Where does the Patient Go from Here? Improving the pathway between health and social care

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Introduction

- Stroke is the leading cause of adult disability in the UK
- Hyper-acute care and thrombolysis has helped with reducing disability to some extent
- Majority of patients will still have some form of disability on leaving hospital

Stroke Rehabilitation

- Inpatient rehabilitation
  - “heavy” patients
  - Benefit from ongoing medical & nursing care
  - More intensive therapy sessions
  - Need for specialist equipment

Early Supported Discharge

- Some evidence from trials showing that appropriate patients benefit from early discharge in a supported environment
  - Reduction in number of patients needing institutional care
  - Better patient satisfaction
- Increased emphasis on ESD in new stroke rehabilitation guidelines

Anticipating problems

- Unrealistic expectations
  - Patients & relatives expectations of full recovery prior to discharge
- Unsuitable accommodation
  - Poor and unsuitable housing
- Difficult family circumstances
  - Family dynamics impacting on discharge

Improving discharge planning

- Talking about discharge early
- Key worker
- Family meeting
  - Setting out stroke pathway
  - Discussing prognosis
  - Exploring options
  - Goal setting

Improving discharge planning

- Improving links with social services
  - Croydon Social services funded stroke care manager
  - Based on the ward
  - Working across the pathway
  - Feedback on problems encountered
  - Ensuring care plans are put in place

Discharge destination

- Important to discuss where patient is going to go to on discharge
  - Own home
  - Other property
    - To children's home
    - Alternative accommodation
      - Are these new properties in the same area or different boroughs
  - Institutional Care

Insitutional Care

- Residential Care
  - 24 hour carers but no nursing input
  - Patients need to be relatively independent
- Nursing Care
  - 24 hour nursing care available
  - More dependent patients
- Continuing Care
  - Complex patients needing high intensity nursing care

Process of placement

- Need to decide what level care patients are
- If patients need nursing home care
  - Continuing care checklist to be filled out
  - If check list is met, continuing care forms to be completed
  - Panel meets to decide whether patients meet continuing care criteria

Case 1

- 54 year old woman
- Admitted with left sided weakness
- CT scan – right thalamic haemorrhage
- Hypertensive
- Initially left hemiplegia
- Made good progress with rehabilitation
- Achieved her therapy goals

Case 1

- Problems
  - Came to light that she lived with an abusive partner
    - Verbal and Financial abuse
  - Concerns about immigration status
  - Discharge destination unknown
    - Essentially homeless
  - Threatened with unemployment
    - Previously worked as carer

Case 1

- Solutions
  - Housing
    - Hospital policy regarding homeless individuals
    - Arranged for B&B on discharge and more permanent housing in long term
  - CICS
    - Agreed for period of rehabilitation at B&B
  - Benefits
    - Care manager arranged for appropriate benefits
    - Supported by Stroke Association

Lessons learnt

- Identifying problem with discharge destination early in order to arrange alternative accommodation
- Social services working together with community team to ensure patient has best outcome

Case 2

- 58 year old man
- Admitted with left sided weakness
- Initial power in limbs 3/5
- CT scan showed ischaemic stroke
- Good motivation with regards to rehabilitation
- Achieve therapy goals

Case 2

- Candidate for Early Supported Discharge with CICS team
- Patient keen for discharge

Case 2

- Problems…..
  - Irate family turns up on ward
  - Informs us of problems with alcohol dependency
  - Patient been estranged from wife but still lived in property
  - Family refusing to have him home

Case 2

- Progress
  - Family meeting
    - Explained process of rehabilitation at home
    - CICS involvement
    - Family still unhappy regarding long term housing
    - Explored possibility of re-housing in sheltered accommodation for patient
    - Benefits explained

Case 2

- Solution
  - Discharged eventually to home with CICS
  - Did well regarding rehabilitation goals
  - Still ongoing relationship issues

Lessons learnt

- Importance of ensuring families are updated about patient's progress and discharge plans
  - But need to maintain patient confidentiality and privacy
- Dealing with substance abuse and impact on rehabilitation

Case 3

- Elderly lady presenting with left hemiplegia
- Originally from Afghanistan
- Residing with son, daughter-in-law and their 4 children
- Has permission to stay in the UK
- Patient uncooperative with rehabilitation

Case 3

- Early discussion regarding discharge with son
- Son expresses the need for re-housing as current accommodation is unsuitable
- Care Manager intervenes early to ensure family is given priority with re-housing

Case 3

- Plans made for discharge to nursing home while awaiting re-housing
- Problems…
  - Other family members turn up insisting that patient is not discharged to nursing home
  - Older son decides to take patient into his flat on discharge
  - Discharge destination changed

Case 3

- Problems
  - Family argue about discharge destination
  - Frequent changes to discharge plans
  - Older son now demanding re-housing if he is to take patient on discharge
- Family meeting called
  - Team made it clear that patient is fit for discharge and made the family come to a final decision
  - Discharge to initial son’s house

Lessons learnt

- Need to discover family dynamics early
- Hidden agenda of patient's relatives regarding re-housing issue
- Importance of getting families to talk to each other
  - We may not resolve long standing family disputes