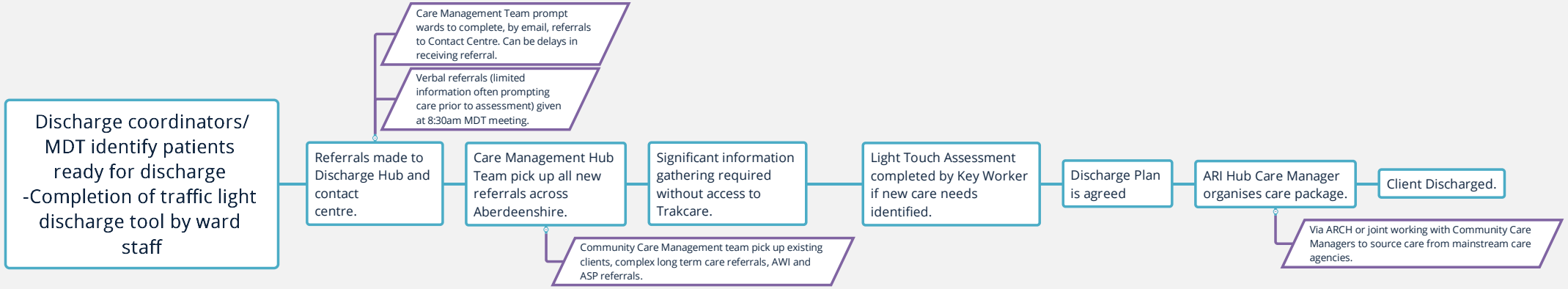
Discharge coordinators/ MDT identify patients ready for discharge -Completion of traffic light discharge tool by ward staff
Referrals made to Discharge Hub and contact centre.
Care Management Team prompt wards to complete, by email, referrals to Contact Centre. Can be delays in receiving referral.
Verbal referrals (limited information often prompting care prior to assessment) given at 8:30am MDT meeting.
Care Management Hub Team pick up all new referrals across Aberdeenshire.
Community Care Management team pick up existing clients, complex long term care referrals, AWI and ASP referrals.
Significant information gathering required without access to Trakcare.
Light Touch Assessment completed by Key Worker if new care needs identified.
Discharge Plan is agreed
ARI Hub Care Manager organises care package.
Via ARCH or joint working with Community Care Managers to source care from mainstream care agencies.
Client Discharged.