Acute and Community Services to support discharge

December 2023
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<tr>
<th>Service</th>
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<th>Contact Details</th>
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<tr>
<td><strong>Liaison Community Support Team (LCST)</strong></td>
<td><strong>Inclusion criteria:</strong> Patients in CUH, MUH, SIVUH, SFH and UHK who are &gt;65 years old can be referred to LCST for: • Home support packages (HSP) • Interim HSP • Transitional care beds (TCB) • Rehab (Kerry Only) <strong>Referrals:</strong> The “Single Referral Form” for LCST should be completed (located in the staff directory under referral forms “Integrated Discharge Referral Form 2023”).</td>
<td><strong>Key contact details:</strong> <a href="mailto:LCST.Cork@hse.ie">LCST.Cork@hse.ie</a> <a href="mailto:LCST.Kerry@hse.ie">LCST.Kerry@hse.ie</a></td>
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<td><strong>Public Health Nursing (PHNs)</strong></td>
<td><strong>Inclusion criteria:</strong> Patients following an acute admission, who are &gt;75 years of age, or have ongoing nursing needs. To identify the correct PHN email, insert the patient’s Eircode into the HSE Area Finder Map. (See page 7) <strong>Referrals:</strong> The “Single Referral Form” for PHN should be completed (located in the staff directory under referral forms “Integrated Discharge Referral Form 2023”).</td>
<td><strong>Key Contact details:</strong> Kerry <a href="mailto:northkerry.phn@hse.ie">northkerry.phn@hse.ie</a> <a href="mailto:westkerry.phn@hse.ie">westkerry.phn@hse.ie</a> <a href="mailto:southkerry.phn@hse.ie">southkerry.phn@hse.ie</a> <strong>North Cork</strong> <a href="mailto:Northwestcork.phn@hse.ie">Northwestcork.phn@hse.ie</a> <a href="mailto:Northeastcork.phn@hse.ie">Northeastcork.phn@hse.ie</a> <a href="mailto:eastcentralcork.phn@hse.ie">eastcentralcork.phn@hse.ie</a> <strong>North Cork City</strong> <a href="mailto:eastnorthcity.phn@hse.ie">eastnorthcity.phn@hse.ie</a> <a href="mailto:Northcorkcitycentral.phn@hse.ie">Northcorkcitycentral.phn@hse.ie</a> <a href="mailto:Northcorkcitywest.phn@hse.ie">Northcorkcitywest.phn@hse.ie</a> <strong>West Cork City</strong> <a href="mailto:Westcork.phn@hse.ie">Westcork.phn@hse.ie</a> <strong>South Cork City</strong> <a href="mailto:blackrockdouglas.phn@hse.ie">blackrockdouglas.phn@hse.ie</a> <a href="mailto:westcentralcork.phn@hse.ie">westcentralcork.phn@hse.ie</a> <a href="mailto:Bandonkincarecarrigaline.phn@hse.ie">Bandonkincarecarrigaline.phn@hse.ie</a></td>
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<tr>
<td><strong>Complex Case Management Team (CCMT)</strong></td>
<td><strong>Inclusion criteria:</strong> Complex patients between the ages of ≥18-&lt;65 years of age, who are encountering barriers to discharge. <strong>Referral:</strong> The “Single Referral Form” for CCMT should be completed, and emailed to the CCMT.</td>
<td><strong>Key contact details:</strong> <a href="mailto:ccmt.south@hse.ie">ccmt.south@hse.ie</a></td>
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| Community Health Networks (CHN) | Each CHN has a weekly Clinical Team Meeting (CTM), where members of the multi-disciplinary team (including GPs, clinical coordinators, allied healthcare professionals, nursing, and home support workers) discuss patients care needs and implement treatment plans. | Key contact details:  
Kerry  
northkerry.chn@hse.ie  
westkerry.chn@hse.ie  
southkerry.chn@hse.ie  
North Cork  
northwestcork.chn@hse.ie  
northeastcork.chn@hse.ie  
eastcentralcork.chn@hse.ie  
North Cork City  
estcorkcity.chn@hse.ie  
northcorkcitycentral.chn@hse.ie  
northcorkcitywest.chn@hse.ie  
West Cork City  
estcork.chn@hse.ie  
South Cork City  
blackrockdouglas.chn@hse.ie  
westcentralcork.chn@hse.ie  
bandonkinsalecarrigaline.chn@hse.ie  
southcorkcitycentral.chn@hse.ie |
| Community Intervention Team (CIT) | Referral:  
There is no referral form.  
Send the patient details and relevant clinical information to the appropriate CHN email address.  
To select the correct CHN email address, input patients Eircode or address into the HSE Area Finder Map (See page 7).  
Inclusion criteria:  
• 16km radius of Cork City, Mallow and Middleton  
• 32km radius of Cork City, Mallow and Middleton for I.V. antibiotics  
• Patients referred for I.V. antibiotics must be administered with two doses I.V. prior to CIT commencing  
• Treatment centre available to those living outside the catchment area.  
Exclusion criteria  
• Chronic illnesses requiring > 72 hours treatment (Excluding I.V. antibiotics)  
• Patients experiencing acute episode of mental illness  
• I.V. fluids and blood transfusions  
• Under the influence of illicit drugs or alcohol  
• Under 16 years of age  
• Residents outside the catchment area and unable to travel to treatment centre. | Key contact details:  
Cork:  
Telephone:  
0818 837427  
Email:  
admin@southwestcit.ie  
Kerry:  
Telephone:  
0867872483  
Email:  
cit.kerry@hse.ie |
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| Outreach Team – Older Adult                  | Home rehabilitation service providing PT and OT rehab and nursing support for patients > 65 years of age with acute care needs. These can be provided for up to 6 weeks within 15km radius of St Finbarr’s Hospital.                                                                                                                                        | **Referral:**  
  • Patients needs to be assessed by a geriatrician prior to referral  
  • Complete outreach referral form and phone call to confirm.                                                                                                                                                                                                 | **Key contact details:**  
  **Telephone:** 0871800953  
  **Email:** corksouth.icpop@hse.ie |
| North Cork Community Rehabilitation Team (CNRT) | CNRT provides home rehabilitation for patients, within a 16km radius. The team consists of PT, OT, and SALT.  
  **Inclusion**  
  • Assessment completed by a PT /OT prior to referral  
  • Inpatients in acute hospitals that would benefit from rehabilitation on discharge.  
  • Patients living in North Cork within 15 mile radius of Mallow.  
  • Patients with neurological conditions or reduced levels of function secondary to trauma/prolonged illness  
  **Referral**  
  • Contact team to accept and send the referral form                                                                                                                                                                                                 | **Key contact details:**  
  **Telephone:** 022-30790                                                                                                                   |
| COPD Outreach                                 | Patient must have confirmed diagnosis of COPD, and have been reviewed by respiratory consultant / registrar during their hospital admission  
  • Will receive support inclusive of home visits, for up to 2 weeks post-discharge.                                                                                                                                                                                           | **Referral:**  
  • Patient needs to be referred to COPD Outreach team prior to discharge.                                                                                                                                                                                                 | **Key contact details:**  
  Maeve O’Grady Clinical Specialist Physiotherapist  
  0864182004  
  Respiratory CNS (post currently unfilled)  
  0864182227                                                                                                                                                                                           |
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<td>Reablement</td>
<td>Provides personalised, therapy-led home support. Reablement seeks to empower clients to regain their functional and social independence after a period of deconditioning, or illness. The service lasts for 4-6 weeks, with 80% maintaining or negating their need for home support. <strong>Inclusion Criteria:</strong> Age ≥ 65, with less than 5 hours Home Support Package, cognitive ability to learn new activities. <strong>Exclusion Criteria:</strong> Requires assistance of 2, existing home support package of greater than 5 hours, or advanced stages of dementia. To refer complete referral form and make contact with Reablement assessor.</td>
<td>All patients with level 3 &amp; 4 priority for home support should be referred to Reablement (subject to availability in the client’s area). <strong>Key contact details:</strong> <strong>CHN 1: Reablement OT Assessor</strong> (Listowel / Castleisland / North Kerry) <a href="mailto:Brid.halpin@hse.ie">Brid.halpin@hse.ie</a> 087 979 0131 <strong>CHN 8: Reablement OT Assessor</strong> <em>Currently paused</em> <strong>CHN 13: Reablement OT Assessor</strong> (Brandon / Kinsale / Carrigaline) <a href="mailto:Anne.ohea2@hse.ie">Anne.ohea2@hse.ie</a> 087 188 1772 Project Lead <a href="mailto:Fiona.geary2@hse.ie">Fiona.geary2@hse.ie</a> 087283 8699</td>
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<tr>
<td>Transitional Care</td>
<td>For older adults (&gt;65) patients who require a short period of care before returning home (less than 30 days). For example, patients awaiting home support packages or housing adaptations.</td>
<td>To refer complete single referral form located on staff directory and email <strong>Key contact details:</strong> <a href="mailto:LCST.Cork@hse.ie">LCST.Cork@hse.ie</a></td>
</tr>
<tr>
<td>Riverstick</td>
<td>• TCB beds under the governance of CUH • Supported by CUH consultant and d/c co-ordinator • Access to physiotherapy and occupational therapy</td>
<td><strong>Key contact details</strong> Send online referral via ICM to discharge co-ordinators (drop down Riverstick)</td>
</tr>
<tr>
<td>Bed Management</td>
<td>Assist with patient flow, diagnostic dependent discharges, and infection control.</td>
<td><strong>Key contact details:</strong> <strong>Telephone:</strong> 0867872130 0867872129</td>
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| **Cork University Hospital Discharge Co-ordinators** | For patients who require input from a discharge co-ordinator to facilitate discharge including home help or long-term care, complex discharges | **Key contact details:**  
Pauline O'Keefe – 0867872131  
Eilish Madden – 0873519819  
Kate Howard – 0871444459  
Edel O’ Leary – 0876176830  
Cliona Sexton - 0870954618 |
| **Cardiology Services CUH**                      | Timely access to critical cardiology services and discharge dependent diagnostics such e.g. ECHO                                                                                                          | **Key contact details:**  
Telephone:  
Cardiology Co-ordinator: 0867872299 |
| **GP diagnostics**                               | GP services have access to:  
• Community x-ray, CT, MRI and DEXA scans for adults over the age of 16.  
• Ultrasonography services for patients over 16 with medical cards/ GP cards.  
• Urgent diagnostics within 1 month, non-urgent within 3 months.                                                                                     | Use website below for full list of available diagnostics  
https://www.hse.ie/eng/services/list/2/pri
marycare/community-healthcare-nets
ets/gp-diagnostics/ |
| **MRI CUH**                                      | To book an MRI to facilitate discharge please contact bed management  
MRI can be organised within 1 week as outpatient.                                                                                                                   | **Key contact details:**  
Telephone  
0867872130  
0867872129  
Email:  
cuh.mri@hse.ie |
| **Community Work**                               | Community Workers’ seek to support community and voluntary services to promote health and social gain.                                                                                                         | **Key contact details:**  
Telephone:  
Cork South: 021 49 23120  
Cork North: 021 49 28370  
Kerry: 066 71 95635 |
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<td>ALONE</td>
<td>National organisation that enables older people to live at home by providing services to support older adults including • Support and ‘befriending service’ • Support through the provision of technology</td>
<td>Online referral: <a href="http://www.alone.ie">www.alone.ie</a></td>
</tr>
<tr>
<td>Age Action</td>
<td>Voluntary service – assist with moving bed downstairs, clear clutter, install equipment, (will not provide the equipment), small DIY jobs</td>
<td>Key contact details: 0212067399</td>
</tr>
<tr>
<td>Social Prescribers</td>
<td>Supports the health and well-being of patients by helping to link them with local supports services and activity-based programmes (e.g. exercise programmes and social clubs)</td>
<td>Online referral: <a href="https://thewellbeingnetwork.ie/community-referral/">https://thewellbeingnetwork.ie/community-referral/</a></td>
</tr>
<tr>
<td>HSE Area Finder</td>
<td>Upon insertion of a patients eircode or address, the map will signpost the user to the correct: • Community Healthcare Network (CHN) • Public Health Nursing Contact (PHN) • Older Person Community Specialist Team (ICPOP) • Chronic Disease Community Specialist Team (ICPCD).</td>
<td>Note: For use by health professionals only</td>
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https://hseareafinder.ie/