Discharge to Recover and Assess: *Home First*

A practical guide for discharge planning to achieve good patient outcomes

DELIVERING FOR QUEENSLAND

Queensland Government

Contents

Framework summary

Key messages

Queensland's public hospitals are facing significant capacity pressures, with reduced acute bed availability and discharge delays for patients who no longer require acute hospital care. These discharge delays are a complex, multifactorial issue, making timely transition out of hospital challenging.

Discharge to Recover and Assess (D2RA) is a patient-centred model that supports safe discharge home as soon as a patient is clinically ready, with recovery and longer-term care needs assessed in the community.

Evidence shows patients prefer to recover at home, achieve better outcomes and independence and have fewer complications.[1-4] When supported with high-quality home-based care, patients have a shorter hospital length of stay, reduced unnecessary re-admissions and this frees up critical bed capacity for incoming acute patients.[4-7]

This guide aims to introduce D2RA and a culture of "Home First", challenging organisations to reframe the language and default settings of care, placing home as the preferred and expected destination for recovery wherever safe and appropriate.

Introduction

Queensland's public hospitals are facing significant capacity pressures, with demand expected to continue rising. These constraints are contributing to delays and disruptions in patient flow, ultimately affecting timely access to care and patient outcomes.

To address current challenges, we looked for proven solutions to help Hospital and Health Services (HHS) across Queensland identify opportunities to improve patient flow and patient care. These models were originally developed by the United Kingdom's (UK) National Health Service (NHS) and have been adapted for the Queensland context, with permission:

SAFEST Patient Journey Home[8]

- Outlines 6 evidence-based principles designed to improve access to care, reduce delays and length of stay, and most importantly, achieve better patient outcomes.

Discharge to Recover and Assess (D2RA)[9]

- This patient-centred model supports safe discharge as soon as a patient is clinically ready, with recovery and longer-term care needs assessed in the community rather than in hospital.

Importantly, the introduction of D2RA represents a significant cultural shift, challenging organisations to reframe the language and default settings of care, placing home as the preferred and expected destination for recovery wherever safe and appropriate.

Purpose

This guide has been designed to assist Queensland Health's HHSs to drive change and support a consistent approach to implementing a D2RA framework.

This guide applies to any adult inpatient (over 18 years old; excluding maternity and mental health) discharging from a Queensland public hospital.

Where local HHSs choose to adopt a D2RA framework, the focus should be on home as the default discharge pathway. To establish long-term or ongoing care needs, comprehensive assessments should be completed following a short period of care and support.

Each HHS has a unique configuration of organisations, care delivery models and populations and will need to implement a D2RA model in a way that suits their local needs and population. This guide should be adapted as required, using a system-wide approach that combines all available resources (i.e. Queensland Health, Commonwealth, non-government organisations (NGOs), etc.).

Strategic alignment

D2RA aligns to Queensland's Department of Health Strategic Plan 2025-2029 in promoting:

Access

A consumer-centric healthcare system that recognises the impact of increasing demand and complexities of services.

Sustainability

Driving a sustainable model of health care to ensure an efficient, equitable, safe and quality service for patients.

What is Discharge to Recover and Assess (D2RA)?

D2RA is a person-centred model that supports safe discharge home as soon as a patient is clinically ready, with recovery and longer-term care needs assessed in the community. The goal is to discharge the patient to the right place at the right time with the right support.

This model provides guiding principles and practical operational foundational components to enable a "Home First" approach. It also provides the language to describe different pathways of care and a reframing of how we manage discharge coordination in Queensland.

What are the benefits of D2RA?

A core component of D2RA is the "Home First" approach. This approach prioritises discharging patients to their own home – wherever safe and appropriate – as the default pathway.

Evidence shows:

- patients not only prefer to recover at home, but also achieve better outcomes in familiar, supportive environments [1-4]
- assessments for ongoing care needs are more accurate when done at home rather than in hospital [5, 10, 11]
- high-quality home-based care services can not only improve patient outcomes and independence but also shorten length of stay, prevent unnecessary re-admissions, lower the risk of hospital-acquired complications such as infections, falls and loss of physical and cognitive function.[4-7]

It also frees up critical bed capacity for incoming patients requiring acute medical care and can reduce costs to the HHSs.[4, 6, 7]

D2RA core components

Patients should only stay in hospital while they are requiring acute care

Patients should only remain in an acute hospital whilst they are receiving treatment that cannot be delivered in any other setting.

To stay longer than this may have a detrimental effect on the patient and deny others access to care.

Assessments of long-term needs should not be made in acute hospital

Assessments of long-term or ongoing care and support needs should not be made in an acute hospital.

Such assessments will not fully reflect the abilities of patients and may well lead to the overprescription of care and support.

Home as default discharge location

Home (or usual residence) should always be the first option on discharge.

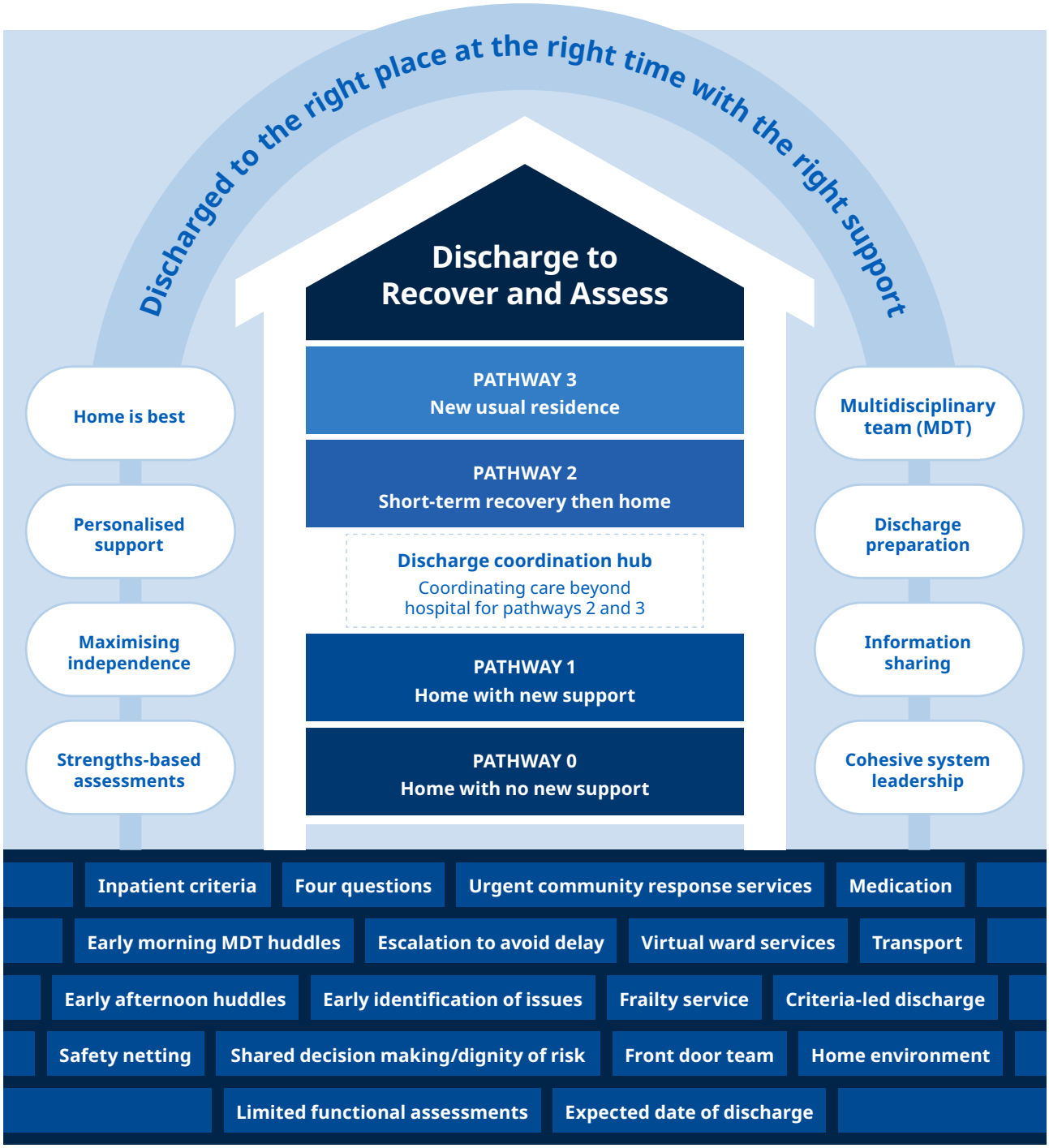
Post-discharge support

A time-limited period of therapy, care and support, should be provided to those who need it on discharge.

This should help patients maximise their independence and meet their personal goals.

Overview of guiding principles and foundations

Figure 1: Discharge to Recover and Assess



Guiding principles

The following principles should be used to guide the effective delivery of a D2RA model with the goal to discharge a patient to the right place at the right time with the right support.

Home is best

Home is best for 95% of older patients leaving hospital for recovery and any further assessment of needs.[5] Timely discharge from acute settings improves a patient's outcomes and reduces the risk of medical complications such as loss of independence, hospital-acquired infections and deep-vein thrombosis.[4, 5, 7] Evidence suggests that 10 days of bed rest leads to significant muscle loss in older adults.[12] See *Appendix 3* for patient stories.

Patients often respond well to the familiarity of their home environment and should, if required, be offered short-term recovery in the community. Discharging patients home requires active risk management to achieve a reasonable balance between safety and independence. Focusing on a "rights-based" rather than a "risk-based" approach can enhance hospital teams' ability to focus on patient needs rather than potential risk.

Personalised support

- Integrated, timely and personalised care rather than care that is convenient for individual organisations.
- Services that say "yes" and tailor their response to the needs of the individual.
- Patients with ongoing care needs can access community-based care and support.

Maximising independence

Many patients will benefit from a short, intensive period of post-discharge support aimed at reducing or eliminating longer-term need for care. Some research suggests that many patients receive more intensive care on discharge than they actually need. A study from the UK including 10,400 patients found that of the patients who experienced a delayed discharge, 32–54% were discharged to a setting where levels of care were not suitable for their needs.[13] Of this, 92% were receiving more intense care than they needed, suggesting a barrier to maximising their independence.[13]

Strengths-based assessments

A strengths-based assessment should be proportionate to the stage and recovery the individual has reached and should involve the individual (and others as appropriate). Assessment should be undertaken at the right time and in the right place to get an accurate picture of the patient's true long-term support needs. Focusing on describing the individual needs, not prescribing solutions. Decisions should be driven by choice, dignity and respect.

Multidisciplinary approach

Engagement of the multidisciplinary team (MDT) is essential to support effective discharge planning, enabling early identification and proactive management of potential barriers. Flexible multidisciplinary teams working with health, social care, housing, the private and voluntary sectors as early as possible creates a culture across organisations that enables personalised services to be wrapped around the individual.

Discharge preparation

Preparation for discharge begins at the point of admission or prior to, for elective admissions to ensure multiple and complex needs are identified early. A culture enabling a person-centred informed approach will enhance the working partnership with the individual and ensure appropriate planning and onward assessment to enable timely discharge.

Information sharing

Timely, high-quality discharge summaries are essential to support continuity of care and follow-up, including in primary care. The hospital should therefore provide accurate and comprehensive information about the patient to ensure that providers of onward care can safely and effectively meet their needs. This includes details about the patient's condition, their medications (especially if changes have been made), equipment needs, safety netting arrangements (see more information below), whether any existing services are to be re-instated, with whom and where follow-up appointments have been arranged, and contact details in case there is an issue or concern following discharge. This should also include information about their communication needs and care preferences (i.e. dementia, learning disability) and their family's or carer's details.

A discharge summary should be sent by the hospital to the patient's general practitioner (GP) on discharge, within 24 hours. It is also best practice to share the discharge summary with the patient on discharge. Patients being discharged to a residential aged care home (RACH) or other facility should have a discharge summary provided at the time of discharge.

Cohesive system leadership

Positive, collaborative system leadership with a clearly articulated vision, trust between partners, and a sense of mutual endeavour to solve problems and blur boundaries as necessary. Success is judged as a system, based on the outcomes achieved for individuals using services, not on individual organisational indicators.

Foundations

The foundational elements below support a practical approach to D2RA and form a framework that enhances patient flow and improves the patient experience. See Figure 1 for an overview of the foundational building blocks. Many of these elements are reflected in the SAFEST Patient Journey Home.

Inpatient criteria

Every acute patient should ideally be reviewed on a twice-daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made.

Requiring Intensive Care Unit or High Dependency Unit care? ✓
Requiring oxygen therapy/non-invasive ventilation (that cannot be provided at home)? ✓
Requiring intravenous fluid? ✓
QADDS >2 (Queensland Adult Deterioration Detection System) ✓
Diminished level of consciousness where recovery is realistic? ✓
Acute functional impairment in excess of home or community care provision? ✓
Last hours of life? ✓
Requiring intravenous medication (including analgesia) > twice daily or that cannot be delivered through an infusion device? ✓
Within 24 hours of an invasive procedure (where there is risk of acute life-threatening deterioration)? ✓
Clinical exception? Must be warranted and justified. Recording of the rationale will assist meaningful, time-efficient review. ✓

Consider the following questions to guide the clinical team's review and support effective decision-making.

- Is the patient medically optimised? Avoid phrases like 'back to baseline' or 'medically fit'.
- What management can be continued as ambulatory or outside the hospital? I.e. heart failure treatment or Hospital in the Home (HITH) for intravenous antibiotics.
- For patients with low QADDS scores – can they be discharged with suitable follow-up?
  - Can their oxygen needs be met at home?
  - They are stable and don't need frequent observations (i.e. every 4 hours).
  - They don't require any medical or nursing care after 8pm.

Look for alternatives

- If they are waiting for results, can they come back, or can you call them?
- Can any repeat bloods be done after discharge in an alternative setting?
- Can patients awaiting investigations go home and come back as an outpatient (with the same wait time as inpatients)?

Early morning rounds

Every ward in an acute hospital should have an early morning round attended by the MDT, including consultants, doctors, nurses, allied health and discharge teams. Every patient will be discussed, plans will be agreed and actions assigned.

See the Multi-Disciplinary Team Huddle Best Practice Guide.

Early afternoon huddles

Tasks allocated at the morning round should be reviewed by the MDT to ensure all actions are on track.

Dignity of risk and shared decision-making

When someone arrives in hospital they should be asked, 'What matters to you?' and 'How can we take account of that while you are in our care?'

This is vital information for the care record and planning. If they cannot answer for themselves then carers, family and/or friends should be asked, with patient consent where practicable. Some patients may also have:

- a Julian's Key Health Passport which sets out important details about how a patient communicates, as well as their support and care needs
- an Advance health directive which sets out their wishes.

Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment. The conversation brings together:

- the clinician's expertise, such as treatment options, evidence, risks and benefits
- what the patient knows best: their preferences, personal circumstances, goals, values and beliefs.

For more information on informed decision-making see: Guide to Informed Decision-making in Healthcare.

Where a patient has capacity to make decisions about what care and support they would like, they should be supported to manage any risks.

- Even if a professional disagrees with a patient's choice, if the patient has capacity to decide, they make the final decision.
- Where there is uncertainty about a patient's decision-making capacity, refer to *Appendix 1* for more information.

Patients should not be required to make decisions about long-term care while in crisis or in an acute hospital bed unless absolutely necessary.

Estimated discharge date (EDD)

Everyone who is admitted to hospital should be given this information as soon as soon as possible:

- The purpose of their admission.
- What will happen once their acute treatment is completed.

This should include their EDD and information about how and when discharge from hospital will occur. This should be estimated on the day of admission and be clearly documented (i.e. Kyra Flow (Patient Flow Manager))' for the MDT to see and be reviewed daily.

Criteria-led discharge

Every patient should have a clinical plan, with an expected date of discharge and clear criteria that must be met for discharge to happen.

- A nurse or allied health professional can discharge without a further review if documented criteria are met.
- A junior doctor can discharge without a further review if documented criteria are met.
- Clarification can be sought by contacting the consultant directly if criteria is only slightly out of range.

Please see the guideline on implementing Criteria Led Discharge (CLD) in Queensland.

Home environment

It is critical to capture information about a patient from the earliest point of contact with the hospital. For patients arriving by ambulance, information collected by the Queensland Ambulance Service (QAS) –including details of home circumstances, carers, family or social supports, property access, and any equipment in place–should be documented at the commencement of admission. For planned admissions, this information would be captured prior to admission.

This will help inform the safe transfer of care arrangements when they are ready to leave hospital.

Medication

A patient discharged from the ED should be provided with any medication prescribed within the ED and/or a prescription for the required medication, and information about any further action they need to take (e.g. contact GP, return for outpatient appointment, etc.).

A patient discharged from the ward should have their 'to take home' medication ordered in good time and delivered to the ward the day before discharge whenever possible. Medication management should include timely

medicines reconciliation, identification of medication changes, and clear communication of these changes to patients and onward care providers. Patients should be provided with clear instructions on how to take their medications following discharge, including any changes made during admission. This should include advice on dosage instructions, administration considerations (e.g. with food), potential adverse effects, interaction risks, and when to seek medical review. Patients at higher risk (e.g. polypharmacy, complex and/or high-risk medicines, or adherence concerns) should receive appropriate counselling and support prior to discharge, which may involve pharmacy where available.

Transport

The choice of options for transport home should start with family, carers, neighbours and friends. Volunteer or NGO services, taxis or public transport may be options.

Hospital transport should only be used when necessary, after all other options have been exhausted. For the few patients who do need non-emergency patient transport service, this must be planned and coordinated with discharge plans and booked with transport service *before* discharge. Some HHSs may consider reviewing their transport capacity and whether extending transport hours could prevent discharge delays.

Front door team

HHSs should establish a 7-day MDT within the ED. This would normally include nursing and nurse navigators, and allied health such as physiotherapy, occupational therapy, social work, and pharmacy staff . These clinicians can rapidly assess patient needs to inform discharge planning, including the appropriateness of referral to alternative care pathways, such as:

Rapid Access Clinics

Rapid Access Clinics (RAC) exist statewide and provide an alternative pathway for emergent new or returning patients, bypassing or diverting from ED to enable targeted management of unplanned presentations, reduce congestion and admissions, and improve patient experience with timely, appropriate care.

Urgent community response services

Urgent community response services provide care for people who do not require hospital admission and are more appropriately supported in the community (i.e. Post Acute Care Services (PACS), Multidisciplinary Avoidance and Post-acute Service (MAPS), voluntary/ community-based support services).

Hospital in the Home

Hospital in the Home (HITH) provides hospital-level care in a patient's residence and/or safe location as a substitute for inpatient care. Eligible patients should not be excluded if they can be treated safely outside the traditional inpatient hospital environment. Specialised models exist for the following care types (HHS dependent): acute, geriatric evaluation and management, rehabilitation, palliative care, maternity, mental health, and maintenance.

Four questions

The patient and their carers, family and/or friends should be kept updated about the plan for their care, treatment and discharge throughout their hospital stay.

These 4 questions are a great way to test if this is happening:

1. What do you understand about the main reason you are in hospital, and what are you most concerned about?
2. What do you understand about what is planned today and tomorrow to investigate and treat your symptoms?
3. Can you explain what needs to happen for you to safely return home, and what support you might need to make that possible?
4. When are you expecting to go home safely?

Frailty/care of elderly service

For patients who may be frail, use of a recognised frailty tool, such as the Clinical Frailty Scale, is good practice.

A frailty/care of elderly service (i.e. Geriatric Emergency Department Initiative (GEDI)) should gather information about how a patient has been managing in the weeks prior to admission and commence discharge planning and linking to community and out-of-hospital services (i.e. Geriatric Evaluation and Management Hospital in The Home (GEMHITH), NGOs/My Aged Care, nurse navigators, etc.).

Comprehensive geriatric assessment during inpatient care is associated with improved outcomes for older patients, with significantly more surviving hospital admission and returning home, fewer experiencing death or functional decline, and more demonstrating improved cognitive function.[14] Comprehensive geriatric assessment is a multidisciplinary, multidimensional diagnostic process that evaluates the medical, psychological, and functional capacity of frail older patients to inform a coordinated and integrated treatment and long-term follow-up plan. It can include such things as:

- medicines reconciliation and optimisation

- patient/carer information and support
- falls prevention strategies
- provision of assistive devices to mitigate risk or improve function.

As with all patients, frail patients' default pathway should be home first with recovery support. However, patients who are severely frail may require a period of step-down care to rehabilitate, regain confidence and assess long-term needs further. This can help maximise independence and delay progression to long-term residential care.

Early identification of issues

On admission, early identification of any potential issues that might affect the discharge arrangements of an individual enables a plan to be implemented in good time. Using the 4 questions and care of the elderly services discussed earlier, along with utilising the multidisciplinary team, can assist in the early identification of issues.

Limited functional assessments

Functional assessments should be enough to enable safe transfer from the hospital, prior to more detailed assessments at home if required. These should take place in good time to enable same-day discharge. Once at home, assessments may be carried out by appropriate Queensland Health community teams and services, or by Commonwealth services, community-based service providers, primary care or volunteer programs.

Escalation to avoid delay

A delayed discharge is a patient safety and system risk. Information on managing delayed discharge can be found in the Delayed discharge – Best practice guide.

Safety netting

A complete hospital discharge process includes a follow-up and monitoring component, often referred to as "safety netting". It is the process through which patients are given advice on discharge and ensuring they are monitored and followed up once they leave hospital. The key principles of safety netting are good communication, maintaining continuity of care and minimising handover. Providing patients with the relevant advice and contact details in a timely manner will enable them to seek the right support after discharge.

A hospital discharge safety netting matrix is provided in Table 1 below. This is to help clinicians and members of the discharge team make balanced decisions to support safe discharge. The preferred method is patient-initiated follow-up where a patient is given the contact details of their discharge team at the point of discharge and advised to make contact if they are concerned. For complex discharges or where a patient is at risk of representation or readmission, HHSs should consider additional post-discharge supports, such as nurse navigation.

Existing models of follow-up care include:

- Post-Operative Discharge Support Service (PODSS): A telehealth service led by Clinical Nurse Consultants (CNCs) designed to reduce unnecessary ED presentations by providing targeted support to post-operative patients within 30 days of discharge. Contact details for PODSS should also be listed on HHS-specific health.qld.gov.au web pages for patients to access.
- Medical Discharge Support Service (MeDSS): A nursing and allied health-led post-discharge support service (via phone call, telehealth or face-to-face review) for known medical patients who have been discharged from hospital within 30 days. Contact details for MeDDS should also be listed on HHS-specific health.qld.gov.au web pages for patients to access.
- Rapid Access Clinics (RAC)
- Minor Injury and Illness Clinics at Satellite Health Centres (formerly Satellite Hospitals)
- Nurse-led walk-in clinics
- Medicare Urgent Care Clinics
- Residential Aged Care Facility Support Service (RaSS)
- Nurse navigators

Virtual wards and HITH should not be used to support safety netting – appropriate use of the discharge pathways should be considered. Virtual wards and HITH should only be used if patients meet the criteria.

Table 1: *Safety Netting Matrix*[9]

SITUATION	CONSIDER	RECONSIDER
Patient is low risk	• Providing patients with the discharge team's contact details and advice to make contact if they have any concerns (i.e. patient initiated follow up). • Encouraging the patient to reintegrate with primary care and their GP as standard.	• Advising patient to attend ED for routine follow-up after discharge • Arrange routine outpatient appointments.
Patient lacks confidence about how they will cope post-discharge	• Scheduling a telephone call with the patient a day or so after discharge to check all is well and provide reassurance. • Encouraging the patient to reintegrate with primary care and their GP as standard.	• Extending a patient's acute hospital admission. • Advising patient to attend ED for routine follow-up after discharge • Arranging routine outpatient appointments.
Patient is awaiting results of investigations	• Providing patients awaiting investigation results with clear instructions on how and when they will receive their results, including a specified timeframe for communication, and ensuring this plan is documented in the medical discharge summary. • Providing the patient with their results as soon as they are available and discussing any required changes to management. This contact may be made by the discharge team or, where care has been formally handed over, by an appropriate community or voluntary team, if care has been transferred to them.	• Requesting the patient's GP or relevant care team to follow up and action results, unless a clear and timely handover has already occurred.
Patient needs a review at a certain time (e.g. for a wound check, removal of drain, trial without a catheter).	• Booking the patient into an outpatient clinic or Rapid Access Clinic.	• Advising patient to go to ED.

Social prescribing

Social prescribing and community-based support is an effective way of supporting discharge and preventing unnecessary hospital admission, through connecting people with their community and wider support via primary care networks.

This can be useful to support people who are affected by the social determinants of health (such as unemployment or loneliness), low-level mental health problems and/or long-term conditions which affect their health and wellbeing. These services take a holistic approach to people's health and wellbeing, starting with what matters to them and can help people connect to voluntary sector support and community groups as well as local directories and self-care resources.

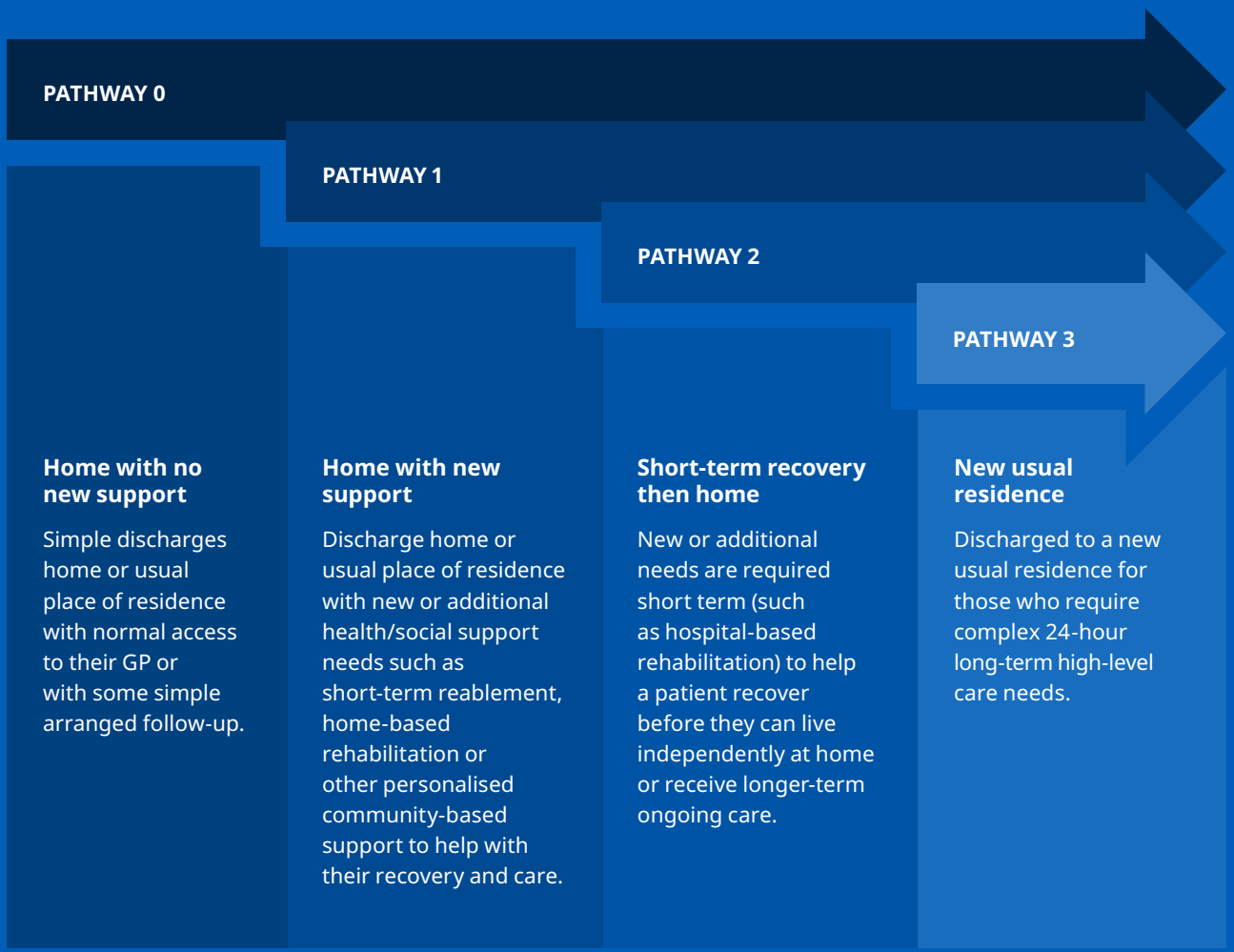
Supported self-management

Supported self-management is a way that health and care services can encourage, support and empower people to manage their ongoing physical and mental health conditions themselves. There are services as part of community care and primary care networks using supported self-management approaches to support people in the community.

Pathways and discharge coordination hubs

Pathways

HHSs may consider adopting the 4 discharge pathways as a consistent way to categorise patients and to guide how they are identified, planned for, and supported as they transition from hospital.



PATHWAY 0

Home with no new support

Simple discharges home or usual place of residence with normal access to their GP or with some simple arranged follow-up. This includes:

- active and unchanged Home Care Packages continuing at the same level as what was delivered prior to admission to hospital
- considering volunteer and NGO sector services, local support networks and/or social prescribing to support discharge and prevent further hospital admissions
- considering the needs of any carers and referral to support where appropriate.

Research out of the UK suggests that over 50% of patients over 65 years old should be discharged on this pathway.[5]

PATHWAY 1

Home with new support

Discharge home or usual place of residence with new or additional health/social support needs such as short-term reablement, home-based rehabilitation or other personalised community-based support to help with their recovery and care.

- This may include services such as Community Transition Care Packages (TCP) and Post Acute Care Services.
- The support should adapt to match the progress of the individual.
- During the recovery period, assessment of long-term needs (such as Aged Care Assessments) can be made by the relevant professionals as soon as they decide that an accurate assessment of future needs is possible.
- The needs of any carers should also be considered and referral to support where appropriate.

Research out of the UK suggests that around 45% of patients over 65 years old should be discharged on this pathway.[5]

PATHWAY 2

Short-term recovery then home

New or additional needs are required short term to help a patient recover before they can live independently at home or receive longer-term ongoing care.

- This includes patients discharged to services such as Residential TCP, rehabilitation or geriatric evaluation facilities for dedicated support and recovery. The intention must still be to get the patient back to their home or usual place of residence following a period of rehabilitation.
- The support should adapt to match the progress of the individual. Regular reviews of progress should be made by the relevant professionals to avoid delay in the patient's return home. It is likely that patients being discharged home will need further community support once at home.
- The needs of any carers should also be considered and referral to support where appropriate.

Research out of the UK suggests that around 4% of patients over 65 years old should be discharged on this pathway and after a period of recovery around 75% should aim to return home with support.[5]

PATHWAY 3

New usual residence

Discharged to a new usual residence for those who require complex 24-hour long-term high-level care needs.

- This includes patients who are moving to a new RACH or National Disability Insurance Scheme (NDIS) supported accommodation.
- No decision should be made to permanently place a patient in a residential care facility for the first time without first giving them an opportunity to recover and/or trial returning home before then assessing them for long-term needs. Placing someone directly from an acute hospital should only occur in exceptional circumstances if all other available services have been exhausted.
- A social worker must be involved in any decision to discharge a patient to a RACH for the first time.
- Early identification of these patients and early engagement with the patient and their family/friends enables shared decision-making and can reduce unnecessary waiting times.

Research out of the UK suggests that ideally less than 1% of patients over 65 years old should be discharged on this pathway.[5]

Discharge coordination hub

HHSs should consider a hub whereby all relevant services across sectors (i.e. interim care, rehabilitation wards, community health, primary care, residential aged care services, QAS, etc.) are linked together to coordinate care and support for patients who need it, to aid discharge, recovery and admission avoidance.

Hubs work in an integrated way providing autonomous clinical decision-making to support the planning of complex discharges, and to seek the required support through available resources (such as HHS executive teams and the Long-Stay Rapid Response Program).

A key function of the hub is to build strong, efficient working relationships with partners to improve system performance and patient care. This includes understanding the availability and eligibility of all services across the HHSs, both Queensland Health and non-Queensland Health providers such as NGOs, volunteers, private services, and primary care.

A critical partnership is with the QAS. Early engagement with QAS, such as timely notification of ward closures or decanting, early booking of discharge transport, involvement in planning for complex or frequent presenters, and consideration of out-of-hours crew availability should be standard practice to optimise patient flow and ensure appropriate, efficient use of QAS resources.

In the context of the NHS model, the hub supports every patient discharged on Pathway 2 and 3. The clinicians nominate the patient is medically optimised but not yet able to return home. Clinicians outline the patient's current care needs. The hub will decide, in consultation with the patient and their advocates, which pathway is the most appropriate based on the handover received from the acute ward, and will assign a case manager to each patient. They will then coordinate their discharge in consultation with the treating MDT.

The hub should be fully or partially co-located with acute care settings and operate 7 days a week with local HHSs determining the hours of operation to ensure adequate coverage. Hub operations should be streamlined as much as possible to support timely connected and coordinated care. Further information on the role of different groups is in *Appendix 2*.

Appendix 1

Specific groups

People at risk of homelessness

Meeting the needs of people who are homeless or at risk of homelessness is often felt to be an intractable problem, which can result in discharges being delayed and people not getting the right services to help with their recovery and housing following discharge. The multiple and complex needs of some homeless people along with their unsettled status means that securing appropriate housing and support services can take time. In addition, preventing discharge that is too early is often an issue for this group.

It is important to be aware that homelessness can be linked to early ageing and high levels of frailty and other issues such as self-neglect. This means the involvement of social care alongside housing and health will often be key to improving outcomes through the D2RA process.

People who are homeless or at risk may be eligible for aged care services from 50 years of age. Additional information and key contacts for homelessness support can be found online.

People who may lack mental capacity or need safeguarding

Supporting people's choices, discussing risk with them and being alert to possible safeguarding concerns is essential to discharge on all pathways. If there is a reason to believe a patient may lack the relevant mental capacity to make their own decisions about their care and treatment, a capacity assessment should be carried out by a suitably qualified professional before a decision about their discharge is made.

For more information on how to complete a capacity assessment see the Queensland Capacity Assessment Guidelines.

Where the patient is assessed to lack the relevant mental capacity to make a specific decision, there is a process to follow to determine who has decision making authority. If an enduring power of attorney has not been appointed, or an appropriate Statutory Health Attorney (such as a spouse, relative or friend) identified, the patient may be referred to the Queensland Civil and Administrative Tribunal to be appointed a public guardian for further decision- making. To minimise any delay to discharge, this should be commenced as early as possible. If acute care is no longer required, timely transition to an appropriate non-acute setting should be considered.

People receiving palliative or end-of-life care

Patients who have palliative or end-of-life care needs, but are not imminently dying, may be discharged on any of the discharge pathways. If implementing D2RA, those who need it should receive a short period of care and support, including reablement and/or rehabilitation, to help them recover, as much as possible, from the incident which led to their hospital stay. Their personalised care and support plan, including any advance care plan, will help to guide their care. This is an important opportunity to help them review and update their advance care plan if they wish, or to initiate advance care planning conversations if one does not already exist. These conversations should be continued after discharge if not already completed.

All healthcare providers to these patients should work collaboratively to minimise any issues or disruptions to their provision of care. This may include:

- anticipatory prescribing
- access to medication, trained professionals and education where necessary
- appropriate equipment (e.g. hospital bed)
- appropriate access to care such as nursing and allied health staff
- access to specialist palliative care advice when required.

Appendix 2

Key roles

Executive Lead	Every HHS should identify an Executive Lead who should act on behalf of the whole system to provide strategic oversight of Discharge to Recover and Assess. The Executive Lead is responsible for ensuring good system governance and positive outcomes for patients discharged from hospitals in their system. They may be employed at executive leadership level and can be from any relevant professional background. Support for the Executive Lead should be provided through a Single Coordinator who will report directly to them and escalate issues as required.
Single Coordinator	This system leadership role should act on behalf of the whole HHS and work both strategically and operationally to ensure D2RA is a success. They should develop a shared system view of discharge, hold all parts of the system to account and drive the actions that need to be taken as a system to address challenges. The Single Coordinator may be employed be from any relevant professional background and should report to a named Executive Lead.
Case Manager	Consider allocating a Case Manager/Discharge Facilitator/Care Coordinator to every patient identified on Pathways 2 and 3. This professional's role is to aid and monitor the patient's discharge and recovery, coordinate and navigate care and support across the system. This operational role should liaise with relevant professionals to support the patient's timely discharge and monitor progress against any identified rehabilitation goals, ensuring adjustments are made or the support is stopped if necessary. After a sufficient period of recovery, if it appears the patient may need support on a long-term basis, the Case Manager should liaise with relevant professionals to ensure timely assessments of long-term care needs. A Case Manager can be from any relevant professional background and may change throughout the patient's journey depending on the patient's needs and local setup.
Hospital Multidisciplinary Team	Together with the patient, their family/carers and relevant people, multidisciplinary teams identify the needs that require support after discharge before a long-term assessment is complete. This could include physical, social, psychological, cognitive, financial and environmental needs, including home modifications or equipment. This can help determine whether the patient's home is suitable for their needs upon discharge. The MDT should adopt a strengths-based and patient-centred planning approach, working together to plan care and carry out joint assessments. Up-to-date knowledge of and seeking input from community teams (Queensland Health, primary care and NGO services) as well as the patient's support network is critical in determining if the patient's needs can be met at home. Hospital-based social workers play a vital role in supporting patient discharge. Their role in hospital and assessment settings is essential for patients whose circumstances are complex. They are experienced in supporting patients to make informed choices and possess advanced knowledge of community supports, aged care pathways, cognitive capacity, mental health, and carer support, enabling individuals to understand their options and navigate their recovery pathway with confidence.

Appendix 3

Patient stories[15]

Mike, aged 89

Mike, aged 89, tripped over the edge of a rug and hit his head on the side of a cupboard. He remained conscious and was able to get to the phone to call an ambulance. He was seen swiftly in ED and was found to have some bruising but no serious injuries. As a precaution, the medical team decided to admit Mike overnight for observation to ensure he was safe to go home.

A day or 2 passed, during which time some tests were carried out. They all confirmed there had been no serious or lasting damage and no underlying cause for the fall; he had simply tripped. Ten days later, Mike was still in his hospital bed. By this time, he had lost a good deal of mobility, so an assessment by the physiotherapy team was arranged. The physiotherapists felt Mike need to be assessed by the occupational therapists (OT) and the social work team, which took time to arrange. The days turned into weeks. Based on the assessments, a recommendation was made for 24-hour residential care and that is where Mike was placed. The OT who conducted Mike's assessment felt very strongly that had the physiotherapists, the OTs and the social care team all worked together as a single unit from the outset, this scenario might have been avoided, and Mike could have gone home, with reablement support for his mobility issues. The teams could have worked in parallel rather than in series, thereby dramatically reducing the time it all took.

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Jane, aged 85

Whilst cleaning her kitchen, Jane, who has had insulin-dependent diabetes for 59 years, slipped on the wet floor and fell. At 85, Jane was enjoying living independently with the support of a care package to help monitor and control her diabetes. She was seen in ED and admitted for observation and monitoring of her diabetic control. Ten days later, Jane was declared medically fit and was keen to go home. There was then a series of delays with discharge because of some internal communication processes not working as well as they should. Three weeks following her fall, Jane developed a severe hospital-acquired infection. Two months after admission to hospital, Jane was discharged – to a residential home.

Had Jane's discharge been managed more effectively, she would have been less likely to suffer a hospital-acquired infection and far more likely to have been discharged to her own home and independent life – as she had wanted.

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