CCT 2 Home Service – SCGH Emergency Department

CCT2Home provides a follow up service for patients that present to the ED and are discharged home, (including Hostels but excluding Nursing homes).

The primary aim of the CCT2Home program is to support patients post discharge to manage safely at home by extending hospital support and outreach for patients thereby aiming to reduce the risk of re-presentations to the ED.
Intervention may be via a phone call or a more comprehensive home visit for functional assessments, provision of equipment and/or more intensive support and education for patients, their families and carers. CCT2Home can liaise with community health professionals, the patient's GP and link patients into community support services.

Who to Refer
There **is no age restriction** and **any diagnosis** is accepted. **All areas** will be assessed or referred to a local provider if more appropriate.

When considering a potential referral please remember these types of patients will benefit from CCT2Home input:

- Patients ***refusing services in ED*** (e.g. I just want to go home and I will be alright…but this is unlikely! These patients are more likely to accept support once home)
- Patients going home but ***identified at risk following*** an Ax (cognitive impairment, falls risk, limited social supports.
- Patients requiring the ***ED education reinforced at home*** immediately after presentation e.g.: reinforce weight bearing restrictions, back care education, pain management, check on newly issued equipment.
- patients with a ***stressed carer / family member***
- Patients with ***recent frequent ED presentations***
- Patients issued with ***new equipment***
- Patients you ***are not sure require a CONNECT or RITH*** referral can be reviewed first by CCT2Home and referred on as needed
- Patients ***not assessed in the ED by the CCT***

Priority referrals are:

- Over 65 FallsdIAL
- Over 65 Back Pain
- Over 65 Upper Limb Fracture living alone
- Other patients with multiple co-morbidities who you think will require more than a phone check i.e. would benefit from a home visit

How to Refer

- Dial: **7926**
- Leave a message including patient's name, UMRN (please speak slowly when stating UMRN), diagnosis and any PMH relevant including cognitive status, social situation etc
- Please state intervention you are recommending i.e. back care education, check patient is managing with new mobility aid, home visit to review environment.
- Please advise of any precautions (e.g. patients weight bearing status, bariatric, or any potential safety issues associated with a home visit)