



GRACE

(Geriatric Rapid Acute Care Evaluation)

NSW Department of Health

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Executive Summary

The number of aged care facility residents being admitted to hospital has been increasing over the past decade. The population is ageing and demanding more from current services.

New models of care are required to meet these increasing expectations and demand for services.

Hospital admissions for aged care facility residents are often physically and emotionally disruptive. In hospital, older patients have higher rates of adverse events and are more likely to become deconditioned.

There is strong evidence that treating nursing home and hostel residents in the home improves outcomes for these patients. While the benefits of caring for residents in an aged care facility rather than in hospital are increasingly recognised, these facilities are often challenged in managing acute and sub-acute illness.

This model of care has been developed by the Hornsby Ku-ring-gai Health Service (HKHS).

Under the *Rapid Evaluation and Acute Care for Aged Care Residents Model of Care* (hereafter referred to as GRACE), hospital staff work in collaboration with general practitioners and aged care facilities to improve the journey of aged care facility residents. Enhanced hospital resources support general practitioners and aged care facility staff to care for residents at home, avoiding hospital admissions.

At the centre of the model is the GRACE Clinical Nurse Consultant (CNC). This CNC, along with other hospital staff, manages a single entry, 7 day per week, telephone triage service for aged care facilities and their general practitioners. The GRACE team also provides support, education and training to staff of the aged care facilities.

When hospital admission is required, care is case managed by the GRACE CNC to facilitate rapid treatment and ensure the patient's stay in hospital is as short as possible.

The success of GRACE relies on partnerships between the hospital, aged care facilities and their residents' general practitioners. It also requires enhanced collaboration between GRACE and other clinical, nursing, community health and administrative staff.

Initial data indicates that GRACE has contributed to high levels of avoided hospital admissions, reduced access block for older patients and reduced average length of stay at HKHS. The GRACE project has enhanced the journey of aged care facility residents and helped to improve communication and trust between the hospital, general practitioners and the aged care facilities.

Lilly's Story Prior to GRACE

Lilly's Story

Lilly's Story

Lilly lives in an aged care facility and her family visit her every second weekend. The staff at the facility notice that Lilly's leg ulcer is not improving and she appears to be tired, confused and unsteady on her feet.

This is her story.

This is based on a true story, only names have been changed.

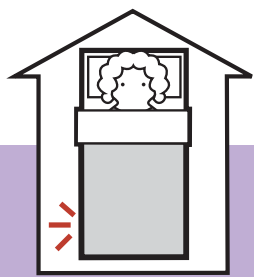
I had not been feeling well for some days and my leg did not seem to be getting better. The Director of Nursing, Evelyn, came to see me and said that she thought it would be good if my doctor came and looked at my leg. When the doctor came, my leg was very sore, I felt very tired, feverish and I could not understand what the doctor was saying. I did not feel like myself at all.

Evelyn told me that my doctor thought it best if they took me to the hospital. I did not want to go to hospital. I just cried and cried.

The last time I was in there it was so noisy I could not sleep. It was difficult to eat in bed. I did not know any of the hospital staff because they kept changing. My family could not come and see me because the hospital is a long way for them and parking is difficult. It took me a long time to get better in hospital.

Evelyn promised to ring the hospital later in the day to check on me and to send all my forms and care plan with me so I would not have to remember everything all the time.

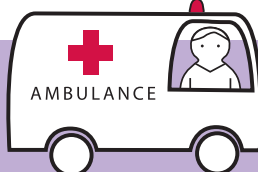
An ambulance took me to the hospital. When I got there I waited and waited and no one came to see me. It was terrible. Everyone was rushing around and it was so noisy. I did not know anyone there. Even the nice ambulance lady went away after a while. I felt very upset and confused and I felt too ill to ask anyone what was happening. I just wanted to go home again. After a long, long time the doctor came to see me and said I would need to stay in hospital until my leg got better. I was very upset and tired and I knew that hospital would not make me feel better.



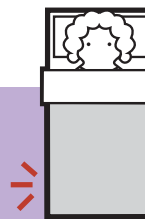
Lilly, resident in a Nursing Home, has a leg ulcer.



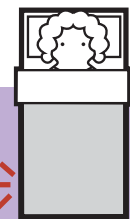
Lilly does not want to go to hospital, but her GP and the facility DoN, Evelyn, have no choice.



Ambulance transports Lilly to hospital.



Lilly waits a long time to be seen. It is too noisy to sleep. Lilly is upset because the doctor says she has to stay in hospital.



Evelyn visits Lilly in hospital. She and Lilly's family are frustrated with the lack of information. Lilly is confused and agitated.

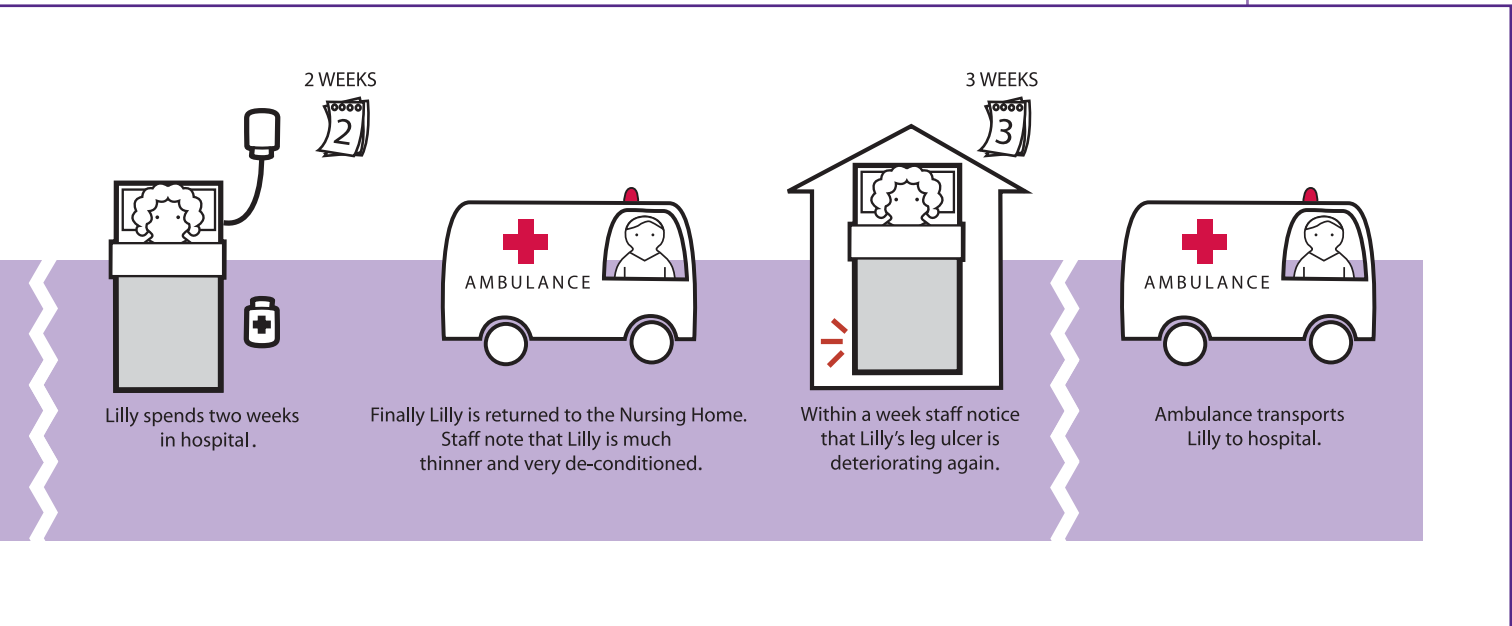


The next day Evelyn phones the hospital again to see how Lilly is going. Lilly's family are concerned that they have not been able to speak to anyone at the hospital. Frustrated and very concerned for Lilly, Evelyn visits the hospital. Lilly seems much sicker, she is very confused and agitated and her care plan has not reached the ward. Evelyn is extremely worried about Lilly and really wants to take her back to the nursing home to look after her.

Over the next two weeks, Lilly is treated in the hospital with intravenous antibiotics, a vacuum dressing and pain relief. She eventually goes home with a silver nitrate dressing. On her return, the staff note that Lilly is much thinner and very de-conditioned. Within a week staff notice that Lilly's leg ulcer is deteriorating again.

What is wrong with this story?

- It is not possible for Lilly to stay at home even though this is her first preference.
- Lilly has an extended stay in the Emergency Department.
- The hospital fails to communicate with the nursing home and Lilly's family.
- Lilly's care plan does not reach the ward.
- Lilly's condition deteriorates in the unfamiliar, noisy and busy hospital environment and she returns home in a worse condition than when she left.



Background to the Model

The population is ageing and older people, including those from aged care facilities, represent a significant and increasing proportion of Emergency Department patients.

Hospital admissions for aged care facility residents are often physically and emotionally disruptive. In hospital, older patients have higher rates of adverse events and are more likely to become deconditioned.

While the benefits of caring for residents in an aged care facility rather than in hospital are increasingly recognised, these facilities are often challenged to manage acute and sub-acute illness.

The Ageing Population

The World Health Organisation states people aged over 80 years are the fastest growing age group in the western world.

As our population is ageing and patients and carers are demanding greater flexibility and choice of services, it is imperative that we improve our models of aged care to effectively meet the growing demands and expectations of this age group and the wider community.

In NSW, an elderly person presenting at an Emergency Department (ED) is far more likely to experience a stay of greater than eight hours (access block), regardless of their admission status, than any other age group. Between July 2004 and March 2005, 40% of patients aged 65 years and over admitted to a NSW public hospital ward or Intensive Care Unit experienced access block in the ED compared with only 23% for all other ages.

Hospital admissions for aged care facility residents are often physically and emotionally disruptive and fraught with the potential for iatrogenic illnesses (Ouslander, 1989). Hospitals are busy, noisy, confusing places for elderly people.

Residences and staff, routines, as well as friends are both familiar and comforting, even more so during a time of illness. Aged care facility staff are familiar with their residents and able to notice subtle changes in their health and wellbeing.

Inappropriate transfers to hospital are potentially a large problem for aged care facilities. A study carried out in the United States (Saliba, 2000) has shown that structured review can help reduce inappropriate transfer.

There is evidence that treating residents in their nursing home or hostel improves patient outcomes (Ackerman *et al.*, 1998). Elderly patients who are treated at home do not have to change their environment or routine and do not need to adapt to the sociological culture of the hospital.

Once hospitalised, older people have higher rates of adverse events (falls, medication errors, infections and ulcerations) and are more likely to become de-conditioned.

A study of nursing home residents in the United States (Zimmer *et al.*, 1997) has found that patients treated in the nursing home or hostel, experienced less confusion and other geriatric complications and had decreased mortality during the acute phase or in the two months following the acute episode, compared with those treated in hospital. McCusker *et al.* (2001) showed that ED screening, standardised nursing assessment and referral to primary and home care services can significantly reduce the rate of subsequent functional decline in older people.

While the benefits of caring for residents in an aged care facility rather than in hospital are increasingly recognised, the reality is that most aged care facilities do not have on-site physicians or the ready availability of diagnostic and therapeutic services. Factors such as rapidly changing technology, limited availability of hospital support and the ageing nursing workforce makes it difficult for aged care facilities to manage acute and sub-acute illness.

Hornsby Ku-ring-gai Health Service

HKHS is a major metropolitan hospital in Sydney's north serving more than 250,000 people.

Population projections indicate that in 2006 there will be more than 20,000 residents aged over 75 years in the hospital's catchment area. Patients over 70 years of age already occupy 70% of the bed days (2002 data).

In 2003/04 patients admitted to HKHS from aged care facilities accounted for:

- approximately 11,000 bed days (30 beds)
- approximately 10% of acute admissions and 19% of acute hospital bed days
- 9,630 Emergency Department bed days or 26 beds.

In 2003/04 patients admitted to HKHS from:

- nursing homes had an average length of stay (LOS) of six days

- other aged care facilities (hostels) had a LOS of seven days.

Despite the introduction of innovative care programs at the hospital and in the community, more had to be done to address the above issues.

A 2004 survey of local aged care facilities by the Hornsby Ku-ring-gai Ryde Division of General Practice identified that staff were very supportive of initiatives to reduce hospital admission for residents and, where hospitalisation was required, stays should be as short as possible. Staff also felt enhanced communication and closer relationships with HKHS and local area general practitioners would reduce problems like the discharge of residents from hospital at difficult times such as late afternoon/evening.

GRACE began operation at HKHS in August 2005.

It developed out of recognition of the increasing needs of the ageing population and the desire to improve care for those people living in aged care facilities.

A familiar story?



5.30 am

Vera, a resident in a nursing home, is taken to hospital by ambulance after becoming unwell.

6 am

The Emergency Department is experiencing very high demand for services. There are several significant trauma cases. Vera waits on a trolley to be transferred from the ambulance to the Emergency Department.

11 am

Vera is transferred to an Emergency Department Bay where she waits for medical assessment.

Noon

Vera is assessed. An x-ray and pathology is ordered. Vera is becoming increasingly uncomfortable and disoriented.

2 pm

Vera has the tests.

4 pm

Vera's tests are reviewed. She has a urinary tract infection. An ambulance is ordered to take Vera home.

5 pm

Freda is one of two registered nurses working at the nursing home. She is about to go home late, after completing a nine hour shift, when she gets a call from the hospital. They are discharging Vera.

5.30 pm

Freda calls home. She has people coming for dinner at 6pm.

6 pm

Vera arrives at the nursing home without medication or a script.

7.30 pm

Freda drives to Vera's GP to obtain a script and drives to a pharmacy to fill it.

8.30 pm

Freda administers the medication. The enrolled nurses do not have authority to do so.

9 pm

Freda arrives home to her dinner guests.



Lilly's Story Under GRACE

Lilly's new Story

Lilly's new story

Lilly is back in her nursing home after being in hospital for two weeks with an infected leg ulcer. The nursing home staff notice that her leg ulcer is deteriorating.

This is her story under GRACE.

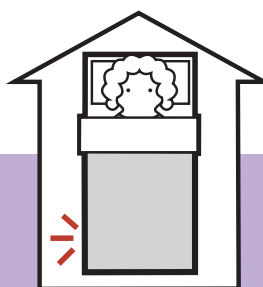
Lilly is a resident of a nursing home. She returned home yesterday after a two week hospital stay for her leg ulcer.

The general practitioner reviews Lilly and is concerned that she may need to go back into hospital. He and the aged care facility Director of Nursing agree to explore the option of GRACE to try and avoid hospital admission. The Director of Nursing contacts the GRACE CNC.

The GRACE CNC completes a Triage Assessment Form with the Director of Nursing over the phone. This assessment helps the GRACE CNC to determine she needs to refer Lilly to the hospital's Wound CNC. The Wound CNC visits the nursing home and quickly establishes that a three-week vacuum dressing is required.

Approval is obtained from the hospital's Director of Medical Services to proceed with treatment. The GRACE CNC organises the vacuum dressing and supporting machinery. She liaises with the dressing company representative to provide in-service training for the nursing home staff as they have not previously used this type of equipment. The company representative agrees to be a resource to assist in managing the use of the new equipment for the vacuum dressing.

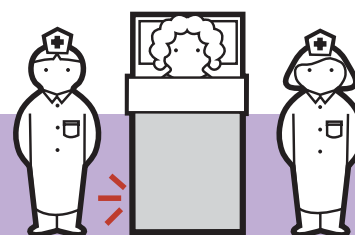
The Wound CNC reviews the wound weekly. The GRACE CNC and other staff are available seven days a week if the nursing home staff have any concerns about Lilly's progress. Within three weeks Lilly's wound has healed sufficiently to apply a moist dressing.



Lilly, resident in a Nursing Home, has a leg ulcer.



The GP or nurse in charge contacts the GRACE CNC who triages over the phone.



GRACE CNC refers Lilly to the hospital's Wound CNC who visits Lilly and establishes that a three-week vacuum dressing is needed.

What is good about this story?

- Hospital admission is avoided reducing the risk of adverse events such as secondary infection, falling or developing delirium. This also avoids a wait in the Emergency Department, potentially reducing access block.
- Lilly is able to stay in a familiar environment, with supportive staff who are aware of her needs.
- Lilly's vacuum dressing is expensive but is extraordinarily cost effective compared with a three-week stay in hospital.
- In service training supports nursing home staff to feel confident with the new product.

Lilly's journey is much better under GRACE.

Lilly is able to be treated in the comfort of her home. A costly admission to hospital is avoided and capacity for acute care is built within the aged care facility.



The GRACE CNC liaises with the dressing supplier to provide in-service training for the nursing home staff on the use of the dressing and after care support.



The Wound CNC reviews the wound weekly, and after three weeks, Lilly has healed enough to allow the application of a moist dressing.



Lilly is happy that she did not have to leave her home.

What is GRACE?

What is GRACE?

Under GRACE hospital staff work in collaboration with general practitioners and aged care facility staff to provide enhanced care “at home” for aged care facility residents. There is provision of hospital resources not traditionally available to aged care facilities.

When hospital admission is necessary, GRACE patients are given access to rapid treatment to ensure their hospital stay is as short as possible.

GRACE Aims

- To reduce hospital access block by supporting general practitioners and aged care facilities with enhanced hospital resources to provide care “at home”. This avoids an unnecessary hospital admission (pre-hospital).

- To reduce the Average Length of Stay (ALOS) of aged care facility residents in the ED and the hospital.

- To collaborate with the general practitioners and aged care facilities to develop a model of care that:
 - provides a decision support system
 - provides hospital resources to assist with assessment and care provision
 - provides coordinated management plans.

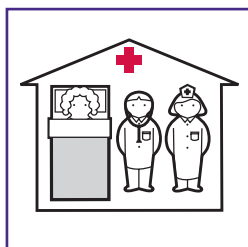
- Increase the profile and uptake of Advance Care Directives in aged care facilities.

Benefits

GRACE delivers these benefits...



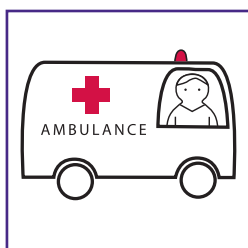
- Patients, once admitted, are fast tracked through the system.
- GRACE advocates for patient's/family's preferred treatment options.



- Improved patient care by providing aged care resources in the ED.
- Reduced hospital presentations and admissions leads to:
 - reduced access block resulting in less elective procedures being cancelled
 - reduced bed occupancy rates
 - reduced pressure on staff by having a single point of communication for facilities and GPs.
- Reduced length of stay can create better bed flexibility.



- Convenient access to dedicated advice and support, 7 days per week.
- Increased acute care capacity of staff.
- Happier, healthier residents as they are able to stay at home.
- Endeavour to return patients back to their facilities during peak staffing times.

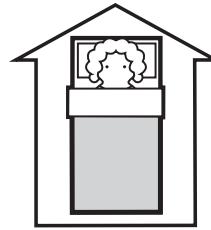


- Reduced need for transport between hospital and aged care facility.



- Hostel residents who may require additional medicine and personal care resources to manage their illness and remain at home.
- If hostel residents require a hospital stay they are admitted to the EMU if their estimated discharge date (EDD) is less than two days. If their EDD is greater than two days, they are admitted to the Acute Care of the Elderly (ACE) ward. The ACE ward is ideal for hostel residents as it focuses on maintaining function.

Figure 2: GRACE Flow Chart for a nursing home resident



Unwell patient in a nursing home

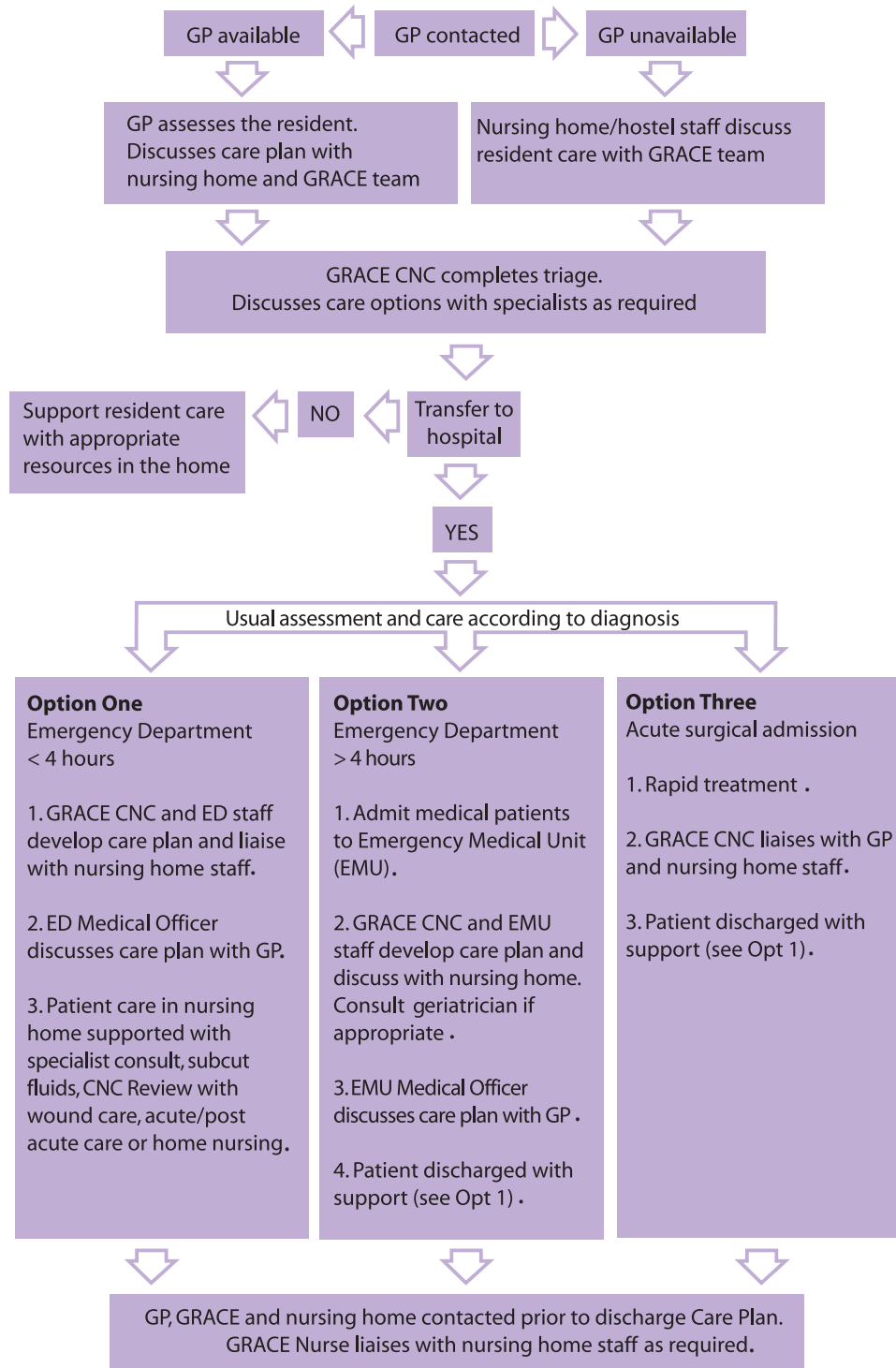
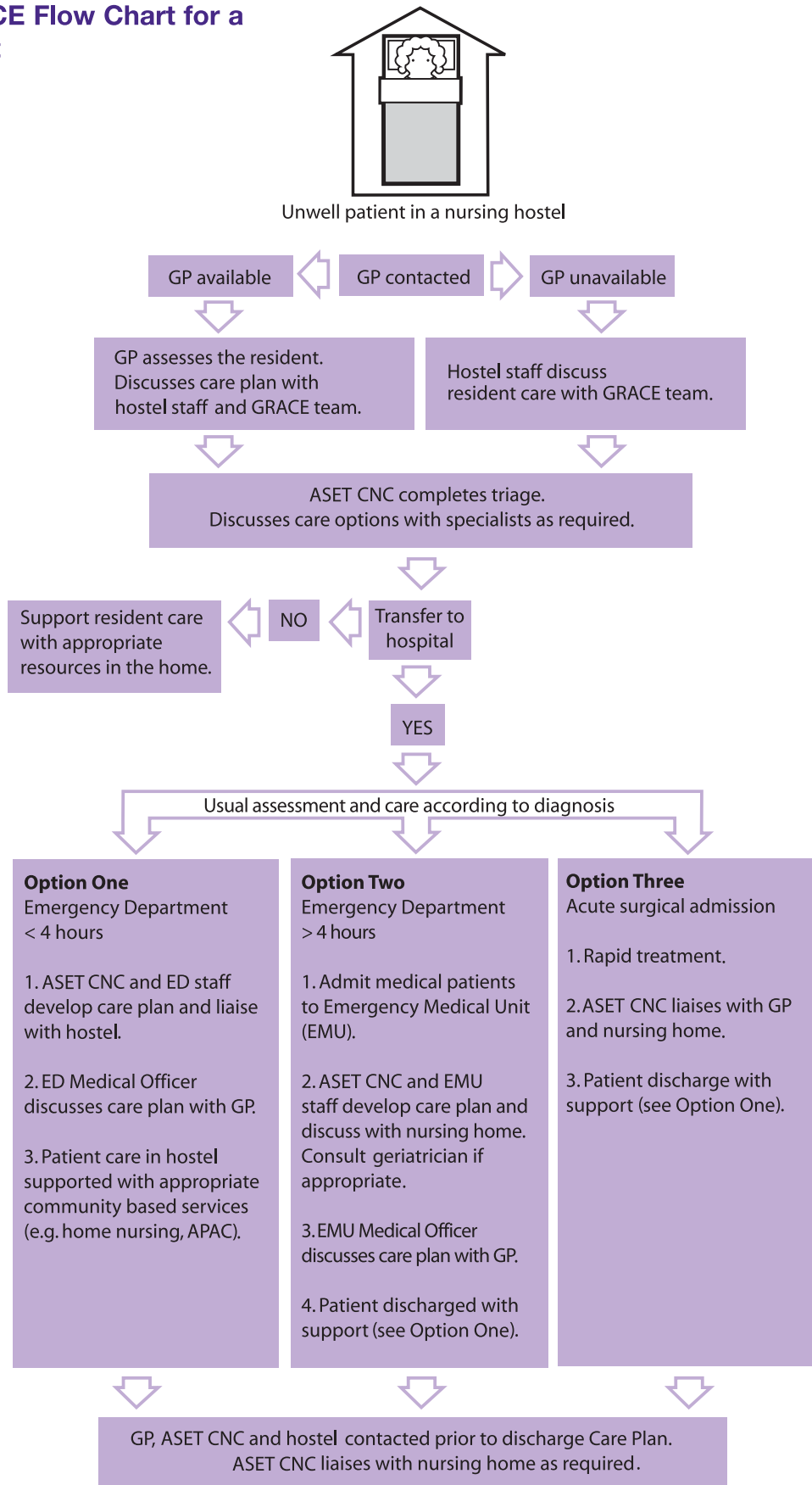


Figure 3: GRACE Flow Chart for a hostel resident



How Does GRACE Work?

GRACE CNC in action

The GRACE Team is contacted by an aged care facility about a patient.

- Uses triage checklist to identify the presenting problem and the nature of the illness.
- In collaboration with aged care facility staff, and the GP, determines the action required.
- Liaises with hospital or community based nursing personnel to assist with specialised functions.
Eg, the GRACE team may refer patient to the hospital's Wound Care CNC. Alternatively, they may visit the facility and provide demonstrations and assistance with subcutaneous fluid packs or the use of a new vacuum dressing system.
- Makes targeted referrals to specialist services such as geriatricians or external service providers.
- Liaises directly with the patient's GP and family to discuss treatment plans.
- In consultation with the GP, GRACE may supply some consumables such as fluids or silver based wound dressings to prevent hospital admission.

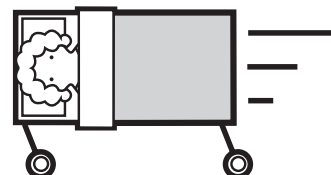
Telephone triage service



Aged care facilities and GPs caring for their residents have a single entry point for advice and hospital services.

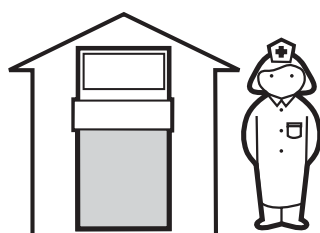
They are able to access hospital services that are usually only available to in-patients. These can include diagnostic specialist medical review as well as clinical nurse consultant review.

Rapid treatment



When Emergency Department presentations are required the acute care patients are fast tracked through the Emergency Department. If admitted their stay is kept as short as possible to reduce the risk of adverse events such as pressure areas and delirium.

Visits to residential aged care facilities



The GRACE CNC and other nursing staff offer support that includes education sessions at aged care facilities on the use of new equipment, infection control and wound care.

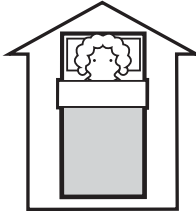
This cost effective support to the facilities has reduced Emergency Department presentations as well as average length of stay for aged care facility residents at HKHS.

Comprehensive treatment of underlying health issues



Emergency Department medical staff review the patient in collaboration with the treating team with geriatrician support as required. The GRACE team, along with the GP, follows up any health concerns that aged care facility staff may have expressed about the patient.

Dedicated GRACE short stay beds

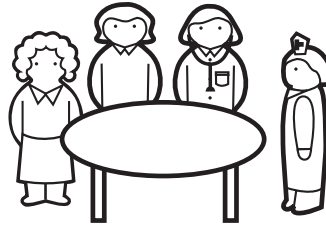


Dedicated GRACE beds in the EMU have modified criteria that allow for a short stay over the normal 48 hours.

The GRACE CNC, with assistance from the GRACE registrar, case manages the short stay beds in the EMU to ensure comprehensive care is provided within the context of a short stay admission.

Four beds in HKHS EMU have been assigned as 'GRACE' beds.

Advance care planning



The GRACE CNC actively works to increase the profile and use of advance care planning within aged care facilities.

GRACE can discuss palliative care treatment options and support general practitioners with linkages to outreach palliative care services. This reduces the number of aged care facility residents transferring to hospital for end of life care.

The GRACE CNC should also work with the Divisions of General Practice to identify needs of local GPs and support their applications for palliative care funding grants.

HKHS has targeted that at the end of one year, 10% of GRACE patients will have Advance Care Directives/Planning in place.

GRACE CNC



Takes responsibility for the telephone triage service and case manages all GRACE patients.

Ensures specialist, holistic, care is provided to the patient and that aged care facilities and the patient's GP have a clear and consistent channel of communication.

Provides outreach advice, support and training to aged care facilities.

Works in partnership with other staff particularly the Agedcare Services in Emergency Team (ASET) CNC and Aged Care Liaison Nurse.

Comprehensive treatment

A nursing home resident with a history of dementia presents with delirium, low albumin levels and fever. It is quickly established that a urinary tract infection is present and IV antibiotics are administered.

The aged care facility Director of Nursing or the nurse in charge requests that the GRACE team investigate the patient's dietary needs as the patient's swallowing ability and physical condition has recently deteriorated.

A Dietitian visits the patient during her two-day stay and a new dietary regime is established. The patient's delirium is resolved with the antibiotic therapy and she is discharged home with oral antibiotics and high protein thickened fluids.

GRACE Emergency Department Flow



8:00 am

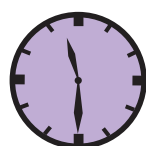
GRACE CNC contacted about an aged care facility resident, José, who has suffered a fall and has hip pain.

GRACE CNC completes triage form over the phone and confirms the need for a hospital assessment. The CNC inquires when patient last ate and advises 'nil by mouth'.



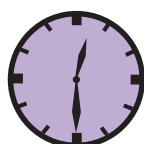
10:30 am

GRACE nurse checks EDIS (patient expected) and ensures the Emergency Department Triage Nurse is aware of José's transfer. José arrives and ED triage contacts GRACE CNC.



11:30 am

GRACE CNC contacts the aged care facility and advises them of status and treatment. The facility staff have a clear and consistent point of contact should they or José's family require an update.



12:30 pm

CNC discusses José's treatment with the Junior Medical Doctor in ED and discusses the reason why José should be returned to his home if there is no fracture evident. Fast track diagnostics allow a timely management plan to be put in place reducing the risk to José of adverse events while in ED.

All GRACE patients have access to rapid geriatric assessment in the EMU if required. The GRACE Team liaises with the aged care facility and the GP on José's progress.



2:30 pm

José returns home.



7:30 am

Hostel manager phones hospital switch and pages the ASET nurse. The ASET nurse performs a phone triage, takes patient history, past and presenting medical concerns. The hostel manager reports that Wendy, an active 75 year old resident, is bypassing her catheter.



7:45 am

The ASET nurse calls the Sydney Home Nursing Service and arranges for the service to visit the hostel that day.

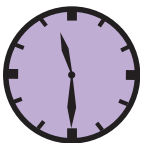


8:00 am

The ASET nurse calls Wendy's GP to consult on Wendy's care plan. The ASET nurse establishes that Wendy had the in-dwelling catheter (IDC) inserted following a hip replacement. Whilst in the private hospital Wendy had only one trial void and was found to retain 500 mls. She was discharged with an IDC and plans made for a suprapubic catheter (SPC).

The GP advises that Wendy is due to have the SPC inserted in two weeks but he feels that if Wendy is given supported trials, a SPC may be avoided.

Trial voids and inserting catheter can not be supported within the hostel. The ASET nurse and the GP agree to assist Wendy in trial voids.



11:30 am

The ASET nurse brokers the Sydney Home Nursing Service to visit Wendy for the next three days.



2 days

After three visits from the Sydney Home Nursing Service, Wendy is catheter free and the SPC surgery is cancelled.



3 days

Wendy is delighted to be catheter free. She is back on her feet. The total cost of this occasion of service was \$150.

GRACE Success Stories

These are true stories that show how GRACE can provide better care for older patients in the home, avoiding the need for Ambulance travel, treatment at an Emergency Department and hospitalisation.

What's good about these stories?

- Residents are cared for in the comfort of their home rather than coming to hospital.
- The capacity of the aged care facility staff is enhanced.
- Access block is reduced.

GRACE avoids 13 Emergency Department presentations

Josie, the Director of Nursing at Pinedale, a local nursing home, phones the GRACE CNC to advise she has six nursing home residents and seven hostel residents with gastroenteritis. Many of these 13 residents are starting to show signs of dehydration and have the potential to present at the ED.

After discussion with the Emergency Department physician it is agreed that the provision of subcutaneous fluids at the nursing home would assist both the nursing home and the hospital to effectively manage the outbreak. The GRACE CNC and another registered nurse take 13 three-day subcutaneous fluid packs to Pinedale.

At Pinedale, the CNC discusses infection control and subcutaneous fluid pack use with the registered and enrolled nurses. The nurses are then able to provide in-service training to other staff. The Director of Nursing also contacts each resident's general practitioner to inform them of the care plan that has been established for their patient. Pinedale staff use half of the subcutaneous packs for the patients who are dehydrated.

None of the Pinedale residents require hospitalisation. As a result, the chance of adverse events such as falls, medication errors, and the development of pressure areas is reduced.

Betty is a 76 year old nursing home resident.

Staff notice Betty has a blocked PEG tube.

The GRACE CNC gives advice over the phone which allows nursing home staff to unblock the PEG tube.

Hospital admission is avoided and Betty remains comfortable at home.

Van is a 90 year old woman in a nursing home.

She has a left CVA, and is aphasic with intermittent wheezing. She hasn't passed urine for 17 hours.

The GP wants to treat her at her home but Van's daughter wants her mum to be treated in hospital.

The GRACE CNC telephones Van's daughter and discusses treatment choices.

With input from GRACE Van is treated at the nursing home.

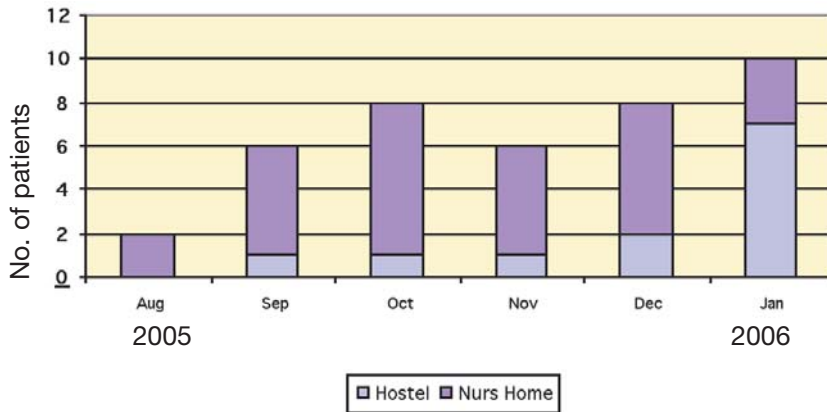
Franco is an 89 year old nursing home resident with cellulitis.

He is admitted to hospital overnight, returning to the nursing home with an IV in-situ for twice daily antibiotics.

The GRACE CNC arranges for the Community Acute and Post Acute Care team to assist with the management of the IV antibiotics.

GRACE sends a medication sheet and the required amount of antibiotics with Franco's discharge letter to the nursing home and Franco is able to continue to be treated at home.

Graph 2: GRACE - ED Avoidable Presentations by Month



Source: Hornsby Ku-ring-gai Health Service

Graph 2 shows the effectiveness of the GRACE project in maintaining residents in their facility. Since August 2005 the number of GRACE patients who have avoided presentation has risen from two patients per month to ten patients per month in January 2006.

Before GRACE was implemented aged care facility residents had an average length of stay of six days. GRACE has helped to reduce length of stay, freeing up bed days. (See Toolkit for other performance indicators showing the success of GRACE).

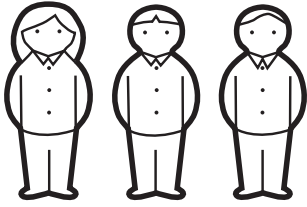
Louise is a 83 year old hostel resident.

Louise has COPD and became increasingly breathless through the night. After a GP visit it is determined that Louise needs IV antibiotics.

The hostel manager calls the ASET CNC, who arranges for the APAC service to visit the hostel and deliver a care plan. The APAC team liaises with Louise's GP and respiratory physician.

After seven days of regular antibiotics injections, physiotherapy and social work visits, Louise is back on her feet.

Establishing and Maintaining GRACE



Leadership and support

Partnerships between the hospital, residential aged care facilities and general practitioners are essential.

Visit each aged care facility and GP Division meetings to explain GRACE.

Find clinical, senior management, and nursing **champions** in the hospital and ED that will assist staff to work collaboratively. Local GP and aged care facility champions like directors of nursing are also critical.

Establish **Steering Committee**.
(See Toolkit for more information.)



Project Management

A **project officer** can pull people together, document, plan, monitor, report on targets and “put the legs on the ideas”.

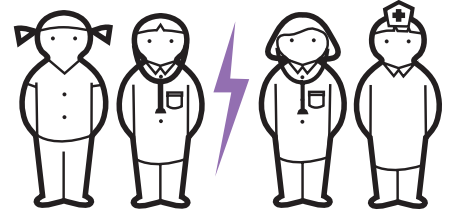
Create a **project plan** that staff own. Involve them in the development but don't make it hard or time consuming. The plan should set out:

- the burning platform for change - evidence about the current patient journey problems
- the vision and ideal patient journey
- objectives and strategies
- roles and responsibilities
- baseline data and key performance indicators.

Set firm but realistic **timeframes** for implementation and stick to them. Allow time for obtaining staff support, orientation to process mapping, developing the model of care as well as documenting KPIs and baseline data.

Key **performance indicators** need to be developed and strictly monitored. These may include:

- hospital admissions avoided
- reduced length of stay in hospital and ED
- reduced access block
- increased patient, hospital staff, aged care facility, and GP satisfaction
- decreased adverse events.



Create tension for change

Talk up the need for change across all facets of the hospital, aged care facilities and among GPs. Create a folder of evidence that can be reviewed at any time. Describe the current patient journey.

Take the time to educate and inform people, particularly the key opinion leaders and the ‘nay sayers’, about the benefits to the patient, aged care facility, ambulance service and hospital of caring for residents ‘in the home’.



Commence Service

Define key GRACE team members*.

Appoint a GRACE CNC and base them in or near the ED.

Interdisciplinary team work is essential.

Continue visits to aged care facilities and GPs.

Hold regular team meetings and review individual patient journeys.

* see section on Staffing.

Marketing & Celebrate Success

This is a critical role for the Project Officer/Steering Committee/CNC.

Foster **good communication** through informal and formal means.

- Produce information sheets, newsletters and presentations for general practitioners, the community, patients and their families, hospital and aged care facility staff.
- Informal sessions over coffee can create the incentive for people to take time from their busy schedules to listen in a non-threatening and collaborative manner.
- Establish methods for rapid feedback from patients and staff in addition to patient surveys. Respond directly to feedback.

Celebrate and communicate every tangible achievement of the project through a variety of means including morning teas, awards, mentions at staff meetings.

Nominate your model, champions and teams for internal and external awards.

Evaluate

Steering Committee and GRACE project team review initial data results, including results of patient, hospital staff, GP and aged care facility surveys.

Refine model as required.

Staffing

Staffing levels will depend on the size of the hospital and the number of aged care facility residents within the hospital catchment area.

These estimates are for the establishment of GRACE within a metropolitan general hospital. They also take into account the need for enhanced collaborative relationships between GRACE and other clinical, nursing, community health and administrative staff.

- 1.0 FTE GRACE CNC.
- 0.5 FTE Geriatric Registrar. At HKHS a full time Geriatric Registrar has been employed to build capacity within the organisation. A key role of the registrar at HKHS will be to spend time with the GRACE project and the Agedcare Services in Emergency Team.
- 0.5 FTE Project Officer (Clinical Nurse Consultant).
- An Agedcare Services in Emergency Team to assess and quickly identify elderly patients, provide support to the GRACE CNC and enhance the ability of the hospital to provide a seven day a week service to the aged care facilities.
- A staffing profile in the Emergency Medical Unit that allows additional nursing care for elderly patients.

Agedcare Services in Emergency Team (ASET)

The ASET assesses elderly patients and provides rapid identification of those whose journey will be enhanced by GRACE. During weekends, the ASET and GRACE CNC roles can combine to provide a comprehensive and extended service to aged care facilities.

Aged Care Liaison Nurse (ACLN)

If an aged care facility patient is admitted to the EMU, the ACLN is able to follow up and identify issues with the patient and has an essential role in ensuring that they have a smooth transition back to their home.

Community Nursing Service and Community Acute/Post Care Team

The Community Nursing Service and the Community Acute/Post Care Team provide expert multidisciplinary care to patients with complex needs once they have been discharged home to an aged care facility.

Emergency Department nurses

The GRACE project has also increased the capacity of Emergency Department nurses by cultivating aged care skills in interested nurses. At HKHS, five ED nurses have completed the GRACE/ASET preceptorship. These nurses now have an increased awareness of aged care issues and community resources, which in turn assists with discharge planning. In the ED, the GRACE and ASET nurses prioritise their patients. When the GRACE/ASET presentations are low these nurses assist the ED staff, allowing full utilisation of their time. After hours the GRACE and ASET teams combine.



Registered and enrolled nurses

At HKHS, the Nurse Unit Manager of the Emergency Medical Unit altered the staffing profile to increase the numbers of enrolled nurses to look after GRACE patients. Aged care facility residents often have eating difficulties and, because of their frailty, require regular repositioning in a gentle manner to prevent skin tears and pressure areas developing. Many elderly patients become disorientated to person, time and place in the unfamiliar environment of the hospital and mobilising them requires additional time and expertise and therefore additional nursing care.

It has also been identified at HKHS that a Geriatric Registrar is required to build capacity within the organisation.

Resources

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For more information about GRACE visit the Models of Care section of the ARCHI website

www.archi.net.au

Here you will find an electronic copy of this document, a resource toolkit and have the opportunity to participate in online discussion groups.

Implementing GRACE

Process Map

Visit the online version of this process map on the ARCHI website at www.archi.net.au/elibrary/build/moc

Here you will be able to access more information on each of the steps in implementing the model. You will have access to tools and templates as well as hints and lessons learned by others who have implemented the model.

	Planning
Governance	<ul style="list-style-type: none"> • Develop partnerships between the hospital, residential aged care facilities and general practitioner • Identify Leaders • Establish a Steering Committee • Develop a Process Map
Patient Journey How do patients flow through the model	<ul style="list-style-type: none"> • Planning the Patient Journey
Policies and Protocols	<ul style="list-style-type: none"> • Identify and review current policies and protocols affecting care of the elderly
People Understand who the staff are, how they function and what role they play in the patient journey	<ul style="list-style-type: none"> • Engage GPs, Residential Aged Care Facility Directors of Nursing, ward and ED clinical, senior management and nursing champions. • Stakeholder analysis
Resources	<ul style="list-style-type: none"> • Survey current resources • Identify resources needed to establish and maintain GRACE
Communication	<ul style="list-style-type: none"> • Develop a communication plan

Prepare and Implement	Operationalise and Review
<ul style="list-style-type: none"> • Develop a Governance Plan • Recruit project officer • Develop key performance indicators 	<ul style="list-style-type: none"> • Monitor and evaluate KPIs.
<ul style="list-style-type: none"> • Incorporate findings from patient journey into TO BE process map 	<ul style="list-style-type: none"> • Regular monitoring of patient experience via regular patient journey mapping
<ul style="list-style-type: none"> • Develop policies and protocols relating to the care of patients 	<ul style="list-style-type: none"> • Use protocols
<ul style="list-style-type: none"> • Develop position descriptions for staff allocated to GRACE (link to blank process page and then link to staffing page 22 in Model of Care) • Develop competencies & an educational program for nursing staff 	<ul style="list-style-type: none"> • Develop a review process
<ul style="list-style-type: none"> • Deliver required resources 	<ul style="list-style-type: none"> • Monitor resource use
<ul style="list-style-type: none"> • Execute communication plan • Identify how results will flow back to the project 	<ul style="list-style-type: none"> • Feedback and review process

