將軍澳醫院
Tseung Kwan O Hospital

醫院管理局
HOSPITAL AUTHORITY

Discharge Support Program Enhances Discharge Process of High Risk Elderly in Tseung Kwan O Hospital

Cheng MK[1], Chan YP[1], Lau CK[1] San J[1], Kwok CM[2], Judy C[2] , Vincent C[3], Lam M[4], Lau IT[1]

[1]Department of Medicine; [2]Intergrated Rehabilitation Services Department; [3]Medical Social Worker, TKOH;
[4]Community Nursing Service KEC

INTRODUCTION

Discharge Support Program (DSP) was launched at January 2010 in Tseung Kwan O Hospital to tackle complex discharge need of high risk elderly by reorganization of multi-disciplinary workforce.

OBJECTIVES

1. 'Up-stream' prevention of unplanned readmission
2. Streamline discharge process and workflow
3. Early intervention of pre-discharge planning and post-discharge support
4. Collaborate internal and external stake-holder to facilitate discharge process
5. Empower patient self-care education & enhancement of rehabilitation

METHODOLOGY

All medical patients fulfilled HARRPE score ≥0.2 and exclusion criteria were recruited from January to December 2010.

Multi-disciplinary team approach led by Geriatrician was adopted with comprehensive pre/post discharge support services. Discharge Support Team Nurse (DSTN) would assess & make MSW referral addressing patient and caregiver's psycho-social discharge needs (within 48 hours).

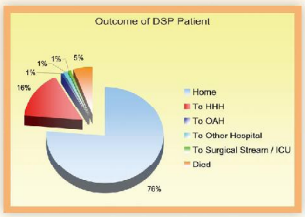
Discharge process was streamlined by auto-referral to PT & OT (within one working day), with patient and caregiver participation to enhance early rehabilitation. Via weekly conference led by Geriatrician, consensus was sought and discharge planning formulated. Post-discharge supportive services including: Telephone Nursing Consultation Services, CNS home visit, community PT/OT services, fast tract clinic & clinical admission would offer to appropriate patients. Liaison with external stake-holder for post discharge support was arranged.

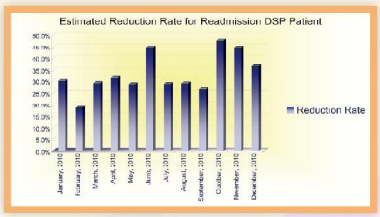
RESULTS

Total 1460 patients were recruited. 58.3% (851) of the population were male and average age for male was 78.8 whereas female was 81.5. The average reduction rate for readmission of DSP patient was 33.08 %.

The average LOS for DSP patients 5.1 days and mortality rate 5.37%. Average numbers of co-morbidity was 3. The most common diagnosis was CHF (14%) , followed by pneumonia (5.7%) and then UTI (3%) 18.3% were daytime alone. Mean modified Barthel Index was 74.17. Mean MFAC (pre) 3.66, (post) 4.24, p=0.000.

1,116 (76.28%) of DSP patients discharged home and 3, 213 calls (14,915 min.) were made for telephone follow up. CNS home visit accounted 71 cases. 45 cases received community physiotherapy service, 18 cases received community occupational therapy service, 9 & 5 cases referred for post-discharge care project and pilot project with local NGO respectively. 46 patients were referred for fast track clinic while there were 12 clinical admissions.





CONCLUSION

DSP can reduce unplanned readmission rate and streamline discharge process in TKOH

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