

Transitional for Older People  
Making a Difference  
26 & 27 March 2009 (Sydney)

The Journey of a Younger  
Person

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# Presentation Overview

- Profile of the Eastern Health service
- Staffing Profile
- Challenges of TCP
- What is the TCP+ Pilot Program
- Case Study – Mrs C
- Challenges of TCP+ for Mrs C
- Discharge planning and outcome

# The 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 HLC
- 66 beds at Residential sites
- 22 home based (Contracted to Care Connect)
- 6 TCP+ (not yet active),
- 6 beds for the TC Cognitive Assessment and Management Pilot (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
- Contract with Care Connect for HB program – requiring involvement of 2 case managers (Care Connect and EH Case Managers)

# Current Staffing Profile

- Program Manager – 1 EFT
- Case Coordinators – 6.37 EFT
- Physiotherapy – 2.4 EFT
- Occupational Therapy – 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
- Administration assistants – 1.5 EFT
- Pharmacy – 0.5 EFT
- Clinical Nurse Consultants – 1 EFT
- Wound Consultant – 0.1 EFT
- Diversional Therapist – 0.6 EFT (still to be appointed)

**TOTAL EFT: 19.87**

# 1<sup>st</sup> Year Challenges and ongoing challenges

- **Many and varied!!!**
  - **Referral process up to admission and pressure to take all referrals** - immigrants, VAC dressings, dialysis patients, behaviour concerns, under 65
  - **Calibre and condition of prospective clients** – cognition, physical status (high falls risk grp), complex social situations, dysfunctional family units, tools in use to detect possible problems, increased screening taking place, younger clients with complex needs
  - **Determination of medical readiness for discharge to TCP** – behavioural concerns, IV therapy, sub-cut fluids, wound mgt, poor oral intake, palliative care, nasogastric, PEG feeds,

# Challenges.....

- **Medical cover at residential facilities** – increased recently to 5 sessions at one campus and 2 sessions per wk at other residential facility and limited locum cover (drug charts and medications)
- **Unrealistic expectations of TCP** - staffing levels, physical facility, therapy provision, diversional therapy, security, **restraint use**
- **“Goal” focus** – cognition issues, general condition, conflicting family expectations, need for team input, high falls risk group

# And More...

- Ave client age 84
- Younger pt's have been flagged or referred to TCP
- Varying perceptions of role of TCP by referring hospitals
- Inability to adequately manage some referred pts
- How to manage pts not suitable for TCP or acute/sub acute (Agencies, vacancy register)
- High no. of pts requiring VCAT input for guardianship/administration – long time frames
- High no. of pts requiring psych/neuropsych input and assistance
- Equipment issues and requirements are overwhelming at times
- Focus on younger clients referred & TCP+

# TCP Plus, What is it?

- Address the gap of clients medically stable in hospital but cannot return home
- Need for a specialist support service
- Target Group:
  - NWB for a limited time (6wks)
  - High practical nursing care requirements
  - Awaiting home modifications
  - Younger people usually excluded from TCP and waiting for long term care provision
  - Young people at risk of entry into aged care

# TCP+

- Timeframe for Pilot – 4 months  
(01/02/08 – 31/05/08)
- No ACCR required
- 12 week program only
- No extensions allowed
- Bed Based TCP+ (no home based)
- Consequently, a number of young patients were referred to this program including Mrs C (Case Study)

# Challenges within TCP + for EH

- Younger patients referred
- Difficulties around discharge planning
- Clients not suitable for HLRC, LLRC as not eligible for ACAS
- Involvement from Disability Services
- Environment not suitable, Carer Stress
- Long waiting lists for external case management, housing, individual support packages eg. ARBIAS
- Case Study - Mrs C

# Mrs C

(Journey through the Health System)

➤ 56 yr old referred to the TCP+ in Feb 2008

## Past History:

- Multiple Sclerosis (MS)- diagnosed 20 yrs ago
- Uses wheelchair for mobility
- incontinent of urine, (takes diuretics)
- needs continuous toileting for 4 hours in the morning

# Mrs C & Background History

- Admission in Feb 2008 to EH Hospital
- Reasons - # left Fibular and patient NWB for 6 weeks
- Carer/Husband (Mr C) suffered from severe/chronic back pain and unable to support Mrs C at home because now NWB
- Mrs C had a linkages package which was providing 5 hours per week:
  - 1.5hrs x 3 per week – P/care & H/help
  - Physiotherapy – ½hr per week

# BACKGROUND.....

- Additional to Linkages, Mrs C received:
  - 3.5 hrs respite p/w from Uniting Care Community Options (short term funding)
  - 4 hrs p/w of respite and home help from local council
- Referred to TCP+ on 18/02/2008
- Family meeting held with Mr & Mrs C
- Agreement reached that Mrs C to be listed for TCP+
- Mr and Mrs C aware TCP+ in ACF (single room)
- Mrs C fed up of sharing a hospital ward
- Mr & Mrs C requested discharge ASAP
- Discharged occurred on Friday 21st<sup>th</sup> February 2008

# TCP Admission - failed

- After being admitted to TCP+, Mrs C's husband discharged her at own risk home on Sat 22 February
- F/up via phone with Mr C on 24.03.08 and feedback that ACF not appropriate b/c of Mrs C's age
- Threatening to take Mrs C to ED due to acopia
- Liaised with Linkages C/mgr to refer to HARP to avoid ED admission and provide extra services if possible
- 05/03/08 P/call from ED Care Coord that Mr C unable to cope and Mrs C in ED, ? TCP+ again
- Mr & Mrs C refuse TCP+ in residential setting
- Demand TCP+ in the community (not available within EH)

# Discussion with Mr and Mrs C

- F/mtg scheduled with SW, Linkages C/mgr, Care Connect C/mgr, TCP C/mgr for 12/03/08.
- Linkages f/back that Mr C not coping for some time
- Discussed constraints of TCP+, demand HB TCP+
- Mr C insists TCP+ provide 4 hrs of service daily for 6/7
- Discussed a long term plan as TCP+ only for 12 weeks
- Mr & Mrs C agreeable to
  - Respite care
  - Permanent care at an MS facility if required
  - Nursing home placement if deemed necessary
  - Referral to Disability Services for an Individual Support Package and Disability Housing
- DHS emailed to consider request

# Negotiation with DHS and Discharge Plans

- DHS agreeable for Mrs C to receive 24 hrs per week over 6 days
- Linkages can top up services if required because Pilot Program
- Linkages to provide 4 hrs of respite on a Tuesday night so Mr C can go out

# Family Meeting Outcome

- Services for 4 hrs a day for 6 days a week.
- Services to assist with toileting, showering and home help, respite care.
- Contenance assessment, continence products and case management support.
- Referral to MS for permanent care, regular respite, waitlist for ISP, ACAS referral to be sent once home and if deemed necessary nursing home listing to occur
- Discharge home ASAP

# Where to from here?

- Patient moved to Rehab on 31/03/08 whilst waiting for TCP+
- Rehab not deemed suitable very quickly
- Discharged to TCP+ (HB) on 14/04/08 with services
- H/visit done by 3 case managers, Linkages C/mgr, Care Connect C/mgr & TCP C/mgr
- OT and PT attended home visit on 14/04/08
- At present, Mr and Mrs C happy and coping well
- H/visit planned in a month's time
- Linkages C/mgr advocating strongly with Disability Services for an ISP to keep Pt out of residential care

# Challenges

- ACAS refused to do ACCR unless letter from Disability Services
- Mr and Mrs C now reluctant to follow through with initial discussion about long term care plans (permanent care)
- Another h/visit done with all 3 c/mgrs on 14/05/08 (1 month into TCP+)
- Discussion around future care plans.
- Mrs C refuses to have a catheter due to having regular UTI's w/o catheter

# Challenges & Future Care Plans

- Mr and Mrs C refuse to consider permanent care as a long term plan
- Mr C insistent that Disability Services provide an ISP
- Lack of understanding around waiting list timeframes for an ISP
- Lack of understanding around TCP+ ending in 8 weeks and then back to 8 hrs of service per week

# Challenges & Future Care Plans

- TCP+ to reduce services from Wk 5
- Mr C believes he can return to the Linkages package of 8 hrs per week (lack of insight, was not coping before TCP+)
- Mr C's resolution if not coping, send Mrs C to hospital.
- Services to be reduced over the next month by reducing days of service to 4/7
- Another f/mtg planned for 05/06/08

# Challenges & Future Care Plans

- H/visit on 05/06/08 where services now in for only 4 /7 for the past 3 wks
- Mr C not coping, but Mr and Mrs C not willing for catheterisation
- Main issue still surrounding diuretics and Mrs C requiring continuous toileting for 4 hrs in the am
- Mr C's back problem exacerbated due to reduction of services
- Ongoing advocating by Linkages C/mgr with Disability Services for the ISP
- Regular feedback to DHS about Mrs C

# In Conclusion

- Mrs C came close to her 12 wk time frame
- Requested DHS for an extension
- Explained long w/list for ISP
- Mr C regular visiting EH Disability Services with no outcome, willing to go to Local MP & Media
- DHS TCP Rep (Betty) updated regularly
- Betty liaised with Disability Service

**Outcome** - Mrs C to have an interim ISP until a permanent package is made available

- Mrs C able to stay home with Mr C as carer
- 30 hrs of service per wk (4hrs a day over 7 days)

# CONTACT DETAILS

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QUESTIONS????

