Discharge to Assess

FROM THE HOSPITAL TO THE COMMUNITY

Discharge to Assess Principles

The Discharge to Assess model works on the principle that Adults do not stay in hospital any longer than they need to. Adults are discharged as soon as their acute medical treatment is complete and for all assessments to be completed within the community.

Hospital discharges should apply the Home First Approach, and the discharge planning should be started as soon as they are admitted.

The Discharge to Assess model is evidence-based practice where it is explored to consider the most effective way to support adults to be discharged safely when medically optimised. It is best practice that any assessments for long term needs are completed during an adult's recovery journey.

Discharge Pathways

Pathway 0: discharges home or to a usual place of residence with no new or additional health and/or social care needs

Pathway 1: discharges home or to a usual place of residence with new or additional health and/or social care needs (Reablement provision, Domiciliary provision) ECL is the main provider for this services, and Passion Tree as are Alternative Care Provider. Both providers work with a Trusted Assessor Approach.

Pathway 2: discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support (This could include Community Hospital or a Care Home)

Pathway 3: discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances.

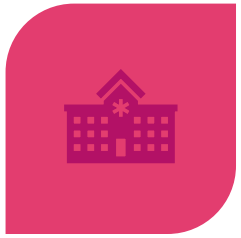
(https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance)

Hospital discharge process:

Integrated discharge team:

Operational Lead for Integrated discharge/ TOCH: Dawn Gardner
Senior Nurses assessors: Philippa Parish, Val White and Cilby James

The Nurse Assessors will undertake the assessments for adults who are currently in an acute hospital where there are complexities associated with their discharge. They will also complete the following:



UPDATE CARE PLANS FOR ADULTS WITH EXISTING FUNDING WHEN READMITTED TO HOSPITAL.

ASSESSMENTS WHERE RESIDENTIAL INTERIM PLACEMENTS COULD BE REQUIRED

STEP DOWN BEDS

LINKS WITH RAPID DISCHARGE TEAM/HOSPICE AT HOME

ASSESS FOR INTERMEDIATE CARE (IMC)

Post Hospital Discharge

The development of the Transfer of Care HUB continues for Mid Essex. This is a HUB where coordination of partner agencies should confirm on the lead for post discharge actions required.

ASC currently support with all Care Act assessments, reassessment and reviews within the first 6 weeks of discharge for adults where they are being supported by an in-lieu provider for reablement, domiciliary care, residential placement and nursing care. The aim is to ensure that all assessments are started within the first 2 weeks of discharge, but this remains an ongoing challenge due to the number of referrals that have been received.

ASC works in partnership with other providers including Provide and the ICB to ensure that we explore the correct outcome for the adult.

Discharge to Assess : Meet the team

Adult Social Care: Discharge to Assess Team 1 and 2.

- Team Managers: Sarah Green and Madeline Carroll
- Deputy Team Managers: Keji Crook and Napoleon Albert

As two ASC teams – we all work on a 7-day working rota to ensure that we continue to work in partnership with the hospital, adult, families and providers over the week.

Our team consists of:

- Senior Social Workers and a Senior Occupational Therapist
- Social Workers
- Occupational Therapists
- Community Support Worker

- The team has focused work and leads around Care Technology, Recovery to Home, Safeguarding.