



RADAR: Rapid Assessment of the Deteriorating Aged at Risk

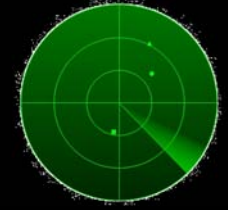
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Aged Care & Rehabilitation Service
ACT Health

Synopsis



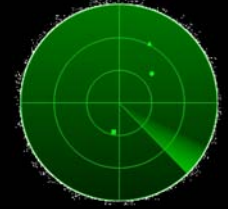
- Context for service
- Service framework
- Initial experience
- Lessons
- The way forward

The existing scenario



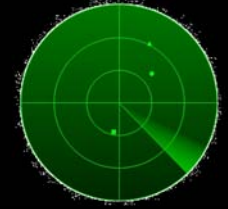
- Increased numbers of clients aged >75yrs presenting to ED
 - ~10% increase/year to The Canberra Hospital ED*
- 9.6% present from residential aged care facilities
- 7.8% by direct GP referral

The existing scenario



- ACT Access Improvement Program 2005/6
- Stakeholders perceived issues as:
 - Severe shortage of general practitioners resulting in lack of access to home visits and often delayed waits to see GPs
 - Aged care services difficult to negotiate with multiple providers and referral points. GP does not know where to start
 - ED departments poorly equipped for assessment of elderly clients, particularly those with complex care needs and dementia
 - Older clients spending large amounts of time in ED departments and contributing to bed block
 - Perception that most presentations to ED from RACFs could be avoided

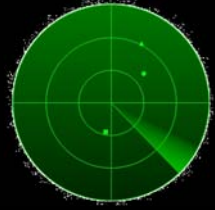
Preventable admissions



- 100 patients of home or hostel patients aged 75+ admitted through ED at POWH
- In 79 of these patients opportunities existed for earlier intervention that would have lessened the risk of admission

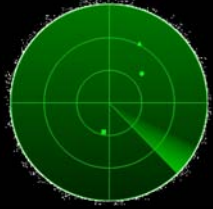
Rosenfeld et al 2003 GPEP project 810

Aged Care Nurse Practitioners



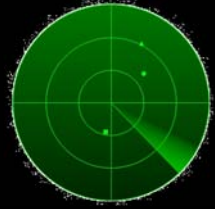
- Aged Care Nurse Practitioner Project 2005
 - Local NP training program established and scope of practice explored
 - Part of training process involved attachments to GP surgeries
- One NP already employed within ACT Health to deliver post acute interventions to reduce readmissions for elderly frequent flyers

ACRS response to the problem



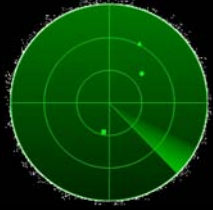
- RADAR (COAG funded program)
- *Rapid Assessment of the Deteriorating Aged at Risk*
- Appropriate level of response for clients in the community whose own GP requires short term assistance with comprehensive assessment and management in order to prevent hospital admission

Philosophy



- Patients should be cared for
 - in the most *appropriate environment*
 - with an emphasis on *maintenance of function*
 - and *sustainable ongoing care plans*

Where do patients come from?



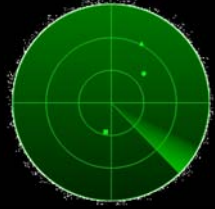
- Admission criteria
 - Aged 65+ (or 50+ for ATSI descent)
 - Patient has suffered decline in function which would result in a high likelihood of an acute hospital admission in next two weeks
 - Patient does not require immediate hospital admission
 - Will be able to stay in usual place of residence
- All patients
 - Are *living in the community* including residential care facilities
 - Are *formally referred* by their primary care practitioner (GP)

Where are patients seen?



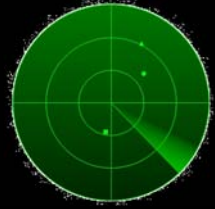
- Hot clinics at The Canberra Hospital
- In their own home
- Residential care facility

What do we aim to do?



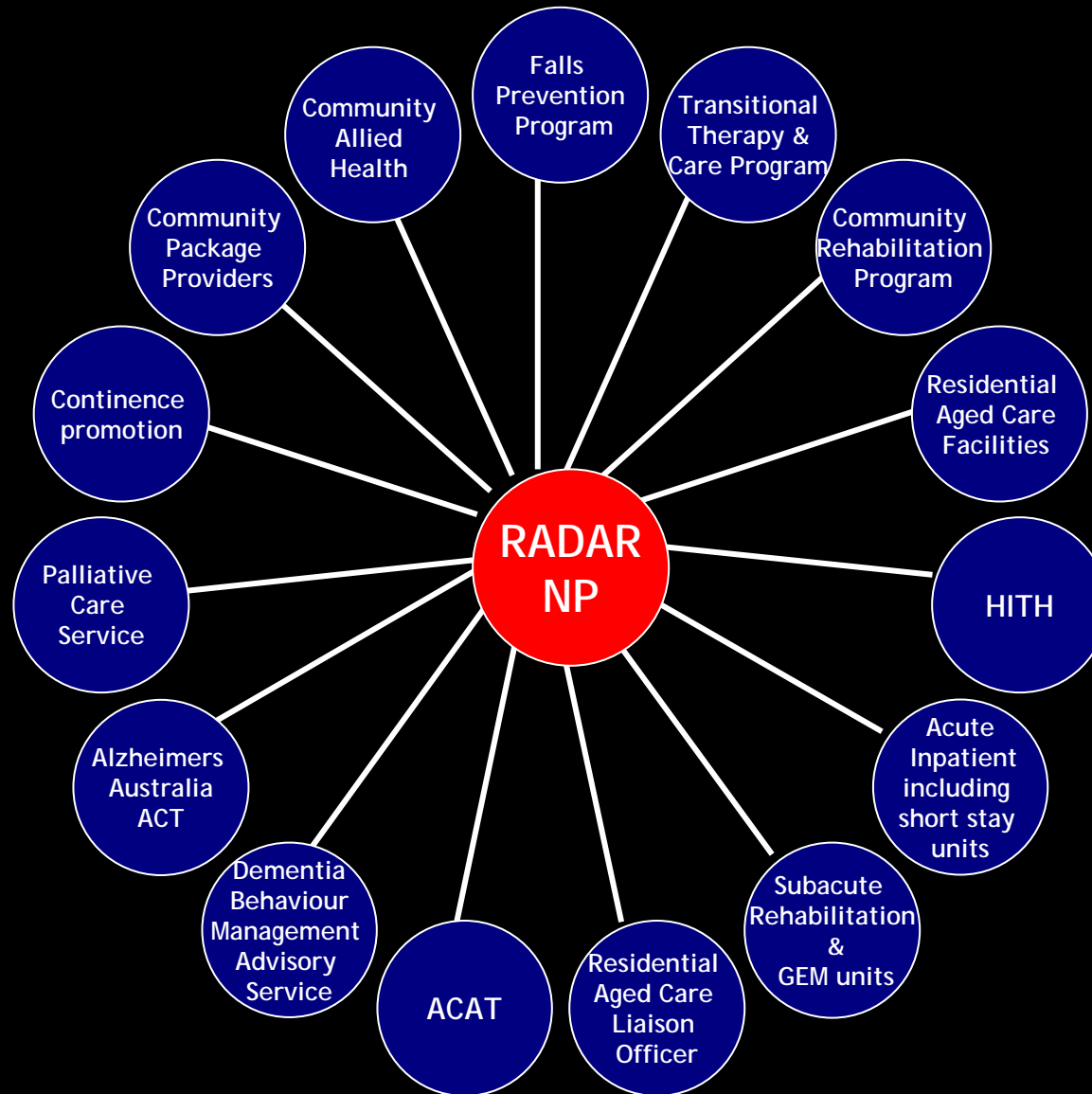
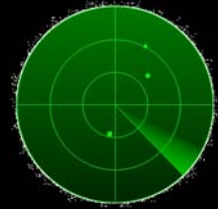
- Aim for initial assessment within 48 hrs of referral where possible
- Length on program 2 weeks
- Staff (aged care nurse practitioners backed up by geriatrician) carry out full comprehensive assessment and liaise with other care providers as necessary to obtain full picture of function and social networks available

What do we aim to do?

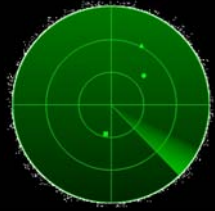


- Management plan negotiated with carers, GP to ensure patient remains safe and maintains function
- Plan includes appropriate follow up
- Where patient needs admission, team liaises with appropriate services to avoid emergency department presentation wherever possible

Service coordination

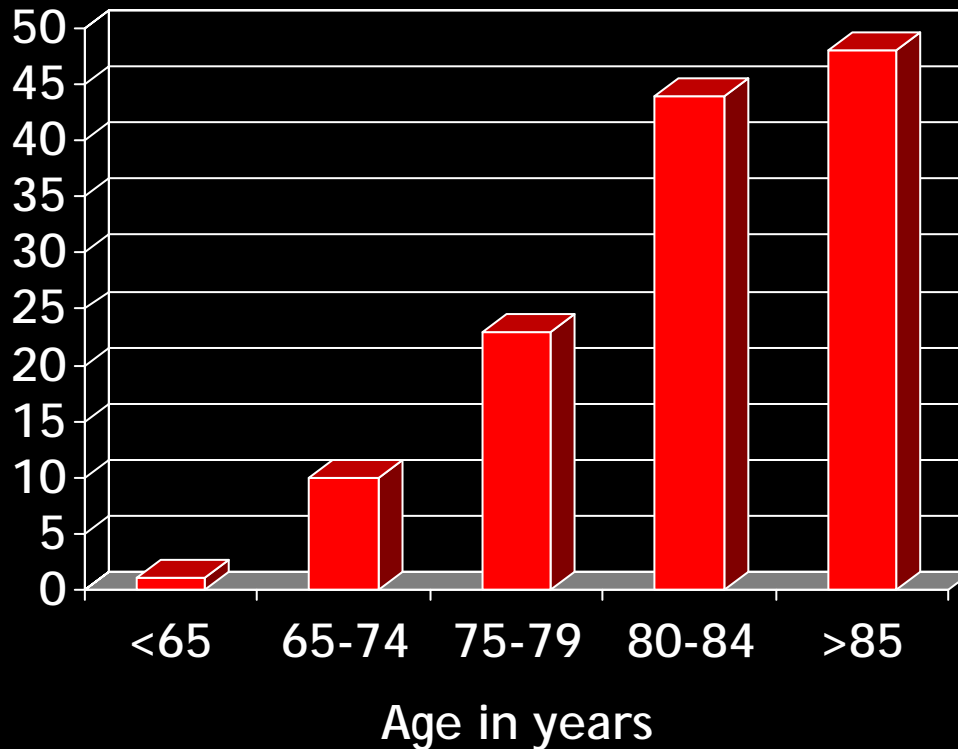
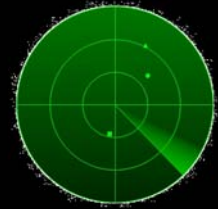


Exit from service



- Sustainable care plan in place (referrals made especially Alzheimers, RACLN)
- ACAT current to access services
- Medical condition has started to stabilise or not getting worse
- GP appraised of current state of play and any ongoing follow-up planned (eg geriatrician follow-up)

Age of clients



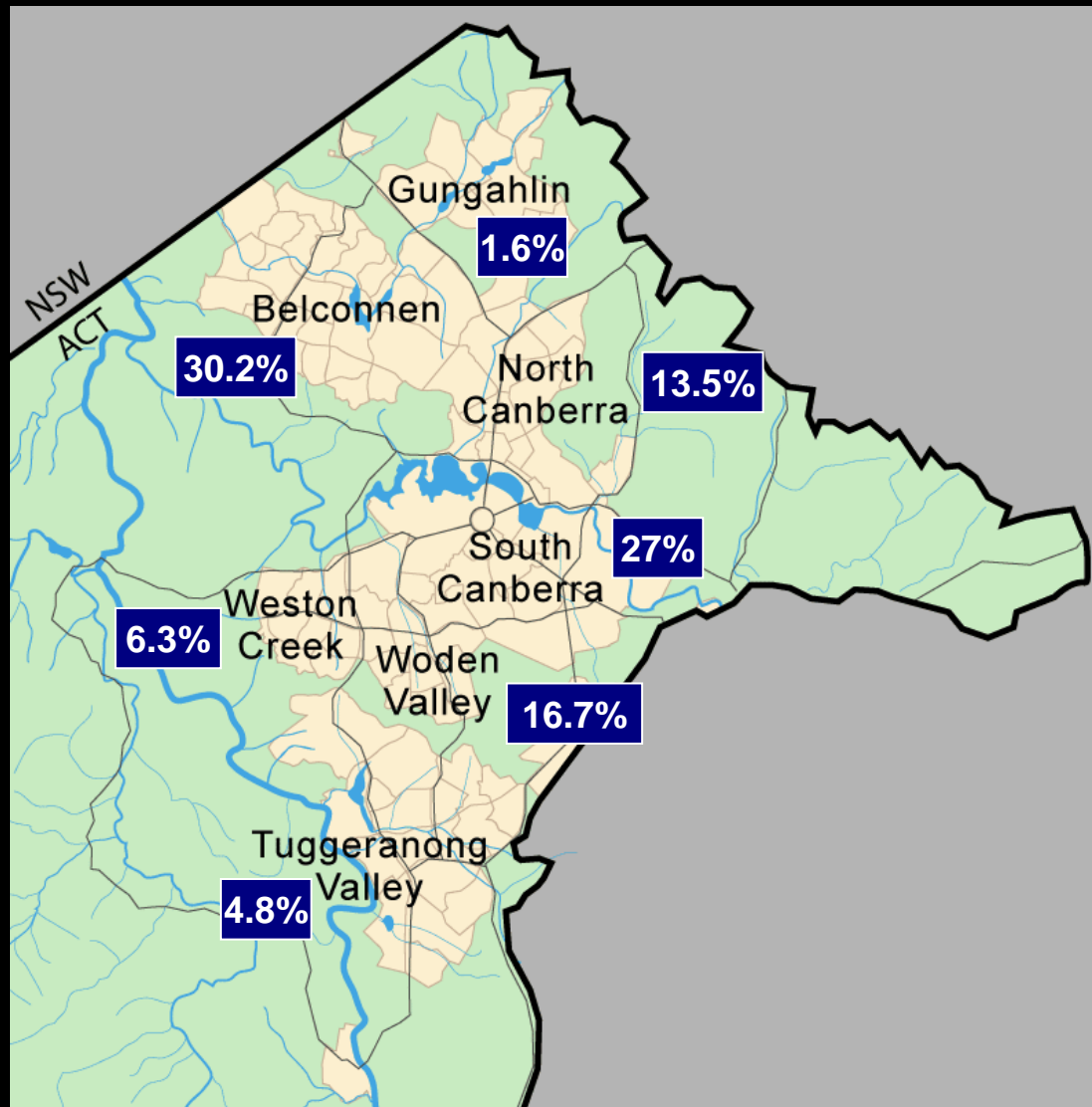
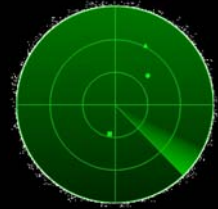
Graph indicates absolute numbers of clients in each category
Range 62-100yrs, Mean age 83.44+/-6.88 yrs
73% aged >80 yrs

Client demographics

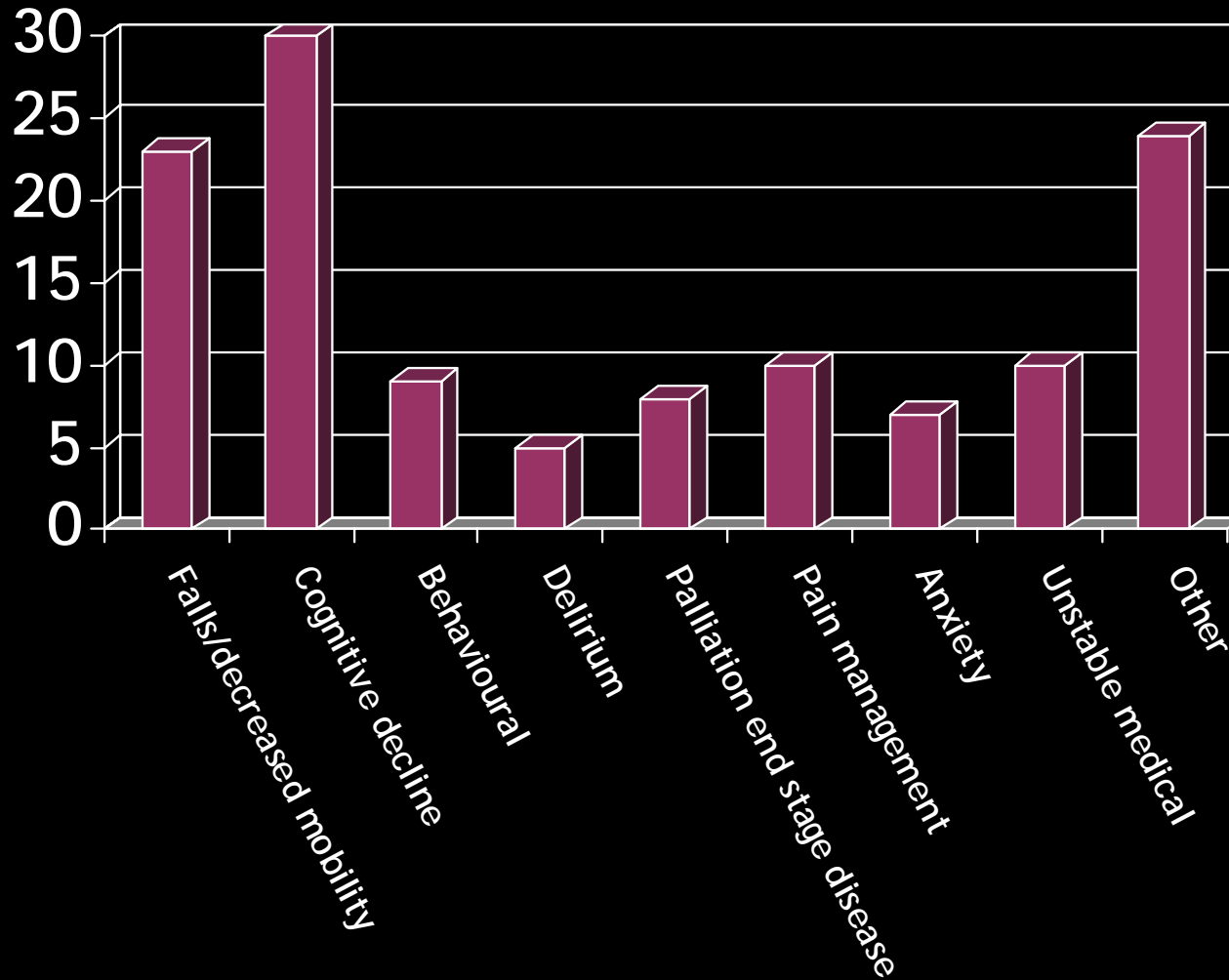


- Gender 64.3% female
- Living alone 54.8%
- Living with spouse/family 24.6%
- Living in residential care facility 20.6%

Geographic location of clients

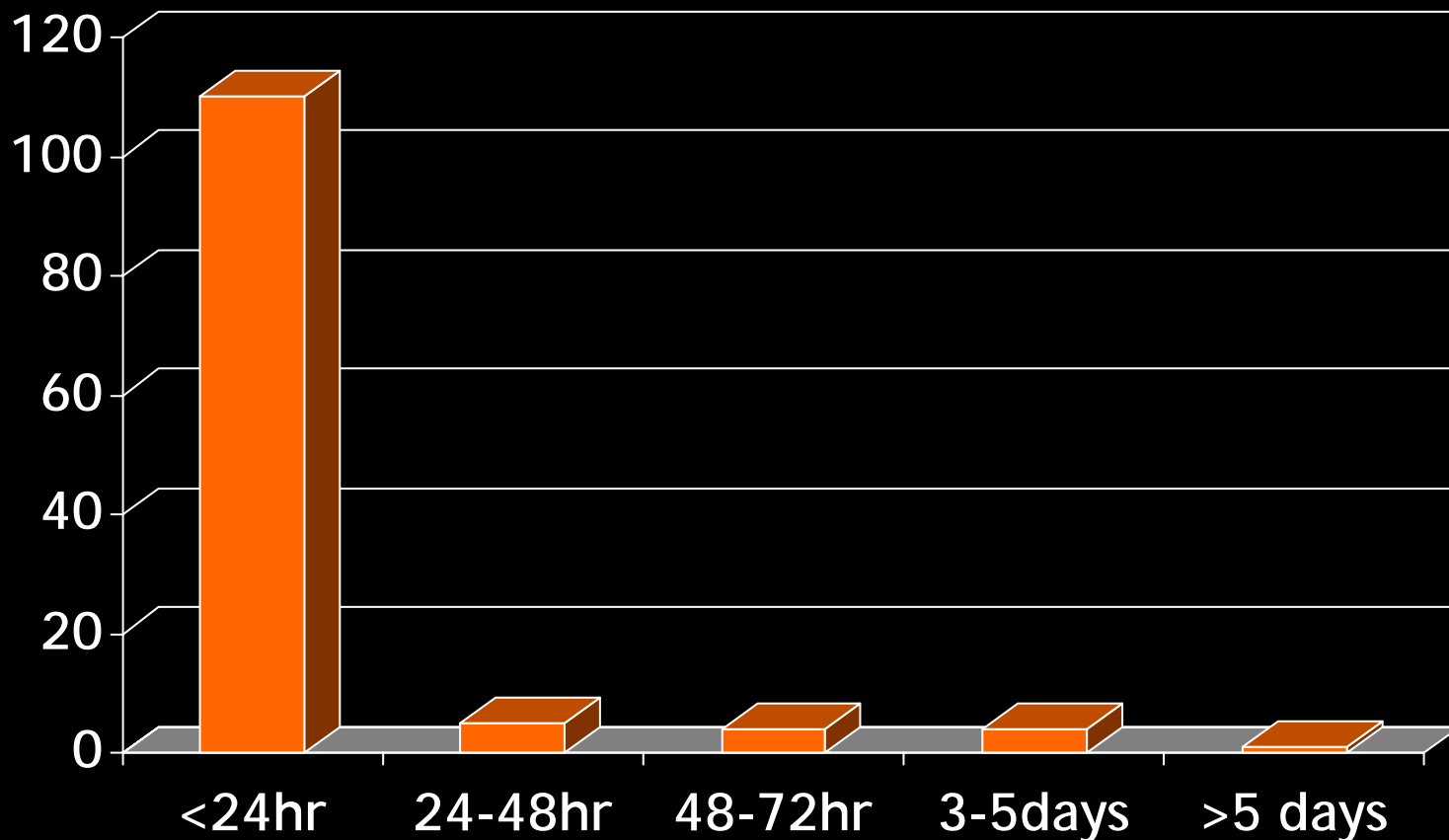
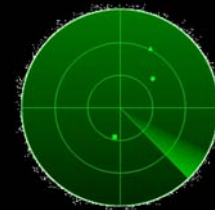


Reason for referral



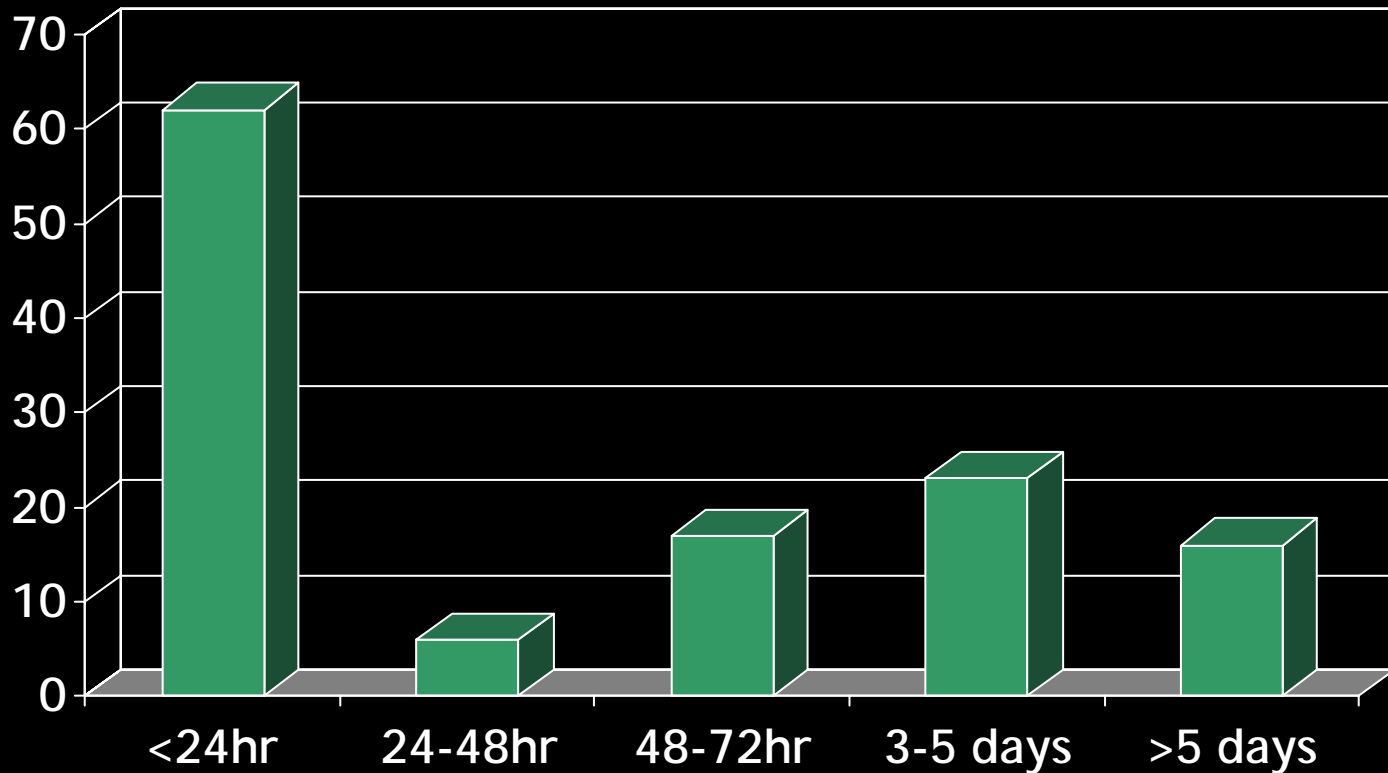
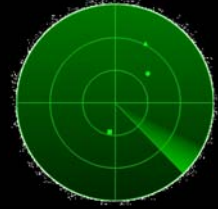
Graph indicates absolute numbers of clients within each group

Time to first contact (n=124)



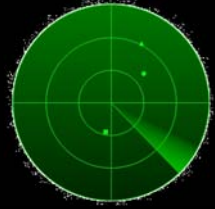
Graph indicates absolute numbers within each group, Time includes non-working days
88.7% patients/carers contacted within 24hrs, 96% within 3 days of referral

Time to first visit (n=124)



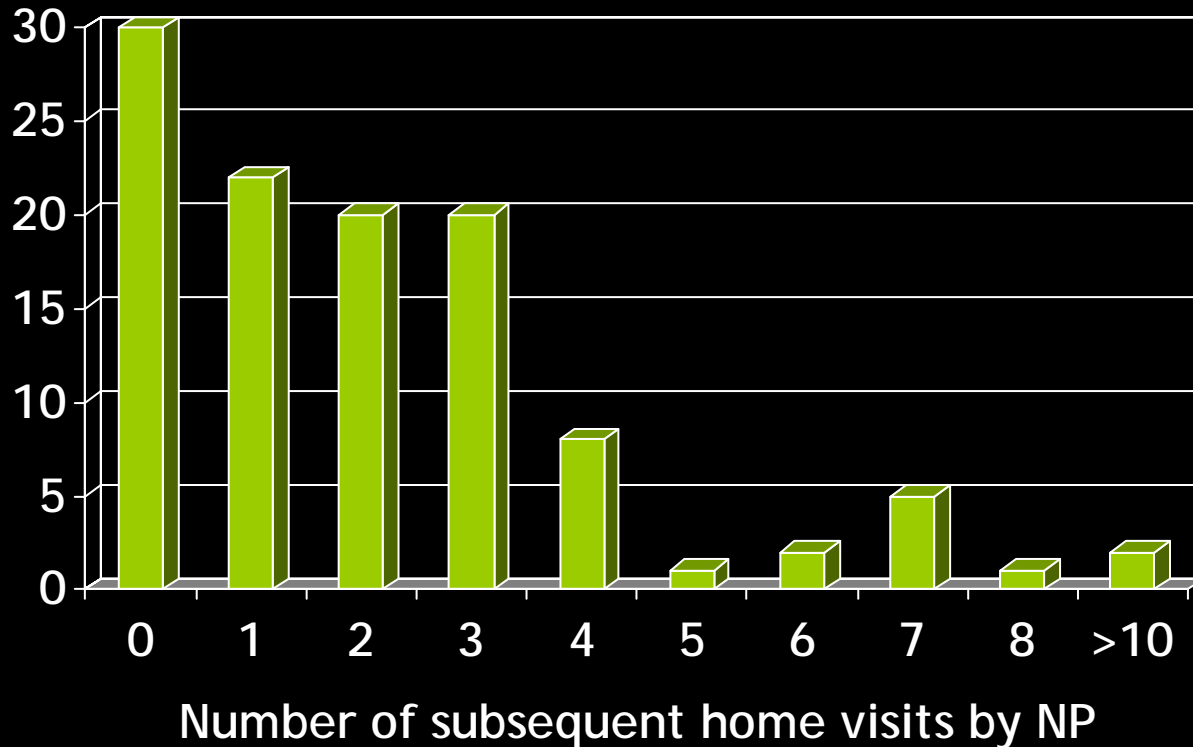
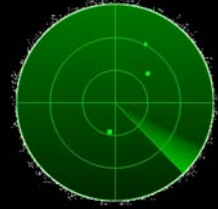
Graph indicates absolute numbers within each group, Time includes non-working days
50% seen within 24hr of referral, 68.6% within 3 days of referral

Location of first visit



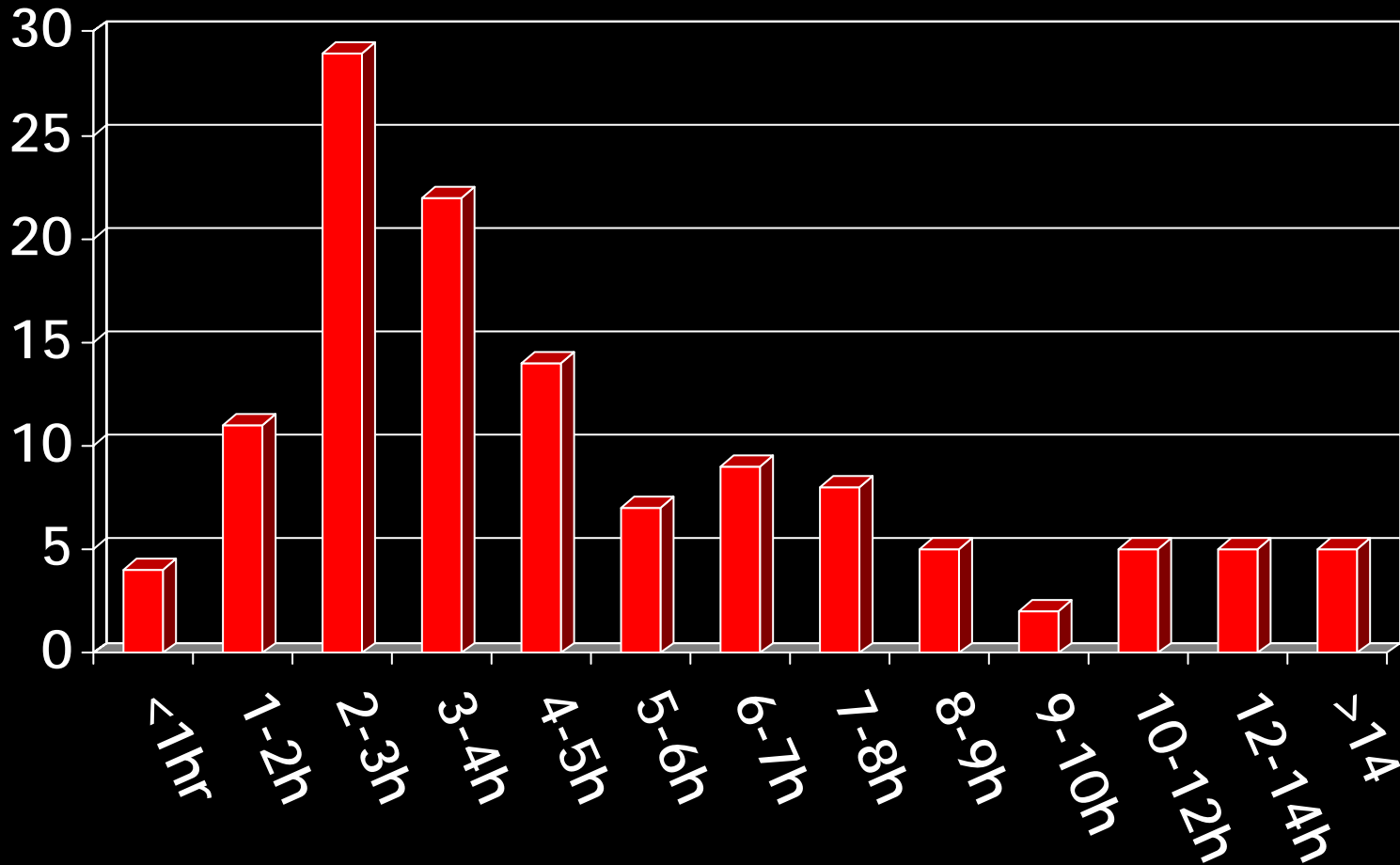
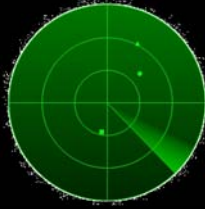
- 11/126 (8.7%) first seen in hot clinic
- 112/126 (88.9%) first seen in own home or residential care facility
- 1 client seen in another location
- 2/126 clients not assessed face to face (both re-referrals)

Number of subsequent visits (n=111 completed episodes)



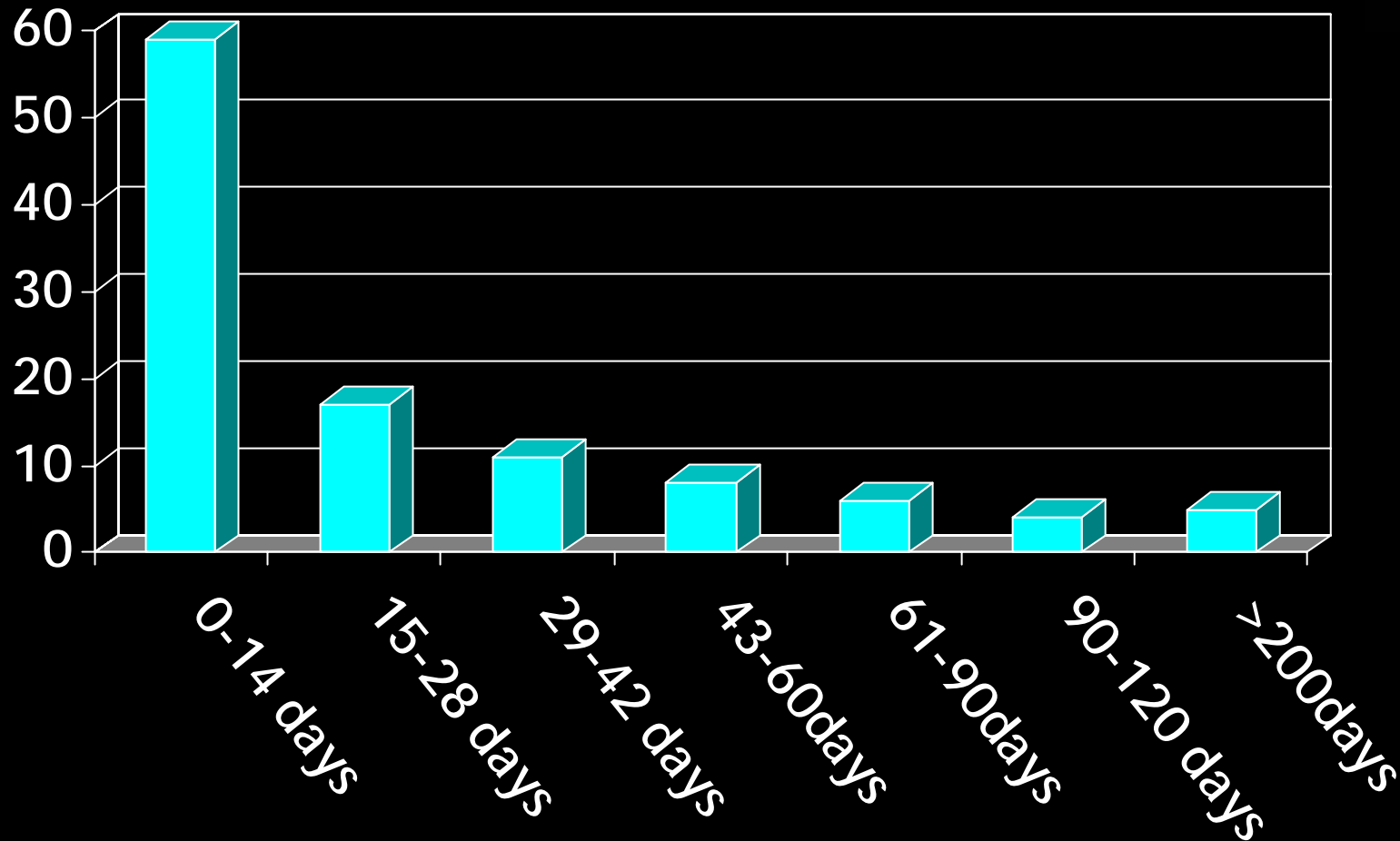
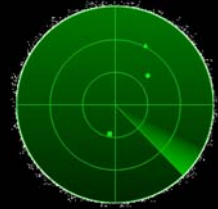
Graph indicates absolute numbers within each group
Range 0-18, median 2 follow up home visits.
39/111 (35.1%) required 3 or more follow up home visits

Time spent by nurse practitioner



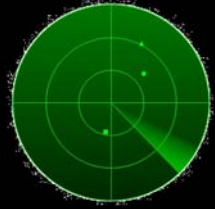
Graph indicates absolute numbers within each group
Median time spent per patient 3.5 hrs. Range 40 mins to 22hrs 40mins.
63.5% took <5hrs.

Days on program (n=110)



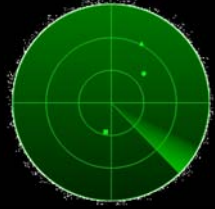
Median time on program 14 days, Range 0-325 days
69.1% discharged by Day 28

Services utilised



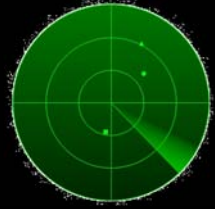
- Urgent ACAT 23%
- New community services/care package instituted 31%
- Existing care package upgraded 12.7%
- Respite organised 7.9%
- RACLAN involvement 7.1%
- Geriatrician review during episode 59.5%

Admissions (n=35)



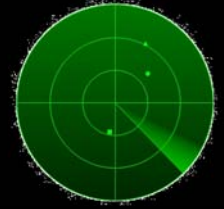
- Clients successfully avoided hospital admission in 91/126 episodes (72.2%)
- 9/35 (25.7%) admissions were within 24 hours of referral (patients may not have been appropriate for hospital avoidance in first instance)
- 31/35 (88.6%) admissions were arranged by RADAR team after review by us
- 26/35 (76.2%) admissions avoided ED
- A further 5 patients not on database as presented for emergency admission before any contact could be made, usually within a few hours of referral

Emergency department presentations



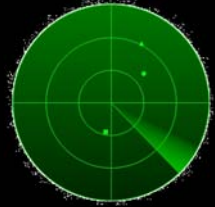
- Only 10 presentations identified across all clients on program, 9 of these being for admission
- 5 of these ED presentations arranged by us as no other mode of admission available after investigation
- All of the unplanned (5) ED presentations occurred out of hours/weekends/public holidays

Lessons



- Stay somewhere within your own box (help others feel confident in expanding theirs)
- Be proactive in pushing for other models of care to fill the gaps (social support team)
- Capacity building needs to start from day 1
- The most important success story here has been the close working relationship possible between GPs and NPs

The way forward.....



- Based on 12 month evaluation:
 - *Further round of GP education* required
 - *Audit patients representing to ED* within one week of an admission (numbers increasing on ED database)
 - *Learn more about hospital avoidance in residential care clients* with aim to upgrade this arm of our service. Use of emergency decision support tools
 - Continued development of links and agreements with community services and other medical services to develop *streamlined pathways for subgroups of patients* (eg. mental health, dementia). Appointment of program social worker in August 2008 will assist with this.
 - Develop links with CAPAC, HITH, LINK to ensure gaps are filled and to consider capture of *clients presenting out-of-hours* who may be suitable for one of these services
 - *IT support* to keep pace