Repat Neuro-Behavioural unit

Admission Pathway

Day of admission	Within 24 hours	Within 48 hours	One week	Progression	Prior to DC	Discharge	Post Discharge
Pre arrival handover – morning Integrated Management System (IMS) Brief (Medical team and interdisciplinary team daily) Pre Arrival Phone Transfer from sending ward, using the SALHN Interward Transfer Form including confirming Section 32 Status and advanced care directive. Confirm ITO has been revoked if applicable. Check sending ward have completed NPI, sent sunflower and 'insights into me document' if completed by family/NOK. Arrival time as arranged Ward Clerk completes admission on Electronic Medical Record (EMR) including commencing CBIS episode of care Family/carer/substitute decision maker (SDMs) notified of arrival to unit Welcome pack provided to family/carer/SDMs if present by staff. Pack includes orientation of environment, processes and ensuring personal safety whilst on the unit. Informed & documented to collect when they next attend the unit if not present. Physical orientation to entire unit provided by carer consultant Medical Assessment Commence Maudsley format assessment (incorporating collateral from accompanying documents, carer-provided information & consumer history). Identify co-morbid mental health conditions and non-dementia/BPSD risks. Identify chronic, concurrent or acute medical conditions. Verify medications from referral source in with Pharmacist. Summarise relevant developmental history across the life-span. Mental State & Physical Examination. Collate relevant prior pathology and radiology results- new baseline investigations not expected, with requests only if clinically indicated. Formulate assessment and document plan. Review prior 7-Step Pathway and verify validity with nominated Guardian Risk Assessment Nursing staff in collaboration with admitting doctor, incorporating information from referral and accompanying documents Nursing Assessment Receipt of SALHN Interward Transfer Form (Nursing Handover). EMR Nursing and Midwifery Admission document. Pressure, Continence + Skin Integrity Assessment; Falls Risk Assessment; Cognitive, Nutrition and Delirium screening; MUST, Allergies, Pain Assessment; CRE and MRO screening; Review of cultural/spiritual beliefs. Daily physical observations or as clinically indicated Identify trauma history Visual Observations Form commenced (intermittent 8 hours) Responsive behaviours: Behaviour assessment documents commenced Physiotherapy assessment on arrival if admitted, otherwise as soon as able. Including transfer, mobility, falls risk assessment Pharmacy Assessment, Med-Map Allied health assessment competed according to clinical need – OT, DT, SW, SP, Swallowing recommendations documented if concerns or handover from transfer. About Me Sunflower Tool – Nursing to check with family if this has been completed Falls Screen and Interventions identified and implemented Consumer valuables list completed, and property search attended. Labelling of personal items as required (HONOS 65) data set commenced by nursing Wellbeing folder initiated – Family/carer have 'insights into me' document to complete Activity/Therapy commences	Consultant psychiatrist to review patient Remaining allied health Assessments completed Remaining nursing admission completed Family/carer/SDMs contacted and provided with Welcome Pack if not already completed Medical team to contact family/carer/SDMs RNBU care plan commenced including liaison with family/carer/SDMs Falls Plan developed and implemented Sensory Profile, About Me Sunflower Tool continue to be completed	Sensory Profile Completed About Me Sunflower Tool completed Geriatrician Review Identify Primary Nurse Check in with family/carer Review 'insights into me' document *Feeding Assessment (EdFED) by Nursing Staff Pharmacy Assessment completed	Cognitive Testing as clinically indicated RNBU care plan updated, including goals of care established with family/carer/SDMs Interdisciplinary discussion including wellbeing review and review of responsive behaviours/ behavior assessment Assessment of 'key indicators' Communication Profile Completed – Speech Pathology IMS Huddle Board tracking Falls/ Risk and Responsive Behaviours	Daily brief and medical task review at IMS board with Multidisciplinary team Team huddles convened as required for care priorities Monitoring and adjustment to care plan including falls Plan, Sensory Modulation Program, behaviour assessment, RNBU care plan & supports Completion of weekly orders (weight, Braden) Interdisciplinary Review fortnightly (wellness review), carers/SDMs attendance monthly Ongoing communication with family/carer/SDMs regarding progress Review of 7-Step Pathway with SDMs where clinically indicated Encourage engagement with unit activities and therapy programs Ongoing allied health review and intervention including diversional and lifestyle activities. Weekly Med Map by pharmacist HONOS 65 data set reviewed at 91 days Risk Assessment Review monthly OR where clinically indicated IMS Huddle Board tracking Falls/ Risk and Responsive Behaviours	Family/carer/SDMs to complete IPAD survey 1 – 2 weeks prior to discharge Family/carer/SDM notified of discharge date and processes Week prior to discharge medications will be ordered from FMC pharmacy or facilitated through community pharmacy. Education will be provided to patient / family / carer / SDMs as required NIMC – long stay completed Newly prescribed anticholinesterase and memantine medications require script completion on discharge for six months of treatment and documented guidance on monitoring improvements in the discharge summary Prior to discharge follow up arranged (RDNS, transport, equipment, appointments, Older Persons Mental Health Services follow up) Discharge Summary completed by team Day Prior to discharge HONOS 65 data set completed Medical handover to GP Contents of Well- being folder copied, care plans and strategies/ supports	Discharge Summary finalised and provided to facility/ family/GP Wellness folder contents, Care Plan, provided to facility/ family/ SDM NIMC long stay provided to facility Verbal handover provided to facility including care plan support strategies 'Safety Alert for Transfer to Residential Care' completed by nursing staff Pharmacy Summary of Medications and medications/ NIMC long stay provided to facility/family MRU engaged (if required) to support transition to facility Return valuables to NOK/ family Verbal notification of patient leaving ward to family/carer/SDM (documentation in EMR) Check in with family/carer/SDMs	Support available via MRU, SBRT. Older persons Mental Health Services, RNBU Nurse Consultant Place of care in RNBU held for seven days 7 Day post discharge follow up phone call (CBIS)

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