Patient arrives on the ward

Thorough assessment of patient.

Minimum dataset including verifying collateral status

- Within 24 hrs of arrival on 1st ward.
- Patients nurse to complete the Safety Booklet.
- Store in the Nursing Notes folder at the end of each patient bed along with the Purple Discharge Planner.
- Give the patient NHSE discharge information leaflets and letters about D2A, no choice

1st Board Round review makes an MDT decision; Capturing discharge pathway/EDD

- Board Round on admission day or within 24 hours dependent on time of arrival on ward
- Use safety Booklet to guide pathway decision
- MDT decision EDD identified at same time to enable discharge planning immediately
- Board Round lead to capture on whiteboard
- Patients nurse to capture pathway & EDD on Purple Discharge Planner/Medway

Proactive discharge planning.

- To commence within 24 – 48 hours of arriving on 1st inpatient ward use Purple Discharge Planner.
- Nursing & AHP teams to document plans and update with progress in discharge planner.
- Planner to be kept in the Discharge Folder.

Daily Board Round review of Discharge Pathwav

- Board Round to do MDT review of pathway progress & EDD
- Board Round lead to capture on Medway whiteboard
- Patients nurse to capture any amendment in Purple Discharge Planner

BSUH Discharge Pathways Referrals Management Process
November 2020
bsuh.dischargegovernancecontrolcentre@nhs.net

Pathway 0

- Patient returns to usual place of residence (including Care Home)
- Fully independent – not further support required
- Restart POC with no changes
- May require settle at home service Red Cross
- Has pre-existing community services in place
- Possibility people.

Pathway 1

- Patient returns to usual place of residency with interim support.
- New POC or increase of existing package.
- Temporary reablement to maximise independence.
- Assessment and some additional care and support (including therapy, nursing domicilary care new equipment.
- Safe between calls/overnight.

Pathway 2

- Patient is transferred to a non-acute bed and receives rehab and assessment until able to return safely home.
- Short term bedded rehab with or without reablement and assessment.
- Unsafe to be at home overnight/between care calls.
- Includes specialist rehab.

Pathway 3

- Patient is transferred to a new long term bed, assessment bed or usual residence and receives the complex support and/or assessment for their needs.
- Complex/significan health and/or social needs in usual residency or significant change requiring new placement.
- Longer term placement
- Life changing health care needs
- Complex end of life or mental health needs.
- Complex housing and homeless needs
- Live in care or more than QDS POC with multi professional input.

- Ongoing MDT care and progression with discharge planning concurrently

- Encourage own transport where applicable
- Book transport as per current guidelines
- Red cross

Patient discharged