Berkshire Healthcare NHS
NHS Foundation Trust

Earlier Supported Discharge Service (ESD)

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Learning Outcomes

To gain an understanding of:

- ESD service provision
- ESD care pathway
- Primary benefits of BHFT model
- Recent and Upcoming developments

Service Provision

- **Earlier Supported Discharge for Stroke patients (ESD)**

  The service aims to enable an earlier supported timely discharge from RBH to home and to support rehabilitation to maximise independence post stroke.

  Rehabilitation is provided for 6 weeks, with daily intervention as required

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Stroke Specialist Nurse

Earlier discharge facilitation
Prevention and education
Medication management

Physiotherapist

Exercise programme
Gait
Balance retraining
Upper Limb rehab
Posture management
Positioning

Occupational Therapist

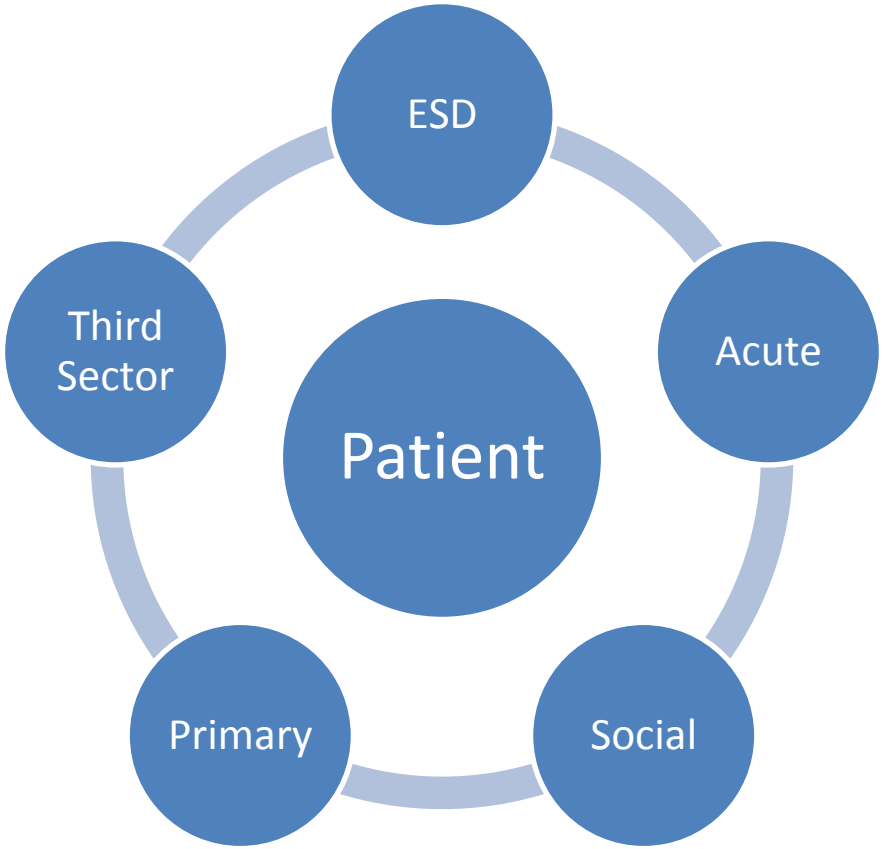
Everyday tasks in the home
Upper Limb Rehab
Perceptual difficulties
Cognition
Leisure pursuits
Vocational Support

Speech & Language Therapist

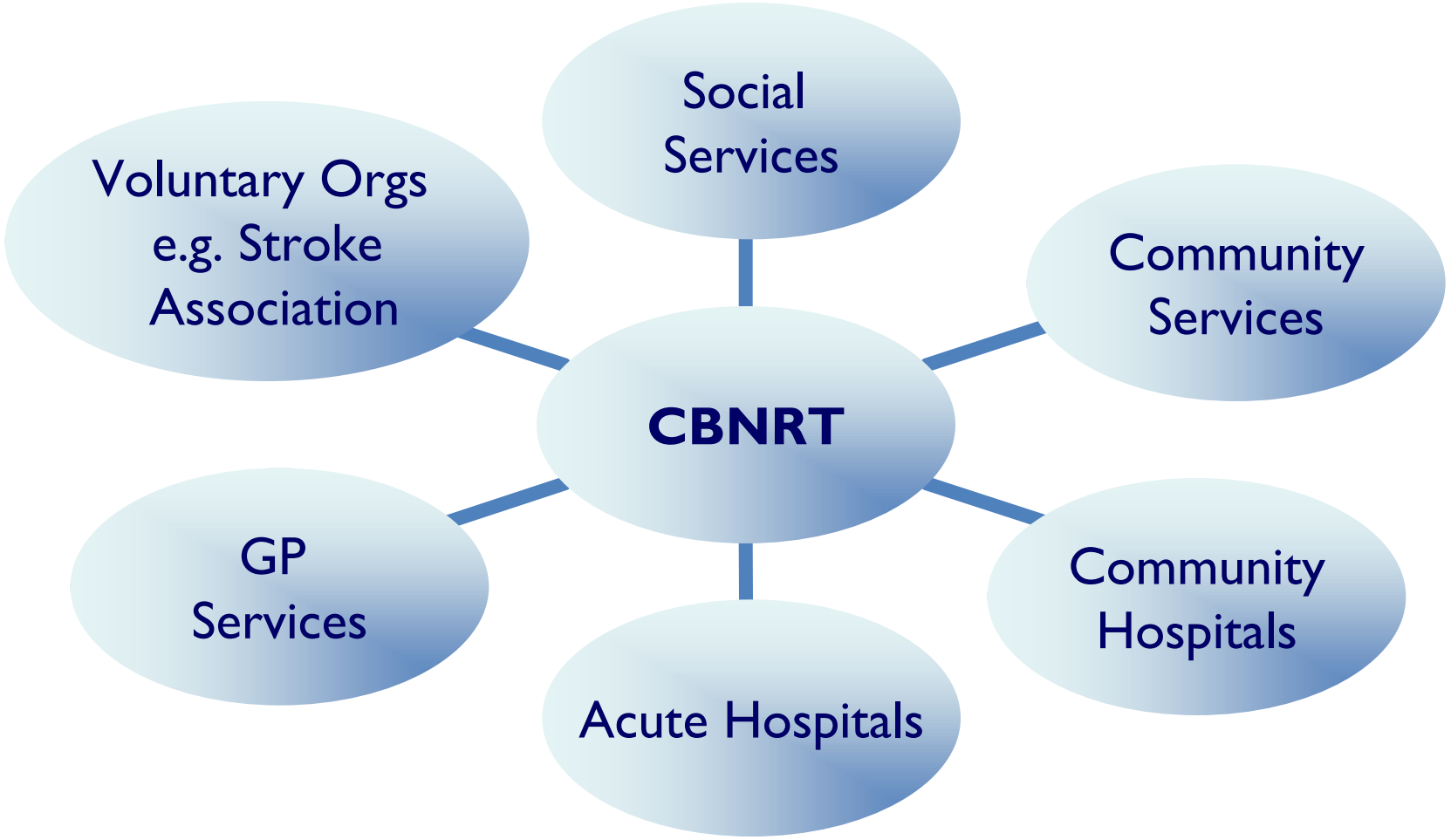
Word finding programmes
Strategies and advice for communication
Swallowing

Neuro-psychologist

Managing anxiety, anger, depression, adjustment
Family adjustment/managing anger
Vocational Support
Cognition and concentration


ESD
Acute
Social
Primary
Third Sector
Patient

LINKS TO OTHER SERVICES



ESD Criteria

- Neurological deficits that can be managed at home
- Medically stable
- Rehabilitation potential identified
- Mobility and transfers are manageable within the home environment, including during the night
- Meal preparation/provision managed
- Complex language
- Sensory/proprioceptive issues, weakness of limbs
- Mobility and balance Cognitive issues
- Complex perceptual issues
- Psychological issues
- Work related rehabilitation goals
- Nursing issues/Secondary Prevention & Lifestyle Modification
- Those patients and their family/carers who are anxious regarding returning home

Process

Referral:	ASU MDT Information to SPoA for entry onto RIO
Intervention:	Assessment, Goal Planning and Treatment
Evaluation:	Outcome Measurement, Referral onto / continuation with other Services (eg. Voluntary, LA, Employment Services, CMs, Leisure Centres)

ESD Referrals

Patient Name _____ **NHS No:** _____

DOB:_____ **Diagnosis:**_____

Date of admission to RBH _____ **Date of ESD referral:** _____

Patient address:_____

Telephone Contact:_____**NOK**_____

A. White British	**G.** Mixed any other	**N**. Black or Black British African
B. White Irish	**H.** Indian or British Indian	**P.** Black or Black British other Black background
C. White Other	**J.** Pakistani or British Pakinstani	**R**. Chinese
D. Mixed White and black Carribean	**K.** Bangladeshi or British Bangladeshi	**S.** Any other Ethnic group
E. Mixed White and Black African	L. Asian British/any other Asian background	
F. Mixed White and Asian	**M.** Black or Black British Caribbean	

- ❒ Berkshire West GP _____
- ❒ Locality Wokingham Reading West Berks
- ❒ Patient has rehabilitation needs and is able to participate with rehabilitation program.
- ❒ Patient agrees to ESD Team referral/input
- ❒ Medically stable _____
- ❒ Aware of diagnosis? Yes No _____
- ❒ On oral food and fluids or PEG.....
- ❒ Transfer independently or with a relative with/ without equipment.(Consider bed and toilet transfers).
  Method of transfer: _____
- ❑ **Stairs** assessment completed _____
- ❒ Able to complete washing and dressing with equipment and formal/informal care. Details if appropriate _____
- ❒ Any continence issues able to be managed independently or by relative/ carer on a day to day basis _____
- ❒ If appropriate Access visit completed or planned (by acute staff)_____
- ❒ Any equipment essential for discharge ordered and in place (by acute staff)
- ❒ Arrangements made for drink and meal preparation_____
- ❒ **Medication management** ❑ Independent (assessed by ward) ❑Family/Carer to administer
- ❒ NOMAD/Dispensing system arranged FP10 sent _____ ❑ Community pharmacy confirmed delivery date_____
- ❒ Able to summon help in emergency (phone / pendant alarm)_____
- ❒ Cognitively able to recognise danger and safety issues if will be **alone**
- ❒ Strategies in place to ensure safety of people with communication problems if at home alone (including fluent aphasics) _____
- ❒ CBNRT (& carers) able to access property e.g. key safe, door entry, NOK, patient
- ❒ Falls risk assessment completed for at risk patients
- ❒ Patient/carer/family anxiety re: hospital discharge. Emotional support required to prevent possible readmission.

Therapy needs?

- ❒ RN
- ❒ OT
- ❒ SLT
- ❒ Psychology
- ❒ PT

Issues to be resolved prior to discharge :- _____

_____

_____

Anticipated date for discharge :- _____ Reason for Change/delay in discharge date:_____

_____

Update of information

Date

_____

_____

_____

_____

_____

Summary

Clients perception of their problems:

Any other relevant Information:

Name_____

Signature_____

CLIENT CENTRED, GOAL ORIENTATED REHABILITATION

- Following an assessment, ideas for goals are generated by patients and/ or carers ‘what do you want to achieve?’
- Through discussion goals are refined with consideration for what is considered realistic and achievable
- Goals may be related to daily living tasks, work or leisure

Primary benefits of BHFT model

- Links between ASU and ESD
  - Co-ordinator attends MDT and completes Ax on ward
  - Co-ordinator meets patients prior to discharge
  - Stroke Association Information, Support and Advice Officers
- COPM as team outcome
- Specialist Interdisciplinary team
  - Client centred / Inter professional goal setting
  - Goal orientated rehab
- Multi skilled Therapy Assistants
  - Include different elements in one session
- Smooth transitions to ongoing rehab
  - ASU to ESD

Recent and Upcoming Developments

- Collaboration between Headway and BHFT
  - Living with Brain Injury Group
  - Carer adjustment intervention

- Improving liaison links
  - U/L Stroke Groups (CHC)
  - Dom Physio
  - Dom SLT
  - Int Care teams

- Development of formal pathway for Psychological Care
  - Use of stepped approach:
    - Assessing and monitoring psychological wellbeing
    - Giving support, information and advice
    - Activity scheduling
    - Motivational interviewing
    - Problem-solving

- Development of formal pathway for Carer Support

MR B

- Age 76
- Lives alone
- Left MCA infarct 26/03/2010
- Admitted to ASU
- PMH: L POCI with visual field deficit and STML, HTN, DM (tablet controlled)
- Previously independent with family support

ESD Referral:

- Seen by CBNRT Specialist Nurse and Clinical Psychologist on the stroke unit prior to discharge
- Independent mobility
- Mr B was aware that visual and cognitive difficulties impacted on function
- However did not always retain this and would become anxious and need explanations repeated
- **Agreed ICT to provide care** 3 times a day to assist with personal care, medication prompts and meals

Sign and Symptoms:

- Visuo spatial difficulties
- Right inattention
- Word finding difficulties
- Cognitive impairments; decreased speed of processing, sequencing and planning and recall
- “ I don’t know where things are”

Problems Identified	Links to other Services
• Unable to go to **Caribbean lunch club**	• Voluntary Sector: Readibus; Lunch club
• Visual difficulties affecting ability to: – Walk independently outdoors – Manage kitchen activities and medication	• Joint working between ICT Carers, SW and ESD Therapists
• Cognitive impairments affecting planning and carrying out ADL activities, **managing medication** and **financial management**	• Joint working between ICT Carers, SW and ESD Therapists and Stroke Specialist Nurse
• Word finding	• Joint working between ICT Carers and ESD SaLT/ESD Team
• **Safeguarding issues**	• Joint working between SW and ESD team

Outcomes

- Walk to local shop independently
- Cross road to get bus to town
- Shower and dress independently
- Heat up prepared meal (lunch) in microwave
- **Inconsistency with orientation to the day**
- **Breakfast preparation variable**
- **Ongoing problems with medication management**
- **Lack of support network necessitates**
- Court of protection application with regard to capacity to manage finances

Referrals On

- Nil
- Set up with Readibus to attend luncheon club/socialise
- Referral to SS for installation of shower rail.
- Nil
- **2 care calls a day plus ongoing SW support (significant reduction in number of calls and length of call)**
- Support from CBNRT Clinical Psychologist

Canadian Occupational Performance Measure: (COPM)

What is it?

- Individualised measure
- Normally used by occupational therapists
- Self perceived changes over time

How is it used?

- Identify performance problems, concerns and issues in the areas of:
  - Self care
  - Productivity
  - Leisure

COPM Outcomes

Going to the Club:

- Performance: 4
- Satisfaction: 1

- Post Intervention:
  - Performance: 10
  - Satisfaction: 10

Kitchen Activities:

- Performance: 3
- Satisfaction: 3

- Post Intervention:
  - Performance: 6
  - Satisfaction: 7

Change Score:

Performance = 7.5 **Satisfaction = 3.5**

A change score of 2 or more denotes Clinical Effectiveness

Pathway from Acute to Community