Enabling an Integrated Seamless Pathway for Stroke patients requiring ongoing Occupational Therapy services in the Community in Perth & Kinross

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Key Policy Drivers

- The Public Bodies (Joint working) Scotland Act 2014
- National Health and Wellbeing Outcomes.
- Of the 9 Outcomes of Health and wellbeing, stroke services particularly focused on:
- Outcome 3) People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Outcome 8) People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Outcome 9) Resources are used effectively and efficiently in the provision of health and social care services.
- These policies required the **implementation of integration of Occupational Therapy Services which were being delivered separately by Perth and Kinross Council and NHS Tayside.**

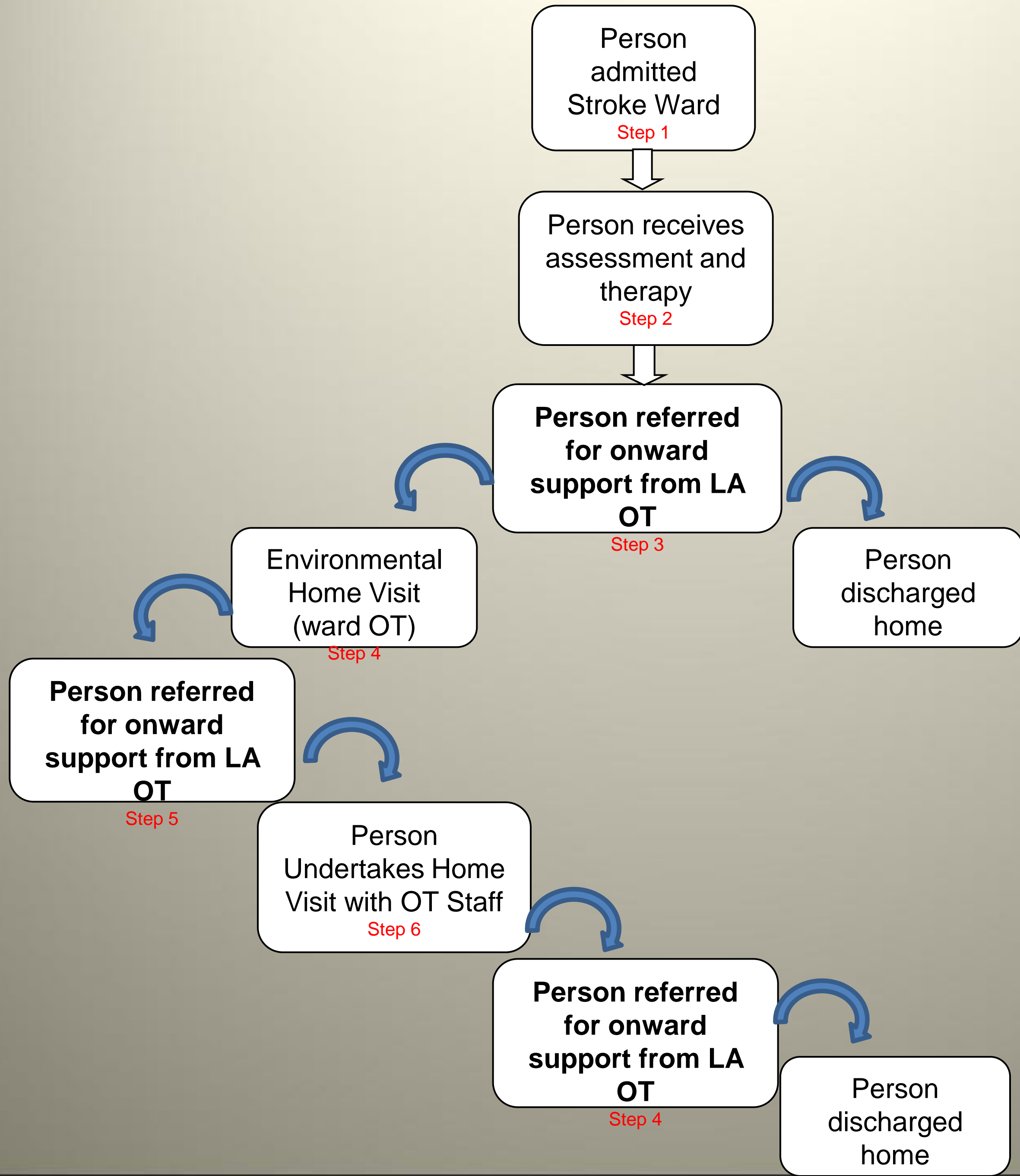
Key Policy Drivers

- Stroke Improvement Plan (Scottish Government) August 2014.
- Priority 7: Transition to the Community:
- “emphasises the need for specialist stroke rehabilitation provided with sufficient intensity and duration to reduce mortality and long-term disability. Appropriately resourced stroke specialist early supported discharge and community teams will optimise patients’ personal outcomes and reduce lengths of hospital stay”

Process

- Occupational Therapy staff from health (stroke unit, community rehab) and local authority services met and mapped current pathway of patients’ requiring ongoing Occupational Therapy input once discharged from the stroke unit (particularly identified as requiring major adaptations/complex home environment).

Existing pathway for Stoke Patients Receiving Occupational Therapy in the Stroke Unit and onto the Community



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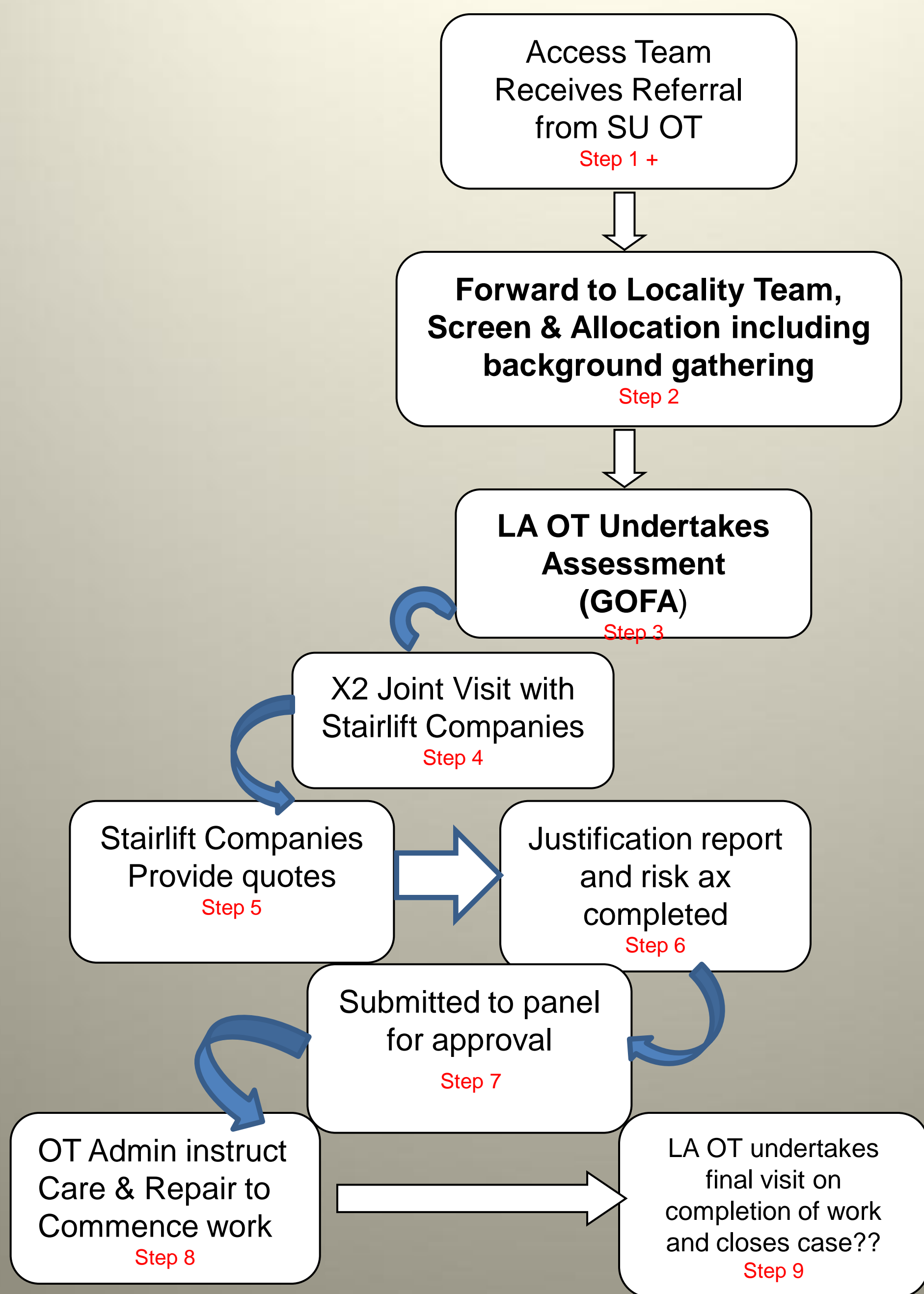

Patient Experience

Patient Feedback

- “Everyone has been very nice and done what they can to help but nobody has seemed to take responsibility for this handrail outside between May and now – October.”
- “If there had just been one person in charge of the whole plan and coordinating what was to get done and by when...that would have really helped”

PDSA Pathway 1
(Major Adaptation and limited rehab potential)

Difference from traditional pathway:

- Once patient identified as requiring major adaptations for returning home, **ward OT would directly contact LA OT** in locality and request patient be allocated to LA OT/COT.
- COT would visit patient on ward prior to environmental visit to collect information/identify needs for discharge.
- **COT** would complete **environmental home visit** and report findings back to patient and MDT.
- COT progress work required for discharge.

Pathway 1: 2 cycles completed

- 1st Cycle:
- Joint environmental visit arranged with ward OT and LA OT due to complex family/social situation.
- Early access to feasibility study for major adaptation (extension at rear of property).
- 2nd Cycle:
- Both ward and LA OT felt early meeting with patient and wife was extremely beneficial to discharge planning. Specialist assessment and advice of home environment by LA OT and specialist assessment and information re: patients' abilities and needs for returning home by ward OT.
- Both ward and LA OT felt regular communication between 2 specialist services assisted with discharge planning with the patient, wife, MDT.

Pathway 2: PDSA
(Major Adaptation and ongoing rehabilitation required)

Difference to traditional pathway:

- Initial PDSA: Identified need for home visit (environmental and/or home visit with patient), **Ward OT** would complete home visit, complete assessment and recommendations and **send to OT panel** (P&K council) to initiate major adaptation work. **Community OT** would then take over adaptation progression as part of patient's ongoing rehabilitation/OT needs post discharge.
- Amendment after 1st PDSA: If ward OT identified patient requiring potential major adaptation and ongoing rehabilitation, **community OT** contacted in patient's locality, community OT would then meet patient on ward, complete environmental home visit and submit assessment and recommendations to OT panel and continue to progress major adaptation work as well as patient's rehabilitation post discharge.

Pathway 2: 2 cycles completed.

- **Cycle 1**:
- Without the process (PDSA), OT staff felt unsure how successful a discharge it would have been as patient and husband benefited from the shared communication and early involvement of Community therapist, along with training .
- Adaptation process started approximately 4 months earlier than traditional pathway - though patients husband still felt it was a long time.
- One less OT involved in the process which saved time,money and duplication. This was due to community OT's previous experience of working both in local authority and the NHS.
- **Cycle 2**:
- Community OT and Ward OT felt it was positive community OT able to meet patient and his family before his discharge. Their feedback was positive in knowing who was going to be involved in his care once he was back in the community and helped allay some anxieties. Also, that something was being looked at re: adapting patient's bathroom (even though there was some delays regarding this).
- Due to issue with bathroom repairs, community OT felt that due to discussions and resubmissions to the panel, this has led to a delay in the patient being able to return to his own home (currently staying at relatives home).

Patient Experience

- “I thought it was quite helpful to meet the person who would work with you outside hospital.”
- “When she (the community OT) came out to look at the house and the bathroom, that was the 1st time I’d slept all night since he came into hospital.”
- “Since coming home she has been putting us in the right direction, she’s done lots for us.”

Actions from Test of Change

- Pathway 1 (Major adaptation only). To be implemented across whole OT service within Perth & Kinross.
- Pathway 2 (Major adaptation and ongoing rehabilitation required). – further mentoring and training support required.

Future Developments

- ?Potentially 1 pathway – best use of skill mix.
- Streamline documentation (?use of administration services).
- Integration of other AHP services in adaptations?

Summary

- Best use of specialisms and resources, avoiding duplication of assessment and documentation.
- Support staff with training needs.
- Streamlined service for patients.