

Transition Care Program

“There’s more to a client...”

A case study that highlights issues with
model of service delivery

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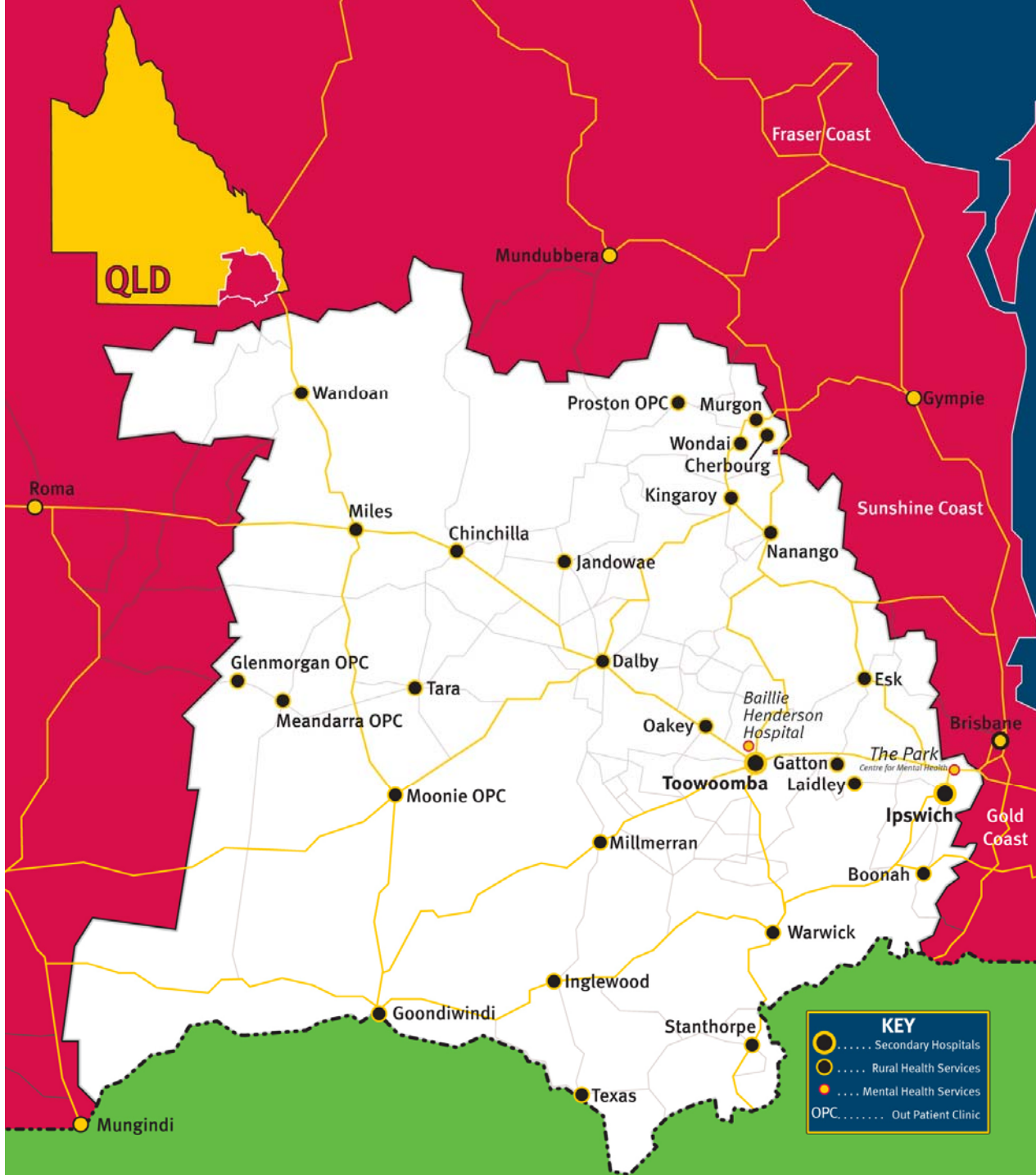
Queensland Government

Queensland **Health**

TCP Centres = Ipswich + Toowoomba

Hospitals providing referrals:

- Toowoomba
- St Vincent's
- St Andrew's
- Outlying hospitals
- Transfers returning from Brisbane



KEY

- Secondary Hospitals
- Rural Health Services
- Mental Health Services
- Out Patient Clinic

History of TCP in Toowoomba

2006 Staff

- RN (Coordinator)
- AHTA
- AO

Partnership model for:

- Allied Health
- PCW
- Domestic & social elements

November 2006

- TCP commenced
- 10 community operational
- 4 residential not immediately operational

2007 Staff increases

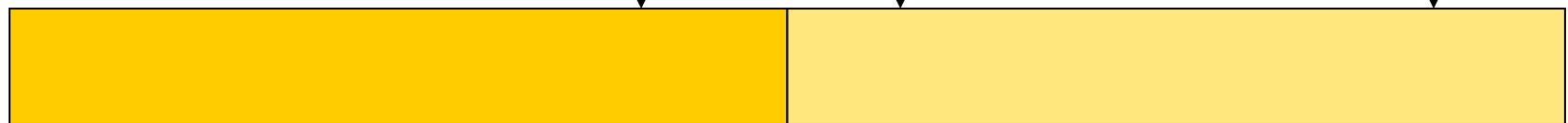
- 1 FTE Occupational Therapist
- 1 FTE Physiotherapist
- 1 NO2 RN for case management
- 0.5 FTE Social Worker

February 2007

- 2 residential beds operational

November 2007

- 2 residential beds operational



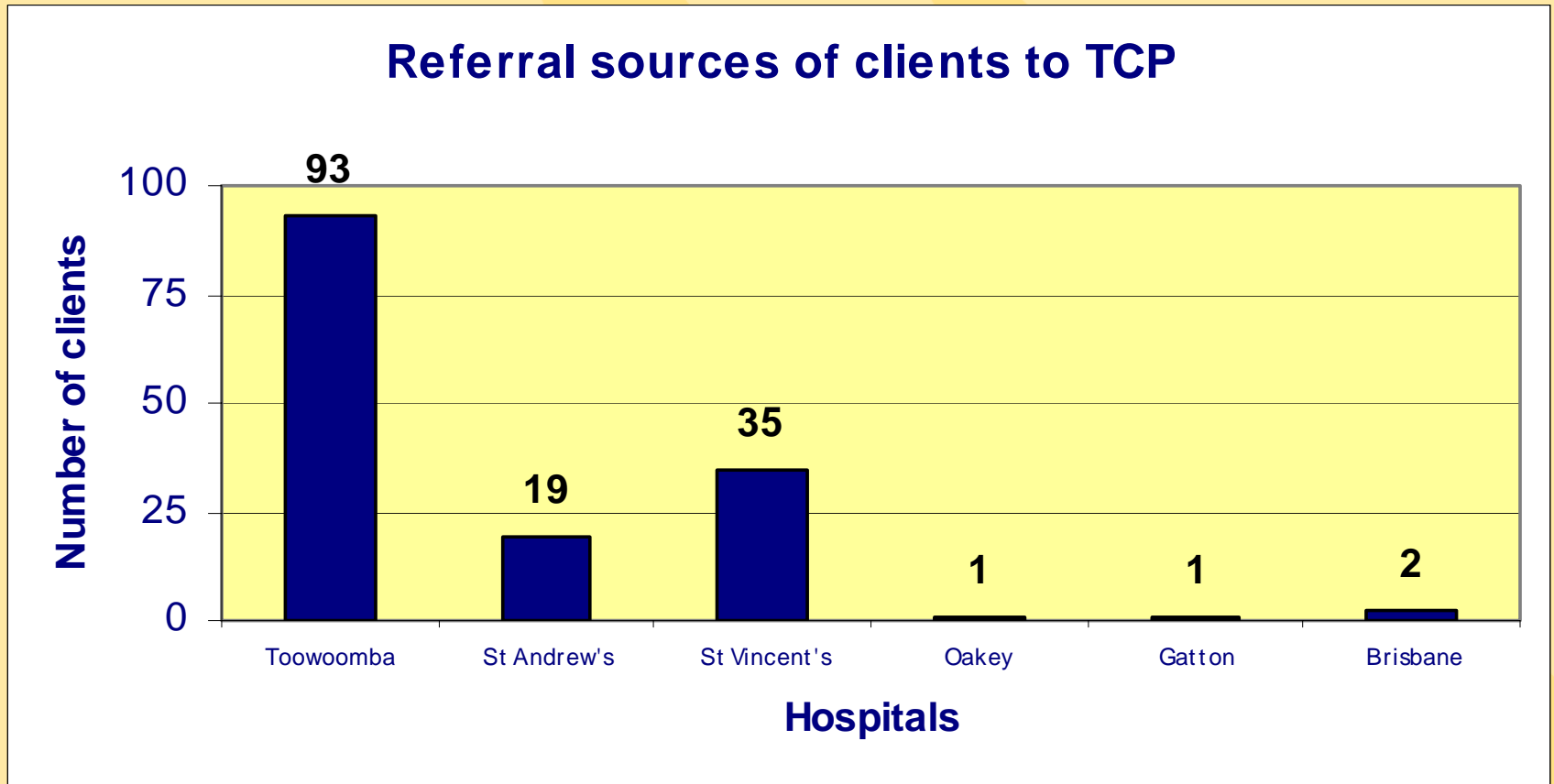
2006

2007

TCP Statistics

- 113 clients in 2008
- Average length of stay = 7.8 weeks

Referral sources of clients to TCP for 2008



Early model

1. ACAT assessment – done by trained TCP team members. Delegate approval obtained from ACAT.

2. A partnership model:

In team

- Case management
- Allied Health therapies (PT, OT, SW, Dietitian)
- RN – health care needs (eg wound, medication)
- AHTA
- Equipment loan

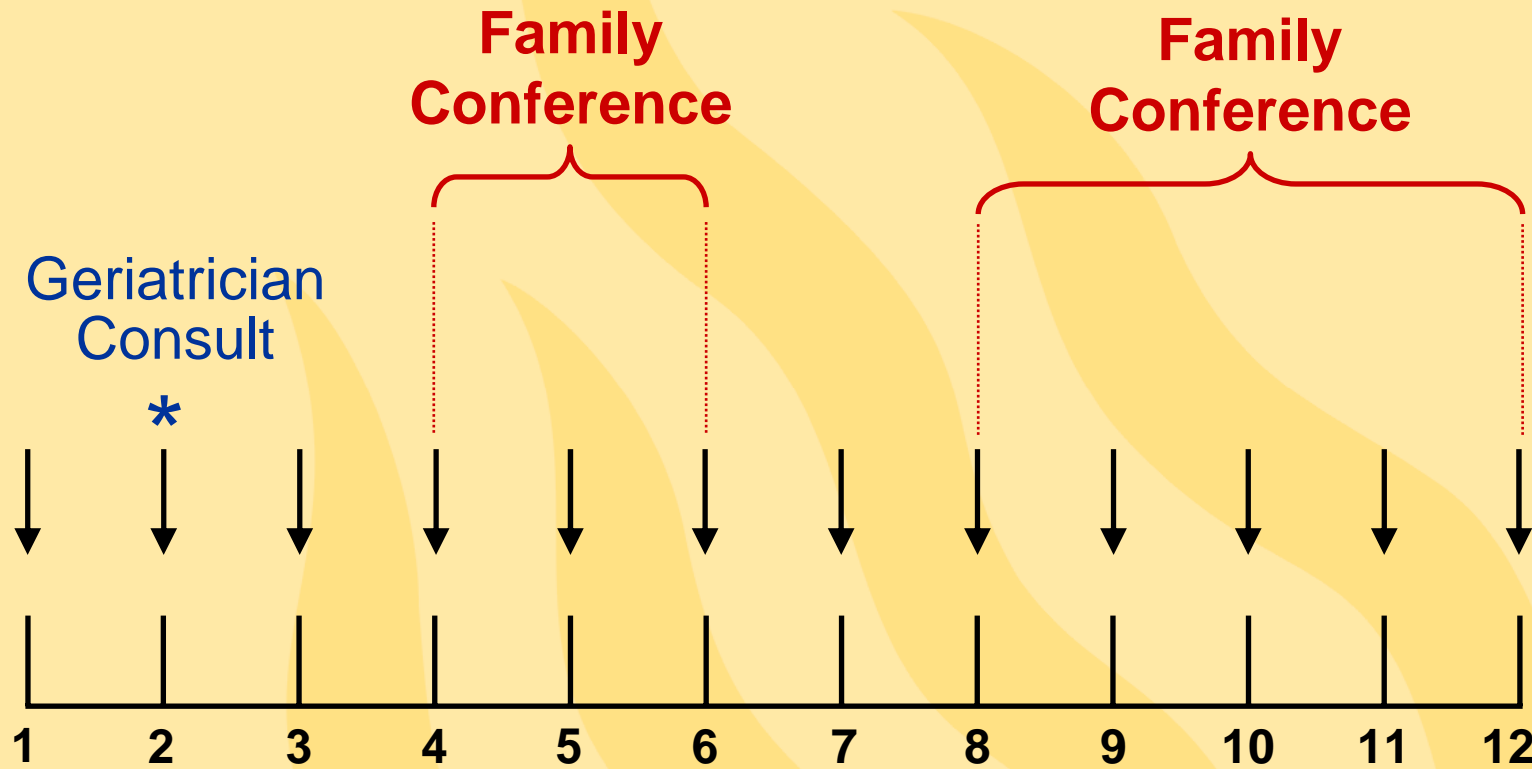
Partnership

- Personal care
- Domestic
- AHTA

Brokered

- Allied Health therapies
- RN – continence
- Personal alarm system
- Meals

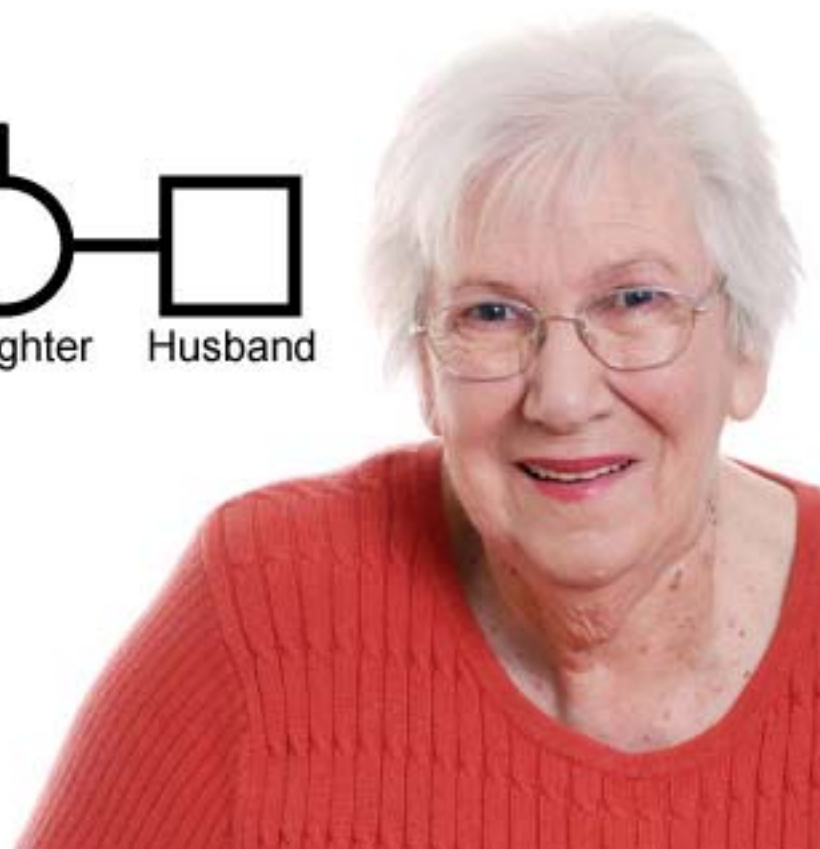
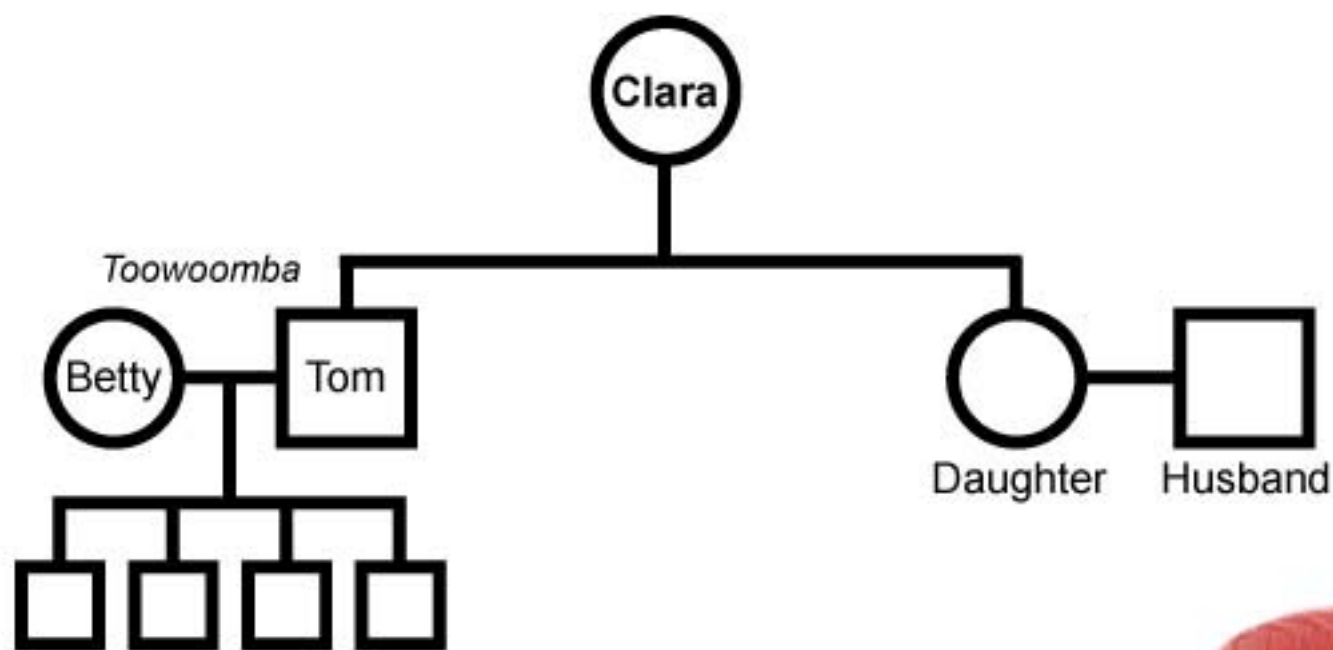
Early model



12 weeks – Case Management

Our Client

Female (Clara), 84 years, English speaking immigrant, previous nursing career. Two children - son in Toowoomba and daughter in remote rural area.



Our client

- The family setting:
 - Lives with son and his wife + children
 - Lives on outskirts of town in newly built home (Clara has her own room and ensuite)
 - Son, Tom, has EPOA
 - Prior to admission, Clara assisted family with washing, afternoon tea and some supervision of children after school

Our client

- Previous medical history – HTN; perforated duodenal ulcer; osteoporosis with vertebral fracture; chronic renal impairment
- Current health episode – MVA 23/12/07.
Admitted to Royal Brisbane Hospital with:
 - # 1-4 ribs
 - # odontoid (without cord compression)
 - large haematoma to chest / breast
 - # manubrium with retrosternal haematoma
 - large bruising on anterior abdominal wall
- Transferred to Toowoomba Hospital on 8/1/08
- Transferred to GEMS program on 15/1/08

ACAT Assessment

- Completed 5/2/08 by team member.
- Medical history & specific needs following current medical episode:
 - MMSE 18/30; MBI 72/100
 - Recommended – PCW for hygiene (Aspen Collar in situ)
 - equipment – 4WW and shower chair
 - personal alarm system
 - nursing care of wound on leg
- ACAT approval obtained and TCP commenced 7/2/08

Transition Care Program

- **Intervention 1**
 - PCW – education of PCW re Aspen collar; coordination of personnel to ensure two persons present to change collar and shower safely
- **Intervention 2**
 - OT recommendations re rails in bathroom and toilet
- **Intervention 3**
 - Nursing care of wound on leg

Transition Care Program

- **Intervention 4**
 - Physiotherapy assessment and program of exercises instigated
- Contact primarily with client within the house.
Betty often sleeping after night shift.
Tom at work.

Discharge

- Readmitted to hospital with # NOF two weeks later

Strengths of this model

- Coordinated ACAT approach with assessment collecting information required for TCP
- Goal driven program based on medical issues
- Discharge planning is integral to program
- Partnership provides range of services on 'as needs' basis

Gaps

About the client:

- Lack of clarity about pre-admission cognitive capacity
- Conflicting information from hospital where the agenda may be about freeing beds
- The process is 'information overload'.

Gaps

About the carer

- Unsure of carer capacity:
 - previously untested
 - after a period of respite
 - significantly changed needs
- Lack of clarity about their knowledge and understanding of medical procedures and community resources, systems or processes

Gaps

About the carer

- Carer's own issues – the assessment fails to identify factors specifically relevant to the carer that are likely to impact on the client's rehabilitation
- ACAT assessment is not able to accurately assess any change to pre-admission family dynamics resulting from health episode

Concerns

For program development

- The client's primary goal is "to get home". Establishing goals that incorporate therapist's 'duty of care' can be difficult in the initial phases of the program.
- Variation in readiness for discharge
- At times, difficult to liaise with GPs who have been out of the loop for a client in the public health system.

Concerns

- Feedback and reporting from brokered services is delayed and can impact on the timeliness of amendments to program.
- To date, it provides TCP only for people who live within close geographical proximity to Toowoomba

Our Client

Information not gathered in ACAT assessment:

- Tom's business was very busy and had staffing problems
- Daughter-in-law, Betty, studying a Masters degree in addition to working full time; permanent night shifts
- 3 of 4 sons had developmental or education special needs
- Family bred special type of cats – 10 cats/kittens in the house
- Significant trip hazard = cat + children's toys

Our Client

Information not gathered in ACAT assessment:

- Carer stress becoming an issue during initial TCP.
- There was already some resentment by Betty of the intrusion of Clara into their family life.
- Some degree of marital conflict over Tom's responsibilities as EPOA and the lack of support / assistance from his sister.
- Clara was not in receipt of an Australian pension.
- Clara had contributed financially to the cost of their current home.

Our Client (TCP 2)

- Readmitted to TCP following # NOF
- Hemiarthroplasty
- Aspen collar still in place

- Betty took time off to become full time carer – but was not prepared to shower or clean Clara's room
- One family car off road for repairs
- Heightened stress in the house, cats and kids
- Partnership services refused participation in domestic cleaning due to health and safety risks

Program 2

- **Intervention 1**
 - Involve Tom in discussions
- **Intervention 2**
 - Social Work – attention to issues of carer stress for both Tom and Betty
- **Intervention 3**
 - Respite care put in place (day and residential)
 - (required HACCC & additional ACAT assessments)

Program 2

- **Intervention 4**
 - PCW – shower and room cleaning
- **Intervention 5**
 - Physiotherapy and ATHA for exercise
- **Intervention 6**
 - Contenance assessment

Program 2 – Communication Strategies

1. Within the team

- More frequent interaction between therapists contributing to program

2. Within the family

- Structured family meetings early in the program

3. Liaison directly with GP

4. Case conferencing weekly to maintain focus on goals

Discharge – Our Client

- Discharge from second program at 7.5 Weeks
- Residential respite for 2 weeks with ACAT approval
- Clara relocated to a low care setting
(not requiring ACAT approval)

Model differences?

During second program

- A range of additional assessments undertaken.
- Increased collaboration within the team to decrease the need for reactivity in the program.
- Earlier involvement of the carers in family discussions.
- More direct consultation with the treating GP.

Learning and future directions

Qld TCPs are seeking to develop a:

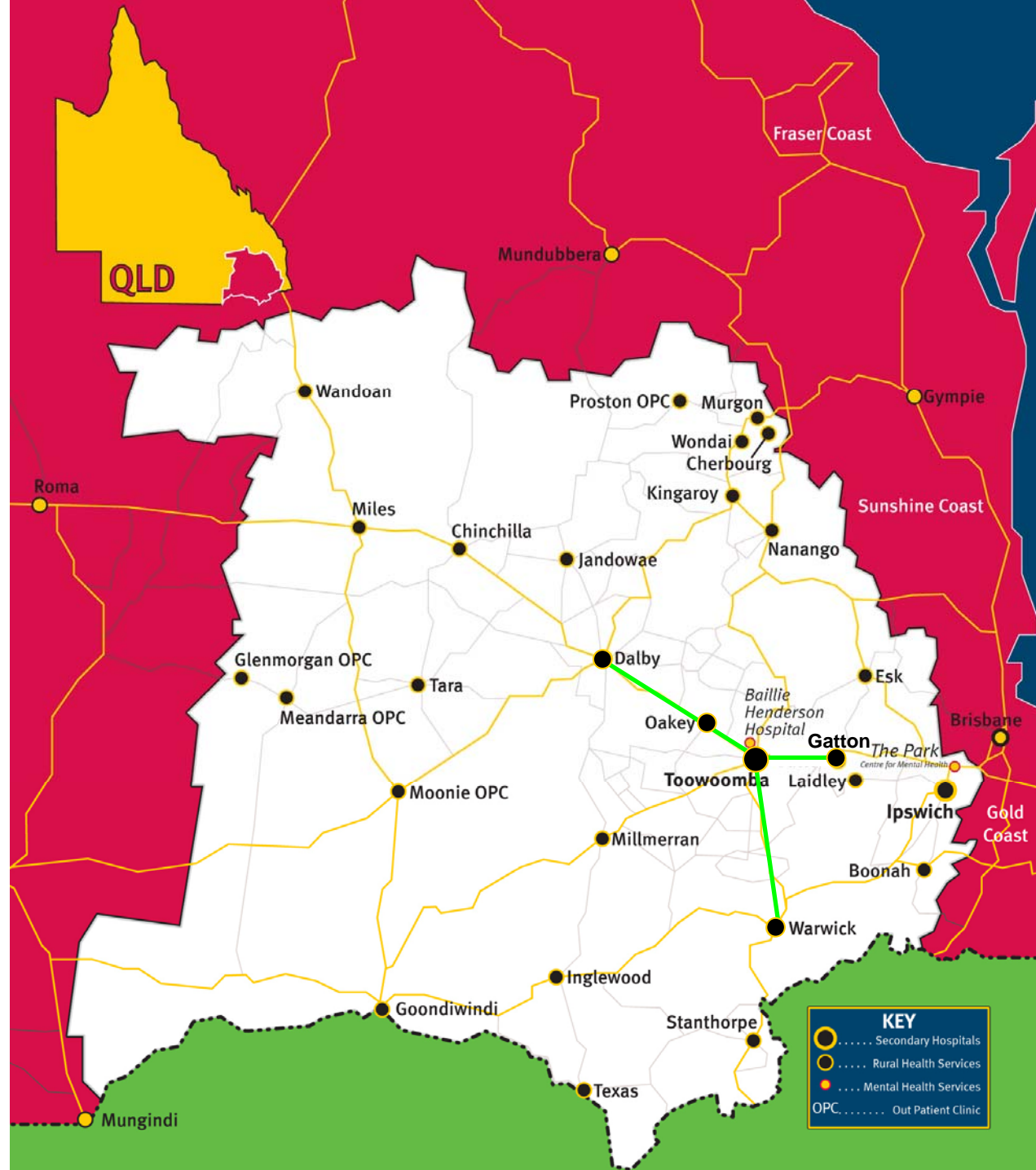
- Comprehensive 2nd tier assessment tool that will identify issues relevant to rehabilitation in a way that enables goals to reflect:
 - a) client's goals
 - b) therapist's duty of care
 - c) proactivity rather than reactivity
- Toowoomba will seek to trial this assessment tool

Future directions / models

Delivery of TCP to rural areas surrounding Toowoomba

Phase 1:

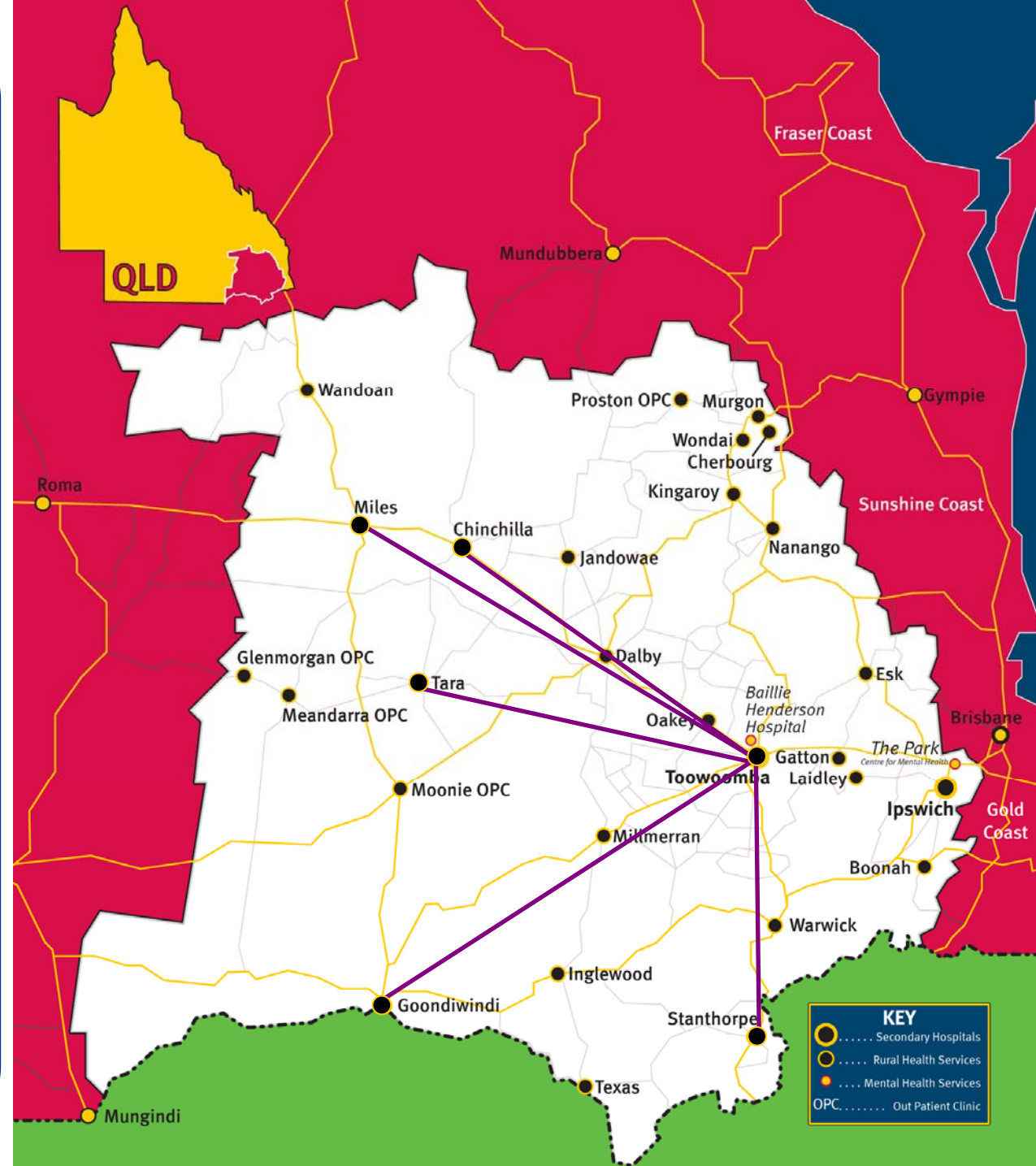
- Dalby
- Oakey
- Warwick
- Gatton



Future directions / models

Delivery of TCP to rural areas surrounding Toowoomba

- Phase 2:**
- Chinchilla
 - Miles
 - Goondiwindi
 - Tara
 - Stanthorpe



Model changes (within Hub – Toowoomba)

- Introduction of 2nd tier assessment tool
- Improved communication strategies between therapists within the case management model
- Improve the partnership model –
 - develop communication and reporting strategies for timely feedback

Model changes – hub to spoke

Replication of the Hub in program design – interventions and timings

- Case management model with brokerage and partnerships in rural communities.
- 2nd tier assessments completed by rural practitioners
- Goals set and monitored through consultation with the “Hub”

Model changes – hub to spoke

- Educational component to ensure rehabilitation focus provided in spoke centres
- Supports to Spoke centres
 - E-hab
 - Phone
 - Visits



Further information:

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