Enhancing efficiency and effectiveness of transitional care by Personalized Admission Care Plan

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Introduction
Public hospitals are facing winter surge demand on acute and post-acute medical services, especially in ageing population with multiple co-morbidities. Challenges in care transitions and community re-integration include poverty, social isolation, old spouse, elderly with disabilities, lack of carer and lack of community care support services. Common barriers to quality transitional care include lack of assessment and care plan, incomplete and fragmented information, breakdown in communication and information transfer, inadequate post-transitional care and follow up.

Objectives
To enhance efficiency and effectiveness of transitional care by personalized admission care plan in a subacute medical ward

Methodology
A 1-page admission care plan designed by author serves as a cognitive framework to facilitate residents to build personalized care plans for patients with targeted goals (inpatient and community) within 2 days of admission. Seven key areas include active problems solving list, key social issues, premorbid mobility status (bed-chair bound, assisted walker, independent walker), expected destiny and carer availability, focus of care (medical or integrated rehabilitation), treatment goals and integrated follow up plan. Senior physician confirms residents' care plan daily and liaise with multidisciplinary team and medical social workers at least once weekly to recommend early and appropriate medical, social and community services. Weekly case
conference confirms team communication and goals achievement. Close liaison with patients and carers by nursing team is essential.

**Result**
In January 2015, 95% of 81 new patients admitted to a 32-bed (1 side room) medical ward had personalized admission care plans by day 2. Prompt medical or rehabilitation care followed problem-oriented solution-focused medical approach and team appraisal of rehabilitation potential. Social and discharge placement problems were referred to MSW within first 2 days. Bed turnover increased 26% compared to prior month, providing more bed-days to support patients from acute hospitals. One-third had MDROs past history alert, 20% allergies / high risk medications alert, 26% confirmed DNACPR, 74% received integrated rehabilitation and medication reconciliation. Patients got supported discharge and follow up plan fitting medical, rehabilitation and palliative care needs. An early admission personalized care plan promptly solving active problems improves not only efficiency but also upkeep effectiveness of transitional medical and community care through enhancement of appropriate resources management.