Improving the Residential Aged Care – Hospital Interface

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Why is it important?

- Public healthcare: finite resources mismatch demand vs capacity
- Whole of health approach to facilitate patient journey
- Resident - patient safety and quality of care
- Peak bodies such as NACA recognise the need for aged care, disability, community and health care systems to align to ensure seamless transition and care that best supports needs (blueprint series 2015)
Ballarat Health Services context

- Large Regional Health Service
  - Acute: 221 beds
  - Subacute: 70 beds
  - Mental Health: 67 beds
  - Residential Aged Care: 444 beds
  - Community Programs
Residential Aged Care

- 10 facilities over 5 sites
- 240 beds are operated as High Level Care (HLC)
  - Registered and Enrolled Nurse workforce
  - Nursing EBA ratios
- 194 beds are operated as Low Level Care (LLC)
  - 3 Tiers of workforce
  - Not regulated by the nursing EBA
- 20 Beds Aged Persons Mental Health
- 10 Transition Care Program beds
- 5 Restorative Care
The Patient Journey
Progression of Care

- Key players in the room / address internal silo’s
- Common purpose Access to care: “Right Patient, Right Place, Right Time”
- Identify key access issues utilising real time data
- Problem solve
- Dispel myths based on data and evidence
“Patients' waiting for Nursing Home placement are blocking beds”
What did we find?

- 45 ACAS assessments undertaken on Acute site annually

- Admissions from Acute to BHS RAC
  - 13 patients 2013-14 (days waiting placement 20)
  - 12 patients 2014-15 (days waiting placement 35)

- Admissions from Subacute to BHS RAC
  - 38 patients 2013-14 (days waiting placement 38)
  - 35 patients 2014-15 (days waiting placement 39)
Outcomes

- Raised awareness of staff to RAC environment
- Respite days utilised
- Social Workers engaged early, support asset assessment.
- TCP use
Transition Care Program (TCP)

Admission Source Ballarat TCP

<table>
<thead>
<tr>
<th></th>
<th>Ballarat - Acute</th>
<th>Ballarat -Sub-Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 -2014</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>2014-2015</td>
<td>34</td>
<td>33</td>
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</tbody>
</table>
TCP outcome data

Discharge Destination From TCP Grampians Region

<table>
<thead>
<tr>
<th>Year</th>
<th>RAC</th>
<th>HOME</th>
</tr>
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<tbody>
<tr>
<td>2012-2013</td>
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<td>2013-2014</td>
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<td>2014-2015</td>
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More than 40,000 older patients visiting emergency departments unnecessarily

Date July 27, 2015

Benjamin Preiss
State Political Reporter for The Age
Residential Aged Care - Emergency Department Interface
Hospital occupancy demand

There were 275 episodes of HODM activation from Feb 2014 - July 2015
Aim to reduce avoidable presentations to ED

- Residential In-Reach Program (NPC Candidate)
  - Advanced assessment and interventions: to prevent presentation to ED along with education and clinical support for nursing staff

- Acute management plans: prevent presentation to ED

- Stop and Watch Program
Stop and Watch

- Early warning tool
- Recognise early stages of deterioration
- Flag need for nursing intervention earlier
- Easy to use for non-registered staff (PCA)
- Interact
Referrals to RIR

Residential Referrals each year

<table>
<thead>
<tr>
<th>Year</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>118</td>
</tr>
<tr>
<td>2012</td>
<td>135</td>
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<tr>
<td>2013</td>
<td>172</td>
</tr>
<tr>
<td>2014</td>
<td>193</td>
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</tbody>
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Reason for RIR referral

- CVS: 19%
- GIT: 15%
- FALL: 4%
- HAEMOTOLOGICAL: 4%
- INTEGUMENTARY SYSTEM: 15%
- RENAL/URINARY SYSTEM: 12%
- RESPIRATORY: 22%
- PAIN: 3%
- ENDOCRINE DISORDER: 2%
- OTHER: 2%
- DEMENTIA: 2%

Total Treating Conditions %
ED Presentations from RAC

ED PRESENTATIONS

- 41% admit
- 75% admit
- 94% admit
- 40% admit

Low Level Care | High Level Care
Emergency Department Presentations

ED Presentations from BHS Residential Aged Care
(2010/11 - 2014/15) by time of presentation

ED Presentations from BHS Residential Aged Care
(2010/11 - 2014/15)

36% Before hours
64% After hours
Resident days in hospital

Hospital Leave Days

18-25% reduction in bed days
Days in hospital by care level

Hospital Leave Days by Care Level

- Total Days Low Level
- Total Days High Level

- 2010-2011
- 2011-2012
- 2012-2013
- 2013-2014
- 2014-2015 YTD
End of Life Framework
End of Life Framework

- Advance Care Plans introduced 2010-2011
- Target > 85% residents to have ACP in place.
- Respecting Patient Choices via Austin Hospital
- Train the trainer model
Goals of Resident Care

- Completed by GP
- Resident, MEPA, family, involved.
- Guide decisions relating to care & treatment such as transfer to hospital or use of life prolonging interventions
- Dynamic and reviewed
- Trigger commencement CDMP
- Transferable to Acute
Care of Dying Management Plan

- Replaced the Liverpool Care Pathway
- Evidenced based care plan for the dying
- Implemented in the last days of life
Conclusion

- Progress in understanding and improving interface of RAC and the Acute hospital.
- Key areas to continue to develop include
  - Avoidable presentations to ED
  - Staffing models in traditional LLC facilities
  - Evaluation of the GOC
  - Information and understating of staff outside the RAC