Acute Team Process
V1.8

Document	Pathways to Care Acute Team Process
Purpose	Additional Guide for the Acute Team which shows the specific processes and pathways to follow on the system.
Version	V1.8
Owner	ICT & Business Transformation Team (Adults System Support)
Last Updated	12/06/2023

Contents

Key principles

1. **Update Pathways to Care throughout the day – it needs to be maintained as a live system and updated immediately when anything changes not after the event. ADD and changing of status to Assessed are the only things to be completed after the event.**
2. Record basic information on case notes about discharge rather than Care Director – keep it brief and ensure that the information is updated immediately.
3. Ensure **Hospital Team – Acute** is added as the team throughout the discharge journey.
4. Use the mobile version of Pathways to Care whilst on the wards to avoid a delay in providing information.
5. Keep the status in **Discharge Planning** until you have a confirmed start date for services.
6. Use the **Abandoned** status for **pathway 0**, **declined a pathway service** etc (see full details below.
7. Add **Does not Meet the Criteria to Reside** date and reason if not discharged on the **EDD.**
8. Change the status to **Awaiting pathway decision** and **EDD** to **01/01/2050** when right to reside criteria is met (not medically fit) and untick **Does not meet the Criteria to Reside** box if ticked.
9. Record the actual date of discharge (**ADD**) in the editable field, update the current location and change the status to **Discharged** once discharge has been confirmed.
10. Remember to fully close the discharge on Pathways to Care by changing the status to **Assessed**, **Abandoned** or **Entered in Error**.
11. **Case notes** can be edited up to 30mins after clicking save – click **add notes** and then **edit case notes.**
12. ***On-call, weekend and bank holiday workers to update Pathways to Care and use as the go to system for discharge information***.
13. Referrals appear in the **Active Referrals not Recently Updated** widget on the 3rd day of the referral not being updated.
14. Use the **Critical Notes** for key information.

Process

Administrators

Administrators create a discharge on Pathways to Care.

1. Input the **Expected Discharge Date** record EDD 72hrs after TOC received – see example below (if a referral is received after 15:00 on, 12/06/2023 for example, you would put the date for the following day after 72 hours. Instead of 15/06/2023 which is 72hrs, you would put 16/06/2023 if you received it after 15:00).

2. **Update Status** to **Awaiting Pathway Decision Assessment.**

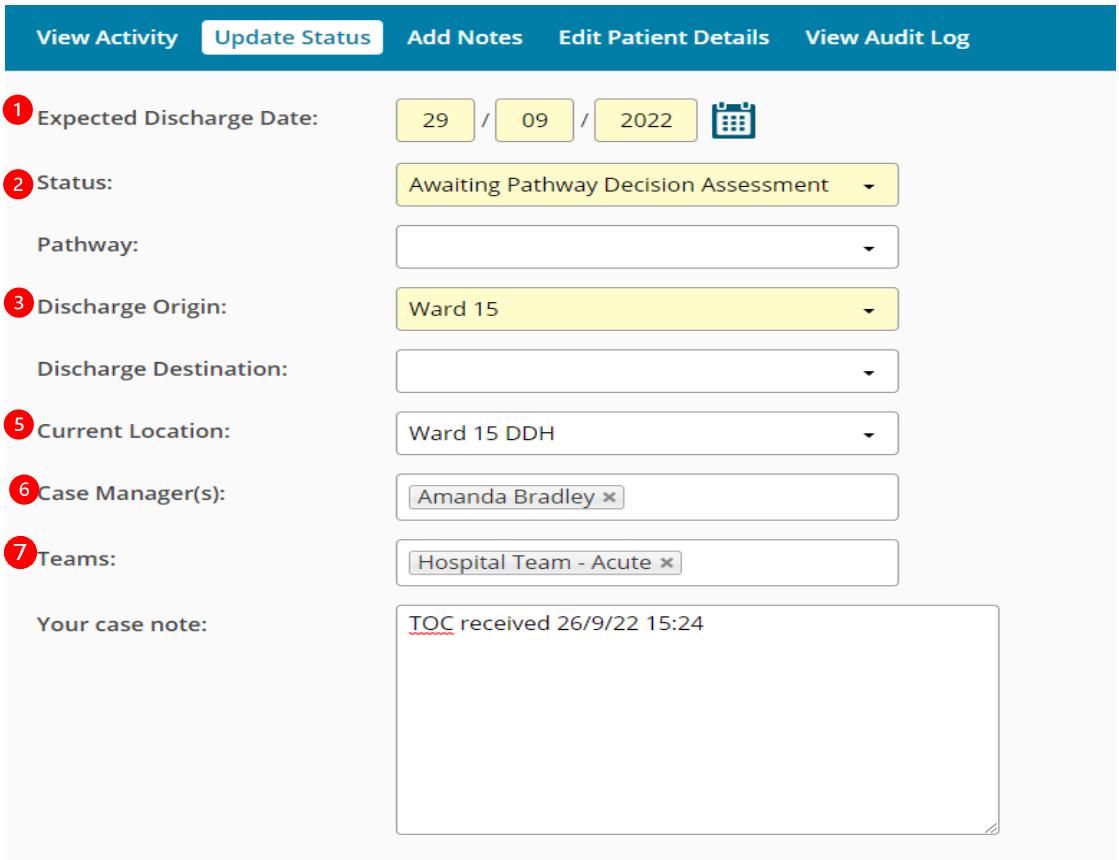
3. Include all the ***mandatory*** information below:

    a. **Discharge Origin.**

    b. **Current Location.**

    c. **Case Manager.**

    d. In **Teams** input **Hospital Team - Acute**



Discharge Planning in Progress

The **Case Manager** (**Allocated Worker)** will view the discharge on their dashboard.

1. Change the **Status** to **Discharge Planning in Progress** immediately and continue in this status until there is a start date for services.

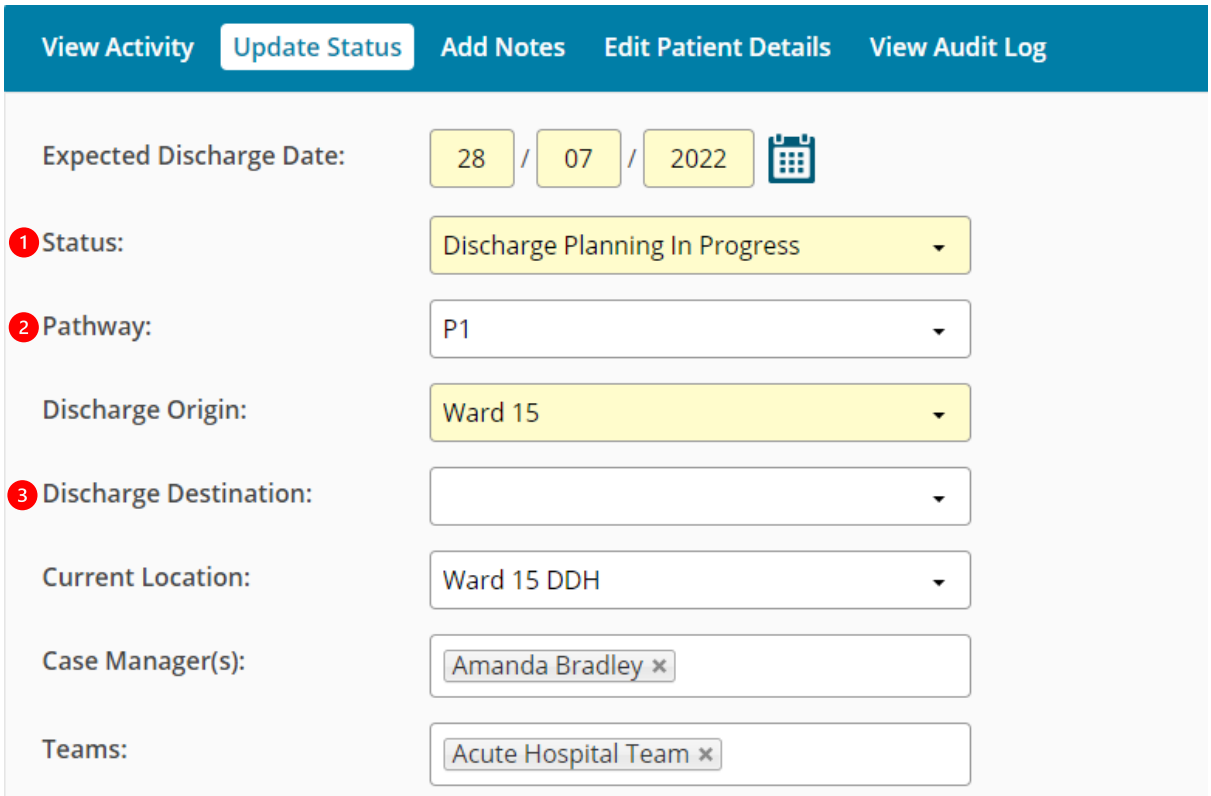
2. Update the following information as soon as it is confirmed:

    a. **Pathway -** *if the pathway changes, please add a brief case note to explain why*

    b. **Discharge Destination.**

3. **Case Notes or Add Notes** to record basic information about the discharge. This information is what you provide to team managers each morning or anything else relating to the discharge. E.G searching for D2A nursing bed.

4. **EDD** – do not update at this stage; see information below



EDD, Does not Meet the Criteria to Reside, Right to Reside, Medically Unfit and Critical Notes

Estimated Date of Discharge

The initial **EDD** is entered by admin when they input the referral onto Pathways to Care. The date is 72hrs after the ITOC referral is received in the Hospital Teams mailbox. The **EDD** is only changed at this stage if discharge will be before this date. This may be before formal services can commence, for example, **EDD** is 27/09/22, POC commences 28/09/22.

Does not Meet the Criteria to Reside, Delayed Discharges

If discharge does not take place on the planned **EDD** date, tick the **Does Not Meet the Criteria to Reside** (DMCR) box and enter the **EDD** date. Add the **primary delay reason** (and a **second delay reason** if required). The **EDD** is then updated with the start date of services and the status changed to **Awaiting Discharge**.

If discharge is delayed again, change the **DMCR** date to the **EDD** date and update the **delay reasons**. The next planned discharge date should be written in the **critical case note.**

Meeting the Right to Reside Criteria (Not medically Optimised for Discharge).

If the person is not medically able to be discharged, untick the **Does not Meet the Criteria to Reside tick box**, record R2R date in **critical case note**, change the status to **Awaiting Pathway Decision** and update the **EDD** to 01/01/2050**.** This enables all persons who meet R2R to be easily identified on Pathways to Care.

Once the person can be discharged, change the status back to either **Discharge Planning in Progress** or **Awaiting Discharge** (if services are still available) and update the **EDD** to no later than 72hrs or the start date for services.

Medically Unfit

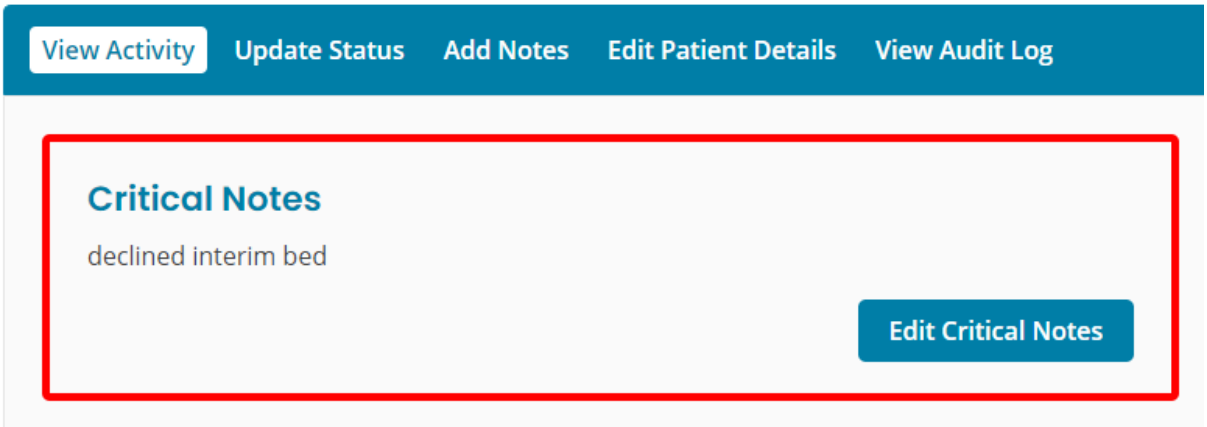
1. In cases where the person is not medically fit, the following actions should be taken:
    a. Change the EDD (Expected Date of Discharge) to 01/01/2050.

    b. Status to “Awaiting Pathway Decision Assessment”

    c. Add a Critical Note stating, "R to R" (Reason to Reside) and the date.

Critical Notes

Use the critical notes functionality to record all important information. This field is fully editable and any removed data does not need to be re-entered as a case note as it is automatically recorded in the activity timeline. The latest discharge plan / decline / acceptance needs to be recorded in this box as a quick look up option.



The critical notes are accessible in the expanded caseload view and allows you to view multiple people simultaneously without the need to click into the person.

Expanded view of the Current Caseload

List of cases

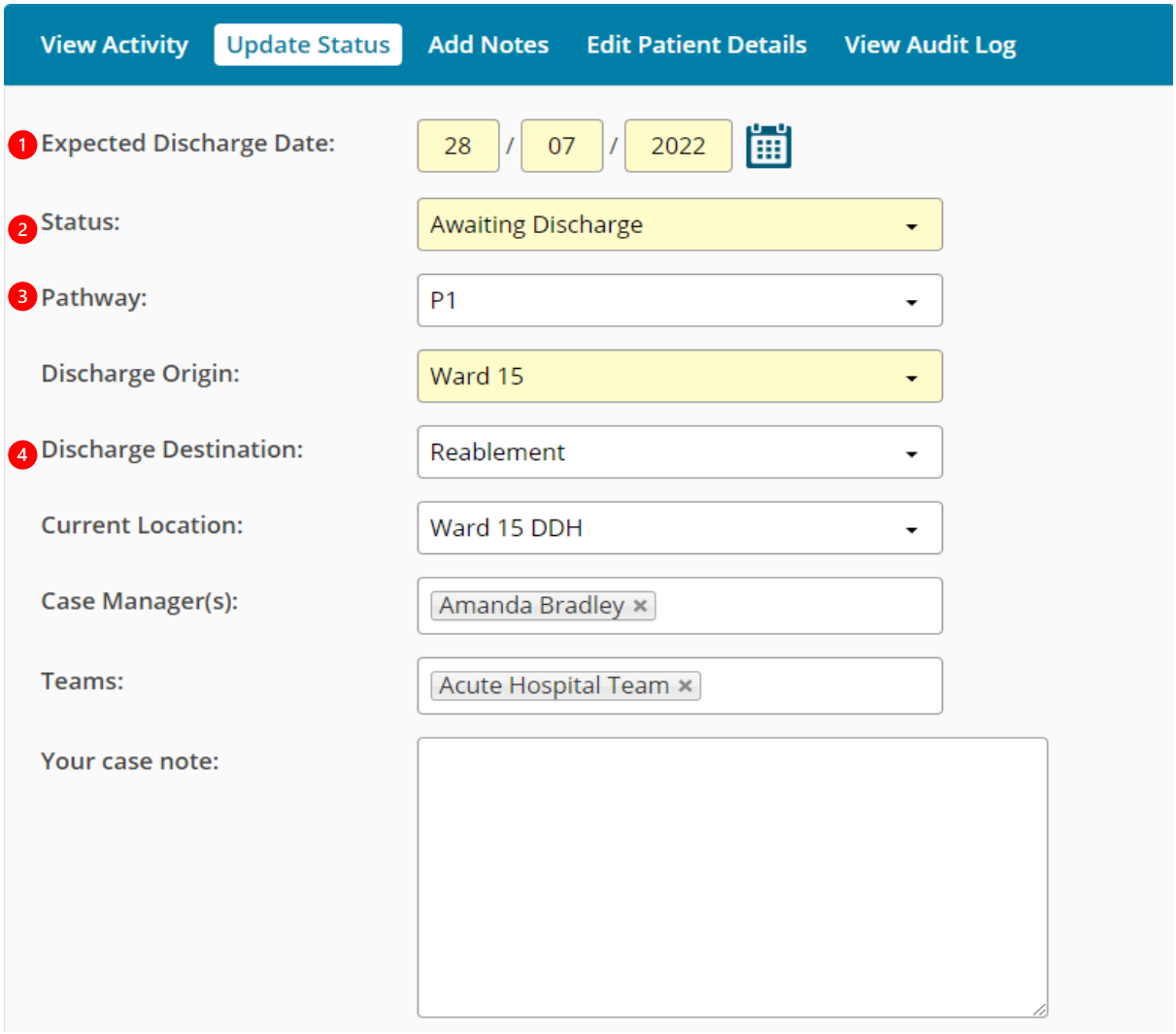
Local Authority	Referral Date	NHS Number	Name	Status	Pathway	Location	Criteria to Reside Date	EDD	Primary Delay Reason	Teams ▼	Covid Status	Critical Notes
Wakefield Council	15/09/22	416 033 9409	TESTER, Jayne (01/01/73)	Awaiting Discharge	P1	Ward 11 DDH	31/10/22	31/10/22	Awaiting transport	Hospital Team - Acute	Unknown	d/c planned for 10/6/23, ward to liaise with family and provider
												TOC received 30/5/23, allocated to Amanda Powell P1

Please Note: It is crucial to emphasise the significance of using the critical note feature instead of case notes on P2C. The critical note provides a specific section for capturing vital and time-sensitive information related to a person's care, ensuring that it is easily accessible and prominently highlighted. Utilising the critical note enhances communication and ensures that critical details are not overlooked.

Awaiting Discharge

Once the discharge plans have been confirmed and there is a start date for services complete the following:

1. Update the **Status** to **Awaiting Discharge**.
2. Update the EDD with the start date of services.
3. Update the **Pathway,** if required adding a case note if it has changed
4. Record the **Discharge Destination**.
5. Add a ***brief*** update about the discharge plans in **Case Note.** This information is what you provide to the Team Managers each morning.
6. If the Does not Meet the Criteria to Reside box is ticked with a delay reason, leave this ticked and update the reasons for delay as required.



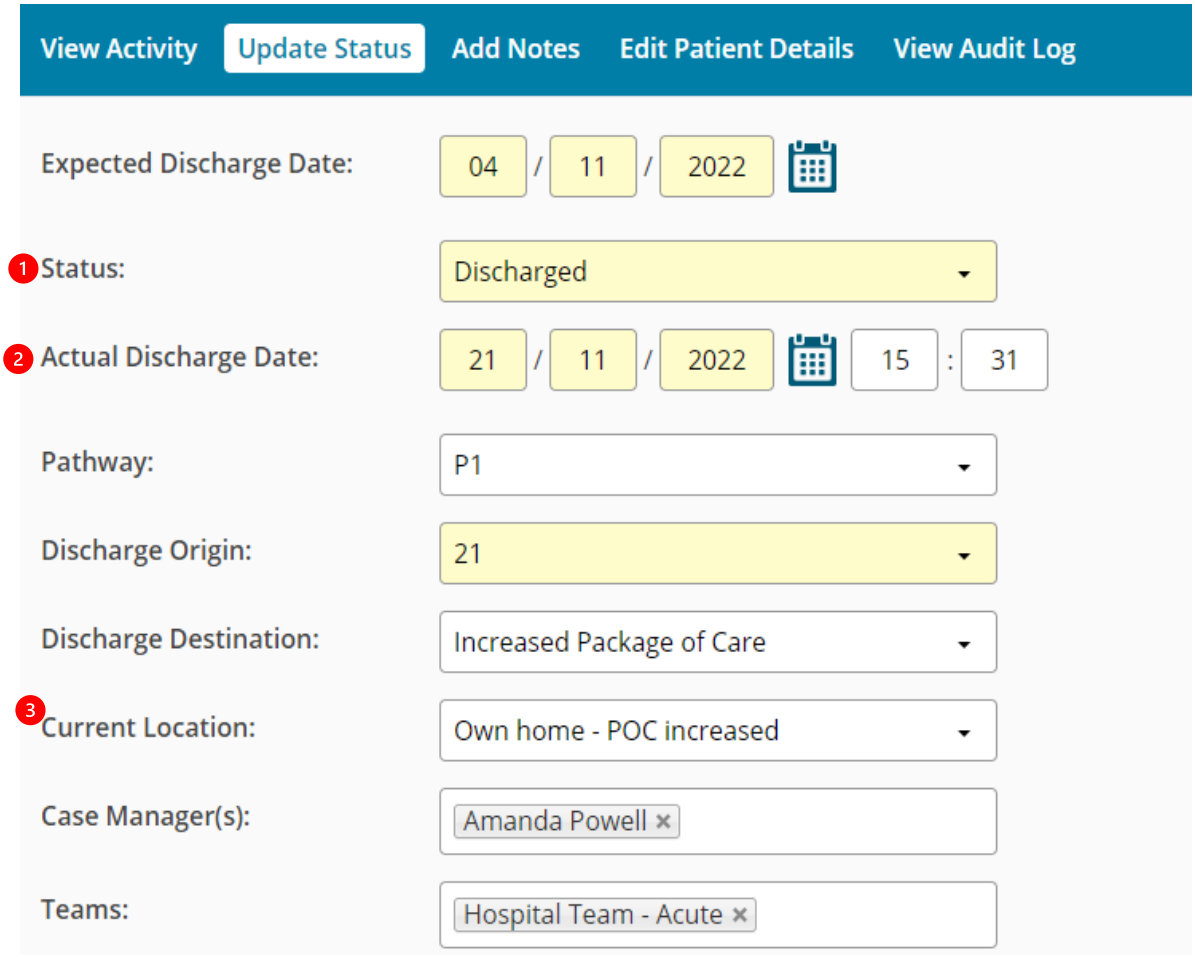
Discharged

1. When the actual date of discharge (**ADD**) is confirmed, the **Status is** changed to **Discharged.**

2. The **ADD** is updated with the actual date of discharge.

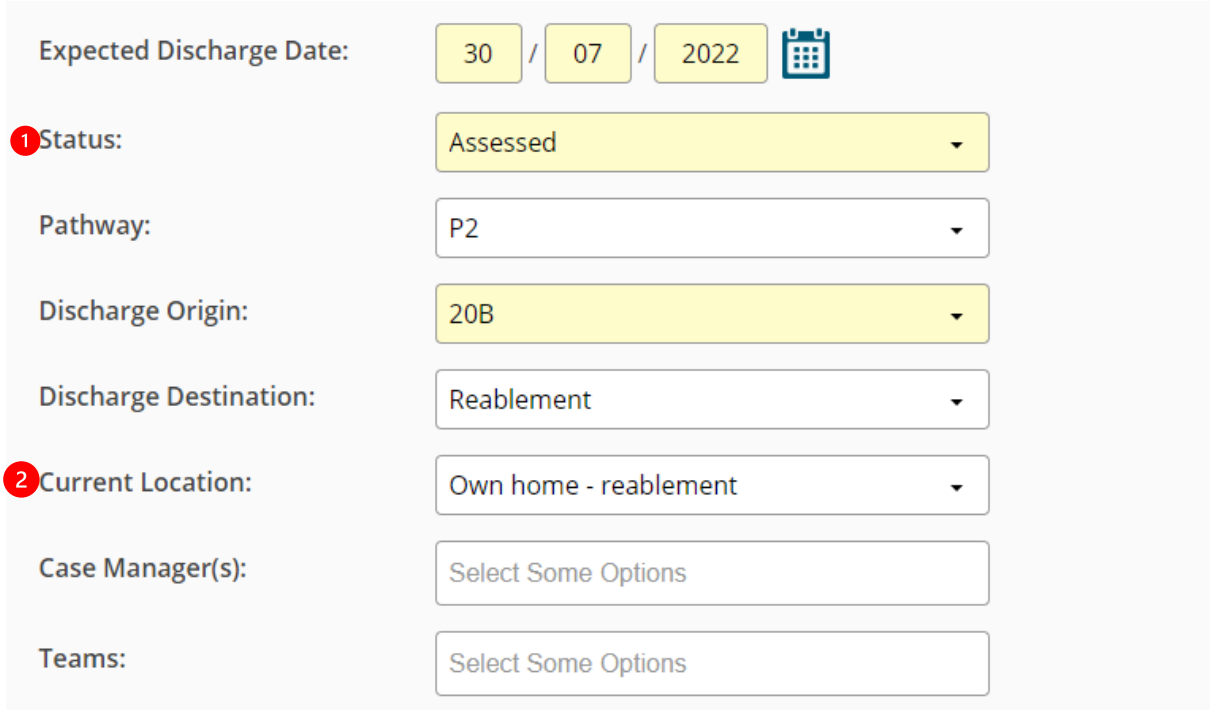
3. Change the **Current Location** to one of the **Discharge Destination** options. E.G own home or Discharge to Assess Bed.

4. Click **Save**.



Closing/ Ending a Referral on Pathways to Care

1. To **Close** or **End** a referral on Pathways to Care, update the **Status** to either:
    a. **Assessed**
    b. **Abandoned (**see below**)**
    c. **Entered in Error**
2. If **Assessed** is chosen, update the current location.
3. Removing the **Case Manager** and/or **Team** will not **close** the referral and is not required to close the discharge and remove them from your caseload.
4. Select **Save.**

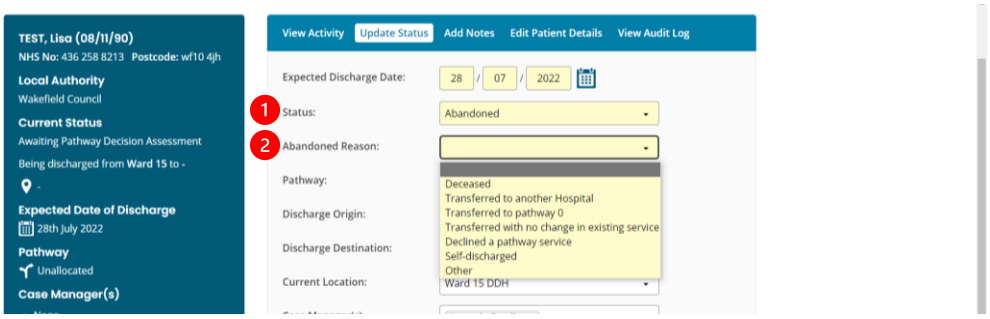


Only when one of three Status' above has been chosen, updated, and saved will the discharge be closed on Pathways to Care.

Abandoned

If the in-patient assessment does not take place or is not concluded follow the below guidance.

1. Change the **Status** to **Abandoned**.
2. This will show a new field called **Abandoned Reason.**
3. **Abandoned Reason Options:**
    a. Deceased
    b. Transferred to another hospital (out of area hospital)
    c. Transferred to pathway 0, *the person has regained their independence and does not require input from the hospital team*
    d. Transferred to no change in existing service, *no assessment or review has taken place or the hospital has restarted services following a referral being raised.*
    e. Declined a service pathway, *the person has declined an assessment or input from the hospital team.*
    f. Self-discharged
    g. Other; *use this for WICU, ICT, Fast Track and FFCHC discharges that the hospital social work team are not planning. Record the discharge destination in the box that appears below.*
4. Select the required outcome and select **Save.**



There is no requirement to record the date of discharge, pathway or discharge destination when the *Abandoned* status is selected.

Frequently Asked Questions

1. **The Referral is still open on Pathways to Care after discharge**.

The status must be changed to either **Assessed**, **Abandoned** or **Entered in Error** to close the referral. Check the status to ensure that it displays one of these options and click save. If the issues persist report to Adults System Support.

2. **The person no longer needs input from the hospital social work team as they are independent.**

Change the status to **Abandoned** and chose **Transferred to pathway 0** in the **Abandoned Reason** box and click save. There is no requirement to record the date of discharge, pathway or discharge destination. This will close the referral on Pathways to Care.

3. **The person or representative declines any input from the hospital social work team with discharge planning.**

Change the status to **Abandoned** and chose **Declined a Pathway Service** in the **Abandoned Reason** box and click save. There is no requirement to record the date of discharge, pathway or discharge destination. This will close the referral on Pathways to Care.

4. **The hospital discharge the person with their existing care services without any input from the hospital social work team.**

Change the status to **Abandoned** and chose **Transferred to no change in existing service** in the **Abandoned Reason** box and click save. There is no requirement to record the date of discharge, pathway or discharge destination. However, if you complete a piece of work with the person (Review, ISP or Reassessment) then follow the **Discharge** process (page 6).

5. **The family are going to provide support until the new or increased package of care can commence the following week.**

Follow the **Discharge** process on page 6, select pathway 1 and **Bridging - Informal Support** in the **Discharge Destination**. Add a brief note with the date the package of care will commence (or if unknown) and who the provider is. Change the status to **Assessed** and update the current location with **New Package of Care** or **Increased Package of Care.** This will show that the person was discharged with informal support until the **New or Increased Package of Care** could commence. If Reablement provide a bridging service select **Bridging – Reablement**.

6. **The initial assessment is not completed by the EDD.**

Leave the **EDD** date as is and tick the **DNMCR** box adding the date and delay reasons**.** Record initial assessment not completed in the **Critical Activity** field**.**

Version Control

Version	Change	Author	By Date
V1.0	Initial Start	SS	31/08/2022
V1.1	Changes/further details	AP	07/09/2022
V1.2	Amendments following review/feedback from HSWT	AP	08/09/2022
V1.3	Changes to using Does not Meet the Criteria to Reside	AP	21/09/2022
V1.4	Recording delay reasons, right to reside and EDD's added	AP	29/09/2022
V1.5	Recording ADD and updating EDD	AP	21/11/2022
V1.6	Formatting and additional medically unfit process	SS	19/05/2023
V1.7	Please note section added to critical note to emphasise the importance.	SS	08/06/2023
V1.8	After 15:00 you would input EDD as next day. Critical note to keep first status.	SS	12/06/2023