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離院支援
無間照顧

POST-DISCHARGE PLANNING: FROM EHCCS TO IDSP

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OUTLINE

- Post Discharge Planning program (EHCCS)
- Integrated Discharge Support Program for Elderly Patients (IDSP)
- Case sharing
- Conclusion

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POST DISCHARGE PLANNING PROGRAM (EHCCS)

Purpose

- Enhance the quality of care provided to the discharged elderly
- Reduce the re-admission rate of elderly

Target

- EHCCS(HK Cluster)

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CONTENT

- Program start from 10/2010
- Para-medical staff：Nurse, Physiotherapist, Occupational therapist

OUTCOME

- Period : 10/2010-3/2012 (18 months)
- Total no. of cases: 128
- 98 Cases (76.6%) over 1 year live stably in the community

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INTEGRATED DISCHARGE SUPPORT PROGRAM FOR ELDERLY PATIENTS (IDSP)

Objectives

- To team up with Discharge Planning Team (DPT) to provide community support for the participants.
- To reduce the risk of unplanned hospital re-admission of the participants.
- To enhance support and training to caregivers.

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INTEGRATED DISCHARGE SUPPORT PROGRAM FOR ELDERLY PATIENTS (IDSP)

Age

- Elders aged 60 or above

High Risk Group

- HARRPE > 0.2 or
- Clinical referral
  - High readmission risk
  - High rehabilitation needs
  - High personal care needs

Exclude

- Service users of mainstream home care services

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ROLE OF DPT & HST(NGO)

Discharge planning Team

DPT

Based on HARRPE List or clinical referral, intake patients in medical ward, refer to Case Management (HA) or HST (NGO)

Home Support Team

HST

Immediate on-site assessment, follow up and provide home care services

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CASE SHARING

- Mr. A, 91/M, alert, blindness, living with spouse with Dementia
- Discharged from Pamela Youde Nethersole Eastern Hospital
- Diagnosis: Reactive hypoglycemia

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CASE SHARING

Early intervention

Meal provision by Home Support Team,

Registered Nurse drug supervision

Re-admission 2 weeks later

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CASE SHARING

Cooperation with Hospital Authority

Case conference with Discharge Planning Team

Re-assessment by Discharge Planning Team

Referred to Diabetes Nurse

Diagnosis: Non-Diabetic hypoglycemia

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CASE SHARING

Adjusted Intervention Strategy

Breakfast preparation, Elderly Sitter, Meal Feeding, Enhanced H'stix monitoring by Home Support Team, Day Respite service twice a week, caregiver training

Improvement

CASE SHARING

Ending Phase

General condition improved

No re-admission

Trained maid available for long term care

Long term care waitlist for Day Care Unit

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CASE SHARING

- Ms. B, 88/F, Hearing impairment, MMSE in Hospital 14/30, live alone in public housing, son ran away from home, Ex-daughter-in-law is the main contact person of client
- Diagnosis: Fracture of hip

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CASE SHARING

Early intervention

Meal provision by Home Support Team

Case refused to open the door

Re-admission due to fall within a week

Patient insisted to go home

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CASE SHARING

Flexible, Fast and Active intervention

Failing to contact patient for several times a day (年廿九)

Visited patient and called police

Provided Transitional Residential Care (TR) immediately

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CASE SHARING

Rehabilitation and Cooperation with NGOs

Patient lived in TR over a month

Mobility improved

Referred to District Elderly Community Centre for long term care follow up

Improvement

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CASE SHARING

Ending Phase

Son appeared and escorted the client back home

Apply funding for purchasing amplified telephone

Client able to self care

Co-work with Neighborhood Elderly Centre (NEC) nearby client's home to provide continuous support

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FIGURES
(FROM NOV 2011 TO APR 2012)

Category	Numbers
Referrals	499
Case Opened	487
Case Closed	242
Refused Intervention	34
Active Cases	211
Transitional Residential Care	25
Attendances of On-Site Carer training	682

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FIGURES
(FROM NOV 2011 TO APR 2012)

Continuity of care and connection with community

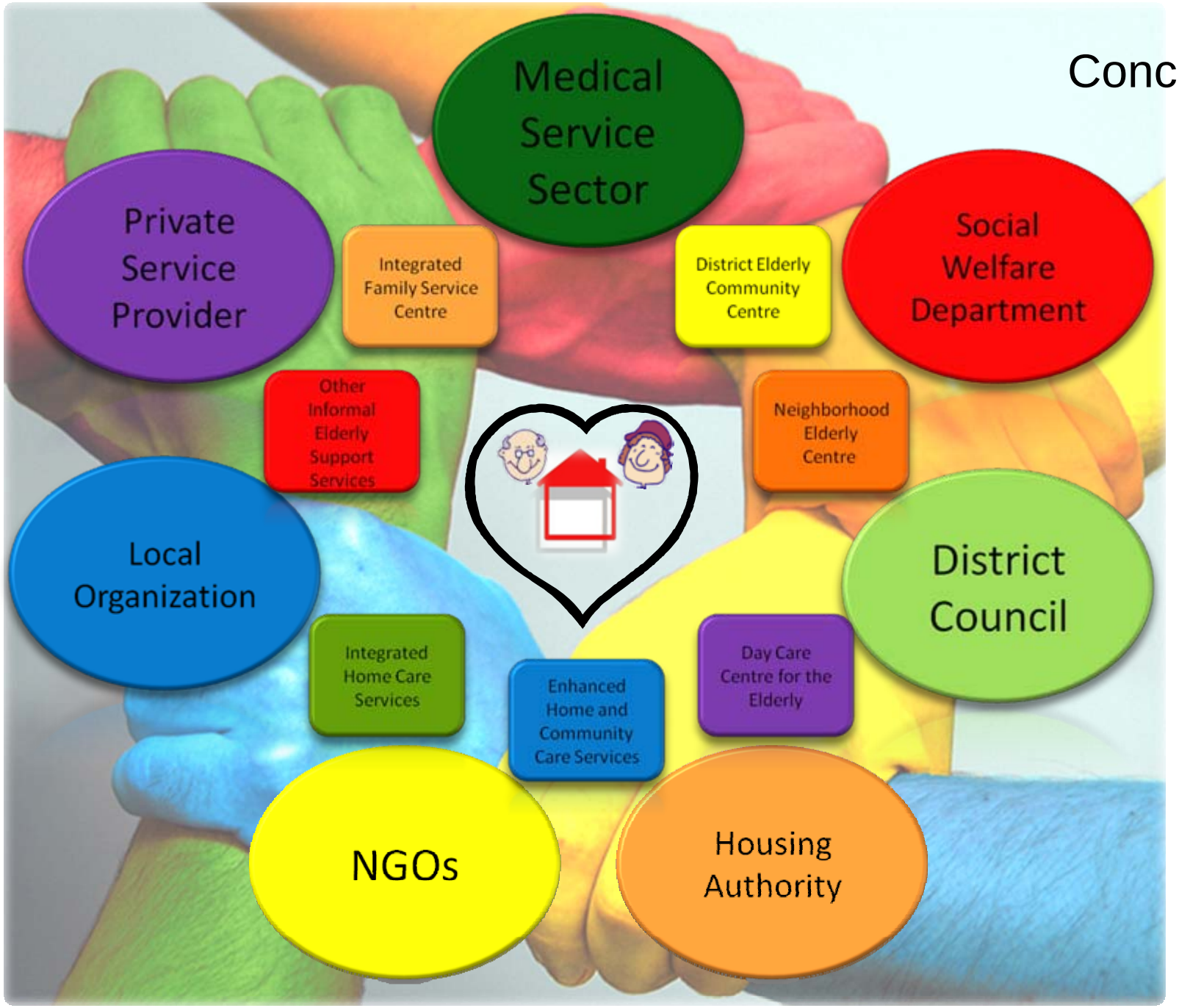
Category	Percentages
Refused Intervention	12.9%
Moved to Residential Home	11.9%
Referred to Community Support Services for the Elderly (NGOs)	17.7%
Referred to Private Home Support Service	1.3%
Optimized Activities of Daily Living (ADL), Instrumental Activities of Daily Living level (IADL) or Medical Condition	14.8%
Carer Support	29.9%

FIGURES
(FROM NOV 2011 TO APR 2012)

Continuity of care and connection with community

Types of Community Care Services	
Category	**Percentages**
Referred to Day-Care Unit	1.8%
Referred to District Elderly Community Centre	14.5%
Referred to Enhanced Home and Community Care Services	7.3%
Referred to Integrated Home Care Services (Ordinary)	**70.9%**
Waitlist on Integrated Home Care Services (Ordinary)	5.5%

Conclusion


Medical Service Sector
Private Service Provider
Integrated Family Service Centre
District Elderly Community Centre
Social Welfare Department
Other Informal Elderly Support Services
Neighborhood Elderly Centre
Local Organization
District Council
Integrated Home Care Services
Enhanced Home and Community Care Services
Day Care Centre for the Elderly
NGOs
Housing Authority

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Knitting the web,
Filling the gap

THANK YOU