International Journal of Integrated Care

Fernandez, Isabel et al 2016 Social work in a Chronic Functional Unit of an acute hospital. *International Journal of Integrated Care*, 16(6): A56, pp. 1-8, DOI: http://doi.org/10.5334/ijic.2999

POSTER ABSTRACT

Social work in a Chronic Functional Unit of an acute hospital

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

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Introduction: MútuaTerrassa has designed and developed a model of clinical care, both in prevention and in the treatment of the Chronic Complex Patient (CCP). The Chronic Functional Unit (CFU) was created and implemented in two levels of care: Primary health care (CFU1) and Acute care (CFU2), under a proactive and transversal model.

This kind of system was created within the framework of the new models of hospital management in which alternatives are proposed to the conventional hospitalization with the aim of providing better support and health care to the elderly population with chronic complex care needs. The CFU approaches th CCP, from a multidisciplinary point of view, both social and healthcare, setting common objectives, which are specific to each professional, and trying to find the best solution for each patient individually.

The role of the social worker (SW) in the chronic patient care is linked to the social risk, the exploration and evaluation of the social resources available to the patient and family and it is based on the continuity of care.

Description: In our acute Hospital Universitari MútuaTerrassa, the Social Work intervention is an added value to enhance the well-being and quality of life of patients and their caregivers. Our main goal is to get to know the family profile of patients cared for by Social work Unit (SWU), in order to have an impact on possible points of improvement in attention and coordination after the discharge, since many hospitals readmissions may be associated with inadequate social support and poor accommodation. Likewise we wanted to confirm how many of these patients were previously known by the SWU, through different protocols.

Method: The SWU reviewed the list of CCP admitted on a daily basis, and after having identified the previously attended patients, they were proactively monitored. Then, the new admission was discussed by the CFU in the daily session, aiming to draw up the plan of joint intervention of what had been evaluated the previous day. After the initial assessment, social workers inform and advise patients and their families, about possible access to services or specific benefits in the area of Social Welfare, as well as other health or social resources. After the discharge, they make follow-up phone calls at home according to the social situation detected, until the attending social worker takes control so as to promote continuity of care.

The data for the descriptive study were collected along 2014.

Results: A total of 301 patients were included, median age of 79 years, 58% men. As regards to coexistence: 43% lived with their partner, 18% with children, and 18% lived alone. Primary caregivers were children and partner (79%). Our intervention was due to our own initiative (67%), 12% at the request of the team and 10% of the families. The main requests were social risk assessment (27%) and access to medium and long-term stay unit (17%). Regarding social resources, a 36% had no previous social support. After discharge, 57% returned home, 21% of which with specific health monitoring support, and 12% had moreover some new support. Among other locations, 15% were at a medium and long-term stay unit (15%), 11% returned to their nursing home and 17% were inpatient hospital deaths. Thus 49.5% died throughout the year. The 55% of the coordination was referred to other external social workers. Professionals were not contacted unless the patient died or if they return to their previous nursing home. A relevant 72% had a previous social history.

Conclusions- Discussion: It has been confirmed that the Social Work unit already knew the majority of patients evaluated. This fact makes us assume that because they are more fragile, they need advise and support in their daily care. The proactive care has proven effective through the systematic identification, teamwork and networking. It is significant that a large number of patients had no previous social support. Although the cause are not known, we want to remark there should be further research as a new object of study. Another conclusion is that a large percentage of CCP died during the year. Finally, the effort made in terms of the transitional care to ensure the continuity of support to patients and their families has proven necessary.

Keywords: social work; continuity of care; proactive team