Bexley Safeguarding Adults Board

SAR-ROSE

7-minute Briefing on Hospital Discharge Pathways (Bexley)

1. Purpose of this Briefing – the key point of learning for SAR-Rose was the lack of information available on Hospital Discharge Pathways across the system. The BSAB has asked for this to be created to clarify the different terminology & access to what's available in Bexley following a hospital admission. There may be frequent changes to this information, so it is always in your best interest whether a professional or a patient/family and/or carer to double-check with Bexley on what to expect from whom and by when. We will share the main options available in Bexley. You can ring 02030457777 and ask for Screeners to access this information.

2. Types of Pathways –

A. Conventional Home Care: This is for when care is required in order to go home but no rehabilitation / reablement services are needed. If someone is 'restarting' following a hospital stay, the same level of support received prior to admission should be emailed to the Hospital Integrated Discharge (HID) Team with the detail and date of discharge who will request the restart. If brand new or requiring an increase to home care, either short term or longer term, complete the Patient Passport and send to the HID Team. Ensure you discuss with the patient and their family/carer as well as confirm the start date with the Hospital Ward prior to discharge.

B. Reablement at Home: If the patient has identified reablement goals, that can be achieved in 6 weeks, no contraindicatory medical conditions, and they have the mental capacity and cognitive ability to retain instructions and new ways of doing things the send the Patient Passport via email to Bexley's Brokerage and Admin Team. The Reablement team has a duty to contact care agencies, email confirmation to care agency, brokerage and liaise with the Hospital Ward as well as the patient and their family/carer.

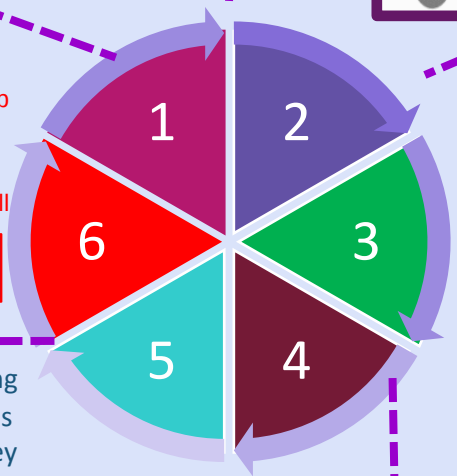
3. If needs are too great for care at home -

then there are options available support a safe discharge from hospital, they are:

A. **Plaster of Paris pathway:** Those who have a fracture/break who can manage at home with support while they await the fracture healing before any reablement can be considered. They'll receive conventional home care until their plaster is removed and their Reablement potential has been assessed, if required.

B. Interim Care bed: The patient is unable to return home safely, has unpredictable care needs that cannot be met with a conventional home care package. They will need to consent to a stepdown placement, with a Mental Capacity Assessment and/or a Best Interest Decision will be required. The Patient's Passport should be emailed to a Senior to review, once reviewed the Patient's Passport should be emailed to Bexley's Brokerage Team and admin by the Senior. There is a duty to discuss the decisions and process with the family/carer and patient at all times. The placement may be Meadowbank rehabilitation. If the patient has a rapidly deteriorating condition, the person may be entering a terminal phase, the professional should complete the Patient's Passport and any other End of Life (EOL) referrals to pass onto the Continuing Healthcare Team (CHC) in Bexley.

C. Enhanced Care: The patient needs 24-hour care, but needs are not unpredictable, but can be met in the community whilst awaiting full assessment, there is the possibility that this level of care is not required long term. The Patient's Passport should be emailed to a Senior to review, then to Bexley's Brokerage Team and agreed by a Senior. There is a duty to discuss the decisions and process with the family/carer and patient. Confirming start date with ward and Next Of Kin.



4. Requesting Social Worker for complex discharge

There should be a request received for a Social Worker (SW) to attend a Multidisciplinary Team (MDT) meeting for complex discharges. Definition of 'complex discharge' is – ***'If you need more specialised care after leaving hospital, your discharge or transfer procedure is referred to as a complex discharge. If you need this type of care, you'll receive a care plan detailing your health and social care needs. You should be fully involved in this process, (NHS).'*** An email request to Senior and admin, Senior to discuss with Social Work Team Manager regarding allocation.

5. Contact Details:

The following are the contact details for the various teams can be found hereat the Bexley Care Hub website - **https://www.bexley.gov.uk/services/health-and-social-care/social-care-for-adults**

OR You can ring Bexley Screeners at 02030457777

6. Other things to consider -

A. Therapy: Basic equipment to be considered, forward to Community Rehab Team

B. Key safes: Contact Patient/Family to determine if they can purchase and install key safe in first instance.

C. Telecare: Complete telecare assessment