HEALTH AND SOCIAL CARE INTEGRATED SERVICES TO SUPPORT DOMICILIARY CARE

CARER + Project
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DEPENDENCY CARE SERVICES

- ELDERLY
- DISABLED
THE DEPENDENCY CARE SERVICES NETWORK

- Care allowance
- Accredited nursing home for either temporary or long-term institutionalization
- Day centre
- Domiciliary care services
- BADANDO Project
ACCESS TO SERVICES

- Multi-dimensional assessment

- Multi-dimensional Assessment Unit:
  - Case Worker (ASC – public utility for service provision)
  - Nurse (Local Health Authority)
  - Geriatrician (Local Health Authority)
    in the most complex cases
Support to domiciliary care is the fundamental strategic principle of the Emilia-Romagna Regional Health and Welfare Service to encourage dependent persons to remain and be cared for in their homes for as long as possible:

- staying at home
- with one’s family
- in one’s living environment
- maintaining a good quality of life
THE ACCESS PROCESS (1)

Hospitalized users

1. The hospital informs the local Nursing Service and the local Case Worker on the forthcoming discharge of a dependent patient.
THE ACCESS PROCESS (2)
Hospitalized users

2. Based on the patient’s conditions the hospital and the local health services jointly identify the most suitable option (either domiciliary care at the patient’s residence or institutionalization).
THE ACCESS PROCESS (3)

Hospitalized users

3. If domiciliary care at the patient’s residence is identified as the most suitable option the discharged patient undergoes assessment by the Multidimensional Assessment Unit and the most appropriate service is put in place.
WHY MULTI-DIMENSIONAL ASSESSMENT?

Dependent patients often suffer from complex health conditions requiring various types of services and professional competences. Although affected by a complex health condition, each patient is considered as a unitary entity expressing specific healthcare needs and social care needs. Hence the joint assessment of both and the joint design of an Individualized Care Plan to respond to the patient’s specific needs.
Encouraging dependent patients to remain and be cared for in their homes means providing **domiciliary care services to patients** and support to caregivers.

The **Individualized Care Plans** describe all the necessary services and support actions to be provided.
Health and social care integration is a synergetic operational model which aims to avoid service fragmentation.

Healthcare professionals involved in domiciliary care services:
- Nurse
- GP (General Practitioner – family doctor)
- Physiotherapist
CARING FOR CARERS

We care about supporting informal caregivers, i.e., family members who take care of dependent patients in their homes.

We care about properly training family assistants, i.e., privately hired carers for dependent patients.
The BADANDO project

The BADANDO training courses for Family Assistants are held by physicians, nurses, physiotherapists: our goal is to integrate health care and social care topics in the training in order to provide an all-round service mirroring the health and social care integration strategy.
Thanks for your attention