Hospital Flow & Discharge.

Heidi Hall

Head of Hospital & Integration teams

IDT Team

- ENHT NURSES inc- FT & CHC Nurse
- HCT nurses & rehab co ordinator
- ENHT/HCT secretaries
- Patient flow co ordinator
- ACS social care
- Age Uk
- CBU care agency
- Impartial assessor (HCPA)& care home choice facilitator

A&E Team

- Patient is brought in to A&E
- Referred by clinician/nurse to front door team (Clin Nav/ Social care/ Age Uk)
- Parallel AX completed by clinicians and above team
- Team have direct access to all pathways/ services
- Parallel planning enables quick DX

Back Door Team

- Daily Board meetings
- Early identification and EDD setting (LOS-72 hours- 5 days)
- Prioritisation
- Shared roles/ Professional relationships/ respect/ trust
- Open and regular communication/ Direct mobile access
- 7 day services
- Escalation

ENH Discharge Pathways

Pathway One

atient needs can safely be met at home

- Age UK – Hospital support
- Specialist Care at Home
- Home care
- Supported Discharge (NH only)
- **Discharge Home to assess (3 Localities)**
- Early Supported discharge - Stroke
- **Front of the house service**
- CHC (Care at home)
- Homefirst

Pathway Two

Unable to return home – patient requires further rehabilitation/ reablement

- Community hospital intermediate care beds
- Non Weight Bearing beds
- Neuro Beds
- **D2A beds**
- Intermediate care beds- Private sector
- Step down beds
- Discharge (enablement) flats
- Short stay beds

Pathway Three

Unable to return home- patient has very complex are needs and may need continuing care

- Residential beds
- Nursing home beds
- **CHC- D2A bed**
- Return to residential/nursing home/ upgrade
- Funding without prejudice

EIV Process

Emergency (red flags) pre-defined pathways

Yes

Emergency response

No

65+?
Dehydration?
Dementia?
UTIs?
Falls?
Minor head injuries
Rapid decline in function

No

Other appropriate response, such as follow up with GP

Yes

Early Intervention Vehicle

Early Intervention Vehicle

- Direct access to frailty advise line/ outpatients clinic
- Escalation to A&E front door team following initial Ax at home if requires attendance
- Heads up on care/ equipment supplied or needed on DX once clinical Ax undertaken
- Early identification of patients and their needs following holistic AX

Case study

- Older lady had a fall at home, brought to A&E for an X ray. EIV attended and supplied equipment for DX. Forwarded assessment detail to A&E team, following X ray and plaster, supported to go home with FOH POC.
- Gentleman having recurring falls, diagnosed with UTI and attended via routine ambulance. Confused on admission and supported to have a short stay on DX, before returning home with ongoing POC.

Key Strengths

- **Daily Oversight-** Board round cover, daily con call, DX list
- **Integration-** 6 organisations under IDT with close links with therapy and MH teams
- **Escalation/checking mechanisms-** LOS
- **Difficult conversations**