

RAD TEAM

Response, Assessment & Discharge

AMBULANCE
DIVERSION PROJECT

Presented by:
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RAD Team Ambulance Diversion Project

Frankston Hospital Major Provider of acute secondary & tertiary hospital services on the Mornington Peninsula – Victoria

336 bed facility

General & specialty medical & surgical services, mental health, maternity & paediatric services.



RAD Team Ambulance Diversion Project

- RAD Team developed in 2000
- Comprehensive assessment & case planning.
- Facilitate the allocation of hospital & community resources to patients at the point of entry to the hospital system.



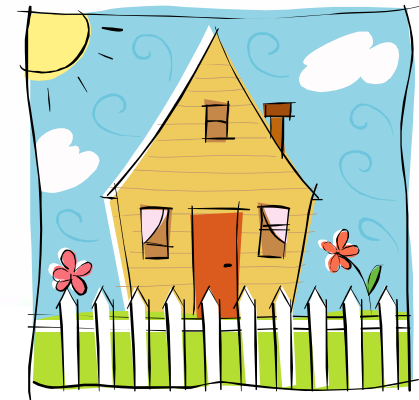
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The Proposal



Allied health outreach program to patients in their own homes.

Triaged by MAS as not requiring transportation to hospital if they could be supported at home.



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The Approach

Multi-disciplinary steering committee

- Medical
- Nursing
- Allied health staff
- MAS representatives



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MAS Referral Service

- Effectively & efficiently utilise resources
- Manage the demand for ambulance resources by identifying patients ringing “000” who do not require ambulance transport.
- Prevent avoidable use of Emergency Departments
- Better match the service provided with patient needs.



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Referral Service Benefits

- Reduced pressure on hospital Emergency Departments
- Increased availability of ambulances
- Ability to refer callers to more appropriate allied health professionals
- Increased patient & community satisfaction
- Increased staff satisfaction within the EDs & MAS
- Pooling of resources within the health sector
- Increased capacity of the health care system to respond to demand.



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Service Model

- 000 call received
- Evaluated by Emergency Communications Victoria.
- Call transferred to 000 Referral Service
- Registered nurses & paramedics conduct triage
- Disposition reached
- Paramedics in field refer to referral service for alternate community service provider



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Receipt of call

- Blackberry device receives electronic referrals from Referral Service.
- RAD contacts patient within 1 hour of referral.
- Home visit scheduled
- Ambulance required
- No further action required



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Types of cases referred

- Balance & mobility problems
- Decreased in ADL function
- Feelings of isolation & loneliness
- Medication management issues
- Social crisis or isolation
- Difficulties transferring to & from bed/chair
- Falls
- Dementia related issues
- Self neglect
- Requiring respite
- Home care



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Case Scenario

- 85 year old lady
- Lives at home alone
- Frequent falls
- MAS called
- No injuries
- Able to weight bear



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Case Scenario

- 78 year old man with dementia
- Lives at home with daughter
- Daughter phoned MAS because of increasing difficult behaviour & lack of understanding of dietary & medication requirements for newly diagnosed IDDM.



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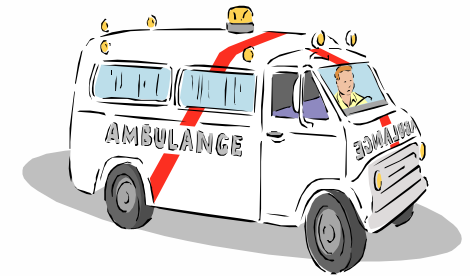
Exclusion Criteria

- Locations requiring police to respond with paramedics
- Patient or carer is at risk of harm
- “Location of Interest” (LOI) tag
- Manual lifting required
- Medications need administration



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Case Management Plans

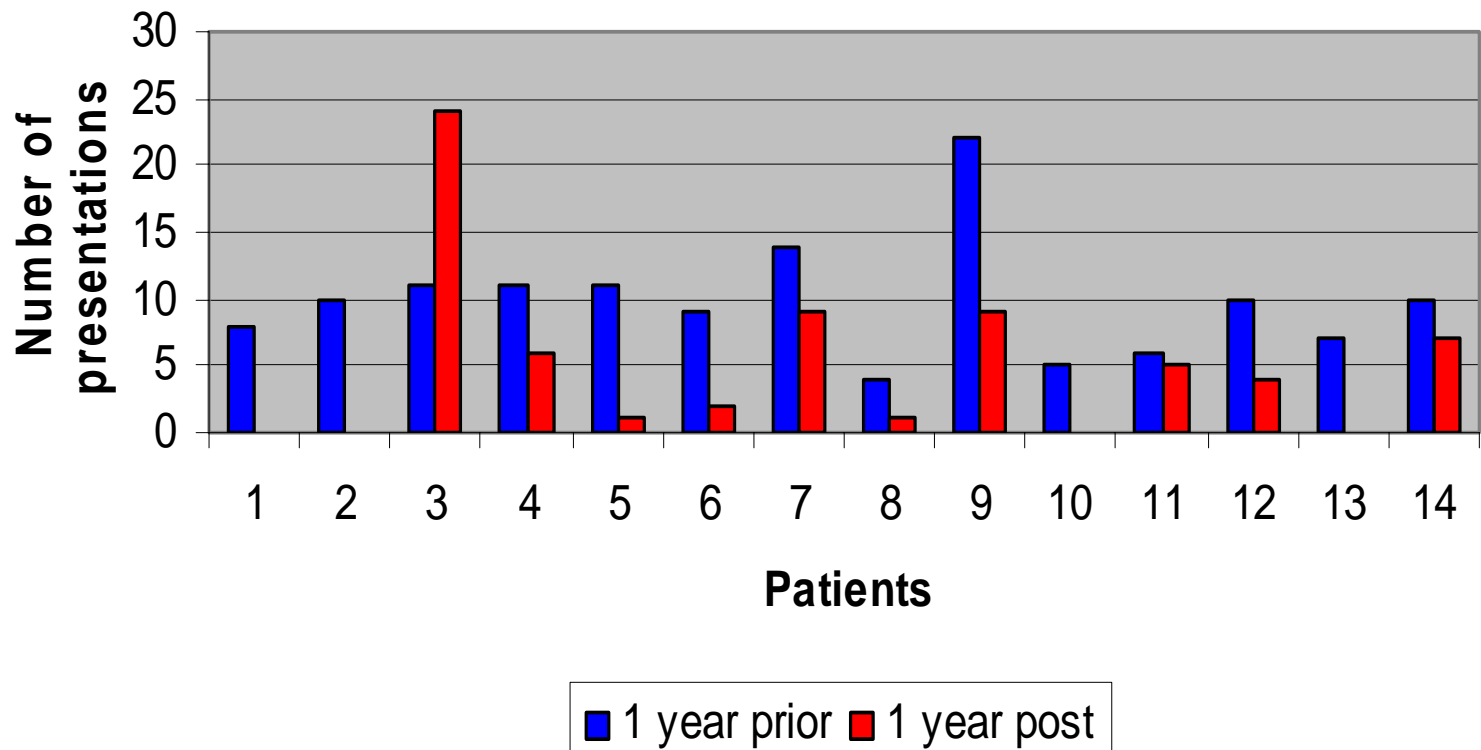


- Complex Care Team
- Case Management Plans
- Referral Service able to redirect patient to case management plan
- Automatic fax sent to case manager
- Dramatic reduction in ambulance attendance.



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MAS Management Plans 1 Year Post Intervention



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Outcomes

Since Referral Service has been implemented in October 2003..

- Over 100 referrals have been managed by the RAD team.
- 100% provided with home based assessment & support.
- 0% referral bounced back to “000” within 24 hrs.
- 78 ambulance call outs saved.



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Future Directions

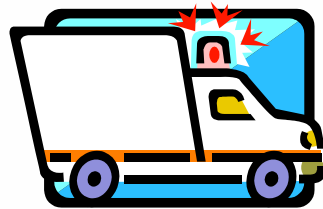


Residential Outreach Support Service

- PEG feeding tube & Catheter Care



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Emergency

Limitations

- Paramedic Education
- Staff rotational system of MAS
- Hours of availability



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Conclusion

- A good alternative to ED presentation
- Positive feedback from patients involved in program.
- Improved relationship with MAS & the Hospital.
- Linked approach with community supports and acute health.

