

Discharge to Assess Model

The 'Discharge to Assess' model is intended to ensure speedy discharge from hospital to home and to deliver assessment in the best place.

People often function differently in their own home than in the hospital environment. The hospital environment is recognised as an institutional and alien setting that can disable people, limiting their opportunity to manage core activities of daily living independently. People are more relaxed in their own home, they know the environment well, are comfortable and the balance of power is more equal.

The principles underpinning the 'Discharge to Assess' model are:

- Patient identified on ward as requiring community based services and as medically safe to transfer
- Speedy initial screening undertaken to identify core needs to support safe discharge
- Discharge to own home supported by the community based MDT
- Comprehensive assessment undertaken by MDT in person's own home

The inpatient process should take no longer than **3 hours** from the receipt of the notification by the discharge team managing the process (for social care needs this will be the hospital based social care team, for Intermediate Care needs this may be the social care team or Community Liaison Team also based in UHNNM) to discharge requirements being confirmed. The aim will be to achieve **same day discharge** as long as this can be achieved safely with all components present, is in the patient's best interests and that transport can be arranged within a safe time. These are:

- Care
- MDT
- Equipment – including provision for activities of daily living, continence etc.
- Medication

There will need to be an agreed point at which this cannot be safely achieved and the model ascribes to the principle that discharges after 8pm are not advisable. Referrals received after 3pm cannot be guaranteed as same day but will be next day

Once home, the person should be in receipt of the right services no longer than 7 days from discharge.

The diagram below sets out the process and time scales.



Discharge to Assess process and timescales

1

- Ward/Portal /social care team identify patient that requires community services to support discharge
- Notification completed by the ward and sent to the complex discharge team completed

2

• **Time scale - 3 hours from referral**

- Referral received, logged and allocated. Initial triage on receipt (1 hour)
- Allocated discharge worker visits patient on ward/portal (1 hour)
- Screening completed to ensure that provider of care receives essential information to support safe service delivery (1 hour)
- Essential documents completed (Transfer of Care form, Medication Form and Diary Sheet)
- Documentation forwarded to service provider (LIS/ICT)

3

• **Time scale - 1 hour from receipt of documentation**

- Service provider receives screening document
- Service provider confirms capacity and rota and confirms discharge (1 hour)
- Arrangements for time and day of discharge confirmed between service provider and discharge assessor

4

• **Time Scale: 7 days from discharge**

- Care provided on discharge
- MDT members identified dependent on needs (1 day)
- Comprehensive assessment completed (3 days)
- Assessment determines whether patient requires Enablement , ICT or long term care and support (on assessment completion)
- Assessor refers on to best service to meet needs (1 day of assessment completion)
- Person accesses appropriate service (2 days of referral dependent on availability)