Two clinical commissioning groups aimed to improve the patient experience and reduce hospital admissions by devising a “hospital at home” community care service.

In this article...

- Why the need for hospital at home services is increasing
- How the service benefits patients in two London boroughs
- Student feedback on the hospital at home service

In the UK at present there is a constant pressure for inpatient beds; with this comes a need to develop services so that patients can be managed in their own homes. Although community nursing has historically been synonymous with district nursing, with the ageing population and the need to manage the increasing numbers of patients who have long-term conditions, community nursing is changing. This article describes a hospital in the home service, developed by one NHS trust; it not only delivers care traditionally provided in hospitals, but is also an effective setting for student nurses to undertake practice placements.

During the winter of 2014-15 problems relating to bed access in hospitals across the UK came to the fore. Due to a lack of social services and/or community resources, many older patients who were in hospital were unable to be discharged home despite being medically fit enough to leave. The knock-on effect was that elective surgical operations were cancelled and some hospitals declared “major incident” status.

Two specific drivers contribute to a significant part of the healthcare workload:
- An ageing population;
- Patients with multiple comorbidities.

Both the number of older people in the UK and life expectancy are rising. There are currently more than 11 million people aged over 65 years, and 3 million are over the age of 80 years (Age UK, 2015). Many older people require regular healthcare in both acute and community settings.

One approach to addressing the pressure on hospital beds is “hospital in the home”. This was first described by Gogan (1958), who proposed that some clinical interventions performed in hospital could be undertaken in the patient’s own home. Since then, many countries have created their own version of hospital in the home services and reported their benefits (Varney et al, 2014; Rodriguez-Cerrillo et al, 2012; Montalto et al, 2010; Van Donk et al, 2009; Caplan et al, 1999).

In Australia, a review of the state programmes in Victoria in 2008-09 recorded 32,462 admissions, which represented 5% of all bed days (Montalto, 2010). A survey of 3,423 admissions revealed that for the majority of these (n = 2,207; 65%), the patients were discharged from emergency departments to local hospital in the home programmes. The primary reasons for referral related to treatment of community and hospital-acquired infections and venous thromboembolism; the programmes delivered 26,653 bed days of care, with patients requiring, on average, nine visits from nurses and four from physicians (Montalto, 2010).

In the UK, there is now a move towards home care, as outlines by The King’s Fund (2012) report. This article reports on the hospital in the home service developed by an NHS trust in London, and its value as a setting in which student nurses can undertake practice placements.
Aims of the @home service
Guy’s and St Thomas’ Foundation Trust developed the @home service to care for patients in their own homes who would traditionally have been managed in hospital. The service, which has the strapline “Bringing hospital care to your home”, was commissioned by both Lambeth Clinical Commissioning Group and Southwark Clinical Commissioning Group to provide acute care in patients’ place of residence. It was developed by the trust’s adult community directorate to work with Guy’s, St Thomas’ and King’s College Hospitals to facilitate rapid discharge from accident and emergency, acute assessment units and acute wards and to work with GPs to avoid hospital admission.

It was envisaged that this combination of admission avoidance and early discharge would ease the access flow issues and demand for beds in acute settings in the inner-London boroughs of Lambeth and Southwark.

The @home service provides intensive care for a short episode through multidisciplinary team work, with the aim of returning patients home after an acute episode of ill health. Patients are reviewed within two hours of being referred to the service, to be referred they should fit the main criteria and be:

- Aged 18 years or over;
- Living in Lambeth or Southwark with an acute onset of illness (including acute exacerbations of long-term conditions).

The @home team operates seven days a week from 8am until 11pm. There are two 12-hour shifts (8am-8pm and 11am-11pm).

Interventions
The service receives an average of 1-4 referrals every day [range: 2-15]. The types of interventions undertaken include:

- Rapid assessment (with diagnosis, treatment and evaluation);
- Medication titration;
- Administration of intravenous and subcutaneous fluids;
- Treatment for respiratory disorders, including nebulisers, antibiotics and physiotherapy.

A range of conditions are managed by the service, including:

- Cellulitis;
- Falls;
- Chronic obstructive pulmonary disease;
- Heart failure;
- Unstable diabetes;
- Palliative care.

The @home team provides a wide range of treatments to patients who have

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BOX 1. CASE STUDY

Mahesh Doshi is 62 years old and has chronic obstructive pulmonary disease (COPD) and diabetes. He was referred to the @home team following assessment by the hospital in-reach nurse.

Mr Doshi was admitted due to an acute exacerbation of COPD. Following the development of “flu-like symptoms”, he reported increased coughing and shortness of breath that caused his health-related quality of life to worsen and reduced the amount of physical activity he was able to undertake. He decided to call an ambulance when his breathing worsened.

On discharge from the ward, Mr Doshi was prescribed the corticosteroid prednisolone (orally) and the antibiotic doxycycline for seven days to manage the exacerbation at home. The @home multidisciplinary team agreed that the physiotherapist should join the Guy’s and St Thomas’ @home nurse to conduct a joint visit and a chest assessment on Mr Doshi. This assessment using the physiotherapist, along with an occupational therapist, proved an effective strategy to manage Mr Doshi’s condition.

At the initial home visit with Mr Doshi and his wife, it was immediately clear that there was a language barrier between the patient and health professionals. This was managed by using simpler language to help explain his new medication further. The nurse’s immediate focus then changed – it became clear that both Mr Doshi and his wife would need support and education to manage his new medication, particularly at such a vulnerable stage of his illness. The nurse ensured Mrs Doshi was involved in all discussions. This was important not only because she was the patient’s next of kin, but also as she appeared to have better command of English than her husband. Mrs Doshi proved a valuable source of information. This use of simpler language and a personalised approach to patient care enabled the @home team to manage their relationship with the patient and his wife and to find more effective ways of communicating his care plan to both of them.

Mr Doshi received a personalised, focused, high standard of nursing care after his exacerbation. The nursing care delivered was indicative of evidence-based practice and adhered to clinical guidelines from the National Institute for Health and Care Excellence (2010) at all stages. Although there was a slight language barrier that could have undermined his care, this was well managed and it did not hinder the outcomes.

Subsequent home visits by the nursing team remained in alignment with Mr Doshi’s care plan. As a result, Mr Doshi experienced good clinical outcomes, an improved health status and improved quality of life.

*The patient’s name has been changed*
complex healthcare needs that can be dealt with in their own homes.

Box 1 highlights the comprehensive clinical assessment, intervention, education provision and multidisciplinary approach that was used when managing the patients referred to the @home service. It shows that the @home team provides complex care to patients, which requires the individual team members to use advanced knowledge and skills in their practice.

Multidisciplinary team

The service mainly employs senior nurses who have acute nursing experience and are skilled at managing patients with complex needs who are acutely unwell. These nurses are usually educated to Master’s level or are working towards their Master’s degree; they also have advanced differential diagnosis skills and are either non-medical prescribers or in the process of working towards this qualification.

Student nurse involvement

Student nurses who are on clinical placement with the @home service were able to get involved in undertaking and managing the care of the patients whose needs were complex; under the supervision of the @home nurse, the students were able to undertake a range of different procedures such as:

- Patient assessments;
- Clinical observations;
- Wound dressings.

Feedback on the @home service from postgraduate diploma student nurses

Pearl Sakoane, second year, postgraduate diploma in adult nursing

“My initial thoughts on finding out I would spend my community placement with the @home team were complete excitement. By chance I had had an earlier encounter with the in-reach clinical nurse specialist at St Thomas’ Hospital; his focus and meticulous approach to his work when dealing with his patients lit a spark of intrigue regarding what the Guy’s and St Thomas’ @home approach was all about.

“The @home team members are a rare breed in that they are a collective of highly specialised and experienced adult nurses. I often called them a team of ‘super nurses’ because, in essence, that is what they are – braving a new frontier of taking acute hospital care into people’s homes. It was easy to see the need for this type of care and provides a promising answer to contemporary community nursing.

“The day always began with the multidisciplinary team gathering and doing a full handover of all the patients in their care. Each patient was respectfully referred to by name and their background was outlined, giving us an understanding of who we were going to see. This stood out for me as it seemed important to the team that it wasn’t just a case of what was going to be treated, tackled or dealt with but who they were going to meet and, ultimately, care for. The nurses usually began by examining each patient’s needs and using their clinical judgement to determine how much time each task was likely to take.

“Planning, coordination and effective time management are essential for every nurse, but when seeing your patients includes using online maps, navigating traffic jams and finding the correct door number, all of those things have a whole new meaning. It was refreshing, hurriedly snaking our way through London traffic to see each patient.

“Contrary to what I have read about the public’s perception of nurses, the nursing team was met with high regard and respect by the members of the community. The interaction with each patient was personal, which helped to build a rapport and understand the patient’s needs.

“Rio [a computerised system] helped me and the nurse with whom I was working to review each patient’s latest notes and plan the diary accordingly. It was easy to see where experience would be required in managing the logistics that interplayed community nursing. It was also easy to understand the pressure the team was under every morning; although each team member was friendly, warm and well humoured, it was as though a large clock above their heads was counting down until each painstaking assessment had been documented, each medication given and each patient seen.

“When the spotlight shone directly on the nurse out in the field – on their own – attempting to care for patients who were acutely unwell with complex comorbidities, it became glaringly obvious just how much experience and knowledge was behind each step of their journey – from which patient to see first to whether a patient could make further attempts to cannulate.

“The team was unbelievably motivated, energetic and thorough, and gave a new meaning to the word ‘excellence’.

Watching highly specialised nurses tackle complex decisions as advocates for patients who are very unwell helped me to understand the absolute necessity of evidence-based decision making in nursing. The entire experience was unforgettable – working with the @home team was a glimpse into the future of community nursing, perhaps even general nursing, in years to come.”

Helen Mulhall, second-year, postgraduate diploma in adult nursing

“When I received the placement information from my university, I phoned the @home office so I could discuss it with one of the matrons. He was more than happy to give me an overview and answer questions and, sensing my nerves, he was extremely friendly and reassured me that I would never be expected to look after a patient beyond my capabilities, and that I would always be supervised and supported. I was impressed at how much thought and preparation had gone into making me feel equipped and welcome on my first day with a detailed orientation and handy document pack.

“The placement was particularly helpful in broadening my understanding of long-term conditions, including diabetes and heart failure. Throughout the placement all the nursing staff, including my mentors, were very kind, approachable and willing to teach and give ongoing, constructive feedback. Their extensive knowledge and clear dedication to their patients was very inspiring. All of the nurses alongside whom I worked demonstrated the knowledge, skills and attitude that I wish to gain through my training and maintain in my future nursing career.”
Such involvement often meant the students felt as though they were truly part of the nursing team in undertaking clinical assessments of the patient and being part of planning care with the @home team.

Student nurses who were doing their undergraduate degree in nursing or a postgraduate diploma in adult nursing at King’s College London commenced four-week clinical placements with the @home team in November 2014. In a group tutorial at their university, they shared their opinions about their placement with their fellow students. What came across was just how much they valued the placement and their surprise at how much it differed from their expectations of a “community” placement.

Based on this informal feedback, the students were asked to write about their own placement experiences; the feedback from those who were studying for a postgraduate diploma are given in Box 2, while those of students working towards their undergraduate degree are described in Box 3.

**Conclusion**

As care shifts from hospital settings to the community, it is envisaged that programmes such as the @home service at Guy’s and St Thomas’ Foundation Trust will become an essential and invaluable part of care in other NHS acute care providers. The service has proved that complex care can be administered in a community setting using a multidisciplinary approach, and the feedback received demonstrates the numerous benefits of placing students in services such as this. NT

**References**


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- What constitutes a community placement?
- Bit.ly/NTCommunityPlacement