



# Managing Challenging Behaviours Conference 2009 TRANSITION CARE COGNITIVE ASSESSMENT & MANAGEMENT PILOT (TC CAMP)

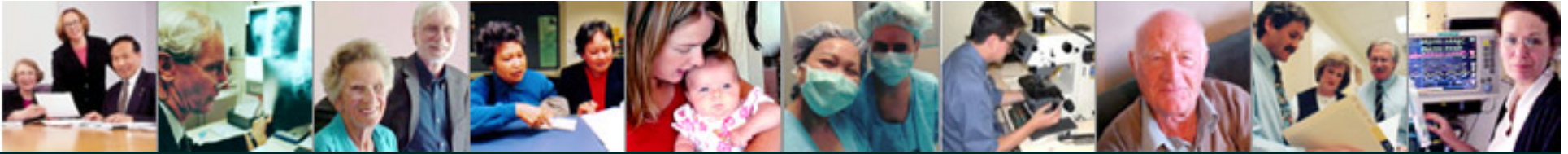
By Seema Desai (TCP Co-Manager) &  
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Members of Eastern Health: Angliss Hospital, Box Hill Hospital, Healesville & District Hospital, Maroondah Hospital,  
Peter James Centre, Wantirna Health, Yarra Ranges Health and Yarra Valley Community Health Service



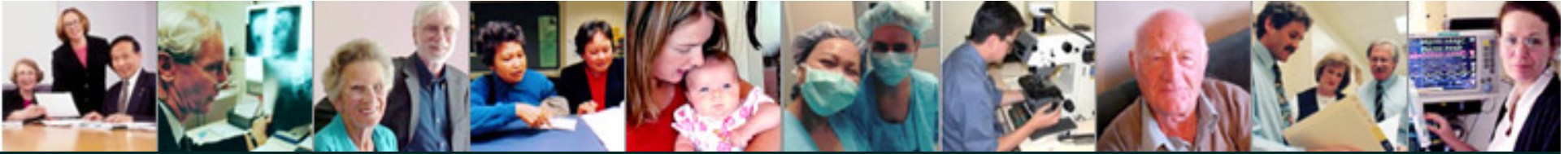
# EASTERN HEALTH TRANSITION CARE PROGRAM (TCP)

- 3 pre-existing pilots and programs (Interim care, Intermittent care and ERP) were wound down by Oct 2006
- Over the past 2+ years, TCP have been allocated extra packages for pilot programs such as TCP+, Winter Demand Program, Cognitive Service
- A cohesive, motivated team was rapidly built to the current EFT of 19.87 (all disciplines)



# THE EH TC PROGRAM

- EH has a very large TCP over 2 HLRCF
- 66 beds at Residential sites
- 22 home based (Contracted to Care Connect)
- 6 TCP+ (not yet active),
- 6 beds for TC CAMP (6 months).
- Total at present = 94 packages
- All Nursing and care services provided as part of contract with RACF's.
- AH services and Geriatrician provided by EH

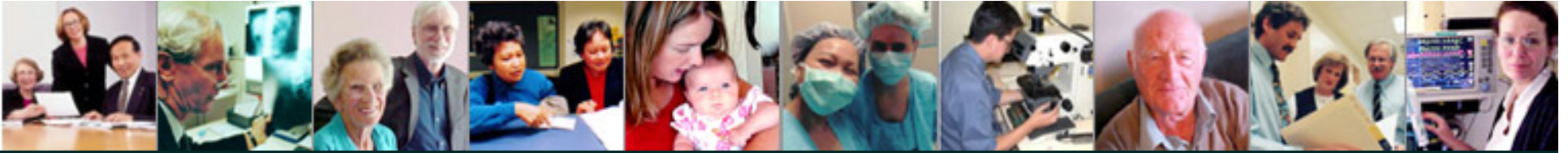


# CURRENT STAFFING PROFILE

- Program Manager - 1 EFT
- Case Coordinators - 6.37 EFT
- Physiotherapy - 2.4 EFT
- O T - 2.3 EFT
- Dietitian - 0.6 EFT
- Speech Therapy - 0.8 EFT
- Neuropsychology - 0.6 EFT
- Allied Health Assistant - 1 EFT
- Equipment Technician – 0.4 EFT
- Geriatrician – 0.7 EFT
- Admin. assistants – 1.5 EFT
- Pharmacy – 0.5 EFT
- Clinical Nurse Consultants – 2 EFT
- Wound Consultant – 0.1 EFT
- Diversional Therapist – 0.6 EFT (still to be appointed)

**TOTAL EFT: 19.87**

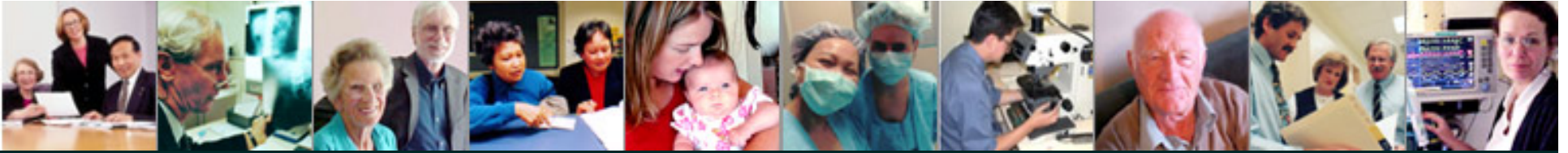




# CHALLENGES OF EH TCP

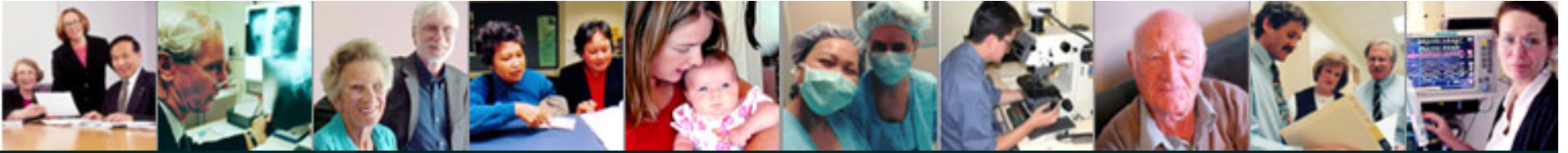
Many and varied!!!

- Referral process up to admission and pressure to take all referrals
- Calibre and condition of prospective clients
- Determination of medical readiness for discharge to TCP
- Goal Focus



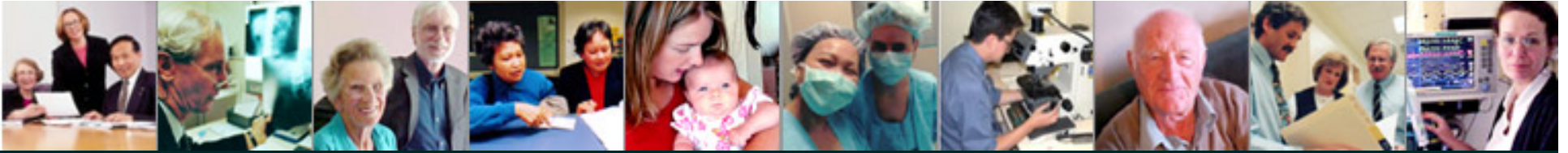
## TC CAMP –BACKGROUND OF PILOT?

- 18-21 referrals received per month for clients with severe cognitive impairment
- Ongoing challenges in regards to management of these clients
- Some clients not accepted



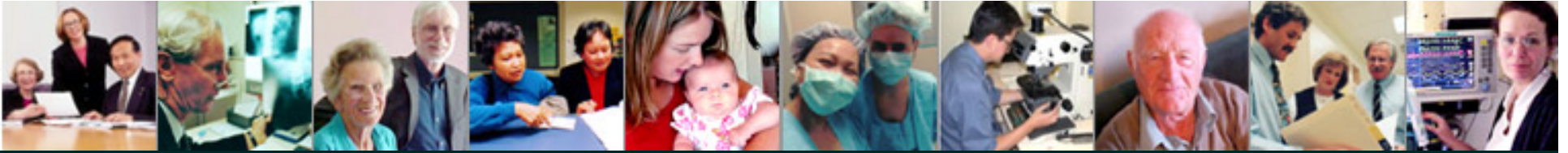
# CHALLENGES OF CURRENT MODEL

- Restraint unable to be considered
- Challenges in sourcing appropriate mental health input
- Lack of staff specialisation
- Family dissatisfaction
- Increased LOS
- Returns to the acute sector
- Ongoing placement issues



# PROPOSAL TO DHS

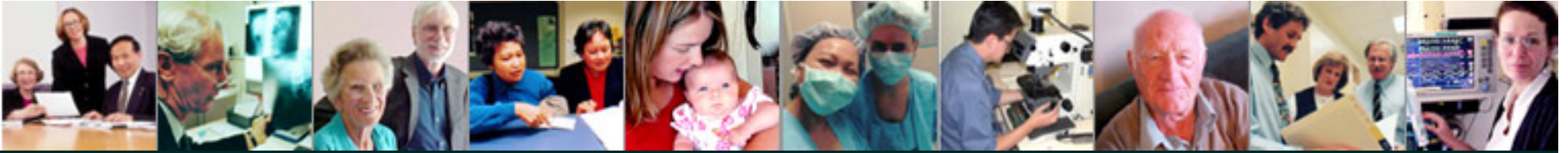
- Due to high number of referrals, Department of Human Services DHS were approached with a proposal
- Discussions were held
- Aim to:
  - develop a steering committee to develop this model of care
  - develop a person centred model of care
  - formal evaluation to be completed by an external organisation (NARI)



# OBJECTIVE OF TC CAMP

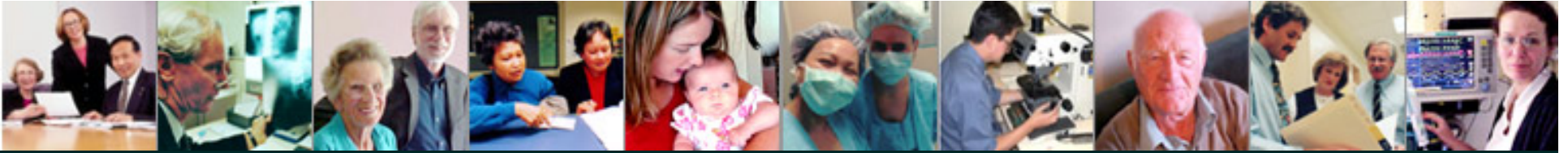
## OBJECTIVES

1. To establish a new and sustainable model of person centred care that achieves optimum outcomes for people with severe cognitive impairment requiring Transition Care
2. To ensure evidence based practice informs the collaborative (that is, staff, cares and family) development of individualized behavioural management strategies for all clients



# MODEL OF CARE

- Referral & Access
- Assessment & Goal Setting
- Environment & Lifestyle Enhancement
- Support and Education
- Management of complex care needs
- Discharge Planning



# THE LAST 8 WEEKS OF TC CAMP

- LOS average is 3 ½ weeks
- Number of referrals = 20
- No. of Pt's accepted = 11
- Discharge Destinations-HLCF
- Challenges – staff (PCA's minimal understanding of BPSD, time)
- Positives – Behaviours settled from acute setting.



# EVALUATION COMPONENT

- NARI
  - Ethics Approval
  - Focus Groups
  - Documentation
  - Model of Care – tools used to determine care, needs of resident.
  - Consumer / carer involvement

# QUESTIONS?



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