Preventing avoidable hospital admissions and facilitating rehabilitation with a rapid response service

As providers of West Lancashire's adult community services, which we run on behalf of NHS West Lancashire Clinical Commissioning Group, we manage a Community Emergency Response Team (CERT) and Short Intensive Support Service (SISS).

The multi-disciplinary CERT team has been in place since 2014, providing a rapid response service to prevent avoidable hospital admissions as well as facilitating short-term rehabilitation.

Care is delivered either in the patient's own home or in a community bed-based facility according to need. The team comprises nurses, occupational therapists, social workers, technical instructors and health care assistants.

Case study (CERT)

The daughter of a 65-year-old lady had contacted her mother's GP as her brother and herself were finding it harder to cope with their mother's care needs. Her mother had a known cerebellar disease that caused frequent seizures and would be left debilitated following a seizure. As she lived alone, her daughter and son had been caring her in between their own lives and job.

Following a referral to CERT, our nurse and therapist visited the lady and assessed her situation. The assessment determined that she required full assistance with daily living activities an air mattress to prevent pressure sores and a slide chair for safe transfer to the toilet.

A referral was made for two carers to visit, four times a day, and social services were informed. The equipment was ordered, to be delivered the next day.

The patient and her family were happy with the plan and grateful for the speediness.

In 2019, we launched the SISS service, which provides care to a patient in the comfort of their own home for up to 72 hours, up to six times a day, helping to stabilise their condition and avoid an emergency admission to hospital.

Ambulance staff, GPs and other health and social care professionals can all refer patients to the multi-disciplinary team, which is led by advanced nurse practitioners and includes occupational therapists, physiotherapists, registered general nurses and generic support workers.

The team sees patients within a two-hour framework from referral where necessary, and clinically, socially and environmentally assess to see where aid is required to help avoid imminent or future 999 calls or hospital admissions.

Generally, patients are under the care of SISS for 72 hours, however sometimes this is extended to ensure that the patient's care plan is completed or can be safely transitioned to the support of other services.

SISS is also integrated with other health, social care and voluntary sector services to ensure a seamless package of care for each patient during and after the 72 hours; supporting them in a fast recovery and in continuing to live independently.

The SISS team, which operates from 9am-10pm, 365 days per year, has discharged more than 500 patients over the past year (since October 2019).

All referrals to the CERT and SISS teams come in through our fully functioning Care Co-ordination Hub which comprises administrators alongside a district nurse and therapist of the day to ensure that patients are put on the correct pathway as soon as possible.

Case study (SISS)

A 93-year-old female who lives with her 92-year-old husband and carer was referred to SISS by her GP for clinical triage of a possible UTI infection. The lady had dementia and mobility issues and her husband was feeling overwhelmed.

The lady was seen within two hours of referral. An assessment by the nurse practitioner diagnosed constipation and dehydration. The generic support worker who accompanied the ANP provided assistance with personal care, food prep and mobility.

A care plan was developed for the lady. Antibiotics and bowel care products were prescribed to support with the UTI and constipation. Her pressure areas were compromised and a referral to short term rehab was made and carers advised to reposition the lady at each visit. The patient was encouraged to get dressed and sit in the lounge to promote a normal routine. A long-term package of care was also requested from social services.

Follow up visits took place over a three-day period and the lady's condition improved. On day three a handover took place to refer her back to her GP and to a community matron for long term monitoring, advanced care planning and crisis care planning as it was expected that her husband would require hospital admission for planned, urgent treatment in the near future. Social services support would also continue.

SISS was able to deal with this situation so that a GP visit, 999 call and subsequent hospital admission (due to deterioration of constipation and UTI) did not arise. A number of issues were flagged that required a more in-depth, proactive MDT approach and this was actioned. Both the patient and her husband were thankful for the response and support given.

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