Think Discharge Planning

Implementing Discharge Planning Algorithms Across CKCH and SSWHG

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Rationale

- To ensure patients are discharged to the appropriate setting i.e. community or residential settings, in a timely, efficient manner, with a comprehensive care plan that meets their assessed needs
- Egress groups SSWHG/CKCH identified a trend in a lack of cohesiveness in the discharge process throughout the area

Aims of Workshop

- To set out clearly all individual components of the discharge process
- To map all the pathways that aid discharges including their individual components
- To identify what currently works well, what doesn’t, gaps etc.?

Discharge Workshop May 19th 2017

- Key stakeholders in the discharge planning process from acute hospitals in the SSWHG, CKCH and Community Healthcare Organisation 5 participated in the workshop
- There were also presentations on the discharge process from the SDU and the Community Bed Bureau
- At this interactive workshop the stakeholders developed the discharge algorithms

The Workshop

- Discharges from 3 core areas were identified and mapped:
  - Emergency Department
  - Wards – non-complex
  - Complex discharges (cognitive impairment, ward of court, social issues such as homelessness, complex disability placements, carer issues, housing issues and capacity issues

Each Group

- Process mapped the patient's journey from admission to discharge
- Identified areas of good practice
- Advised how information is provided to bed management and discharge coordinators
- Reviewed the patient flow, and internal/external communication with key stakeholders to ensure a smooth transition

Issues identified at the Workshop

- Need to develop a suite of common referral forms as there are numerous referral forms in use; need to simplify the referral process to community services to avoid duplication
- Need to commence early MDT meetings and discharge planning especially for patients with complex legal, medical and social issues.
- Requirement for a 3 day prescription for community hospital discharges to facilitate weekend and bank holiday discharges

Key Messages

- Discharge planning should commence on admission
- Implement SAFER Bundles
- Complex issues should be escalated once identified to CNM on the ward
- Any potential delays should be escalated further as required without delay
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Next Steps

- Follow-up workshop to launch algorithms
- Work continues on a common referral form to community services
- Pilot Programme FIT Team UHK implementation