



**Delayed Discharge
Pathway Review**

1. Patient Information:

Patient CHI Number

Admission In hours / Out of hours

Date of Birth (age)

GP referral / self referral

M / F

Admitted from Home / Care Home / Other (specify)

Address Post code

Living on own / with carer

Reason for Admission:

.....

Did the patient have dementia / delirium?

2. Service History:

What services was person in receipt of prior to admission? (List all)

Home care

Community nursing

CPN

OT

Day care

Community Alarm

Other telecare / assistive technology

Was the case open to Social work?

Was a care manager in place?

Was there an advanced / anticipatory care plan in place?

Was carer support provided (if appropriate?)

Previous history of emergency admissions in the last three years?

If so what was the SPARRA score?

3. Inpatient Pathway

(a) Date of admission	Through A&E / direct to ward ?
(b) Initial Ward :	medical assessment / surgical / orthopaedic / psychiatry / other
(c) Subsequent Ward moves (dates and reasons)	
(d) Date of initial AHP contact	OT? Physio?
(e) Date of initial social work contact	
(f) Assessed by medicine for elderly team?	Managed by medicine for elderly team?
(g) Assessed by CPN / psychiatry team?	Managed by CPN / psychiatry team?
(h) Was estimated date of discharge proposed? (If so provide date):	
(i) Was a case conference held? (If yes date):	
(j) Date agreed by MDT as ready for discharge:	
(k) Current ward setting:	
	<i>Acute site - short stay specialty</i>
	<i>Acute site - non short stay specialty</i>
	<i>Post acute site / community hospital bed</i>
	<i>Intermediate care facility</i>
(l) Current Reason for delay (code):	
(m) Current duration of delay (days):	

4. Overview of Care

What services may have prevented this admission?
What interventions could have changed the outcome?
What solutions could have reduced the delay?

Delayed Discharge Pathway Review

Guidance Notes

Purpose

The Delayed Discharge Pathway Tool and guidance note complement the JIT Delayed Discharge : What Works self assessment. These resources have been prepared to assist local partnerships to review and improve the pathway for people whose discharge is delayed in hospital.

The Pathway tool should be used retrospectively on a sample of patients delayed to reflect on the reasons for delays, where these are not fully understood. The purpose is to identify areas where improvements can be made to the patient pathway to reduce avoidable delays in future.

The tool captures information on key steps in the journey of care. It breaks down each patient scenario into a set of processes and services the patient was engaged with prior to, and following, admission. This detailed review can be used to identify where there have been delays or inefficiencies in the pathway and discharge planning. Recurring or important themes emerging from the sample of patient pathways reviewed may provide a focus for redesign and improvement work.

For constructive challenge the tool should be completed by someone not directly involved in the care of that patient. In identifying your 'critical friend' it is helpful to use staff who are familiar with patient records and clinical terminology /abbreviations.

Useful sources of information

Medical records held on ward

Nursing care plans

Shared assessments

Uni disciplinary records

Ward based Admission/Discharge Books/patient management system



Section 1 - Patient Information

This relates to information about the patient at point of admission to hospital.

Reason for Admission will not be the diagnosis in most cases but may, for example, be presenting symptoms and/or social circumstances.

Section 2 - Service History

This information is best sourced and /or verified through social work or primary care records or through the occupational therapist.

Your CHP lead for SPARRA data should be able to provide this information for the patient using their CHI number.

Section 3 - In Patient Pathway

This section may be difficult to complete for people with complex care needs who have been in hospital for several months and may have had multiple moves. In some situations medical records from more than one hospital may have to be pursued.

If necessary complete items (d) – (i) for each location or episode of care on a separate sheet. Record the date of each ward move AND the reason for the move.

Most of the information for this section will be found in the ward based medical records, nursing, AHP & Social work records.

Case conferences are not the same as a routine discussion at a MDT meeting. They include participation by the patient or a representative and are not always clearly documented in the medical notes. If necessary check other records such as social work, nursing or AHP records. In the absence of a clear record from the available information sources, it must be assumed that it did not take place.

Section 4 - Overview

This is a subjective assessment based on the professional judgement of the person completing the tool for that patient. Issues and themes emerging from a number of patient pathways reviewed should be captured in a report to the partnership delayed discharge leads. These themes can be used to inform the partnership work plan to redesign and improve the pathway.