DISCHARGE

Pathway 0

NO ADDITIONAL SUPPORT REQUIRED FOR DISCHARGE

- Fully independent – no further support required
- Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission.
- Patient returns to usual place of residence (including Care Home)
- Restart Package of Care (POC) with no changes
- Has pre-existing community services in place

GIG CYMRU NHS WALES

Click on the link to **Goal 5** where you will find the main documents

TO

Pathway 1

SUPPORTED HOME FIRST

- Patient returns to usual place of residency with short term support.
- Preventative services delivered in collaboration with third and voluntary sector organisations. e.g Meal provision, shopping, housing
- New POC or increase of existing package.
- Short term reablement to maximise independence.
- Assessment and some additional care and support (including therapy, nursing, Pharmacy, domiciliary care & new equipment). e.g Community Resource Teams
- Safe between calls/ overnight.

RECOVER

Pathway 2

SHORT TERM SUPPORTED FACILITY

- Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to return safely home.
- Unsafe to be at home overnight/between care calls.
- Currently needing some care (eg: ADL) support/ intervention 24/7
- Includes specialist rehab. (e.g Stroke, Neuro, T&O)

ASSESS

Pathway 3

COMPLEX SUPPORT

- Patient is transferred to a new long term bed, assessment bed or usual residence and receives the complex support and/or assessment for their needs.
- Complex/significant health and/or social needs in usual residency.
- Significant change requiring new placement.
- Longer term placement
- Life changing health care needs
- Complex end of life or mental health needs.