Right place, right time, right team

Thurrock Rapid Response Assessment Service

A joint Thurrock social care and South West Essex Community Services initiative helps residents in Thurrock get a rapid response and assessment for their health and care needs.

Skills for Health

skillsforcare

Background

The service builds upon the recent Thurrock social care pilot that focused on rapid response. The Thurrock Rapid Response and Assessment Service is an integrated health and social care team, with one dedicated manager. It provides a rapid response and assessment for people in crisis. It co-ordinates and redirects their care to the appropriate intermediate provider or service. The team does not deliver the ongoing care but is the conduit to ensure that happens. Care is delivered in the right place at the right time, through the most appropriate pathway.

Aims and objectives

The aims of the service are to provide a response within 72 hours and:

- prevent unplanned emergency admissions
- prevent unnecessary admission to residential care
- provide intermediate care in the right place, at the right time, by the right team
- support carers.

How it works

The team comprises a team manager, three band 7 prescribing nurses, two social workers, a support planner, two health care assistants and dedicated administrative staff. The service is open from 9 am to 9 pm.

Following referral, the appropriate team members visit the individual at home and undertake a comprehensive health and social assessment. This enables the person to be managed in the right place, with the correct level of support from the most appropriate care provider. This new service works closely with the existing health and social care intermediate services. It ensures ongoing support for patients and carers is co-ordinated.

“My friend’s granddad was recently taken ill abroad and had to fly back to this country. Unfortunately there was no other family around and she had real difficulty in getting help from her local GP etc and after no sleep for two days and exhausting all avenues the rapid response team arrived and she found them to be absolutely brilliant. They assessed him, arranged an admission to hospital, gave good advice and basically took over at a time when she had no energy left.” Interviewee.

The service enables:

- support with the patient or carer’s acute functional deterioration, for example due to a fall, infection or inability to cope
- clinical interventions as a result of assessment and diagnosis by the nurses
- rapid access to intermediate care rehabilitation services, promoting independence
- support for carers
- rapid access to emergency equipment including assistive technology (telehealth and telecare)
- assistance, advice and support for the person to help them manage their condition and avoid unplanned, emergency admissions in the future
- a medication review and prescribing of medication, as required, to prevent unplanned emergency admissions.

Outcomes

Since 1 April 2012, when the service started, 817 patients have been seen. In the quarter, October-December 2012, 327 people were seen and 88% of them avoided the need for a GP call, 66% have avoided residential care and only 3% have required admission to hospital. Encouragingly, GPs are now using the service and the numbers are growing each month.

An interim evaluation identified two key developments:

- that health input would maximise the service through provision of rapid assessment and intervention for vulnerable adults
- the operating hours needed to be extended. Therefore, since 3 December 2012, the full service operates from 9 am to 9 pm and on call services are provided at weekends.

Promoting independence and wellbeing

Mrs M is a 72 year old lady, and there had been a sudden deterioration in her physical wellbeing, impacting on her transfer abilities and daily living tasks. Her assigned nurse referred her to the service. The intervention provided occupational therapy equipment to promote independent transfers and a supporting care package was approved to assist with personal care, minimising the risk of infection. Medication issues were also addressed. On a return visit Mrs M reported she felt much better and her wellbeing had improved, as she was not so reliant on her family and able to transfer independently without having to wake her son at night.

Impact

There have been significant impacts as a result of the rapid response and assessment service:

- reduction in acute hospital admissions – there is evidence that people have been supported at home with health and social care input, ensuring improved outcomes for patients and reduced admissions for the hospital
- prevention of admission into long term residential care – this has been evident for both older people and disabled adults, leading to a longer term improved outcome for the individual. Where required, large and innovative care packages have been provided at home to help people in a crisis
- prevention of carer breakdown – there is evidence that response in a timely manner can prevent a crisis and improve the recovery time, following a critical time in a carer's role
- supporting people to maintain their independence within their own homes – the development of the service has been closely aligned with the development of the joint health and social care reablement service. Early referral into the service and increased use of assistive technology and equipment at early stages shows improved outcomes for individuals, with reduced dependency on services longer term.

Preventing carer breakdown

Mrs A is an 84 year old lady, who was being cared for by her 86 year old sister. The carer was providing round the clock support and physical assistance on all transfers, she was exhausted.

Following the rapid response and assessment service intervention, a supporting care package was approved to assist with personal care and hygiene, together with a profile bed, a riser/ recliner chair, toilet and shower equipment and minor adaptations. The carer was offered a carer's assessment, from which a sitting service was provided, enabling her to have two mornings a week respite from her caring role. The assigned nurse completed a general health check and an agreed referral to the community physiotherapy team for assessment of mobility aid and continence service.

On a return visit both parties were in an elevated mood. Mrs A was not so distressed that her sister had to do everything for her and the carer was happier as she had support and "some time out for me".

The following two nursing case studies show the level of detail of the assessment that is offered to Thurrock residents when the team are called out. Each case study also demonstrates the impact the team is having.

Nursing Case Studies

1. Patient history
Mr H – 92 year old man, referred by social care for loss of mobility, increased confusion, not coping at home already on antibiotic therapy for chest infection.

Rapid Response and Assessment Service (RRAS)
Visited patient within two hours of receiving referral.

Intervention by RRAS
- full physical, psychological and social assessment undertaken
- bloods taken
- vital signs taken (BP, pulse, respirations and temperature)—pyrexia (high temperature) noted.

Outcome of assessment
- symptomatic of chest infection
- care package increased to four times a day visits.

Action following assessment by RRAS
- referred to occupational therapist to assess mobility
- outcome of visit fed back to South Essex Emergency Doctors Service, that the family had contacted with concerns.

RRAS follow up
- blood test taken indicated renal failure, further risk of patient falling identified, inpatient bed booked at Mayflower Community Hospital—avoided acute admission.

2. Patient history
Mrs S – 94 year old lady, referred by social care following telephone call of concern by family; Mrs S found wandering in a confused state.

Intervention by RRAS, Joint health and social worker
- full physical, psychological and social assessment undertaken by health and social care
- bloods taken, sent for dementia screen
- vital signs taken (BP, pulse, respirations and temperature)—nothing abnormal detected
- mini mental state examination
- urinalysis—nothing abnormal detected.

Outcome of assessment
- referred for telecare alarm system
- care package to start four times a day.

Action following assessment by RRAS
- referred to Dementia Team.

RRAS follow up
- hypothyroidism identified following blood test—referred to GP
- awaiting memory clinic appointment.

Next steps

There are some key actions planned:

- the service has been extended from 3 December 2012 and will provide longer opening hours
- there will be continuation of work with the Clinical Commissioning Group in promoting and monitoring the service, with regular updates
- the manager will continue to work with all intermediate care services to ensure improved links
- there will be further exploration of a single point of access and contact for Thurrock across intermediate care services
- a full evaluation will be undertaken of the service, with data being triangulated against acute and residential care home admissions
- a live system is being developed to identify capacity of all intermediate care services
- there will be continued exploration of joint IT systems.

Resources

A range of resources developed to support this project are available.

Contacts

http://www.swessexcommunity.nhs.uk
http://www.thurrock.gov.uk

Further information

For further information about the health and social care integration work between Skills for Health and Skills for Care please contact:
Skills for Care info@skillsforcare.org.uk
Skills for Health office@skillsforhealth.org.uk