GIG CYMRU NHS WALES

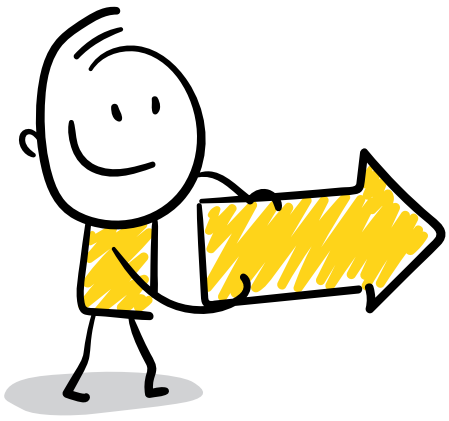
D2RA

PATHWAYS

D2RA PRINCIPLES

What is D2RA?

- Discharge to Recover and then Assess is based on the principles of effective and timely discharge home, ensuring we focus on the "what matters" to our citizens and how we work together with them, to achieve the best outcomes possible for the individual.
- D2RA was launched in Wales in 2019. "Recovery" was embedded as a core principle of the D2RA model in Wales to reflect the importance of a brief 'settling' period before conducting meaningful assessments outside of an acute hospital setting.
- The launch of the 6 Goals for Urgent and Emergency Care Programme in April 22 provided the opportunity for Goal 6 – Home First to progress a review and embedding of D2RA pathways.
- D2RA pathways have been simplified and aligned to the work of Goal 5 - Optimising Hospital Flow, SAFER and Red to Green. This reflects the evolutionary approach to the sustainable implementation of D2RA throughout Wales.
- D2RA, encompassing the terms 'Home First'/Discharge to Assess/Hospital to Home while familiar requires further embedding in practice across Wales. The original pathways have been amended following feedback from users and have been simplified into just 4 (as opposed to the previous 5) pathways.
- As with all transformational change, embedding the D2RA model will require ongoing passion, commitment and adaptation, if we are to truly and transparently deliver the best experience for the people we serve.
- This document also briefly sets out proposed mechanisms to support that continuous development, and to ensure we have the best resources in the right places to make it effectively happen through a phased implementation plan.
- All patients with a decision to admit to a hospital should be assessed and provisionally allocated to one of 4 pathways. This will identify early in a patient's admission what level of support and recovery they will need at the point of discharge to best meet their ongoing care needs. It provides a common language across health and social care and helps to reduce delays and ensures care is given in the right place, first time. The D2RA Model is supported by policy, 'A Healthier Wales – long-term plan for health and social care' and contributes to the whole system flow.



Phase 1

- All Adult inpatient wards excluding specialist inpatient Mental Health and Learning Disability wards

Phase 2

- For further review and engagement:
  - Specialist in patient Mental Health and Learning Disability wards
  - "Front Door" services such as Emergency Departments (ED) and Same Day Emergency Care Units (SDEC)
  - Day Surgery
- Think 'Home First' and keep the individual at the centre of all discharge considerations. The primary motivation for implementing the D2RA model in Wales is to achieve the best outcomes for each individual we serve, and working with them to assess the need for any ongoing care outside of an acute hospital setting. Those outcomes will only be achieved if we truly respond to 'what matters' for them. As professionals we need to recognise that 'what matters' is highly likely to include more than the medical management of their conditions alone.
- Balance risk and agree co-produced, clearly documented plans. With the best intent, health and social care professionals can be 'risk averse' and aim for their view of perfection in an individual's condition, circumstances or environment, before a safe discharge from hospital can be completed. It is essential therefore that D2RA plans are developed with the individual, following an initial strengths-based assessment and mature conversation regarding positive risk taking. The plans must include the contingencies to be implemented promptly if the individual's needs or circumstances change.
- Have the community services infrastructure in place to ensure that proportionate 'wrap around' support and/or equipment to aid recovery is provided in a timely and consistent manner, wherever the individual may live in Wales.

Communicate

- Even the best plans are meaningless unless they are communicated and shared with the people (including unpaid carers) who will be providing support once the person is home.

Process for using D2RA principles within the hospital setting

There are 4 key questions to ask on the board or ward round for patients who may require community support for discharge:

1. **Does the patient actually need any new care support at home? (i.e.: "What matters to me")**

   If they can manage their care needs independently or with informal carers, or they are returning to an existing package of care/care home with no change, or just provided with simple equipment that does not require intervention or review then the ward can manage the discharge independently (pathway 0 – No change in care needs and/or additional support required for discharge).

2. **Why not D2RA ?**

   D2RA should be the default supported discharge position.

3. **Is the patient physically/cognitively safe between visits/overnight. Discuss with Supported Discharge Team if unsure**

   YES = **D2RA pathway 1** ('supported home first' - home with support – health/ social care)

   NO = Ask Q 4

4. **Can the patient meaningfully engage in rehab/reablement?**

   This needs to be a positive shared decision which involves the patient, families and carers.

   YES = **D2RA pathway 2** (rehab/reablement 'supported discharge' community bed – patient can actually/potentially meaningfully engage in rehab/reablement)

   NO = **D2RA pathway 3** (complex supported - likely long term care needs, but further assessment outside acute hospital, can still be considered for Reablement where circumstances support)

- All patients should be allocated to an initial proposed D2RA pathway within 24 hours of a decision to admit.
- This needs to be recorded and discussed with the patient and their family/Carer as soon as possible.
- **D2RA** principles need to be used in conjunction with **SAFER** and Red to Green and should be part of the conversation at ward board rounds. The proposed D2RA pathway must be reviewed daily to reflect any changes in the patient's condition/ recovery whilst in hospital.

All discharges need to be timely with the minimum possible delays for leaving the ward.

- Pathway 0; once a patient has been deemed to be clinically optimised, a discharge should be within 2 hours.
- Pathways 1, 2 and 3; Once a patient has being deemed clinically optimised, they must be discharged or transferred to their next stage of care as soon as possible or from 48 hours any delay needs to be coded to the Pathway of Care Delays and escalated to ensure discharge or transfer can happen in a timely manner.

THE PATHWAYS

D2RA PATHWAY 0

No Additional Support Required For Discharge

Pathway 0 is for those individuals who do not require any further community care support to leave hospital than when they arrived, whether at an emergency department, assessment areas or as an inpatient.

- Adopting a home first principle, enables people to leave hospital safely when they no longer need acute hospital care and supports a timely discharge. These should be viewed as 'simple' or 'routine' discharges that ward staff should be able to independently manage, and can apply to the majority of people needing to leave an acute hospital setting.
- For patients within emergency departments and acute assessment areas, if unsure that the patients' needs have changed, a rapid multidisciplinary team (MDT) assessment should be undertaken within these areas, to avoid full hospital admission and to support a return home with pre-existing community arrangements in place. Please refer to your local community liaison at the front door at the earliest opportunity to ensure a timely intervention to get the patient Home First.
- For patients with an existing service such as a package of care, every ward board round must consider the notification period to restart the existing services and take appropriate action to ensure the patient is able to be discharged in a timely manner with those services in place.
- For inpatients, support timely discharge from an inpatient setting once clinically optimised for those who do not require any support following discharge or any increase in support they were receiving prior to arrival. Patients should leave the ward within two hours of the clinically optimised decision. Where feasible, all discharge tasks must be undertaken with the aim of getting patient's 'home for lunch'.
- Apart from acute assessment areas, the majority of discharges should be expected and planned for as early as possible to ensure a timely discharge.

People who fall within this pathway include but are not limited to:

- Fully independent – no further support required
- Patient returns to usual (same) place of residence (including Care Home)
- Restart Package of Care (POC) with no changes
- Has pre-existing community services in place that do not require changes
- Patients who require new simple equipment with no further review.

What good looks like:

- Timely discharge home with needs met.
- Plans for discharge were enacted early with patients confident their discharge needs are met.

D2RA PD2RA PATHWAY 1

Supported Home First

People are able to return home with new or additional care packages of support from health and/or social care and be promptly assessed in their own environment to then inform any additional care package of support from health and/or social care. This includes people requiring intensive support or care at home that can be safely implemented.

Every effort should be made to follow home first principles, allowing people to recover, reable, rehabilitate or die in their own home.

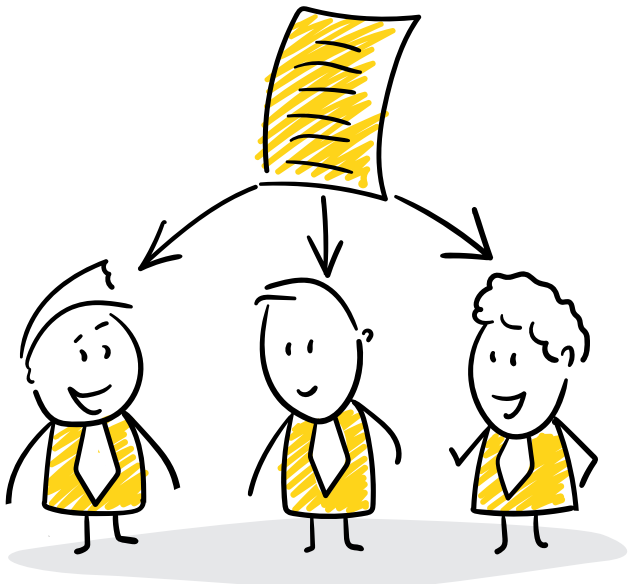
D2RA Pathway 1 should be initiated as soon as treatment is complete in an acute hospital environment (clinically optimised). It is predicated on NOT assessing needs in hospital (we see patients 'at their worst') for longer term support, and thus enabling meaningful assessments at home, in an environment familiar to the patient.

Pathway 1 is designed to support combined inter-agency efforts and existing workstreams for the prevention of avoidable hospital admission and early in patient discharge of patients, where additional wrap-around support is required to do this safely.

People who fall within this pathway include but not are not limited to:

- Patient returns to usual place of residency with short term support.
- Preventative/supportive 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 which requires review). E.g. community resource teams
- Safe between calls/overnight.

To ensure the right services are in place please refer to your local discharge arrangements and teams which would include e.g. Community Liaison/Trusted Assessor/Integrated Care Hub/Single point of access to enable assessment of need at the earliest opportunity to prevent pathways of care delays.



The 'what good looks like' process for D2RA Pathway 1 is as follows:

- Any existing plans, including Anticipatory and Advance Care Plans, will be conveyed to hospital with the patient or electronically. These plans will be actively used in the discharge planning process.
- An early 'What Matters to Me' conversation should take place as soon as possible during admission, ideally on first contact in the hospital. What matters to the individual will be clearly communicated and will form the basis of all multi-disciplinary discussions regarding discharge.
- During the hospital admission/episode, the ward team will use the information provided to minimise risks of avoidable delays in discharge planning/decision making and the related risks of clinical deconditioning.
- The principles of good discharge planning will be adhered to, including ongoing dialogue with the individual and their families (answering the 4 Questions) and the implementation of **SAFER**.
- **D2RA** Pathway 1 will be the default pathway for any individual deemed likely to need new or additional support at home during their recovery period, and/or on a longer-term basis.
- Patients discharged from hospital may need short-term practical support to get back on their feet. This can include for example third sector support such as putting the heating on, settling back in, shopping, washing etc.
- By asking the 4 **D2RA** questions, having the "what matters" conversations, and referring to the pathway 1 criteria, ward teams should be able to determine suitability for pathway 1. Where individual patients appear more complex, there is benefit in a trusted assessor attending the MDT board round to help assess the minimum requirements needed to take the individual home on **D2RA** Pathway 1.
- The rapid review, information gathering and proportionate assessment will be used to co-produce the individual's initial Discharge & Recovery Plan, alongside the community team that will be providing the wrap-around support.
- The full plan and assessment will be developed once the individual is at home. However, the following information must be clearly conveyed to the individual/their family/carers prior to discharge.
- The wrap-around support will be co-ordinated by the care coordinator or a trusted assessor and will be:
- Timely (i.e. available within 48 hours of the individual being clinically optimised)
- Proportionate and focussed on recovery (there is evidence that care and support is currently often over-prescribed);
- Time-limited and subject to timely review to determine any long-term care and support provision.

D2RA PD2RA PATHWAY 2
Short Term Supported Facility

People are supported in a short-term facility to enable recovery, rehabilitation, reablement, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Continue to think 'Home First' and only use D2RA Pathway 2 if D2RA Pathway 1 has been ruled out (i.e.: the patient is not currently physically/cognitively safe between care visits/ overnight, and/or currently has 24 hour care needs). 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 and require intermediate care. 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.

People who fall within this pathway include but not are not limited to :

- Patient is transferred to a non-acute bed and receives rehabilitation/reablement and assessment until able to return safely home.
- Unsafe to be at home overnight/between care calls.
- Currently needing some care support/intervention 24/7
- Includes specialist rehabilitation. (e.g. Stroke, Neurology, Trauma and Orthopedics)

The 'what good looks like' process for D2RA Pathway 2 is as follows:

- Intermediate Care facilities must provide the right environment to maximise recovery and independence. Bedded intermediate care can be delivered in a Community Hospital, in-house local authority facilities, Extra Care or in beds commissioned from independent /third sector providers. It is essential that the chosen environment truly supports recovery by:
- Providing the opportunity for self-care, including independent access to kitchen, beverage stations, and areas for walking etc.; and
- Employing staff who are suitably trained and experienced in rehabilitation and reablement, and who have an enabling ethos. This must include appropriate therapeutic input, which may be provided on an in-reach basis.
- Individuals on this Pathway should be regularly reviewed and, where appropriate, transferred onto Pathway 1 as soon as their recovery permits. Community hospitals/ care homes/teams need to use the 'What Matters to Me' conversation to agree a clear recovery plan, including realistic goals set to support transfer to pathway 1
- The principles of good discharge planning will be adhered to, including ongoing dialogue with the individual and their families (answering the 4 Questions) and the implementation of SAFER.
- D2RA Pathway 2 will only be considered once Pathway 1 has been ruled out. Potential reasons for ruling out Pathway 1 include:

- The individual requires closer observation and/or more frequent intervention than can be provided by periodic intervention calls during the day;
- The individual has night-time needs greater than could be met with intervention calls or short-term night-sitting.
- A clear Recovery and Assessment Plan will be developed, including goals and outcomes agreed with the individual. The purpose of the transfer on to **D2RA** Pathway 2 will be clearly communicated, ensuring that the individual and their family understand that this is a period of supported recovery, designed to help them retain as much independence as possible and return home to their usual place of residence.
- The Trusted Assessor/Care Co-ordinator will:
- liaise with the Intermediate Care facility to ensure that all parties agree that: The individual's needs can be met in that environment; and The Recovery and Assessment Plan can be delivered, with in-reach from community services. Note: Where **D2RA** Pathway 2 is to be delivered in a care home environment, registered providers will be required to meet their regulatory requirements and undertake the relevant assessments before agreeing transfer, ideally using a trusted assessment approach to reduce delays in transfer.
- ensure that all the necessary arrangements (including transport, medication, dressings etc.) are in place for transfer to take place within 48 hours (maximum) of being clinically optimised.
- be responsible for ensuring that the arrangements are clearly communicated to the patient, their family, the Intermediate Care facility (Community Hospital or commissioned care home) and any services providing in-reach support.
- The detail of any in-reach support will be clearly articulated, and include:
- The professions involved;
- The frequency of input;
- Dates for review.
- All individuals on **D2RA** Pathway 2 should be reviewed by the care coordinator/ MDT after 2 weeks, so that the input can be modified in response to changing need/recovery, all discharge assessments have been completed and a discharge plan agreed. 'Home First' transfer to D2RA Pathway 1 must be effected wherever possible. The in-reach team will follow the individual home and provide continuity of support and relationships.
- 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. Ideally patients should be 'stepped down' from **D2RA** pathway 2 within 21 days or less.
- Towards 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.

D2RA PD2RA PATHWAY 3
Complex Support

People who require complex 24-hour support includes people discharged to their usual place of residency, a care home for the first time, existing care home residents returning to their care setting with an increased change in needs.

Those discharged will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs outside of an acute hospital setting

People who fall within this pathway include but are not limited to :

- 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 e.g. a catastrophic event such as a major brain injury.
- Complex end of life or mental health needs.

D2RA Pathway 3 should be initiated as soon as treatment, which can only be delivered in an acute hospital environment, is completed and only if both Pathways 1 and 2 have first been ruled out as inappropriate for the individual's level of need. 'Home First' will always be the first consideration.

D2RA Pathway 3 is designed to support people before being meaningfully assessed for any ongoing need, in order to:

- Avoid further deconditioning and loss of confidence in hospital;
- Minimise exposure to in-patient infection risk;
- Maximise any possible recovery and independence;
- Provide an appropriate pathway and environment for further assessment where the patient is/has been unable to meaningfully engage in rehabilitation/reablement at the point of discharge
- Provide a seamless transfer to longer-term support in the community (including home with support), if required.

Some patients may benefit from a short period of time in D2RA pathway 2 before being progressed via pathway 3 and this should always be considered as a first option. Where it appears likely that an individual may require a care home placement, for example where an extensive package of care at home is no longer meeting their needs, they should still be offered the opportunity to recover and optimise their potential for independence in a calmer, more conducive environment than the acute hospital, and first be given an opportunity to see if they can meaningfully engage in rehab/reablement (D2RA pathway

2). This will provide a more accurate assessment of their level of need and important time for psychological/emotional support (for the individual and their carers) if placement is determined as the most appropriate discharge destination from the **D2RA** pathway.

The 'what good looks like' process for D2RA Pathway 3 is as follows:

- During the hospital admission/episode, the ward team will use the information and advice provided by the family, carer or care home to minimise risks of deconditioning and inform discharge decisions. The principles of good but proactive discharge planning will be adhered to, including multi-disciplinary team discussions to confirm suitability for **D2RA** Pathway 3, ongoing dialogue with the individual, their families and then making appropriate pathway referrals.
- The need to access advocacy should always be considered as per national policy, this support must be identified and actioned as soon as possibly (and well before the patient being declared clinically optimised) in order to prevent avoidable delays to discharge.
- Prior to transfer, the individual, trusted assessor/care co-ordinator and facility manager will participate in relevant assessments in order to co-produce an agreed plan
- Particular attention must be taken to ensure that individual's health and wellbeing needs will be fully met on D2RA Pathway 3 by providing:
- Contact details for the trusted assessor/ care co-ordinator, social worker and planned support services.
- Follow-up appointments.
- Details of roles and responsibilities for the recovery period and, following this, the assessment of need. Facility staff will have a key role to play in the assessment process, using the strengths-based approach.
- The co-ordinator will ensure that the facility or usual place of residence is provided, before or at the time of transfer, with the necessary equipment, medication and disposables (e.g. disposable wound care dressings) to support the individual whilst on **D2RA** Pathway 3.
- **D2RA** pathway 3 patients often need a period of time to 'settle' into the new environment before assessments are started.
- During their period of supported recovery and assessment in **D2RA** Pathway 3, the next steps for the individual will be agreed with them, their families, the facility and the relevant support services.
- For patients that are discharged to their own home environment, are in receipt of complex care e.g. ventilated care, the care coordinator will ensure all identified health and care needs are covered by a comprehensive package of care and support at home.

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.