Joined Up Care Derbyshire

Discharge to Assess

Edition: 1
August 2018

What's the D2A data showing us?

The latest data for April and May 2018 showed a total of 729 people had left hospital on a D2A pathway (194 from Chesterfield Royal and 535 from Royal Derby). Overall, 41% of people left hospital and returned to their own home as planned (Pathway 1) and there were just 4 occasions where someone was moved to a different pathway.

A total of 141 people (19%) left hospital to be assessed in a social care setting (Pathway 2), but this was lower than the expected 319. There were a number of reasons as to why this was the case, but the main reasons for a change were due to the mobility needs and level of support required by the individual. Finally, there were 291 people (40%) who went in to a Community Hospital for their ongoing assessment (Pathway 3).

Further work is currently underway to understand what happens to people on the pathways- types of interventions, duration of assessment period & the outcomes following the assessment period.

If you require any further details please contact
james.chisholm@nhs.net

D2A Guidance

Feedback from staff at a number of D2A development workshops suggested that there was a lack of shared understanding across services regarding what the Derbyshire D2A Model is. The D2A Guidance has been developed to clarify the model and how the pathways should work.

Click here to view.

Patient Story

Mr A required Pathway 2 due to risk of falling between care calls at home, mobilising with hand support, requiring assistance with all personal care and ongoing memory issues. Mr A was transferred to Florence Shipley.

Mr A and his son were keen for him to return home as this has always been his goal.

Mr A appeared to settle well, accepting of all care and participated well with therapy. He was mobile with a zimmer and supervision of 1 on admission; once this had improved he was trialled on the stairs but struggled due to these being very different to home. He agreed to complete a home visit. Once home he was observed to be safe in his own environment using furniture to aid mobility and demonstrated that he was safe on the stairs and independent with all transfers. He was receiving limited care through the night but his son agreed to trial Mr A at home with him staying over to ensure he was safe. Following this trial at home, Mr A was returned by his son to Florence Shipley. His son raised no concerns and advised that his father was able to mobilise around his property, slept upstairs and was able to access the toilet independently during the night. The Community Psychiatric Nurse advised that Mr A had not completed meals or drinks independently for approx. 6 months prior to his admission. He agreed to have a Package of Care in place for discharge- dementia re-ablement service then came in to assist with personal care in the mornings to get him used to the care he would receive at home. He returned home with four calls from the dementia re-ablement team.

Mr A and son were incredibly grateful to the team for getting him home- at present he is safe on the stairs and mobilising using the furniture alone at home. The son and Social Worker are aware to contact us at any time to discuss any concerns. We have made no changes to his home environment but agreed to return if needed.

If you have a story which you wish to share – please forward this to anne.wilson31@nhs.net

Medequip - D2A & TCES Orders

As part of the monitoring of the D2A Pathways new Reasons for Placing Orders are shown as part of the drop down menu on TCES (see picture below). Please choose the appropriate Pathway on which the client is placed to Facilitate Hospital Discharge, if not part of D2A just choose Facilitate Hospital Discharge.

Feedback

We are always looking to improve the content of our newsletters so if you would like anything including in future additions please email:

anne.wilson31@nhs.net