

Service Coordinators

Navigating the Community Health Maze

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Service Coordinator



- A Service Coordinator is a health professional who **assesses and coordinates** the care of complex clients within **24 to 48** hours of discharge from post acute setting and/or GP referral.

Evidence

“Many older people remain in hospital after the acute phase of their illness due to a **delay in implementation** of community services to respond to their ongoing needs for domiciliary care.”

(Wilson 2003)





Service Development

- Change in demographics and type of people presenting to hospital (Poncia et al 2000)
- Difficulty pre-empting clients needs while in hospital (Poncia et al 2000)
- Bed pressure with shorter admissions (Poncia et al 2000 & Pearson et al 2004)
- Waiting list lengths (Hegney, MCarthy, de la Rue, Fahey, Gorman, Martin-McDonald, Pretty, Sundin-Huard 2002)



Responsibilities



Client Centred Service Coordination by:

- Providing support and guidance for: clients, acute facility staff and General Practitioners
- Developing and fostering partnerships between public health services and private services
- Working in direct collaboration with clients, General Practitioners to improve health outcomes

Service Coordination involves:

- Screening/Assessment
- Care Planning
- Service Coordination
- Time limited Intervention Period
- Collaborative Approach



Criteria

Essential criteria

- Client is over 18 years and is medically stable

One or more of these

- Frequent presentations/admissions to an acute facility
- Limited or no social supports
- Poly pharmacy
- Lives alone
- No GP
- Carer strain
- Limited coping ability
- At risk of deterioration
- Concerns about ability to manage activities of daily living
- Cognitive problems requiring intervention



Referral Process

At risk client identified by referral source utilizing Service Coordinator Screening Guidelines

Phone referral to Service Coordinator to identify: at risk criteria from Guideline and Service Coordinator capacity/timeline to respond

Relevant documentation from referrer faxed to SC:

- Hospital Discharge Summary
- GP Medical Report
- ONI 4 pages

Service Coordinator Initial telephone contact within 24 hours
Home visit for care coordinator/planning within 48 hours

Develop client care plan service specific including referrals

2 weeks Service Coordination allotted to client
SC liaise with service providers to action/review plan

Discharge/transfer care coordination to identified case manager
Provide documentation – Care Plan, ONI

Follow up case manager within 7 days



**Referrals to
Internal and External service
providers
for ongoing management and
intervention**

Internal Service Providers

Northside Primary & Community Health Services

Specialist streams provide assessment and ongoing case management.

Streams include:

- Dementia:
- Continence
- Heart failure
- Respiratory
- Orthopaedic
- Acute Wound management
- Personal care (for existing Home Care Clients)
- Complex care

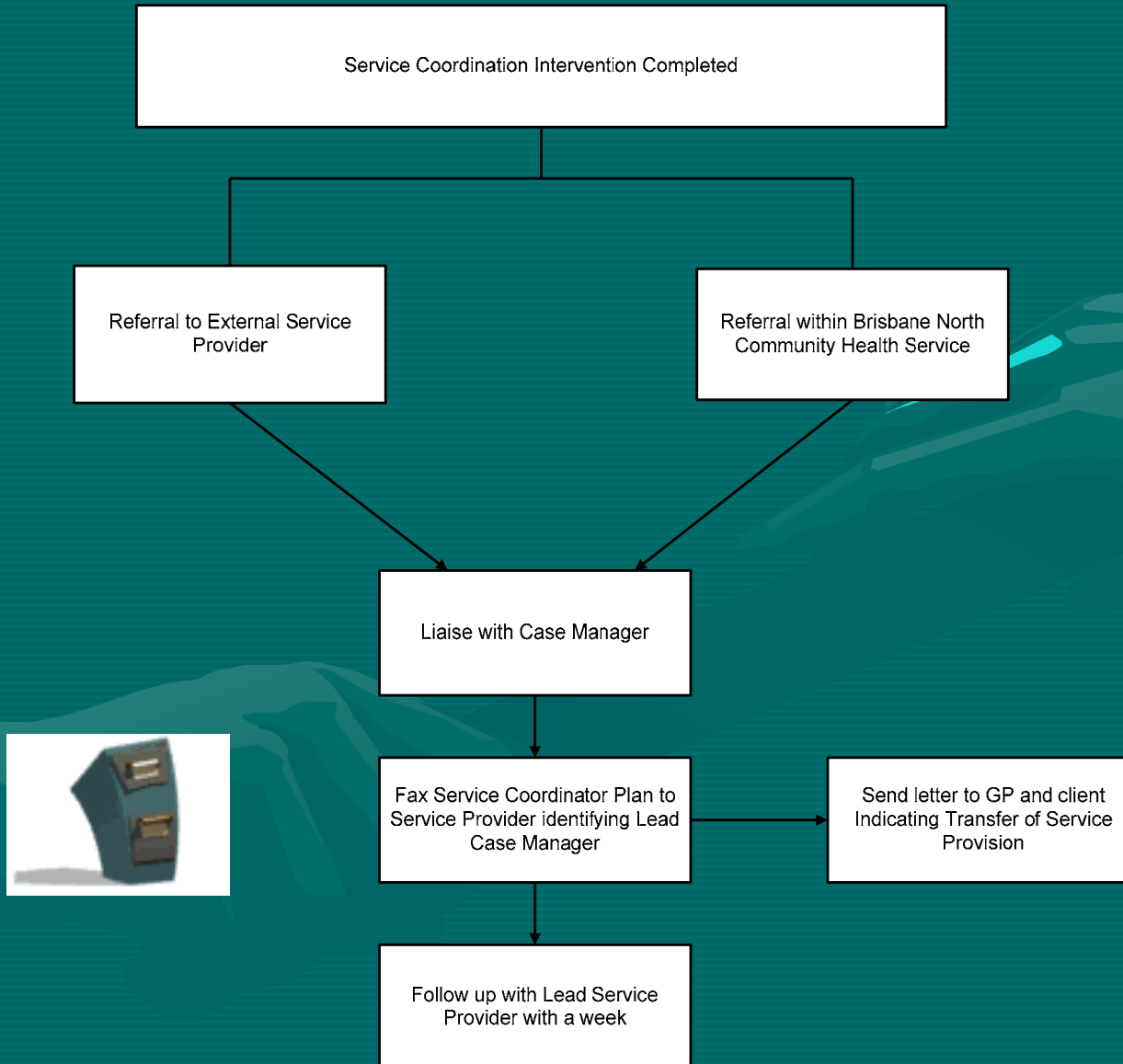


External Service Providers



- Domiciliary Nursing Agencies
- Independent Nursing Agencies eg Mobile Assessment Unit, Nurses, Therapeutics etc...
- General Practitioners
- Allied Health Services
- Self management courses
- Support groups

Closure and Referral



Case Study

- 70 year old lady with a history of dehydration
- & falls secondary to Parkinson's' disease
- 70 year old husband is the carer
- No social or community supports
- Husband not coping with sleep deprivation due to clients nocturia
- Client medically stable for discharge but declined further hospital rehabilitation
- Client identified at high risk of readmission if community supports not in place upon discharge
- Seen by CCC/DF and client refused any in home supports
- Agreed to Service Coordination consultation and assessment in home environment
- CCC/DF referred client to the Service Coordinator for assessment and follow up





Needs Identified



- Areas of risk identified on ONI Screen and Assessment Tool:
- Medication errors
- Falls
- Urinary Incontinence
- Unable to Self Care
- Unable to complete domestic duties
- Impaired cognition
- Carer Strain



Discharge/Transfer



Service Coordinator:

- Arranges services accepted by client.
- Service Provision commenced
- Case is transferred to service provider.
- Client and GP notified in writing of transfer
- Case Closed to Service Coordination
- Discharge/transfer letter sent to referral source

Benefits

- Client Centred
- Early intervention Integration of care across the continuum
- Partnerships
- Access to Services
- Reduction in hospital stay/readmission
- Cost effective

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