Independent older Australian develops an Acute medical Illness

Presentation at HKH Emergency Department. Patient, family/carer input

Patient may bring health assessment, care plan referral letter and/or medications from hostel or home. GP, community care and information from carer/family

ED Assessment attended. Risk Assessment and Discharge planning (RADP) tool completed information from GPs health Assessment /Care Plan and other community referrals noted

Involvement of ASET Team in ED regarding ACE criteria

Allocated to Specialist Physician

Patient identified as ACE. Admitted to the ACE unit in Ward 1B

ACE unit prepared environment.
Early mobilisation. Shared care with Specialist Physician and Geriatrician. Multidisciplinary Team

Patient seen by the medical team daily, geriatric team within 24-48 hours. Patient carer/family input invited

Nursing promote early mobilisation and ADL independence

Day 3-5 assessment regarding future management i.e. Fast track to rehab or services organised for home. Liaise carer/family

Discharge from HKH

If appropriate Rehabilitation Discharge Team provides 4 weeks follow up post discharge

Patient receives discharge summary for GP, Nursing discharge summary for community nurse

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

Over 65 years assessment by Aged Care Assessment Team (ASET)

Leverage point
More accurate data on patient function in the community

Leverage point
Baseline data available, reduces repetitive questioning of patient

Leverage point
Comprehensive assessment. ACE registrar is also ASET. Registrar assists with identification of ACE patient

Leverage point
Orientates patient to ward, clarifies expectations

Leverage point
Reduces risk of deconditioning and loss of confidence

Leverage point
Early identification of reduction in function and appropriate action taken

Patient given ACE information brochure during first ACE round

Nurses with focus on function and independence

Commence ACE Assessment Tool, which integrates with RADP Tool and tracks functional trends

NUM or Team Leader make allied health referrals on admission

Leverage point
Hospital Volunteers read papers and chat to patients to assist orientation and decrease risk of depression

All records transferred to Rehab Unit. Dialog between health professionals of acute and sub-acute care

Admission to Rehab unit follows casual care

Patient recieves discharge summary for GP, Nursing discharge summary for community nurse

Patient and relatives consulted regarding discharge date. Services organised for home supported by existing projects/services e.g. CACPs

Referred back to previous community services, new services organised as required