

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 180000 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

¹Residential aged care in Australia 2010 – 2011 : a statistical overview (Australian Institute of Health and Welfare)

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

Mobile Assessment Treatment Service (MATS)

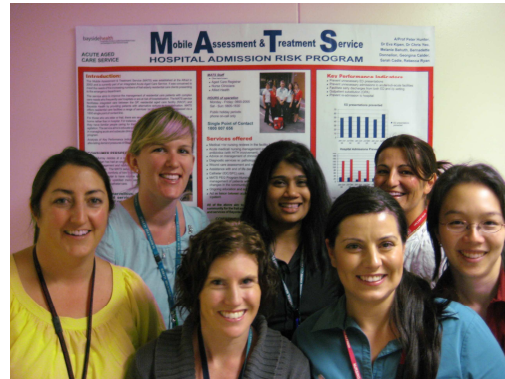
- A Residential In reach service
- Operational since 2001
- Fundamental belief that there is a better way to look after frail older people from residential care
- Goal is to provide appropriate care in the appropriate environment
- ***Individualise treatment plan to suit the patient***

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: through 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

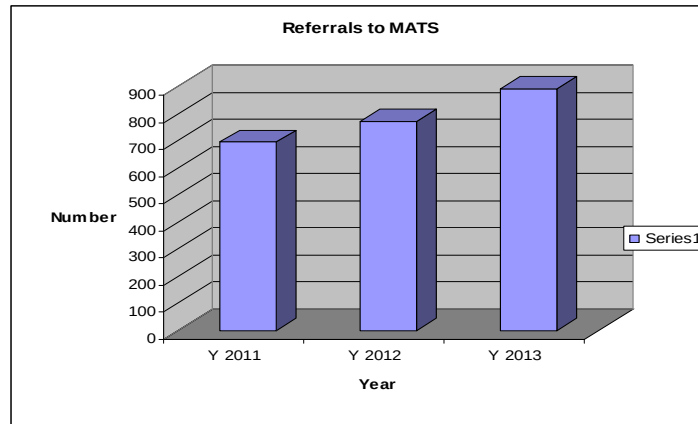
Training of Basic and Advanced Trainees

- 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

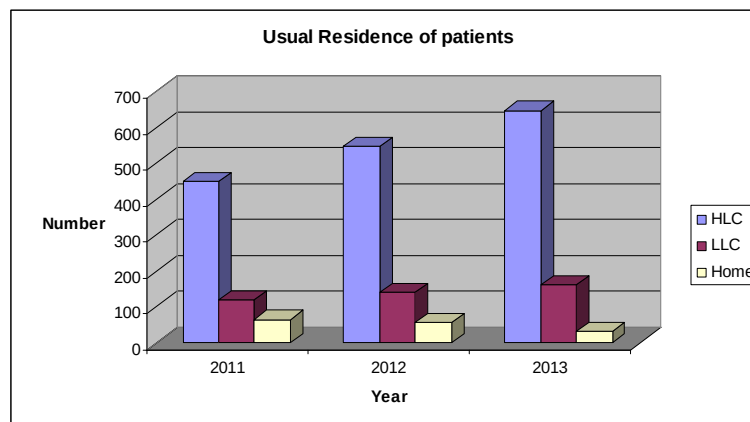
Partnerships

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

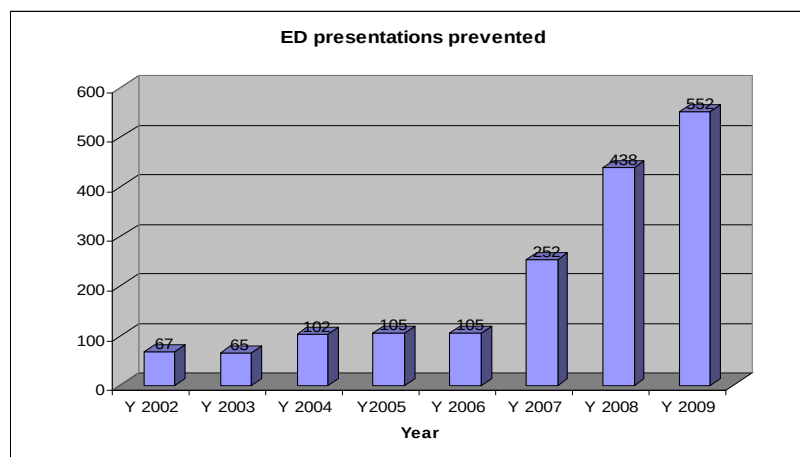
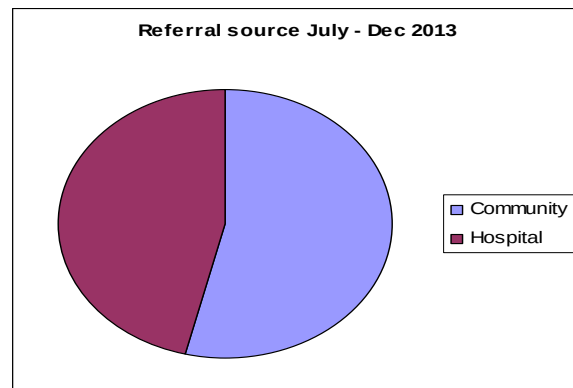
Referral Numbers



Usual Residence of Patients



Source of Referral



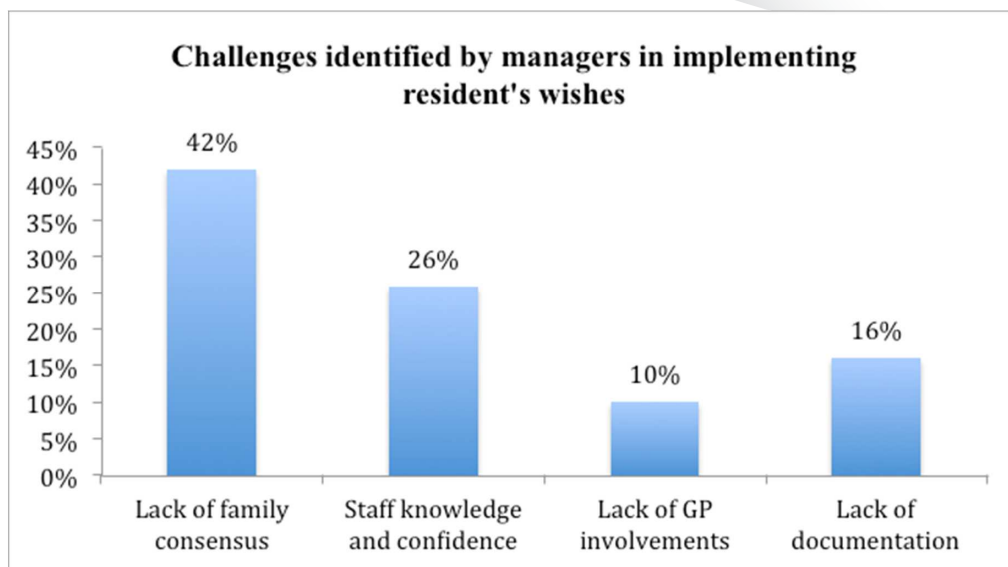
Advanced Care Planning (ACP)

- 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%).
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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



