IMPROVED DISCHARGE PLANNING THROUGH A COMMUNITY & AMBULATORY IN-REACH MODEL

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Aim
Improve hospital discharge planning through effective transition from hospital to the community.

Method
Trial of a hybrid version of two in-reach models in two sub-acute inpatient wards at Caulfield Hospital.

A clinician from the Intake & Referrals department attended journey board meetings on an aged care and rehabilitation ward for 6 months. The Intake worker acted as a resource for clinicians to facilitate referrals to community services.

Results

AUDIT OF TIMELINESS OF REFERRALS TO COMMUNITY SERVICES

| Ward                     | Pre Project | Post Project
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<tbody>
<tr>
<td>Aged Care Ward</td>
<td>21%</td>
<td>36%</td>
</tr>
<tr>
<td>Rehabilitation Ward</td>
<td>43%</td>
<td>48%</td>
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| Ward                     | Pre Project | Post Project
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<tbody>
<tr>
<td>Aged Care Ward</td>
<td>10%</td>
<td>16%</td>
</tr>
<tr>
<td>Rehabilitation Ward</td>
<td>81%</td>
<td>81%</td>
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Prior to discharge Day of discharge After discharge

Pre project

Post Project – Aged Care Ward

Post Project – Rehabilitation Ward

Average length of inpatient stay (days)

Staff satisfaction survey

75% of respondents found the in-reach model useful and reported an improved knowledge of the available community & ambulatory services that their patients could access.

Conclusion

The Caulfield In-reach model was able to demonstrate a 25-40% reduction in unplanned readmissions which not only improves patient care, but results in improved efficiency.

Improved awareness of discharge resources in clinicians also improved the timeliness of referrals to community and ambulatory services.