



Intermediate Care & Rehabilitation Project

Waverley Intermediate Care Pilot

Interim Evaluation Report

October 2008

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1.0 Introduction

- 1.1 The shared principles of Changing Lives and Delivering for Health direct a shift in the way that services are delivered, with a greater emphasis on self care and independent living.

The reports identify the need for change in the ways that services are delivered, with shifts to inter-agency service redesign and the need for a whole system approach to early intervention, prevention, rehabilitation and enabling.

- 1.2 *Co-ordinated, Integrated and fit for Purpose: A delivery Framework for Adult Rehabilitation* now places rehabilitation at the core of service redesign.

- 1.3 *Intermediate Care in Scotland A Partnership Approach* is a scoping report produced by the Joint Improvement Team (JIT) in June 2007. It states that

“an increasing number of intermediate care projects are being developed by partnerships in Scotland...whilst there is no specific national strategy or guidelines for intermediate care in Scotland, recent policy is directing the development of services to support people as far as possible in their own communities in the context of a whole system approach.”

The JIT report also states that

“The success and effectiveness of Intermediate Care services depends upon the range of existing services, including social work services, the extended primary care team and the role of acute and community hospitals. Where services report their greatest successes, it is where the interface between intermediate care services and other hospital or community services are well managed.”

- 1.4 Definitions (provided in JIT report):

Intermediate Care: “A service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early discharge and prevent premature admission to residential care.” (Making Connections, Change Agent Team, 2006)

Rehabilitation: “A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients and service users, and their family carers.” (Kings Fund 1998)

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- 1.5** Over the past year, Scottish Borders Council has been carrying out a Best Value Review within the Social Care and Health department. A work stream within this review is the Intermediate Care and Rehabilitation Project. A work stream within this project is the development of an intermediate care resource that will deliver intensive rehabilitation based on the above definitions.
- 1.6** Earlier this year an eight bedded wing of Waverley Residential Care Home was redesigned to provide a seven bed intermediate care resource. This new service was launched on the 26th May 2008 and will run as a twelve month pilot to explore the viability of such a service as a future model of service delivery.
- 1.7** This report is the interim evaluation of the unit and the impact and outcomes of this service for clients, services and organisations. It covers the period between 26th May 2008 and 30th September 2008. Information within this report has been gathered from client feedback questionnaires, key stakeholder questionnaires, validated client dependency rating tool and a locally designed data collection and recording system. Three case studies have been included in the appendices (appendix 1) to illustrate clients that have been admitted to the unit to (1) prevent a hospital admission, (2) prevent a care home admission, (3) facilitate a hospital discharge.

2.0 Statistical Data

2.1 Referrals

From 26th May 2008 to 30th September 2008 there have been 15 admissions, figure 1. Within the first month of opening it was agreed to limit admissions to one per week to allow staff within the unit and who support the unit to adjust to their new role and new processes and procedures. The unit was been full on two occasions. The 85% occupancy rate for bed management has resulted in an effective system for turnover of beds. Referrals tailed off towards the end of August and only one referral was received in September. It is unclear as to why this period was less active however it may be that it mirrors NHS activity levels which show a similar pattern. Since September the referrals have picked up again and the unit is once again under demand.



* Note: referral rates at end of September to end of October resulted in 14 new referrals, resulting in 9 admissions in October. This resulted in an 8th bed being opened temporarily and a waiting list created.

Figure1

2.2 Reason for Referral

Of the 15 referrals, 6 have prevented a hospital admission, 7 facilitated a hospital discharge and 2 prevented an admission to permanent residential care home, figure 2.

Figure 2



2.3 Referrer

Of the 15 referrals, 3 were from BGH, 2 from Community Hospitals, 2 from GPs, 7 from Social Work Teams and 1 direct from A&E, figure 3.

Figure 3

2.4 Diagnosis

The diagnosis is categorised by the main presenting illness, condition or disability at the point of referral. Of the 15 referrals, there was 1 surgical, 1 medical, 3 mobility, 2 neurological and 8 orthopaedic/falls, figure 4.

Figure 4

2.5 Average Dependency Score

The pulses dependency scoring tool is a validated tool which was already being used by the Rapid Response team before the unit opened. It was agreed at the outset of the pilot that this tool would be used for the purposes of the pilot as the staff were already familiar with its use. However it is recognised that any one tool has its limitations and that perhaps a more useful approach to measuring outcomes for individual need would be a 'basket' of tools that can measure more specific needs. It is hoped that this can be explored during the second period of the pilot. Of the 15 admissions, 12 demonstrated a reduction in dependency on discharge, 1 scored the same on discharge as on admission, 2 were still in the unit and had therefore not yet been scored. The average fall in dependency decreased from 13 to 10, figure 5.

Figure 5

2.6 Average length of stay by presenting condition

The average length of stay overall is 29 days. Figure 6 breaks this figure down according to the main presenting condition, disability or illness at the time of admission. It should be noted that the neurological category's above average length of stay is due to the lady that is waiting for a permanent care home placement.

Figure 6

Average length of stay for facilitated discharge was 29.7 days, prevention of admission to care home was 48 days and prevention of admission was 22 days.

2.6 Discharge Outcome

Of the 15 referrals, 13 were discharged to their own home, 1 moved into interim arrangements within a respite facility as he had become homeless and required sheltered accommodation and 1 remained within Waverley (marked unknown) as she was found to be unsafe to return to her own home and was at the time of writing waiting on a permanent place within Waverley residential care home, figure 6. A point to note, for the lady that could not return home, her stay in Waverley and particularly her home visit highlighted the level of risk for this lady and helped her family and the care manager come to the decision that a permanent care home provision was the most suitable alternative for her. Had this lady returned straight home from hospital it is believed that she would have undoubtedly come to harm even with a large care package and required readmission to hospital.

Figure 6

2.7 Average Size of Care Package

The average hours of care package has almost doubled on discharge from the unit, figure 7.

Figure 7

It should be noted that although the care package hours for some people has increased this has supported individual clients to continue to live in their own homes. This supports the following HEAT targets and Single Outcome Agreement:-

T1 : By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008.

T8 : Increase the level of older people with complex care needs receiving care at home.

Of the 13 referrals discharged home, 7 had an increase in care package, 5 stayed the same, 1 had a reduction resulting in no support at all. For those clients that stayed the same or had an increase in care, their stay in the unit directed specific areas of targeted care for those individuals. The Intermediate Care team were able to say specifically what that client required and when. For example, one lady presenting with confusion, although not her main diagnosis, did not have a care package pre-admission. On discharge she was assessed as needing 10.5 hours for medication prompts by a home carer. Telehealthcare was not considered suitable at this time due to the individual's level of confusion and practitioners were unfamiliar with what could be provided. This removes the ambiguity that is often found in care packages such as 'requires home care' but not always clear when and for what specific task. One gentleman who fell under the diagnosis of ortho/fall that did not have a care package pre-admission and required 15 hours per week on discharge. His admission to the unit prevented a hospital admission. Given his 'actual length of stay' in the unit was 31 days, this potentially would have cost NHS Borders £5953 for the same duration in hospital. It would have cost £944 home care rate for that same length of time if he had been able to stay in his own home. His length of stay in the unit cost £2879 plus the loss of income cost to SBC of £702 giving a total cost/loss to SBC of £3581 (Table 1 p17).

3.0 Client Questionnaires

3.1 The client questionnaires have provided qualitative feedback on their experience of their stay in Waverley. Fourteen questionnaires have been returned (93% of all admissions). The questionnaires indicated clearly that clients were happy with the service they received in the unit. Clients felt that they achieved the aims of their rehabilitation, improved their ability to carry out activities at home, increased their confidence and felt safer and more able to support themselves at home. Clients also felt that their length of stay was about right. Clients indicated that they found the staff friendly, courteous and efficient and provided encouragement. There were three negative comments regarding the food and several clients suggested that there should be shower facilities. One client complained that there was only one toilet and another complained that there were no en-suite facilities. One client complained that there were no calendars. Comments included:-

3.2 Best thing about my stay:

“Having time to come to terms with what happened and having staff to keep me comfortable. I felt secure that the staff knew what they were doing.”

“Encouragement. I especially appreciated the additional physio support from the team following the physio’s instructions. Very happy with care/support from physio herself, boosting my confidence. A bit of space to recover a bit more before going home and be encouraged that I could make a good recovery.”

“Staff were extremely friendly and efficient. Allowed me to get out of hospital earlier and prepared me for returning home.”

Worst thing about my stay:

“It was not what I required or needed other than the exercises.”

“Nothing”

4.0 **Key Stakeholders Questionnaires**

4.1 Thirty questionnaires were returned. Eleven questionnaires indicated that they had not had involvement with the unit. The main reason cited was that they had not identified a suitable client/patient during the period being evaluated. Nineteen questionnaires indicated that their service had involvement with the unit. Thirteen of those questionnaires had referred clients to the unit and six stated that they provided a service within the unit.

4.2 Of the people/services that had referred into the unit, seven responses were from social work (SW) based teams (all but Peebles responded), three were from general practitioners (GPs) (2 Galashiels, 1 Earlston) and three were from Department of Medicine for the Elderly (DME) Consultants. The frequency of referrals was either once or occasionally for all but one referrer. One referrer (Galashiels locality) stated that they had very frequent involvement with the unit.

4.3 **Of the three GPs that responded**, three stated that there had been minimum impact on their service. One GP stated that there had been an impact on their budget as the client’s own GP had refused to prescribe the medication. Two GPs stated that they were satisfied with the service and one stated that they were very satisfied. All three GPs stated that the admission to the unit had prevented an admission to hospital, prevented a care home admission, facilitated an hospital discharge or a combination of

these. All three GPs stated that there had been positive outcomes for clients. None identified an impact on training, travel, policies or practice.

- 4.4 Of the three DME Consultants that responded**, two stated that there had been minimum impact on their service and one stated that there had been normal impact. One stated that there had been no impact on their budget, and two did not respond to this question.

All three stated that they were satisfied with the service. Two consultants stated that the admission had facilitated a hospital discharge, one of which was an earlier discharge and that there had been positive outcomes for clients.

When asked if there was a role for other members of their service to provide input to the unit, one consultant indicated concerns that patients were admitted/discharged without specialist geriatric review.

The consultants identified no impact on budget, training, travel, policies or practice.

- 4.5 Of the seven SW based teams that responded**, three stated minimum impact on their service, two stated normal impact, and two stated that there had been intensive impact which had resulted in capacity issues for their staff. It is worth noting that these SW teams were from areas which support the BGH and Waverly.

Two teams stated that they were very satisfied with the service; three stated that they were satisfied with the service, and two felt unable to comment as they had not had a client admitted to the unit.

Four teams stated that the admission had facilitated a hospital discharge and prevented a permanent care home admission; one stated that admission to Waverly had prevented a hospital admission. Five stated that there had been positive outcomes for clients, of which two also stated negative outcomes, one of which was not having a care option available to the client who was unsafe to return home. The other team did not indicate why.

Four teams stated that there had been a positive impact on care packages/costs, of which two of the three stated that there were both positive and negative impacts. Three did not comment.

Six teams stated that there had had not been an impact on their budget, with one of those teams stating that it had a positive impact on their budget as the person could return to their original care plan on their return from the unit.

Two teams stated that there was no increase in travel costs, two stated minimal increase, and two identified an increase. There were no training needs identified. Four teams stated that they have not had to change their service policies, procedures, philosophy or model of practice, whilst two teams stated that they had, in as much as the unit helped promote the rehab agenda and helped staff be mindful of the facility.

4.6 Comments from sections of questionnaire:-

“provided a new and safer option for discharge from A&E. Without this service either an emergency care home admission or additional home care would have been required. Waverley provided an opportunity to take an holistic approach which CCA was able to participate in.”

“as a result of direct experience, the team has been in a better position to promote the use with other agencies eg GP practices.”

“very worthwhile pilot, though still need to work on the prevailing culture.”

“not convinced that an old residential care home is the most apposite of premises.”

“altogether a positive experience for Social Worker and client with no gaps identified.”

“enabled client to return home to care of husband who felt more enabled to continue his role as main carer.”

“staff have felt they have had to give a high degree of input both during, and immediately after, a placement by one of our service users.”

“satisfactory in the majority of cases. However there have been a number of cases where we have questioned how much rehabilitation is actually taking place on a daily basis. We have difficulty with the eligibility criteria for the unit – we would have questioned the appropriateness of some placements (but they seemed to suit the unit), whilst access to the service was denied for some service users we thought would benefit.”

“Waverley offers a very valuable resource and one which should be considered first prior to looking at Care Home or more intense package post hospital which may not be successful as service user not confident/fit enough on discharge to take on board all responsibilities both practical and emotional.”

4.7 Six teams/services stated that they provide a service within the unit, as follows:-

Gala District Nurse (DN) Team – stated occasional/frequent involvement. This is in part due to attending the weekly multi-disciplinary team meeting. The impact on the DN service is minimal as patients involved have few nursing needs. One patient from out with Gala practice required intensive input. The impact on travel had decreased as a client was seen within the unit instead of the nurse having to travel to their home.

There has been no impact on budget as access for prescription for dressings has been provided by the client's own practice.

There was no change to policies, procedures, practice noted. There were no training gaps identified. The teams input in the unit was stated as satisfactory although communication not always clear.

An identified gap in the unit was stated as the nurse not always being aware of the client's full care needs. It was stated that premises are suitable as a fair representation of the home environment, and more so than a hospital setting. Admission to the unit facilitated a hospital discharge and resulted in positive outcomes for individuals.

Professional opinion is that individuals who have returned home are more independent and confident.

4.8 Borders Ability Equipment Store – stated occasional involvement with minimum impact. There was a very slight impact on travel and budget. No training needs were identified. They stated that their team's input to the unit as very satisfactory. There were no gaps identified although telecare equipment could have potentially been utilised more. It was also stated that there was a positive impact on costs/care packages.

4.9 Home Care – stated that involvement has been on one occasion and there was a normal impact on the home care service. There was no impact on the service budget. There had been an impact on day to day business due to sickness and annual leave, but there were no changes required to policies and procedures

With regard to training Home Care Service would like to see all home care assistants trained in rehabilitation. The team input to the unit stated as very satisfactory. The feedback stated that the Home Care Service would like to see Home Care Assistants work with service users in the unit and follow them home to continue the rehabilitation work. They also stated that the premises were suitable and that there had been a positive impact on costs/care packages. They felt that admission to the unit has resulted in positive outcomes for service users and this had allowed individuals to stay in their own home longer.

4.10 Rapid Response (RR) – stated that involvement has been very frequent and the impact on their service has been intensive. They are the core team providing rehabilitation to the unit. Eight of the 15 admissions have required a care management role from RR staff. The manager, staff and secretarial support have all had to change the way in which they work. This has had negative and positive impacts on their team.

The RR team have prioritised working within the unit and are working to a rota system to provide cover. This has had a direct impact on their ability to take on RR referrals within their own localities and how they take annual leave due to staff being part-time and the need to cover the unit. Input in the unit initially was intensive. Time spent in Waverley was 97.5 hours in June, 64 hours in July and 33 hours in August. In June Physio input was 22% OT 30%, July Physio 8% OT 30%, August Physio 9.5% OT 7.5%.

RR practitioners that responded stated that they are able to utilise their professional skills has resulted in a more rehabilitation-focused approach across all aspects of their work. This has led to an increased understanding of rehabilitation across health and social work services. It has enhanced their skill base and they are transferring new systems and processes, for example treatment programming, into other aspects of their work. Some practitioners have felt challenged in their practice and this has resulted in the RR Manager spending additional time with staff to work through the issues.

There has been an impact on travel costs as RR practitioners have had to travel from Peebles, Duns and Hawick to cover the rota. There has been an impact on RR response budget as 14K additional budget not enough to provide additional professional staff time. They are however currently employing temporary Community Care Assessor to manage some of the workload.

Training requirements have been identified for RR practitioners. For those RR practitioners that responded they stated they are satisfied in relation to their input into the unit and the RR Manager stated very satisfied.

Gaps identified within the unit are: the bathroom is inadequate for rehabilitation; further equipment is required; and there was some concern with the kitchen although the specific issue was not given. RR practitioners stated that some areas do not wish to promote the unit as it is based in Galashiels. RR practitioners feel there is potential for nurses within RR to be more active within the unit, for example: taking blood pressures, medication, diabetes management, taking bloods. This would lead to potentially increasing the remit of the unit. RR practitioners stated that the premises are suitable however still room for improvement.



RR practitioners stated that there has been a positive and negative impact on care packages/costs. Some clients have required an increase in care following discharge from the unit however this has allowed the client to stay at home. Some clients have required less care. Some clients have required a small package of care however this has been reviewed by RR and removed when assessed as appropriate.

RR practitioners stated that admissions to the unit have prevented hospital and permanent care home admissions and facilitated hospital discharge. Outcomes for individuals have been positive although some more than others and that admission to the unit has resulted in individuals being able to stay in their own homes longer, as evidenced through the Pulses scoring tool and outcomes of discharge destination. Although one lady required a permanent residential care home placement the RR practitioners stated that the process of assessment and home visit greatly helped the family come to an informed decision about future care needs and provided the care manager with detailed information based on information gathered over a 24 hour period. The RR Manager stated that there is also an option to explore whether one or two beds in the unit could be used as assessment beds for people who do not require hospital admission but may be unable to stay at home.

RR practitioners stated that 3 people have been readmitted to hospital following discharge from the unit. One individual who was re-admitted after 24 hours had complex mental health issues and this followed her normal pattern of behaviour. Another individual who was re-admitted three days after admission had another health issue that required hospital care. A further client re-admitted two days after discharge had changed health needs.

- 4.11 Waverley IC staff** – stated that their involvement in the unit has been very frequent and the impact on their service intensive. Staff has had to work in a more rehabilitative/re-enablement way to deliver treatment programmes with individuals. Staff had received training in this area. Senior staff responsibility has increased to manage the unit with frequent admissions and discharges and be involved in regular meetings with key people involved in the project. This will have impacted on senior staff time in the other 4 units. There has been an impact on Waverley’s budget of £9004.10 for set up and alterations to the building (appendix 3). There is an additional cost to staff the unit based on an additional two care staff between 08.00 and 22.00 hours (appendix 2).

There has been a minimal impact on the service’s day to day business. This has involved the development of multi-disciplinary team meetings, increased joint working, higher turnover of admissions and discharges, and ongoing management and evaluation of the unit. Policies and



procedures have had to change including the introduction of new criteria for admissions to the unit, a brochure for the service, new paperwork and filing systems. Training needs have been identified for staff.

Waverley staff stated that they are very satisfied in relation to their input to the unit. They also stated that the unit is a very suitable environment for the intermediate care service although there needs to be provision of a shower facility.

Waverley staff stated that there has been a positive and negative impact on costs/care packages. The unit provides a free service for several people who have been in receipt of large care packages at home. A negative impact is the additional staff costs and loss of income from the removal of eight beds from the system.

It was also stated that admission to the unit has prevented hospital admission and facilitated hospital discharge and has had positive outcomes for individuals, including increased independence, ability to remain at home longer, increased confidence, identification of risk (although this is also stated as a negative outcome for an individual as it resulted in a move to permanent care). Waverley staff also stated that admission to the unit resulted in individuals being able to stay in their own homes longer due to the re-skilling and empowerment of those individuals following their rehabilitation programme.

5.0 Costs & efficiencies

- 5.1** Table 1 P.17 provides an overall summary of the admissions to Waverley. It demonstrates the estimated costs and savings for each individual client as well as the estimated total costs and savings to both Scottish Borders Council and to NHS Borders for the first four month period of the pilot. It should be noted that the weekly unit cost for Waverley includes the cost of both occupational therapy and physiotherapy input which is funded jointly by SBC and NHS Borders (Appendix 2).
- 5.2** It is clear from the figures that although SBC has achieved some actual and potential savings (£6989) these appear considerably less than the potential savings to NHS Borders (£62099). The overall estimated costs and loss of income to SBC is (£45629). However it can be argued that the potential savings to SBC are in fact higher. The two cases that have 'prevented admission to care home' are showing a saving based on actual length of stay in the unit. Had they gone into a permanent care home placement the average length of stay is 22 months. This equates to a cost of £43084 per person for 22 month period. Therefore for those two clients that did not result in a permanent care home placement the saving is potentially £86168. If the pilot was to demonstrate 2 prevention of care



home admissions every four months this would result potentially in a saving of £258504 in a year. Although these calculations are partly based on estimated and potential savings and costs, they do give an indication of the potential long term impact on efficiencies for both organisations.



SCOTTISH BORDERS COUNCIL 2008/C

SUMMARY OF WAVERLEY INTERMEDI,

6.0 Discussion and early recommendations

- 6.1** The overall principles and philosophy of this pilot is to support older residents of the Scottish Borders to live in their own homes as long as possible. It aims to prevent unnecessary admission to hospital, facilitate hospital discharge and prevent premature admission to residential care. The pilot so far has achieved one or more of these aims for all clients, with the exception of one.
- 6.2** Early indications from clients and key stakeholders are that this is a valuable service which fills a previous gap in the continuum of care.
- 6.3** The environment in which this service is provided appears to be suitable on the whole but requires further redesign and upgrading.
- 6.4** Teams and services appear to have adapted well to this service, some making better use than others of this resource. There has been a significant impact on specific teams and this will need to be monitored carefully. Some teams and services have not yet made use of this resource as it is centrally based and therefore not meeting the needs of each community. Early indications would suggest that there may be a need to have similar resources available in each locality area.
- 6.5** Initial fears before the project started regarding the potential impact specifically on District Nursing and GP services has not been founded. However it should be noted that the majority of clients that have been admitted to this service have been residents living in the central area and would therefore already be known to local DN and GP services.
- 6.6** There are early indications that there are gaps in this service. The pilot has demonstrated a need for general assessment beds for people who do not require hospital care. There have been several enquiries for admissions for people who do not fit the criteria according to age. Interest has also been shown from out of hours services as to the possibility of being able to refer to this service out with normal hours.
- 6.7** The data has evidenced positive outcomes for clients particularly in relation to increased confidence and safety on their return home from the unit. For some clients their stay has resulted in increased packages of care however this has allowed clients to continue living in their own homes.
- 6.8** The pilot so far has demonstrated benefits to both SBC and NHS Borders in the development and running of this service. However the figures demonstrate an inequity on impact on budget with regard to estimated costs for delivering this service. It is unclear at this stage as to whether SBC would be able to sustain the loss and cost of running and supporting this service once the pilot ends. Consideration therefore must be given at this early stage as to whether the outcomes for clients are such that both organisations wish to develop this model of service delivery further and therefore how budgets need to be developed to shift the balance of care.

Case study 1 – Facilitate a hospital discharge

This 76 year old lady had been knocked over and sustained a fracture of her neck of femur. This had been operated on and she was now trying to mobilise. Her husband had had a similar experience a few months before and he was still dependent on his wife.

This lady was admitted to Waverley to continue with her rehabilitation following an eleven day stay in Borders General Hospital. She had been in Ward 9 post operatively. She mobilised using a wheeled Zimmer frame and she lacked confidence to progress from this.

PMH:

Osteoporosis

Hypertension

Angina

Previously this lady had been fit and well and cared for her husband after his operation. She would need to be able to continue to assist him on her discharge.

Process

Admitted and a treatment programme completed by the Occupational Therapist and Physiotherapist for the support workers to deliver.

She progressed to two sticks very quickly.

She self medicated as per protocol and as she would do at home.

She made her own tea and meals as able, setting the table and washing dishes.

Discharge home visit

Care Manager: Central Rapid Response

Outcome

Pulses score on admission 11 out of 24

Pulses score on discharge 9 out of 24

Based on length of stay in Waverley, this reduced this lady's stay within an acute hospital bed by 13 days. If this lady had been discharged straight from the BGH she would have required a large care package for support. She did not require a care package at the point of discharge from Waverley.

This lady was discharged with minimal help from family and DNs to change her TED stockings for a few days. She was able to help her husband and get out and about as per her previous lifestyle. Rapid Response continued to provide a further 6 weeks rehab and review after discharge.

Comments from herself

“ I wish my husband could have come somewhere like this it would have been easier”

There was an email received from a family member remarking on how wonderful the service was and how supported they all felt.

Case study 2 - Prevention of admission to Care Home

A 64 year old lady living at home (Hawick area) with her husband. This lady presented with significant health issues and due to these and the breakdown in the carer's ability to continue to manage her increasing needs at home was on the verge of discussion of admission to Care Home facilities. There was extreme carer stress and he was at "the end of his tether" and felt unable to continue in this role.

PMH:

Stroke 1999 with right sided weakness
Frequent urinary tract infections
Insulin dependent diabetic
Recent deterioration in health and mobility
Low mood since hospital admission March 2008 for reduced mobility

Past history

Had been able to transfer with one and a bed lever.
Had walked with a tri-walker and some supervision.
Able to transfer on/ off the toilet independently.
Required assistance in / out of car
Transferred on/ off chair with little assistance
Managed to wash / dress with some assistance

Recent history

Unable to transfer without two carers
Unable to transfer in/ out of bed or chair
Requires carers to support to toilet.
Requires full assistance with personal care and dressing
Unable to manage diabetic regime independently

Process

Admitted and fully assessed by Occupational Therapist and Physiotherapist within intermediate care (IC) unit.
Treatment programme developed and training given to support staff within the unit.
This lady's room in Waverley was adjusted to replicate the layout at home.
Husband enjoyed a week's holiday abroad which re-energised his commitment.
Care manager in Hawick attended multi-disciplinary team meetings to plan discharge.
Home visit carried out to assess requirements for discharge and to allow carer to discuss concerns. This resulted in the decision by the lady and carer to have a profiling bed set up in another bedroom. This was to allow carers to attend at night if required and to reduce husband's need to get up through the night, which was resulting in lack of sleep and stress. Home care support discussed and care manager arranged this.

A second home visit was provided to test the new arrangements and make adjustments to home care provision as this lady required more time to manage tasks herself.

Other assessments carried out within her time in the IC unit were:-

- Urine specimen sent to own GP and prescription for antibiotics sent to Waverley .
- Speech and language therapist assessment of swallowing. This provided evidence that this lady was at risk of aspiration. This resulted in a change to her diet. This would not have been done had she remained in the community as it had not been highlighted.
- Continence assessment.
- Diabetic Nurse assessment - changes to regime and improved control, new blood monitor which she found easier to use.
- Dentist appointment arranged and attended
- Moving and handling training provided to husband and carers.

Outcome

Discharged home with a large care package and a change to accommodation layout to enable carers to manage her needs more efficiently.

Care package before admission 14.75 hrs
Care package on discharge 17.5 hrs

Pulses score:

On admission 20/24

On discharge 18/24

This shows only a slight improvement however this change made it possible for this lady to go home and continue to be maintained there. This lady would be considered for another admission during the year if it allowed her functioning to remain stable and allowed her to continue to live at home.

The carer has been in contact with the Team Leader to express how good it is to have his wife home and it is working well. He felt her time in Waverley had been a success. His stress has reduced greatly and he now feels able to manage with the support he is receiving. They have both been out several times and have recently been away on holiday together.

Rapid Response provided a further 2 visits after discharge re: moving & handling issues/ check carers managing OK and taking on recommendations from IC staff etc. This shows the flexibility of Rapid Response staff and the need for skill transference to support SW staff.

Case Study 3 – Prevent admission to hospital

A 94 year old lady living alone at home. This lady is supported by her daughter (aged in her seventies) who lives locally. This lady was taken to A&E following a fall at home. X-ray to left ankle confirmed soft tissue injury rather than a fracture. There was also a laceration to her right elbow. This lady required physiotherapy input to improve her mobility and use of walking aids and the occupational therapist felt that this lady was unable to return home at that time.

Process

This lady was admitted straight from A&E into the Intermediate Care unit at Waverley. Previously this lady mobilised independently. The Intermediate Care team worked on improving mobility and improved confidence to manage at home. It was also noted that this lady's daughter was also unwell due to a chest infection and required her own treatment and recovery time.

Outcome

Pulses score on admission 12 out of 24

Pulses score on discharge 9 out of 24

Increased mobility, walking with one stick, balance excellent (having improved).

Carrying out kitchen tasks and folding laundry.

Increase mood

Increased confidence

This lady's daughter felt that she was now able to cope at home as her mum was more mobile and more confident.

Scottish Borders Cou Cost of Intermediate

Description

Staff Costs:

Management Time

2 x Social Care Assistan

1 x Social Care Assistan

1 x Night Staff (Social C

1 x Night Staff (Social Care As

Scottish Bord Breakdown o

Cookworks Signatu

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