

A Collaborative Care Outreach for Residential Aged Care Facilities (RACFs) across Sydney Local Health District (SLHD)

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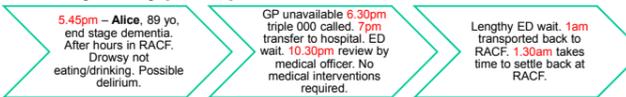
Case for change

Untimely care, lack of clinical expertise and support for RACF residents results in many RACFs referring residents to the Emergency Department (ED), often resulting in a hospital admission.



As in Alice's journey below, evidence suggests hospital ED transfer are a cost to the system, often result in poor health outcomes and are avoidable with improved supports in the RACF.

Alice's journey pre-implementation



Goal

The ACCORD project aims to meet the needs of residents in RACFs who could benefit from Outreach supports, to be cared for in their facility in collaboration with RACF staff, General Practitioners (GPs) services and other relevant stakeholders. The project will seek to enhance care and interventions for residents by increased utilisation and capacity of SLHD ACT and RACF Outreach.

Objectives

1. Increase the number of residents who receive support by SLHD RACF Outreach services and therefore did not transfer to hospital, from 45 to 73 per month by August 2018.
2. Increase utilisation of the ACT RACF Triage service from an average 46 calls a month to 70 calls per month by August 2018.
3. Increase utilisation of the RACF Outreach service from 48 Occasions of Service per month to 70 Occasions of Service per month by August 2018.

Method



The project has been completed as a Clinical Redesign project with the Agency for Clinical Innovation (ACI). This is a robust six stage project methodology using process redesign and change management for the improvement of health care systems and patient outcomes.

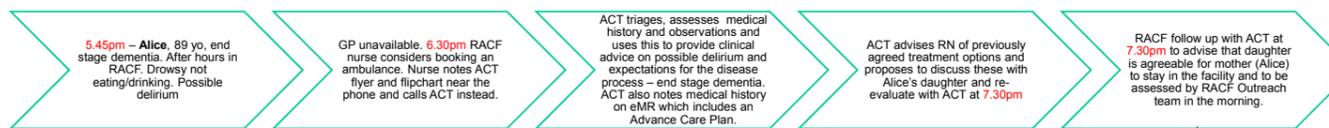
During the diagnostic phase the project team consulted and engaged widely with key stakeholders and residents' carers:

Quantitative Data	Internal Stakeholders	External Stakeholders
<ul style="list-style-type: none"> Pre Existing Data SLHD/ACC&R File Audit TCH (103) Clinical Log (40) 	<ul style="list-style-type: none"> Clinical Nurse Consultant (CNC) interviews (13) ACT Staff interviews (8) Geriatrician interviews (3) ED: Aged Services Emergency Team (ASET) interviews (3) ED Medical Officer interview (1) HITH Medical Officer interview (1) 	<ul style="list-style-type: none"> Resident/Carer Interviews (2) GPs phone interviews (4) RACF Directors of Nursing (DONs) Interviews (17) RACF Staff survey (106)

58 issues were identified and consequently themed allowing the Root Cause Analysis to establish 3 key issues.

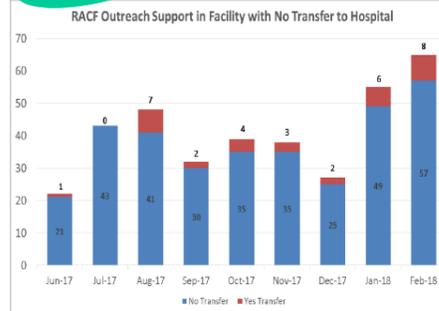
Results

Alice's journey post-implementation

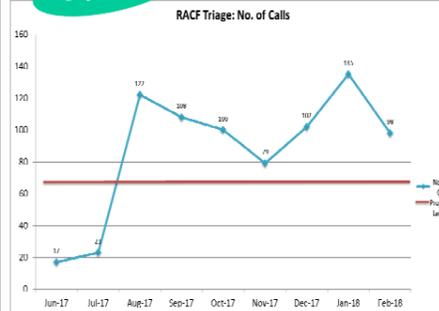


- Outreach Services:
- RACF Outreach (Medical & Nursing led team)
 - Hospital In The Home (HITH)
 - Continence Nursing
 - Sydney District Nursing (SDN) Palliative Care

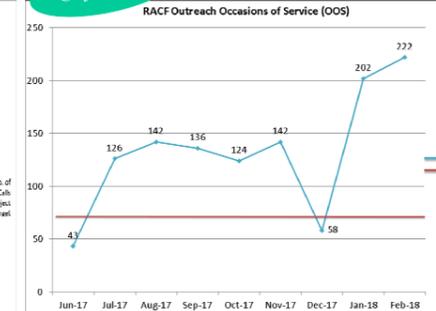
Objective 1



Objective 2



Objective 3



- Survey March 2018 (n=25) – Outcomes:
- 100% heard of ACT
 - 88% heard of RACF Outreach
 - 96% had used ACT recently
 - 75% had used RACF Outreach
 - 91% felt that ACT had addressed their referral queries adequately
 - 94% were happy with RACF Outreach once used the service.

Solutions

- Develop a Model of Care (MOC) for SLHD wide Residential Aged Care Facility (RACF) Outreach Services
- Build capacity to improve processes and connections for RACF Outreach and ACT
- Improve awareness and knowledge of stakeholders of RACF Outreach support services within SLHD
- Provide assessment of deteriorating residents in a more timely manner: Establish medical governance.
- Work with NSW Ambulance to streamline and integrate processes.

Project still undergoing implementation with full evaluation of the project to be completed in August 2018, measuring:

- the number of ACT triage calls per month
- RACF Outreach Service occasions of service
- number of residents supported by RACF Outreach services each month
- RACF staff satisfaction with the ACT triage and RACF Outreach Service.

Acknowledgements

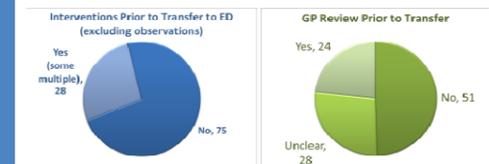
Project Sponsors: Associate Clinical Professor John Cullen, Debra Donnelly
 Clinical Redesign SLHD: Dimitra Kaidelis, SLHD Executive Unit
 A/Prof Ghauri Aggarwal, Irwan Anang, Kim Clowes, Cassandra Dearing, Karen Errington, Gina Fletcher, Fungayi Foya, Dr Alison Free, Trish Gillett, Charles Lo, Dr Robyn McCarthy, Jodi McLeod, Pamela Moore, Heitham Sabri, Dr Rosemary Sheehy, Dr William Thoo, Claire Walker.
 All interview and workshop participants including GPs, RACF staff and resident's carers; Medical and Nursing staff of SLHD, CESPAN and ACT staff
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Diagnostics

The Canterbury Hospital (TCH) - File Audit (n=103)



RACF DON quote: "We need to have access to information about available services and we need to encourage our staff to use services and pass the information on to them."



- 99% no call to ACT
- 77% were not known to RACF Outreach

Quote: "RACF residents are often more complex. More difficult for ED staff to move through ED. They are at high risk of complications as they don't present in a typical manner. Need more time to make decisions about this group and ED staff quite often do not have this extra time. They have to allocate resources based on urgency of need rather than solely the magnitude or complexity of need." ED Medical Registrar.

Interviews with SLHD / RACF staff, GPs & carers

- Themes summary:
- Poor timeliness of services
 - Poor RACF and GP knowledge of system
 - ACT: Skill mix / clunky-ness / lack of clinical leadership
 - Family influence in transfers
 - Poor GP accessibility
 - Duplication / lack of clarity in MOC
 - Poor continuity of staff in RACF

Root Cause Analysis- Key issue summary:

- RACF and GP not utilising ACT
- Outreach Model not meeting the needs of RACF residents
- Transfer to ED without exploring other options

Sustaining change

A district RACF Outreach Service Advisory Committee will be established, building on the existing ACCORD Project committee to support ongoing implementation and management.

Endorsement of MOC by SLHD CE and Clinical Council. Enhancements of services including; new manager ACT, RACF Outreach and HITH; specialist Aged Care Nurses (6) with CESPAN funding, and Geriatricians (2).

Connections between teams, education and clinical leadership being implemented within ACT. Promotion of services and education for RACFs in-built into new service model.

Conclusion

The aim of this project and the MOC is to achieve right care in the right place at the right time for residents of RACFs.

This project is addressing a complex problem, which has required system level change and collaboration with stakeholders outside the SLHD. Long term investment, commitment with a phased in approach of the MOC is necessary for sustainable change in practice and long term improvements in RACF resident health outcomes.

The model may accommodate transfer to the aged care community setting. A range of organisational changes are implemented embedding this model into routine practice.