Independent older Australian develops an Acute Medical Illness

In ED Risk Assessment and Discharge Planning Tool commenced or completed. Patient family/carer input

Allocated to ACE Unit in Ward 1B

Risk Assessment and Discharge Planning Tool checked and completed by nursing staff as necessary. Patient family/carer consultation

NUM or Team Leader refers patient to Allied health as appropriate

Commencement of ACE Assessment Tool to track patient function and identifies de-conditioning

Leverage point

Development of specialist medical teams eg. Cardiac. Patient looked after by Cardiac Team not Respiratory Team

Reviewed by Specialist Medical Team daily. Reviewed by Geriatric Team within 48 hours of admission, and Mon, Wed and Fri. Medication review with Pharmacist weekly

Monday-Weekly ACE Team Case conference and discharge planning

Ward 1A and 1B team case conference including all medical officers and ACE medical officer. Service needs identified and potential discharge date

Day 5. Discharge Plan- Progress reviewed, decision rehab or not

Patients and relatives consulted/notified of decision and predicted discharge date

Leverage point

NUM, social worker and discharge planner coordinate discharge. Patient referred to appropriate services

Leverage point

Discharge Summary with medications, services, Carelink information given to the patient

Leverage point

Discharge from HKH

Follow Rehab flow chart

Leverage point

The following flow chart represents the Discharge Planning Process after May 2002 for a functional Australian over 65 years who has developed an Acute Medical Illness

Leverage point

Identification of previous function, identifies patient/family goal and potential barriers to discharge

Leverage point

Early referral to maintain strength, function and return to previous accommodation i.e. Discharge to home, not hostel

Leverage point

Monitoring of progress and expected outcomes

Leverage point

Early assessment and identification of function, medication issues and barriers to discharge

Leverage point

Multidisciplinary identification of barriers to discharge and goal

Leverage point

An opportunity for formal discussion between medical and geriatric team

Leverage point

NUM, Social Worker and discharge planner liaise with family, hostel/nursing homes and community services

Leverage point

ACE Patient to be given patient guide for taking medications completed my MO

Leverage point

Use of Commonwealth Carelink initiatives and flyers

Note: The areas defined in blue denote the ACE discharge planning flow. Pink boxes denote leverage points. A leverage point is an opportunity of improving patient care by changing a process.