Service Priorities and Programmes

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Overall review of Integrated Care & Discharge Service for Elderly Patients in RHTSK

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Introduction

Reducing avoidable hospital admissions is one of the Hospital Authority (HA) key service strategies. Statistics showed in 2010Q2, overall unplanned readmission rate (within 28 days) of medicine specialty in whole HA is 18.8%. A study by the CUHK in 2009/10 found that unplanned re-admissions were reducible if supportive services were well coordinated in community. The Integration Care & Discharge Support for Elderly Patients (ICDS) service was thus established in RHTSK in October 2011.

Objectives

1. To facilitate early discharge and reduce the risk of unplanned re-admission 2. To provide transitional support from discharge to home 3. To relieve the stress of caregivers by providing training and supportive service.

Methodology

High risk elderly patients with admission HARRPE score > 0.2 were automatically referred for pre-discharge planning, referrals from all specialties are also accepted. Link nurse conducted risk and needs assessment as to facilitate early discharge planning and coordination of multi-disciplinary service. Elderlies would be referred to Case Management service or Home Support Team (HST) for about 8 weeks' home follow-up according to their needs on disease management or community-based care. All would be supported by fast track clinic or arranged for clinical admission if needed.

Result

During the period of 1/4/2012-31/3/2013, 4,138 cases were assessed, within which 12.8% were referrals. 382 cases were recruited into case management, 2,648 home visits were paid by case managers. 359 cases were referred to HST with average service duration of 70.8 days. 17 transitional placement. 89 fast track clinics and 63 clinical admissions were arranged, most complaints are heart failure, shortness of breath (SOB), cough and hypertension. By reviewing retrospectively, the key needs for service were understanding disease nature and care (40.8%), education on life

style (15.2%) and medication reconciliation (12.2%). Two satisfactory surveys were conducted on clients. One survey on case management showed over 90% agreed that their AED attendance were reduced and over 84% agreed that their knowledge on self-disease management were enhanced. The other survey on HST service shown 99% clients rated ‘satisfaction’ or above. ICDS is a patient centered and evidence-based model with care coordinated and supported across sectors and time. It fills the service gap between the transitional periods from early hospital discharge to home. Patient and care-givers’ empowerment with the on-site training and monitoring are enhanced to ensure treatment compliance. Through the fast track medical support, early detection and prompt intervention can decrease progression of diseases. Furthermore, with the collaboration with Non-government Organization, elderly clients’ social needs were well addressed.