

Care Co-ordination Team

Royal Perth Hospital



Smoothing the transition from Residential Care

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BACKGROUND

- CCT service commenced at RPH in 2007
- COAG Older Person's Initiative



STAFFING



Multidisciplinary Allied Health Team

- Occupational Therapists
- Physiotherapists
- Social workers
- Discharge Nurses

Experienced staff, based in the Emergency Department

AIMS OF CCT



- To facilitate safe and timely discharges;
- To prevent unnecessary and / or inappropriate hospital admission;
- To commence early intervention for patients requiring admission to reduce length of hospital stay;

AIMS OF CCT



- To link patients to community services such as:
 - Rehabilitation in the Home (RITH)
 - Hospital in The Home (HITH)
 - Silver Chain
 - Residential Care Line (RCL)
 - ACAT, Day hospitals, Falls & Memory Clinics
 - Outpatient services

Services



Services include:

- mobility and functional assessment
- assessment and referral to social supports
- equipment provision
- discharge planning
- community referrals

TARGET GROUP



- Screening and assessment of patients over 65, over 45 ATSI
- Other patients can be assessed by CCT on referral
- Average 700-800 (over 65 over 45 ATSI) people a month assessed

Smoothing the transition from Residential Care



- 84yr old lady from low care facility
- History of trigeminal neuralgia and dementia
- Presented to ED with increased pain and reduced oral intake
- CCT Assessment

Smoothing the transition from Residential Care



- RITH and ED pharmacist referral
- Discharged back to hostel from ED
 - to a familiar environment
 - antibiotics and change in medication regime
 - distraction techniques

Outcome: Pain better managed and patient able to increase oral intake.

Detailed Assessment in ED



To facilitate decision making and discharge planning, CCT contact the Residential Aged Care Facility (RACF)

- High care/ low care/ aging in place?
- Preadmission function
- Detail of presenting complaint

Detailed Assessment in ED



- Is facility coping with patient care?
- Are there plans to change facilities that can provide appropriate care if not coping?
- Family/ patient requests

RACF patients- CCT Input in the ED

- Liaising with RACFs
- Patient and family advocacy
- Mobility assessments
- Respiratory physiotherapy
- Referral to OPAL (Older person's Psychiatric Assessment and Liaison service)
- Referral to ward allied health as indicated
- Referral to RITH, HITH, HATH
- Linking with RCL (residential care line)

RMO Education



- Medical staff rotation
- Capacity for low care facilities to provide opiate based medications
- RACF ability to provide care if patient has reduced function.

NOT every residential care facility is a nursing home!

Challenges



- RACF transfer document not always accurate or lacking required information
- RACF phone number missing or don't answer
- Limited RN access especially after hours
- RACF agency staff who don't know patient
- Aging in place (high care needs but no increase in care availability)

RCL



- At the commencement of RCL we referred patients who didn't need to present to an acute hospital but could be managed in the community, in order to increase awareness of RCL services.

July 2008 RCL	-	171 community referrals
	-	18 CCT referrals
May 2009 RCL	-	241 community
	-	6 CCT referrals

Outcomes



- To date, our staff satisfaction and patient satisfaction surveys have demonstrated positive views of the service (not RACF specific)

Future

- SHRAC research
- “complex patient”



THE END

Questions?