Providing rehabilitation to people within their own homes in order to maintain independence and prevent premature admission to long-term care

- Ruth Broadbent
- Clinical Co-ordinator Intermediate Care Rehab
Salford Intermediate Care Service

Salford City

- Population of approx 250,000
- 37 square miles
- 35000 over 65

Over next 5 years
- 6.6% rise in over 65s
- 9.8 % increase in over 65’s with mobility need
- 8.5% increase in over 65’s with falls prediction
- 9.1% increase in over 65’s unable to manage 1 domestic task
- 8.7% increase in over 65’s unable to manage 1 selfcare task

POPPI – Projecting older people information system
Preventing unnecessary admission to hospital

Supporting early discharge from hospital

Preventing premature admission to long term care

Rapid response

Bedded units

Supported discharge

Community rehab and falls

Intermediate Home support service

Intermediate care services
Salford Intermediate Care Service

Maintaining Independence
(preventing premature admission to long term care)

Single entry point
- AHPs
- HCA
- SWs
- DNs
- GPs
- Hosp O/P
- Rapid Response
- Bedded units
  - Intermediate Home support service
- Amputee clinic
- Community rehab
- Falls service
- Supported d/ch

Community based groups
- postural stability class
- Private home care agencies
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- Intermediate care rehab
- 10.9 WTE Physio – including AP
- 3 WTE OT
- 9.6 support staff band 3 and 4
- SW

- Supported discharge team
- Community rehab
- Falls Service
Overview assessment

- Personal details
- Assessment details
- Consent and capacity
- Other People involved
- Nursing needs
- Activities of daily living
- Cognition and mood
- Your relationships, carers and social history
- Your sight, hearing (senses) and communication
- Your safety
- Your home and finances
- Summary
- Goals
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Thorough, holistic, person centred assessment to ensure:

- Health needs are met
- Functional needs are met
- Psychological needs are met
- Social needs are met

- Patient choice and desires are addressed to ensure over all wellbeing can be maintained.
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Staff training

- Observation of experienced staff
- Completion of overview observed
- Goal setting training – based on ICF/model of disability
- Therapy Outcome Measure (TOMs) training.
- Passporting of equipment
- Falls Assessment
Key to maintaining a person at home

- Optimising physical function
- Addressing issues important to the person
- Giving people the tools to maintain their wellbeing
- Access to equipment including assistive tech
- Making a change that is sustainable
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- TOMs data – Oct 15

- 124 people with 2 or more contacts
- 13% (16) no change in any area
- 108 patients that made a +ve change in at least one area 14% (15) made change in 1 area only

<table>
<thead>
<tr>
<th>Impairment</th>
<th>activity</th>
<th>Social participation</th>
<th>wellbeing</th>
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<tbody>
<tr>
<td>59%</td>
<td>62%</td>
<td>59%</td>
<td>49%</td>
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Patient story - Stella

- If the doctors and surgeons saved my life – Diane saved my sanity
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Developments

- Salford HomeSafe project
- Discharge to Assess model
- Different ways of working within existing services
- Resourced to be responsive.
- Increase in OT – co-ordinators.
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- Preventing unnecessary admission to hospital
- Supporting early discharge from hospital
- Preventing premature admission to long term care

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Developments

- Salford HomeSafe project.
- Discharge to Assess model.
- Different ways of working within existing services.
- Resourced to be responsive.
- Increase in OT – co-ordinators.
- Integrated co-ordinated approach across services/agencies
Ruth Broadbent – Clinical Co-ordinator
Intermediate care rehab

ruth.broadbent@srft.nhs.uk
0161 906 1550