What are the benefits to me?

Being discharged into a residential or nursing home setting enables an assessment to be undertaken in a more appropriate environment to hospital. It removes the risk of hospital acquired infections. It also reduces the chances of developing confusion, further loss of mobility and independence.

Assessment and support will focus on maximising your independence and will ensure you are able to lead discussions regarding your own Health and wellbeing.

What will happen when I arrive at the care home placement?

A member of the discharge to assess team will make contact within 2 working days of placement.

During this initial visit, the following will be discussed: the individuals wishes and goals following discharge, including their intention to return home, reablement goals/potential, professional involvement required, and care and support required.

The Discharge to Assess team will support with short term reablement goals, working alongside the Care Home and DTA MDT as required.

Whilst we will always try to support people to return home, in some cases it may be necessary for people to remain in residential or nursing homes. Where this is identified longer term support will be discussed and can include continuing health care funding, adult social care funding, individuals self funding or contributing to their care, or access to other services and facilities, including universal services.

How much does the service cost?

Being placed on the Discharge to Assess pathway is funded by Health and Social Care for Plymouth, and is a free service. However, if you are identified as having long-term needs at any point during this service, you will be assessed to financially contribute to the care provided for your long term needs.

How long will this service last?

The timeframe for DTA support is based on identified short term reablement goals. The duration of this service will be discussed with individuals and reviewed throughout involvement from DTA.

Can I refuse this service?

Yes, if you are able to make an informed decision around your discharge from hospital you are able to decline being discharged home via Discharge to Assess.

We would recommend individuals and/or families discuss with staff on the ward initially, or where appropriate the Integrated Hospital Discharge team.

Useful Contact Numbers;

Integrated Hospital Discharge Team (IHDT) - Tel: 01752 434747

Discharge to Assess Team (DTA) - Tel: 01752 435860

Plymouth Adult Social Care - 01752 306900

Livewell Southwest

Discharge To Assess

Homefirst and Bedded

Information for individuals and families

My allocated worker is: -

What is Discharge to Assess?

Discharge to Assess (DTA) is a way of relocating people in hospital who are waiting for an assessment or a care plan, to a more appropriate setting where these assessments can take place.

Whilst the hospital is a safe environment for people who need an acute hospital bed, it is usually not an appropriate environment for people who are medically fit to leave . People who do not medically need an acute hospital bed are at risk of infection, and of deteriorating health through muscle wastage. It is therefore considered safer for such people to be discharged to a more appropriate environment for on-ward care assessments to take place.

Who are the Discharge to Assess team?

A multi-disciplinary team of Nurses, occupational therapists, physiotherapists, business support staff, therapy support workers, social workers and community care workers.

How does the service work?

Discharge to Assess means that you will be medically discharged from the hospital, and relocated into the community. Wherever possible this will be back to your home, although in some instances you may need to go to a residential or nursing care home.

The Discharge to Assess Team will then undertake an assessment and if appropriate, arrange short term, reablement focused support based on goals that are agreed with you.

Why am I being offered this service?

The hospital teams know you are medically stable and well enough for this service. They believe you may avoid a potentially lengthy stay in hospital by being supported via Homefirst or Bedded (residential of nursing home) pathway.

What is Homefirst?

Homefirst brings people out of hospital once they are no longer acutely unwell so that assessments can be done in the comfort and safety of their own homes.

What are the benefits to me?

We know going home improves an individual's health and wellbeing, and ability to gain or regain independence. We will ensure you lead discussions about how best to achieve your goals. It removes the risk of hospital acquired infections. It also reduces the chances of developing confusion, further loss of mobility and independence.

What will happen when I get home?

You will be visited by a DTA 'responder'. This may be an Occupational Therapist, Physiotherapist, Nurse, Social Worker or Community Care Worker. The responder will complete an assessment, order any necessary equipment and identify if care support is required. They will identify and agree with you short term goals to help you towards living as independently as possible, and will coordinate the Multi-disciplinary support you need to do so.

If your care needs appear to be long term rather than short term we will discuss your longer term care needs – this will involve a financial assessment and you may have to pay towards your care at this point.

Who are Independence at Home Reablement (IAHR)?

The DTA team work closely with IAHR who are a provider of reablement care. Following agreement of your short term goals, and if required, the DTA responder will arrange for care workers from IAHR to support to you regain the skills and confidence needed to promote your independence. The DTA team will be responsible for liaising with IAHR reablement to review progress and adjust your plan accordingly.

What is the Bedded pathway?

Bedded (or Placement) based discharges, enable individuals to leave hospital when they are no longer acutely unwell, but perhaps not able to return home at this time. The decision around whether someone is able to return home, is decided by a multidisciplinary team (MDT) within hospital and agreed with the individual or appropriate representative. This decision gives consideration to whether someone's care and support needs can safely be met in their own home, at this time.