FLINDERS MEDICAL CENTRE

Emergency Department
Falls seminar 07
Preventing Bounce Back

DEB CHARLISH
DISCHARGE COORDINATOR

DEBBIE McCARTHY
SENIOR SOCIAL WORKER

PREVENT BOUNCE BACK

- ROLE OF DISCHARGE COORDINATOR
- DATA - PRESENTATIONS TO ED 65yrs and over
- PROCESS OF ASSESSMENT IN ED
- PROCESS OF ADMISSION OR DISCHARGE FROM EMERGENCY DEPARTMENT
- DEB McCARTHY – SENIOR SOCIAL WORKER PSYCHOSOCIAL EVALUATION & INTERVENTION STRATAGIES FOR COMPLEX CASES.
- WHERE TO NOW?

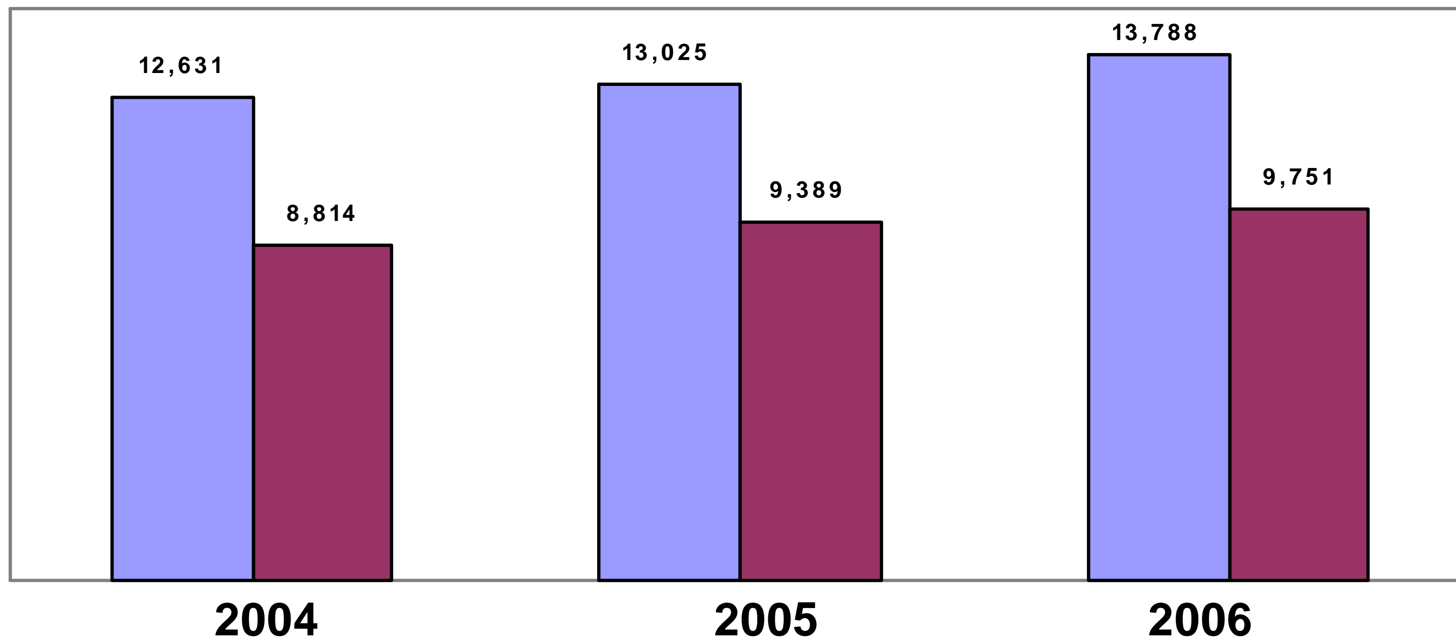
DISCHARGE COORDINATOR'S ROLE IN EMERGENCY

- The role commenced in July 06 as part of the winter bed demand strategy as a four month project, due to its success has since been made permanent.
- 7 day service 0800 – 1630
- Facilitates the safe discharge of patients to other health care facilities both private, public and refers to community services.
- Attend 0800 & 1200 ward rounds to identify potential patients for discharge and or transfer to other facilities
- Regularly checks hospital's data base which highlights private patients and falls patients. Falls data is collected and sent through to Physio department.

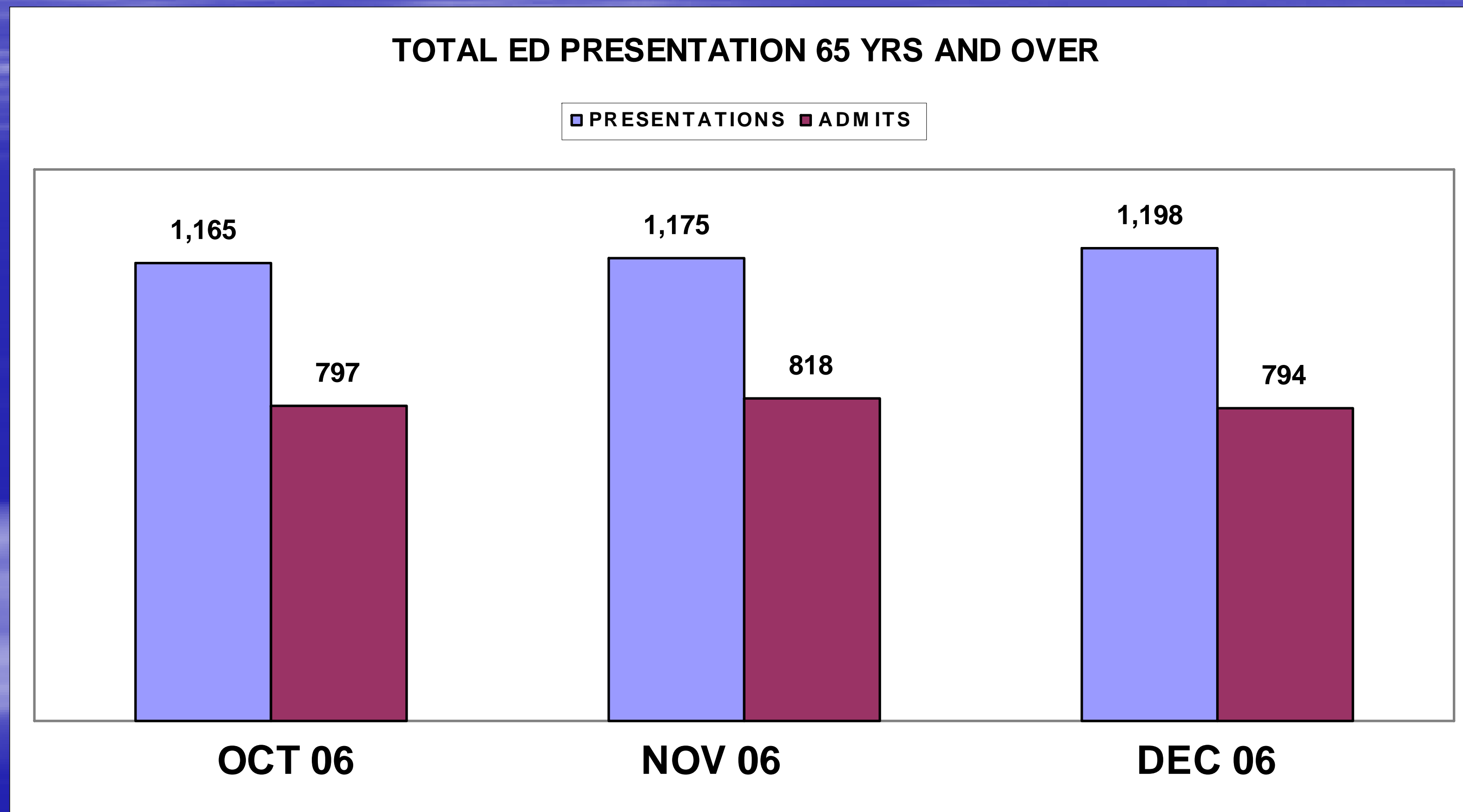
ROLE OF DISCHARGE COORDINATOR

- Team approach working closely with Medical / Nursing staff / Social Worker / Metro Home Link
- Regular contacts with bed managers at Repat, Flinders Private, Noarlunga Health Service & Griffiths and other smaller hospitals both private and public to establish bed availability
- Resource to all staff – options for discharge
- **Aim - is to get the patient to the right place with the right service at an appropriate time safely.**

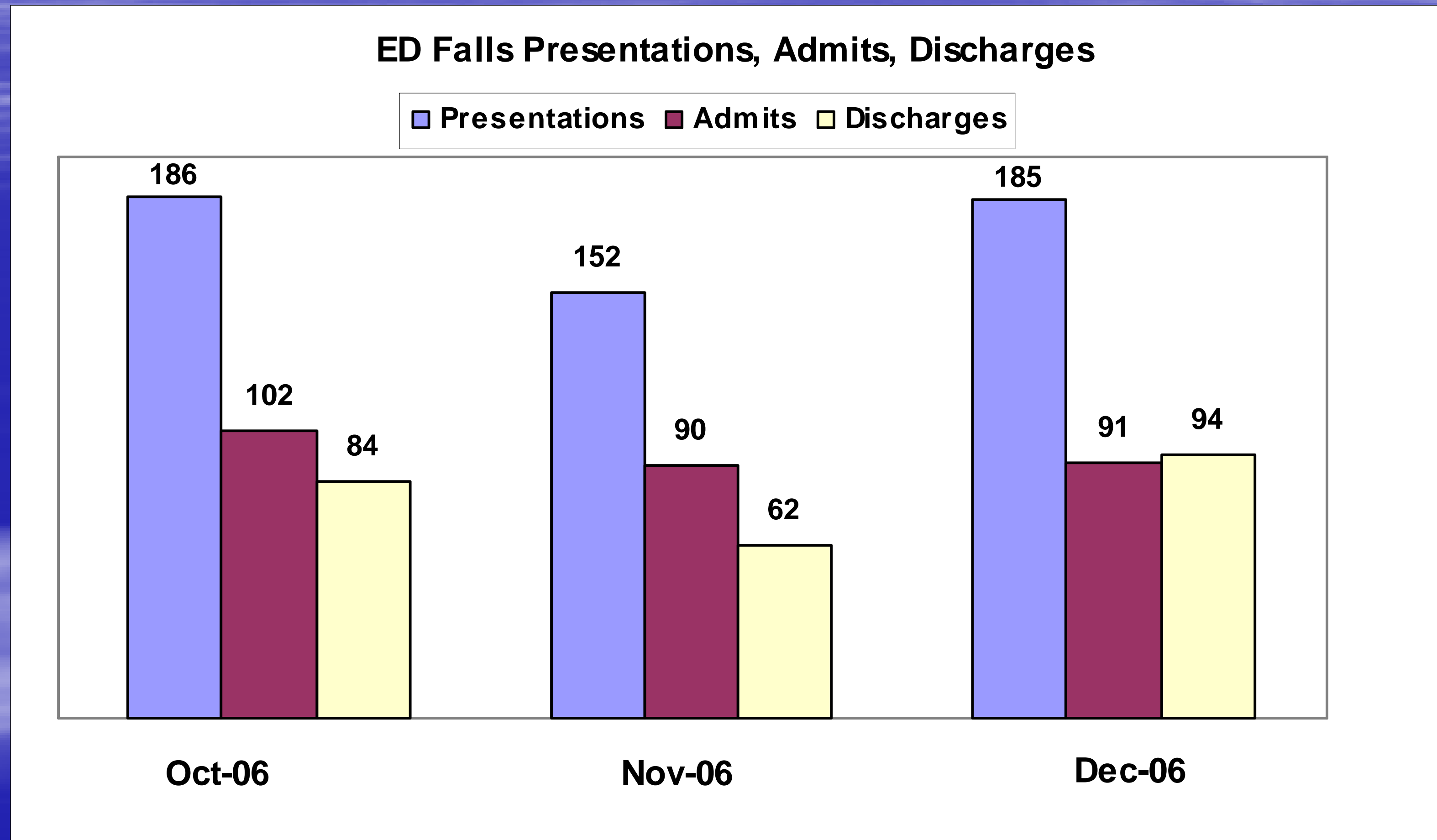
TOTAL PRESENTATIONS TO ED



TOTAL PRESENTATIONS TO ED
3 month snapshot



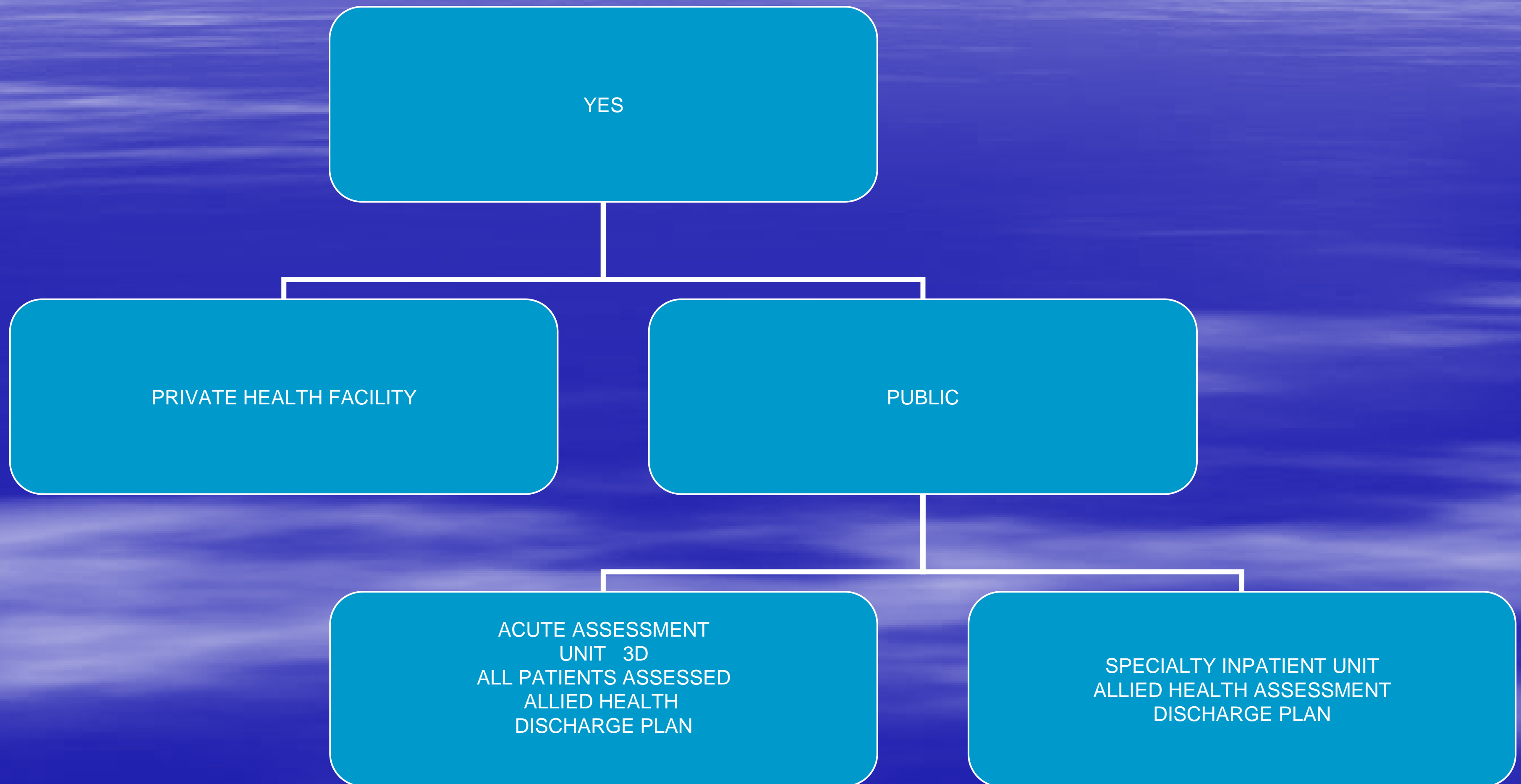
Fall Presentations in ED



PROCESS OF ASSESSMENT ED MEDICAL TEAM

- Presentation to triage includes brief history – mechanical fall or collapse
- CT / Diagnostic tests to identify acute medical / surgical condition.
- Evaluate function & safety level from patient and family
- If acute admit
- If non acute refer to discharge coordinator
- If complex refer to social worker

Acute admission required



NO ACUTE MEDICAL CONDITION
REFER DISCHARGE COORDINATOR

- Assess current needs
- Home situation – ? lives alone
- Support network – family, community services
- Refer Metro Home Link - OT assessment or home check visits
- Increase supports already in place if possible.
- Falls brochure
- If patient frail / afraid, bruised – convalescent care organised with links to falls management
- If needs are complex refer social worker

COMPLEX NEEDS

- COMPLEX NEEDS REFER SOCIAL WORKER
- Assessment
- Linking to community services
- Emergency respite options
- Identifying future options
- Empowering consumer to identify their own needs through education and providing resources

Psychosocial Assessment

- Conducting a psychosocial assessment which identifies problem issues and highlights discrepancies as perceived by patients & families
- It is essential to establish an effective discharge plan for complex social situations
- Identifying the needs of the patient
- Suitable services to meet both short and long term needs

What does the assessment involve ?

– Age impact and suitability
– Current accommodation
– Financial/employment eg DVA , private health
– Supports formal /informal eg community services
– Family composition /dynamics/care issues
– Premorbid coping
– Psychological
– Past & present coping capacity
– Current emotional response
– Understanding of issues
– Patient's & family expectation

Discharge planning

- Depending on social situation the social worker works with the team to ensure both care and social needs are meet
- Working with Metro Home Link to link long term home services and extend respite options
- Arrange respite in nursing homes and permanent placement
- Arrange urgent ACAT assessment in community if nursing home bed available
- Supportive care for short and long term needs
- Empowering patient and carers through participation in decision making and education of long term options available if care needs are changing

Team Work

- Early intervention and a proactive approach is implemented by the multi-D team in the Emergency Department

- Team work and education is the key to establishing an effective discharge plan and for preventing bounce back

Demography

- In 2004, South Australia recorded the oldest population in the nation
- Over the next 15 years it is projected that the Southern Adelaide Region will have the highest percentage of aging population in the state with an increase of 7.3%

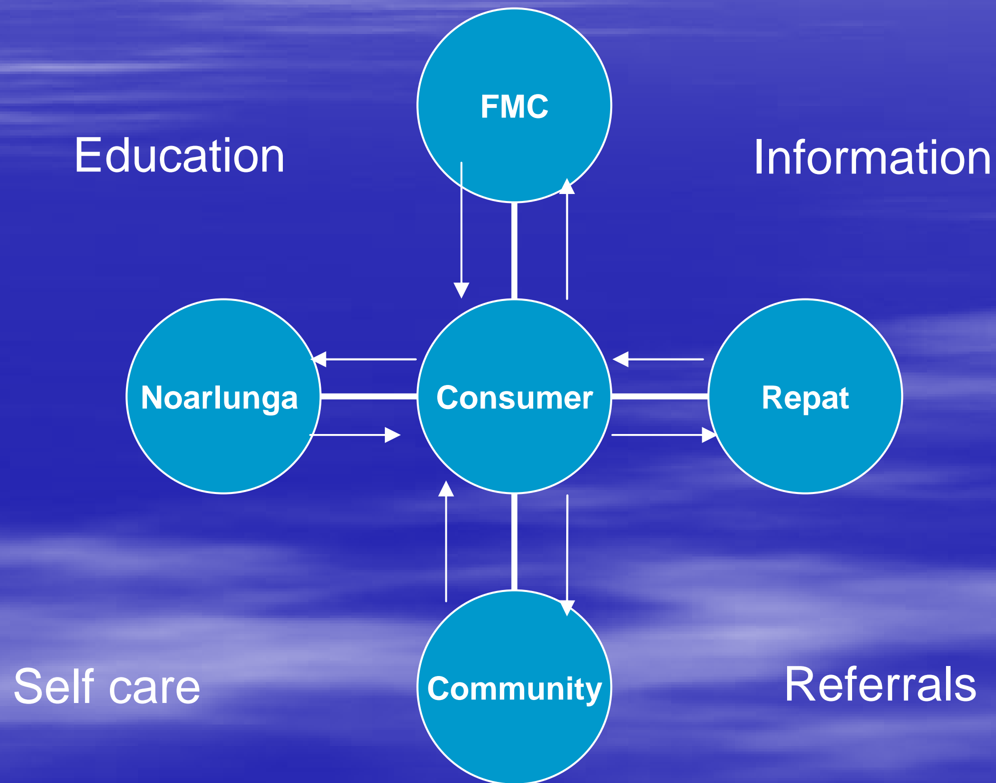
http://www.abs.gov/Aussstats/abs@nsf/0/b52c390d894336dca2568a9001393c1?Open

http://www.agedcare.org.au/factsheet1%20anageingaustralia.htm

Hospital

- In 2000-01 the 65 years and over presented 33.1% of all hospital separations and 48.0% of bed days (AIHW, Austr Hosp Statistics, 2000-2001)
- 26% of long term patients (14-30 days) primary concerns about leaving hospital was re-infection, mobility and after care requirements (Research conducted by Dr Johnson & Prof Bev O'Connell)

Regional Approach



The Flinders Medical Centre Emergency Department

- Promotes Positive Aging Principles
- Enables a collective approach to aging through participation, health and security
- Promotes collaboration between the consumer, community and both public and private sector

Where to now ?

- Collaboration between the consumer, community, public and private sector
- Communication and networking
- Service improvement and evaluation
- Development of transitional pathways integrating acute and community services.