Integrated working

PLT Wednesday 31 January 2018
LIFE
Living Independently For Everyone

Dr Veronica Montgomery
Kathy Wocial
A multi-agency service providing reablement, rehabilitation, and recovery for patients with complex health and care needs to support early discharge and prevent admission to hospital.
What is included in LIFE?

Services incorporated into LIFE
- Rapid Response
- A&E Liaison
- CICs
- Hospital Discharge
- Community Reablement
- Voluntary Sector (Age UK)
- Domiciliary Care Providers – Surecare

Who work in LIFE
- Physios
- OTs
- Nurses
- Social Workers
- Reablement / Support Workers
- Brokerage
- Community Geriatrician
Mary is an independent 83 year old, who lives in a Warden Controlled Flat. Her son visits her every weekend.

Following a fall at home, Mary is admitted to hospital.

She is identified at the Daily Ward Board round for the Discharge to Assess, and following an initial assessment is referred to the LIFE Team.

Prior to discharge, a Package of Care is arranged with Surecare who visit her at home within 2 hours of her discharge from hospital.

The discharge summary is sent to the GP informing them that Mary has been referred to the LIFE Team and has gone home with a Package of Care.

Package of Care commences at home with 3 calls a day to assist with washing, dressing and meal prep.

Part B assessment is completed at home within 24 hours of discharge and package of care remains unchanged.
Service User Journey through LIFE via Discharge to Assess

Surecare report that Mary is independent in using a trolley and can heat her own meals therefore lunch call suspended.

2 calls a day

Surecare reduce AM call to alternate days

Last call Mary reabled

Letter sent to GP upon Discharge from LIFE Service

Email from son: “Many many thanks to you and the whole team for looking so very well after my Mum. She had done immensely well over the 6 weeks. Your team has been patient and encouraging. She seems to be coping quite well.”

Part B assessment is completed at home within 24 hours of discharge and package of care remains unchanged.
Joe, 87 years old and recently widowed. He is diabetic, has high blood pressure and also arthritis

Joe regularly attends a diabetic clinic

Joe’s package of care has recently been increased

Joe has been discussed at the ICN Huddle and identified as having increased frailty and would be benefit from Reablement.

A key worker is identified to complete the Initial screening form and make the referral to the LIFE Team via the LIFE inbox

LIFE Team allocate a key worker to complete the Part B assessment within 48 hours

Joe’s package of care and Care Plan are reviewed by his key worker and reported back to the GP Huddle. If further care is needed then a Dom care referral is made
How do GPs and their practices work with LIFE?

LIFE
- Rapid Response
- A&E Liaison
- CICs
- Hospital Discharge
- Community Reablement
- Voluntary Sector (Age UK)
- Domiciliary Care Providers – Surecare

GP
- ICN Core Team

Proactive management of people with complex care needs

ICN Core Team

Reablement, Rehabilitation & Recovery

establish & maintain Coordinate my Care (CMC) plans
LIFE services began at the end of September initially on only 3 wards at CUH implementing “Discharge to Assess”.

It has now rolled out to all wards and since December has been working in A&E to prevent admissions. In February, the services will be introducing direct referrals from GPs and other community services, building on current Rapid Response referral routes.

- LIFE have assessed over 350 patients. Now averaging 35 referrals a week.
- 95% of people receive care support within 2 hrs of arriving home
- All Patients received full assessment within safe time limit, 74% within 24 hrs.
- 5% readmitted to CUH – all cases reviewed
Video of LIFE Staff experience

https://www.youtube.com/watch?v=zJOZXS3_s4M&feature=youtu.be
Huddles
How integrated working is helping patients

Dr Dev Malhotra
Dr Adnan Siddiqui
Integrated working from a pharmacist’s perspective and case studies

Janice Steele ICN Pharmacist
Background

• Patients beliefs/concerns
• Stockpiling
• Memory difficulties
• Manual dexterity
• Swallowing
• Accessing medicines

Problems with comms at the interface

• Multiple prescribers
• Out of sync communications e.g. discharge summary
• Duplication of prescriptions

High risk medicines or complex regimens

• Anticoagulants
• Anti-hypertensives
• NSAIDs
• Steroids
• Hypoglycaemics

Cognitive/physical impairment

• Memory difficulties
• Manual dexterity
• Swallowing
• Accessing medicines

Adherence concerns

• Patients beliefs/concerns
• Stockpiling

5-15% of admissions are medicine related
Influences on patients' decisions:

- Evidence base
- Clinical expertise

Factors:

- Internet
- Daily Mail
- PILs
- Friends & family
• To support patients with, or at, high risk of medicines related problems to use medicines appropriately; and to manage independently for as long as possible.

• Work alongside health & social care professionals/voluntary sector to identify problems and support appropriate medicines related interventions and referrals.
Case Study 1

- **Reason for referral**
  - Huddle meeting, requests for home visits but declining support
  - Bkg – 88 yr old, PD on dose reduction regimen of co-careldopa, hypothyroid, bipolar
  - C/O hallucinations, unsure of cause
    - ?20 to his mental health history or SE from medication

- **Visit findings**
  - Hadn’t implemented dose reduction from neurologist
  - Change in dose timings
  - Missed MRI head scan
  - Constipated and potential dehydration (concern as on lithium)
  - Nervous about triggering a mental health admission
  - Weight 48kg

- **Recommendations and outcomes**
  - Agreed dosage reduction regimen with appropriately timed intervals
  - Spoke to neurologist – agreed plan and delayed FU appt
  - Counseled re importance of fluids
  - Arranged blood tests to check U+Es, TFTs, lithium level
  - Discussed food first options
• **Reason for referral**
  - Post discharge referral from medics reconciliation
  - PH; 62F, recent admission with chest pain requiring GTN infusion. Known HTN, asthma, IHD.
  - Unable to tolerate ISMN, not taking beta blocker.

• **Visit findings**
  - Identified concerns with bB.
    - CIs on PIL, “strong” medicine, community pharmacy phone-call
    - Concerned about exercise tolerance
    - Amlodipine had not been given during hosp admission

• **Recommendations and outcomes**
  - Explained the role of bBs in IHD
  - Shared decision to avoid future admission
  - Addressed her concerns re withholding amlodipine
  - Start with lower dose bB and titrate up
  - FU with GP in 2-3wks for asthma r/v, BP check and med r/v
• Cognitive impairment - medicine related?, tailored solutions e.g. folic acid
• Polypharmacy- multiple prescribers, prognostic value, adverse effects, anticholinergic burden
• Sensory impairment / Manual dexterity
• Mobility issues- access may be a problem- home delivery/monitoring
• Decreased clearance/metabolism of drugs (DOACS)
• Dehydration- sick day advice for family and carers
Benefits of collaborative working

• Holistic approach to solving problems
• MDT Huddle
  • Chance to bring individual expertise and knowledge of the patient
  • Real time discussion
  • Actions agreed at the time
  • Chance to feedback on outcomes
• Fast response to deteriorating patients/ situations
• Access to wider support network e.g community geriatrician, community pharmacist
• Best use of members of the teams skill set
• Joint visits
  • Community matron
  • Personal independence co-ordinator (PIC)
Attend 2 of the 3 Workshops

Building connections
LAS and primary care work together to improve patient outcomes
Main Lecture Theatre	Dr Agatha Nortley-Meshe

Working in Care Homes
Working together with community teams within the care homes
Small Lecture Theatre	Dr Chris Bell

Getting it right for people with dementia in Croydon
Working together to make dementia care and treatment simpler and better.
Seminar Rooms A&B	Dr Daniel Harwood