#TEXTGillAngus
Manager05.03.02
#CODE
GA - new post - newly created 6 months
Audit discharge planning
Develop links with PCT - especially for winter.

Trust app

WP - discharge planner in ward (Medicine)

Wider focus - look at using community resources

Winter - extra person - extra funding

GA - WP & ME collect discharge data
GA - meets social work managers and sign off any delays, Friday's collect info from team.
GA attend SITREPS looking at SITREP reporting - have found variations in collecting of data, open to Interpretation.

GA - accountable - line manage - patient access manages - operations director.

Monthly report - Trust Board
Capacity planning, service provision

Good practice meet with social services

Problems with 'other' column in data collection.

No. 45 delays - week before 40
After 70 = time of year.

No. of days individuals wait.
Housing issues 100 days/individual

Care homes - 600 day/individuals

No database - weekly paperwork

Care of elderly rehab - 10/15 patients
Care packages - could be 2-4 weeks wait

Central interest > efficiency, are able to offset numbers
Reconfiguration, Haslar issues, closing down nursing home.

Weekly meeting with representation from PCT - cps manager, social services sometimes.

How best to use the criteria to match the patients eg. Sultan patients seeking residential homes - to stay in community hospitals until found homes.
But dependable on GP, individual case.

Indentifying patients - discharge

(WP) - If people need to discharge cared elderly consultant. ID patients best option - requested by social services.

Nothing will happen until OT has made observation.

No rush into homes too quickly.

Potential for rehab to be given a good opportunity.

Timing of rehab assessment - taking too long so people are not labelled too quickly.

Waiting - acute wards - some physio/OT, some rehab input.

Locality of OT's - will treat depending who individuals are being treated at acute.

If someone needs care home - referred to care of elderly.
St Mary's - waiting for home and rehab, nurse led ward
Haslar - nurse lead ward.

Would receive the S/A medical
Nurse lead - rehab, acute?

Patients going to GWMH.

GA - Care of Elderly consultants.
Transfer to GWMH for further rehab.
No involvement

Involvement with acute hospital when patient are deemed medically fit for transfer.

Consultants/nurses talk to patients and relatives about discharge.

Transfer - consultant write in notes, continued medical supervision from ward, contact to find out where on the list, (CE office phones ward), only involvement if to Sultan ward.

Diff in patient going to Sultan/other two.

GP beds - medically stable, package of care and equip, not quite available, use bed for only two weeks.

Other wards - those requiring rehab.

Fluctuation in patients condition.
They are reassessed but not by geriatrician.

Geriatrician initiates the transfer.

Expectation of condition of patient.

GA community hospital - inappropriate transfer
Mental health needs were greater
Seen to be manageable within ward therefore condition is seen differently.

The transfer has been a frightening experience.

Expectation of condition - this has been decided by consultant.

Information to families

Elderly consultant showed document the purpose of transfer.
Advice, continuing care, rehab - is circled by consultant in notes.

Nurses have access to Service profile to understand the transfer.

There should be limited risk of wrong communication of expectation of medical condition.

*Service profile - generic transfer document for each ward.

Other responsibilities - liase with social services for packages

Referrals to OT, chasing up packages

Teaching ward staff - what availability, why need for discharge planning.

Timing of bringing in social services - prob, when someone is admitted they are aware that a discharge package is available but the procedures deals social services package of care is being organised.

WP
Preventing consultants from discharging earlier - what consultants deem medically fit is not the S/A as what nurses deem medically fit

Resources needs - need more.

Regular ward staff too busy so discharge planners need to organise but it should be more nurse lead.

P/C notes to community hospitals. Transfer letter verbal handover - followed by transfer letter.

Transferring patients to GWMH - GP beds
Prob - time of social service pickup delay at GWMH 6-8 weeks

Closing the case and restarting case in community hospital.

GWMH (GA) prioritise clients in homes not at hospital.

GWMH - incident where GA rang GWMH to transfer to Sultan bed, GP happy when understood. It would be 2 week - but then realised that it was 6-8 weeks before social services would pick up.

But GP refused
GA found out there were beds available

Acute beds full so a patient was admitted directly to GWMH - who turned out to be an

inappropriate admission.

* Discharge link meetings?
Imp transport are warned in advance for transport? Need to let transport know by 12pm the day before.