

Community in-reach to deliver Early Supported Discharge for Stroke Patients

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Why?

Intensive Community Rehabilitation for stroke patients discharged from Mark Ward at St. Thomas' Hospital and Friend's Unit at King's College Hospital was initiated to allow for the earlier discharge of stroke patients from hospital to community and for

their rehabilitation to continue in their home setting. Earlier rehabilitation at home has been shown to increase the chance of survival from stroke and improve adverse outcomes (Langhorne et al 2005), as well as reduce bed days in hospital.

How

Additional posts to the neuro pathway community team in Lambeth Adult Therapy Team:
1 whole time equivalent (WTE) physiotherapist,
1 WTE occupational therapist

0.4 WTE speech and language therapist
0.6 WTE team leader
2 WTE rehabilitation support workers (RSW).
0.1 WTE stroke consultant doctor.

What's different about this service?

The service is able to:

- be responsive to patients immediately on discharge
- be offered within the usual service provision, without having a separate stroke team
- tailor the intensity of the service provision to patients need
- tailor the use of a social service care package to need in first weeks after discharge
- coordinate therapy sessions with social service care workers
- inform care package review with social worker and therapist
- be evaluated qualitatively and financially as cost-effective

In-reach to acute wards

Therapists in-reach to acute wards multi-disciplinary meeting (MDM) on rotational basis, to plan discharge of patients with acute team and accept referrals in person.

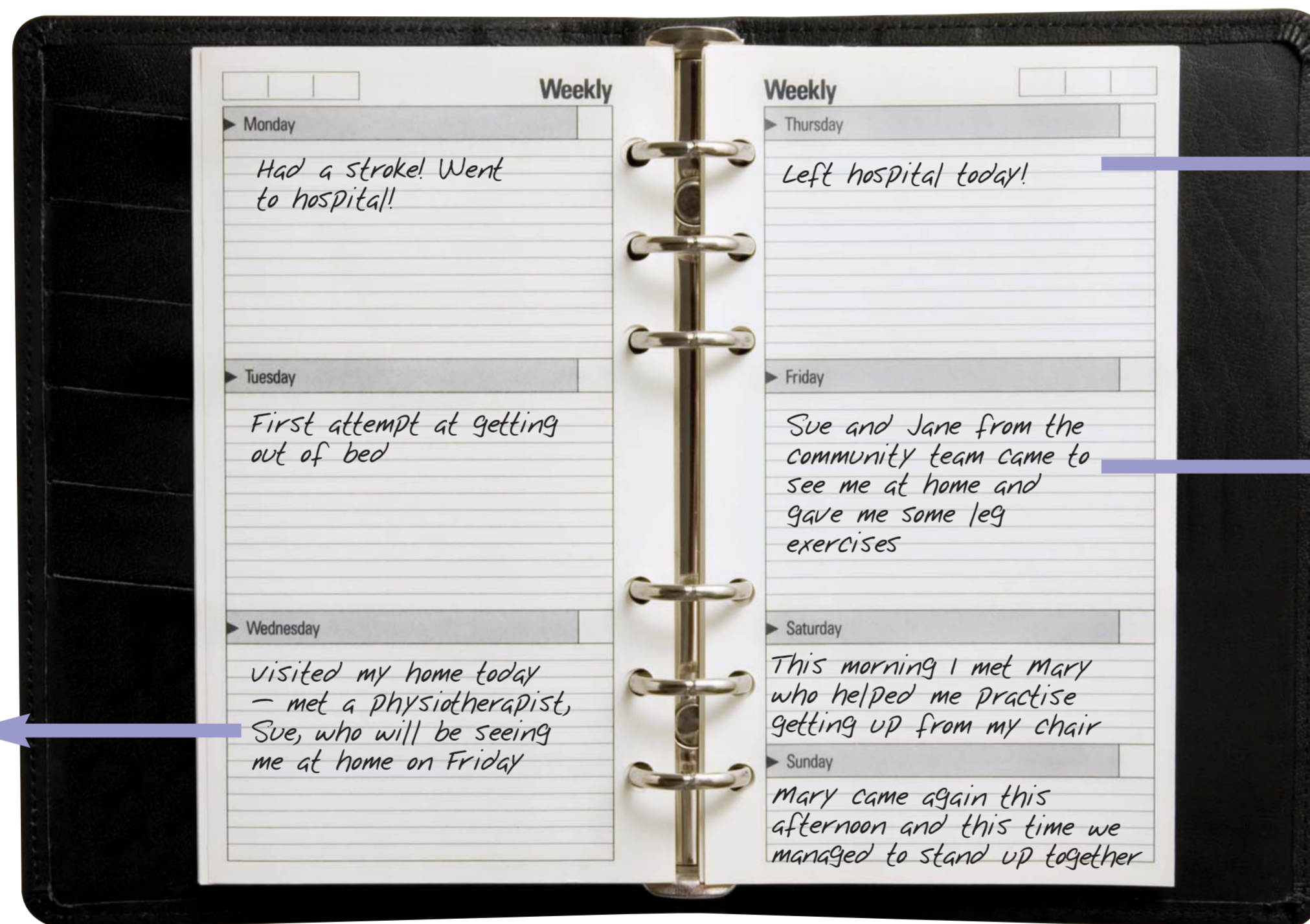
Feedback from service users and carers

"We felt as a family at the hospital that it was far too early for him to go home however, the success and care he has received has proved us wrong, thank you for that."

"We could not believe that on the day she was discharged from hospital you came to see her and

you set up her programme for the intensive community rehab team to start visiting her the following day.

The progress that she has made is all down to the way that the team dealt with her. She was treated with such kindness and dignity by all."



Planning with patients

Patients are allocated therapists and coordinated by the Neuro pathway Lead Therapist. Allocated therapists create a timetable of the patient's daily planned sessions at home, which is kept in the home file.

Planning with the team

Weekly MDM discussions are held with the team to plan ongoing rehabilitation. Intensity of the programme is reduced according to need over time. Consultant clinic or domiciliary visit for consultant review is booked at MDM

the process and to give feedback about patients progress at home as this fosters trust in the primary care service

- Communicate with newsletters to primary care staff with progress of pilot
- Meet monthly with therapy and RSW staff and managers to review and update the process
- Present graphic representation of each patients' progress
- Review stroke coordinator role e.g. we changed from nurse to therapist to better challenge acute colleagues discharge decisions and pull patients through
- Create time in diaries for allocated therapists to start rehabilitation sessions immediately on hospital discharge
- Create care plans for RSWs to carry out therapy exercises after initial home assessment by therapist
- Seek service users views of their rehabilitation

Lessons learnt

Implementation of the pilot was successful and it is now a viable service with an average of nine days saved per patient. 28 patients have received this service since November 2006, all patients requiring this service have been accepted.

- Jointly discuss and agree operational plan for service with both acute and community teams
- Meet regularly with acute hospital staff to review