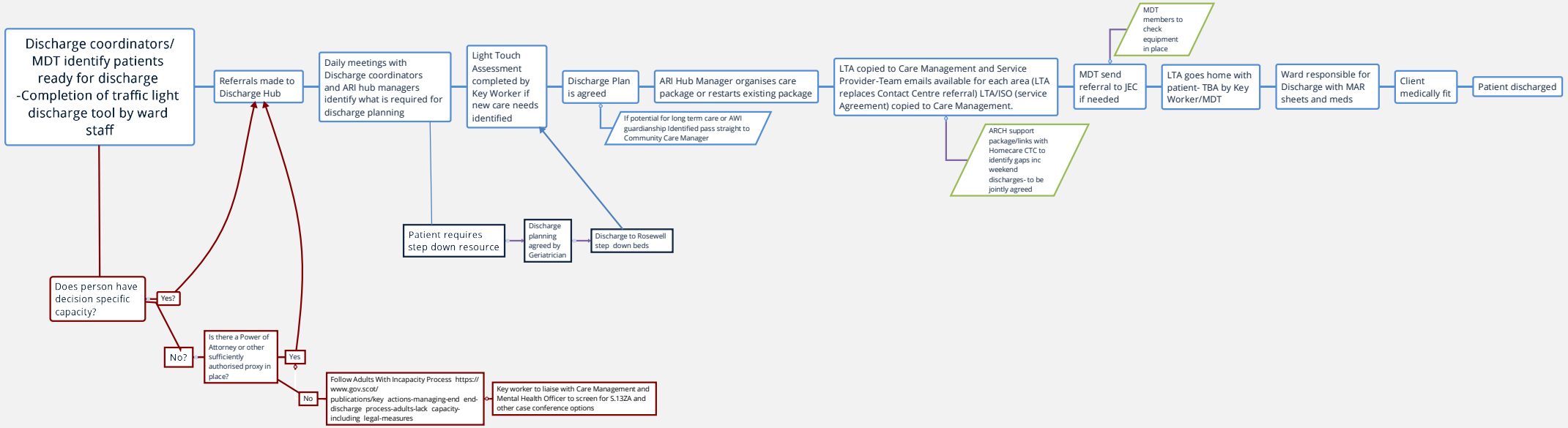
Discharge coordinators/ MDT identify patients ready for discharge -Completion of traffic light discharge tool by ward staff
Referrals made to Discharge Hub
Daily meetings with Discharge coordinators and ARI hub managers identify what is required for discharge planning
Light Touch Assessment completed by Key Worker if new care needs identified
Discharge Plan is agreed
If potential for long term care or AWI guardianship Identified pass straight to Community Care Manager
ARI Hub Manager organises care package or restarts existing package
LTA copied to Care Management and Service Provider-Team emails available for each area (LTA replaces Contact Centre referral) LTA/ISO (service Agreement) copied to Care Management.
ARCH support package/links with Homecare CTC to identify gaps inc weekend discharges- to be jointly agreed
MDT send referral to JEC if needed
MDT members to check equipment in place
LTA goes home with patient- TBA by Key Worker/MDT
Ward responsible for Discharge with MAR sheets and meds
Client medically fit
Patient discharged
Patient requires step down resource
Discharge planning agreed by Geriatrician
Discharge to Rosewell step down beds
Does person have decision specific capacity?
Yes?
No?
Is there a Power of Attorney or other sufficiently authorised proxy in place?
Yes
No
Follow Adults With Incapacity Process https://www.gov.scot/publications/key actions-managing-end end-discharge process-adults-lack capacity-including legal-measures
Key worker to liaise with Care Management and Mental Health Officer to screen for S.13ZA and other case conference options