Nurse Practitioner-led Outreach Rapid Response Acute Aged Care Service

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Background
- The Nurse Practitioner (NP) – led Outreach Rapid Response Acute Aged Care service was implemented in March 2012
- The service is delivering a patient-centred and Integrated Health model of Care framework
- It’s effectiveness was recognised and selected as the winner of Integrated Care for 2015 Mid North Coast Local Health District (MNCHLHD) Quality Awards.
- It has been also awarded for Integrated Care Finalist for 2015 NSW Health Innovation Awards

Purpose
- The purpose of the service is to minimise incidents of unnecessary acute care hospital presentations through,
  providing timely access to acute care
  reducing unnecessary complications to older persons, &
  increasing the satisfaction of the older persons and their families

Method: Appropriate care in the right place at the right time
- The service is available to RACFs, GPs, older persons & families in the Coffs Harbour region
- The service is also accessed by ED, discharge planners as well as the community health care services to provide appropriate care to older persons in the right place at the right time
- Monthly data of the NP’s monthly total occasions of service (OOS) (Fig. 1) shows that on average patients are being seen by the NP on 92 occasions
- The OOS for the avoidable hospital presentations (Fig. 2 & 3) demonstrate that the average monthly hospital avoidance achieved by the NP is 71 occasions (Fig. 2), which is up to 70% of the monthly OOS received the appropriate care in the right place at the right time.

Results...So far
Older Person – Centred Care:
- The NP-led Outreach Rapid Response Service has made an impact in bettering older persons care outcomes particularly in RACFs

Efficiency of the NP-led Service:
- 86% in 2013 and 74% in 2014 of RACF residents received their medical care and end-of-life care from the NP in their home environment
- Total 900 / 1046 OOS of hospital avoidance in 2013
- Total 791 / 1067 OOS of hospital avoidance in 2014
- Above figures translate to many avoided bed days & $$$

Anecdotally, in addition to the statistical data, there has been a significant reduction in older persons presenting in ED from RACFs as frequently claimed by staff specialists and nursing staff in ED, CHHC

Collaboration | Integrated Health Care Service:
- The hospital avoidance DRGs and geriatric syndromes are being assessed and treated in RACFs in collaboration with the GPs including older persons & their families

Empowering | Capacity Building in RACFs:
- Education / training sessions are delivered by the NP
- Communication & Collaboration with / via
  - ISBAR style in communication
  - Emergency Decision Guidelines booklet
- Recognising the deteriorating older persons educations
- 6 out of 13 RACFs capable of administering IV antibiotics & hydration at the RACFs
- 2 out of 13 RACFs capable of cannulation autonomously
- Timely coordination of end-of-life | advance care directives, ensuring a person-centred good death for older person & his/her family
- IDC, SPC & PEG change independently
- Complex wound management

Conclusion & Implications
- The NP-led Outreach Rapid Response Acute Care Service is making positive efficiencies in limiting unnecessary hospital presentations from the Coffs Harbour Community to CHHC.
- Therefore, demonstrating the practically and transferability of the NP-led model of care.
- This illustrates that there is a need for future planning for the education and training of RNs for the NP role

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