An introduction to the Community Fast Track Response Service

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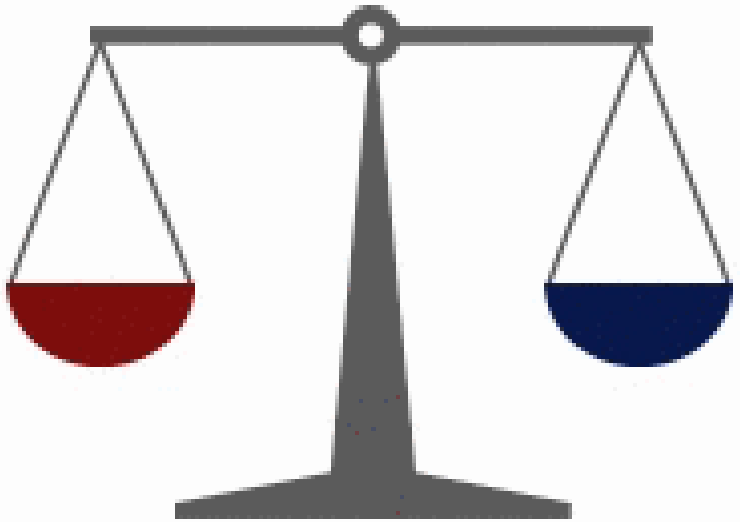
Monash Health

To meet COVID care demands across our **four key pillars**, and with significant workforce constraints across professional groups, we have rationalised our services to strengthen our **COVID-Peak response**

Monash Health Community Service rationalisation



FOUR KEY PILLARS

- HOSPITAL CAPACITY & COMMUNITY
- COMMUNITY CARE PATHWAYS
- CONTACT TRACING & TESTING
- COVID VACCINATION

Community Priorities

ED Diversion

- COVID Care Pathways
- ED to Community Fast Track
- Rising Risk – Clinical Escalation Pathway
- High-Level Social Supports
- AH Care Coordination

Discharge Support

- Early transfer out of hospital
- Minimise risk of hospital representation
- Support patient flow
- Multidisciplinary critical service delivery

Bed Substitution

HITH expansion

- Traditional HITH cohorts
- COVID positive pathway escalation for intervention including Sotrovimab clinic
- Nursing services unable to be sourced in primary care (traditional PAC level care)

Fast Track Response Service

Purpose of Fast Track Services

- A single point of reference and streamlined referral pathway
- Diversion of care from ED to best clinical or social support pathway
- Identification of vulnerable and high-risk complex patients that can be treated by Community
- Provide responsive and flexible care as close to a person's home as possible
- Facilitate early discharge from acute hospitals

ED & Discharge Support

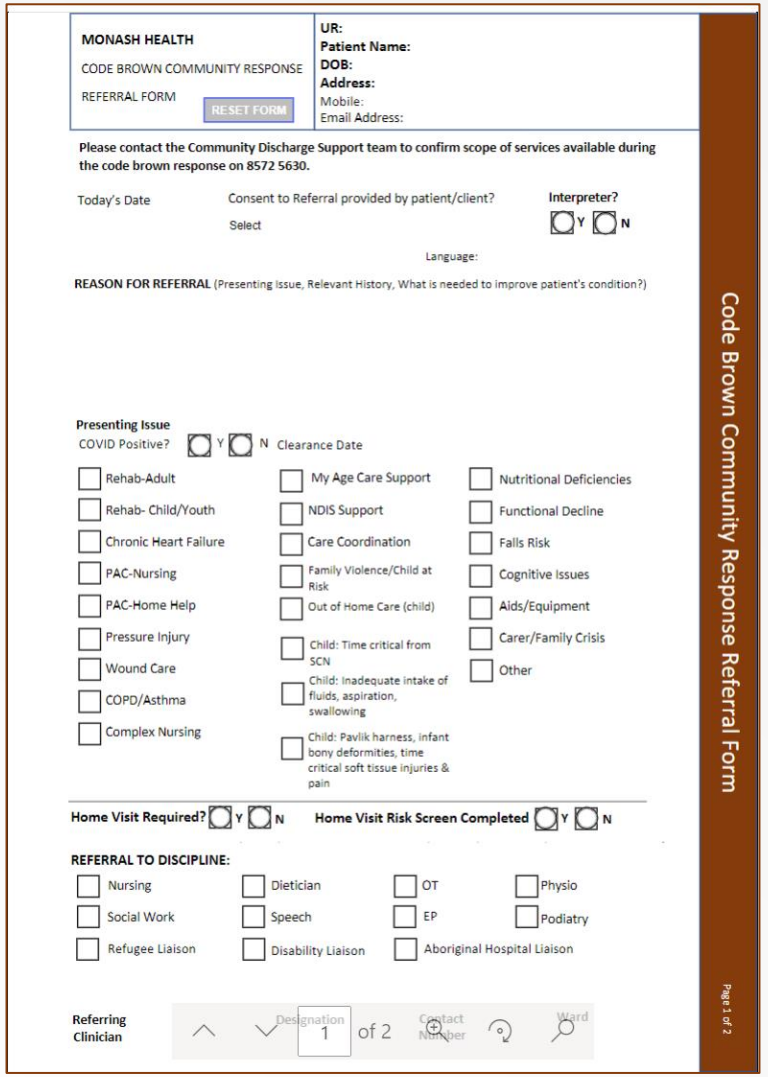
Fast Track Response Service

Available 7 days a week (8:30am to 5:00pm)

One hotline: 03 8572 5630

One email: cb.communityreferrals@monashhealth.org

One referral form



MONASH HEALTH
CODE BROWN COMMUNITY RESPONSE
REFERRAL FORM
RESET FORM

UR:
Patient Name:
DOB:
Address:
Mobile:
Email Address:

Please contact the Community Discharge Support team to confirm scope of services available during the code brown response on 8572 5630.

Today's Date
Consent to Referral provided by patient/client?
Select
Interpreter? Y N
Language:

REASON FOR REFERRAL (Presenting Issue, Relevant History, What is needed to improve patient's condition?)

Presenting Issue
COVID Positive? Y N Clearance Date

- Rehab-Adult
- Rehab- Child/Youth
- Chronic Heart Failure
- PAC-Nursing
- PAC-Home Help
- Pressure Injury
- Wound Care
- COPD/Asthma
- Complex Nursing
- My Age Care Support
- NDIS Support
- Care Coordination
- Family Violence/Child at Risk
- Out of Home Care (child)
- Child: Time critical from SCN
- Child: Inadequate intake of fluids, aspiration, swallowing
- Child: Pavlik harness, infant bony deformities, time critical soft tissue injuries & pain
- Nutritional Deficiencies
- Functional Decline
- Falls Risk
- Cognitive Issues
- Aids/Equipment
- Carer/Family Crisis
- Other

Home Visit Required? Y N Home Visit Risk Screen Completed Y N

REFERRAL TO DISCIPLINE:

- Nursing
- Social Work
- Refugee Liaison
- Dietician
- Speech
- Disability Liaison
- OT
- EP
- Aboriginal Hospital Liaison
- Physio
- Podiatry

Referring Clinician Designation Contact Number Ward

1 of 2

Code Brown Community Response Referral Form

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One place to find all your information:
https://monashhealth.sharepoint.com/sites/CommunityCOVIDCommunications/SitePages/Community-Fast-Track-Response.aspx

How Community Fast Track Response actually works

Monash Health

Community Fast Track Response in Action -1

- 74 year-old Female
- Lives with family
- History:
  - Type 2 Diabetes
  - HTN
  - OA
  - COPD
  - ischemic stroke (2015)

1

28/1/2022 Presented to ED. Admitted to Gen Med.

- Presented with worsening COVID+ symptoms, lethargy, dementia, reduced oral intake
- Admitted under Gen Med
- Offered equipment for use at home – family declined - felt they could manage without.

2

6/2/2022 Discharge

- Going home would require 2x assist for all cares. Risk of pressure injuries, carer burnout. Needing social supports for assistance/care.
- Community Fast Track referral for next day OT visit

3

7/2/2022 Interventions provided at Home

- Next Day: OT assessment for pressure injury risk and to provide education and carer training in home environment
- Day 2: Linked social work to assist with access to social supports
- Dietetics referral for assessment/management of malnutrition risk

4

Ongoing:

- Discharged from Fast Track with internal referral for ongoing for Community Priority Service (CRC or Community Health) with immediate effect.

Community Fast Track Response in Action - 2

- 53 year-old Male
- Lives independently
- Previously independent with mobility
- Nil gait aid

1

6/2/2022 ED

- Presented for pain on weight bearing following a fall 6/2/22
- 2x hip dislocations since R) THR in Dec 2021.
- Assessed – no current dislocation.

2

6/2/2022 Discharge

- Medically cleared for discharge - concerns about ability to manage at home due to mobility and home set-up
- Community Fast Track referral for next Day OT and Physio visit

3

7/2/2022 Interventions provided at Home

- Physio assessed mobility and prescribed gait aid to ensure safe mobility and reduce falls risk
- OT assess/provide equipment to enable independent completion of ADLs whilst remaining within strict R) posterior hip precautions

4

Ongoing:

- Discharged to GP with advice on re-referral to CRC post Code Brown for ongoing rehab.

Community Fast Track Response in Action - 3

- 84 year old
- Female
- Lives alone – supportive family
- History of chronic heart failure frequent presenter
- Type 2 diabetes – insulin requiring
- COPD – FEVI 59%
- Anxiety

1

3/2/2022 ED

- Presented with unstable blood sugars and fluid overload
- Reviewed by nurse practitioner (NP)
- Discussed with consultant in charge – decision to treat patient at home

2

3/2/2022 Discharge

- Discharge 4 hours after arrival
- Referred to Complex Care Nursing Team through Fast Track Response

3

4/2/2022 Interventions provided at Home

- Next day: NP home visit review/consultation for titration of fluid tablets, initiation of ACE inhibitor
- Clinical nurse consultant physical exam, inhaler technique review
- Internal referral for blood glucose management and diabetes

4

Ongoing:

- GP contacted re: medication changes, ongoing treatment.
- Referral to MAC for package review
- Ongoing training and advanced care plan booking

What's the best option for my patient?

- If a patient is medically fit for discharge, what are the barriers to safely managing them at home?
- Could a solution to this barrier be provided by the Community Fast Track Response Service in the patient's home?

I need more information:

- Speak to the Discharge Support Leads on wards
- Call the Fast Track Hotline on **03 8572 5630**