Opportunities for Promoting Care in Appropriate Sites

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Acute Care for Older People from Residential Care Facilities (RACF)

- Background
- Mobile Assessment and Treatment Service (MATS)
- Barriers
- Advance Care Planning
Older People in Residential Care

• There were over 180,000 operational residential aged care places in Australia in 2011.

• 76% of residents are high care

• In the 12 month period between 2010 – 2011, 26 percent had taken hospital leave at some point¹


Older People in Residential Care

• Most facilities provide both High Care and Low Care

• Many Low Care Facilities now provide “aging in place” but may not have an RN on site overnight

• Numbers of RNs are decreasing, numbers of Enrolled Nurses (EN) / Personal Care Attendants (PCA) are increasing.

• A Single RN can be responsible for a large number of patients

• High turnover of staff in RACF
Residential Aged Care Facilities

- Most GPs work in private clinics and visit patients in RACF once a month

- Most GP’s will do a visit if called by facility to see a sick patient. However they will only do visits after their clinic closes.

- Often GPs do not have cover when they are on leave

- Locum services often only operate after hours (leaving a gap during business hours)

Patient Transfers from RACF to the Emergency Department (ED)

- Evidence from multiple sources suggests that a meaningful proportion of transfers from RACF to ED can be avoided

Australas J Aging, 2010 Dec; 29 (4) 167 – 71
Mobile Assessment Treatment Service (MATS)

• A Residential In reach service
• Operational since 2001

• Fundamental belief that there is a better way to look after frail older people from residential care

• Goal is to provide appropriate care in the appropriate environment
  • *Individualise treatment plan to suit the patient*

MATS: AIMS

• To provide the best care for older people in the most appropriate environment
• Focus is on people with complex care needs who are at risk of hospitalisation
• To provide patient centred care in the comfort and the security of their familiar environment.
• To minimise disruption to older people’s routine
• To provide residential facilities, community providers, families and general practitioners with support and access to acute aged care expertise in Alfred Health.
STAFFING

• RN : 5 EFT
• Part time Geriatrician(0.5)
• Two registrars
• Weekend on call medical staff:
  > Geriatrician/ ED physician

HOURS OF OPERATION

• Weekdays: (Nursing and medical) 8am to 8 pm
• Weekends: (Nursing, medical on call) 10am to 6 pm
• Nurse available on phone overnight
REFERRAL SOURCES

- Directly from the community
  - GP
  - Residential care facilities
  - Community case managers
  - Ambulance
- Emergency department
- Medical wards

CONDITIONS MANAGED

- Infections – pneumonia, cellulitis/ wound infection, UTI, (with HITH)
- Dehydration/renal impairment
- Cardiac failure
- COPD
- Falls
- Delirium including the agitated patient
- Diabetes
- Pain
- Polypharmacy review
- General geriatric assessments and interdisciplinary management
- Advanced care planning/ medical treatment plans
Nurse driven services

- PEG
- Catheter changes
- Wound management
- Education sessions for residential care facilities

Diagnostic Investigations

- Bloods (through Alfred Pathology or Private providers)
- Radiology:
  - X-rays and ultrasound (private mobile radiology. Patient has to pay)
  - CT scans / ultrasound: though Alfred or private radiology
- ECG: Alfred and private pathology
MATS

- Each new patient that is referred from the community can take between 45 minutes – 120 minutes to assess and make a management plan.
- Management plans are individualised.
- Patient’s family and GPs are always involved in decision making
- Frequency of patient review post referral depends on need. It can be daily or weekly.
- Length of MATS involvement: 1 day – 7 days (usual). Up to six weeks if required
- Phone liaison with GP at least once

Clear Documentation

- Agreed plan of care:
- Next scheduled MATS review:
- Patient for resuscitation: Yes / No
- Patient for transfer to acute hospital for escalation of care: Yes / No

Discussed with
- RACF representative: YES / No
- Local Medical Officer: YES / No
- Family Member/Person responsible: YES / No
Palliative Care

- If the plan is palliative care, MATS will initiate the management
- Syringe driver initiated by MATS when required
- Palliative care consulted on the phone for advice when required
- Patients with difficult symptoms are referred to Palliative care

Admission to Hospital

- If hospital admission is required, steps are taken to avoid the emergency department.
- Acute Assessment Unit (AAU) at the Alfred
- Aged Care bed at Caulfield Hospital
Training of Basic and Advanced Trainees

• Provides valuable exposure to community medicine
• Provides insight into some of the logistic problems
• Forces them to ‘think outside the box’
• Valuable part of geriatric training

Partnerships

• Hospital in the Home (HITH)
• Mobile Aged Psychiatry (MAPS)
• Aged Care Assessment Service (ACAS)
• Local Palliative Care Services
• Transition care Program (TCP)
Referral Numbers

Usual Residence of Patients
Source of Referral

Referral source July - Dec 2013

<table>
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<th>Community</th>
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<td>252</td>
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ED presentations prevented

Year

- Y 2002: 67
- Y 2003: 65
- Y 2004: 102
- Y 2005: 105
- Y 2006: 105
- Y 2007: 252
- Y 2008: 438
- Y 2009: 552
Advanced Care Planning (ACP)

- Essential from a medical perspective

- Guides the decisions that are made by family and health professionals when the patient becomes acutely unwell

- Many patients in RACF have dementia and cannot engage in ACP. Hence this will have to be done by families (not ideal but the only option)

- Each facility has their own policy on ACP

- ACP is not an “requirement” for aged care facilities

An audit of the prevalence and characteristics of Advance Care Planning for patients from Residential Aged Care Facilities referred to the Mobile Assessment and Treatment Service (MATS)

- Part A - to determine the prevalence of ACP for patients from RACFs referred to the Residential In-reach service of the Alfred Hospital

- Part B – to gain an insight into how ACP has been approached by the managers of those RACFs
Results

- Prevalence of **ACP 38%**
- This is higher than previously published Australian data
- But still not adequate
- The amount of information in the advanced care plans was inadequate

- Part B
  - The 100 patients in part A of this study were referred from 37 facilities. From the managers of those 37 facilities who were requested to take part in the survey, 19 participated (response rate of 51%).
Conclusions

• Prevalence of ACP is low
• Lack of a systematic approach in the process of ACP in RACFs.
• A broad variation in practices between facilities.
• There need for better systems in place to ensure ACP occurs in every patient in RACF
• GP involvement is vital

Major Barriers to Providing Acute Care to Older People in RACF

• High turnover of nursing staff in facilities means regular marketing is required
• RN has responsibility for high number of patients hence not keen to look after sick patient
• Lack of adequate GP cover during leave
• Lack of adequate ACP
• Unrealistic family expectations
What makes MATS successful?

- 7 day a week service with access to overnight RN advice
- Ability to respond to a referral on the same day
- Individualised management plan
- Availability of avenues for direct admission to acute and subacute beds if required
- Communication with GP, facility staff and next of kin occurs for every patient
- Discussion about limits of care for every patient
- **Medical leadership /Skilled nursing staff**
- Established Partnerships.

Future for MATS

- Innovations to models of care with
  - TeleHealth
  - Nurse Practitioner