Halton Council

Halton - Good practice on hospital discharge:

Halton Integrated Discharge Team has a single electronic assessment document which is completed by Intermediate Care Practitioners and Social Care staff. This holistic and person centred approach is used across all discharge pathways to commission services including: Intermediate Care, Reablement, Care Packages, and 24hr care placements. Where there is a change in the service user's needs, the document can be duplicated, so avoids a new assessment being started and the discharge being delayed. This also enables multi-disciplinary working across health and social care disciplines to share knowledge and expertise.

Halton - Case Study:

Mrs A was admitted to hospital with shortness of breath, they were generally unwell, and had confusion. They had a CT head scan which was clear. The Service User previously had no support from Social Services, and family were concerned about the increased confusion, and thought they may need a 24hr care placement, due to the risk of falls. The allocated worker discussed Mrs A's current presentation with the therapy staff, and was able to evidence, as part of the hospital discharge plan, that they were not at their baseline and had potential to improve. Through joint working with an Intermediate Care Nurse Practitioner, an Multi – Disciplinary meeting was held with health and social care professionals and family present, and it was identified that Mrs A could be discharged home with Intermediate Care at home.

If you have anything you would like to share with colleagues across the North West please get in touch to secure a future space in the featured case study/best practice section.