NSW GOVERNMENT Health
Hunter New England
Local Health District

medicare local HUNTER
Connecting health to meet local needs

Adapting ACE to a Rural community

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Staff Specialist Clinical Governance, HNE

In partnership with:
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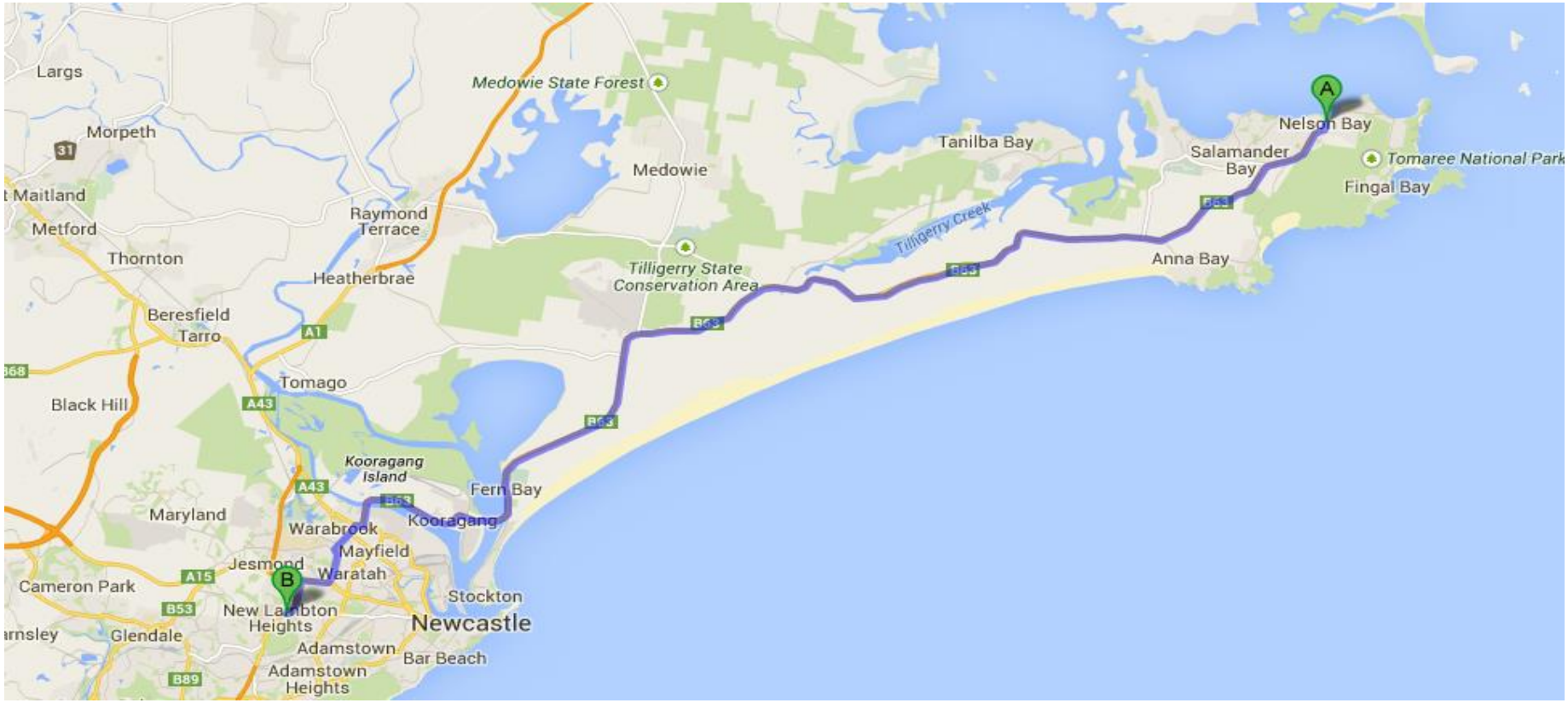
Hunter Medicare Local (HML) After Hours Service

Aim Statement

To reduce primary transfers from the Tomaree Peninsula RACFs to the Calvary Mater and John Hunter Hospitals by 40% by December 2014.

Tomaree Demographics

- Tomaree Community Hospital to John Hunter Hospital = 57.2 km



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History of ACE

- 2010 - 2012 pilot at JHH Newcastle
- Now, approx. 80% of RACFs in Hunter region (Newcastle, Lake Macquarie, Maitland and Manning region) have implemented the system
- EDs participating include JHH, Belmont, Calvary Mater, Maitland Hospital and Manning Rural Hospital, Tamworth, Armidale and Tomaree Community Hospital
- MoU between HNELHD and HML guides practice and policy

Aim of the ACE service

- Improve and maintain relationships and collaboration with HML, HNEH, RACFs, GPs, Ambulance NSW
- Provide evidenced based algorithms for common problems
- Provide telephone advice and support to RACF staff
- Establish patient goals of care prior to transfer
- Provide care coordination within ED aligned with patient goals of care
- Provide education and empowerment of key clinicians
- Change management and coordination for the ACE service key stakeholders

Team members & role

Project Sponsor: Karen Kelly Nursing and Midwifery HNE

Project Team Leader: Jacqui Hewitt: ACE CNC

Advisors to project:

- Dr Carolyn Hullick: Clinical lead for the ACE Service HNE, Staff Specialist Emergency Medicine & Clinical Governance HNE.
- Sarah Rivett: Ambulance Liaison Officer ASNSW
- Jenny Carter: Service Manager PFU HNE

Participants: Primary and Community HNE

- Gary Spain: Service Manager for TCH
- Christine Smith/ Meiko McKeon: NUM TCH
- Dr Sheahan Ranisinghe : TCH

Acute Services HNE

•Dr Cameron Dart: Director of Emergency Medicine CMN

•Margo Smith: ASET Nurse CMN

GP representation:

•Dr Tony Plummer: GP Nelson Bay Medical Centre

ASNSW:

•Shawn Breen: Station Officer Nelson Bay ASNSW

•Mark Gardiner: Inspector / Duty Operations Manager / Hunter New England Sector / Zone 2 Regional Operations

RACF Representation

•Fran Bowtell/ Kacey Snell: Clinical Nurse Specialist Harbourside Haven RACF Shoal Bay

•Community Representative/ Patient Advocate

•Jeanette Antrum

Evidence for there being a problem worth solving

- Patients managed at home in RACFs have similar survival rates and fewer complications compared to those transferred to hospital

(Stokoe, et al 2015)

- If hospital transfer is necessary, it needs to be to a hospital that can meet their clinical needs in line with the patient's goals of care.

(ACE evaluation Conway & Higgins 2011)

Evidence for there being a problem worth solving

- Most transfers to hospital from Tomaree RACFs are consistent with the ACE service :

  Falls, General Medicine, urinary symptoms, pain, constipation, Respiratory Issues, lethargy, dizziness and diabetes issues

- Most of these conditions do not require tertiary hospital intervention

Evidence for there being a problem worth solving

- 80% of presentations from Tomaree RACF's are transferred directly to either CMN or JHH ED with only up to 20% being transferred to Tomaree Community Hospital

(Ambulance and IPM data 2014)

- Reducing ambulance transfers frees up ambulance resources.
  - Geographic isolation of Port Stephens

Pre- ACE patient journey - Mrs G

Patient background:

- End stage Dementia
- Behavioural, long history mental health issues
- Advance Care Directive (ACD) - not for CPR
- Daughter is enduring guardian

Situation:

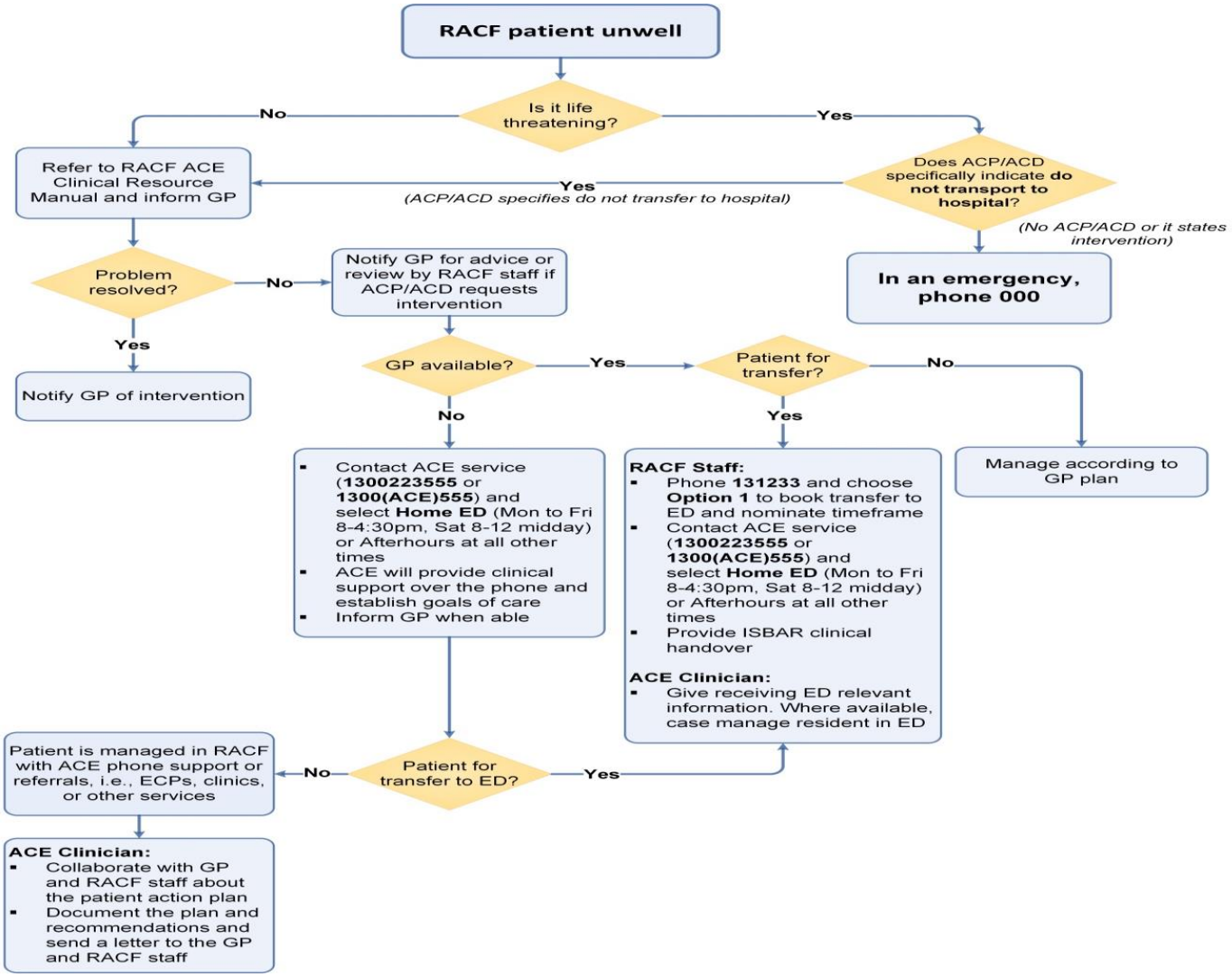
- Patient stopped eating and drinking
- Minor fall with no apparent injuries but refusing to weight bare
- Increased confusion will exacerbate in hospital

Patient journey continues

What happens next?

- RACF call 000
- Patient transferred via Ambulance to CMN
- Ambulance off stretcher delays at CMN
- X-rays show no fracture
- Bloods show low Potassium treated with Intravenous fluids
- Family unable to visit due to work, family commitments and distance from Port Stephens
- Patient more confused and distressed without family
- 3 days later delayed discharge due to transport availability

Flow Chart of Process



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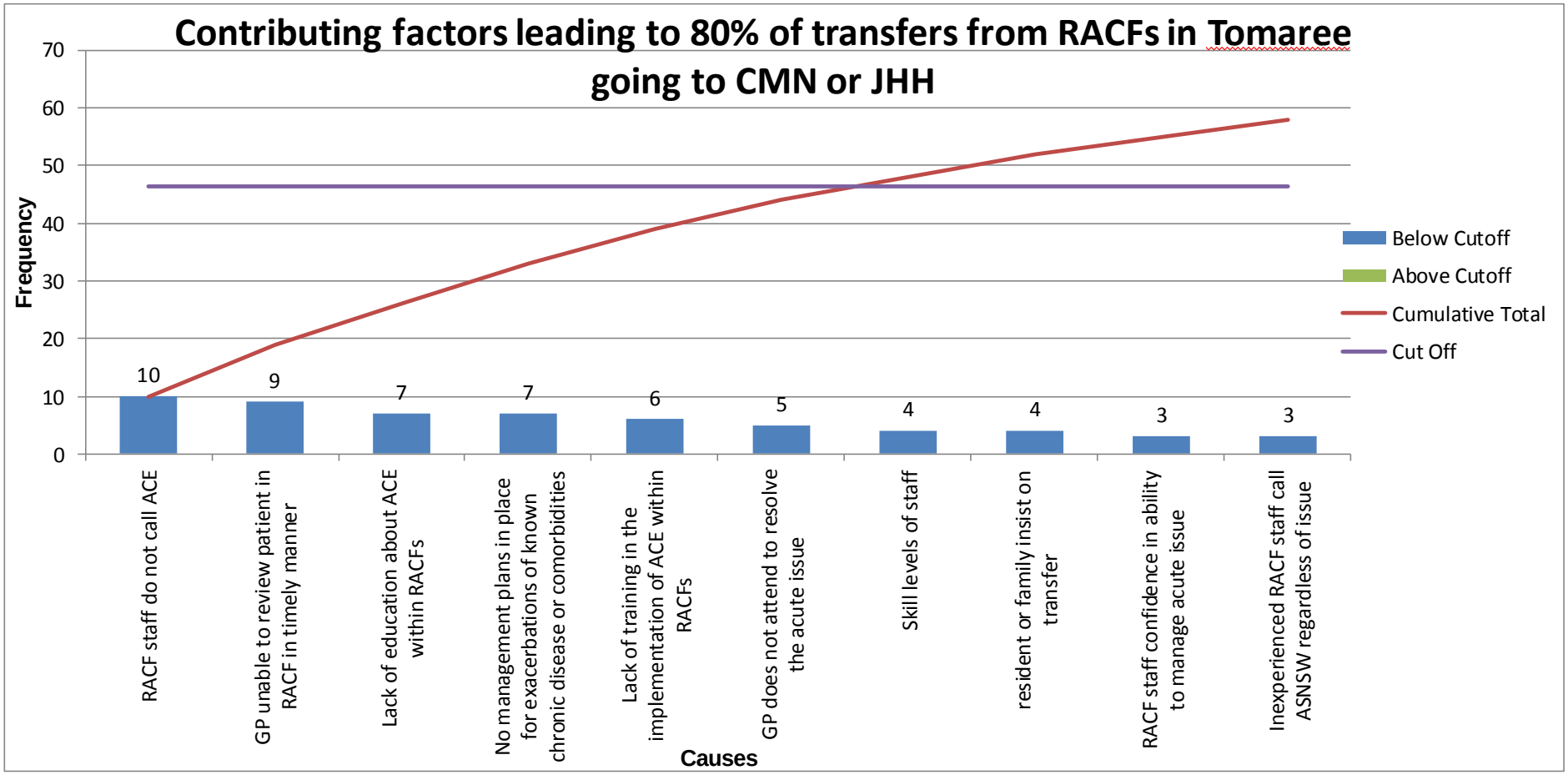
Pareto Chart



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Possible solutions

- Reinvigorate ACE service with Tomaree RACFs
- Local home ED is Tomaree
- GP or GP practice nurses first port of call then ACE (ISBAR saturation to RACFs)
- TCH staff take ACE handover from RACF staff
- Local interagency meetings
- Trial specific management plans via GP

Data – Ambulance 1st month of ACE

- Ambulance P3 data - transfers to CMN and JHH reduced by 35.5% when calculated against pre implementation data
  - 5% short of Target after only one month of implementation
- In real numbers this equates to 15 less transfers to CMN and JHH
- Ambulance costs include transfer and return of patient:
  - JHH $1534.64. CMN $1385.96
    - (call out fee is $349 x2 and $ 3.15 per km x4)
- Ambulance cost savings in one month = $21,904.50
- Ambulance are more available to community for 000 calls

Cost savings for ACE from reduced ambulance transfers

Data- Ambulance 2nd and 3rd Month of ACE

- Ambulance P3 data Transfers to CMN and JHH reduced by 66% when calculated against pre implementation data. 26% above target.
- In real numbers this equates to 70 less transfers across 2 months = $102,221.00
- Overall transfers to Tomaree Hospital from RACFs were also reduced by approx 30%

Post ACE patient journey - Mrs G

Patient Background:

- End stage Dementia
- Behavioural, long history of mental health issues
- ACD- not for CPR
- Daughter is enduring guardian

Situation:

- Patient stopped eating and drinking
- Refusing to get out of bed, not interacting with staff, not eating
- Staff concerned patient may have UTI
- Falls and increased confusion exacerbated by hospital

Patient Journey Continues

What happens next

- RACF phones ACE
- Collaborative decision to transfer to Tomaree via booked Ambulance
- No UTI and Potassium found to be critically low
- Discussion with daughter regarding treatment
- IV fluids given over 24hrs at Tomaree
- Family able to visit to support patient with Dementia care
- Returned to RACF the next day
- No ambulance or off stretcher delays
- Follow up phone call after discharge to check she is OK

National Safety and Quality Australian Standards

ACE aligns to the following standards

Standard 1 – Governance for Safety and Quality in Health Service Organisations 14

Standard 2 – Partnering with Consumers 22

Standard 4 – Medication Safety 34

Standard 5 – Patient Identification and Procedure Matching 40 (Goals of care)

Standard 6 – Clinical Handover 44

Standard 8 – Preventing and Managing Pressure Injuries 54

Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care 60

Standard 10 – Preventing Falls and Harm from Falls

Excellence and Core Values

- Every Patient : Every time
- Strategic Priorities

1. Community – Empower communities
   - Engage as partners
   - Reduce health disadvantage
2. Service - Cooperate and collaborate with our partners
   - Develop a culture of service and person centred care
3. Safety and Quality – Provide safe, evidence based, effective healthcare
4. Resources – Effective use of finite resources
5. Positioning for the future - Research, education, innovation, sustainable technology
6. Work place and Culture – Ethical and accountable for upholding shared core values

Strategies for Sustaining Improvement (holding the gains)

- Regular local Interagency meetings have been shown to improve relationships, maintain compliance and support solutions
- Continue education with all stakeholders
- Monitor data ongoing (new iPM data)

Strategies for Spreading:

This Project can be replicated for similar stakeholder groups or adapted to suit the following:-

- Whole of hospital approach for RACF patients
  - Data visibility will focus attention
- Chronic disease management plans including escalation plans for RACF residents
- Older people living at home
- People with disability
- Tele-health
- GP models of care including rural

Thankyou