Aged Care Emergency

Model of Care

November 2013

Emergency Care Institute
NEW SOUTH WALES

NSW GOVERNMENT Health

INTRODUCTION

It is well documented that older people require emergency care more often than other populations, and generally have longer Emergency Department (ED) length of stay and higher admission and readmission rates. Older people account for greater than 60% of hospital admissions and are at risk from hospitalisation itself, particularly delirium.

Older people who become acutely unwell in Residential Aged Care Facilities (RACF) are a considerable proportion of ED presentations. A number of studies have found that for certain disorders or conditions, effective treatment does not necessitate presentation to ED from the RACF. For example, those with acute infections treated in their residence have similar or better survival and fewer complications compared to those transferred to hospital for treatment, even accounting for severity.

While there is evidence that there are conditions that have resulted in presentations by older people to the ED which could be equally or better managed in other settings, the ED is likely to remain an important point of entry to the health care system for older people and that the older person's health care needs are different to other populations in both ED and hospitals. The literature and policy documents consistently identify the need to improve cognitive assessment, pain management, and transitional care in both directions between RACFs and EDs.

When older people do present to the ED, be it from a RACF or the broader community, they often require supportive care to ensure their immediate safety and other needs are met in the ED environment. There is also a need to minimise risks associated with ED attendance, hospitalisation and readmission (in particular delirium, disorientation, pain and falls) through screening for risk factors and providing early intervention.

The Aged Care Emergency (ACE) program was successfully implemented at John Hunter Hospital Emergency Department during 2010-11 and 2011-12 and is designed to address the identified gap in supporting staff in RACFs to facilitate residents' non-life threatening acute care needs being met within the facility and avoiding an ED presentation. A further 10 NSW Hospitals were also provided with funding to implement the model.

The ACE model was developed based on the models previously developed at Hornsby Kur-ing -gai Hospital (Geriatric Rapid Acute Care Evaluation – GRACE) (available at http://www.archi.net.au/resources/moc/older-moc/grace) and the Aged Care Triage(ACT) model developed at Concord Hospital.

This document describes detail of how the model works including key principles and business rules, benefits and challenges of the model, what is required to run the model and how the model should be evaluated.

Several documents are available to assist with implementation of the ACE model and include:

- A general guide for setting up a new ACE service, a generic ACE clinical algorithms manual and links to educational material for use in establishing ACE
- Examples of promotional material for the various stakeholders involved in the ACE program (RACF staff, General Practitioners, ED staff and patient's relatives and carers).
- The final evaluation reports of the model's implementation at 11 NSW Hospitals
  These documents are available on the NSW Emergency Care Institute's website www.ecinsw.com.au

ACE Model of Care

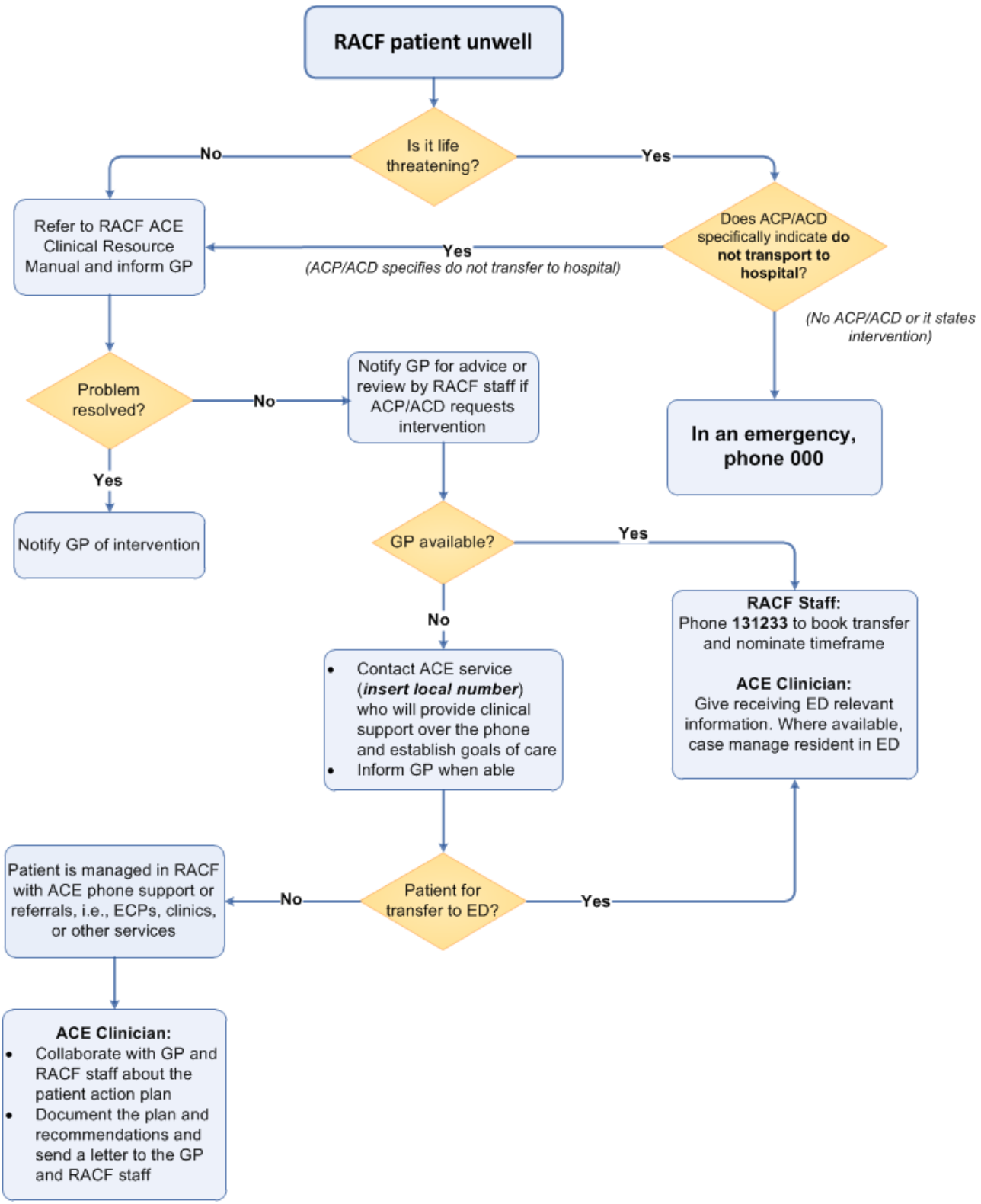
What is the model?	Implementation of the ACE Service is designed to address an identified gap in supporting staff in RACFs to facilitate residents' non-life threatening acute care needs being met within the facility and avoiding an ED presentation. The ACE model is specifically aimed at reducing the need for residents of Residential Aged Care Facilities (RACFs) to present to an ED for acute care, or where ED presentation is required, to proactively manage the visit. The ACE model should work in conjunction with Aged Care Services in Emergency Team (ASET) nurses in the Emergency Department (ED) if available or other suitably identified resources which manage care of aged care patients.
Why use the model?	The ACE model is a strategic approach to better manage residents from RACFs who become acutely unwell. It is built upon a collaborative relationship between the management and staff of RACFs, the ED and hospital for the benefit of the residents/patients. Acknowledgement of the varying stakeholders, organisational funding structures, reporting and business rules is essential for this model to function. ACE incorporates • a telephone consultation process with the staff from RACFs. • Evidenced based algorithms for common problems experienced by residents from RACFs so RACF staff can better manage the acute symptoms experienced by the resident. • Establishing patient and ED goals of care prior to transfer. • Proactive case management in ED.
Key principles	• The ACE Service is implemented with the aim to better manage demand on EDs or avoid the need for transfer to the ED, improve the patient experience and quality of care of residents from RACFs. • The ACE Service serves the following two purposes: o provide support to RACF staff to better manage residents experiencing acute onset symptoms or conditions within the facilities and avoid transfer to ED when appropriate o enhance the flow and coordination of care of patients who are appropriately transferred to the ED from the RACF. • The ACE Service should have the following core components: o a telephone liaison/consultation service to RACFs o an educative and supportive service to RACFs o a collaborative working relationship with GPs, community and hospital care providers • The ACE program should aim to empower RACF staff to manage acutely unwell or injured residents, rather than take over responsibility for the care. • The hospital and acute care services must work in partnership with the RACFs, Medicare Locals and NSW Ambulance to ensure that the patient's goals of care are

	met. • Communication of and respect for the patient's and their families wishes in relation to Advanced Care Plans should be evident throughout all parts of the care continuum • Collaboration and relationship building with all relevant stakeholders is essential to the success of this model between and should be maintained through regular communication led by the hospital ACE service.
Benefits of the model	• A positive experience for all stakeholders including ED and hospital staff, RACF staff and patients and their families. • Positive impact on inpatient services demonstrating a 35% reduction in hospital LOS at the pilot site. • The service discriminates effectively and safely the needs of older people in terms of whether to transfer an older person residing in a RACF to the ED/hospital or not. • Has been demonstrated to provide a 16% reduction in presentations to the ED from RACFs. • Improved relationships between ED/hospital and the RACFs with a shared philosophy of care for older people. • Guides RACF staff in relation to care practices and demonstrated to reduce transfer of older people to ED • A greater appreciation of the context of residential aged care for ED and hospital staff and vice versa has been highlighted. • National Emergency Access Target (NEAT) performance improvements for this cohort.
Challenges	• Sustainability of the model either as an adjunct to existing resources or within existing resources. • RACF organizational policies and protocols may not always allow compliance with the ACE clinical algorithms. • Accurate data collection is a challenge, as there is large variation in the method for identifying that a patient resides in a RACF • Change management of a variety of stakeholders • Competing ED priorities depending on activity (i.e. Staff Specialists assisting with clinical advice for ACE nurse in a timely way) • Risk that the primary carer (GP) will feel alienated from the resident's care if not engaged adequately and early. • Documentation of decisions in the patient medical record • High turnover of RACF staff, RACF staff skill-mix (heavily orientated to the non-professional workforce)

Case for implementation	Stocktake of existing Hospital and Local Health District outreach services that support RACFs is an essential first step in this process. You may only need to add to existing services, rather than implement an new service such as ACE. To prepare for implementation or refinement of this model in your ED/hospital consider the following: • What is the activity of patients that present from RACFs to your ED? • Are there particular RACFs that frequently send patients to the ED for low acuity, low complexity problems? • Are there particular RACF's that frequently send patients to the ED for chronic problems where goals of care are not evident? • Does your ED experience inefficient patient flow for patients from RACFs? • What is the average length of stay, particularly for discharged triage category 3-5 patients, from RACFs? • What proportion of patients from RACFs that are admitted to hospital may have benefitted from early intervention and support which may have reduced the requirement for transfer to the ED? • Is there a history of adverse events for patients that present to ED from RACFs that may be addressed by a focus on the care of this patient cohort?
What you need to run the model	Staff • ACE CNC to have ready access to ED Consultant, Geriatrician or equivalent GP VMO as appropriate for acute care consultation • Engage Geriatrics or General Medicine services in the Hospital • ACE CNC with the following attributes: o Change manager o Ability to build relationships o Have both acute care and aged care skillset o Experience in the delivery of clinical education o Excellent written and communication skills Physical resources • Office space with access to computer and relevant programs • Access to pool car • Dedicated phone line either mobile or desk • Stationary and printing Goods and services • IT support • ACE Clinical Support Manual • ACE brochures for GPs, families& carers and ED staff

Business Rules	Leadership • Senior medical leadership is essential to this model. Relationship building and support • ACE staff are responsible for engaging and establishing relationships with RACF staff Medicare Locals and GPs (i.e. regular stakeholder meetings). ACE are also responsible for maintenance of these relationships. • ACE should address appropriate educational gaps identified by RACF staff (in relation to the ACE algorithms). • The ACE service should case manage the patient's arranged ED visit according to clinical need, the patient's goals of care and any Advance Care Plans. • In addition to providing support so that the patient does not require ED care, the ACE service may facilitate access to non-ED outpatient care. Communication • ACE staff carry phone between nominated hours • ASET or other nominated staff carry the ACE phone on weekends or after hours (please consider that there may be competing priorities here , staff need to be able to return calls to RACFs in a timely manner to deal with their issue if they are engaged in direct patient care or interviews in ED at the time of an ACE call) • Clear boundaries must be established with regards to transport of the patient to the most appropriate hospital by ambulance. The ACE service may provide advice to a large number of RACFs within the Local Health District, however when an ambulance is called, the patient must still be transported to the closest, most appropriate hospital. ACE is responsible for contacting the appropriate hospital and advising of the RACF's contact with ACE and advice given. Documentation • When an ACE call comes in, ACE will log phone call onto the nominated IT system (eg outpatient record , telehealth or other) • ACE is to clearly document the presenting problem, vital signs, past medical history, which algorithm was identified as suitable for the patient, patient goals of care , Advanced Care Plans in place and any other relevant information. ISBAR can be used for this purpose. Recommendations and outcomes should also be documented (e.g. stay in RACF with GP follow up , present to hospital/ED for X-ray, is patient appropriate for Extended Care Paramedic intervention if available?) • At the completion of interaction, ACE is to complete a discharge letter from the ACE service for RACFs and GP (email or fax) Reporting ACE is responsible for maintaining accurate data collection and reporting to the local stakeholder group

Monitoring & evaluation measures	• Review of health outcomes related data • ED Length of Stay data • Hospital LOS • Bed days utilised by patients from RACFs • Number of ED presentations from RACFs • Rates of re-presentation to same ED within 48 hours • NEAT • Collaborative meetings and documentation of discussions with all stakeholders • Adverse outcomes monitoring (IIMS) • Compliments and complaints • ACE phone call record


RACF patient unwell
Is it life threatening?
No
Yes
Refer to RACF ACE Clinical Resource Manual and inform GP
Does ACP/ACD specifically indicate do not transport to hospital?
Yes
(ACP/ACD specifies do not transfer to hospital)
(No ACP/ACD or it states intervention)
Problem resolved?
No
Notify GP for advice or review by RACF staff if ACP/ACD requests intervention
In an emergency, phone 000
Yes
Notify GP of intervention
GP available?
Yes
No
RACF Staff:
Phone 131233 to book transfer and nominate timeframe
ACE Clinician:
Give receiving ED relevant information. Where available, case manage resident in ED
Contact ACE service (insert local number) who will provide clinical support over the phone and establish goals of care
Inform GP when able
Patient is managed in RACF with ACE phone support or referrals, i.e., ECPs, clinics, or other services
Patient for transfer to ED?
No
Yes
ACE Clinician:
Collaborate with GP and RACF staff about the patient action plan
Document the plan and recommendations and send a letter to the GP and RACF staff