TRANSITIONAL CARE PATHWAYS

RECOVERY AND REASSESSMENT PATHWAY
Medium to High Complexity

Support at Home
Community Hospitals
Residential or Nursing Homes

Individual requires a period of recovery (including non weight bearing) and / or assessment to determine ongoing needs and / or funding.

Short Term intervention
Step up or Step Down

Home should always be considered as the first option at the point of transfer.

Home is not an option but permanent residential care is not an inevitability.
or
A placement where patients needs are very complex and where long term nursing and or care is very likely.

Non Chargeable to the patient

REHABILITATION / REABLEMENT PATHWAY
Medium to High Complexity

Support at Home
Community Hospitals
Residential or Nursing Homes

Individual requires a period of rehabilitation, motivation, confidence building. Optimising individuals levels of independence

Short Term intervention

Step up or Step Down

Home should always be considered as the first option at the point of transfer.
or
Home is not an option but permanent residential care is not an inevitability.

Non Chargeable to the patient

LONGER TERM OR SPECIALIST PATHWAYS

ADULT CARE SERVICES
Medium - High Complexity

Brokered home care services
Residential and Nursing Homes

Individual has met their optimal levels and/ or is not going to make any further progress, therefore ongoing needs are identified and clear at point of discharge

Home is an option with a package of care.
or
Residential care home where long term care is very likely.

Chargeable to the patient (adult care)

Palliative Care Pathway
End of Life Pathways
Medium – High Complexity

Supported discharge home
Residential and Nursing homes
Community Hospitals
Hospice
Day therapies

Individual has palliative care needs and requires an identified level of specialist support on returning back to their usual place of residence

Individual has been identified as being 'end of life' and follows the Fast Track process

Non Chargeable to the individual

- **HOME First and Discharge to Assess are the key PRINCIPLES and apply to the Transitional Care pathways**
- **An individual has complex needs and requires community expertise and knowledge to remain at home or return home as soon as possible.**
- An individual who no longer requires acute hospital care is returned to their usual place of residence as soon as it's safe to do so.
- The community (Integrated Care Team) respond by ensuring the right skills and support are in place to assess, identify and meet the individual's immediate and longer term needs.
- **This principle will reduce the demand on adult care and Continuing Health Care (CHC) assessments to be completed in an acute setting, and will move the responsibility to the community.**