1 Identify accommodation types

To correctly identify the accommodation type of residents of aged care on admission as either independent living units, hostels or nursing homes.

Strategy
- Development of a residential aged care facility accommodation identification system

Performance indicator:
- Database and accommodation identification system developed.
- 75% of patients correctly identified within 3 months.
- 100% of patients correctly identified within 6 months.

2 Reduce access block

Reduce the level of access block for aged care facility residents presenting to hospital

Strategy
- Monitor the number of avoided admissions from aged care facilities.
- Monitor the number of aged care facility residents who are transferred to the Emergency Department and returned to their home without a ward admission.
- Monitor the number of residents transferred to the Emergency Department Unit Ward and medical wards.
- Monitor access block performance
Performance indicators

- Increase in the number of avoided admissions within six months.
- Decrease within nine months of the number of patients transferred to the Emergency Department and returned to their aged care facility.
- Within six months, 80% of all nursing home residents will be admitted to the EMU wards.
- Within six months, 80% of GRACE hostel residents will be admitted to the ACE Ward.
- In the first year of operation increase to over 100 those patients with an acute illness who have facility based care without hospital presentation. This will be measured by the number of notifications to the GRACE triage nurse for the provision of consumables or service provider staff and will exclude palliative care patients.
- A 20% reduction based on the base line data of hospital presentations from residential aged care facilities.
- Reduce from the baseline data the ALOS for GRACE patients in the Emergency Department.

3 Reducing length of stay

*Reduce the length of stay (LOS) of patients admitted to hospital from residential aged care facilities.*

Strategy

- GRACE staff to prioritise GRACE patients.

Performance indicators

- LOS reduction from baseline year for GRACE nursing home residents presenting to the Emergency Department.
- Percentage increase on baseline year of GRACE patients admitted to the short stay GRACE beds.
- Comparison of short stay bed admissions with the general ward admissions.
4  Discharge care plans

*Increase the number of aged care facility residents who have discharge care plans to enhance their care*

**Strategy:**
- Care plans developed for all GRACE patients in collaboration with the aged care facility and the general practitioner.

**Performance indicator**
- Documented evidence that 50% of the GRACE target group have a discharge care plan that enhances their care within six months of project start.

5  Advance care planning

*Aged care facilities begin conversations with all their residents and/or their families/responsible person about advance care planning.*

**Strategy**
- Increased awareness and support for aged care facilities, their residents and residents families, in the development and use of advanced care planning.

**Performance indicators**
- Documented evidence that GRACE staff have discussed advanced care planning with all telephone triaging referrals.
- Work has begun with identified aged care facilities about how to increase the use of advanced care planning.
- 10% of the target group will have advanced care planning within the first 12 months of the GRACE project.

6  End of life transfers

*Reducing the number of residents from aged care facilities transferring to hospital for palliative / end of life care.*

**Strategy**
- Increase the use of advanced care planning.
• Support facilities to provide end of life care through access to appropriate hospital resources not previously available to the facilities and GPs.
• Work with the local Divisions of General Practice to assist them to identify and acquire palliative funding grants for GPs.

Performance indicator
• Within the first year, reduce by 50% the number of deaths of aged care facility residents that occur within the hospital.

7 Enhance residents journeys

*Provide an outreach service and a system of prioritised hospital treatment to enhance the aged care resident’s journey. This will be done through building trust and communication between the hospital service, aged care facilities and general practitioners.*

Strategy
• Provide a single entry point telephone triage system to the GRACE project for aged care facilities and general practitioners to discuss treatment options.
• Build capacity within aged care facilities through education and supervision of new treatment options under a brokerage system.
• Provide aged care facilities with access to the community acute/post acute care services where appropriate.
• Provide aged care facilities and general practitioners with access to services where appropriate that are generally only available to inpatients. This may include access to diagnostics, specialist review and access to allied health and CNC review.
• Offer a prioritised care system in the Emergency Department and Emergency Care Unit combined with ongoing GRACE feedback to the patient’s aged care facility and general practitioner.
• Hold regular meetings with the aged care facilities to discuss patient care and other GRACE project issues.
Performance indicators

- Operational single entry point established with widely advertised telephone number.
- The number of aged care facilities and general practitioners using the service within six months of the GRACE project start.
- Increasing numbers of aged care facility residents are using GRACE and CAPAC services to avoid an admission.
- Adequate systems are in place to provide outreach services e.g. diagnostics.
- Prioritised care in the Emergency Department and Emergency Medical Unit is reflected in their ALOS.
- Regular meetings between the hospital and aged care facility staff are occurring.
- Aged care facilities have identified their education needs and a program is place to support this. This will begin within six months of the GRACE project start.

8 Flexible and responsive service

The GRACE Project will be established and managed in a way that can be flexible and responsive to the needs of residents/families, facilities and general practitioners.

Strategy

- The development of staff, general practitioner, aged care facility and patient satisfaction surveys.

Performance indicators

- Initial surveys are completed with six months of the project start and repeated within 12 months of the project start.
- A report of the results of the satisfaction surveys is completed and disseminated with 18 months of the GRACE project start.

9 Fostering cultural change

The GRACE CNC fosters cultural change by undertaking a staff mentoring role about aged care within the Emergency Department. This will assist with the confirmation that aged care is a core business for the Emergency Department.
Strategy

- The GRACE CNC mentor the GRACE/ASET staff.
- Development of a GRACE/ASET preceptorship program.
- GRACE CNC and project officer will provide in-service training and opportunities for discussion of aged care issues pertinent to the Emergency Department.
- The GRACE/ASET “out of hours” staff are ED staff that have volunteered to work in GRACE. They will also be able to mentor other ED staff regarding aged care issues.

Performance indicators

- Effectiveness of mentoring will be reflected in the retention of staff or progression to other specialised aged care roles.
- GRACE/ASET preceptorship program in place.
- The staff satisfaction surveys to be administered at six and twelve months will assist with testing the cultural change in aged care nursing.

10 Cost benefit analysis

*The GRACE project will be able to demonstrate an effect cost / benefit to its implementation.*

Strategy

- Development, collection and maintenance of an accurate database of GRACE patients.

Performance indicators

- GRACE patients will be coded by DRG and these will be compared with patients of the same aged group and DRGs admitted to hospital.
- The cost of consumables versus DRGs and LOS will be tracked using a similar methodology used in the CAPAC service.