Livewell Southwest

Early Supported Discharge Team Operational Policy

Version 1

Review: April 2020

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Team Manager**

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Reader Information

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Version no.	Type of change	Date	Originator of change	Description of change
0.1	Full review	March 2017	Team manager	New document
1	Minor changes	April 2017	Team Manager	Ratified

Early Supported Discharge Team Operational Policy

1 Introduction: Overview of Service

1.1 The Early Supported Discharge Team (ESD) is located within the Community Urgent Care Services. It offers specialist assessment and treatment to people over 18 with an acute stroke within their own place of residence.

1.2 The aim is to provide a multidisciplinary goal orientated approach to recovery for people who have an acute stroke with holistic individualised care. The team focus is on recovery, prevention of deterioration and/or self-management.

1.3 The service consists of physiotherapists, occupational therapists, speech and language therapist, therapy support workers and administration support. Regular contact is made with other services, including Acute and Community Stroke Units, LCC Therapy Unit, neuro-psychology, Community Therapy Teams, Social Workers and Social Care services and can access medical support from rehabilitation consultants, orthotics, wheelchair services, and dieticians.

1.4 The service has an office base in the Beauchamp Centre at Mount Gould Hospital. Clinically all patients are treated within their own place of residence.

2 Purpose

2.1 The aims of the ESD are as follows:

- To provide a specialist multi-disciplinary rehabilitation service for assessment and treatment of people with an acute stroke. The team focus is on recovery, prevention of deterioration and/or self-management.

- To provide multi-disciplinary, holistic assessment, treatment and advice and to promote self-management, education, independence and improved quality of life.

- To prevent hospital admission

- To facilitate earliest possible hospital discharge from Acute Stroke Unit, Derriford Hospital and the Stroke Rehab Unit within Mount Gould Hospital as an in-reach system to ensure smooth transfer of care for inpatients with first appointments being made prior to discharge whenever possible. To support early discharge from other Acute and Stroke Rehab Unit that refers into the service. The service may also in reach into other hospital wards as required.

2.2 The objectives of the Early Supported Discharge are as follows:

- To provide a specialist stroke service using assessment and treatment by Occupational Therapy, Physiotherapy, Speech and Language Therapy and Nursing.

- To set time-limited, functional goals with each patient

- To provide advice, education and information to promote self-management

- To coordinate discharge in a timely way, with onward referral where appropriate

2.3 Expected Outcome of the Early Supported discharge Team:

- To meet patient-led functional goals within a reasonable time period.

- To improve functional outcomes, measured by using validated outcome measures.

- To meet patients' expectations of the service provided, measured by the Friends and Family test

3 Definitions

3.1 ESD Early supported discharge team

MGH Mount Gould Hospital

TSW Therapy Support Worker

TU Therapy Unit

4 Duties & responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

4.2 Responsibilities of **Director(s)** are to assist the Chief Executive in delivering this policy by ensuring its implementation within their services across all localities.

4.3 Responsibilities of the **Locality/Deputy Locality Managers** are responsible for the day-to-day compliance with this policy and to work with the team managers to make any changes to the policy as necessary

4.4 Responsibility of **line managers** is to update this policy as necessary and ensure that the operational policies are adhered to, and to ensure that any deficiencies found in the audit process are acted upon

4.5 Responsibility of all **staff** to be aware of and work in accordance with this policy

5 Staff Team

5.1 The Early Supported Discharge team is managed by a Team Manager. The team also includes Physiotherapists, Occupational Therapists, Speech and Language Therapist, Nurses, Therapy Support Workers and Administration staff. Workforce planning and skill mix reviews are on-going and integral to the safety and cost effectiveness of the service.

5.2 Physiotherapists

Provide specialist assessment by analysing movement and function. Treatment includes physical therapeutic modalities, home exercises, education and advice to improve and maintain function and independence.

This includes:

- Neurological therapy
- Strengthening, maintaining joint range of movement and improving sensation
- Assessment and management of muscle tone
- Reducing pain and swelling
- Acupuncture for pain
- Advice and exercises for facial paralysis
- Improving balance and gait
- Assessment and provision of appropriate walking aids
- Strength and balance group
- Taping
- Assessment for functional electrical stimulation
- Signposting to other appropriate services
- Advice regarding posture and seating

5.3 Occupational Therapists

Provide specialist assessment of occupational performance skills, environment and cognition, enabling patients to develop and maintain independence in personal, domestic and vocational living skills.

This includes:

- Specialist functional assessments including wheelchair, seating, cognitive, perceptual testing
- Specialised treatment including splinting, joint protection and daily living skills
- Provision and training in the use of rehabilitation and specialist equipment
- Environmental assessment and the provision of, and recommendation for, adaptations
- Driving assessment
- Rehabilitation of upper limb movement and function
- Vocational rehabilitation
- Fatigue management

5.4 Speech and Language Therapist

Provides specialist assessment and therapy for communication and swallowing impairments with the aim to minimize the effect of impairment, increase participation and social interaction as well as optimizing well-being and quality of life.

This includes:

- Assessment of swallow function at bedside, while facilitating access to specialist instrumental assessment (e.g. videofluroscopy) where indicated.
- Provision of swallow recommendations, incorporating compensatory strategies (e.g. regarding texture modification, posture, rate and amount per bolus).
- Provision of specific swallow rehabilitation exercises following instrumental assessment which target the area of impairment (e.g. Shaker).
- Detailed formal and informal assessment of communication.
- Detailed analysis of assessment including that relating to linguistic and phonetic data.
- Provision of communication recommendations and a communication therapy plan relating to the patient driven goals.
- Identification of mood screens that allow for communication impairment.
- Assessment and facilitating access to high or low tech AAC (Alternative, Augmentative Communication).

5.5 Stroke Specialist Nurse

Provide specialist nursing and support enabling patients to develop, maintain and enhance independence and promote self-management.

This includes:

- Psychological support and adjustment management
- Medication management and concordance
- Continence support
- Sexual health
- Carer Support
- Fatigue Management
- Pain Management

5.6 Therapy Support Workers

Support therapists in the application of a treatment plan in order to achieve patient goals relating to function, mobility and activities of daily living

This includes:

- Joint treatment sessions with therapists
- Progression of exercise programmes in discussion with qualified therapist
- Meeting regularly with appropriate therapist to review episode of care, goals and treatment plan
- Identifying when referral to other agencies would be appropriate
- Assessment for and ordering aids and equipment (including for home environment)
- Maintenance of therapy environment
- Practice and development of strategies for memory loss
- Implementation of strategies for fatigue management/pacing
- Updating/maintain information for patients/therapists e.g.: community groups, exercises classes, pool access

5.7 Additional contact with the multi-disciplinary team occurs when required in accordance with specific patient needs via phone contact, email and face to face meetings. There is also a weekly MDT meeting to discuss patients. The Clinical team are supported by a senior Management structure. This includes a Matron who is accountable to a Deputy Locality Manager/Locality Manager for Community Urgent Care Services.

6 The Environment

6.1 The team office is based at the Beauchamp Centre, Mount Gould Hospital, Mount Gould Road, Plymouth, PL4 7QD shared with the TU service.

6.2 The Team work out in the community within the patient's place of residence, which can include, but not exhaustive of, Nursing and Residential Homes, Supported Housing and Hostels.

7 Day to Day Operations and Referral Process

7.1 The Early Supported Discharge Team (ESD) operates from 8am to 5pm Monday to Friday and 8am to 4pm Saturday and Sunday, providing a 7 day a week service, this includes Bank Holidays.

7.2 ESD accepts referrals for people registered with a South East Cornwall, Plymouth, South Hams and West Devon GP

7.3 Patients are seen as in their chosen place of residence, or if necessary shortly before discharge from an inpatient unit as part of an in-reach service.

7.4 Referrals can be made via the ESD referral email (Livewell.esdreferrals@nhs.net). The ESD referral form (Appendix 1) must be fully completed for the referral to be accepted and attached to the email.

7.5 Referrals can be made by Allied Health Professionals, Stroke Specialist Nursing, GPs, Adult Social Care, District Nurses, Community Therapy Teams including TU, Psychologists, Consultants, Specialist Nurses, voluntary sector and secondary care. There is currently no service provision for self-referral.

7.6 Referrals are received in the ESD inbox which is checked four times daily during the week and twice daily at weekends.

7.7 ESD are able to offer same day response either by telephone contact or home visit following triage of referral.

8 Inclusion Criteria

8.1 Eligibility criteria include:

- Clinical diagnosis of confirmed acute stroke.
- Patient aged 18 years or above.
- Patient is medically stable and able to be managed medically in Primary Care setting.
- The patient and carer have been given clear information and consented to ESD.
- The patient and their family/carer are agreeable to rehabilitation at home and agree to identified goals.
- The patient has been deemed to have adequate cognitive ability to be safely at home with or without care and to have an appropriate level of communication/ ability to gain help in an emergency if they live alone *(i.e. pendant alarm in place and able to use).*
- They are able to transfer from bed to chair alone or with assistance of 1 carer ± equipment.
- Achievable rehabilitation goals can be identified.

9 Exclusion Criteria

9.1 Exclusion criteria include:

- Not registered with a South East, Plymouth, South Hams or West Devon GP.
- Under 18 years of age.
- Self-referral.
- No confirmed diagnosis of acute stroke.
- Not medically stable.

10 Discharge criteria and planning

10.1 It is expected that the service to the patient will last approximately 6 weeks.

10.2 The discharge planning process starts at assessment, when treatment plan and SMART goals are agreed. Goals are discussed with the patient and their carer/family as appropriate within the first 2 treatment sessions and documented within the notes. Treatment is goal directed and time limited and this is discussed with the patient at the time of setting goals. Patients are also given a copy of their goals. Once this timescale is reached, the goals should be reviewed together and either re-set if there are outstanding therapy needs, or the patient should be discharged at this stage.

10.3 Caseload management is carried out with all staff via their line manager, providing support for therapists making decisions regarding discharge.

10.4 Plans for discharge will be discussed with the patient and anyone who attends with them.

10.5 Onward referral will be made, with the patient's consent (or in the patient's best interests' if consent cannot be obtained), to other appropriate services.

10.6 Once discharge has been agreed, a discharge report is sent to the referrer, GP, the patient if required and any other services involved.

11 Patient and Carer Information

11.1 The Early Supported Discharge Team actively promotes patient independence and self-management. Patients are strongly encouraged to maximise their function and fitness in order to manage their condition successfully at home and maintain their own wellbeing as far as possible.

11.2 Patients will be signposted to condition-specific organisations, expert patient programmes and support groups to support them with managing their condition. Information regarding the PALS service is provided where appropriate.

11.3 Patients and their carers are given contact details for services/groups, website addresses and leaflets relating to their specific needs.

12 Communication

12.1 Monthly team meeting - this is held on the first Wednesday of each month to discuss clinical and non-clinical issues within the team, including service development plans and matters directly related to the operation of the Early Supported Discharge team including patient feedback, risk management and safeguarding alerts raised.

12.2 MDT Clinical Meetings - These are held weekly every Thursday to review all patients on the team caseload to review progress, discuss goals and plans for treatment. New referrals are discussed and decisions made regarding the outcome.

12.3 Service meetings - The Manager/deputy or nominated staff may attend meetings within the organisation, feedback to other staff within the team and action any points from this meeting.

13 Training implications

13.1 On appointment all staff should receive a corporate and local induction.

13.2 Each staff member is allocated a line manager who takes responsibility for regular line management supervision, caseload management supervision and annual appraisal. Additionally the Organisation supports staff to engage in 1-1 practise supervision in line with policy.

13.3 The Organisation provides a programme of mandatory training for every employee.

13.4 All staff are expected to engage with Continued Professional Development and should keep a record of the training, reflection and supervision that they have participated in. All staff are expected to maintain their professional competencies using the ratified documents to support this.

13.5 Local clinical in-service training is also provided alongside other neurological teams within Livewell Southwest on a fortnightly basis. Staff are expected to attend where possible.

14 Management responsibility

14.1 The Early Supported Discharge Team Manager has responsibility for the unit during working hours supported by the deputy and all other members of the team, and is responsible to the Matron for Neurological Services who in turn is accountable to the Community Urgent Care Services Locality Manager.

15 Service user involvement

15.1 Service Users are involved in all aspects of their care, along with carers as appropriate, and are assisted to access resources as required. Service user questionnaires are completed on discharge and on an annual basis.

15.2 A service user representation is encouraged as part of open staff meetings, service development initiatives and as part of interview panels.

16 Clinical Governance

16.1 Services are monitored for compliance against Care Quality Commission Standards. These are reviewed on an on-going basis and evidence is kept on a shared drive. The Current Key Lines of Enquiry focus on the service being Safe, Effective, Caring, Responsive and Well Led.

16.2 There is a process of clinical audit in place across the year which includes action planning where standards fall short.

16.3 There is an identified link person to attend Infection Prevention and Control meetings, and to contribute to Infection Control audits.

16.4 The service has defined systems and processes in place to continually monitor and improve the quality of care delivered.

17 Information Governance

17.1 Service Users are informed of how as an Organisation we store and share confidential information via our Electronic Patient Record (EPR).

17.2 The service provides an information booklet on the first contact visit containing information around SystmOne, Confidentiality, Data collection and Compliments, Complaints and Concerns procedure.

17.3 All staff are responsible and must adhere to policies, procedures and systems that are in place to ensure that confidentiality of information is maintained.

17.4 All staff should receive training around confidentiality and sharing of information.

17.5 Information Governance incidents are routinely monitored across Livewell Southwest

18 Managing safety and risk

18.1 The organisation takes seriously its responsibility for staff and service user safety. All staff however have a responsibility for safe working practices and to follow Health and Safety Guidelines, Lone Working policies and the LSW's Violence & Aggression Management Policy.

18.2 There is an electronic risk register on the unit that must be kept up to date.

18.3 All staff must use the white board to record visits/activities outside the unit and must report back at the end of any visit/activity. All staff carry a Sky guard device in accordance with the lone worker policy.

18.4 All staff complete an environmental risk assessment on initial visit.

18.5 If there is a known risk in visiting any service user then appropriate safeguards should be put in place according to the Loan Worker Policy.

18.6 All staff must be aware of any warnings recorded on SystmOne and update these if necessary in line with SystmOne policy.

18.7 All staff should be trained in conflict resolution and physical intervention techniques.

19 Monitoring compliance

19.1 Compliance with this policy is monitored through patient feedback via the Friends and Family test, local audits of documentation, regular line management and appraisal of all staff, NICE guidance review and monitoring service statistics and waiting lists. Results of these are reviewed by managers and deputies and shared with the team to monitor team performance.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Michelle Thomas, Director of Operations

Date: 10th May 2017

Appendix One

Stroke Early Supported Discharge Referral and Contact Assessment Form

Patient Details	**Ethnic Code:**	**Patient Hosp No:**
Full Name:		**NHS No:**
Address:		**Date of Birth:** dd/MM/yyyy **Gender:**
Tel No:		
Consultant:		
GP:	**Practice:**	**Tel No:**

Next of Kin Name:
Tel No:
Relationship:

HAS CONSENT BEEN GAINED?	**Patient**		**Carer**	
	Yes ☐	**No** ☐	**Yes** ☐	**No** ☐

Estimated Discharge Date: dd/MM/yyyy

Diagnosis (please include CT/MRI results & date of stroke)

Past Medical History

Medication
Current Medication: SEE DISCHARGE SUMMARY
Self-medicating: YES ☐ **NO** ☐
Compliance Aids: YES ☐ **Aid:** **NO** ☐

Medication

Issue/Concerns:

Home Environment (please attach home visit report where appropriate)

Social History:

Previous Function:

Hobbies & Interests:

Functional Ability on Discharge (please attach EV/HV report where appropriate)

Mobility:

Transfers:

Personal Care:

Toileting:

Exercise Tolerance

Fatigue levels:

Domestic Tasks:

Performance Components (please include or detail recent assessments)

Motor:

Tone/Splinting:

Cognition: **MOCA** ☐ **Score:** ☐ **Score:**

Vision/Perception:

Sensation:

Mood:
DISCs ☐ **Score:** **BASDEC** ☐ **Score:** **SADQ** ☐ **Score:**

Swallowing:

Communication:

Skin Integrity:

Functional Ability on Discharge (please attach EV/HV report where appropriate)

Waterlow ☐ **Score:** ☐ **Score:**

MUST Score:

Bladder Function:

Bowel Function:

Discharge Information

Support Services **Date to commence:**

Package of Care	☐	Reablement	☐	Family	☐

Goals

Goals agreed with patient:

Risk Assessment

Do you consider there to be any risk factors associated with this patient?

Lone Visit	☐	Environmental	☐	Access	☐
Infection	☐	Pets	☐	Other	☐

Details:

Seen by discharge

OT	☐	PT	☐	SLT	☐
Psychology	☐	Dietician	☐	Other:	

Additional Notes

Date: **Signature:**

Referral

Date Referred	Name of referrer	Profession	Contact Number

Referral			

Contact Assessment by ESD			
Name	Profession	Contact Number	Date