

# DRIVING CARE HOME

*The journey to attain the greatest  
independence and the best quality  
of life possible*

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# The Home Hospital Service THHS



**OP and RS**

Older Persons and  
Rehabilitation Services

# Mr Smith





# The Home Hospital Service

- Home based service
- Virtual ward
- Inpatients
- Interdisciplinary team
- Rehab focused
- 7day a week service
- RN 0800-2200 with an on call service overnight
- Up to 14 days



- On call geriatrician
- Operates within city boundaries
- Maximum of 15 patients
- Medically stable
- Requires at least 2 different health professionals
- Refer on to other services following discharge (if necessary)

# Criteria for Admission

- Consent to our service
- Agree to partake in rehabilitation
- Condition not expected to deteriorate
- Intermittent visits—up to three per day
- Usually over 65 years
- Environment is safe
- Patient safe to be left at home
- Mobilise without assistance (if no carer at home)



# Conditions Often Include:

- Stroke
- Joint replacements
- Medical Conditions e.g. CHF, COPD
- Surgical e.g. bowel surgery, skin grafts, amputees
- Pain management e.g. arthritis
- Medication management e.g. diabetes, warfarin
- Palliative e.g. stable



# Benefits of Rehab in the Home

- Patients preferred choice
- Familiar environment for patients
- Privacy and comfort
- Patients with dementia/delirium cope better
- Family involvement in rehabilitation
- Assessment of home environment
- Reduced costs



# OPandRS in the Community

A future service will be developed around the following concepts:

- **SUPPORTIVE DISCHARGE SERVICE**– providing up to six weeks intensive home based support following discharge from Waikato hospital
- **RAPID RESPONSE SERVICE** – operating out of ED, to prevent hospital admissions by delivering up to six weeks intensive home based support



The new service will aim to reduce referrals to:

- **Home Based Support Services**  
and
- **Residential Care Facilities**

It will be part of the broader continuum of care for older people ensuring a seamless transfer of services from hospital to the community



## **It will Offer:**

- Culturally appropriate, goal orientated, rehabilitation plan
- Client centred care
- Prevention of admission to hospital
- Reduced length of stay
- Seamless discharge service
- Immediate and responsive intensive rehabilitation care packages

# ED Pilot Project

- Commenced two months ago
- RN based at ED
- Monday-Friday
- 1330-1630hrs
- Screen over 75yr olds - that are likely to be discharged home

- Liaise with ED staff by way of internal referral
- Check data base to identify potential patients
- Follow up any patients identified by ED as requiring OPandRS input

# Screening Tool

Patients must be:

- Assessed as clinically stable
- Not requiring hospital admission
- And meet one of the criteria listed on the next slide

# Screening Tool

- Cognitive impairment
- Social issues
- Decline in function
- Falls
- Frequent flyer
- Multiple medications
- Self neglect
- ED staff have concerns

# Current Services

- Assessments
- Follow up phone call
- Acute service referrals
- DSL referrals
- Emergency respite care
- The Home Hospital Service referral
- Assessing and Outpatient referral
- Equipment
- Transitional care
- Transport (in some circumstances)
- ACC (not contracted)



- The ED pilot is likely to link into the rapid response service.
- Establishing a service prior to the redevelopment of a community service will allow for a smoother transition



# **OPandRS COMMUNITY SERVICE in the FUTURE**

**Watch this space**

# Reference

- Baird, J., Parson, M. & Wood, P. (2008) Assessment, treatment and rehabilitation hospital build review. Waikato District Health Board.



# Acknowledgements

- The Home Hospital Service Team
- Mr Smith (not his real name)