Frail older people deserve integrated specialist care – a nursing solution

"The yellow brick road"

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Overview

- Demographics – Hutt Valley NZ
- Timeline
  - Feasibility Study
  - Case Review/mentorship programme
  - Pivotal roles
  - Pivotal teams
  - Coming together – Virtual Gerontology Nursing Team
- Learning

Demographics

- Hutt Valley 140,000 people
- Maori 16.8% (15.5%), Pacific people 7.8%(6.5%)
- 21,000 65+ yrs, increasing to 24,000 by 2020

Timeline

2008-09

Feasibility study

NP role health of older people

2010-11

Case review/mentor-ship programme pilot

2nd NP role older persons mental health

2012

Programme expanded to include 8 aged-care facilities

2013

Case review programme offered to in-patient rehab

Geriatric Liaison Speciality RN role

Early Supportive Discharge team – clinical support through case review

Complex Care Group (April)

2014

Clinical support offered to community health

Speciality gerontology RN role

Increase in ESD nursing time

Concept of "virtual gerontology nursing team"

2015

Community health join ESD to review referrals – case review included

ESD and community health one point of referral

Comprehensive Geriatric Assessment Workshop

ESD/community health – common manager

2008 – Feasibility Study

- To develop a community based nurse practitioner role that focuses on older people with long-term conditions
- Wide consultation
- Identified aged-care as a focus

- **“Wish List”**
  - Clinical support and mentorship – “another pair of eyes”
  - Leadership
  - Linking across services

    → **Case review/mentorship programme**

Case review/Mentorship Programme

- Pilot 2010/11 – 2 aged-care facilities
- Aims
  - Build critical thinking and nursing expertise
  - Develop team work
  - Improve links across services

Principles & Learning

- Nurses' identify **their learning needs**
- Flexibility
- Dynamic round table approach – team work

- All-round "buy-in" essential
- Needs to be seen as adding value
- It takes time

Programme expanded

- 2012 - 8 aged-care facilities
- 2013
  - Rehabilitation in-patient wards
  - Early Supportive Discharge
- 2014 – Community health

- 2012-2014
  - 185 sessions held with 1210 participants (aged-care)
  - 69 sessions with ESD from mid 2013

- Positive feedback

Pivotal Roles

- Nurse Practitioner – health of older persons (2008)
- Nurse Practitioner – older persons mental health (2010)
- **Geriatric Liaison Specialty RN** (2013)
- Early Supportive Discharge (2013)
- Speciality Gerontology RN (2014)

Pivotal Teams

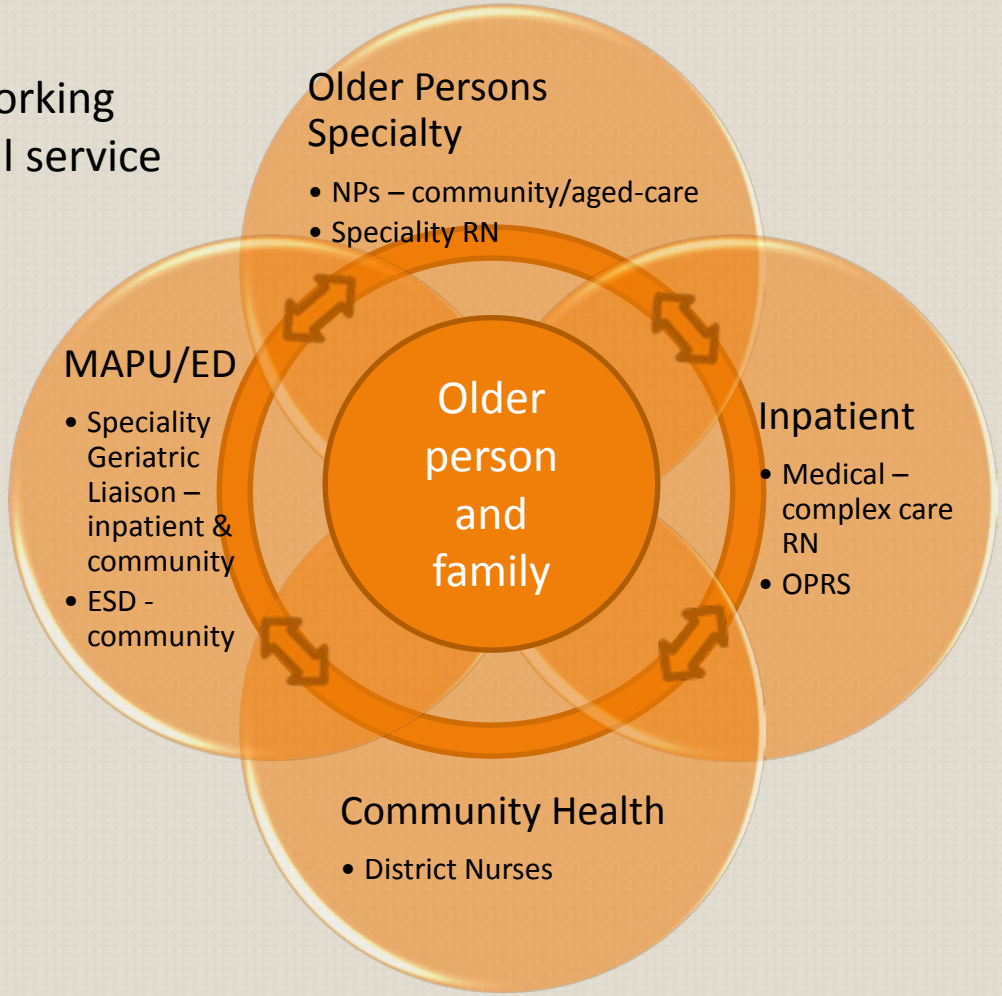
- Older Persons and Rehabilitation Service (OPRS)
  - Nurse Practitioners
  - Speciality Gerontology RN
- Medical Assessment & Planning Unit (MAPU)
  - Early supportive discharge (ESD)
  - Geriatric Liaison RN
- Community Health
  - District Nurses
- Links – inpatient OPRS, Medical Ward, CCU, MAPU and ED

Coming Together

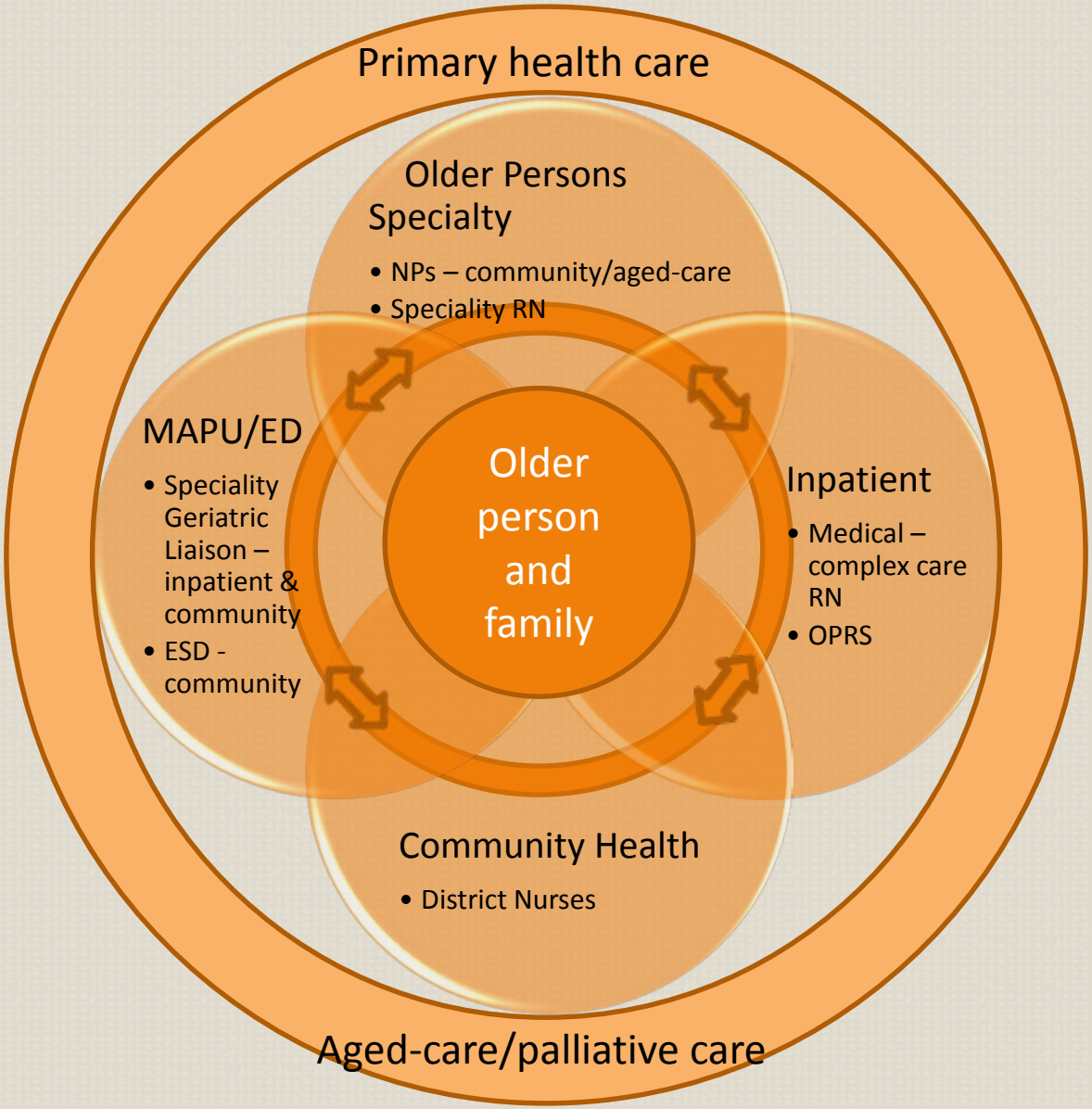
- Daily screening meeting for new referrals
  - Community health
  - ESD
  - Links with OPRS twice weekly
- Developing expertise
  - Case review/mentorship
  - Comprehensive geriatric assessment workshop

Virtual Gerontology Nursing Team

Senior Nurses working across traditional service boundaries



Looking forward



Learning

- Recognition of complexity
- Early identification and/or response to clinical need
- **Flexibility – working together**
- **Right people** in right place at right time

A model for working across the community