Discharge to Recover then Assess (D2RA) Pathway 2 flowchart

It is recognised that many of the people we may be supporting have multiple or long-standing conditions and will never be fully 'medically fit' or 'medically optimised'. D2RA Pathway 2 should be initiated as soon as treatment, which can only be delivered in an acute hospital environment, is completed and only if Pathway 1 has first been ruled out as inappropriate for the individual's level of need. 'Home First' will always be the first consideration.

D2RA Pathway 2 is designed to support people to recover in a bedded intermediate care facility before being assessed for any ongoing need, in order to:

- Avoid deconditioning and loss of confidence in hospital;
- Minimise exposure to in-patient infection risk;
- Maximise recovery and independence;
- Provide a seamless transfer to longer-term support in the community, if required.

Within CTM, the D2RA Pathway 2 model has been developed to encompass the following specific pathways:

Focus	Pathway	Definition
	Discharge to Recover then Assessment (D2RA) Pathway 2.1	**bedded rehabilitation** where care needs cannot **currently** be supported at home (and where alternative capacity not available)
	Discharge to Recover then Assessment (D2RA) Pathway 2.2	**bedded reablement** where care needs cannot **currently** be supported at home (and where alternative interim residential home/extra care housing capacity not available)
	Discharge to Recover then Assessment (D2RA) Pathway 2.3	Transitional care (**short term 'bridging'**) for those awaiting D2RA Pathway 1 (home with support) where alternative home care capacity not currently available and supported with 'light touch' reablement during inpatient stay (**as per pathway 2.2**). D2RA P2.3 will provide bridging ideally for up to 5 days. **Red delay code EXT ER6** (D2RA (discharge to recover then assess) Pathway 1 (Home with support) will be applied for this period until discharge into D2RA P1 (effective from date of transfer into D2RA P2.3)

Definition of Rehabilitation

Rehabilitation is the provision of personalised support to enable people to **recover from periods of physical and mental ill-health**. Rehabilitation ranges from supporting people to manage long-term health conditions and disabilities through primary care services to acute hospital settings preparing people to return home and back to their local community. Rehabilitation is about enabling and supporting individuals to recover or adjust, to achieve their full potential and to live as full and active lives as possible, and reflecting what matters to them as individuals.

Restorative rehabilitation focusses on interventions that improve impairments such as muscle strength or respiratory function and cognitive impairment to get **maximal recovery of function**. This is a common form of rehabilitation after surgery, illness or acute events such as a major trauma or a stroke.
Supportive rehabilitation increases a person's self-care ability and mobility using methods such as providing **self-help devices** and teaching people **compensatory strategies or alternative ways of doing things**. This may include the provision of assistive equipment or environmental modifications. This is sometimes referred to as adaptive rehabilitation.

Definition of Reablement

Reablement services aim to encourage and support people to **learn or re-learn skills necessary for daily living**, following a period of illness or after a stay in hospital. Reablement support is about helping people to discover what they are **capable of doing for themselves** reflecting their personal wishes, and to give them **confidence** when moving around their home and with tasks such as washing, dressing, managing medications and preparing meals. Reablement services must have the aim, through therapy or treatment, to support someone to **recover** or **maintain their ability to live independently at home**.

Review every patient against the 5 prompts (COVID-19 National Hospital Discharge Service Requirements [Wales] April 2020, Section 8.3):

- Has this person recovered to the point that their care now be provided in another setting? Think 'Home First'
- What is value added for this person remaining on a community hospital ward, balanced against the risks?
- Why not home? Why not today? (use CTM D2RA Pathway 1 criteria poster to confirm earliest point for home)
- If not today, when? (Expected date of discharge)
- What needs to happen next? (Actions for today)

D2RA Pathway 2 - Explore if patients still require rehabilitation/reablement in a community hospital setting

D2RA Pathway 2 - Ensure that all nursing care delivery maximises independence 7/7 and aligns with the patient's rehab/reablement plan and goals ('preventing PJ paralysis')

Discharge to Recover then Assess (D2RA) Pathway 2.1 – Bedded rehab

Colour coding key

Colour of box	Definition
Blue	Acute Hospital ward based actions/process steps
Cream	Timeline within which to undertake/complete in order to prevent unnecessary delay(s) for the patient
Grey	Provides additional information related to the process step for addition guidance/context
Brown	Navigation Hub based actions/process steps
Green	Community Hospital ward based actions/process steps

Patient is inpatient in acute hospital and requires a supported discharge

Within 24 hrs of admission

Ward staff must conduct a "What matters to me" conversation with patients – the outcome of this along with patient condition and response to treatment in hospital indicates they will require formal care support at point of hospital discharge (once medically optimised/no criteria to reside). **Issue national discharge leaflet A**

Patient has mental capacity re: discharge and may have worries about returning home

Within 24 hrs of admission

The "What matters to me" conversation with patients will be key in terms of confirming patient wishes but also giving staff an early opportunity to work with patients/families around **managing expectations** on discharge – even where there are concerns about coping, we may collectively decide to discharge home 'at risk'

Patient is **currently *NOT*** deemed to be safe between care visits/overnight

Within 24 hrs of admission

Ward staff to refer to **D2RA pathway 1 safe between visits criteria poster** for guidance/confirmation that not safe, along with "What matter to me" discussion, and advice from Supported Discharge team (SDT) where required – **"Home First" – why not home? Why not today?** D2RA pathway reviewed daily at **board round** – does the plan need to change? **Issue national discharge leaflet B2**

Board round daily review - Patient has the ability/potential to meaningfully engage in rehab

Patient will be able to **meaningfully engage in rehab** if:

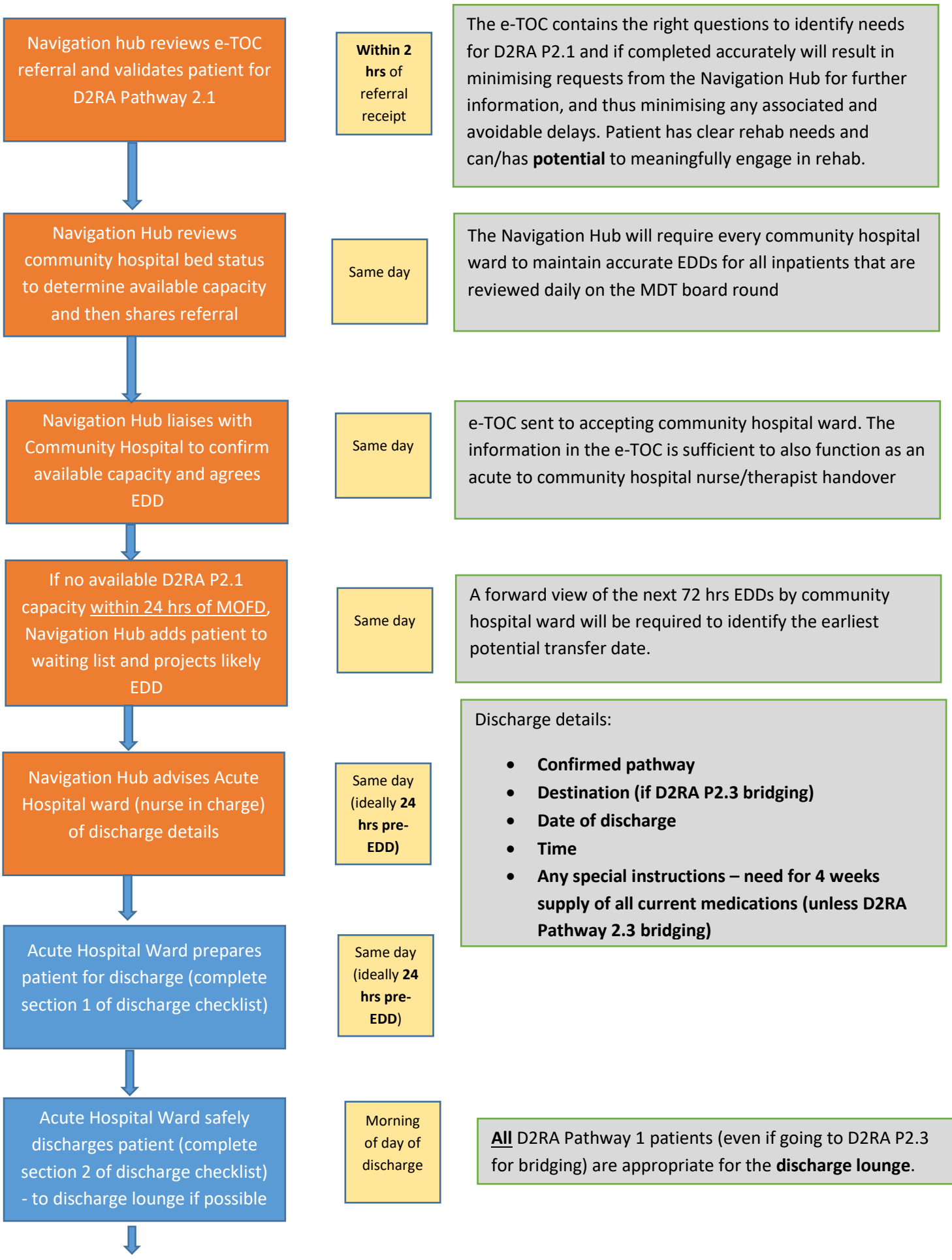
- They can understand instructions from therapists to carry out exercises/instructions
- They can remember what they were told and carry out exercises/instructions safely and correctly even when the therapist is not here
- They have manageable levels of pain that enable them to carry out the required level of rehab
- They don't have a physical problem that makes it difficult/impossible to carry out the required level of rehab (eg: large wounds, fractured limb)

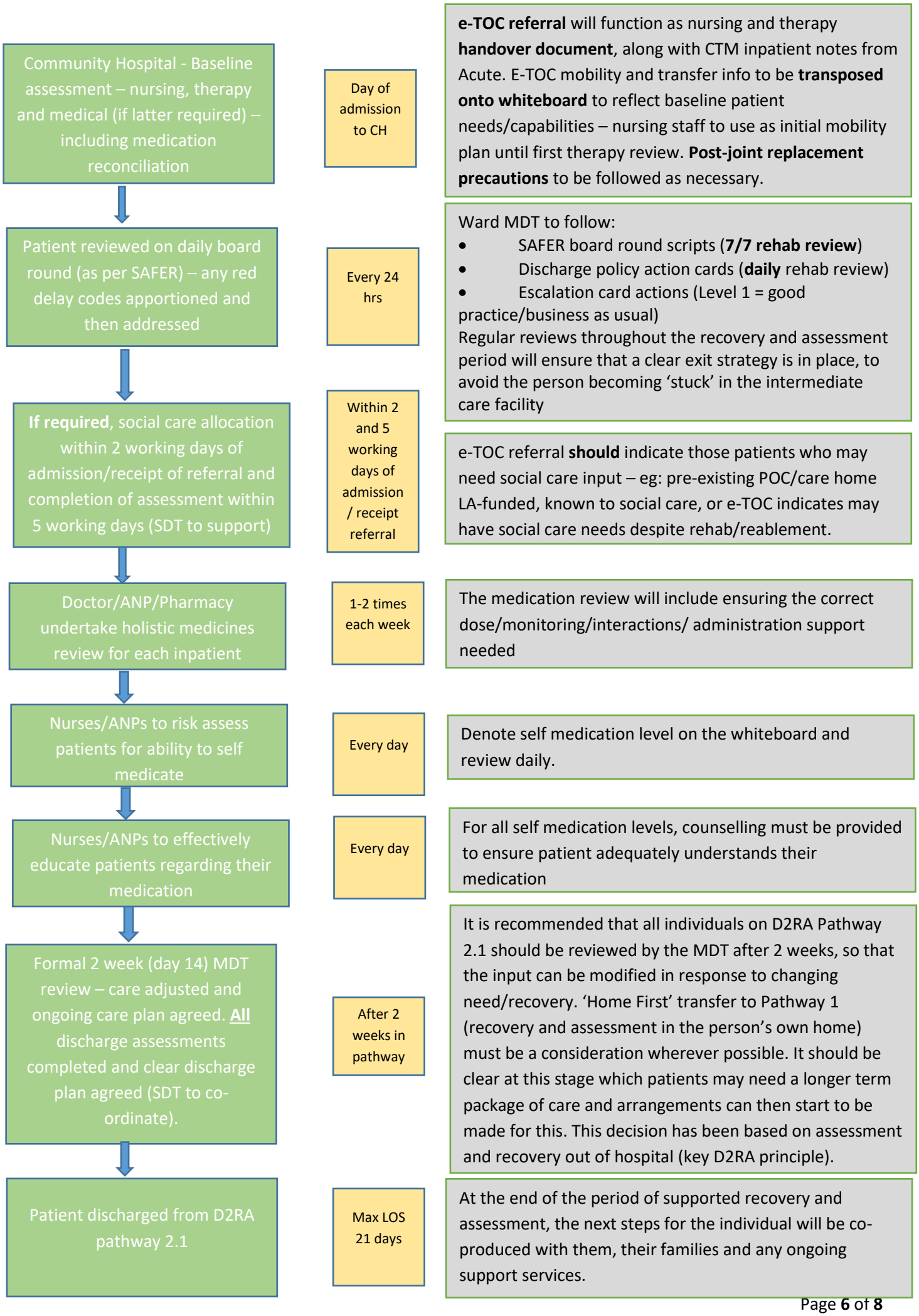
Ward to submit D2RA Pathway 2 e-TOC referral to Navigation Hub **24-48 hrs pre-EDD**

24-48 hrs pre-EDD / MOFD date

Continue to think 'Home First'; only use Pathway 2.1 if Pathway 1 has been ruled out. The motivation for implementing this pathway is to achieve the best outcomes for the individual, and it should only be used where their needs rule out support for recovery and assessment in their own home. These needs are likely to be medium to high level and include overnight assistance greater than could be provided by short-term night-sitting or periodic calls. Individuals on this Pathway should be regularly reviewed and, where appropriate, transferred onto Pathway 1 as soon as their recovery permits

Electronic Transfer of care (e-TOC) referrals must accurately detail patient's care needs and abilities at that point and on that basis suggest the most appropriate discharge pathway from ward MDT perspective.


Navigation hub reviews e-TOC referral and validates patient for D2RA Pathway 2.1
Within 2 hrs of referral receipt
The e-TOC contains the right questions to identify needs for D2RA P2.1 and if completed accurately will result in minimising requests from the Navigation Hub for further information, and thus minimising any associated and avoidable delays. Patient has clear rehab needs and can/has potential to meaningfully engage in rehab.
Navigation Hub reviews community hospital bed status to determine available capacity and then shares referral
Same day
The Navigation Hub will require every community hospital ward to maintain accurate EDDs for all inpatients that are reviewed daily on the MDT board round
Navigation Hub liaises with Community Hospital to confirm available capacity and agrees EDD
Same day
e-TOC sent to accepting community hospital ward. The information in the e-TOC is sufficient to also function as an acute to community hospital nurse/therapist handover
If no available D2RA P2.1 capacity within 24 hrs of MOFD, Navigation Hub adds patient to waiting list and projects likely EDD
Same day
A forward view of the next 72 hrs EDDs by community hospital ward will be required to identify the earliest potential transfer date.
Navigation Hub advises Acute Hospital ward (nurse in charge) of discharge details
Same day (ideally 24 hrs pre-EDD)
Discharge details:
Confirmed pathway
Destination (if D2RA P2.3 bridging)
Date of discharge
Time
Any special instructions – need for 4 weeks supply of all current medications (unless D2RA Pathway 2.3 bridging)
Acute Hospital Ward prepares patient for discharge (complete section 1 of discharge checklist)
Same day (ideally 24 hrs pre-EDD)
Acute Hospital Ward safely discharges patient (complete section 2 of discharge checklist) - to discharge lounge if possible
Morning of day of discharge
All D2RA Pathway 1 patients (even if going to D2RA P2.3 for bridging) are appropriate for the discharge lounge.


Community Hospital - Baseline assessment – nursing, therapy and medical (if latter required) – including medication reconciliation
Day of admission to CH
e-TOC referral will function as nursing and therapy handover document, along with CTM inpatient notes from Acute. E-TOC mobility and transfer info to be transposed onto whiteboard to reflect baseline patient needs/capabilities – nursing staff to use as initial mobility plan until first therapy review. Post-joint replacement precautions to be followed as necessary.
Patient reviewed on daily board round (as per SAFER) – any red delay codes apportioned and then addressed
Every 24 hrs
Ward MDT to follow:
SAFER board round scripts (7/7 rehab review)
Discharge policy action cards (daily rehab review)
Escalation card actions (Level 1 = good practice/business as usual)
Regular reviews throughout the recovery and assessment period will ensure that a clear exit strategy is in place, to avoid the person becoming 'stuck' in the intermediate care facility
If required, social care allocation within 2 working days of admission/receipt of referral and completion of assessment within 5 working days (SDT to support)
Within 2 and 5 working days of admission / receipt referral
e-TOC referral should indicate those patients who may need social care input – eg: pre-existing POC/care home LA-funded, known to social care, or e-TOC indicates may have social care needs despite rehab/reablement.
Doctor/ANP/Pharmacy undertake holistic medicines review for each inpatient
1-2 times each week
The medication review will include ensuring the correct dose/monitoring/interactions/ administration support needed
Nurses/ANPs to risk assess patients for ability to self medicate
Every day
Denote self medication level on the whiteboard and review daily.
Nurses/ANPs to effectively educate patients regarding their medication
Every day
For all self medication levels, counselling must be provided to ensure patient adequately understands their medication
Formal 2 week (day 14) MDT review – care adjusted and ongoing care plan agreed. All discharge assessments completed and clear discharge plan agreed (SDT to co-ordinate).
After 2 weeks in pathway
It is recommended that all individuals on D2RA Pathway 2.1 should be reviewed by the MDT after 2 weeks, so that the input can be modified in response to changing need/recovery. 'Home First' transfer to Pathway 1 (recovery and assessment in the person's own home) must be a consideration wherever possible. It should be clear at this stage which patients may need a longer term package of care and arrangements can then start to be made for this. This decision has been based on assessment and recovery out of hospital (key D2RA principle).
Patient discharged from D2RA pathway 2.1
Max LOS 21 days
At the end of the period of supported recovery and assessment, the next steps for the individual will be co-produced with them, their families and any ongoing support services.

Discharge to Recover then Assess (D2RA) Pathway 2.2 – Bedded reablement

Colour coding key

Colour of box	Definition
Blue	Acute Hospital ward based actions/process steps
Cream	Timeline within which to undertake/complete in order to prevent unnecessary delay(s) for the patient
Grey	Provides additional information related to the process step for addition guidance/context
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Acute ward - follow D2RA Pathway 2.1 identification and referral process

Pre-referral

The reablement approach supports people to do things for themselves. It is a 'doing with' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness.

Navigation Hub reviews e-TOC referral and validates patient for D2RA Pathway 2.2

Within 2 hrs of referral receipt

The e-TOC contains the right questions to identify needs for D2RA P2.2 and if completed accurately will result in minimising requests from the Navigation Hub for further information, and thus minimising any associated and avoidable delays. Patient has clear reablement needs (does not fulfil rehab definition) and can/has potential to meaningfully engage in reablement.

Navigation Hub reviews e-TOC referral and liaises with community hospital around immediate plans to support **reablement** needs and expedite a safe transfer

Same day

The reablement environment must be conducive to enabling patients to address their reablement needs – this may include availability of side rooms with ensuite/assisted bathroom, dedicated area for therapy support in relation to mobility/transfer, and a safe area to prepare basic food/drinks under supervision.

Community Hospital - Baseline assessment – nursing, therapy and medical (if latter required)

Day of admission to CH

Baseline assessment must identify what reablement support the patient needs in terms of daily activities of living and reflects “What matters to me”

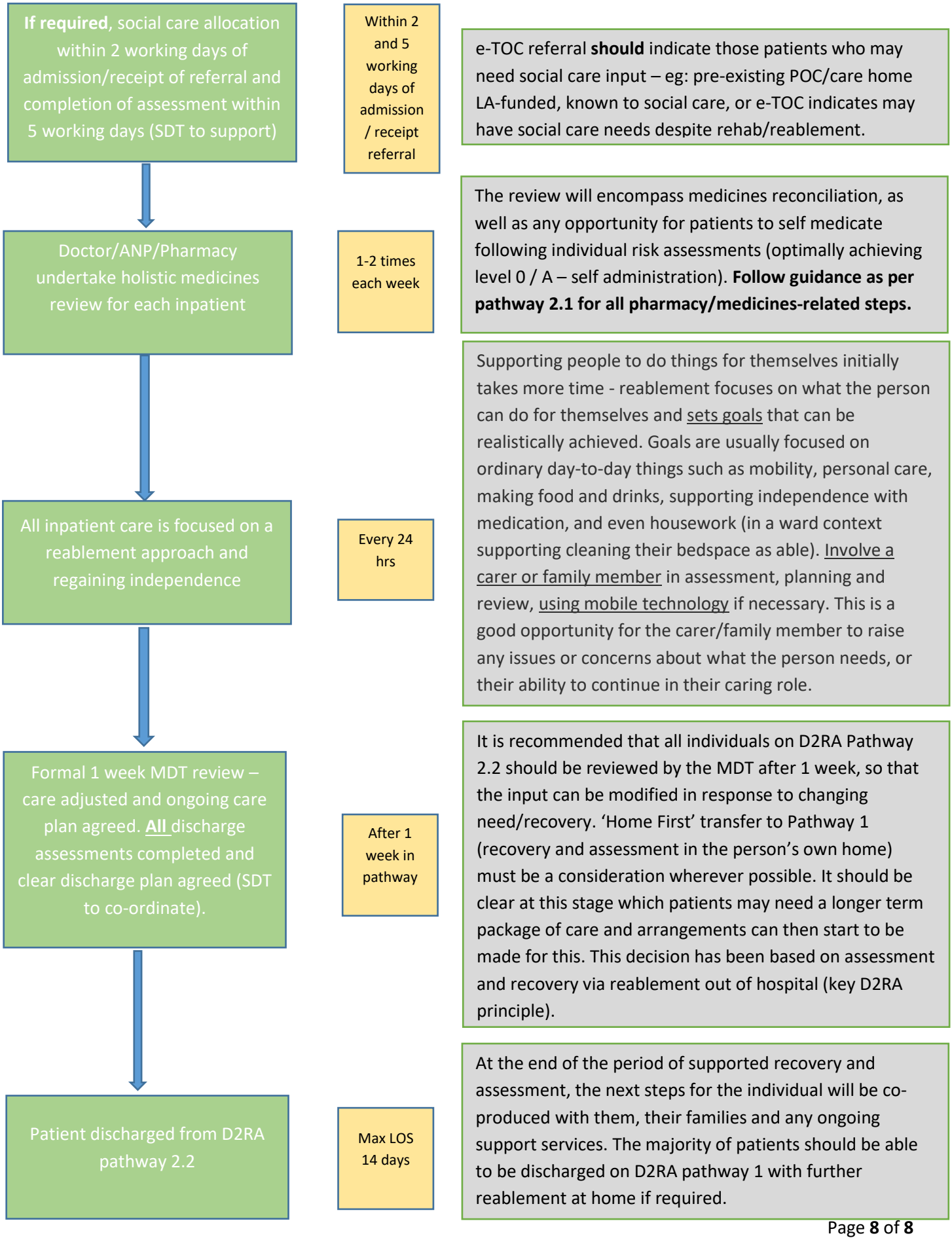
A plan to support and enable reablement needs agreed and implemented, and reviewed daily

Every 24 hrs

The reablement approach supports people to do things for themselves. It is a 'doing with' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness - to enable the individual to do ordinary activities like cooking meals, washing, dressing, moving about. Support workers are taught to stand back and allow the person the time to complete a task on their own. This may involve the person being shown a different way to carry out the task to achieve independence, such as putting the weaker arm with the least amount of movement into the sleeve of a top first. Support reablement by managing pain effectively and using mobility aids as required.

Patient reviewed on daily board round (as per SAFER) – any red delay codes apportioned and then addressed

Every 24 hrs


If required, social care allocation within 2 working days of admission/receipt of referral and completion of assessment within 5 working days (SDT to support)
Within 2 and 5 working days of admission / receipt referral
e-TOC referral **should** indicate those patients who may need social care input – eg: pre-existing POC/care home LA-funded, known to social care, or e-TOC indicates may have social care needs despite rehab/reablement.
Doctor/ANP/Pharmacy undertake holistic medicines review for each inpatient
1-2 times each week
The review will encompass medicines reconciliation, as well as any opportunity for patients to self medicate following individual risk assessments (optimally achieving level 0 / A – self administration). **Follow guidance as per pathway 2.1 for all pharmacy/medicines-related steps.**
All inpatient care is focused on a reablement approach and regaining independence
Every 24 hrs
Supporting people to do things for themselves initially takes more time - reablement focuses on what the person can do for themselves and sets goals that can be realistically achieved. Goals are usually focused on ordinary day-to-day things such as mobility, personal care, making food and drinks, supporting independence with medication, and even housework (in a ward context supporting cleaning their bedspace as able). Involve a carer or family member in assessment, planning and review, using mobile technology if necessary. This is a good opportunity for the carer/family member to raise any issues or concerns about what the person needs, or their ability to continue in their caring role.
Formal 1 week MDT review – care adjusted and ongoing care plan agreed. **All** discharge assessments completed and clear discharge plan agreed (SDT to co-ordinate).
After 1 week in pathway
It is recommended that all individuals on D2RA Pathway 2.2 should be reviewed by the MDT after 1 week, so that the input can be modified in response to changing need/recovery. 'Home First' transfer to Pathway 1 (recovery and assessment in the person's own home) must be a consideration wherever possible. It should be clear at this stage which patients may need a longer term package of care and arrangements can then start to be made for this. This decision has been based on assessment and recovery via reablement out of hospital (key D2RA principle).
Patient discharged from D2RA pathway 2.2
Max LOS 14 days
At the end of the period of supported recovery and assessment, the next steps for the individual will be co-produced with them, their families and any ongoing support services. The majority of patients should be able to be discharged on D2RA pathway 1 with further reablement at home if required.