Aged Care Emergency model evaluation

Hospital and Local Health District: Tamworth Rural Referral Hospital, Hunter New England Health District

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?

Tamworth Rural referral Hospital applied for funding to implement the ACE model of Care with the expectation it would;

- Improve patient/ Carer / Family experience
- Reduce avoidable Emergency Presentations of Residents in Residential Aged Care Facility's in the selected area.
- Reduce Emergency Length of Stay within current NEAT strategies and improve NEAT results for Tamworth.
- Reduce avoidable acute hospital admissions and occupied bed days and ensure the resident receives the right care in the right place. It is also expected that the ACE program will improve the dignity and respect of older people by facilitating the ability for them to have appropriate care in their familiar environment.
- To improve the Patient journey
- To build clinical capacity in the RACF through regular education and improved linkages to existing services

In response to the 2021 NSW Health goals Tamworth Rural Referral Hospital saw that by applying for funding and implementing the program the project team could closely align itself to the goals of;

- Keeping people healthy and out of hospital
- Provide world class clinical services with timely access and effective infrastructure.

The need for implementation was identified through assessing baseline data. There are currently 539 Residential Aged Care Facility (RACF) beds in Tamworth. Tamworth Emergency prior to the start of the ACE program had 170 presentations from Tamworth RACF's with a LOS averaging 441 minutes and an admission rate of 44%. Tamworth Emergency has a patient's discharged home goal of 90% and the ACE program supports this being done safely for people residing in RACFs. (*Concerned this makes sound like not safe for other patients, thoughts?).*

2. **Objectives of the implementation of ACE**

The objective was to implement the ACE model of care which provides flexibility to treat the patient in their place of residence or in the Emergency Department. This is with a view to return the patient to their familiar place of

residence as soon as possible thus meeting the needs of patients who are acutely unwell and residing in a local RACF. The objective is to improve patient outcomes by reducing adverse advents that may occur with transfer for this cohort of patients. The psychosocial, communication and patient preferences will also be enhanced through coordination of relevant service provision. The main objectives are to reduce avoidable Emergency presentations, reduce Emergency length of stay (LOS), reduce avoidable acute hospital admissions and occupied bed days, to improve the patient journey and continue to build clinical capacity in the RACF and communication through regular education and improved linkages to existing services.

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?

Due to the fact that the first ACE program was implemented within the same local health district at John Hunter Hospital we have used the same Model of Care and have had no need to alter it.

In Tamworth we currently work in conjunction with the ASET team who carry the ACE phone 7 days/week from 8am-1630hrs. This initially was not the plan however after assessment it was decided that this would increase the access the RACF's had to the ACE service.

Further deviation to the original ACE model included the fact Tamworth does not have access to Extended Care Paramedics (ECPs). The use of ECP's was included in the original clinical algorithms; this had to be adjusted for Tamworth.

4. Methodology used in the implementation

This section should evaluate the success or otherwise of the methodology used to implement the model of care. What were the barriers and enablers to project success or otherwise? What was your communication strategy and how effective was it? What recommendations would you offer other Hospitals about to commence implementation of ACE?

It can be seen that in the limited time ACE in Tamworth has been implemented a significant change is apparent. Barriers included initial consultation with GP's. It was difficult to make contact with the large number of GP''s involved in caring for residents in RACF's in the area. Documentation received from John Hunter Hospital stated

the program was a collaborative approach with GP's and this angered a GP as there was no consultation with GP's in Tamworth prior to the project being rolled out. The collaboration had been with Newcastle GP's only. This particular hurdle was overcome by welcoming that GP onto the local steering committee and welcoming his feedback and advice for the program. This has been working well.

One particular RACF has not had the level of engagement desired. I am unsure of why this is as the same communication strategies have been used at all 5 facilities

3. Measures of success of the implementation of ACE

First 3 months of ACE

No of ACE phone calls	22	
No of ACE phone call resulting in ED presentation	5	
No of ACE phone calls resulting no ED visit	17	
ED Presentations (total)	46	
ED LOS (mins)	20794	Average 452 mins/patient
Hospital admissions from ED	17	37%
In Patient LOS (days)	110	Average 6.4

Table 1 Presentations, length of stay, admissions and in-patient admissions for 5 RACF in Tamworth city limits 25th February 2013 -25th May 2013.

Second 3 months of ACE

No of ACE phone calls	17	
No of ACE phone call resulting in ED presentation	3	
No of ACE phone calls resulting no ED visit	14	
ED Presentations (total)	52	
ED LOS (mins)	19282	Average 370mins/patient
Hospital admissions from ED	29	55.7%
In Patient LOS (days)	150	Average 5.1

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Table 1 Presentations, length of stay, admissions and in-patient admissions for 5 RACF in Tamworth city limits 26th May 2013 -25th AUGUST 2013

Total 6 months of ACE

No of ACE phone calls	39	
No of ACE phone call resulting in ED presentation	8	
No of ACE phone calls resulting no ED visit	31	
ED Presentations (total)	98	
ED LOS (mins)	40076	Average 408 mins/patient
Hospital admissions from ED	46	46.9%
In Patient LOS (days)	260	Average 5.6

Table 1 Presentations, length of stay, admissions and in-patient admissions for 5 RACF's in Tamworth city limits 25th February 2013 -25th August 2013

The above data shows us that of the 39 ACE phone calls on 8 (20.5%) resulted in needing a transfer to Tamworth Emergency Department. Of the 98 who presented to Emergency 46 (46.9%) where admitted to the hospital. The average LOS was 408 minutes per patient. In regard to meeting NEAT targets and interesting fact need to be acknowledged. When this data is broken down further and specifically at the second 3 months of ACE implementation shows that of all patients in ED those admitted had an average ED LOS of 422 minutes. Those residents being discharged back to the facility had an average LOS of 279 minutes. Of the 23 being discharged back to the facility transport was documented as a reason for significant delay for 11 of them. Other reasons identified include waiting for CT, Chest x-ray, blood results (including 8 hour troponin) and lengthy To Be seen wait times.

It is important to note that what is not captured in the data are those patients who prior to the introduction of the ACE Service would have been sent to the Emergency department but since the introduction of the ACE service have not been sent nor has there been a call to the service.

Anecdotal evidence suggests that RACF staff have improved communication and clinical skills when managing un well residents.

Staff from the facilities have reported;

" Feeling more supported and empowered knowing they have direct access to the ACE support line"

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“I have found this service to be very prompt and informative. The ACE line I believe has been an enormous improvement for resident aged care facilities. Most importantly, this service further insures the residents receive quality care in a timely manner”

Many thankyous and compliments from families of residents also need to be noted. Included is a letter from a family member

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[redacted]
CEO Tamworth Base Hospital
[redacted]
2340

20th May 2013

Dear [redacted]

On behalf of our family, I would like to express, our sincere gratitude for your care, understanding, both medically and personally, of our Mother's needs in the last days of her life.

It was very timely that you came to introduce the hospital's programme at McKay Nursing Home, at just the right time for our Mother.

As you are no doubt aware it is very upsetting for the elderly to be taken from the Nursing Home to Hospital, they do not adapt to change, and especially if they have any form of dementia, it seems to stress them even further. The fact that this programme has been implemented to visit and assess them in their environment is a great benefit to them and I might add, their families.

Mum's needs were very ably assessed by you and the Dr, and thankfully Mum was then a lot more peaceful, and able to die with dignity in familiar surroundings.

We are truly thankful for the implementation of the service, and hope that it continues, so that many others, in the same situation as our Mum, will benefit greatly from it.

Sincere Thanks

[redacted]
For and on Behalf of the family of [redacted]

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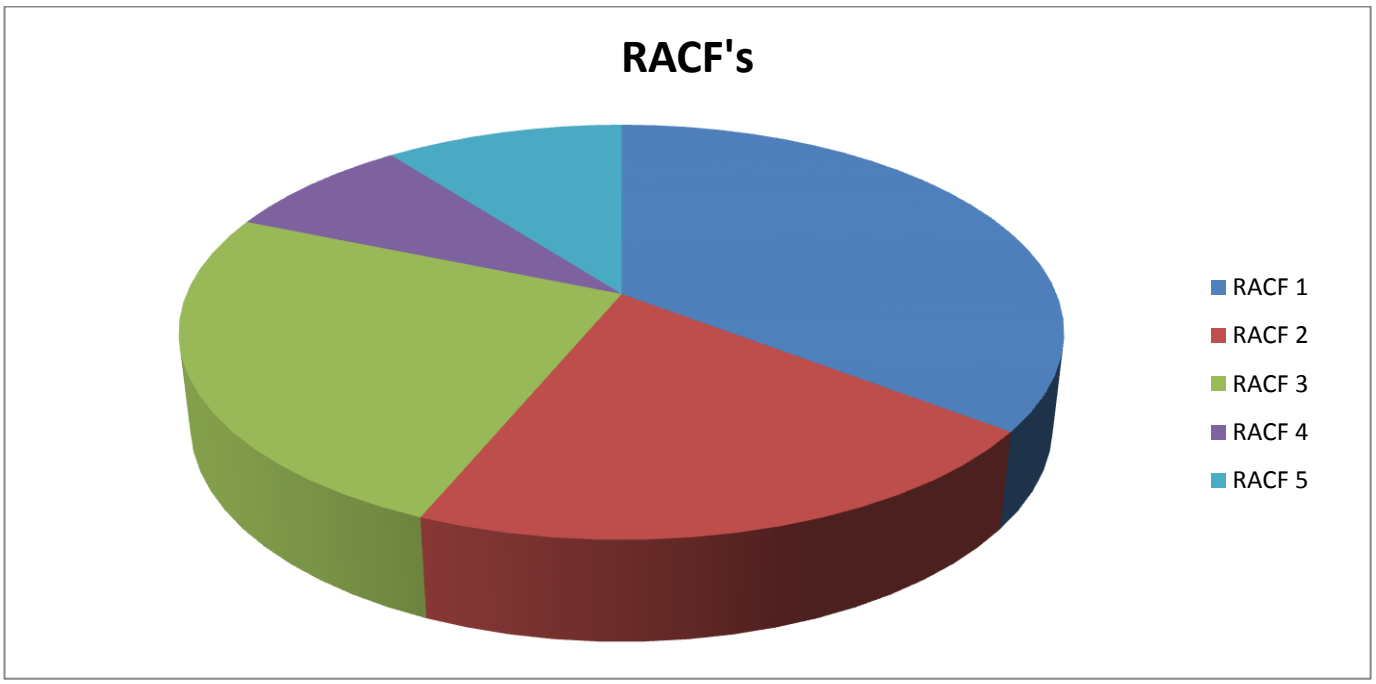

RACF 1 has had very poor engagement in the ACE program. Comments like “if in doubt ship them out” still prevail and little contact and relationships have been developed despite the ongoing efforts of the ACE and ASET teams. They continue to have significantly higher presentations as can be seen above. What is also important to note is that RACF 1 has 24/7 Registered nurse cover. Interestingly RACF 4 and RACF 5 do not have overnight and evening RN cover.

In regards to representations within 48 hours only two represents. One patient had a fall within 24 hours of being discharged and one resident represented for head CT as she developed dizziness and giddiness a day after being seen in Emergency post fall. On the initial presentation nil head CT was performed.

Nil IIMS or complaints.

Discussion

Was the implementation of ACE successful, why or why not? What were the lessons learnt during this implementation? What impact has this model had on management patients from Residential Aged Care Facilities? What would you do differently next time and why? What strategies did you put in place to ensure sustainability of ACE?

The implementation of the ACE Model of Care was successful and continues to be a success. It has had limited time to have a full effect as it has only been active for 6 months. With increased education as planned, increased access to ACE after hours (planning in place with Medicare Local New England) and time the impact will be more significant.

Next time I would ensure the education currently being developed in conjunction with Medicare Local is delivered in the area prior to the ACE program commencing. In the future as ACE is rolled out within the Local Health District, ensuring education and engagement is imbedded in the facility is a priority. I believe this can be achieved if the correct education is in place prior to the ACE model of Care being implemented.

6. Conclusion

Where to from here? Please include plans for further evaluation of the impact of ACE on your Hospital and sustainability of this model in your Local Health District.

The future of ACE in Tamworth is very exciting. The extraordinary support from internal stakeholders, such as hospital management, emergency management, ASET staff combined with the support of the majority of RACF's and GP's locally has seen that ACE will be sustained. Not only will it be sustained at a local level with integration with the ASET role the plan is implement the ACE Model of Care across the entire Hunter New England Local Health District.

From a Tamworth perspective in alliance with Medicare Local New England the current model will be expanded to include a more defined focus on general practice and RACF's by actioning the following key deliverables;

- Expand the scope and availability of the current ACE model with concentrated focus on general practice;
- Engage with local aged care facilities to assess current competencies in regards to advance care plans, clinical handover and clinical competence;
- Deliver education and training to improved advanced care planning, clinical communication, competence and coordination of care;
- Deliver education and training to participating RACF staff on electronic clinical guidelines (ACE guidelines);
- Establish a model of train the trainer within each RACF;

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- Develop an evaluation framework and service quality improvement cycle including regular ‘pulse checks’ to validate proof of concept;

- Improve communication, access to, efficiency and effectiveness of coordinated and integrated care across all stakeholders,

- Provide education and training to both RACF’s and general practice to an expanded geographical area including Tamworth, Kootingal, Bundarra, Walcha, Uralla, Armidale and Guyra.

- Develop capacity within RACF’s to better manage residents clinical concerns after hours and in a timely, clinically appropriate fashion.

Chief Executive sign off on final report

Name:

Signature:

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Date: