DEPARTMENT OF HEALTH

# Aged Care Planning Group REPORT

(DRAFT)

## FORWARD

The Aged Care Work Group has pleasure in presenting this Report. It has been a challenging time of the year to produce this work and I am very grateful for the excellent support I have had from the Group.

I would particularly wish to express thanks for the assistance provided by Gail Milner, Jamil Khan and Peter Goldswain from the Aged Care Policy Directorate in the preparation of the document, and Leon Flicker for assistance with the calculations and tables.

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## TABLE OF CONTENTS

**INTRODUCTION** .......... **2**

**DEMAND PROJECTIONS** .......... **2**

1 DO THE DEMAND PROJECTIONS IN THE CSF FIT WITH YOUR UNDERSTANDING OF YOUR SPECIALTY'S FUTURE MORBIDITY /MORTALITY TRENDS? AND IF NOT, WHY NOT? .......... 2

**INPATIENT CARE** .......... **1**

2 WHAT CONDITIONS, CURRENTLY TREATED BY YOUR SPECIALTY AS INPATIENTS, COULD HAVE BEEN PREVENTED BY TIMELY AND EFFECTIVE CARE? .......... 1

3 HOW SHOULD PATIENTS WHO HAVE DISEASES OR CO-MORBIDITIES THAT EXTEND BEYOND ANY ONE SPECIALIST MEDICAL GROUP BE BEST CARED FOR? .......... 1

4 WHAT WOULD YOUR SPECIALITY NEED TO DO DIFFERENTLY TO REDUCE TOTAL BED DEMAND BY 30%, WHILST MAINTAINING/IMPROVING PATIENT OUTCOMES? .......... 2

**NON-INPATIENT CARE** .......... **4**

5 FOR PATIENTS IN YOUR SPECIALTY WITH CHRONIC CONDITIONS, HOW MANY HAVE EASY ACCESS TO .......... 4

6 WHAT NEEDS TO BE PUT IN PLACE TO ALLOW 20% OF YOUR SPECIALTY'S CURRENT INPATIENTS TO BE CARED FOR IN OTHER ENVIRONMENTS E.G. DAY HOSPITAL, OUTPATIENTS, COMMUNITY, STEP DOWN FACILITIES? .......... 4

**CLINICAL LINKAGES** .......... **6**

7 WHAT RELATIONSHIPS DOES YOUR SPECIALITY HAVE WITH OTHER SPECIALITIES OR SERVICES THAT THE ARCHITECTS NEED TO BE MINDFUL OF, WHEN DESIGNING NEW/REFURBISHED HOSPITALS INCLUDING THOSE WHERE IT MAKES CLINICAL OR ECONOMIC SENSE TO CO-LOCATE TOGETHER? .......... 6

**WORKFORCE** .......... **7**

8 WITH THE KNOWLEDGE THAT THE HEALTH WORKFORCE IS PREDICTED TO DIMINISH IN THE FUTURE, HOW COULD .......... 7

9 WHAT WOULD YOU CHANGE TO MAKE TO THE WA HEALTH SYSTEM SAFER AND TO HELP RETAIN EXISTING STAFF? .......... 8

**TECHNOLOGY/INNOVATION** .......... **9**

10 WHAT CHANGES IN THE WAY THAT CLINICAL INFORMATION IS CAPTURED AND EXCHANGED BETWEEN CLINICIANS CAN YOU SEE WORKING FOR YOUR CLINICAL SPECIALTY? .. 9

11 WHAT CHANGES TO THE WAY THAT CLINICAL DECISION SUPPORT EG CLINICAL GUIDELINES, ARE USED IN THE COURSE OF YOUR EVERYDAY WORK WOULD IMPROVE THE RELIABILITY, SAFETY & APPROPRIATENESS OF CLINICAL CARE. .......... 9

12 WHAT MEDICAL EQUIPMENT OR TECHNOLOGY WILL BE IMPORTANT TO THE WAY YOU PRACTICE IN 10 YEARS TIME. .......... 10

13 WHAT EXPERIENCE HAVE YOU HAD IN OTHER HEALTH SYSTEMS THAT SHOULD BE IMPORTED INTO WA? .......... 11

14 FOR YOUR SPECIALTY, WHAT COMMON CONDITIONS SHOULD HAVE A MORE AGGRESSIVE PREVENTION STRATEGY IMPLEMENTED. DO YOU HAVE SUGGESTIONS FOR DOING THIS? 11

**TEACHING/RESEARCH** .......... **12**

15 GIVEN THE ANSWERS ABOVE, HOW DO WE ENSURE THAT TEACHING AND RESEARCH STILL HAVE THEIR APPROPRIATE PRIORITY? .......... 12

**OTHER** .......... **13**

16 ANY OTHER ADDITIONAL KEY CLINICAL PLANNING ISSUES RELEVANT TO YOUR SPECIALTY. .......... 13

**ATTACHMENTS** .......... **21**

## INTRODUCTION

Two important demographic trends drive the overwhelming and urgent need to adequately plan for a range of services for the aged population cohort. Firstly, older people in WA are an increasing proportion of the WA population. Secondly the population over 65 in the period 2001 to 2044-45 will double.

By contrast the population share of the oldest old (over 85) – the group for whom the health and aged care costs are the highest, will increase by 65% in the similar period[1].

These demographic trends are set against a backdrop in which the clinical care needs of the aged population cohort is often complex, the delivery of care often occurring across a range of different care settings with the transition between the different settings confusing and uncoordinated for many consumers. This situation is further complicated by the involvement of different levels of government with different funding responsibilities, the residential aged care sector, the primary care sector and the community care sector.

Hence we have first attempted to respond to the planning questions asked of this group and then have continued to add additional information, proposals to ensure that the best interests of patients of aged care services are preserved.

## DEMAND PROJECTIONS

***1 Do the demand projections in the CSF fit with your understanding of your specialty's future morbidity /mortality trends? And if not, why not?***

The Hardes demand model whilst robust has focused entirely on the acute care area.

For a service of last resort needs based modelling is far more appropriate. The tables presented in this paper are based on ACAT area based projections. See Table 1 (appendix)

The 2006-2015 modelling work would benefit from a more sophisticated epidemiological analysis that captures incidence/prevalence data and also link up with burden of disease analysis for those conditions that impact on the older population e.g. COPD, Continence, Falls, DM, CHF etc. We have only been able to do this in the most superficial terms in regards to stroke and fractured hip patients.

In ambulatory care, with increasing co-morbidities, the community services will come under increasing pressures to cope with the range of illnesses and their adequate support.

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[1] Productivity Commission Research Report Overview (2005), Economic Implications of an Ageing Australia"; Australian Government,

The SNAP (smoking, nutrition, alcohol and physical activity) primary health initiatives will impact on the demand projections of the Hardes model and therefore need to be factored into any medium to long-term demand modelling as well.

For complex care needs being managed at home and for those in low level residential care where there is ageing in place, hospital admission during periods of acute illness may be required.

Therefore not only are numbers of the aged in the population increasing but their care needs are also becoming more and more complex. There are increasing expectations by patients and their families for high quality interventions, including Multi Disciplinary Team (MDT) rehabilitation principles in the acute setting.

## INPATIENT CARE

***2 What conditions, currently treated by your specialty as inpatients, could have been prevented by timely and effective care?***

The impact of primary and secondary preventative care on life-style related degenerative conditions are well known. While these strategies help reduce the burden of disease in all categories of clinical care, it has a particular significance for those conditions which form the bulk of clinical work for Aged Care sector.

In particular the following conditions are identified as of prime importance for any long-term preventative care planning, which would have a positive impact in reducing the hospital demand for Aged Care services.

Falls and consequent injuries; Osteoporosis management

Incontinence Management
Dementia
Palliative Care
Adverse drug events
COPD
Parkinson’s Disease
Diabetes and complications
Chronic Pain
Stroke
Pressure Ulcer Management
Depression
Congestive Heart Failure

## INPATIENT CARE

***3 How should patients who have diseases or co-morbidities that extend beyond any one specialist medical group be best cared for?***

The desired outcome of intervention for all patients is the ability to function at the best possible level, physically, mentally and socially.

Many health professionals working in acute hospitals continue to be concerned by ‘ageism’, the view held by many that old people do not need or have the right to be in hospital, especially tertiary hospitals. Unfortunately over the years there appears to have been no real attempt to change this attitude. The availability of MDT functional recovery orientated care and early access to rehabilitation and post – acute care will reduce the sense of professional disempowerment that fosters ageism.

Aged Care is oriented to provide specialised clinical care to older patients across different clinical disciplines. Hence, the crossing over of boundaries of clinical care between different clinical groupings is to be expected. It is therefore considered that such care can be offered by a generalist physician (Geriatrician) with support from a multidisciplinary team. Patients of this age need to be under Geriatricians, as they better manage the “whole person”. Input from other specialists would remain on a consultative basis

With “Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings” about to be rolled out across metropolitan hospitals, there will be a wider emphasis on function and after care for the aged.

In essence a client centric multi disciplinary approach needs to be further strengthened across the continuum of care that is evidenced by coordination and collaboration. This partnership approach across disciplines in primary, secondary and tertiary care will ensure the best possible clinical outcomes for clients with co-morbidities.

Psychogeriatric services have a target population that overlaps with aged care. Issues relating to old aged psychiatry are included in a paper developed by Older Mental Health Services at the request of this planning group and contains strategies which will need to be further developed at the service level. The paper is attached as Attachment A.

Increasingly the ambulatory care model should form the basis of future aged care services with the hospital being for acute episodes of care. (See section 6).

### *4 What would your speciality need to do differently to reduce total bed demand by 30%, whilst maintaining/improving patient outcomes?*

The need to reduce the bed demand by 30% will be counterbalanced by an expected increased demand due to the ageing of the population, which has not been previously encountered in Australia. In a comprehensive review of bed based services within Australia, it was noted that over the last 10 years there had been a 10% reduction in acute beds, with a modest increase in beds for aged care services (Dorevitch & Gray 2000). In the case of Aged Care, this expected increase in demand is particularly significant as it is linked with the increase in the population of the aged and an expected reduction in the

availability of the workforce across the board in the health sector of WA.

With the demand for aged care beds, demand management will become critically important for Aged Care.

The drivers for the increase in the demand will be multifactoral; therefore its management strategies will also need to be multifactoral.

A number of strategies will need to be employed to work towards the goal of managing a reduction in provision of beds to population (see table under section 1), which will still require a net increase in bed stock.

In this regard, the prevention strategies discussed earlier will play a critical role in reducing the demand. Some of the innovative models of care, which have already been tested in WA and found, to be efficient and effective will need to be scaled up for statewide implementation.

- Geriatrics Evaluation and Management Unit (Attachment B)
- Step-down care i.e. Subacute Geriatrics Medical Care
- RADAR (Attachment C)
- RAILS (Rehabilitation Acute Intervention & Liaison Services) (Attachment D)
- Use of HITH/RITH (Attachment E)
- Supervised Care Unit (Attachment F)
- Care awaiting placement units
- TCS/ICS Transitional/Intermittent Care Services
- Post-acute Home Care Packages (HCPs); Personal Enablement Packages (PEP)
- Home and Community Care (HACC)

Further to the above-mentioned models there is potential for "process re-engineering" within existing models.

- Aged Care Services Emergency Teams (ASET): Multidisciplinary care coordination teams situated in the Emergency Departments, aiming to facilitate early safe supported discharge of its target population (Attachment G)

- Access to 7 day a week Community Services:

- Geriatric Review of 70 plus In Patients: It may help if frail patients 70 years or above, who have been in hospital over a certain period, particularly in Surgical wards, should be reviewed by Geriatric Services which would expand Geriatrics role as a 'consultation-liaison' service rather than just an acute, GEM or rehab service. This model has been successfully trialled in SPC. This is also evident in the success of the orthopaedic/geriatric liaison service previously trialed at SCGH.

- Rural Health Liaison: Possibilities exist for creating rural geriatric units in the major centres eg Bunbury, perhaps coupled with a

rehabilitation role. The use of Telehealth to create a link between rural an Urban centres would continue to be fostered.

- In Geriatrics/rehabilitative units the preponderance of medical problems in contrast to the patients rehabilitative potential should be reflected in NHPPD (Nurse Hours per Patient Day).

- We recognise that acute in-patient geriatric care by General Physicians will need increasing supplementation by geriatricians in future years. Given the mean age of General Medical in-patients. This reflects population aging and differential success in recruitment rates by the respective specialities.

## NON-INPATIENT CARE

***5 For patients in your specialty with chronic conditions, how many have easy access to***

***a) Best practice guidelines?***

***b) Regular follow up and monitoring/ case management?***

***c) Early medical intervention as required?***

***d) Patient education and empowerment?***

*There are:*

- Nationally agreed Age-friendly principles and practices that assist in managing older people in the health service environment

- Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings.

- Best practice guidelines for assessing older people in hospitals.

- Best practice guideline for assessing people in non-acute and community settings.

The best practice guidelines are available and are mostly accessible to the workers in Aged Care. In particular the guidelines for Falls, Memory, Continence and Delirium are easily accessible. There are also best practice guidelines for those patients referred to the Aged Care Assessment Team.

Patients have access to day hospital at restorative units and the majority of them have access to follow up care however there are many barriers to this access.

***6 What needs to be put in place to allow 20% of your specialty's current inpatients to be cared for in other environments e.g. day hospital, outpatients, community, step down facilities?***

It is anticipated that Ambulatory Services will reduce demand for inpatient beds. Care packages may also allow greater numbers to be

cared for in the community. Better partnerships with primary care may ensure that more patients could be managed in primary care.

The CSF planning principles include the following:

- Primary and Community Care Services strategies shall complement and, where necessary, integrate with Hospital Emergency and Ambulatory Care functions to avoid unnecessary hospital admissions.

- Health care shall be provided in the most appropriate setting.

- New models of care are to be developed using an evidence-based and patient-centric approach.

Working Group submissions have been productive and mostly related to existing models of care in regard to: acute, GEM, RADAR, consultative service and potentially, consult/liaison role at tertiary level, and (acute), restorative unit, day hospital, specialty clinic, consulting and home visiting at secondary level. All articulating with primary care.

The ACAT spans these 3 domains of tertiary, secondary and community and the whole of Aged Care articulates with transitional care, intermittent care, care awaiting placement and residential care.

The guiding principles strongly advocate models of care that mitigate demand at the level of tertiary and, to a lesser extent, secondary care by delivering services through the community and primary care.

A response to this is the proposal to establish Chronic Disease Management Teams (4 North, 4 South). These will have allied health support.

**PROPOSAL: NEW MODEL OF CARE**

Geriatric Medicine is likely to be able to contribute significantly to care at a level between hospital (secondary and tertiary care) and primary care through involvement in centres populated by Geriatricians (with Registrar support) and sub-specialists together with allied health support, including Rapid Access Teams of Allied Health Staff who would have parallel links with proposed primary care-based Nurse Outreach to the community. This nursing function is to fill a current gap in Primary Care, which is seen to lack responsiveness to urgent community needs.

These new Clinic models would receive referrals from Co-ordinated Care Teams (CCTs) [yet to be established] in the Emergency Departments as well as from primary care and direct community referral. The latter might be triaged through St John's Ambulance by redirection to this new model of care as well as Health Call Line redirection to new model of care such that there would be down-stream referral from Emergency Departments and up-stream referral from primary care and the community.

The new model of care would articulate with ACAT's at a district level as well as with conventional Geriatric Centres with their spectrum of care services available i.e. Subacute beds, assessment and restorative beds, day hospital and access to ACAT coordinated community care services.

The new model of care, in addition to being appropriately populated with specialist medical and allied health staff, would benefit from primary care doctors sharing time in these settings and possibly other services, such as Palliative Care. This New Model of Care would be part of the extra-mural or virtual hospital and require adaquate clerical, ICT, facility and transport arrangements to be effective. Commissioning would be stepwise on local area trial basis. These services will be linked or integrated into Chronic Disease Management Teams (CDMTs)

These services should operate seven days per week during office hours and complement GP after-hours as well as Emergency Department programs.

On the other hand, a number of best practice models have been developed for aged people. Implementing these best pratice models and guidelines will also help in reducing the pressures on the acute sector. Some of these innovations include supporting and implementing the nurse practitioner role in both community and hospital based aged care settings; developing allied health support roles in providing care to the low complexity clients in an ambulatory settings, will help open up day-hospitals and multi-day units for high complexity acutely ill patient care.

## CLINICAL LINKAGES

***7 What relationships does your speciality have with other specialities or services that the architects need to be mindful of, when designing new/refurbished hospitals including those where it makes clinical or economic sense to co-locate together?***

It is the view of this group that Geriatric Medicine should consider collocation with

- Some stroke services (see Model of Stroke Care for Western Australia-Feb 2006)
- Orthogeriatrics and orthopaedics, and Psychogeriatrics. The working group requested inputs from psychogariatric psychiatry and their suggestions are included in the Attachment A).

Additionally, easy access to procedural, cardiology and radiological investigations are required. There is a need for a specially designed physiotherapy department for aged care within the unit area

Space is the most important thing for aged persons. While designing the hospital facilities it is important to keep in view that need for spacious bathrooms for hoists, shower beds and turning room for

people with aids such as pulpit frames and Zimmer frames. The space designing should also try and create an environment that encourages wellness rather than dwelling on sickness. Using the principles of a therapeutic environment would be advantageous.

As a general principle of facility planning, all bed/wards should be age friendly which means that there should be an added a focus on view to outside, extra wide door and toilet entrances, hoist tracks from the roof, hand holds, toilets close / in room, uncluttered corridors, adequate lighting, ventilation, noise control, quiet areas with room to walk, movement detectors for lights to come on at night etc.

Use of modern technology should be actively pursued so that less labour intensive technologies can be developed and deployed in facilities being built for the use of aged patients.

The GEM and Supervised Care Units should be included within acute hospitals, and should be located near the acute care wards the Geriatricians manage. It would also be helpful to be near the physiotherapy and occupational therapy treatment areas. agree

## WORKFORCE

***8 With the knowledge that the health workforce is predicted to diminish in the future, how could***

- **Your role be done differently**
- **Some of your work be done in a different setting**
- **Elements of your role be done by another Health Care Worker while still achieving best clinical outcomes, efficiency and safety?**

Role of aged care practitioners needs to be developed. In this regard there should be efforts to re-distribute clinical roles and functions to workers best suited for such jobs. In particular one could look at an enhanced role for Nurse Practitioners within aged care to enhance and coordinate the clients care. There are precedents and models of care involving rehabilitation, continence, diabetes, COPD and CHF, which could all contribute with, focus on community care. This model could also support the residential sector and rural and remote care.

In addition to the above, increased use of acute and sub acute ambulatory care will also help in better demand management of Aged Care pressures on the acute sector. Newer less labour intensive models may be explored either in the Eastern States or internationally for introducing in WA.

Multidimensional Clinical Assessment Protocols for use by Aged Care workers are required that can add confidence to standardised quality assessment work. These will add efficiency to case finding for more complex cases requiring geriatrician evaluation.

Hospitals should consider recruitment of staff whilst still at University to assist in their education and training to meet their specific demands similar to private sector Apprenticeships. This may assist in staff recruitment and retention.

**_9 What would you change to make to the WA health system safer and to help retain existing staff?_**

The group recommends the following interventions and strategies, which could help make the WA health system safer as well as retain existing staff:

- Encourage more systematic support of audit of clinical and service performance by funding appropriately trained personnel in database utilisation and reporting through clinical departments.

- Optimise access to professional development including opportunities to seek experience by attendance at distant meetings, coursework and achievement of higher degree from workplace.

- Seek to reward achievements including performance targets. Investigate workforce expectations on types of incentives and rewards considered desirable.

- Increase capacity to cope with bottlenecks and areas where unsafe practise is a potential hazard e.g. ED, Mental Health

- Appropriate utilization of staff will increase the health professionals capacity to perform high-level tasks and will promote job satisfaction. Management support and a cultural change in 'young' health professionals require a demonstrated application of existing flexible employment provisions

- Appropriate staffing ratios for allied health on wards and staff outpatient services need to be achieved and maintained. This will improve patient outcomes, improve safety for both patients and staff, and decrease staff stress. Early functional recovery makes for earlier discharge and reduces readmission rates.

- Equity across health services in relation to professional classifications: Enhanced criteria progression for rehabilitation workers would improve attraction and retention through an improved Career structure for Allied Health staff.

- Expansion of academic aged care in particular clinical lecturers would assist with the education and increase support to our students and also to the post-graduates, thus investing in future care of the ageing population

## TECHNOLOGY/INNOVATION

***10 What changes in the way that clinical information is captured and exchanged between clinicians can you see working for your clinical specialty?***

The group recommends the following suggestions with regards to technology and innovation in capturing and exchanging clinical information between clinicians:

- Allied Health and medical staff are spending more time in the community therefore any new portable digital technology which can provide easy access to medical records, information, statistics, data, assessment information and intervention plans, would assist with better time management and therefore would increase clinical contact time of therapists.

- Hospitals need to automate medication charts thereby creating links between pharmacy, doctor and the nurses, which would potentially reduce risk of errors. Legibility issues would not exist and on discharge there will be a link up with the pharmacy and printed "medi-pal" for the patients.

- Central Databases in Aged Care should be used to collect and store clinical information on patients, which is then accessible to all staff involved with providing care within the current or future episodes of care. Implementation of encryption software to free up electronic exchange of clinical material; between hospitals and community providers.

***11 What changes to the way that clinical decision support eg clinical guidelines, are used in the course of your everyday work would improve the reliability, safety & appropriateness of clinical care.***

Although clinical pathways are useful in many subspecialties of internal medicine, the patients treated by geriatric medicine have multiple complex chronic diseases, with concomitant disabilities and frequently interfering adversely with their environmental milieu. For these reasons, clinical pathways have limited utility. Fortunately, clinical guidelines immediately applicable to the Australian context have been published and are freely available on the Australian Society for Geriatric Medicine website, http://www.asgm.org.au

Similarly the Australian Health Ministers Advisory Committee, Committee of Older Australians Working Group have published several guidelines of best practice and can be accessed at www.health.vic.gov.au/acute-agedcare & www.health.gov.au/minconf.htm

The only major impediment for implementing these guidelines are a lack of a stable planning infrastructure, to embrace these clinical improvements, particularly in regards to the acute hospital system.

Staff need to be adequately and regularly trained in the use of clinical guidelines and the training should be competency based.

The development of some clinical pathways are appropriate in aged care, such as delirium management, memory assessment, orthogeriatric and osteoporotic care, and Parkinson's disease. The ability to have IT support and clerical support to coordinate and role these out for all of our staff and junior staff in a timely fashion and to educate and train them would help, as staff turnover is moderately high within aged care.

This is particularly relevant in the case of all clinical staff when it is quite time consuming to re-train and educate staff every two years. This is another aspect of IT support or at least increased staff including academic staff that would assist in this process.

***12 What medical equipment or technology will be important to the way you practice in 10 years time.***

While state of the art for technology is in a continuous flux, it is hard to predict the type of equipment and technology, which will be needed in the next ten years. Having said this, based on the current trends it is fare to assume that the bulk of such technology and equipment needs will revolve round patient equipment as well as Information and Communication Technologies (ICT).

Higher dependency patients e.g. over 65 year olds with neurological conditions, or multiple diagnoses, require increasingly complex and expensive technical equipment. The communities' expectations of this patient equipment are also steadily increasing. Some of the examples of such equipment include; powered wheelchairs with increased technological options, postural seating systems, pressure care equipment, home modifications, communication devices, etc.

There is also a need for increased use of electrical beds and an increased use of safety devices to prevent patient injury e.g. sensor pads to alert staff to patient movement for patients at risk of falls, to decrease physical load of nurses. Improved availability of pressure management equipment will also further improve efficiency and quality of care in our hospitals.

Greater access to technical services such as 24 hour ambulatory BP monitoring and holter monitoring is required. Improved access to urology services urodynamics and continence assessment will improve best practice out comes in incontinence care.

Fully resourced Gait and motion laboratory –one is needed for the State. Current gait equipment and facilities need urgent upgrading and staff resources as per estimates dating back to 2000. It is important that increasingly complex and expensive assistive technology is subject to objective evaluation if demand is to be metered and costs are to be constrained while not denying the advantages of the technology where it is of tangible benefit.

The current gait facility requires upgrading and resourcing. Its inclusion in planning will ensure that the adult rehabilitation program (at State Tertiary Service level in WA) is brought up to reasonable peer standard in keeping with paediatric facilities used by RCH (Vic) and PMH and adult services at Centres like the Austin Hospital (Royal Talbot Rehab. Centre) and Monash Medical Centres in Melbourne. This is provided so that close links are maintained with physiotherapy, technicians and surgeons.

The tertiary hospitals have easy access to video and clinical photography. The peripheral hospitals that will be managing the vast majority of rehabilitation and stroke disease and Parkinson's disease need this for documentation and monitoring.

Medical illustrations (video and clinical photography) should be made available to both the tertiary and secondary hospitals.

***13 What experience have you had in other health systems that should be imported into WA?***

The major problem facing the health system in WA, is the lack of clinician involvement in resource management. Recent initiative to set up clinical network for aged care has the potential to provide a forum and opportunity for an increased engagement of clinicians and other stakeholders in the aged care planning and provision process.

In the UK, there was an emphasis on allied health practitioners working in primary care. For example, Government funded Physiotherapists were collocated with GPs, in the community which decreased barriers for clients attending therapy, and improved the coordination of care between the therapist and GP.

Additionally, the ability for aged care departments to hold significant funding that allows the purchase and maintenance of community support services for the frail and elderly should be allowed for 6-12 weeks that would allow the transition to more generic services subsequently. At the moment we hold no dollars of great significance and we therefore struggle when there is no community package or EACH package or other services available for support until a period of time has passed.

Ability to pool funds within an Area Health Service to enable old aged people to remain at homes until a suitable care package becomes available will facilitate efficient delivery of aged care services.

***14 For your specialty, what common conditions should have a more aggressive prevention strategy implemented. Do you have suggestions for doing this?***

Public health messages regarding vascular disease reduction and prevention strategies need constant renewal and projection so that younger people see them as they now see seat belt use. Falls risk prevention allied to osteoporosis education and risk reduction require

renewal and repetition. Primary and secondary prevention and reduction of disease progression require enhancement of primary care. This will require innovative recruitment of nurse and generic workers to support the programs including through outreach from primary care centres. These strategies would link with ambulatory care centres and special access high-risk clinics as a spectrum of risk and demand management actions. (See section 6).

## TEACHING/RESEARCH

### *15 Given the answers above, how do we ensure that teaching and research still have their appropriate priority?*

The lack of investment in teaching and research, is shortsighted, and will contribute to future workforce issues and impede the translation of research into best practice. There is a need to plan and resource teaching and research as well as clinical services. There is a requirement for this to be an active issue now. The major requirement in workforce for an ageing population will occur in 10 years, which gives an adequate period of preparation.

The State of Western Australia is responsible for much more research output than would be expected for its population base. This is heavily dependent on just a few individuals and thus is fragile. The current competitive advantage that key researchers in WA have developed could be lost in just a couple of years. This research foundation needs building up for the future years.

Hospitals in particular could tailor training programs for staff in which there are perceive gaps in delivery. This would ensure that staff can be trained in the areas most relevant for service providers such as gap areas or where staffing levels are deficient. This has particular relevance to clinical services guidelines as students would have exposure to this from much earlier within their clinical training.

If we do not have appropriate clinical teaching, audits and access to research, then the ability to attract bright young minds into aged care and other areas will plummet. This is not only in the medical field, but in our multidisciplinary teams, the educational approach to our nursing staff and allied health is extremely important in increasing enthusiasm and hence support within the multidisciplinary team. Most services have combined meetings involving allied health, nursing and medical staff in co-education and such things as journal clubs and meetings across town, such as Parkinson's disease and stroke, which have been valuable in increasing enthusiasm and support. Allied Health and Nursing should have quarantined time for teaching, research and education, with opportunities for presentations/meetings, as well as involvement in under- and post-graduate activities. Some of these should involve the professions in the Residential Care field

Additional on site training programs should be expanded in areas such as Hostels and Nursing Homes, which may also assist in, improved care levels within these institutions as residents have access to greater

staff input. This may be particularly relevant in areas of Nursing and Allied Health.

In this regard some innovative suggestions could include:

- Student placement units, which are co-funded by universities, with remuneration for supervisors/tutors and academic staff
- Health Graduate Programs, Health Service University Scholarships with subsequent bonded employment

## OTHER

### *16 Any other additional key clinical planning issues relevant to your specialty.*

A clinical issue raised not infrequently concerns the difficulties experienced in response to requests for assistance in dealing with discharge planning for persons not appropriate for care in Aged Care facilities. This maybe because of difficulties at the interface with Disability Service Commission responsibility, or because of behavioural or technical support concerns that preclude acceptance by Aged Care facilities. The absolute number of such cases is small, but their requirement for bed days in the hospital system escalates rapidly.

More flexible programs are required to replace those that previously operated through the old state Government Nursing Home sector. The model of care involving additional funding through expressions of interest in targeted areas is worthy of development.

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The following is reproduced from an earlier report prepared in response to a clinical service planning exercise carried out last year. While some aspects of this report may duplicate with answers to some of the above planning questions, the group has retained the report in its entirety to maintain its cohesion.

The group feels that this report can provide additional information regarding issues that are of interest for aged care service planning in WA.

### *16.1 Types of service delivery models that are appropriate for the aged population target group.*

**Modern aged care services use an integrated model over diverse settings, seeking to provide seamless transitions across the care continuum. These services are an essential part of clinical services**

The previous outdated compartmentalised model produced substandard outcomes and inefficient services. It is important that appropriate services are available in a timely fashion, wherever an older person accesses services. Abundant evidence exists that any delay in provision of such services not only causes immediate inappropriate consumption of resources but in fact increases the time required for resolution of the underlying problem once appropriate services are instituted. Thus access to service must occur in both tertiary and secondary acute hospital settings, subacute hospital settings, community rehabilitation services such as day hospitals and community liaison services, especially those that work at the interface with Commonwealth services. In addition to these generalist services, there are subspecialty models within geriatric services that are gaining increasing dominance. These include Memory, Parkinson's, Falls and continence services. Geriatric Services have a major role to play in both Stroke and Orthogeriatric rehabilitation and the decentralisation of these services are specifically referred to in the Rehabilitation Plan. It is thus central that the role differentiation of tertiary and secondary public hospitals for the delivery of aged care services should be given detailed consideration, particularly given the emphasis on the increased role of secondary hospitals in the CSP. Specific planning targets are needed for the milestones of 2011 and 2021. In this section we have provided such targets.

### *16.2 Position of Aged Care Services*

Although the Services are based around population groupings, aged care medicine involves clinical services for individuals, not groups of people. Each individual requires treatment for their individual circumstances based on their disease entities, and their concomitant disability and the impact that this results on their lives. For this reason, aged care medicine has to be administered as part of Clinical Services and not Population Health.

### *16.3 Role of the Australian Government*

The Clinical Services Plan must be cognisant of the major population planning role played by the Australian Government in terms of allocation of funding for Aged Care Assessment Teams (ACAT's), their locations and functions and the impending ACAT reforms in relation to comprehensive assessment of older people.

### *16.4 Interface issues at transition points across the continuum of care that impact on the care needs of the consumer.*

Care Awaiting Placement Programs and Transitional Care Programs have successfully improved the interface between different sectors in the care continuum for some clients and are an important part of integrated aged care services. These types of facilities need to be expanded and promoted in the future with strategies to reduce financial barriers to access to these services by the target population.

While issues such as care coordination at the interface between different care settings, patient assessment practices, information recording and management may not fall within the strict definition of clinical service planning for older people, these issues have been shown to have an impact either directly or indirectly on overall lengths of stay in acute public hospitals, readmission rates, emergency department presentations and most importantly, the quality of care for the older person.

### *16.5 Aged Care Workforce Planning*

Planning to ensure an adequate workforce should begin immediately and focus on long term strategic workforce development that targets the community care and residential care sector workforce, the public hospital workforce involving carers, nurses, allied health workers and medical practitioners.

The most critical single issue facing the aged care sector is that of its workforce. This spans the spectrum from initial training and education, attraction, retention and planning across the continuum of care. Staff shortages are particularly acute in the allied health and nursing professions. In addition to the difficulty recruiting adequate numbers of staff, clinical leaders in allied health and nursing frequently describe challenges in attracting and retaining of experienced staff.

There are many factors relevant to the medical workforce, which need careful consideration in formulation of the final Clinical Services Plan. Specialist medical training is subject to the requirements of The Royal Colleges, which require an adequate breadth and depth of training and will mandate well resourced learning environments prior to granting accreditation. Recently Western Australia has been successful in attracting and retaining a disproportionately large number of Advanced Trainees in Geriatric Medicine. This is a result of a dynamic training programme led by a group of enthusiastic and supportive Senior Geriatricians, major research opportunities at all training sites and innovative approaches to supporting trainees. The adequacy of the Consultant Physician workforce is one of the strengths of Geriatric Medicine in Western Australia and it is vital that full utilisation of young specialists is enabled during the reform process, to prevent ‘brain drain’ internationally and to the other states. There has been increasing demand for geriatricians to have greater responsibilities for liaison activities and acute medicine for older people, and this has increased the need for an expanded medical workforce.

### *16.6 Role of supporting services*

**The importance of supporting services cannot be ignored, in particular psychogeriatric and orthopaedic services.**

If aged care services are to provide post-acute care in hospitals, as the CSP envisages i.e. Fremantle, Osborne Park and Bentley which currently have very limited supporting services, then provision must be

made for ease of access by these hospitals, as well as adequate resourcing of these sub-specialties.

### *16.7 Access to acute care by Rehabilitation services*

**Specialised acute aged care is an essential component of holistic aged care, maximizing efficiencies in multidisciplinary care of the acutely unwell older person, avoiding iatrogenic harm, and facilitating linkages to other care services. Acute care services include inpatient services as well as domiciliary services.**

The Clinical Services Framework definition of Rehabilitation Services indicates that a Level 6 hospital is defined as having 'access to acute care'. We believe that this should be interpreted as having acute medical care beds for the elderly under a geriatrician similar to that currently operating at Royal Perth Hospital, and with the ability to admit and assess patients directly from Emergency Department. This will be in addition to providing a Geriatric Evaluation and Management Unit at the designated Level 6 hospitals.

### *16.8 Services for the Aged Population*

**The Australian Government also provides major resources in Residential Care Services as well as Transitional Care Services. Increasingly the complex medical care for this extremely frail population is requiring better coordination and specialist support. Although primarily a responsibility of general practice specialist expertise is increasingly required to support this system.**

It is also important to plan for the types of services that are required by that segment of the older population cohort which do not necessarily relate to the ageing process but simply require the management of particular chronic conditions.

### *16.9 Healthy Ageing*

**Preventative and health promotion based planning approaches are required within the Clinical Services Plan at the Area Health Service level to promote healthy ageing across the older population cohort in WA.**

In conclusion, there is a need to advocate for a collaborative and inclusive planning approach that would assist in addressing the range of issues outlined above that impact on the delivery of aged care services in Western Australia.

### *16.10 Indicative Bed Numbers*

In planning service units of the future we have concentrated on the bed stock as this will form the building blocks of such services and has the longest lead time before implementation. This is not meant to diminish the importance of specific ambulatory care services such as Day Hospital, Specialty Clinics, decentralised outpatient stroke and

orthogeriatric rehabilitation etc. Rather these inpatient units will provide a resource for the development of such outpatient services. The development of such bed-based services will have major regional geriatric team implications eg the Rockingham unit may require a specific ACAT. The population projections in Table 1 are based on the current ACATs. In no region does the population actually diminish. Thus we are providing evidence for planning growth across the regions. The bed numbers for stroke services are based on the Stroke planning working party, and the disparate numbers refer to both comprehensive stroke units and rehabilitation units.

Although largely based on the population projections some other factors were also taken into account. Eg the suggested growth at Mercy Hospital was partly to offset the disappearance of RPH. The creation of a separate Rockingham unit and expansion of the Peel Unit will be a priority in the near future. Rural issues have not been discussed but the case for separate units for Bunbury, Geraldton and possibly Northam is compelling.

## Table 1 Projected Populations Over the Age of 70 years Based on ACAT Regions

| *Metropolitan* | 2003/04 | 2006 | 2011 | 2016 | 2021 |
|---|---|---|---|---|---|
| SCGH | 19,899 | 19,856 | 21,373 | 24,076 | 29,158 |
| RPH | 12,568 | 12,952 | 13,994 | 15,578 | 18,563 |
| FH | 18,538 | 19,598 | 21,900 | 25,468 | 31,872 |
| OPH | 20,129 | 22,995 | 29,293 | 37,915 | 51,332 |
| Bentley | 22,186 | 22,763 | 25,230 | 29,620 | 37,300 |
| Armadale/Kelmscott | 6,192 | 7,033 | 8,847 | 11,225 | 14,740 |
| Swan | 11,625 | 13,455 | 17,093 | 21,954 | 28,869 |
| Sub-Total | 111,136 | 118,652 | 137,732 | 165,836 | 211,833 |
| | | | | | |
| *Country* | | | | | |
| Mandurah | 14,723 | 17,172 | 22,098 | 27,637 | 35,173 |
| Bunbury | 11,080 | 12,114 | 14,456 | 17,659 | 22,700 |
| Albany | 5,216 | 5,724 | 6,646 | 7,789 | 9,481 |
| Narrogin | 1,569 | 1,554 | 1,702 | 1,919 | 2,340 |
| Kalgoorlie | 2,344 | 2,637 | 3,233 | 4,010 | 5,218 |
| Northam | 4,080 | 4,473 | 5,238 | 6,151 | 7,525 |
| Geraldton | 4,353 | 4,996 | 6,010 | 7,109 | 8,689 |
| Kimberley | 947 | 1,151 | 1,533 | 2,092 | 3,007 |
| Pilbara | 565 | 669 | 960 | 1,341 | 1,956 |
| Sub-Total | 44,878 | 50,490 | 61,877 | 75,706 | 96,089 |
| | | | | | |
| Total State | 156,014 | 169,142 | 199,609 | 241,542 | 307,922 |

**TABLE 2 -** Aged Care Bed requirement predictions for 2011 and 2021

| | 2006 | | | 2011 | | | | | 2021 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Res | GEM | Acute | Res | GEM | Stoke | Ortho | Acute | Res | GEM | Stroke | Ortho | *Acute* |
| **Joondalup** | 24 | | | 24 | 12 | 15 | | 10 | 36 | 12 | 15 | 15 | 20 |
| **OPH** | 50 | 34 | | 60 | | 30 | 30 | | 60 | | 30 | 30 | |
| **SCGH** | | | | | 30 | | | 20 | | 30 | | | 20 |
| **RPH** | | 17 | 25 | | | | | | | | | | |
| **Mercy** | 24 | | | 24 | | 12 | 12 | | 24 | | 12 | 12 | |
| **Swan** | 24 | | 10 | 24 | 24 | 12 | 10 | 15 | 36 | 24 | 12 | 15 | 15 |
| **Totals** | 114 | 47 | | 132 | 66 | 69 | 52 | 45 | 156 | 66 | 69 | 72 | 55 |
| **Bentley** | 36 | | | 36 | | 15 | 15 | | 48 | | 15 | 20 | |
| **Armadale** | 24 | | | 24 | | | | 10 | 24 | 12 | | 10 | 10 |
| **Fremantle** | 28<br>30<br>(Kall) | | | 36 | | 10 | 15 | | 48 | | 15 | 20 | |
| **Rock** | | | | 24 | | 10 | 10 | | 24 | 12 | 10 | 15 | 10 |
| **Murd** | | | | | 30 | | | 12 | | 30 | | | 20 |
| **Mand** | 12 | | | 24 | | 10 | 10 | | 24 | 12 | 15 | 10 | 10 |
| **Totals** | 130 | | | 144 | 30 | 45 | 50 | 22 | 168 | 66 | 55 | 75 | 50 |
| **Grand Totals** | 244 | 47 | 35 | 276 | 84 | 114 | 102 | 65 | 324 | 132 | 124 | 147 | 105 |

ATTACHMENTS

(ATTACHMENT A)

Draft Report

**Older Adult Mental Health Services**

For the Metropolitan Clinical Services Master Plan

Aged Care and Rehabilitation Services Working Group

13/02/2006

**Compiled by Stephen Fenner (Psychiatrist, Inner City MH service for Older Adults) in consultation with heads of other metropolitan Older Adult MH Services.**

Specialist mental health services for older adults (OAMHS) began in the early 1970s when the UK Department of Health encouraged psychiatrists to collaborate with geriatric physicians and welfare workers, who were already making progress in the previously neglected field of dementia care. A 'comprehensive model' evolved in which specialised centres provided integrated assessment and management of the physical, psychological and social needs of dementia patients and their carers. Participating psychiatrists then widened their brief to include the treatment of older people with functional disorders (depression, anxiety and psychosis). The comprehensive model spread to Australia in the late 70s. In the 1980s The PECUs were built and clinical activities were increasingly extended out from specialised centres into the community. Domiciliary assessments became the norm and multidisciplinary community teams evolved. In the 1990s emphasis was placed on community treatment using the case management model.

Now in Perth, the majority of older people with psychiatric disorders are assessed and treated in their home or in a residential care facility by a multidisciplinary team, headed by a psychiatrist. Usually the team collaborates with the patient's GP and carers. About half the patients treated by OAMH services have dementia complicated by behavioural or psychological symptoms; the remainder have 'functional' psychiatric disorders. Hospital admissions are kept as short as possible by careful planning and frequent clinical reviews. Bed numbers have been reduced and patient turnover has increased substantially. It is worth emphasising that many of the patients managed by OAMH services are so disturbed in their behaviour or mental state that they are at great risk themselves or pose a great risk to others. Such patients cannot be managed by any other service. A proportion of the work of OAMHS is also to respond to urgent referrals from the police, families and residential care staff. Urgent interventions by OAMHS often divert patients away from hospital emergency departments.

The current OAMH service model: intensive, multidisciplinary community case management supplemented with the focussed use of inpatient resources when necessary: has been highly successful in Perth as elsewhere. Good outcomes have helped to overcome the nihilistic attitudes that were once associated with mental health disorders in older people. That in turn has lead to increasing referral rates and productive collaboration with GPs, geriatricians and other care providers.

Notwithstanding the progress made in the past 30 years and the effectiveness of the current service, OAMH clinicians are aware of problems that limit access, prevent

timely intervention and create an unnecessary burden on general hospitals. The recommendations in this report attempt to address these issues so that existing OAMH inpatient resources can be used more efficiently. Secondly there is a need to increase current OHMHS resources in some parts of the metropolitan area to create equitable access. Finally OAMH services require development in order to cope with the ageing and expanding population.

**KEY CONCERNS**

In Perth, the number of acute OAMH beds has been reduced in the past 10 years from 158 to 143, and long-stay psychiatric beds were abolished completely with the closure of Lemnos Hospital in 1998. There was no commensurate increase in community services so this represented a substantial loss of resources to OAMH services. The proliferating private residential care sector was expected to take over the role of accommodating people dementia and severe behavioural and psychological disabilities, but they were only able to do this to a very limited extent. The result has been strain on the remaining OAMH acute inpatient services. Urgent cases frequently wait many days to be admitted. Less urgent cases often cannot be admitted until a crisis occurs. In either case it is likely that the patient will spend unnecessary time in a general hospital emergency department or medical ward prior to OAMHS admission. Patients are then often admitted at some distance from their homes and families because they cannot access local OHMHS beds, losing continuity with their local OAMH community team.

**The difficulty admitting patients has several causes but the most pressing is that we have a major problem discharging patients to the residential care sector.** Patients whose acute treatment is complete and who are awaiting transfer to residential care currently occupy approximately one third of OAMH acute inpatient beds**. This includes patients with minimal or no residual behavioural problems, who will easily be managed in mainstream residential care facilities but are awaiting a vacancy in a facility of their choice. OAMH does not have access to 'care awaiting placement' (CAP) beds and so has no option to accommodate such patients for weeks until they find accommodation. Granting access to CAP beds would greatly assist in relieving congestion in the inpatient units. There is also a group of dementia patients with more severely disturbed behaviour, who are refused accommodation by private sector facilities or consistently fail placements because the mainstream residential facilities have inadequate staffing and training to manage them. These patients currently face very protracted admissions in acute OAMHS facilities, lasting years in some cases.**

In the UK and Victoria, the solution to this latter problem has been to create special residential facilities (sometimes called 'psychogeriatric nursing homes') or small units within mainstream facilities (sometimes called 'high dependency units': HDUs), which have sufficient resources to manage residents with dementia and chronic behavioural disturbances.

In 2002, Southern Cross Aged Care was granted special funding to accommodate patients in HDUs, however the funding provided only 16 places. The turnover in these places has been so slow and access so difficult that the HDUs have had little practical impact on the movement of patients through the acute facilities. Patients must have been deemed 'care awaiting placement' in an acute inpatient facility for twelve months to qualify for the waiting list for HDUs. International and interstate

benchmarks suggest that Perth requires about 200 HDU places (1 per 1000 population aged >65). If the State Government were to provide funds to supplement the Commonwealth Aged Care funding, a number of existing residential care places to be converted into HDU accommodation relatively quickly. To build small, jointly funded units within mainstream private sector facilities would be the best solution. Interstate experience suggests that HDUs are effective but to operate efficiently, old age psychiatrists should control access to them, should review the residents regularly and manage them actively. OAMHS community teams could take on this role but would require some additional resources.

Another factor contributing to congestion of the inpatient beds is the absence of psychiatric ambulatory care centres known as 'day therapy' centres or 'day hospitals' in some areas of Perth at present. These are an important part of a comprehensive service model. If well-run, they significantly reduce the pressure on acute inpatient beds by providing; an alternative to admission; a step-down option to facilitate the transition from hospital to community, thereby reducing inpatient 'length of stay'; and rehabilitation/relapse prevention for patients with functional psychiatric disorders.

The current model of OAMH service provision relies on linkages with a variety of other care providers including geriatric medicine and rehabilitation services, general practice, general hospitals, emergency departments, residential care organisations and community support services. These care providers form a network with overlapping concerns and often, shared patients. If any component of the network is unable to function to capacity, the burden is displaced to other components. Clinical experience over many years has shown that the knowledge and skills of the staff in organisations such as residential care facilities and general hospitals, regarding OAMH issues, has a major effect on their capacity to manage patients with dementia. The rates and patterns of referrals to OAMH services is very sensitive to this. Pilot projects at Selby OAMHS and Fremantle OAMHS have confirmed clinical impressions that clinician time spent educating residential care providers creates a disproportionate reduction in inappropriate referrals, late referrals and hospital admissions. It is therefore 'core business' of OAMH services to provide education, training and ongoing support for staff in fields related to ours. At present most OAMH services do this in an ad hoc way and do not have adequate resources for the task.

The Commonwealth Ministerial Task Force on Dementia is producing some well–funded initiatives in the field of dementia training for professionals and carers. OAMHS should be involved in the implementation of these initiatives but similar needs exist for the training and support of carers and health care providers in relation to 'functional' psychiatric disorders. OAMH community teams need sufficient resources, possibly in the form of dedicated staff positions, for the training and support of health care and residential care providers.

Future staffing has been highlighted as a problem. A major determinant of recruitment and retention of staff is workplace milieu. It is important to encourage a dynamic attitude amongst staff at all levels by providing ongoing training, staff development and career structures. Linkages with the academic psychiatry through participation in clinical research can vitalising and motivate a clinical service as well as promoting best practice. More junior medical staff are needed since experienced consultants are frequently left without support at present and training opportunities are lost. Registrars in general psychiatry and geriatric medicine should be encouraged into OAMHS training positions and a cohesive, supportive training culture should be

fostered by the consultant body and the clinical academics, through the local Faculty of Psychiatry in Old Age.

**RECOMMENDATIONS**

**1. General**

Bed-block on the acute inpatient units is seriously reducing the efficiency of an otherwise highly successful model. Over the next ten years the services should be expanded to ensure that older people have equitable access across the metropolitan area to:

- Multidisciplinary, community-based mental health teams,
- Acute OAMH inpatient facilities
- Specialised ambulatory care units (day hospitals)
- Specialised long-stay residential care facilities.

The allocation and distribution of future resources should consider the need remedy *current* insufficiencies and inequities as well population projections showing the rapid expansion of our target population.

**2. Leadership**

2.1 Both North and South Metropolitan Areas require an Older Adult Mental Health Programme Director. This position should be allocated to a consultant psychiatrist 0.5 FTE with clerical and project officer support. Alternatively a single, statewide director should be appointed. A programme director would provide leadership for the OAMH services, but would also represent OAMH services in planning processes, provide linkages with the Adult MH programme and crucially, with other organisations in the field of aged care. Currently there is a lack of central planning and representation for OAMHS

**3. Acute inpatient services**

3.1 The number of acute inpatient OAMH beds should be increased to 1.0 per 1000 population aged >65 across all catchment areas (see Table 1).

3.2 Additional beds should be provided for the admission of patients from rural areas (see Table 1) until rural OAMH services are created.

3.3 OAMH inpatient units should be given the same access to CAP beds as geriatric medicine units. This should happen immediately due to the congestion of acute OAMH beds.

**4. Specialised long-stay residential facilities**

4.1 The number of State/Commonwealth-funded, long-stay residential care places for older people with severe behavioural and psychological disabilities should be greatly increased from the current total of 16 to 80 immediately and to 200 places by 2011, so that there is a ratio of 1.0 place per thousand population aged >65. These beds should be in private sector facilities distributed across each catchment area.

4.2 Local OAMH services should be funded to review regularly and actively manage all residents in State/Commonwealth long-stay facilities to ensure the most efficient use of these facilities and to avoid blocking the acute inpatient units.

**5. Day therapy services**

5.1 Psychiatric ambulatory care facilities (termed ‘day therapy’ services or ‘day hospitals’) are required in each catchment area. The benchmark should be 1.0 place per 1000 population aged >65. This is a cost effective way to reduce pressure on inpatient beds by providing an alternative to admission, a step-down option and rehabilitation. It may be possible to integrate these with existing geriatric medicine or rehabilitation facilities.

**6. Community services**

6.1 The existing multidisciplinary community teams should be expanded to ensure adequate numbers of case manages in all parts of the metropolitan area and access to social work and clinical psychology services. The benchmark should be 0.4 case managers per 1000 population aged >65. Services that operate with inadequate staffing have difficulty responding to urgent cases, leaving referrers little option but to refer to hospital emergency departments.

6.2 The current Rockingham/Peel OAMHS community team should be replaced by separate teams in Rockingham and Mandurah, to correspond to the disposition of geriatric medicine teams.

6.3 Adequate resources should be allocated to community teams to facilitate regular structured training and liaison with GPs, hospital emergency departments, residential care providers and community support providers.

6.4 Access to community support services for older people with psychiatric disabilities should be increased. More community aged care packages (CACPs) are needed, and a percentage of CACPs in each area should be granted to agencies (NGOs) with a special interest in, and understanding of mental health issues.

## 7. Consultation/Liaison Services

7.1 A dedicated OAMH consultation/liaison service should be provided at each metropolitan teaching hospital comprising a psychiatrist, a registrar and at least one CNS.

7.2 Community teams should have adequate resources to provide consultation/liaison services to the smaller geriatric medicine and rehabilitation units with which they are associated around the metropolitan area,.

## 8. Linkages and integration

8.1 OAMHS community teams, inpatient facilities and ambulatory care (day therapy) centres should, wherever possible, be co-located with geriatric medicine services and should share identical catchment areas (RANZCP Position Statement).

8.2 The possibility of geriatric medicine and OAMHS sharing inpatient and day hospital facilities, allied health staff and registrar training posts should be considered. This happens only occasionally at present on an informal basis but there may be scope to improve clinical outcomes and service efficiency by integrating facilities, while preserving the autonomy of each specialty.

8.3 Formal linkages should be encouraged between OAMHS and the local NGOs that manage community aged care packages. Some community support organisations such as Southern Cross Aged Care have developed a pool of staff with the interest and capacity to support people with psychological and behavioural disabilities, which greatly enhance the capacity of OAMHS to manage patients in the community.

8.4 Linkages between OAMHS and UWA Department of Old Age Psychiatry should be encouraged in the interests of furthering research and maintaining staff development and moral.

## 9. Rural OAMH

9.1 A statewide plan is needed to create decentralised OAMH services. In particular an OAMHS in the Southwest region is urgently required (population aged >65 was 11157 at last census).

9.2 Until rural services are established, metropolitan OAMHS should develop a coherent system to support rural aged care and mental health services. Metropolitan OAMHS need the capacity to admit patients from rural areas when required. 40 additional beds are needed for this (1.0 per 1000 rural population aged >65). Clinician time and resources for regular teleconferencing, rural clinics and the training of rural practitioners.

Table 1. Current and Projected OAMH Acute Inpatient Bed Requirements Based on ABS Population Projections

| **Area** | **2003** | | **2011** | | **2016** | |
|---|---|---|---|---|---|---|
| | Population aged >65 (ABS) | OAMHS current bed numbers | Population aged >65 (ABS) | Projected OAMH bed requirements | Population aged >65 (ABS) | Projected OAMH bed requirements |
| Armadale | 13,505 | 8 | | 12 | | |
| Bentley | 23,542 | 24 | | 24 | | |
| Fremantle | 26,043 | 16 | | 16 | | |
| Rockingham | 11,723 | 0 | | 12 | | |
| Mandurah | 12,107 | 0 | | 12 | | |
| Swan | 16,599 | 16 | | 16 | | |
| Inner City | 17,350 | 12 | | 16 | | |
| Selby | 15,589 | 40* | | 40* | | |
| Osborne | 26,004 | 24 | | 24 | | |
| Joondalup | 13,195 | 0 | | 16 | | |
| WA Rural | 40,833 | 0 | | 12 | | |
| Ratio | 0.69 beds per 1000 population aged >65 | | 0.98 bed per 1000 population aged >65 | | 1.0 bed per 1000 population aged >65 | |

***Selby OAMHS currently admits overflow patients from other services and from rural areas**

(ATTACHMENT B)

# DEPARTMENT OF GERIATRIC MEDICINE

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## Executive Report: Geriatric Evaluation and Management (GEM) Unit

### Background

**The GEM Unit[1] at Royal Perth Hospital was established by the Department of Geriatric Medicine as a 12-month pilot project in July 2002. The GEM Unit provides:**

- Early access to rehabilitation
- Multi-disciplinary assessment
- Complex discharge planning

The Department of Geriatric Medicine believed that there were a significant number of patients receiving acute care at Royal Perth Hospital who would benefit from early rehabilitation. The AHMAC Working Group on Care of Older Australians Project II[2] reported that approximately 3% of patients in acute care require rehabilitation. The primary aim of the GEM Unit is to enable elderly people to receive rehabilitation at the earliest opportunity, preventing deconditioning and subsequent extended length of stay that can occur if there is a delay while awaiting transfer to a conventional rehabilitation unit.

**Patient Numbers and Access to the GEM Unit**

697 patients have been discharged from the GEM Unit in the 52 weeks since establishment (22/7/02 – 18/7/03). The implementation of the GEM Unit has enabled increased access to Geriatric care within the acute RPH setting, with 37% of patients transferred to the GEM Unit from specialties other than Geriatric Medicine. This percentage is increasing over time (see Graphs, Appendix A). Transfers to the Unit are occurring in a timely manner, the average wait for transfer is 1.4 days, with 89% of patients being transferred in 3 days or less (see Table 1, Appendix B).

**Discharge Outcomes**

Patient discharge outcomes have been favourable, with a high number of patients discharged from the GEM Unit to their pre-admission residence (see Tables 2 and 3, Appendix B). Functional measurements taken on admission and prior to discharge from the Unit indicate favourable improvements in the majority of patients (see Tables 5 – 8, Appendix C).

1 Patient and Carer Satisfaction

Two patient and carer surveys were implemented on the GEM Unit in February and April – May 2003. Evaluation has indicated very positive patient and carer satisfaction in the care

[1] Rubenstein LZ, Josephson KR, Wieland GD, English PA, Sayre JA, Kane RL. Effectiveness of a geriatric evaluation unit. A randomised clinical trial. NEJM 1984; 311:1664-70

[2] Data sourced from the West Australian branch of the Australian Health Minister's Advisory Committee. Project II commissioned by the AHMAC Working Group on Care of Older Australians.

received on the GEM Unit (see Table 9, Appendix D). Overall, 93% of patients and carers surveyed indicated they believed they were well cared for on the GEM Unit.

## Collaboration with General Practice

Working extensively with the Canning Division of General Practice and Perth and Hills Division of General Practice has facilitated improved communication with General Practitioners (see summary, Appendix D). It was also intended to raise GP awareness of Enhanced Primary Care item numbers to enhance the care of GEM Unit patients, once discharged, and of Division of General Practice support available to GP's who require assistance to utilise them. The results of the GP survey suggest there is continuing potential to highlight support available to GP's to assist them to utilise these items.

### 1 Recruitment and Retention of Nursing Staff

Recruitment and retention of nursing staff on the Unit was initially identified as a potential problem. Prior to the commencement of the GEM Unit, the aged care ward (7B) had a vacancy rate of 35%. However, the GEM Unit has been successful in attracting and retaining nurses on the Unit due to the rehabilitation focus and changes in skill mix to provide rehabilitation care. This has resulted in a high level of staff satisfaction and the ability to attract and retain staff from the sub-acute sector. The GEM Unit is currently operating at a vacancy rate of 9%, while the overall rate for Medical Specialties is currently at 28%.

### 2 Falls Risk Assessment and Intervention Initiative

The GEM Unit commenced the pilot of a Falls Risk Assessment Tool[3] in February 2003. The tool has since been trialed on wards 5A, 5B and 9C at Royal Perth Hospital. A research proposal has been submitted to the Foundation for Nursing Research for funding to enable further evaluation of the tool and development of clinical interventions.

### 3 Costs

To **create** the GEM Unit, the 17 beds were re-allocated from existing aged care beds. It is difficult to describe the cost benefits of the GEM Unit as there is no control group nor similar Unit operating with the same criteria to benchmark against. However, we believe the operational costs of the ward would not have increased following the establishment of the GEM Unit for the following reasons:

- **Increased number of enrolled nurses and consequently, a decrease in the RN/EN staffing ratio.**
- **Decreased reliance on agency nursing staff.**
- **A Clinical Nurse Manager position for the GEM Unit to implement and promote rehabilitation philosophy and address staff issues.**
- **An additional part-time (3hr/day) physiotherapy aide position was required to enable safe supervision of patients in the ward therapy area. This was identified as a safety requirement given the Senior Physiotherapist is frequently called to ED and other Wards to assist. This**

[3] Falls Risk Assessment Tool adapted from the Queensland Health Department Quality Improvement and Enhancement Program, Falls Prevention in Public Hospitals and State Government Residential Aged Care Facilities.

**was approved when the GEM Unit was required to relocate from ward 7B to 3K, due to Hospital renovations.**

- **The GEM Unit has been able to decrease the use of PCA companions for wandering or at risk patients. The majority of patients transferred to the GEM Unit who have required companions on different wards have been able to be managed effectively on the GEM Unit without a companion. It is anticipated that this would represent an additional cost saving to the Hospital.**

**Summary of Outcomes**

- **Increased access to Geriatric care for elderly people in the acute RPH setting.**
- **Provision of early rehabilitation and comprehensive multi-disciplinary geriatric assessment, treatment and discharge planning for elderly people.**
- **Average length of stay for DGM has decreased by 24% (see Table 4, Appendix B).**
- **Favourable functional and discharge outcomes for the majority of GEM Unit discharges.**
- **Decreased wait times observed for patients awaiting transfer to Restorative Units at Regional Hospitals**
- **Improved communication with General Practitioners**
- **Improved recruitment and retention of nursing staff**
- **Reduced use of PCA companions**
- **Although a true cost analysis has not been possible, the GEM Unit appears to be cost-efficient and sustainable.**

## Recommendation

The Department of Geriatric Medicine is confident that the GEM model of care has had a positive beneficial effect and added value to the existing services provided at Royal Perth Hospital.

The Department of Geriatric Medicine commends this model of care and seeks Executive endorsement of its ongoing role at Royal Perth Hospital.

Date

**Dr Mark Donaldson**
**Consultant Physician in Geriatric Medicine**
**Chairman/Head of Department**
**Director, Aged Care Services EMHS**

(ATTACHMENT C)

# RAPID ACTIVATION OF DISCHARGE AND REHABILITATION 2005 (RADAR)

## ROYAL PERTH HOSPITAL

## BACKGROUND

Formation of this Unit was precipitated by closure of the Geriatric and Management Unit No.2 (GEM-2 Unit) in Ward 10 Shenton Park Campus, in February 2005.

The RADAR Unit is now established as a substitution program for the SPC Ward 10 program. It is similar in principle, with an emphasis on multi-disciplinary care.

The RADAR program comprises a team of medical and allied health staff who, under the direction of a geriatrician, will provide a GEM-like service to patients within the Internal Medicine wards at RPH. This will augment the GEM Unit service already provided to elderly patients in the GEM Unit (ward 3K). Appropriate patients for this program will be identified from the Department of Internal Medicine (DIM).

### *AIMS*

For appropriate patients within the DIM long-stay patient pool, this program aims to:

- Improve outcomes for care of these Elderly patients.

Facilitate discharge by early instigation of complex discharge planning and reduce length of stay.

- Improve efficiency in providing patient access to alternative Geriatric Services such as Restorative Units, Transitional Care Units or Outpatient Community Packages.
- Provide assistance with teaching of undergraduate students and junior medical staff.

### *THE TEAM*

| | | |
|---|---|---|
| Consultant Geriatrician | - | o.4 |
| Resident | - | **Full time** |
| Social Worker | - | **Full time** |
| Occupational therapist | - | Full time |
| Physiotherapist | - | Full time |
| Speech Therapist | - | 0.2 |
| Dietician | - | 0.2 |

### *ADMISSION CRITERIA*

- Patients should be over 65 years
- Must have rehabilitation needs and a requirement for multi-disciplinary care.
- Must be able cognitively and physically to engage in a rehabilitation program.
- Must be clinically stable.
- Exclusion criteria include patients who are non-weight bearing, are delirious, require assisted ventilation (CPAP or BiPAP) and those with significant behavioural problems.
- Patients awaiting Restorative Unit transfer.

### *REFERRAL PROCESS*

1. Decide whether patient is suitable for GEM unit or RADAR.
2. Contact nominated staff for RADAR admission confirmation
3. DGM office also has contact details for RADAR referrals.
4. Note date of RADAR referral in medical notes.
5. May be occasions when a GEM referral is suggested after RADAR review.
6. GEM referral system unchanged.

### *OPERATIONAL POLICY WITHIN INTERNAL MEDICINE*

1. RADAR patients will initially be capped at a number of 12. Patients will reside on the Internal Medicine wards.
2. RADAR will take appropriate referrals Monday to Friday principally from the four long stay medical units, but if appropriate from the short stay medical unit (SSMU). SSMU patients approaching day five of inpatient stay may be suitable for RADAR according to the selection criteria.
3. Patients suitable for RADAR should be identified at the daily registrar handover meeting (0:800 hrs), at the multidisciplinary team meetings held according to roster, and at the registrar discharge meetings on Fridays. The ward nursing and Allied Health staff may also identify appropriate patients and approach the medical team to suggest RADAR referral.
4. To comply with clinical audit, a request for RADAR review should be dated and documented in the medical notes.

5. Once a patient is accepted by RADAR a change of episode of care form must be completed and handed to the ward clerk. No patient will be accepted for RADAR unless approved by the Unit Consultant.

6. **Registrar cover:**

   i **Day-time:**
   - RMO will regularly consult with the RADAR consultant concerning medical problems. If a patient requires review by a registrar, the registrar of the referring long-stay medical team should be contacted. In the event that this registrar is not available, the 2nd on-call medical registrar will provide cover. Urgent medical problems should be referred to the 2nd on-call registrar or to a MET-call, as appropriate.

   ii **After-hours:**
   - 2nd on RMO
   - 1st on-call medical registrar

   iii **Weekends:**
   - 1st on-call medical registrar

7. **Handovers**:

   **i** The RADAR RMO will handover routine problems and duties to the 2nd on intern at 16:30 hrs on a daily basis. After consultation with consultant, difficult medical problems should be handed over to the 1st on medical registrar after 17.00hr

   **ii** Acute medical problems encountered in RADAR patients overnight should be handed back to the RMO at the 08:00 hrs daily registrar meeting. Special problems should be handed over directly to the RADAR consultant, after 07:30 by the night registrar

   **iii** Handover of RADAR patients for the weekend cover to the carried out at the registrar discharge meeting. It is essential that the RMO attend this meeting.

8. **Consultant Cover**:

   **i** During the week the consultant will provide cover up to 18:00 hours Monday to Friday.

   **ii** After 18:00 hours and during the weekend the 1st on call consultant should be contacted.

   **iii** Consultant absence/leave consultant cover will be provided from the pool of consultants in the Department of Geriatric Medicine.

9. **Transfer from RADAR to long stay medical units**:

Patients may occasionally require transfer back to Internal Medicine in which case the rule of the referring unit should apply. In cases where patients are admitted to RADAR via the Emergency Department or from the SSMU and require transfer back into Internal Medicine, patients will be transferred to the on-call medical team of the day.

| Head of RADAR Unit | Head of Department |
|---|---|
| **Department of Geriatric Medicine** | **Internal Medicine** |

**(ATTACHMENT D)**

# RAILS 2

## WINTER STRATEGIES FOR DEPARTMENT OF REHABILITATION & AGED CARE.

As per the recent discussions the focus now appears to be aiming for a reduced length of stay to get us into the top quartile to allow increase throughput and to utilise our beds more frequently and have no impact on elective surgery.

**Factors that can influence hospital length of stay in Aged Care Services.**

1. Delays in timely and frequent family meetings and Social Work provision of information, especially ACAT and service provision.
2. Delays in equipment, home modification and packages and services to organise safe discharge home.
3. Co-ordination of discharge plan including; nursing care and pharmacy medication planning.
4. Lack of some services available over weekend with ability to purchase some on Saturdays and Sundays would allow earlier discharges.

The proposal that I would like to put forward is as follows;

## RAILS
## REHABILITATION ACUTE INTERVENTION AND LIAISON SERVICES.

This is an enhanced integrated multidisciplinary approach to aim for the following;

1. Reduce length of stay and to go from a very good throughput to a great throughput and placing us in the top quartile across both sides.
2. Provide a service that allows the local General Practitioners to potentially bypass a need for an emergency department admission via a phone liaison service that will triage people to
    - Urgent home visit and support services implementation.
    - Urgent day hospital medical review.
    - Direct admission to medical/ rehabilitation beds (with discharge planning and rehabilitation commencing day 1).
    - Acute implementations of care packages and support services in the home.

To achieve this I have had meetings with Jenny Wignall regarding Allied Health requirements and plan and to integrate this with our ward nurse managers and community home visiting nurses at a meeting on the 13th April 2005.

**A: Ward Based Services (3/4/5)**

To improve throughput and numbers utilising the 74 medical and rehabilitation beds at the Osborne Park Hospital campus there is a need for the following;

1. Allied Health.

   3 FTE Social Work with 2 level 3/5 and 1 level 6, to assist with discharge co-ordination, more timely family meetings and ACAT planning and to assist with budgetary allocation of packages (to be discussed further later).

   This would allow some flexibility with the Social Workers being available till 7pm at night to meet with families who other the last 5 years have had increasing difficulties meeting during the day with our Social Workers. So we have had delays of up to 4 to 5 days to try and start a process of ACAT approval and planning which is far to long.
   1 FTE Physiotherapy (between 3 & 4)

2 FTE Physiotherapy Aides
To assist with rapid assessment and rehabilitation.

2. Nursing Staff Requirements.
   Community Home Visiting nursing staff and discharge co-ordination planner. Currently we have two home visiting nurses who are at present involved in ACAT and community assessments as well as discharge planning and discharge follow ups for wards 3 & 4 only. At times they have had 10 on the waitlist and delays of up to 7 to 10 days to perform some of their services.

   To improve the early discharge co-ordination and to ease the follow-up into the community, and the management of ongoing dressings and medical management. A further 4 home visiting nurses are required at a level 2 to link with the current nursing staff and to provide an on call triage system for the GP's in the community to be discussed later.

   Currently the community nursing staff for ward 3 and 4 provide discharge follow up and have reduced readmission rates and stopped drug errors and other problems as well as making sure that services have occurred and there is no carer stress, which ultimately can lead to a readmission or re-attendance to the emergency department.

   We have a similar community based nurse to follow-up those discharged from the public rehabilitation unit from Joondalup into the community. Staff attend team meeting, multidisciplinary, that assist with continuum of care out into the community and provide a focus for the families to liase with when there are future crises as well as a point for the General Practitioners to contact.

3. More Care Awaiting Placement beds I understand that liaison is occurring with Kingsley Brightwater to try and improve the numbers this would be of great benefit and assist with us aiming for an improved length of stay.

**B: Home Package Funding.**

Currently Osborne Park Rehabilitation Services has a small budget for some packages, which, usually runs out around late January, early February to assist with the timely discharge and to provide a bridge between when generic services can be commenced. We need a significant increase in the budget holding for Brokering care packages, EACH packages and community support for patients at the time of discharge. **Budget needed to provide rapid early discharge 5 – 7 patients a week is $200,000.**

Currently ward C14 provides a triage system and a delirium unit. They are primarily aiming for the general rehabilitation cases to predict those that will be less than 14 days. The prolonged discharge planning process patients are being transferred to ward 3,4 and 5.

**C: Stroke/Rehabilitation patients (Ward 5 OPH).**

Currently on ward 5 Dr Andrew Granger has co-ordinated a stroke/rehabilitation service. To continue to improve this a reduce length of stay, additional;

- 1 FTE Physiotherapy
- 1 FTE Occupational Therapy

This would assist with home rehabilitation and early discharge planning for these patients who will be occupying beds during winter on ward 5.

**D: Engineering Support.**

Improved access funding and co-ordination of engineering support for home aids equipment and home modifications, which will assist in reducing delays to equipment installation so therefore further budgetary funding is required here and I know that Mr David Mulligan and Mr Robert Aeschlimann are working on the figures for this.

**E: Community nurses on call liaison service for general practice.**

As described above we would utilise the GP liaison officer to communicate to our local GP's the ability for them to contact the new community nursing staff in the Department of Rehabilitation and Aged Care rather than sending the person to the emergency department of aim for a hospital admission.

We have utilised this type of process in the Parkinson's Clinic at Osborne Park Hospital and the Parkinson's Association has also utilised this. The Parkinson's Nurse Specialists and in Private Rehabilitation where a general practitioner can get information and contact with the Consultant Physician in a timely fashion and this can circumvent attendance to A & E and admission.

Plan

Requirements are for a mobile contact system (Phone/e-mail suggest blackberry's) and an increase in the car pool to facilitate the community visiting staff attendance and equipment installation.

- Mobile phone/ e-mail system (blackberry's x7).
- Lease further 6 cars (For community nurses and home visiting allied health staff).
- We would have the nursing staff on call by the mobile phone 5 days a week from 8am through to 7.30pm and this would provide the following;
    - The triage system and ease of contact with the on call Consultant Physician.
    - Co-ordination of urgent home visits by either nursing staff or allied health.
    - Urgent appointment at the day hospital at Osborne Park or Sir Charles Gardiner Hospital (increased staff support required at the day hospitals for this process to be discussed later).
    - Possible direct admission to rehabilitation bed, which would facilitate a discharge planning process occurring immediately.
    - Implementation and utilisation of the Care Package money to provide home supports, respite and all of the services that allow people to remain at home rather then attend A & E.

**F: Allied Health Community assessment and rehabilitation.**

Staff to assess and maintain people at home admitted to be the following;

- 2 FTE Social Work for the Gardiner and Osborne Park region.
- 2 FTE Physiotherapy.
- 2 FTE Occupational Therapy.
- 0.5 FTE Speech Therapy.
- 0.5 FTE Dietetics.
- 0.5 FTE Clinical Psychologist.

This above team will allow a link between those discharged or those requiring an urgent assessment and maintenance, Physiotherapy and work within the community as well as acute assessment of falls and introduction of community based support services and equipment.

**G: Day Hospital clinics enhancement.**

Currently the Day Hospital has 15 people on the waitlist for Physiotherapy and approximately a two week wait for assessment of falls, balance work, memory impairment, general medical assessments and post discharge rehabilitation and intervention. If the throughput and length of stay is to be increased through our service and for our patients to be seen quickly through the general practitioner we would need to increase the day hospital staff at both the Sir Charles Gardiner and Osborne Park Hospital campus.

**Sir Charles Gardiner Campus** would require 1 FTE Physiotherapy, RN and 1 FTE Occupational Therapy. **Osborne Park Hospital** would require 1 FTE Physiotherapy, 1 FTE RN and 1 FTE Occupational Therapy.

**H: Medical Staff.**

Currently the medical input would have to be done through the existing staff. We have had an increased ability of one of our Senior Registrars to work as a half time consultant, but unfortunately the job cycle is at the wrong end now for any planning. I would strongly recommend consideration of a further;

- 1 FTE Senior Registrar at Sir Charles Gardiner
- 1 FTE at Osborne Park Hospital

For planning in October, November this year to commence appointment in January 2006. This would then allow us to expand the expertise into the emergency department at Sir Charles Gardiner and into the community at Osborne Park Hospital and increase the timely assessment of people in the community.

Summary

Staff requirements for the integrated liaison service;

- Community home visiting nursing staff, day hospital nursing staff 6 FTE.
- Physiotherapy 5 FTE (1 FTE Level 6).
- Physiotherapy Aides 2 FTE.
- Occupational Therapy 5 FTE (1 FTE Level 6 and 4 FTE Level 3/5 ).
- Social Work 5 FTE (3 at level 3/5 and 2 being a level 6).
- Speech Therapy 0.5 FTE.
- Dietetics 0.5 FTE.
- Clinical Psychology 0.5 FTE.
- Pharmacy 1 FTE (Level 6).
- Administrative support 1.5 level 2 FTE. With the increased throughput and the co-ordination of care packages.
  ACAT information and data as well as planning for family meetings and care awaiting placement meetings and assistance with managing the budget and finance flows would require to minimum of 1.5 level 2 FTE. (There would also be increased typing and we have no typing pool at Osborne Park Hospital and discharge summaries).

**I: Pharmacy.**

With rapid turnovers and reduced length of stay, an additional 1 FTE (Level 6) of pharmacy staff is needed.

**J: Non Staff Support Funding**

1. Increased engineering out sourcing or support for home aids equipment modification.
2. Budget holding for community packages as a bridge between generic services.
3. Six leased cars.
4. Blackberry's total 11 (Community Team).
5. Computer equipment, to maintain communication, e-mail and documentation of the service there will be a requirement for Intranet and e-mail access for these staff. This would require a minimum of six desktop computers and for the community visiting staff we have recently had good success using the PDA's for the medical staff with respect to drug prescribing in the MIMS. I would see a requirement for eleven PDA's or blackberry's that would allow e-mail co-ordination and storage of the medication MIMS for the staff who are in the community to communicate quickly information and to look up appropriate drug information, particularly the nursing staff obviously.
6. Consideration of office space ward 4 for Community team area utilising 1 – 2 rooms and cost of fitouts.

I would be happy to discuss with you further as we have already discussed the office and building requirements and the understanding that this is ongoing funding, not just winter from May to October. This needs to be a sustained service that can be evaluated and lead us towards hopefully a great service.

Yours sincerely

**Dr Barry Vieira**
Consultant Physician
Head of Department
Rehabilitation & Aged Care

# RAILS 2

**WARD 3**
**Existing: 2 PT level 3/5 + 0.5 PTA**
**Supervision by level 6 section senior**

**Proposed new: 0.5 PT + 0.5 PTA**
**W/E service: 0.16 PT shared with surgical Ward.**

**Proposed TOTAL: 2.66 PT level 3/5 + 1 PTA**
**Include W/E penalties**

**WARD 4**
**Existing: 1 PT level 3/5 + 0.5 PTA**
**Supervision by level 6 section senior**

**Proposed new: 0.5 PT + 0.5 PTA**
**W/E service: 0.16 PT shared with surgical ward.**

**Proposed TOTAL: 1.66 PT level 3/5 + 1 PTA**
**Include W/E penalties**

**WARD 5**
**Existing: 1 PT level 7, 1.4 PT level 3/5 + 1 PTA**
**W/E service Stroke: 0.16 PT level 3/5, 0.16 PTA**

**Proposed new: 0.6 PT level 3/5**
**W/E service Rehab service: 0.16 PT shared with surgical ward.**

**Proposed TOTAL:**
**1 PT level 7, 2.32 PT level 3/5, 1 PTA.**
**Include w/e penalties**

**COMMUNITY LINK**

**New Service**

**Proposed:**

**1 PT level 6 Senior Physiotherapist Community Services**

**0.5 PT level 3/5**

**DAY HOSPITAL**

**Existing:**
**1 PT level 6, 1 PT level 3/5, 0.3 PT level 8**

**FALLS CLINIC/POST ACUTE**

**Existing: 0.5**

**Proposed: Post Acute service to be transferred to the Community service, permitting the Falls service to expand.**

**PARKINSON'S CLINIC**
**Existing: 1 PT level 6 + 0.5 PTA**

**Proposed new: 0.5 PT level 3.5. 0.5 PTA**

**Proposed TOTAL:**
**1 PT level 6, 0.5 PT level 3/5, 1 PTA**

**TOTAL NEW FTE REQUESTED**

| | |
|---|---|
| **Ward 3** | **0.5 PT level 3/5 + 0.5 PTA** |
| **Ward 4** | **0.5 PT level 3/5 + 0.5 PTA** |
| **Ward 5** | **0.6 PT level 3/5** |
| **PD Clinic** | **0.5 PT level 3/5 + 0.5 PTA** |
| **Weekend service:** | **0.48 PT level 3/5** |
| **Community Service:** | **1 PT level 6 + 0.5 PT level 3/5** |

**Subtotal: 1 PT level 6**
- **PT level 3/5**
  **1.5 PTA**

TOTAL: 5.58 FTE

**MISSION: To reduce hospital admission by providing a flexible service that will provide services in the patient's home, ensure successful transition from hospital to home, and speed the rehabilitation process to promote earlier discharge.**

**All staff working in the new service would have the flexibility to work either in hospital or in the patients' home.**
**Flexible rostering arrangements could provide a seamless approach to service delivery: staff working weekdays could also work the weekend.**

***CURRENT PROBLEMS*:**

**Wait lists:**
**Parkinson's Clinic, for home visits.**
**Day Hospital, for initial assessments.**
**Falls clinic, for initial assessments.**

**Delayed discharge on wards 3,4 & 5:**
**While carers are trained to handle patients at home.**
**Because patients' rehabilitation is protracted due to Staffing constraints.**

**Re-admission: To Day Hospital because walking aid does not suit home space constraints.**
**To ward or Day Hospital because patient's carer cannot manage in the home setting.**
**To ward or Day Hospital because patient's mobility level is not sufficient to manage at home.**

**Proposed service:**

- **Would provide a senior physiotherapist to co-ordinate the community service, ensuring an integrated service encompassing the hospital services and the community, expertise in service delivery and training/supervision of basic grade physiotherapists and assistants.**
- **Would provide extra staff to work both weekdays and weekend to enhance rehabilitation and speed recovery.**
- **Flexible approach would allow ward staff to follow discharged patient to the home to ensure successful transition.**
- **Would provide home visits for initial assessment, ensuring care/aids & equipment are suited to the home environment.**
- **Home visits would enhance access for patients who cannot travel easily or who cannot easily access transport. This would ease wait list in Day Hospital, which is increased by patients failing to attend appointments.**
- **Falls Clinic access would be enhanced by the removal of the Post Acute service from the position, and its inclusion in the Community service.**

(ATTACHMENT E)

# REHABILITATION IN THE HOME

## BACKGROUND

South Metropolitan Area Health Service (SMAHS) Rehabilitation in the Home (RITH) was initially developed in 2004, driven by SMAHS allied health staff, to improve patient flow and patient outcomes and support demand management, by creating virtual beds in the community. The Department of Health Strategic Intent Document 2005 – 2010 and Health Reform Committee reported a need to diversify hospital services and to provide care closer to the client's home, especially in the south of Perth, in line with changing demographics of the Metropolitan Area of Perth. Implementation of programs such as RITH were recommended to improve the sustainability of the health system, in particular to decrease demand on traditional hospital services through the use of non-hospital ambulatory care services. This project is also part of a process redressing a significant imbalance in ambulatory and community based services across the metropolitan area. In particular there has been an absence of Rehabilitation in the Home and other ambulatory services in the SMAHS, compared to Sir Charles Gardiner Hospital and Royal Perth Hospital, in the North Metropolitan Area Health Service (NMAHS). Rehabilitation in the Home is externally funded by the Department of Health, through the Acute Demand Management Unit, as part of the Winter Strategy 2005 for SMAHS. This funding will allow the program to continue until 25th February 2006.

## CURRENT SERVICE

RITH provides short term, hospital-substitution allied health therapy, allowing early discharge, assistance in the hospital to home transition and prevention of readmission to hospital. RITH services are available to clients living within the SMAHS, and referrals are accepted from tertiary and secondary hospitals. Clinical services for the SMAHS Rehabilitation in the Home service commenced on July 11th 2005. The service consists of a Program Manager (1 FTE), Physiotherapy (2 FTE), Occupational Therapy (1 FTE), Social Work (1FTE), Dietetics (0.2 FTE), Speech Pathology (0.4 FTE), Therapy Assistant (2 FTE) and an Administration Assistant (1 FTE). Nursing care is provided through the SMAHS Hospital in the Home Program. The specific goals of the RITH program are to:

- Provide additional capacity in the public health system, particularly in periods of increased activity; and
- Work in collaboration with existing services to promote client independence, assist with the transition of clients from hospital to home, reduce admissions to hospital and reduce the need for a long term care in the community or residential care.

## REHABILITATION IN THE HOME ACTIVITY

RITH received 193 referrals from 11th July 2005 to November 30th 2005. The monthly number of referrals and discharges from RITH are outlined in Table 1. A summary of referrers to RITH are outlined in Table 2. RITH provided 1873 occasions of service (OOS) to November 2005 (Table 4). NMAHS and SMAHS have a reciprocal arrangement for referrals with a number of NMAHS clients receiving treatment in a SMAHS hospital being referred to HomeLink in NMAHS for early discharge home discharge. As well as cost savings to the hospital, RITH has made significant improvements to referred clients functional ability, and physical capacity following intervention.

## COST EFFECTIVENESS

RITH received external funding for $340 000, including set up and infrastructure costs. Expenditure, bed day savings and cost effectiveness of RITH are outlined in Table 3. Notional cost savings demonstrated by RITH to October 31st are $678 697.

## LESSONS LEARNT

1) All potential referrals need to be screened by RITH prior to acceptance onto the program, to ensure they are suitable and adequately set up at home for RITH input. In addition, palliative clients need to be scrutinised, regarding their suitability for RITH. Implementation of this screening process has resulted in a decrease in the number of difficult discharges to RITH.
2) Limitations in the current hospital administrative systems impede the ability for a RITH to become a SMAHS service, and limits metropolitan wide integration of Rehabilitation in the Home/Hospital in the Home services. HRIT have planned implementation of new administrative systems that will address these issues in the future.
3) Readmissions initially appeared to be high for RITH clients, as 17% represented to hospital during their RITH admission. Following a retrospective note audit, it was established of the representations to hospital 3% were planned, 53% were acute exacerbations not related to the original condition, 26% were acute exacerbations related to the original condition, and 18% were discharge failures. None of the readmissions were due to inadequate, or unsuitable therapy input provided through the RITH program.

## STRATEGIC OPPORTUNITIES

1) Rehabilitation in the Home has developed linkages with a number of programs in the SMAHS including HITH. Rehabilitation in the Home provides allied health support to HITH clients. In addition, RITH is currently working with the Chronic Disease Teams to develop alternatives to hospital admission for clients under management of the Chronic Disease Teams.
2) RITH strategically sits with other ambulatory care programs in the South Metropolitan Area Health Service. In particular, it is strategic for RITH and HITH to be aligned and work collaboratively, to allow seamless delivery of hospital-substitution services, and efficiencies in service provision through the development of common processes and resources.
3) Further opportunities exist to expand RITH via increased referrals from SMAHS secondary hospitals. Increases in referrals will assist in increasing the number of hospital beds available throughout the SMAHS.

## SUMMARY

Since July 2005 RITH has demonstrated an ability to assist with demand management within the SMAHS. RITH has saved an estimated 801 hospital bed days, at a notional cost saving of $636 253 to November 30th, creating an additional 6.7 hospital beds within the SMAHS daily. RITH requires additional funding from 25th February 2006 to enable to program to continue within the SMAHS.
This briefing note was prepared by:

Nicki Newton
Program Manager
Rehabilitation in the Home

Appendix 1

## Table 1: Referrals and Discharges to RITH

| | Referrals | Discharges |
|---|---|---|
| | Number | Number |
| July 2005 | 17 | 5 |
| August 2005 | 46 | 29 |
| September 2005 | 36 | 30 |
| October 2005 | 46 | 40 |
| November 2005 | 48 | 54 |
| December 2005 | 39 | 36 |
| **2005 Total** | **232** | **194** |

**Table 2: Referrers to RITH**

| | **Percent** |
|---|---|
| FHHS Inpatient wards | 67% |
| HITH | 7% |
| FHHS Emergency | 14% |
| Other SMAHS hospitals | 6% |
| NMAHS | 7% |

Table 3: RITH Activity, Bed Day Savings and Cost Effectiveness

| | **RITH Activity to November 30th 2005** | |
|---|---|---|
| A | Accepted referrals (July to November 2005) | 193 |
| C | Occasions of Service | 1873 |
| D | RITH Hospital bed days (July to November 2005) | 3670 |
| | **Bed Day Savings (excluding NMAHS clients)** | |
| F | Bed days saved by preventing admission (1) July to Nov 30 2005 | 60 |
| I | Bed days saved by early discharge to RITH (2) July to Nov 30 2005 | 741 |
| L | Total bed days saved | **801** |
| M | **Additional hospital beds available daily** | **6.7** |
| | **Financial Summary** | |
| N | Set up and infrastructure costs | 16300 |
| O | Recurrent costs YTD | 188497 |
| P | **Total expenditure to Oct 31** | **204797** |
| | **Cost Effectiveness** | |
| Q | Cost of acute hospital bed day | $ 1,050.00 |
| R | Cost per RITH bed day | $ 55.80 |
| S | | |
| T | Gross Hospital savings (L x $1050) | $ 841,050.00 |
| U | Notional Hospital savings to Nov 30 (3) | $ 636,253.00 |
| V | **Projected twelve month cost savings** | **$1,908,759.00** |

(1) Admitting teams estimate the number of bed days saved by not admitting clients from Emergency Department to an inpatient bed
(2)Treating teams of hospital inpatients transferred to RITH estimate the difference between the esimated discharge date and actual discharge date
(3) Hospital bed day savings are notional as no hospital bed days closed behind RITH clients

(ATTACHMENT F)

## Supervised Care Unit,

## Fremantle Hospital and Health Service

### Introduction

Fremantle Hospital is a 450 bed tertiary teaching hospitals, one of only three in Western Australia. The Supervised Care Unit (SCU) was established in January 2002 as a ten bed unit at Fremantle Hospital. The SCU, the first of it's kind in an Australian acute hospital, is designed to deal with patients primarily with dementia, who require increased nursing supervision during their acute hospital admission. A small number of hospitals in Australia have successfully trialed the use of volunteers to provide a sitting service for this group of patients. The SCU model uses trained nursing staff,

### Development **of Supervised Care Unit**

The Supervised Care Unit was developed at Fremantle Hospital as a result of the change in restraint policy within the hospital in response to a change in the hospital restraint policy to a minimal restraint policy. As a result of this change, there was a large increase of patients requiring 1:1 or 1:2 nursing supervision or 'specialling' for patients who exhibited challenging behaviours such wandering, falling, calling out and pulling at lines and catheters. As the increased nursing needs were largely met by using agency staff, the cost to the hospital was considerable.

At the same time, there was increasing awareness amongst hospital staff that an acute medical ward was often not the best environment for many of these patients, and their behaviours were not being dealt with in the best possible way.

As a result, the Supervised Care Unit was developed to both decrease the cost of providing increased nursing supervision, and to provide a more appropriate environment for patients with dementia during an acute hospital stay.

### Admission **Criteria**

Patients who are appropriate for admission to the SCU are those who require constant surveillance because of agitation, confusion, wandering or who are deemed to be at high risk of injury/falls. Patients are also admitted if they are from a secure residential facility. Both medical and surgical patients are admitted to the SCU.

The admission criteria for the SCU are documented as;

- **patients that require supervision to prevent absconding from the hospital,**
- **patients at risk of harming themselves or others,**
- **patients considered to be at high risk of fall,**
- **patients causing significant disruption.**

Alternatively, if the patient is admitted from a secure residential facility and if considered suitable for the Unit.

Each patient is individually assessed for their suitability prior to admission to the Unit.

**The** Supervised **Care Unit Environment**

The SCU is currently a 14 bed unit, with two four bed rooms, and three two bed rooms. It is a secure ward, with keycard access, allowing patients, who wander, to do so safely. There is an increased nurse to patient ratio on the ward compared to acute medical wards with one nurse for every 2.8 patients during morning and afternoon shifts and for 4.6 patients overnight. Patients admitted to the SCU are transferred to the medical care of a Geriatrician.

The nursing staff aim to replicate the routine that the patient undertakes at home (eg. Showering at the same time if possible). The unit has a lounge and dining area, where patients are encouraged to spend most of the day, instead of in bed. Meals are eaten at the table, and these meals are designed specifically for people with dementia. Highly nutritious finger food is available at all other times during the day and night.

Families are encouraged to bring in the patient's clothing and items from home, to help make the hospital environment more familiar. Daily activities are undertaken during the day by nursing staff, and the ward also has a weekly Saturday BBQ, which family and friends are encouraged to attend. Talking books and music are used to stimulate, or soothe patients, when appropriate.

Evidence **of SCU Success**

An early pilot study of the unit indicated that there were reductions in adverse events such as falls for patients on the unit, as well as substantial cost savings in cohorting these patients. The pilot study was followed by a case note audit of the first twelve months of the unit's operation.

The case note audit identified that for the group of patients admitted to the SCU, their falls rate was reduced by 63%. There was a reduction in the use of physical restraints by 15% and chemical restraints by 24% in this patient group once they were admitted to the SCU. In addition to these findings, the length of stay for this group of clients was reduced from a median of 14.5 days to a median of 8 days at the completion of the project. This was due to the coordinated multi-disciplinary care approach in the unit. The use of a risk screening tool for early identification of issues allowed early intervention.

A significant decrease was achieved in the number of bed days for patients who were specialled outside the SCU but were suitable for SCU admission. The number of hospital bed days per month that were being used by patients suitable for admission to the SCU decreased from 82 hospital bed days to 12

hospital bed days. For the twelve months prior to the opening of the unit (January-December 2001), the cost of caring for patients with behavioural problems was $1,199,350 (based on cost per bed day), with an average cost per bed day of $830. Following the opening of the Supervised Care Unit (January-December 2002), the total cost of caring for these patients decreased to $958,035 with an average cost per bed day of $663. The estimated savings over a twelve-month period are $241,315, (20%). Facility set-up costs have not been included in this analysis.

**This was combined with a carer satisfaction survey, carried out by a consumer representative from the SCU's steering committee. Of the people** surveyed 69% of people said the care provided in the SCU was better than on a medical ward.

The aspect of care the respondents liked best about the SCU was the staff's caring attitude, the nurses continuous presence, the social aspect of the dining room, maintenance of normal routine, security, the personal attention and the friendly staff.

A staff satisfaction survey was also undertaken of nursing, medical and allied health staff who worked on the unit. This identified that staff felt that the Supervised Care Unit created a better environment for patients with dementia to be cared for within the acute hospital environment.

### National Applicability of the Supervised Care Unit

The proportion of the Australian population over 65 has increased from 9.6% to 12% in the last twenty years. In the next 20 years, it will grow to 18%; and by 2051, it will exceed one-quarter of the population. With this increase in the ageing population, there will be an associated increase in the prevalence of diseases associated with ageing, including dementia. This group of patients often struggles in the acute environment of a hospital, due to the unfamiliar nature of the hospital, their acute illness, and staff not having adequate time or skill to best care for these patients. With the increase in the ageing population, it can be reasonably expected that this patient group will continue to grow.

An appropriate environment for these patients needs to be consistently developed within acute hospitals to ensure that patients are provided with the best possible care, with limited use of chemical and physical restraints, in an environment that is safe, without excessive increases in cost to the hospital. The Supervised Care Unit developed at Fremantle Hospital provides an excellent example of an appropriate model of care for the elderly patient with dementia that could be easily applied to acute hospitals throughout Australia.

## CONCLUSIONS

The creation of a Supervised Care Unit at Fremantle Hospital has been an innovative idea to provide a safe and secure environment for elderly patients with dementia. This group of patients have been traditionally difficult to care

for within the acute hospital environment. However, the Supervised Care Unit has been shown to reduce the incidence of falls and the use of chemical and physical restraints for elderly patients with behavioural problems. It has provided a unique model of care tailored to the elderly person with dementia, and the benefits of this model have been identified by both family/carers of patients as well as staff. Additionally, it has been able to reduce the cost of caring for this group of patients within the acute hospital.

*This report was prepared by Nicki Newton on behalf of Fremantle Hospital and Health Service.*

(ATTACHMENT G)

## AGED CARE SERVICES EMERGENCY TEAM (ASET)

A/Prof Gideon Caplan
A/Director, Geriatric Medicine

## INTRODUCTION

Older patients more frequently present to the Emergency Department (ED) compared to younger patients and are more frequently admitted to hospital, general wards, coronary and intensive care.[2,3] They also have more pathology and radiology tests.[2]

Patients aged 75 years and older who are attend the ED and are discharged home have a higher risk of being admitted to hospital over the next fortnight or month, as well as being at increased risk of death.[4,5] They have a wide variety of medical problems, and at the greatest risk for subsequent admission are those who have lower scores on indices of activities of daily living, mental status and those receiving support at home.[3] These observations suggest a role for comprehensive geriatric assessment (CGA) to improve outcomes in older patients discharged from the ED. However assessment of function of older patients is unusual amongst junior doctors in the ED, who see most of the older patients there.[6] Junior doctors may have greater difficulty coping with this complex bio-psycho-social assessment required for older patients.

At Prince of Wales Hospital we have demonstrated in a randomised controlled trial involving over 700 patients aged 75 and over in the Emergency Department that comprehensive geriatric assessment does decrease admission to hospital, and that there is an improvement in the patients cognitive and physical function for 6-12 months afterwards which flows on to significant reductions in readmissions noticeable even after 18 months.[7]

This work provides the intellectual basis for the Aged Care Services Emergency Teams (ASETs).

In late 2002 multidisciplinary ASETs were established in 36 metropolitan and rural hospitals across NSW at a cost of $5.5 million recurrent: 21 ASETs in metropolitan Emergency Departments, 9 in smaller metropolitan and county EDs and 6 in other rural EDs.

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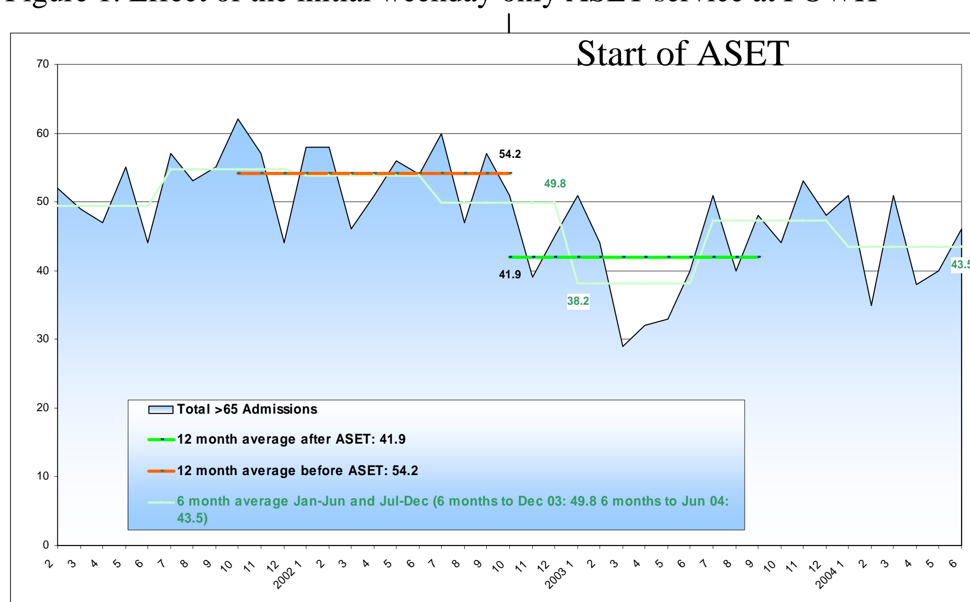
[2] Gerson LW, Skvarch L. Emergency medical service utilization by the elderly. Ann Emerg Med 1982:11: 610-612.
[3] Sanders AB, Morley JE. The older person and the emergency department. J Am Geriatr Soc 1993:41:880-882.
[4] Caplan GA, Brown A, Croker WD et al. Risk factors for admission after Discharge of the Elderly from the Emergency Department - The DEED Study. Age Ageing 1998; 27:697-702.
[5] Currie CT, Lawson PM, Robertson CE et al. Elderly patients discharged from an accident and emergence department – their dependency and support. Arch Emerg Med 1984; 1: 205-213.
[6] Caplan GA, Croker WD, Brown A. Recognition of deficits of physical and cognitive function in the elderly by medical staff in the emergency department. Emerg Med 1998; 10: 19-24.
[7] Caplan GA, Williams A, Daly B, Abraham K. A randomised controlled trial of comprehensive geriatric assessment and follow up after discharge of elderly from the Emergency Department - The DEED II study. *Journal of the American Geriatrics Society* 2004; 52: 1417-1423.

## EFFECT OF ASET

Evaluation of ASET performance by the DOH since inception shows that ASETs play an important role in improving care and risk management of older people presenting to EDs. ASETs can help to reduce unnecessary re-presentations to ED, avoid inappropriate admissions to hospital and reduce length of stay through early identification of co-morbidities such as pressure wounds, delirium and high falls risk.

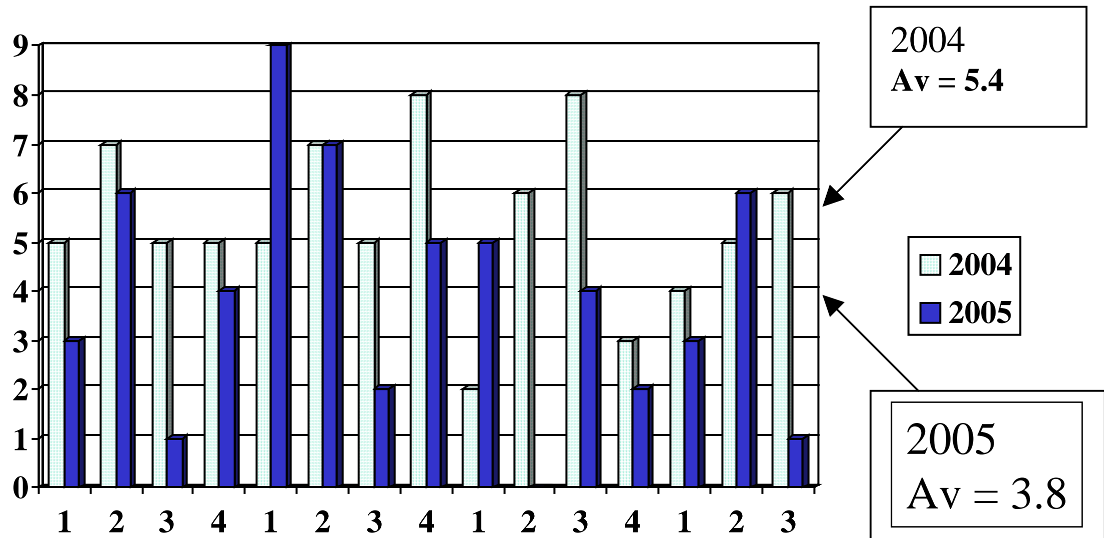
At POWH we were able to demonstrate that initial introduction of the ASET on a Monday-Friday schedule reduced the monthly average number of weekday admissions to Geriatric Medicine by 12.3 (22.7%) from 54.2 to 41.9 patients. This is a comparison of the 12 months before and after ASET started. At the same time there was a slight increase in monthly average weekend admission to Geriatric Medicine from 14.5 to 16.0. (Figure 1) The decrease in weekday admissions was immediate, and the link to the ASET team was temporal and obvious. There was also widespread appreciation in ED of the work of the ASET staff.

Figure 1. Effect of the initial weekday only ASET service at POWH




In February 2005 we began a trial of weekend ASET service. Examining the first 3 months of this service and comparing it with the same 3 months in 2004 demonstrates that average monthly weekend admissions have decreased from 21.6 in 2004 to 15.2 in 2005. This equates to a reduction of 29.6%, or a saving of approximately 70-77 bed-days per month, which equates to a monthly saving of $46,000 at an average bed-day cost of $600. This is much more than the monthly cost of the service and indicates definite cost-effectiveness. (Figure 2)

Figure 2: Average number of admissions per weekend the year before and immediately after start of weekend ASET service. This demonstrates a decrease in weekend admissions of 6.4 per month.




The ASET team have recorded the number of patients they have seen over these weekends.

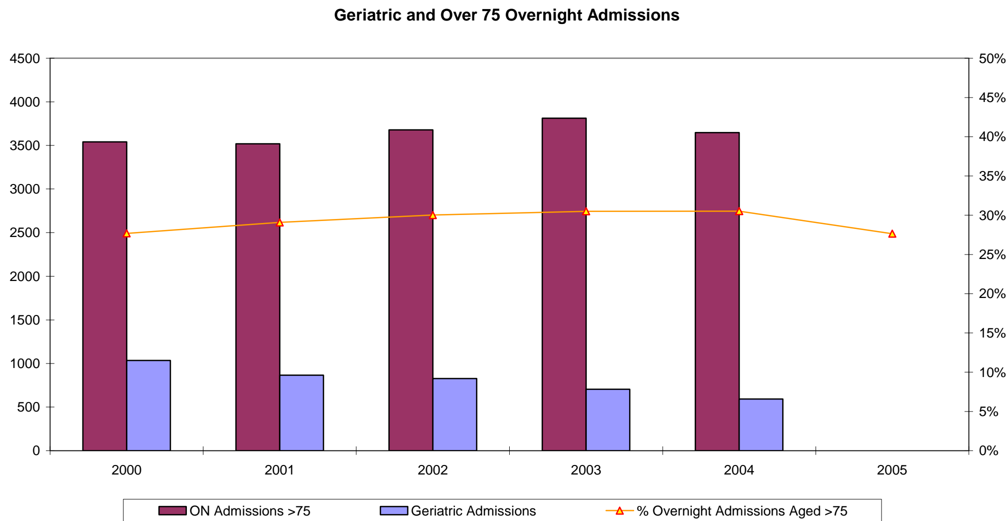
**Number of patients seen.**

| Date. | No of patients seen. | CNC | S/W | P/T | O/T | Adm. | Dis. |
|---|---|---|---|---|---|---|---|
| 5/2/2005 | 9 | 8 | 5 | 5 | 1 | 0 | 9 |
| 6/2 | 11 | 9 | 6 | 4 | 3 | 3 | 8 |
| 12/2 | 12 | 8 | 6 | 4 | 3 | 4 | 8 |
| 13/2 | 10 | 10 | 3 | 1 | 1 | 1 | 9 |
| 19/2 | 9 | 5 | 4 | 2 | 4 | 2 | 7 |
| 20/2 | 11 | 9 | 5 | 3 | 3 | 3 | 8 |
| 26/2 | 9 | 8 | 3 | 3 | 2 | 2 | 7 |
| 27/2 | 9 | 5 | 4 | 7 | 1 | 5 | 4 |
| 5/3 | 12 | 8 | 8 | 3 | 3 | 5 | 7 |
| 6/3 | 12 | 12 | 8 | 2 | 3 | 6 | 6 |
| 12/3 | 13 | 10 | 8 | 4 | 2 | 5 | 8 |
| 13/3 | 17 | 11 | 8 | 3 | 3 | 8 | 9 |
| 19/3 | 12 | 9 | 6 | 12 | 4 | 4 | 8 |
| 20/3 | 14 | 7 | 9 | 1 | 3 | 5 | 9 |
| 26/3 | 16 | 10 | 8 | 4 | 2 | 8 | 8 |
| 27/3 | 15 | 9 | 6 | 3 | 4 | 8 | 7 |
| 2/4 | 12 | 9 | 0 | 3 | 3 | 3 | 9 |
| 3/4 | 10 | 9 | 0 | 4 | 2 | 4 | 6 |
| 9/4 | 10 | 8 | 4 | 5 | 1 | 4 | 6 |
| 10/4 | 13 | 10 | 7 | 3 | 3 | 8 | 5 |
| 16/4 | 14 | 8 | 7 | 3 | 3 | 4 | 10 |
| 17/4 | 13 | 11 | 4 | 3 | 4 | 4 | 9 |
| 23/4 | 12 | 8 | 5 | 3 | 3 | 4 | 8 |
| 24/4 | 7 | 6 | 4 | 1 | 3 | 0 | 7 |
| 30/4 | 10 | 8 | 5 | 4 | 3 | 6 | 4 |
| 1/5 | 15 | 8 | 8 | 3 | 3 | 7 | 8 |
| 7/5 | 13 | 9 | 5 | 2 | 1 | 6 | 7 |
| 8/5 | 10 | 8 | 6 | 1 | 3 | 7 | 3 |
| 14/5 | 8 | 6 | 7 | 0 | 1 | 2 | 6 |

| 15/5 | 6 | 2 | 2 | 1 | 3 | 0 | 6 |
|---|---|---|---|---|---|---|---|

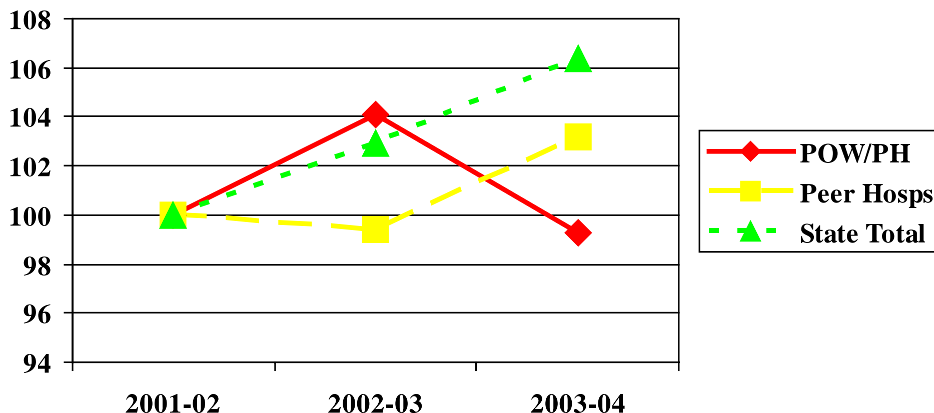
This demonstrates how extraordinarily effective this team has been in efficiently triaging and directing the treatment and management of large numbers of patients. Not all of the patients seen by the weekend ASET were sent home. Of those who were admitted, not all were admitted under Geriatric Medicine, so it should not be assumed that ASET is Geriatric Medicine exclusive.

Figure 3. Overnight Admissions to POWH of all patients over 75 and of all patients to Geriatric Medicine




This effect of the ASET team, in conjuction with other initiatives of the Department of Geriatric Medicine and Post Acute Care Services such as the Advanced Care Directives in Nursing Homes program, which has reduced bed-days occupied by nursing home residents in POWH/StVH by 10,000 per year, and Hospital in the Home has resulted in a decrease in patients over 75 admitted to Prince of Wales Hospital. Department of Health data indicates that bed-days occupied by patients >75 at POWH decreased by nearly 5% from 2002-03 to 2003-04. In comparison at our peer tertiary metropolitan hospitals (1A) the number increased by nearly 4%, and across NSW as a whole increased by 3.5%, which equates to an extra 59,168 bed-days across the state. If the whole state did as well as POWH we would have saved 87,000 bed days by comparison, equivalent to an 180 bed hospital closing down.

Figure 4: Bed-days occupied by patients over 75 at POWH, our peer tertiary metropolitan hospitals and across the state, with 2001-02 converted to 100, and subsequent years as a percent of that. This demonstrates that POW is now moving in



a different direction to its peers and the state.

A similar decrease has not been seen in other patient groups. For example, looking at DRG E62, Respiratory Infections/Inflammations with and without complications shows that separations for this group, comparing 2002-03 to 2003-04 increased at POWH by 1.5%, at peer hospitals by 5% and across NSW by 5%. Interestingly, if you look at DRG E62 patients only over 75 you see the same pattern as with all admissions, POWH separations decreased by 4.5%, peer hospitals increased by 5.5% and whole NSW increased by 3.3%. If you look at only patients under 75 for DRG E62, POW increased by 7.6%, peer hospitals by 9.3% and the state by 6.2%.

Figure 5: Overnight admissions by patients in DRG E62 Respiratory infections + inflammations. 2001-02 converted to 100 and subsequent years a percentage of that. Here POWH is moving in lockstep with its peers, except for patients 75+.

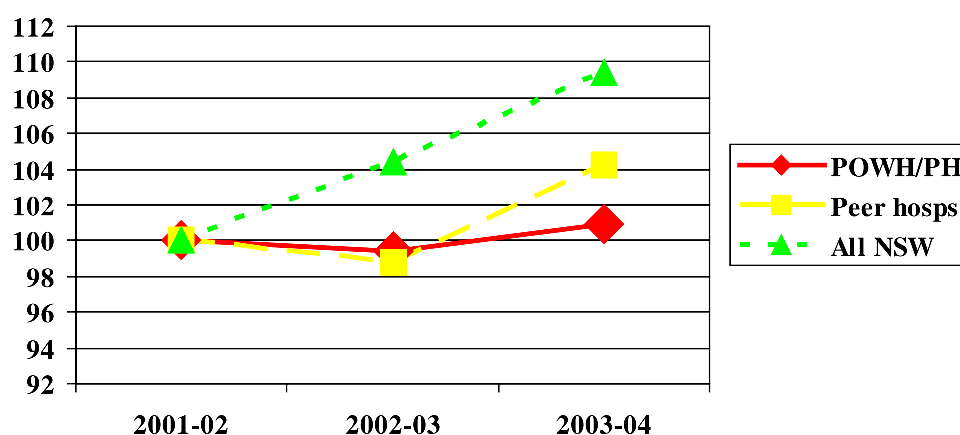



Table 2: Separations of DRG E62

| | Group | 2002/03 | 2003/04 | Percent |
|---|---|---|---|---|
| POWH | All | 533 | 541 | |
| | 75+ | 283 | 272 | -4.5% |
| | Under 75 | 250 | 269 | +7.6% |
| Peer Hospitals | All | 4354 | 4591 | |
| | 75+ | 1873 | 1880 | +5.5% |
| | Under 75 | 2481 | 2711 | +9.3% |
| NSW | All | 19182 | 20091 | |
| | 75+ | 7238 | 7403 | +3.3% |
| | Under 75 | 11944 | 12688 | +6.2% |

This age-specific change, which goes against the demographic trend of an increasing number of people aged 75+ in our local area and across Australia, indicates a powerful program specific effect, which cannot be ascribed to generic changes such as an increase in ED physicians which, if it was responsible for decreasing admissions, would be expected to have an effect across all age groups. While the work of ED physicians is vital and important, the best practice care of frail elderly in the ED requires the presence of skilled, aged care-trained staff. There is no doubt that multidisciplinary assessment using aged care nursing, allied health and medical staff provides optimal care for the frail elderly. This has been documented in numerous randomised controlled trials and meta-analyses.[8] It is imperative that, where evidence

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[8] Stuck SE, Siu AL, Wieland GD et al. Comprehensive geriatric assessment: a meta-analysis of controlled trials. Lancet 1993;342: 1032-1036.

is available, we use the best available evidence to improve the service that we, as an organisation, provide.

## CONCLUSION

The weekend ASET service should continue and further strengthening of the ASET is warranted.