Aged Care Emergency model evaluation

St Vincent's Hospital - SVMH Local Network

ST VINCENT'S HOSPITAL SYDNEY

1. Overview of the implementation of Aged Care Emergency (ACE) program

Please provide a concise overview of why you applied for funding to implement the ACE model. How did you assess the need for implementation of the ACE model?

St Vincent's Hospital applied for funding to implement the ACE model of care with the objectives of

- Reducing admissions by 25% from RACF to SVH
- Reducing ED presentations from RACF thus reducing ED activity (estimated at 1%)
- Reducing hospital length of stay by 2 days.

Geriatric and Ambulatory Medicine Program provides SVH with specialist geriatric medicine services including assessment and management of acute and chronic illness presenting in older people, comprehensive geriatric assessment and management of geriatric syndromes.

Services are provided within an in inpatient hospital setting both in the ward and short stay Medical Assessment Unit and in ambulatory (outpatient) and community care setting.

Having a capacity of providing an alternative model of care at St Vincent's Hospital made the application of the ACE Model of Care a good fit for the Organsiation in the provision of quality patient centred care aimed at reducing avoidable admission and reduce the length of stay of those patients admitted.

The objectives of the ACE program at St Vincent's Hospital (SVH) was to

- Support GPs and Residential Aged Care Facilities(RACF) to manage residents where they are living
- Reduce the avoidable presentations and admission of residents to the ED and SVH
- Reduce the length of stay of RACF residents in ED and the acute hospital
- Develop relationships between the ED, geriatric medicine services, GPs and RACFs to improve the flow of information and provide care to residents from RACF in the most appropriate location
- Assist the ED in meeting the National Emergency Access Targets (NEAT)

Between 1 May 2012 and 31 November 2012 there were 639 presentations to the SVH Emergency Department of residents identified from Residential Aged Care Facilities. 80% of those presenting were triaged as Category 3 or 4.

The admissions represented 7.8 ED hours 63% of these patients were admitted to an inpatient ward from the Emergency Department with an average of 7.6 inpatient bed days.

2. Objectives of the implementation of ACE

Please state the objectives you set out to achieve with implementation of the ACE model, was there any change to this during the project?

The ACE Model of Care incorporated

- A telephone consultation service for RACF staff
- Model of Care clinical algorithms for common problems experienced by residents that lead the initiation of care within the RACF
- ED transfer care goals
- Proactive management in the ED

The objects and measurable outcomes of the project were to

- Reduce the number of presentations by RACF residents to the ED by 50% within 12 months
- Reduce the number of hospital admissions of RACF residents by 25% within 12 months

- Reduce the LOS in ED for 75% RACF residents to less than 4 hours within 12 months
- Reduce readmission or representation rates of RACF
- Build relationships between SVH ED, geriatric medicine services, GPs and RACFs
- Increase ED and ASET team staff satisfaction in their ability to manage RACF residents
- Improve patient and carer experience of RACF residents

Once the ACE Project was commenced at St Vincent's Hospital it became apparent that some of the assumed criteria were not applicable.

The factors that influenced the changes were

- *The distinction between Residential Aged Care Facilities*
    - RACF presentation to the ED comprised of residents from high and low care facilities and emergency housing/hostel.
    - 39% of presentations were from high care/aging in-place facilities
    - 45% were from low level care and independent living facilities
    - 16% were from emergency/hostel housing.
    - The ability of staff to manage residents within the Facility varied significantly as the capacity and staffing within the local RACFs including the presence and number of RNs differed between the level of care.
    - Many residents within the RACF did not have an Advanced Care Directive and those that did have one did not preclude them from transfer to hospital.
    - The availability and access to GP services within the Facility - especially after hours and on weekends
    - The type of facility and the pressures of patient and family with specialist doctor and/or religious ties at St Vincent's Hospital impacted on the facility staff to transfer the resident.
- *The implementation of Emergency Models of Care* that were in progress as the ACE Project started affected the capacity within ED to embrace another change.
- *The redesign of services within Geriatric and Ambulatory Medicine* at SVH that impacted on the ACE project.
- *The Organisational restructure of the East Sydney Medicare Local*

3. Scope of the implementation and ACE model used

What were the specifics of the ACE model you implemented in your Hospital? In what ways did you deviate from the documented NSW ACE model and why? How did you determine the elements of the model that would suit your Hospital's purposes?

SVH ACE Model of Care Implementation

Processes to support implementation:

1. Selection of RACF. It was decided to work with 7 high care RACFs within the SVH Local Health Network as these represented 23% of ED presentations and 58% from the high care facilities.
2. Communication and Engagement with Stakeholders

Who	How
➢ RACF	Resident journeys from transfer to SVH ED and return to RACF Monthly meetings Surveys and questionnaire Visits and building relationships
➢ NSW Ambulance	Meetings and discussions around transport within local area and out of area ED presentations. Utilisation of the ECPs where possible

➢ GP champion	Clinical algorithms Care of the unwell (deteriorating) resident Advanced Care Directives and end of life planning
➢ Eastern Sydney Medicare Local	Care and access of the elderly in RACFs Clinical algorithms Care of the unwell (deteriorating) resident Advanced Care Directives and end of life planning
• SVH Geriatric and Ambulatory Medicine	Patient journeys from presentation to discharge back to RACFs Geriatricians engagement ED Aged persons Models of Care Alternative Models of Care for the elderly and those presenting from RACFs
• Emergency Department	Patient journeys from presentation to discharge from ED Facilitating clinical care to reduce ED LOS

3. The outcomes of inclusive stakeholder engagement was the ability to:
   I. Identify the factors that influence the transfer of patients from residential aged care facilities (RACF) to hospital emergency departments (ED),
   II. Identify the issues that prevent RACF from managing residents who become unwell within the Facility.
   III. Develop strategies to assist the RACF to care for the residents within the facility
   IV. Identify strategies that facilitate the care of residents who are transferred to ED.

The main themes that emerged

a) Implementation of the Clinical Algorithms was dependent on clinical capacity within the RACF, GP availability and support as well as residents having an Advanced Care Directive.

b) Staffing and skill mix in RACF over a 24 hour and 7 day week period - including staff retention (some staff travelled in excess of 3 hours per day by public transport) and access to education and skills training.
A Skills Assessment Questionnaire was sent out to 7 participating high care RACF
Findings:
   i. 0/7 insertion of urethral catheters
   ii. 0/7 manage PIC lines
   iii. 0/7 manage PEG tubes
   iv. 2/7 manage IV cannulas
   v. 0/7 administer IV antibiotics
   vi. 2/7 administer medications such as GTN
   vii. 2/7 will manage a transfer back to the facility after hours (one – conditional on the family agreeing and organising a care companion)
   viii. 7/7 requested access to any education and training that could be offered by SVH,

c) The need for clinician agreement on what constituted an appropriate transfer to ED and developing a clinical pathway with treatment options both within the RACF and SVH.
d) A strong preference among staff and residents to ensure that ED transfers were appropriate.
e) All stakeholders agreed on the need for GP engagement in instigating and supporting the end of life decision-making.
f) Access to GP services out of hours was dependant on the ability to prevent transfer to ED.
g) Facility communication and managerial (profit and not for profit RACFs differed) requirements. One Facility had undergone a complaints process with the Department of Health and Ageing – the recommendation was for the Facility to “transfer to Hospital when a resident becomes unwell”.
h) Improvement in the flow and quality of clinical communication about residents

4. Methodology used in the implementation

The program has been modified as necessary to meet the needs of SVH and the RACF that are associated with SVH.

The design and implementation of the MoH ACE Model of Care was designed to endure residents of RACF received “the right care in the right place”. While the Model appeared to work well within the John Hunter Emergency Department it became apparent that St Vincent’s Hospital ED did not have the same Organisational structure or relationships with key stakeholders.

Governance issues needed to be resolved in regard to clinical decision making at a medical level and what constitutes an appropriate transfer as well as a clinical review the Clinical Algorithms prior to implementing

There was a vacuum in relationships between RACFs and SVH and acceptance of the Model of Care within the RACF. It was clear the Model of Care could not be undertaken without commencing a dialogue and building a relationship.

Functionality of the Model in regard to processes, policies and procedures and documentation and care coordination could not be sustained without preliminary work on clinical observation, information and handover.

The overall effectiveness of the Model in the long term and ongoing sustainability is contingent upon the education and skills of the staff within the RACF and effective clinical support.

The aim and priorities of the SVH ACE intervention is to:

1. Support RACFs in the care of residents who become unwell in the facility.
2. Improve the clinical handover to ensure timely and appropriate care of residents transferred from RACF and enhance the flow and coordination of care of patients who are transferred
3. Improve the flow of clinical communication from SVH to RACF though improved discharge communication.
4. Support clinical decision making by assisting in the up- skilling the staff of the RACF in the principles of clinical observation, assessment and handover with the flow on effect to
    a. Raise the confidence of staff within the RACF to care for the resident who experience a non life threatening event within the Facility
    b. Raise the confidence of clinicians to support staff in the RACFs to care for the residents within the facility
    c. Reduce the number of transfers from high care facilities
    d. Reduce the number of readmission/representations to SVH ED
    e. Raise family and carer confidence in the ability of the RACF to care for residents when they become unwell.
5. Develop alternative care pathways for residents using existing SVH services to support clinical decision making.
6. Facilitate the introduction of care pathways in consultation with Geriatricians for residents who are admitted to minimise their length of stay

The Transfer to Hospital Envelope is being implemented to the 7 participating RACF over September to December 2013. The implementation will be evaluated and if successful will be implemented to the all the RACF in the area.

The purpose of the Envelope is to improve the clinical assessment and handover of residents

- Help RACF staff undertake an assessment of the resident
- Provide a tool to assist in the documentation processes required for clinical handover or clinical communication
- Enable effective verbal handover for GPs, ACE CNC, the Ambulance Officers and SVH Staff.

5. Measures of success of the implementation of ACE

The ACE CNC role has been extended and supported by the Executive of SVH to enhance healthcare delivery for elderly patients presenting from RACFs

- To date the ACE CNC has established a credible clinical relationship with the local RACFs

  RACF ACE Assessment

  All participating RACFs agreed that
  - the ACE Model of Care (right care in the right place) improved the care of residents within RACF
  - their experience in the Project gave them a greater appreciation of the care environment of SVH
  - SVH had a greater understanding of the care environment of RACFs
  - all wanted to continue working to implement the ACE model of care and working with SVH to improve the care pathways for residents.
- Implementation of a contact service for the participating RACFs.
- The implementation of the Transfer - to - Hospital envelope will be complete by December 2013.
- Initiating the education program in RACFs regarding clinical handover and observation and assessment of the unwell (deteriorating) resident.
- There has been a small 10 % improvement in presentations from 7 participating RACF during the implementation (from 179 presentations May – July 2012 to 162 presentations (May - July 2013)
- ED waiting times have not been impacted on.
- Extending the ED Acute Care Initiate Nursing role to facilitate chronic care planning for elderly residents to prevent re-presentations.
- There is an identified need to have a process and procedure for the transfer of residents from SVH back to the RACF after hours to ensure quality care for the residents and to reduce the negative impacts of after-hours transfers. This initiative will assist in freeing up beds and thus impact on patient flow.
- Stream line Discharge Planning to incorporate Pharmacy Services to ensure residents are discharged back to the Facility with medication changes appropriate for discharge to the RACF and addressing continuity of care. This will prevent representations.
- Extended Care Paramedics have supported the care of residents within the Facility e.g. attending to suturing of residents who fall without a head injury.
- Developing a SVH clinical support service that assist RACF to care for residents within the Facility,
- Eastern Sydney Medicare Local has supported the ACE Project by posting ACE information on their web site.
- Strengthening partnerships with the Ambulance Service and the flow on effect of effective clinical handover with the aim of reducing waiting times in the Ambulance holding bays.
- Progress towards developing Models of Care that involve integrating existing Geriatric and Ambulatory Medicine services with the aim of facilitating fast tracking and alternative entry pathways including
  - Flexi care services
  - MAU
  - Hospital in the Clinic
  - Outreach services such as Wound Care and IV CNCs
  - Hospital in the Home
- Clinical documentation and capture of data through CHIME.
- Working with SVH Geriatric and Ambulatory services to develop a framework and processes aimed at goals of care to facilitate the return of the resident back to facility in a timely manner.

- Supporting aged care initiatives and research projects including Advanced care Directives and End of Life planning.

7. Conclusions

The transfer of residents from RACF to ED is influenced by multiple interrelated factors

The implementation of Advanced Care Directives and End of Life Planning was not in the scope of the Project – rather it was recognised as a discrete project in itself

Eastern Sydney Medicare Local was not in a strong position to support the ACE Project as Aged Care was not part of their priority spending and the Service is currently undergoing change management.

RACFs were disengaged from the acute hospital setting and felt they were perceived as isolated in clinical decision making and not included in partnership of residents health care providers. There were often delays in discharge communication and lack of communication such as notifications when a resident died.

SVH staff - both ED and the Wards – were disengaged from RACFs. They felt frustrated by the quality of clinical communication and found it difficult in accessing to staff within the facilities when trying to elicited information about the Residents.

The Ambulance Service was often frustrated about long waiting times at the Facility when responding to a call and the variation is the clinical handover.

NSW Ambulance did not view the RACF in the SVH locality as a high priority due to competing requirements within the Area – especially after hours and the proximity of Kings Cross and the pressures on ECP services.

After hours transfers from the RACF and discharge to RACFs posed the greatest problem.

Residents admitted in ED and awaiting transfer to the ward were often delayed in due to bed availability

Lesson Learnt: The transfer of residents from RACFs to ED was found to be influenced by multiple interrelated factors. While the SVH data reflected the burden of presentations on the ED and acute hospital service - the factors within the RACF that affected this data were not articulated or recognised.
The skill set of RNs within RACF is varied.

Clinical decision making cannot be done in isolation.

What worked: Building relationships with the RACF is important in the continuum of care for residents. Many RNs working in RACF feel isolated from their nursing colleagues in the “acute” setting

The ACE Model of Care at SVH will continue to support aged care initiatives within SVMH.

The role will continue to support the RACFs in the care of their residents with the objective to reduce ED presentations by

- Providing support in the care of residents with non life threatening situations.
- Providing access to SVH education and training for RACF staff
- Providing access to alternative care provision that keeps the resident in the Facility and prevents transfer to ED
- Improving care planning and discharge planning for residents admitted through ED through
    - Improved clinical handover

  - Facilitated care pathways in ED
  - Alternative clinical entry pathways at SVH
  - Improved discharge planning
  - GP engagement
- Continued evaluation of the Project
- Facilitating discussions and planning for Advanced Care Directives and end of life care plans

Chief Executive sign off on final report

Name:

Signature:

Date:

Program Manager Geriatric & Ambulatory Medicine

Name: Drew Kear

Signature

Date: