

Step 1. Get to know the individual via CTR Meetings, an initial visit to their current setting and through careful review of their care plans, risk assessments and PBS plans.



We understand the past to make sense of the present and to have a better outlook on the future.

Step 5. We help the individual to move into their new home and to manage adjusting to life outside of an ATU. Our support is ongoing for as long as is required to stabilise.



We call upon the relationships that the team have built and fostered and use familiar positive support strategies to reassure and adjust.

The Bridging Support Model

Step 2. Build the bespoke team by looking at experience, skill sets, personal interests and characteristics. We take the time to truly personalise care for the individual.



We share compliance records and profiles for all Care Bridge Specialists as one aligned & consistent team throughout.

Step 6. We partner with the incoming Care Provider to give them the space, time and insights to select, onboard and train a new team based on 'best fit'.



We recommend and support valuesbased recruitment to find a team who are caring and compassionateensuring it's a person centred match. Step 3. Complete hospital inductions. At first shadow and then work alongside to role model best practise and provide consistency as part of an existing inpatient team



We recognise that existing support might be desensitised to the current situation or drawn unintentionally into closed cultures.

Step 7. We pro-actively share knowledge and handover our high trust relationships and withdraw gradually as the new support team is phased in and working well.



A gradual approach drastically reduces the risk of a placement breakdown. At this stage costs will start to significantly decrease.

Step 4. We future plan with Housing Associations/ Social workers/ future Care Providers. By sharing our experience of the individual we advocate to give them a voice.



We work collaboratively and creatively to help design holistic support arrangements that remove barriers to discharge.

Step 8. We are around in the background for an agreed period ready to support if there are any challenges, issues, or signs of concern as a new life is established and takes root in the community.



Long term benefits come to fruition. The individual's needs, requirements, aims and aspirations are at the centre of any future support that is received.

ON THE WARD

Shadowing then embedding into an existing team. Feeding back all handovers and observations to the relevant Professionals and into MDT Meetings.

IN-REACH

Introducing and working collaboratively with Housing Associations, Social Workers and Care Providers.

TRANSITION

Once settled into their new home work begins with the new Care Provider to support person- centred recruitment and upskill their new team.

DISCHARGE

Care Bridge fade out support, taking a gradual and controlled approach when everything is stable and well established.

