An innovative approach to delivery of patient care within the Knoll Community Hospital:

N Macdonald, L McCallum
Primary Care Team

Background

The Knoll is a 23 bedded Community Hospital situated in Duns, Berwickshire. Delivery of care within a local community offers great advantages in comparison to a district general hospital. These include easier visiting, local knowledge relating to community services and comfort for the patient to be in a familiar environment. Traditionally, these beds have been managed by the local GP cluster however 18 months ago, the GPs decided that this was no longer a viable model. An interim measure was put in place with a part time retired GP however this was not a long term solution. Given the national shortage of GPs, a different solution was required to deliver sustainable, long term care.

Methodology

An alternative model of staffing was proposed utilising our Advanced Nurse Practitioners with overview from a medical consultant (delivering a once weekly medical review). This model would have the ANP present in the Knoll from 0900-1700, Monday – Friday and would deliver significantly more time for patient care than the interim situation.
A pilot process was commenced in October 2018 for a 14 week period using project management methodology.

Aims

In line with the 2020 Vision ***"There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission"*** and Realistic Medicine this project had the following aims;

1) Improved patient care
   - Increased medical cover
   - Consultant led care
   - Active input to the multi-disciplinary team (MDT) process
   - Collaborative working between community based clinical staff, including social care team

2) Anticipatory care planning
   - Aim to deliver 100% anticipatory care plans focussing on active involvement of patients and relatives in all decisions
   - Aim to deliver 100% decision making around resuscitation and escalation decisions

3) Patient flow
   - Reduction in length of stay (LoS)
   - Reduction in readmissions to the Borders General Hospital
   - Reduction in delayed discharges

The above measures aim to support people to get home to their own environment as quickly and safely as possible.

References

1. "Everyone Matters – 2020 Workforce Vision" https://www2.gov.scot/Topics/Health/Policy/2020-Vision
2. "Realistic Medicine – Chief Medical Officer's Annual Report 2014/15" https://www2.gov.scot/resource/0049/00492520.pdf
3. "Health and Social Care data spreadsheets, Scottish Government, Nov 2014" **https://www2.gov.scot/Topics/Statistics/Browse/Health/Data/CareData**

Acknowledgements

Knoll hospital clinical care team, their patients and families.

Results

Patient feedback:

'Excellent Service and Care"

"All staff are more then happy to answer any questions"

"Staff respond quickly to my queries even if they have to go away and find out from someone else"

Figure 1: Anticipatory Care Planning and Delayed Discharges

	Knoll to BGH transfers	DNACPR % complete	Escalation Plan % complete	Number of patients
22nd - 28th Oct 2018		60.87%	73.91%	23
29th Oct to 4th Nov	0	82.61%	100.00%	23
5th-11th Nov	1	73.91%	100.00%	23
12th- 18th Nov	2	86.36%	100.00%	22
19th -25th Nov	0	100.00%	100.00%	22
26th Nov - 2nd Dec	0	100.00%	100.00%	22
3rd-9th Dec	0	100.00%	100.00%	18
10th-16th Dec	0	100.00%	100.00%	19
17th-23rd Dec	1	100.00%	100.00%	20
24th - 30th Dec	0	100.00%	100.00%	23
31st Dec - 6th Jan 19	0	100.00%	100.00%	23
7th Jan - 13th Jan	0	100.00%	100.00%	23
14th Jan - 20th Jan	1	100.00%	100.00%	23
28th Jan - 3rd Feb	0	100.00%	100.00%	22
4th Feb- 10th Feb	1	100.00%	100.00%	23

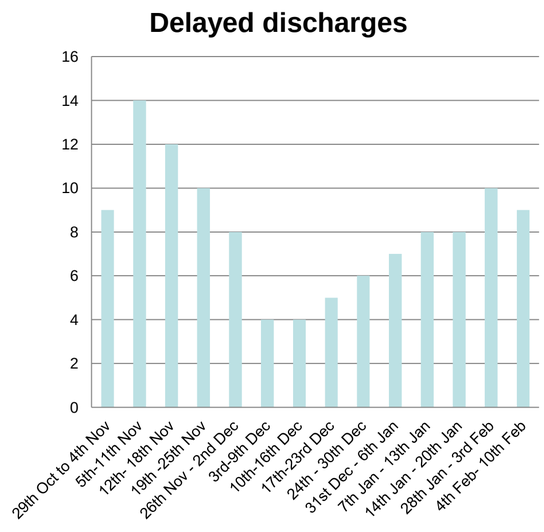
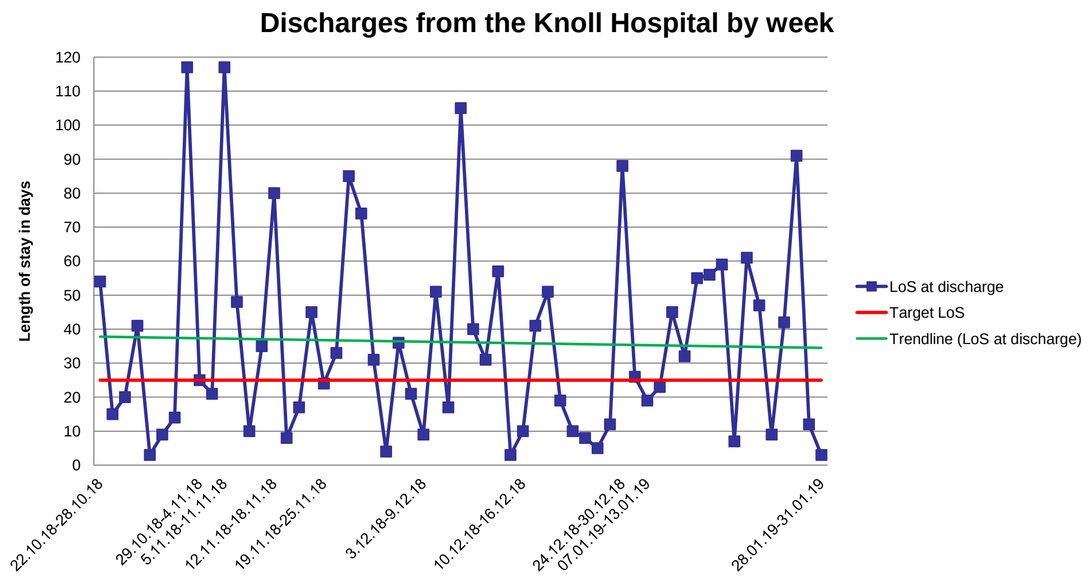


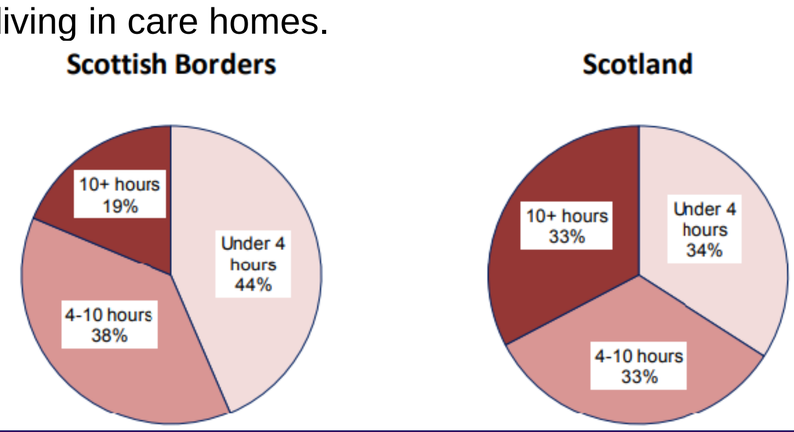
Figure 2: Reducing length of stay throughout the project.



Additional Challenges:

The Scottish Borders has fewer hours of care available per week for clients compared to the rest of Scotland. This places additional challenges for patients within the Community Hospitals waiting to be discharged. There has also been a downward trend with people living in care homes.

Figure 3: Breakdown of weekly care hours for home care clients aged 65yrs + (March 2014)



Conclusions

1) Patient care has improved due to the presence of a full time ANP
2) 100% anticipatory care plans in place
3) Reduction in length of stay has been achieved, reducing from 38 days to 34 days. Delayed discharges dropped however many other elements influence this data including lack of local care provision.