
The Community Transition Service Auckland City Hospital

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Population

N.Z – 4,301,812

Auckland – 1,303,068

ADHB – 420,000

approx – 10% >65

yrs age



History

- Health of Older People Strategy -2002
- A+ Links Home and Older Peoples Health (A+ Links) – Integration of Community Health and Health Services for Elderly
- Service development

A+ Links Home and Older People's Health Service Development

- **Closure of Day Ward**
- **New Stroke Day Assessment unit**
- **Auckland City Memory service**
- **Community Rehabilitation Team > 65yrs**
 - stroke
 - frail older adult
- **Short term home care services**
- **Specialist nursing teams – Gerontology, Oncology, Ulcer, Ostomy.**
- **Multidisciplinary triage**
- **Needs Assessment Service (NASC)**
- **Aged Residential Care Sector NS**

Community Transition Team (CTT)

4 Phases

- **A+ Links initiative**
- **Introducing Community based Gerontology Nurse Specialist to acute setting**
- **Collaboration with AED/APU**

Adult Emergency Department (AED)

- Major trauma centre for Auckland. N.Z and Pacific Islands
- Located in Central Auckland- large number of homeless people: near major entertainment centre:

Assessment and Planning Unit

- 46 bed short stay unit next to AED
- 14 monitoring beds
- Patients treated under relevant specialty
- Stay usually 24-36 hours – discharged home or admitted to wards.



Statistics – Nov 2007- 31 Oct. 2008

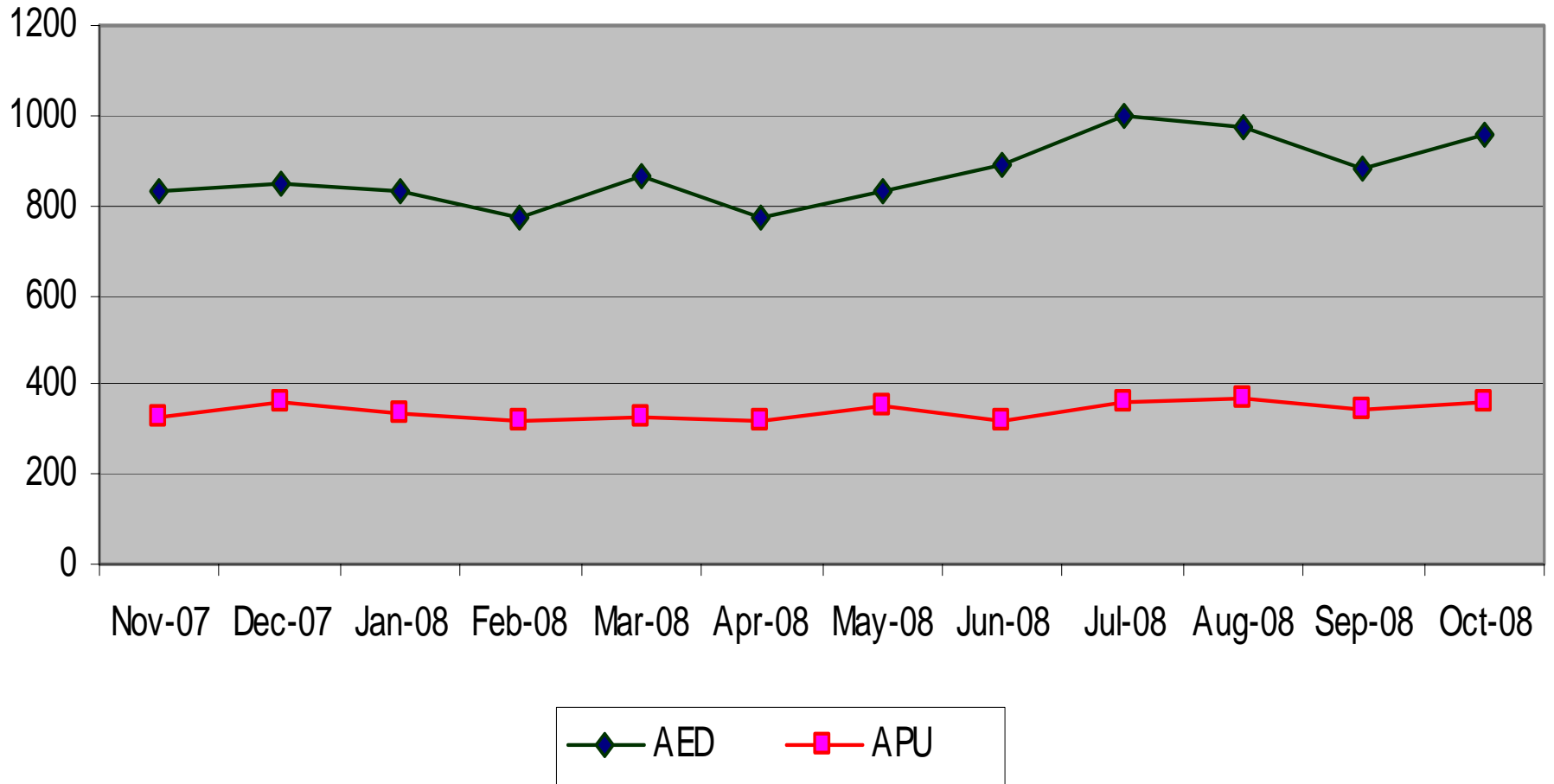
55.124 Admissions to AED and APU

26% \geq 65 yrs (14,544)

- 10,446 admitted to AED
- 4,096 admitted to APU
- 8908 self referrals
- 8867 admitted to AED from home
- 43% discharged from AED and APU



Admissions over 65 years to AED or APU, Nov 07 to Oct 08



Community Transition Service

A service for people over the age of 65 admitted to ED and/or APU and subsequently not requiring inpatient admission will be supported to return home safely.

Four Phases

Phase 1 – two week orientation and patient profile

Phase 2 – October 2008 to April 2009 – introduction and service development

Phase 3 – July 2009 - service expansion to Gen Med and Orthopaedic acute services

Phase 4 – TBA. To all acute services

CTT team

- Gerontology Nurse specialist in ED and APU
- Health Care Assistants – Community Health
- OPH medical team – geriatricians, registrars, ward staff.
- Community health team

Readmission process – Readmit to OPH ward

After hours- call District Nurses or GP

Screening

- Clinically stable
- No evidence of delirium
- Have key to front door
- Connected phone
- Able to physically get from car to door.
- Be safe over night
- Have medical support



If accepted ---

Contact family/support people



Research IS for past history



Contact GP for information and support



Refer to HCA, providing a plan for service



**Client returns home with family/ HCA
with equipment/scripts/discharge letters**



**Settled at home with warmth, food,
medication, equipment, contact numbers**



Arrange to visit next day to ensure client settled



**GNS follows through with HCA, family/client
→ on going assistance determined**

**Visits, phone calls, referrals on , liaison with other services for
Follow for
apprx. 2 weeks**

CTT Outcomes

- Reduced readmission rate
- Early discharge
- Timely referrals
- Improved quality of life
- Delayed residential care placement

Phase One - orientation

AED Issues

- Interrupting usual ED assessment/ interventions
- Discharge letters
- Confusion re existing relationship with A+ Links OPH inpatient referral pathway and CTT/ GNS.
- Building relationships with allied health, social workers, pharmacist,
- ACC home help delay in service provision
- Introducing a community focused nurse into an acute hospital setting.

Phase one – orientation (cont)

APU

- Multiple medical teams
- Developing a patient profile
- Increased response to patients from residential care
- Gaining a understanding of processes and acceptance
- Out of hours referral process

Phase Two - AED /APU

- GNS role important as liaison – Gerontology skills, advocacy, support patient/family/whanau
- Established working relationship with AED/APU staff including pharmacists.
- Inclusion in AED/APU complex patient plans.
- Direct transfer to residential care from AED/APU
- Short term home care assistance supplementing long term service delays.
- Accident Compensation (ACC) funding for interim home support
- Improved communication and collaboration between acute and Primary services.
- F/u - home reviews, assessment and phone f/u provide acute services with bigger picture

Case 1-AED

Mary -83yrs old, living alone

Admitted during night with abdominal pain

Diagnosis – constipation

AED case -1 continued

CTT input

- **Liaison with niece who assisted her home.**
- **GNS visited next day**
- **Prescription not filled**
- **Confusion re laxatives**
- **Weight loss, ↓ reduced appetite, ↓ fluid intake**
- **Had had home invasion 4wks earlier now too scared to leave house**
- **Lying on couch most of time**

APU - case 2

Jim, 95yrs old, lives in serviced apartment

No family in Auckland

Admitted with SOB, lower leg oedema

Known to have CHF

Lonely since wife died 1 yr ago

CHF stabilised over 2 days

Concerns from staff re safe discharge

APU – case 2 – cont.

CTT input

- **liaise with medical team**
- **Taken home by GNS – prescription organised**
- **HCA visiting in afternoon and twice daily until Jim safe.**
- **Noted to have difficulty understanding instructions**
- **Confusion re medications**
- **Cognitive testing identified short term memory loss and comprehension limitations –Addenbrooke score 75/100**
- **Organised blister pack medications**
- **Referred to long term home services and for further memory testing.**
- **Referred to community gerontology team for support with CHF management.**

Profile of CTT client group

Several groups of older people

1. The frail older person – functional limitations, well known to services. (expected profile)
2. The older person with undiagnosed physical, psychosocial, cognitive, functional problems, elder abuse
3. The older person with complex chronic diseases, frequent admissions under acute services
4. The older person in a residential facility
5. Families struggling to understand processes
6. Unwell older people with dependent spouse at home.

Interim statistics (<i>n</i>)	AED	APU
Total number of patients to 28/2/2009	97	86
Average age	83.4yrs	83.2yrs
Live alone	44	38
ACC	34	15
Assist home	23	4
GNS assessment	88	67
Inpatient review	4	12
Home f/u by GNS	49	22
Phone calls	39	14
Referrals made	43	22

Where to from here

- Liaise with GPs – several patients had been unwell for several days prior to acute admission
- Age friendly patient information – constipation, dehydration, pain
- Develop Gerontology NP role.
- Extend routine risk screening and targeted GN assessment in ED/APU
- Develop a service accepted screening tool
- Develop gerontology resource nurses in acute areas.
- Collaboration with St John's and other NGOs
- Patient held record book for improved communication.

Service limitations

- Was a trial – GNS maintained some current responsibilities limiting time available to AED/APU
- Inclusion in A+ Links data base delayed. Data collection incomplete at this time.
- Uncertainty of funding

My Impressions

- A GN in ED is supported not only by research but by the older people and their families.
- Important to work with the acute services
- ED/APU provides an opportunity for timely interventions and improved quality of life.
- ED/APU staff have compassion and understanding for the needs of older people but not the time to intervene
- An acute MDT older peoples transition team is needed
- No longer the ambulance at the bottom of the cliff.

Community Transition Service

A big thank you to –

A+ Links: Manager, Nurse Advisor, Nurses,
Geriatricians, Registrars, clerical staff

ED/APU: Nurse Manager, Nurse Consultant.
CD Gen Med and CD APU, N.Ps, Nurses, ED
Consultants, Registrars, JMOs. Allied Health,
clerical and pharmacy staff

THANK YOU

References

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Teamwork, Collaboration, Communication

*We are all angels with but one wing
It is only when we help each other
that we can fly.*

Florence Nightingale

