HEALTH CARE FOR OLDER PERSONS EARLIER (HOPE) STRATEGY

Geriatric Medicine Department

WESTMEAD HOSPITAL

Sydney West Area Health Service

17th June 2008

Contents

Westmead HOSPITAL Health Care for Older Persons Early (HOPE) Strategy

Synopsis

This is a new strategy to better manage the increasing numbers of elderly presenting to hospitals. Features include:

- a move away from the traditional reliance on the Emergency Department as the portal of entry to care within the public hospital system,
- better access to specialist care for the elderly and those with chronic disease
- improved access to specialist assessment for residents of Aged Care Facilities
- improved linkages between hospital and community care programs
- greater flexibility in care of elderly and those with chronic disease
- integration within an established comprehensive aged care service

Background

The Westmead Hospital Older Persons Review and Assessment (OPERA) project was developed in 2005 so as to improve the management of elderly patients presenting to the hospital's Emergency Department. The project introduced a model of care that enabled appropriately selected patients to enter specialist aged care earlier than previously possible.

The OPERA program was revolutionary in that it placed the elderly patient at the centre of the care pathway. It also provided an alternative model of care to the traditional ED “packaging” approach prevalent in NSW. Unfortunately limitations in the availability of space at Westmead prevented (co-)location of the OPERA ward within the ED as initially envisaged.

Elderly patients underwent an initial assessment as to suitability, according to agreed criteria, for transfer to the OPERA ward (B4c) located in the existing main ward block, some distance from the ED.

While the original intent of improving the patient journey was achieved, there remained considerable scope for further improvements, particularly by focusing on the services available to patients within, and at the boundaries of the ED, namely:

- Quicker determination of patient suitability for transfer to specialised assessment areas.
- Improved capacity of such areas to complete multi-disciplinary assessment of such patients and implement achievable and sustainable longer-term management of such patients. Such plans could involve transfer of care to appropriate sub-specialised units (including Geriatric Medicine) or early discharge via speedy linkage with community based support services such as PACC, ComPacks and other agencies.

A. HOPE Model of Care

Establishment of a comprehensive strategy to facilitate the more timely assessment, management and appropriate discharge of elderly patients from hospital (Health Care for Older Persons Earlier – HOPE) to:

- Further improve the quality of the care experienced (patient journey) by older persons presenting or referred to Westmead Hospital or affiliated aged care services by:
    - Acknowledging both the benefits and potential hazards of hospitalisation for elderly patients
    - Facilitating appropriate referrals for hospital admission
    - Preventing inappropriate referrals to the hospital
    - Facilitating early assessment and management plan formulation
    - Providing realistic alternatives to hospitalisation
    - Avoidance of hospitalisation when appropriate
    - Facilitating early discharge

This strategy is dependant on the juxtaposition of the elderly patient and the attendant specialist care as early in the treatment process as possible. Rather than rely on changes to practice within the ED an alternative entry to the hospital (3rd door) is proposed.

The service includes:

- An Aged Care Residential Facility (ACRF) Liaison and Outreach Service
- A 4 bed unit located adjacent to, but separate from, the ED together with
- An associated 11 bed ward based area.

The liaison service provides an access point for ACRF and/or associated health professionals to discuss patients whose condition is of concern to the individual, the facility's staff or the person's family. Appropriately skilled staff will activate plans best suited to the patient's needs. Such plans might include:

- A visit to the facility to discuss appropriate care planning
- Transfer of the patient to the hospital for rapid assessment and management
- Other recommendations following discussions with the attending general practitioner

The HOPE_ED unit (4 beds) provides for the initial rapid assessment of patients for either admission to hospital or rapid assessment, treatment, provision of aids and appliances and referral to services or follow-up consultation so as to enable discharge home. Assessment and treatment will occur within an anticipated average of 4 hours and a maximum of 8 hours.

The 11 bed ward area provides for more in-depth assessment, treatment and management plan formulation. This will occur within an anticipated average of 24 hours and a maximum of 48 hours.

The units are staffed with clinicians possessing specific skills in the diagnosis and management of acute and chronic disease and their impact on physiological and social function.

The HOPE Ward complements the existing rapid assessment units including the OPERA unit which has similar objectives and a maximum length of stay of 72 hours.

B. Referral Policy

Referral to the service;

1. From the Community

- Referral to the service from care agencies, particularly those involved in the management of persons with chronic disease and/or disability. These include:
  - Aged Care Residential Facilities
  - General Practitioners
  - Consultants
  - Community nursing
  - Other community based support agencies
  - Aged Care Assessment Teams (ACATs)
  - Other geriatric medicine based intake systems (see Appendix 3)

  Such referrals will be either via the ED triage or directly to the unit depending on perceived urgency and confidence in the assessment provided by the referring agent

2. From ED

- Direct referral from the ED Triage station according to clearly defined criteria (see below)

- Referral of patients initially assessed and managed in ED but subsequently thought appropriate (must meet other eligibility criteria including ED LOS < 4 hours)

C. Staffing and Roles

The 4 bed HOPE_ED assessment area is staffed by a nurse to provide personal care assistance for those undergoing assessment. Assessment is undertaken in the first instance by an additional specially trained senior nurse. This nurse has specific skills in the assessment of such patients, together with the authority to undertake venesection and other diagnostic and procedural tasks. She oversees initial investigations and is authorised to admit the patient to the 11 bed ward based assessment and treatment area. Arrangements with the Imaging Service have been strengthened to ensure that patients transferred to the ward area do so without loss of any priority of access (Emergency priority, Appendix 12).

A senior medical person (registrar) is rostered to be available within 30 minutes (or sooner according to clinical need) to assist the senior nurse in the ED assessment area in determination as to the appropriateness of any decisions about which there is uncertainty on her part. This person will also assist in the diagnostic evaluation and multidisciplinary assessment of patients thought likely to not need admission if appropriate alternative care options can be arranged. Assistance in such assessment is provided by other members of the HOPE staff together with staff from existing hospital and community based programs including the Domiciliary Care Team, a component of the existing Westmead Integrated Aged Care Service.

The service is staffed with a full complement of allied health, medical, pharmacy and nursing staff so as to provide a rapid assessment of the patient's medical condition and consequent needs. This is in accordance with the principles of a comprehensive

geriatric medical assessment. Such an assessment is to be completed within 48 hours and the patient discharged from the unit. Discharge destinations could be:

- Inpatient care
  - Further assessment, eg specialty assessment areas ARAs
  - Another ward based acute care area
  - Inpatient rehabilitation

- Non-Inpatient care
  - GP follow-up
  - Consultant follow-up
  - Home based care
    - ACBT
    - COMPacks
    - Community Beds
    - Post Acute Care in Community (PACC, [CAPACS])
    - Other

Staffing (see appendix for details)

- Medical director,
  - physician with expertise in geriatric and general medicine and functional sequelae
  - new position
- geriatricians and potentially other physicians,
  - recruited from existing hospital staff
- JMO support,
  - Additional
    - Registrar
    - Rmo
- Allied Health staff
- Skilled nurses
  - ED assessment (incorporating some roles of current ASET)
  - ACRF outreach and support
  - Ward based
- Clinical support
  - Pharmacy
  - dietetics
- Administrative support
  - Ward clerk

D. PATIENT ELIGIBILITY CRITERIA

1. From the community

- **Appropriateness determined by consultant on call**

2. From ED Triage

- Triage category 3-5
- No suspected surgical condition
  - ?orthopaedics excepted
- Not under ongoing sub-specialty treatment
  - Renal dialysis
  - chemotherapy
- Other specialty groups

- Negotiations with Mental Health Services are ongoing to ensure appropriate discharge prioritisation should such patients be admitted to the HOPE Ward. This will avoid the long delays in the ED often experienced in obtaining "medical clearance" before being accepted by mental health services.

3. From ED floor

- Referrals must meet other eligibility criteria including LOS within ED
  - Triage categories 1 & 2
    - Patients initially triaged as categories 1 & 2 and, within 4 hours, deemed sufficiently stable to be considered for admission via the HOPE_ED program
  - Other
    - Direct referral of medically stable patients from senior ED medical staff after assessment and management undertaken.
      - For admission
      - For facilitated discharge

E. Hours of operation

- The 4 bed assessment area:
  - This functions as an assessment area from 08.30 to 18.00 hours Monday to Friday
  - Intake hours are from 08.30 to 17.00 hours Monday to Friday
  - These hours and weekend coverage will be increased once additional staffing and funding are available.
  - Outside of the hours of operation of the unit, the area will not be staffed by the HOPE_ED program and may be utilised for other agreed to purposes (with a requirement that the area be vacated by 0800).

- The 11 bed ward area will be a fully functioning medical and nursing care area providing 24 hour patient support, seven days a week. Admissions to this area will take place as follows
  - 08.30-18.00, Monday-Friday: From the HOPE_ED assessment area
  - From other areas, including ED, at any time once fully admitted and accepted by the geriatrician on call.
  - Patients will only be admitted to this area under the care of Geriatric Medicine with the consent of a geriatrician or delegate.

F. Governance (Appendix 4)

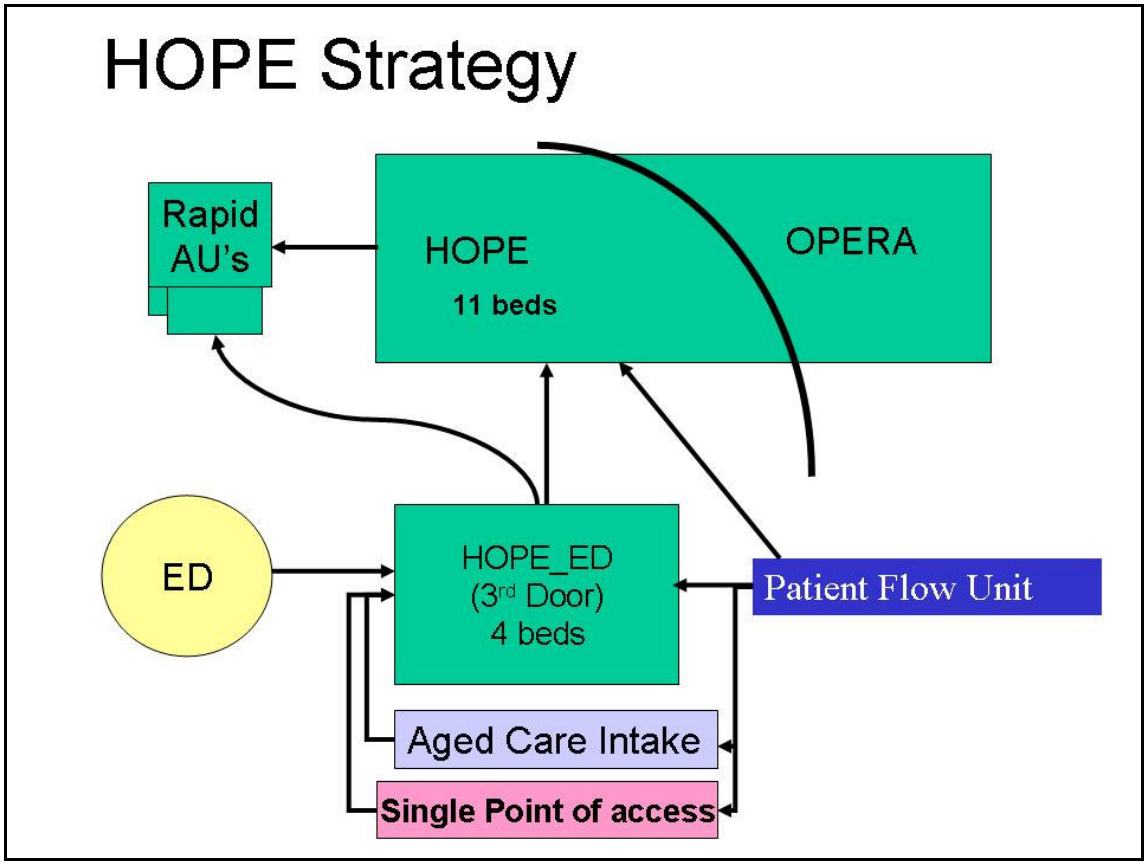
This project is a component of the Geriatric Medicine Department, Westmead Hospital. The operational manager is the Department Head or his delegate.

Geriatric Medicine Department, Westmead Hospital is part of the Aged Care, Neurology and Stroke Directorate, Aged and Chronic Care Network, Central Cluster, Clinical Operations, SWAHS.

G. Operational policies

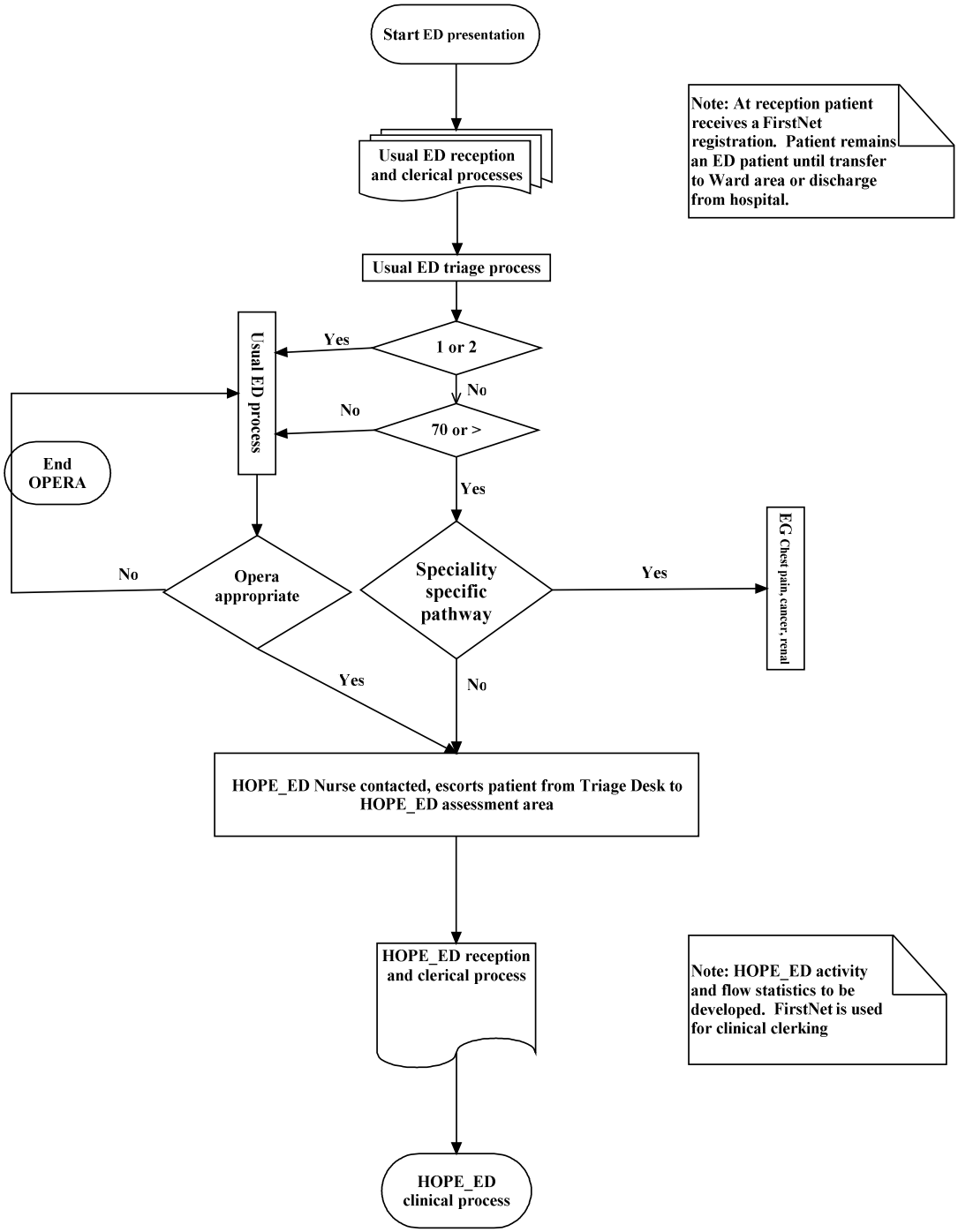
Operational policies or business rules cover the following issues:

- Transfer of patients into and out of the HOPE_ED unit (appendix 5)
- Management of patient deterioration in HOPE_ED (Appendix 6)
- Patient flow within Aged Care Service, particularly movement of patients from HOPE ward to other areas allocated to Geriatric Medicine (Appendix 7)
- Direct ward admissions (Appendix 8)
- Allied Health cover (Appendix 9)
- Nursing care to program (Appendix 10)
- Medical inputs (Appendix 11)
- Imaging services (Appendix 12)


HOPE Strategy
Rapid AU's
HOPE
11 beds
OPERA
ED
HOPE_ED
(3rd Door)
4 beds
Patient Flow Unit
Aged Care Intake
Single Point of access

Appendix 1

Flow Relationship between ED and HOPE_ED at Westmead



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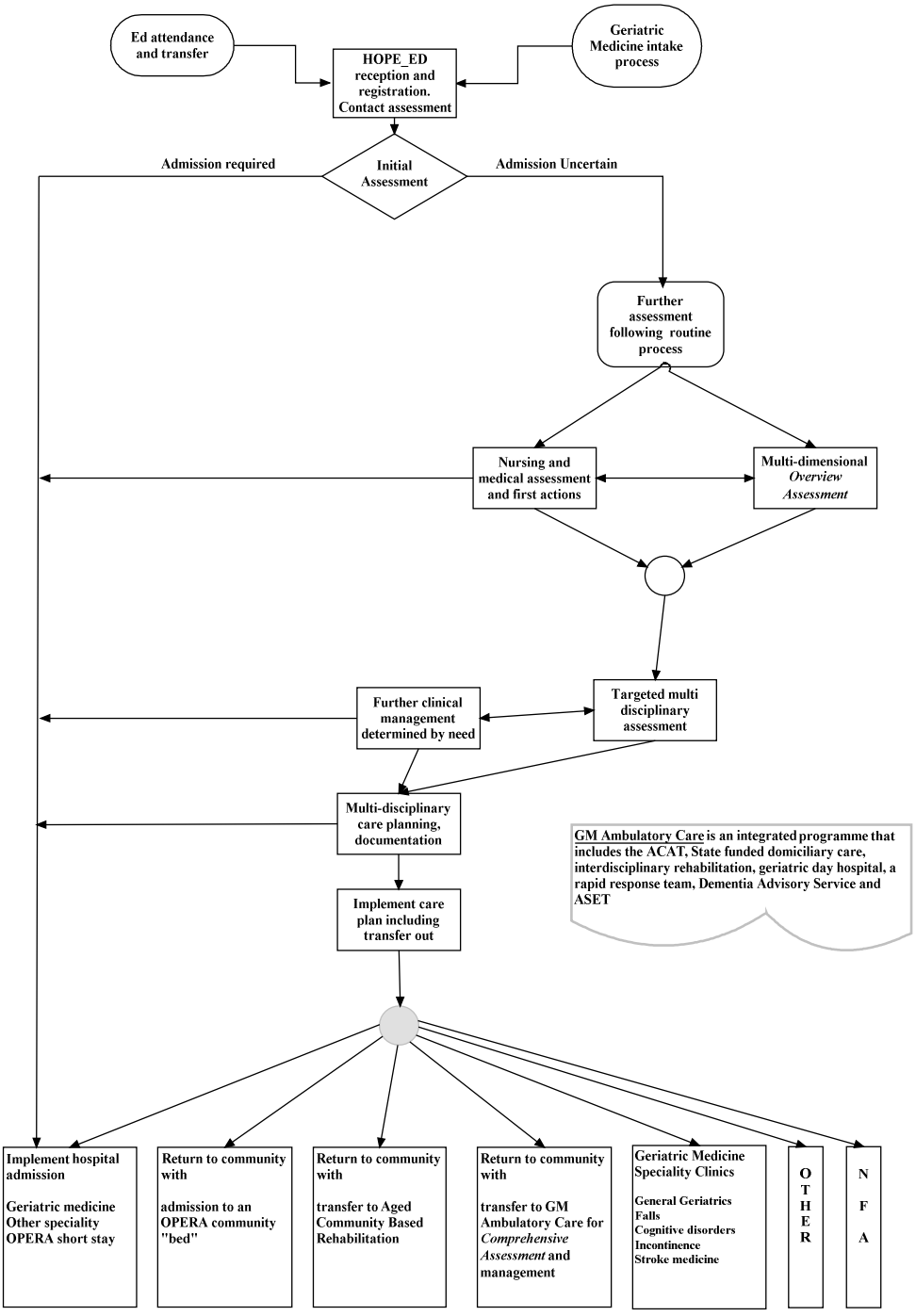
Appendix 2

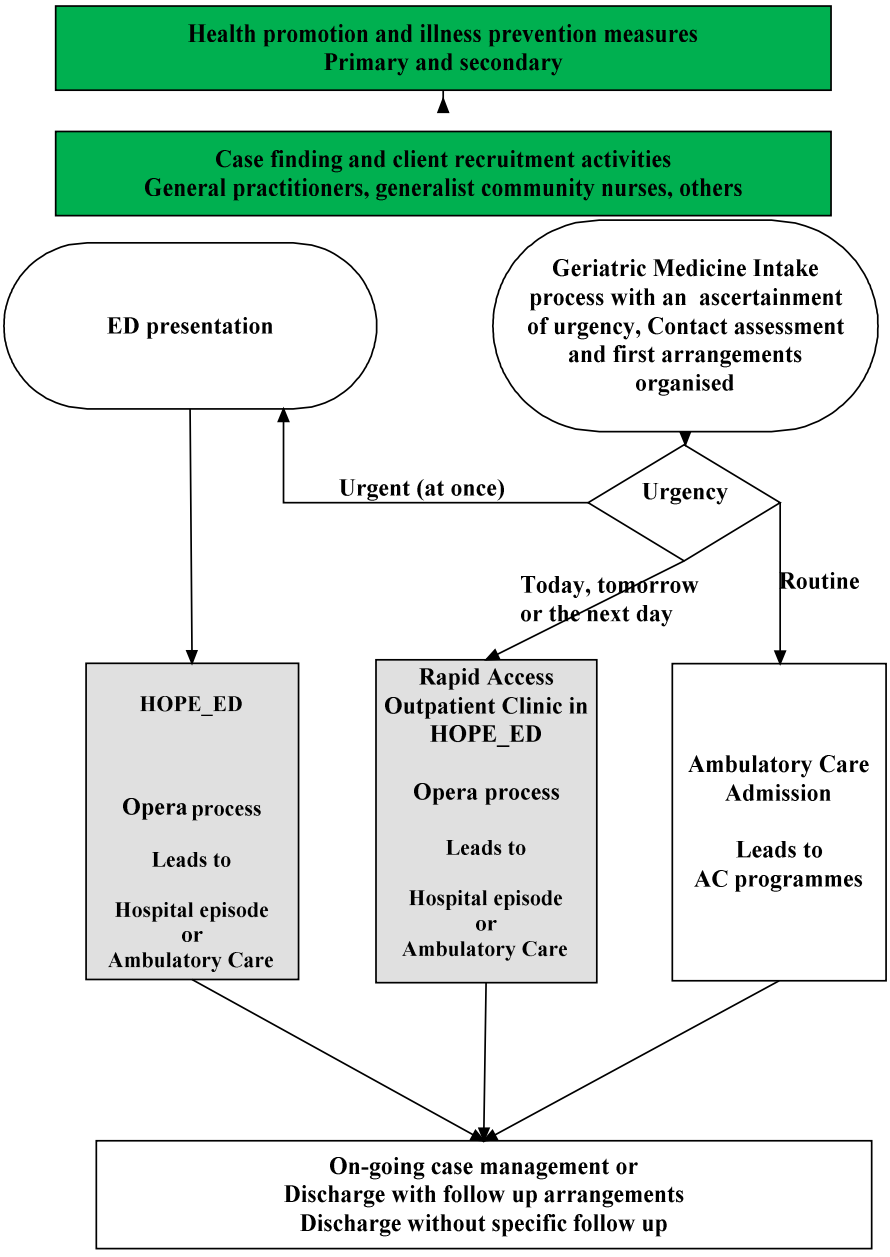
Proposed clinical process flow in HOPE_ED at Westmead Hospital



Care plans developed in OPERA or during an acute or subacute hospital admission or care in an OPERA community bed, community based rehabilitation, from the ambulatory team and ACAT management or from a speciality clinic could involve engagement with community health (generalist community nursing), Aged Care Psychiatry, Home Care, Community Aged Care Packages, Dementia Support, Respite Services, Meals-on-Wheels, ATSI & CALD groups, ACRF providers and others.

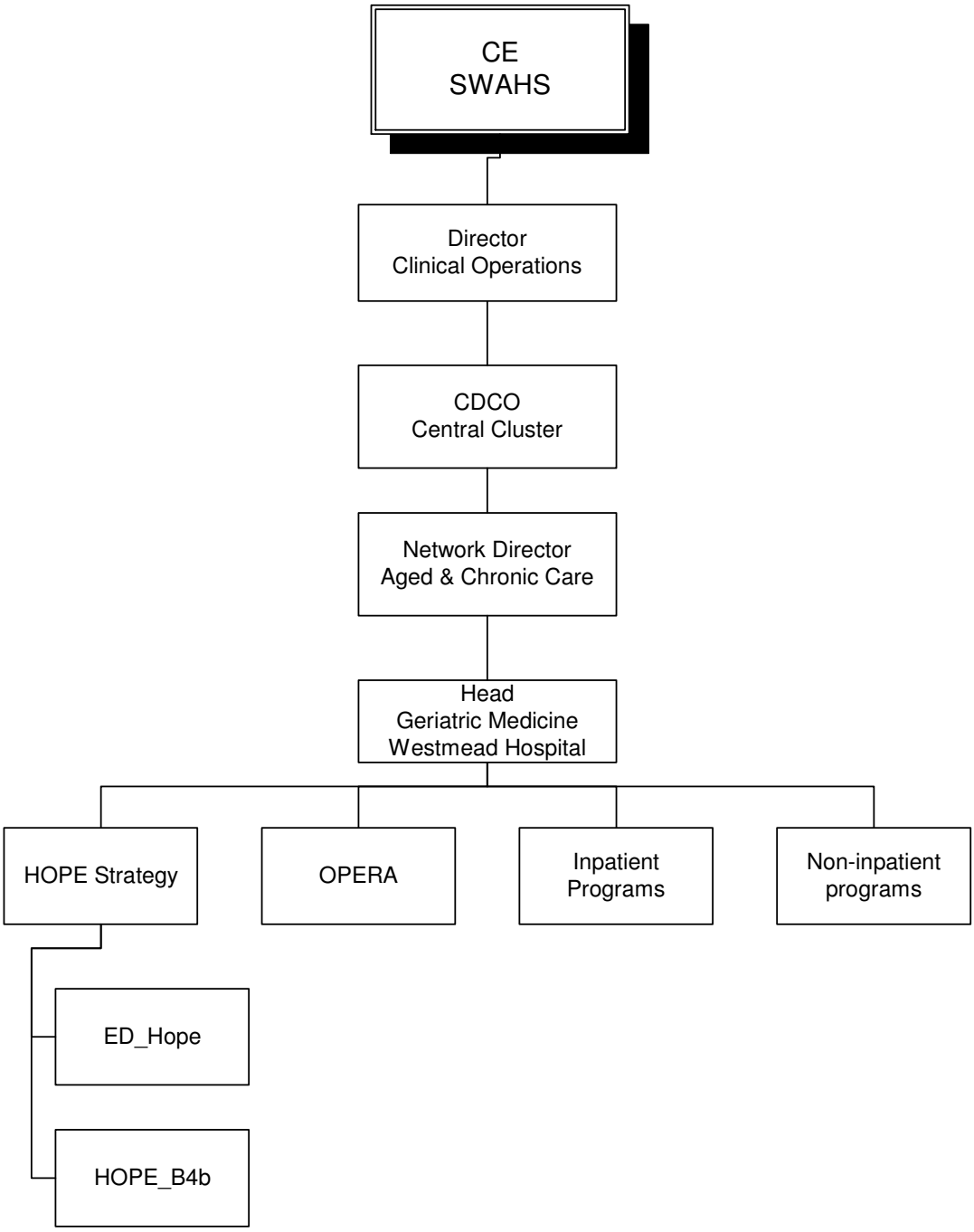
Appendix 3

Overview of the geriatric medicine programs at Westmead Hospital, showing the relationships with the HOPE_ED enhancement



Appendix 4

Clinical Governance
Hope strategy, Westmead Hospital



Appendix 5:

Patient Flow Business Rules for HOPE_ED Unit

Preamble

Adherence to the following business rules is essential to ensure that appropriate patients are allocated to the HOPE_ED Unit and that effective communication between ED Triage and the HOPE_ED is maintained.

Hours of operation:

08.30 – 2000 hours.
The OPERA Clinical Coordinator will primarily be located within HOPE_ED unit and be able to access FirstNet.

Eligibility

Triage categories 3-5, not under ongoing care of subspecialty team. (see Model of care document)

Process

1. Identification

   Patients meeting eligibility criteria will be identified by triage nurse.
   This information will be conveyed to OPERA Clinical Coordinator via FirstNet and paging/DECT phone

   Responsible Person: Triage Nurse

2. Selection

   OPERA Coordinator will screen identified patients for appropriateness for transfer.

   Responsible Person: OPERA Clinical Coordinator

3. Transportation

   Selected patients will be transported to HOPE_ED unit by Coordinator, with or without additional assistance from HOPE_ED Unit staff. Movement will be via the back corridor rather than through the acute treatment area

   Responsible Person: OPERA Clinical Coordinator

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4. Information Management

   FirstNet will be used to track patients awaiting HOPE_ED assessment and within unit.

   Responsible Person: OPERA Clinical Coordinator

5. .Alternative Access to HOPE_ED Unit

   Patients who have had treatment initiated within the acute care area of the Emergency Department but are within 4 hours deemed suitable for the HOPE_ED unit may be transferred into the unit.
   Responsible Person: OPERA / ASET Clinical Coordinator.

6. Upon arrival in HOPE_ED

   Firstnet will be updated and assessment commenced. This will be documented in FirstNet as “Protocol commenced”

   Responsible person: OPERA Clinical Coordinator.

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7. Initial Assessment

   Basic observations and Initial assessment will be undertaken by the senior nurse in the HOPE_ED Unit. Patients may be rapidly transferred to an inpatient area (following consultant approval) or remain for more thorough assessment.

   Responsible Person: HOPE Registrar / OPERA Clinical Coordinator

8. Ongoing assessment

   May take place in HOPE_ED with a target stay of less than 4 hours.

   Responsible Persons: HOPE Registrar and Patient Flow Unit

9. Discharge/Disposition

   Patient disposition location will include:

   - inpatient areas;
   - Aged Care Residential Facilities
   - home (with or without domiciliary based care programs including ACBT and Community OPERA and PACC), either directly or via the
   - Patient Discharge Unit.

   Responsible Persons: HOPE Coordinator and Patient Flow Unit

Appendix 6

Business Rules for HOPE Emergency Department PACE Escalation

Preamble

In the circumstances where patients in the HOPE_ED deteriorate it is important that the following escalation plan is adhered to ensure patient safety.

Process

1. Patients who meet the Pace criteria in the HOPE_ED will have a PACE call made in order for the geriatric registrar covering HOPE ED to attend and begin medical intervention.
   Responsible Person: HOPE ED staff

2. Patients who meet the ALS criteria will have an ALS call initiated and basic life support commenced by HOPE_ED staff.
   Responsible Person: HOPE ED staff

3. The internal emergency buzzer will be activated, which will notify the emergency department staff of the situation and who will provide ALS support.
   Responsible Person: HOPE_ED staff

4. If required the patient will then be moved into the emergency department this may involve swapping of patients into HOPE_ED to enable this to take place.
   Responsible Person: HOPE_ED staff / NUM ED

5. If a non-OPERA/Hope patient is the only patient able to be identified to move into the OPERA ED area, this is to occur without delay.
   Responsible person: HOPE staff / NUM ED

Appendix 7

Patient Flow Business Rules
For
Movement of Patients from the HOPE ward beds

Preamble

To ensure there are sufficient beds available to support the movement of patients from the HOPE Emergency Department beds into the HOPE ward it is imperative that there is continued movement from the HOPE ward beds into other appropriate Aged Care beds (OPERA, D4c and C4c).

1. Process

1.1. Patient Flow Unit (PFU) notified by OPERA / ASET Clinical Coordinator (Business Hours) or Team Leader HOPE ward (after hours) of identified HOPE ward bookouts. PFU will liaise with OPERA Unit / D4c/C4c and allocate bed as per PFU Business Rules.
Responsible Person: OPERA /ASET Care Coordinator, HOPE ward Team Leader.

1.2. Discharge from HOPE Beds to ward beds is to receive the same priority as ED beds. The HOPE transfers are to OPERA, D4c, C4c or other specialty wards if care transferred to other appropriate teams.
Responsible Person: PFU Bed Manager, Patient Flow Coordinator and After Hours Senior Nurse Managers

2. Quarantining of HOPE beds

2.1. To ensure rapid turnover and bed availability, HOPE Beds are to be quarantined from non-HOPE admissions at all times.

2.2. Use of HOPE beds by non-HOPE patients.
HOPE Beds can only be used for non-HOPE patients with the ***authorisation of the Unit Director, the Geriatrician on call or the Eastern Cluster Director of Clinical Operations***.
Responsible Person: PFU Bed Manager, Patient Flow Coordinator and After Hours Senior Nurse Managers

3. Authority to transfer care

OPERA Consultants have the same delegated authority as Senior Emergency Department Staff to determine if, after careful review, a patient would be more appropriately cared for by another clinical unit. **(See Westmead Hospital Emergency Department Admission Policy, December 2004).**

Appendix 8:

Patient Flow Business Rules for
Direct Ward Admissions

Preamble

The Patient Flow Unit seeks to place unscheduled patients directly to a ward who are reviewed by a CMO or Registrar and deemed to require urgent admission or admission within a 24-48 hour period. These patients may require a Day Only bed or an overnight bed. They may be patients from clinics, private consulting rooms, previously admitted Westmead patients from the community, Day Only Ward. This does not interfere with the current process for overnight admissions that require a recommendation for admission (RFA).

Process

Additional patients will not be added to the Day Only or Long Stay list unless determined as urgent or ONLY where bed capacity can accommodate this patient for discharge the same day. This will be monitored and discussed with the PFU NM for each occasion. The Admissions and Bookings staff will call PFU regarding any clarification or addition.

- The PFU clerk will print the Day Only Booked Admission List from iPMS and monitor those patients that convert to overnight admission.
  Responsible Person: PFU Clerical

- Bookings and Admissions will fax a copy of the Day Only Ward list at 0730 hours and this will be compared by PFU to the iPIMS list for any variations. Registrars or CMO's with additional patients will be directed to the PFU.
  Responsible Person: Bookings staff

- The Day Only Ward will oversee all the Day Only cases and continue the same arrangements for Bookings into Day Only Ward. Registrars or CMO's with additional patients will be directed to the PFU.
  Responsible Person: DOW Manager

- On receiving a call from the Medical Staff PFU will document all the appropriate details, liaise with the appropriate ward re ability to accommodate an extra patient. Where a bed is unavailable PFU will make an alternative and appropriate arrangement to accommodate patients.
  Responsible Person: PFU Bed Manager

- An RFA or DOW RFA will be completed by the medical staff immediately and faxed to Bookings and Admissions for processing.
  Responsible Person: Medical staff

- The PFU will contact the team, Recovery, Day Only Ward, Patient Enquiries, Bookings and Admissions directly with the bed allocation.
  Responsible Person: PFU Bed Manager

Appendix 9:

HOPE_ED beds Allied Health Service

The HOPE/ OPERA Allied Health staff will work together as a single clinical unit.

Each day there will be a designated clinician from each discipline OT/ PT/ SW who will provide service to the HOPE_ED beds. The rostered clinicians will carry the HOPE_ED pager for their discipline. When paged by HOPE_ED staff to assess a client in an HOPE_ED bed, the clinician will respond within 15 minutes.

If the rostered staff member is away on unexpected leave the senior (or delegated senior) will ensure that this workload and pager is allocated to a clinician for each shift.

To ensure efficient continuity of care, the same Allied Health clinician will continue to manage the patient as they transfer within HOPE_ED, HOPE/OPERA and OPERA Community Units.

Appendix 10:

HOPE Nursing Model of Care

Two separate, but linked units - ED_HOPE and HOPE Unit will operate.

Nursing in HOPE will:

1. Provide early identification, selection, assessment and transfer of patients from the ED to ED_HOPE;
2. Initiate appropriate Nursing care during the stay in ED_HOPE unit and HOPE Unit;
3. Co-ordinate and manage transfer from ED_HOPE to HOPE UNIT, OPERA, or appropriate destination.

- ED_HOPE will be staffed from 08:00 to 20:00, Monday to Friday.
  - Staffing will consist of;
    - AM: 0700 – 1530 RN
      0800 - 1630 : Clinical Co-ordinator
      1000 - 1830 ASET Nurse } cover both HOPE &
      1130 – 2000 ASET Nurse } ED
    - PM: 1130 - 20:00: **RN**

+ RN/New Grad/EEN

Nursing in this area will be directed towards identification of patients, early initial assessment and care, and planing and implementing movement to an appropriate destination. This will be based on the planned 4 hour LOS.

- Clinical Co-ordinator will initiate HOPE intervention by
  - Secondary assessment of patients aged 70 years and over, triage category 3-5
  - Identification of patients suitable for OPERA-ED utilising Firstnet and through liaison with GPS
  - Facilitate ordering of imaging and pathology
  - Consult with HOPE registrar regarding patients
- ASET/HOPE Staff will support the initial review by the Clinical Co-ordinator:
  - Reviewing aged care clients in ED and identify patients suitable for HOPE
  - Commence liaison with allied health staff and community services regarding both inpatients and patients for discharge
  - Referring appropriate patients to the Clinical Co-ordinator or A/H Registered Nurse (ED_HOPE) for transfer into ED_HOPE.

- HOPE Unit (B4B) will be staffed 24 hours, 7 days a week.
    - Staffing will consist of;
        - AM (0700 - 1530)
            - CNS/RN Team leader without Patient Load (Mon - Fri)
            - **RN + RN/NG/EEN**
            - PSA (for ED_HOPE and HOPE Unit)
        - PM (1400 - 2230)
            - CNS/RN Team leader without Patient Load (Mon - Fri)
            - **RN + RN/NG/EEN**
            - PSA (for ED_HOPE and HOPE Unit)
        - ND: (2130 - 0730)
            - **RN + RN/NG/EEN**

Patients will be received from ED_HOPE. Nursing care will be directed at further assessment, and planning of care. Interventions will be continued or commenced, and transfer or discharge will be based on the planned 24 hour LOS.

Morning and Afternoon Team Leader will co-ordinate discharges and patient moves between HOPE and OPERA and between HOPE/OPERA and other wards.

Night Team leader will be from within HOPE and OPERA staffing numbers.

Staffing will be managed on a combined HOPE & OPERA roster, providing suitable staff and skill mix for the particular roles outlined above.

Appendix 11. Medical Care

Medical cover will be provided by the Geriatric Medicine Department

The Department consists of:

13) 5 consultant based teams,
    Each with their own registrar and jmo.
    Each team is responsible for all patients under the care of their respective consultant except those patients in the OPERA ward

14) OPERA
    Specific allocation of Registrars, Career Medical Officer, SRMOs and JMOs working under guidance of consultant who provides continuity of care once patient leaves unit to other ward area and care of team mentioned above

Consultant cover to HOPE

There will be a consultant rostered on duty for each day. This will be **"Team of Day"** Consultant will be available to

- Discuss care of patients with ED_HOPE coordinator or Registrar
- review patients in ED_HOPE on request or when felt appropriate
- Such availability will be compatible with operational policies
- Review patients in the HOPE ward at least twice daily on day of on-call and following morning
- Attend to other duties as per current arrangements or as directed by Departmental Head

ED-HOPE

- Medical cover will be provided by Registrar of Team of day
- Registrar will be available to respond to calls from ED and ED_HOPE to review patients
- This response will be within 30 minutes if requested
- Response will be irrespective as to whether patient previously known to geriatrician other than that on duty for that day.
- Registrar will discuss patient with consultant and determine if patient is to remain in ED_HOPE with view to being discharged that day or to be admitted to ward area.
- If admitted to HOPE/OPERA area registrar will hand over care to those teams
- If admitted to other ward area then registrar will retain responsibility of patient until care accepted by another team where appropriate in accordance with GMD policies and procedures.

HOPE Ward

- Consultant cover will be provided by the Team of the day
- Direct medical care will be provided by the HOPE/OPERA medical teams
- There will be 3 teams each consisting of a senior doctor (AT, SRMO or CMO)
- Patients will be allocated by the senior medical officer (AT or CMO) so as to maintain equitable workloads and maximum procedural efficiency
- Patients will remain under the care of those teams whilst in the HOPE/OPERA area

- The registrar of the Team of the Day will accompany the consultant on rounds of this area so as familiarise himself with the patients likely to be transferred to other ward areas

Appendix 12: HOPE_ED Imaging guidelines

HOPE_ED is a 4 bed unit adjacent to the Emergency Department

Patients in the unit are tracked with FirstNet.
Patients remain designated as being within the Emergency Department until transferred to a ward area or discharged.

Requests for imaging are to be regarded as being from the ED with the same KPIs.

This access priority will be retained for patients transferred to acute review areas (ARA's) including HOPE, OPERA and the Stroke Unit so as to avoid delays in transfer to the wards and inappropriate stays in the HOPE_ED.

Imaging will be undertaken in the main X-ray area, not the ED radiology suite.

Requests for imaging will be made as follows:

1) Non-CT
    - Ring radiology nurses station, 56621 or 57208 with request
    - leave request in sleave of, or attached to, patient's medical file.

2) CT
    a) 0800 – 1700 Monday to Friday (non-holiday)
        - Contact CT registrar by ringing 56522 and have CT registrar voice paged to discuss request.
        - Fax or deliver request to CT, (984) 58354

    b) Other hours, weekends and holidays
        - Contact CT registrar by pager, 22778 and discuss request.
        - Fax or deliver request form to CT, (984) 58354

    If request faxed to CT please leave original attached to notes.

3) MRI
    - By arrangement with the MRI fellow