

**Primary Options Programme Northland (POPN)
EARLY DISCHARGE PATHWAY**

Ward social worker/staff contact POPN coordinator
On 0800 PRIMARYOPS (0800 774 627) with patient referral.

Suitable patients are those who can be safely cared for in a residential care environment for a period of 3 days or less, and would normally have spent this time in hospital.

POPN Coordinator assesses suitability for Early Discharge Pathway (in consultation with POPN Clinical Director as necessary)

No

Yes

Referral declined and patient remains in hospital care.

POPN coordinator contacts Residential Care Facility to confirm bed available then contacts the patient's GP to discuss the referral and determine whether they will accept clinical responsibility for their patient during residential care stay.

GP DECLINES CLINICAL RESPONSIBILITY

GP ACCEPTS CLINICAL RESPONSIBILITY

1. POPN coordinator contacts Residential Care Facility and arranges care for patient.
2. Ward staff fax/email discharge summary to GP (and POPN coordinator) and call GP to discuss handover.
3. Residential care facility faxes medication chart to GP to chart medication.
4. GP charts medication and faxes back to Residential Care Facility, who arrange to obtain required medication from pharmacy and administer to patient.

**PATIENT RECOVERS IN 3-DAYS OR LESS AND IS RETURNED HOME
OR, IF CONDITION WORSENS, PATIENT IS REFERRED BACK TO GP**

DISCLAIMER: This guideline is intended to assist clinical decision making and provide General Practitioners with guidance on the appropriate use of the Primary Options Programme Northland services. It is not entirely inclusive or exclusive of all methods of reasonable care. It should not replace clinical judgement in managing each individual patient.