1 Aspects of holistic assessment.

There are a number of generic assessment tools, each reflecting the emphasis of the particular nursing model or theory upon which they are based. However, whatever the nuances of the underpinning theory, adopting a holistic approach is essentially about recognising that *each individual amounts to more than just the sum of their physical parts*.

Focused assessments

Focused assessment tools are designed to provide a detailed understanding of a resident's abilities and needs in relation to a specific risk or problem. The use of these tools is largely triggered by the results of the initial holistic assessment. However, such is the impact of some healthcare deficits on older people generally that several of these specific tools now form a routine part of the initial holistic assessment.

It is now common practice to routinely screen all new residents using pressure ulcer, falls and nutritional risk assessment tools, and also to repeat these assessments periodically.

Examples of some specific assessment tools nurses might use to produce a personal care plan that fully and accurately reflects the residents needs include:

Cognitive Assessment	• Mini Mental State Examination (MMSE) • Abbreviated Mental Score (AMT) & AMT 4
Conscious Level	• Glasgow Coma Scale
Nutritional Status	• MUST, Malnutrition Universal Screening Tool • MNA, Mini Nutritional Assessment • NHS Oral Health Assessment tool
Mobility	• Falls Risk Assessment Tool (FRAT) • Dewing Tool for Wandering Assessment
Pain	• Abbey Pain Scale • Visual Analogue Scales
Pressure Ulcer Risk	• Waterlow Score • Braden Risk Assessment Scale • Norton Scale

Note: This is not an exhaustive list.
For details of these and other scales, see Appendix 1: Rating Scales.

Problem identification

The result of the assessment phase should be a set of clear statements setting out the actual and potential problems facing the resident at that point in time that have, wherever possible, been discussed and agreed with the resident. For example:

> Anxiety due to admission into unfamiliar surrounding indicated by verbal comments and increased heart rate.

This example illustrates the problem the resident is experiencing (anxiety), the likely cause (unfamiliar surroundings) and how it is manifested (verbal comments and increased heart rate).

When they are expressed in this way, problem statements provide the basis for a modified SMART approach to the later steps in the nursing process. They prompt the expression of anticipated outcomes (a reduction in anxiety), provide an indication as to what the planned care should address (familiarisation with the new environment, other residents and staff) and suggest criteria that can be used to evaluate the success or not of the planned interventions (changes in the resident's expressed feelings and heart rate).

This example also highlights the value of involving the resident. Nursing and care staff might make the reasonable assumption that most new residents will experience some degree of anxiety, however it is just as important to recognise the underlying cause. A resident might be more concerned about how their care will be financed or the fate of a pet than their new surroundings. In each case, the interventions detailed in the care plan will be very different.

Short-stay admissions

In addition to those taking up permanent residence in a care home, others are admitted for what is intended to be a brief interlude. Residents admitted for convalescence, intermediate or respite care may stay for a few days or several weeks, and come with needs that vary from rest, rehabilitation and a good diet to 24-hour nursing care.

While the principles of assessment remain the same for these residents, the priority assigned to different aspects of the assessment and the emergent needs may be different.

For someone admitted for one or two weeks of respite care, it may be more important to focus on ensuring that their physical needs are identified and met than devoting the time required to gain a detailed insight into their social history in the way one would with a new permanent resident. Of course, if the period of respite is the first of what might be many, then the social history and family relationships assume a greater significance and will demand more attention.

It is up to the nurse conducting the assessment to exercise discretion over what is prioritised, and to work with the resident and family to ensure the care is both appropriate to the resident's needs and aligned with their expectations of the stay and the respite or convalescence care provided.

Top Tips: Short-stay check list for care home staff

Very often the same documentation is used whatever the resident's anticipated length of stay; however some issues assume more significance in short-stay situations and are worth emphasising. These include:

- Emergency contact information for the resident's family or friends.
- Contact details of the resident's GP.
- Medication, including nutritional supplements – what is prescribed and how will it be provided?
- What medical consumables will be required, for example incontinence pads, wound dressings, stoma bags and so on, and how will these be provided?
- Resident specific information: allergies, preferences about diet, meal times, sleep patterns, washing/bathing/showers and so on.
- Have any necessary items of equipment been provided, for example specially adapted cutlery, walking frames?
- Does the resident have sufficient clothes and toiletries for the stay?
- Departure date and time, transport arrangements.

Further reading

RCN, London, 2004. *Nursing Assessment and Older People. A Royal College of Nursing toolkit*. www.rcn.org.uk/_data/assets/pdf_file/0010/78616/002310.pdf [Accessed October 2013]

1.3 Assessment of residents before admission to the care home

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Key points

- Each potential resident should have a detailed, sensitive, compassionate pre-admission assessment.
- Pre-admission assessments should ideally be done in private, and the potential resident should be asked whether or not they want someone else to be involved in the discussion.
- This assessment includes confirming biographical data, ascertaining why admission is being sought, determining the individual's specific likes and dislikes, their cultural preferences and other needs, as well as obtaining details of possible infections and their investigations.
- A list of practical tips is given to facilitate this assessment.

Location

The pre-admission assessment usually takes place wherever the potential resident is at the time of referral. Ideally, this will be somewhere that is familiar to the future resident. This helps to make the process less stressful, and also means relatives or friends can be present to contribute to the assessment.

Unfortunately this is not always possible. The assessment may take place in hospital, with the pressure to agree a discharge date and free a bed competing with the need to get a clear understand of the future resident's potentially complex and still emerging needs.

Confidentiality

While many of those contemplating a move into a care home will appreciate the contribution that their family and friends can make to their assessment, others will not. Rather than make assumptions about the older person's wishes, the nurse conducting the assessment should start the process in private and ask the resident who they want to be involved. (See Chapter 4.6.)

The purpose

Wherever it is conducted, and whatever the competing issues, the pre-admission assessment is an important stage in any planned admission to a care home, primarily because it is about deciding whether or not a particular home is the right place to meet the resident's particular needs. For all of these reasons, it is a job that requires a confident and experienced nurse who is able to focus on the future resident's actual and potential needs and how these will need to be met.

In the pre-admission assessment, you should concentrate on:

- Confirming essential biographical information.
- Understanding the key reason for admission being sought to a care home.
- Gathering information about the individual's significant needs (whether clearly identified or only suspected), including specific requirements, such as equipment.
- Gaining insight into the individual's sociocultural expectations and preferences.

  Where the pre-admission assessment takes place in hospital, pay particular attention to:
  - The level of observation the patient is subject to, and whether this reflects their actual care

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needs or is the way in which the risks associated with the hospital environment are being managed.
- The nature of confirmed or suspected infections, and whether there are any outstanding results from specimens taken for culture and sensitivity.

The need for compassion

Although coming to the right conclusion about where a person's needs might best be met is the whole point of the pre-admission assessment, it is also important that the nurse conducting the assessment manages it sensitively. The encounter may be the first time that the prospective resident, rather than their family, has met any of the staff who might become responsible for their care.

Some pre-admission assessments will culminate in the decision that the individual would be better cared for elsewhere. Most, however, will lead to an admission. It is therefore important for the nurse conducting the assessment to appreciate that this early contact is frequently where the process of building a professional relationship based on honesty and openness with a resident and their relatives starts.

A pre-admission assessment is a useful precursor for both care home staff and future residents; however it is not always possible.

For some older people, the admission to a care home is an urgent response to a sudden change in personal circumstances or care needs. For these residents, the process of relationship-building starts when they arrive in the care home. It is at best a stressful time, but one made all the more so by the precipitating factors, whatever they are, and the speed with which the change in the resident's world is effected; something the staff managing the admission have to keep in mind.

Top Tips: Pre-admission assessment in hospital

Organising a pre-admission assessment in hospital can be difficult. Some things to consider are:

- Contact the Charge Nurse, Sister or Ward Manager to arrange an appropriate time to visit. If this person is not available, try to speak to the patient's named nurse. If unsuccessful, find out when they will be available, leave a message and call back.
- When arranging your visit, check that there are no imminent plans to move the patient to another ward, and whether any off-ward investigations are booked.
- Make a note of the name of the nurse who will be in charge on the day of your visit.
- Agree that you will call to check your visit is still OK to go ahead before setting off to the hospital. It is useful to make a note of the ward's direct line telephone number.
- If appropriate, inform the patient's relatives of the arrangements in advance.
- Finally if you are not familiar with the hospital, check out the parking provision and the location of the ward before you set off.

Further reading

Centre for Policy on Ageing. 1996. Entering care. Chapter 3 in: *A Better Home Life*. www.cpa.org.uk [Accessed October 2013]