What pathway is your patient on?

Pathway 0 - No additional support

- Fully independent - no additional support required
- OR restart of existing services

0 → Patient returns to usual place of residence (including care home)

Pathway 1 – Additional support at home/usual residence

- Assessment and some additional care and support (including therapy, nursing, domiciliary care, new equipment)
- Safe to be at home/usual residence

1 → Patient returns to usual place of residence with interim support

Pathway 2 – Rehab +/- reablement in a temporary bedded setting

- Short term bedded rehabilitation +/- reablement and assessment
- Unsafe to be at home/usual residence
- Includes specialist rehabilitation bed

2 → Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to safely return to place of residence

Pathway 3 - Complex

- Complex/significant health and/or social care needs
- Longer term placement
- OR Complex support in usual residence
- OR Significant change in need requiring new placement

3 → 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

Discharge to Assess

Ward led

IDT led

Further discharge pathway information

Pathways are determined by discharge destination and level of patient need

Pathway	Details
Pathway 0 – Simple discharge • Discharge home / usual place of residence • Discharge back to care home • Restart packages of care	• Largest majority of discharges • Restart of existing package of care with no change • May include routine community nursing • Discharge home with family or unpaid carer • May require access to settle @ home services including Meals on Wheels
Pathway 1 – Support to recover at home • Patient returns to usual place of residence with interim support	• Discharge to Assess pathway (Responsive Services / JCR) • New care package required or existing care package increase • Temporary reablement to maximise independence • Nursing / therapy assessment / intervention, eg new equipment or new community wound care
Pathway 2 – Rehab/reablement in a bedded setting • Patient transferred to non-acute bed for period of rehab/reablement • Patient transferred to non-acute setting for a period of assessment of ongoing needs	• Short-term rehabilitation to maximise potential • Bedded assessment for health and/or care needs in order to return home • Bedded assessment for health and/or care needs in order for a new home/usual place of residence to be determined • Specialist rehabilitation • As examples, SCFT community rehab bed, D2A bed, dementia assessment beds, Sussex Rehab Centre, delirium pathway, non-weight bearing needs
Pathway 3 - Complex • Majority of patients are no longer able to return home and require a long term placement (include health, social care or self-funding placements) • Life changing event • A small number may return home with significant support	• New long term care home placement (nursing or residential) • Complex Continuing Healthcare needs Examples of this pathway may be: • Complex End of Life Care • Complex mental health needs • Complex housing and homelessness needs • Live in or more than QDS POC with multi-professional input