

# Royal Brisbane and Women's Hospital

## *Hospital to Home: Community care for patients post-discharge*

Post Acute Funding	Post Discharge Palliative Care funded services	Hospital in the Nursing Home (HINH)
<p><i>Purpose &amp; type of care provision</i></p> <p>To provide community care during the immediate post acute phase for a period of transition to community living.</p> <p><i>Eligibility</i></p> <p>The recommended intervention must be related to the reason for presentation to RBWH.</p> <p><i>Hospital role</i></p> <p>Arrange safe discharge:</p> <ul style="list-style-type: none"><li>• Ensure all community providers assisting with post discharge care receive medical, nursing and allied health (if relevant) discharge summary.</li></ul> <p>Funded services could include:</p> <ul style="list-style-type: none"><li>• daily medication management, including IV antibiotics – administration/education; insulin; eye drops; etc</li><li>• wound care (including consumables)</li><li>• support services such as home help may be provided in special circumstances</li><li>• personal care (exceptional circumstances)</li><li>• not equipment</li></ul> <p><i>GP role</i></p> <p>Usual care</p> <p><i>Time frames</i></p> <p>Limited to 2 weeks post discharge, may be extended at the discretion of the Nursing Director of the discharging area.</p> <p><i>Key contacts</i></p> <p>Contact Discharge Facilitation Unit: ph 07 3636 1593.</p>	<p><i>Purpose &amp; type of care provision</i></p> <p>To provide funded services and care support for patients palliating at home (for people with a progressively deteriorating illness which is not responsive to curative treatment).</p> <p><i>Eligibility</i></p> <p>Patients of RBWH who have been clinically determined as unlikely to survive more than three months.</p> <p><i>Hospital role</i></p> <p>Post discharge service support is arranged via Discharge Facilitation Unit from all clinical units (incl Outpatients and Dept of Emergency Medicine) at RBWH.</p> <p>Funding is needs based and can be arranged for:</p> <ul style="list-style-type: none"><li>• domiciliary nursing care and palliative support</li><li>• allied health interventions</li><li>• equipment</li><li>• clinical consumables</li><li>• in-home respite care and domestic assistance (after negotiation of accepting Health Service District)</li></ul> <p>The patient may be linked to a Palliative Care Service which operates separately to the funding for care and services post-discharge for example Metro North Primary and Community Health Services Community Palliative Care Services.</p> <p><i>GP role</i></p> <p>Maintain usual post discharge care to the palliating patient according to the Discharge Summary/Referral.</p> <p>Needs to be willing to see patient on call.</p> <p><i>Time frames</i></p> <p>Four weeks and then funding arrangement handed over to patients 'home' District. DFU need to be aware of other Districts budgetary limitations.</p> <p><i>Key contacts</i></p> <p>Contact Discharge Facilitation Unit for more information: ph 07 3636 1593.</p>	<p><i>Purpose &amp; type of care provision</i></p> <p>Provides follow-up care, management and support to RACFs and GPs when patients are discharged home from the Emergency Department or RBWH inpatient wards.</p> <p><i>Eligibility</i></p> <p>Residents of residential aged care facilities.</p> <p><i>Hospital role</i></p> <p>HINH provides RACF clinical education relevant to the acute care of the resident.</p> <p>HINH consults and supports GP's, aged care facilities and RBWH health care teams regarding medical and nursing management of aged care residents.</p> <p><i>GP role</i></p> <p>Manage the medical care of the resident in the nursing home.</p> <p>Seek acute care advice from hospital clinicians via HINH service.</p> <p><i>Time frames</i></p> <p>Maintains support as required to GPs, and residential nursing staff until the acute medical issue has resolved.</p> <p><i>Key contacts</i></p> <p>Clinical Nurse Consultant: ph 07 3636 4627; 0407 571 840</p> <p>Ambulatory nurse: ph 07 3636 4627; 0407 571840</p>

## Heart Failure Service

### *Purpose & type of care provision*

A specialised multidisciplinary team to support patients living with heart failure in hospital and post discharge management by telephone, home visits, clinics and rehabilitation programs.

### *Eligibility*

Any patient admitted to RBWH with a confirmed primary or secondary diagnosis of congestive heart failure (includes those in residential aged care facilities).

### *Hospital role*

- Acute Phase: establish self management strategies - emergency action plan; daily weighs; diet etc.
- Planned exercise program
- Pharmacy review
- Post Acute Phase
- Follow-up as required and appropriate by phone, home or clinic visits
- GP Liaison
- Care plan support
- Medication titration in liaison with GP and hospital consultant
- Activity and exercise programs.

### *GP role*

- Participate in medication titration.
- Maintains involvement in care planning and management in liaison with Heart failure Service and hospital consultant.
- Assists patient to self management.

### *Time frames*

3-12 months depending upon patient need, with option of re-connecting back to Service at any time.

### *Key contacts*

RBWH Heart Failure Service:  
ph 07 3636 6465, 7:30am to 4 pm  
Mon to Fri.

## Maternity Share Care

### *Purpose & type of care provision*

Facilitates the sharing of antenatal care between the patient's local General Practitioner and the hospital.

The program is supported by GPpartners.

### *Eligibility*

Patients with identified low risk pregnancy.

### *Hospital role*

- Provides antenatal midwifery care. Hospital visits scheduled for 'booking in' (approx. 16 wks), 20 wks, 30 wks, 36 wks and, should the baby be overdue, 41 wks to discuss the management of post term pregnancy.
- Completes the patient held record on each patient visit and reviews the GP's records.
- Provides specialist obstetric support throughout the pregnancy.
- Advises the GP immediately if there is a complication of the pregnancy which alters the patient's eligibility for the program.

### *GP role*

- Provides antenatal care.
- Provides usual patient care.
- Completes the patient held record on each patient visit and reviews midwifery information in the record.
- Conducts routine antenatal pathology and imaging throughout the pregnancy in accordance with the RBWH and GPpartners Routine Antenatal Tests Schedule.
- Advises hospital immediately if there is a complication of the pregnancy which alters the patient's eligibility for the program.
- Phones one of the specialist obstetric staff, or schedules an extra visit to the hospital if any problem detected at any stage of the pregnancy.

### *Time frames*

Antenatal period – maximum nine months.

### *Key contacts*

Maternity Shared Care Coordinator:  
ph 07 3636 1305

## Maternity Midwifery Service

### *Purpose & type of care provision*

To provide support and education for post natal patients and to refer to community based agencies as required.

Attend to minor procedures such as wound dressings and collection of NNST.

### *Eligibility*

Must have given birth at the RBWH and reside within a defined geographical area within Metro North Health Service District.

### *Hospital role*

- Collects data relevant to the pregnancy and birth.
- Obtains written permission for visit.
- Provides education and written resources to enable Mother to make decisions regarding childcare and feeding.

### *GP role*

- Receives notification of discharge.
- Conducts Day 5 neonatal examination according to Pregnancy Health Record.
- May be required to treat emergent medical problems related to birth and lactation, e.g. mastitis.

### *Time frames*

Up to 10 days post discharge.

### *Key contacts*

RBWH Community Midwifery Service:  
ph 07 3636 1305

## Mental Health GP Liaison Program

### *Purpose & type of care provision*

Aims to identify and coordinate transfer of patients from Inner North Brisbane Mental Health Services (INBMHS) to GP. Only those with stable and well managed mental illness are transferred to own GP for Holistic health care.

Complements Clozapine Shared care Program and GP Psych Opinion Service.

### *Eligibility*

Long term consumers who have been mentally unwell for at least 12 months.

### *Hospital role*

- Provides initial visit to GP with consumer.
- Provides GP written feedback/Mental State Examination after each contact with consumer.
- Provides suitably qualified and skilled mental health staff.
- Assists GPs in identifying which Mental Health Service is required.
- Develops transfer plans.
- Provides education around the Mental Health Act as required.
- Data collection and collation for research purposes.

### *GP role*

- Receive case management support from INBMHS.
- Monitor the consumer/patient as necessary.
- Administer depo medications using the INBMHS Guide to monitor for possible co-morbidities.

### *Time frames*

Minimum of one year with 3 monthly contacts from INBMHS – usually home visits.

Contact may be extended or more frequent if needed.

### *Key contacts*

GP Liaison Co-ordinator:  
ph 07 3114 0813; 0402 790 916

## Mental Health Share Care Program Clozapine Share-Care

### *Purpose & type of care provision*

Aims to provide support to GPs who manages the care of stabilised patients on Clozapine therapy.

### *Eligibility*

Consumers/patients who have been stable for 12 months who are able to self manage reasonably complex situations.

### *Hospital role*

- Consumer remains an active patient of the Mental Health Service (with designated case manager).
- 3 monthly review by psychiatrist and additional support if concerns arise regarding their Clozapine treatment.
- Written feedback to GP by Psychiatric registrar or consultant.
- Develops transfer plans.
- Provision of medication and 3 month scripts.
- Registration and training of new GPs for Clozapine Share Care.
- Manage the manufacturer data base.

### *GP role*

- Management of stabilised patients on Clozapine therapy.
- Monthly monitoring of blood results as per Clozapine Manufacturer (Clopine Connect) Policy and Procedures.
- Monthly observations completed.
- Annual ECGs\ and echocardiogram.
- Monitor for signs of infection.

### *Time frames*

Graduated process. Mental Health case management closed when consumer care transferred to GP

### *Key contacts*

GP Liaison Co-ordinator:  
ph 07 3114 0813; 0402 790 916

## Mental Health Share Care Program GP PsychOpinion

### *Purpose & type of care provision*

Specialist consultation advice on issues such as clarification of diagnosis, review of management plan for GPs who wish to manage own patients with mental illness.

### *Eligibility*

- Patients with mental illness residing in INBMHS catchment area.
- NOT suitable for patients requiring ongoing mental health follow-up.

### *Hospital role*

Provides one-off assessment and advice to GP on issues such as clarification of diagnosis, review of management plan for GPs who wish to manage own patients with mental illness.

Written faxed response provided to GP including assessment and plan.

Specialist Outpatient Clinic coordinate appointment.

### *GP role*

Maintain usual patient care and management based on advice from INBMHS.

### *Time frames*

Once-off assessment.

### *Key contacts*

Referrals can be directed:  
ph 07 3636 1148  
fax 07 3636 5267

## Primary and Community Health Services Home Based Acute Care Service (HBACS)

### *Purpose & type of care provision*

To provide a public health service option of acute care for low risk patients as a substitution to hospital based acute care (a hospital in the home service).

### *Eligibility*

- Identified as suitable for home based hospital care by the hospital treating team.
- Medically safe to treat at home.
- Over 15kgs.
- Patient and carer acceptance of HBACS.
- Phone dial-out facility at patient's home.
- Lives within Metro North Health Service District.

### *Hospital role*

Maintains medical accountability and management of acute illness.

Identifies suitable patients and arranges transfer to HBACS for continuing acute care for the following range of conditions:

- Requires acute nursing or allied health
- Pre-op care otherwise requiring hospital admission
- Comprehensive assessment
- IVT, Point of contact INR
- Wound care, Medication support
- Personal care
- Physiotherapy, Occupational therapy
- Short term equipment supply and trial.

### *GP role*

- Receives transfer notification to Home Based Acute Care.
- Receives Discharge Summary from hospital and HBACS.
- May be required to treat minor illnesses unrelated to the acute care problem, e.g. flu.
- In the interests of patient safety, please contact HBACS prior to making any changes to patient care during HBACS care period.

### *Time frames*

For the time patient requires an acute care bed.

### *Key contacts*

Central Referral Unit  
Mob 0448 626 654

## Primary and Community Health Services Transition Care Program

### *Purpose & type of care provision*

To support older people with short term assistance that will help them recover to their full potential following a hospital stay.

### *Eligibility*

- Current hospital inpatient.
- Aged 70+ (50+ indigenous patients).
- May take 65+ with age related condition – confirm with Transition Care Program Nurse Unit Manager first.
- Capacity to improve physical function.
- Would benefit from a goal oriented, therapy focused program.
- Requires allied health AND nursing and/or personal care.
- Be medically stable and ready for discharge from hospital.
- Requires ACAT assessment for Transition Care Program.

### *Hospital role*

This service provides therapy-focussed packages, including:

- case management
- allied health services (e.g physio/ OT/ Speech path/ social work/ dietician/ podiatry etc)
- nursing care (wound, medication)
- continence management)
- links with GP and Geriatrician
- personal care, domestic assistance, transport, meals, vital call.

### *GP role*

Usual post-discharge management and care according to the Discharge Summary/ Referral.

### *Time frames*

Up to 12 weeks post-discharge.

### *Key contacts*

Transition Care Program: ph 07 3360 4871  
Discharge Facilitation Unit: ph 07 3636 1593

## Primary and Community Health Services Metro North Health Service District

### *Purpose & type of care provision*

Provides a broad range of services in the following areas:

- Primary Health & Care Coordination Services – services and programs for people 18 years+ that focus on long term chronic disease and risk factor management.
- Rehabilitation & Consultation Service – short term intervention for people 18 years+ with serious health conditions. Delivered by multidisciplinary teams; aimed at healthy ageing, chronic condition self management and rehabilitation.
- Healthier Children & Families Service (Redcliffe/Caboolture) – home visiting program, Child Health Services inc drop in services, feeding and settling clinics, and parenting support.
- Alcohol and Drug Service
- Sexual Health and HIV Service
- Indigenous Health Service

### *Eligibility*

Eligibility criteria can be obtained from the Primary and Community Health Central Referral Unit (CRU).

### *Hospital role*

Can refer patient to a Primary and Community Health Service following acute treatment.

### *GP role*

- Can refer clients directly to service.
- Care plan in partnership with a service.
- Client can be discharged from service to GP for usual care following service episode.

### *Time frames*

Primary Health and Care Coordination Services – case management time limit up to 12 months.

Rehabilitation & Consultation Service – up to 12 weeks most cases.

Refer CRU for:

- Healthier Children & Families Service (Redcliffe/Caboolture)
- Alcohol and Drug Service
- Sexual Health and HIV Service
- Indigenous Health Service

### *Key contacts*

Central Referral Unit:

North Brisbane suburbs and Pine Rivers:  
ph 1300 658 252

Redcliffe, Caboolture and Kilcoy:  
ph 07 3049 1225