CAA18 Congress
Incorporating IRCP 6 - 9 August
Hilton Auckland New Zealand

The Patient: At the centre of everything we do
Ko te tūroro: Ki te pokapū o mātou mahi

caa.net.au

PAC4RAC
Providing Appropriate Care for Residents in Aged Care

Jonathan Tunhavasana
NSW Ambulance [AUS]

How Chance Connected NSW Health Minds

Potential to Innovate & Collaborate

NSW Ambulance

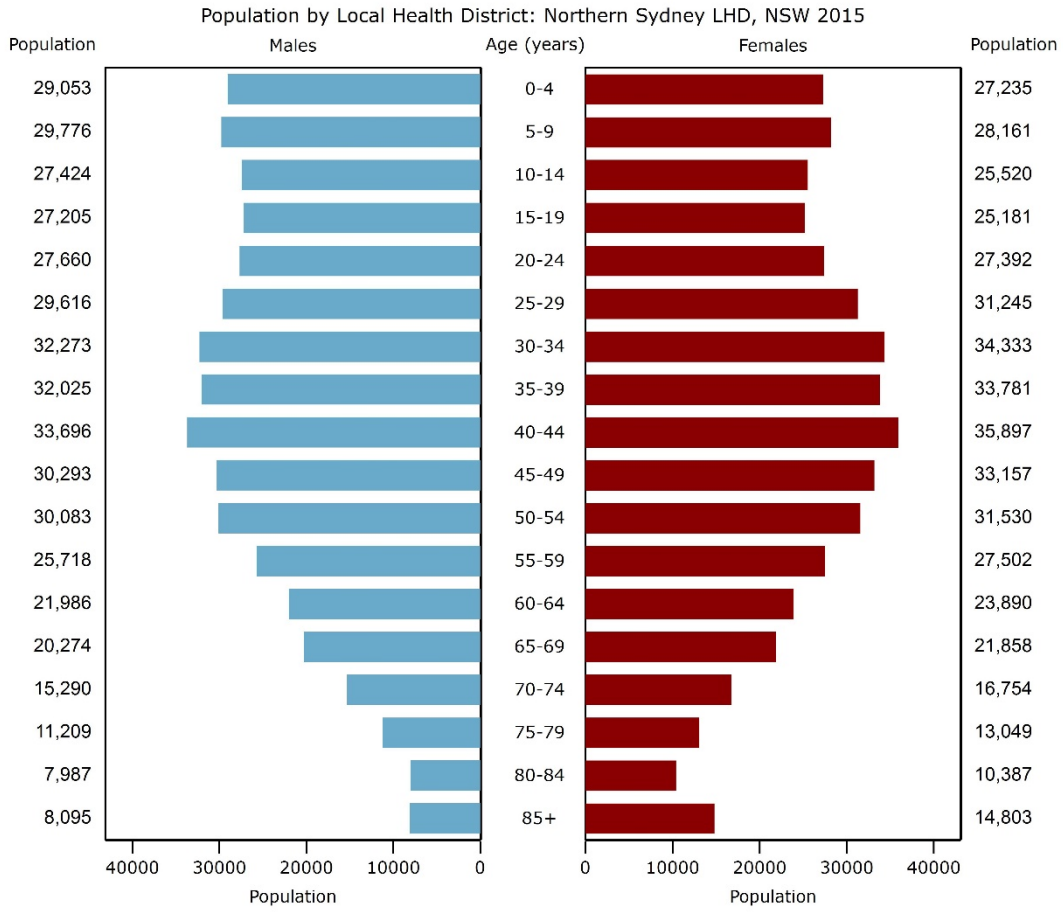
Twilight AGED CARE

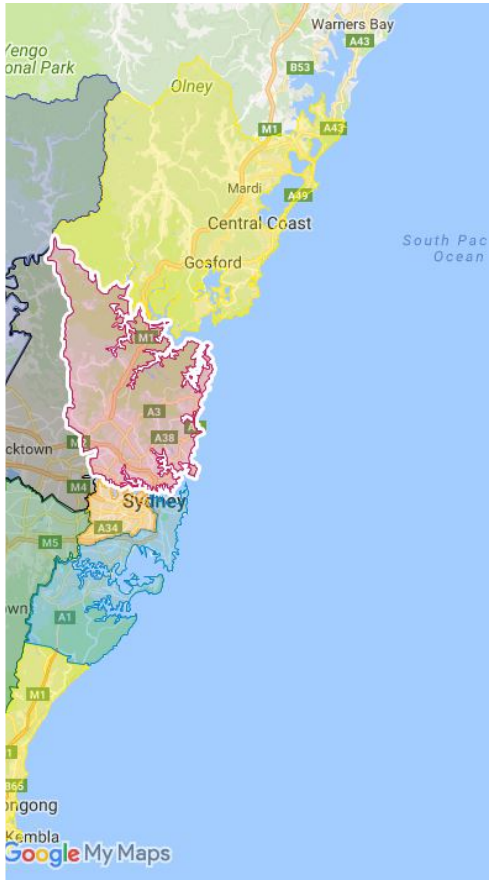
I think we should Partner

Should we Innovate & Collaborate?

- 5 Twilight Aged Care Facilities located in the north of Sydney
- 147 Triple Zero (000) calls from Twilight Aged Care Facilities in 12 months
- NSW Ambulance transported 141 patients to Northern Sydney Local Health District (NSLHD) Hospitals

Should we Innovate & Collaborate?





Did we have all the ‘Partners?’

PROCESS

Twilight AGED CARE

NSW Ambulance

NSW GOVERNMENT Health
Northern Sydney Local Health District

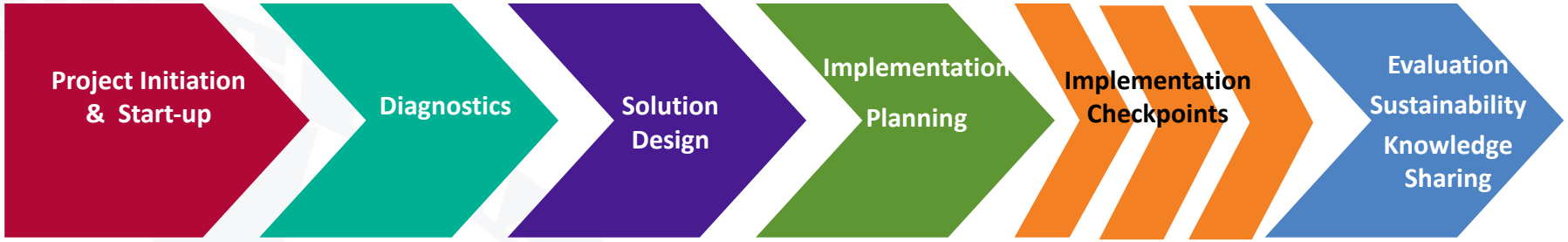
Which minds can we connect?

Project Team

Jonathan Tunhavasana: HRM NSW Ambulance
Jacqui Edgeley: DON Mona Vale Hospital NSLHD
Claire Bannister-Jones: Facility Manager TAC

How can we be Innovative Partners?

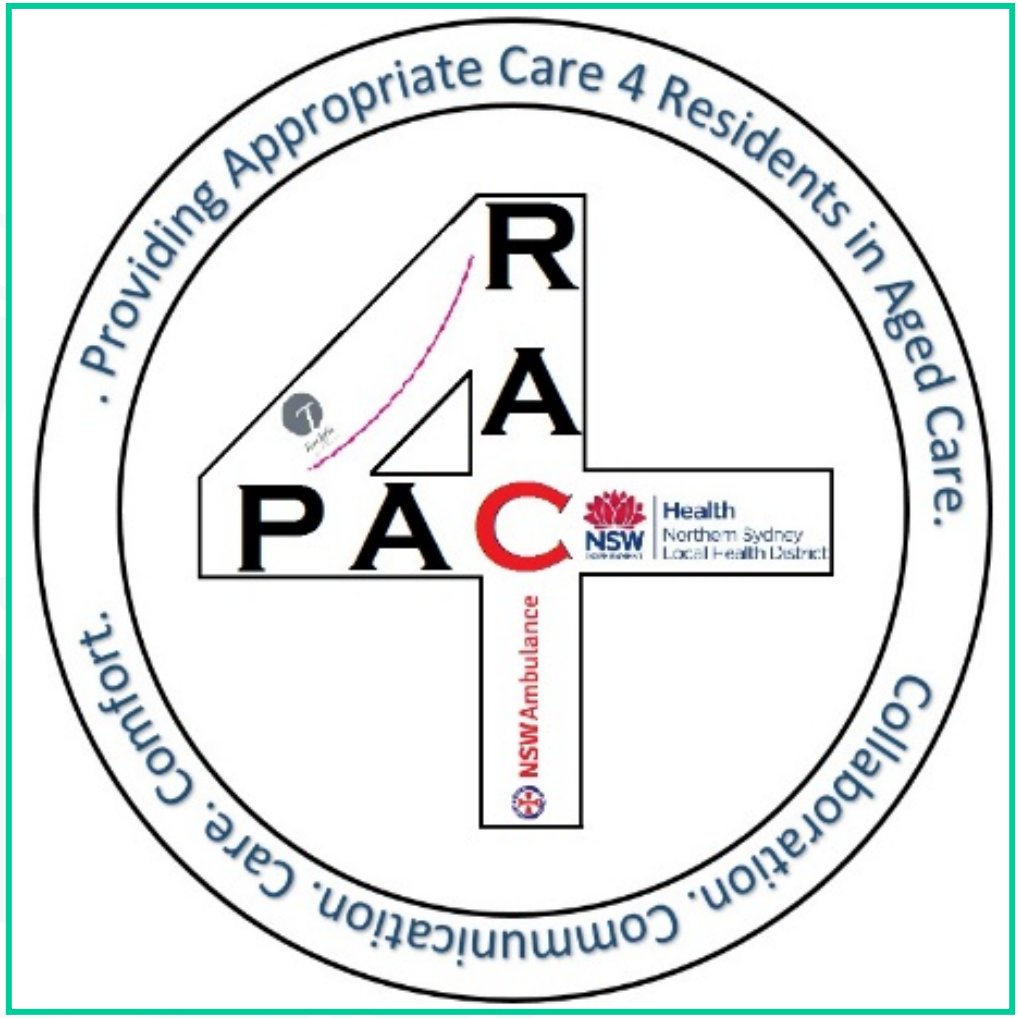
Redesign Methodology



Industry Frameworks & Methods used in Redesign:

- Business Process Re-engineering
- Lean Thinking
- Six Sigma
- Theory of Constraints
- Systems Thinking
- Accelerated Implementation methodology (AIM)

PAC4RAC was Born



What was the Case for Change?

All RACF across NSLHD

2015

5800
Calls to Ambulance

4000
Admitted to NSLHD facilities

Average LOS is 6.6 days
Cost: $1475 /day
Cost of ambulance ~$400 per response

26,400 Bed days
~ $38.94M

147
Calls to Ambulance

141
Transported by Ambulance to NSLHD facilities

27
Discharged from ED

114
Admitted to NSLHD facilities

752 Bed days
~ $1.11M

+
A cost of ~ $13,200 for the use of NSW Ambulance where transport could have been avoided

TAC Facilities

2015

Objectives

- By June 2017, the number of TAC residents requiring transport via NSW Ambulance to Emergency Departments within NSLHD will be reduced by 25 % from 141 patients a year to 106 patients a year.

- By June 2017, the number of “000”calls received for TAC residents to NSW Ambulance will be reduced by 25%.

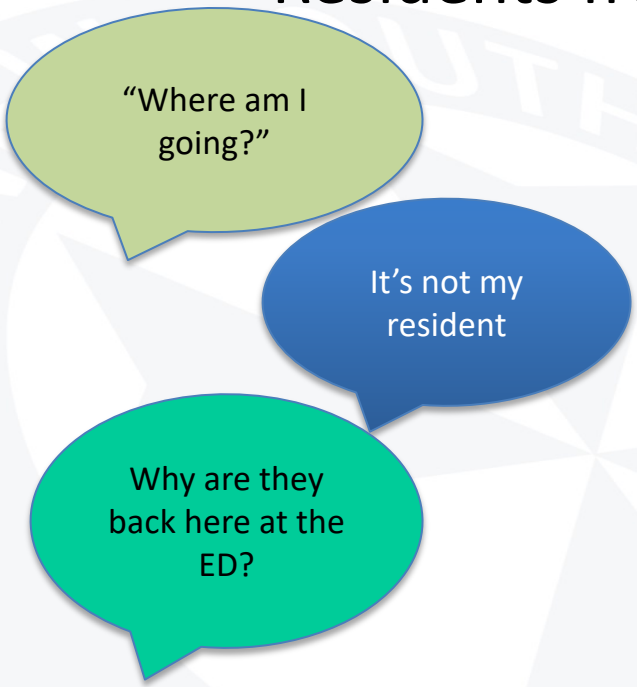
- By June 2017, all agreed identified treatable conditions will be managed within TAC 50% of the cases (low acuity).

Scope

- Determining In and Out of Scope:
  - Patients
  - Process
  - Technology

The Patient Journey

Residents from Twilight Aged Care Facilities will receive the:



Right care,

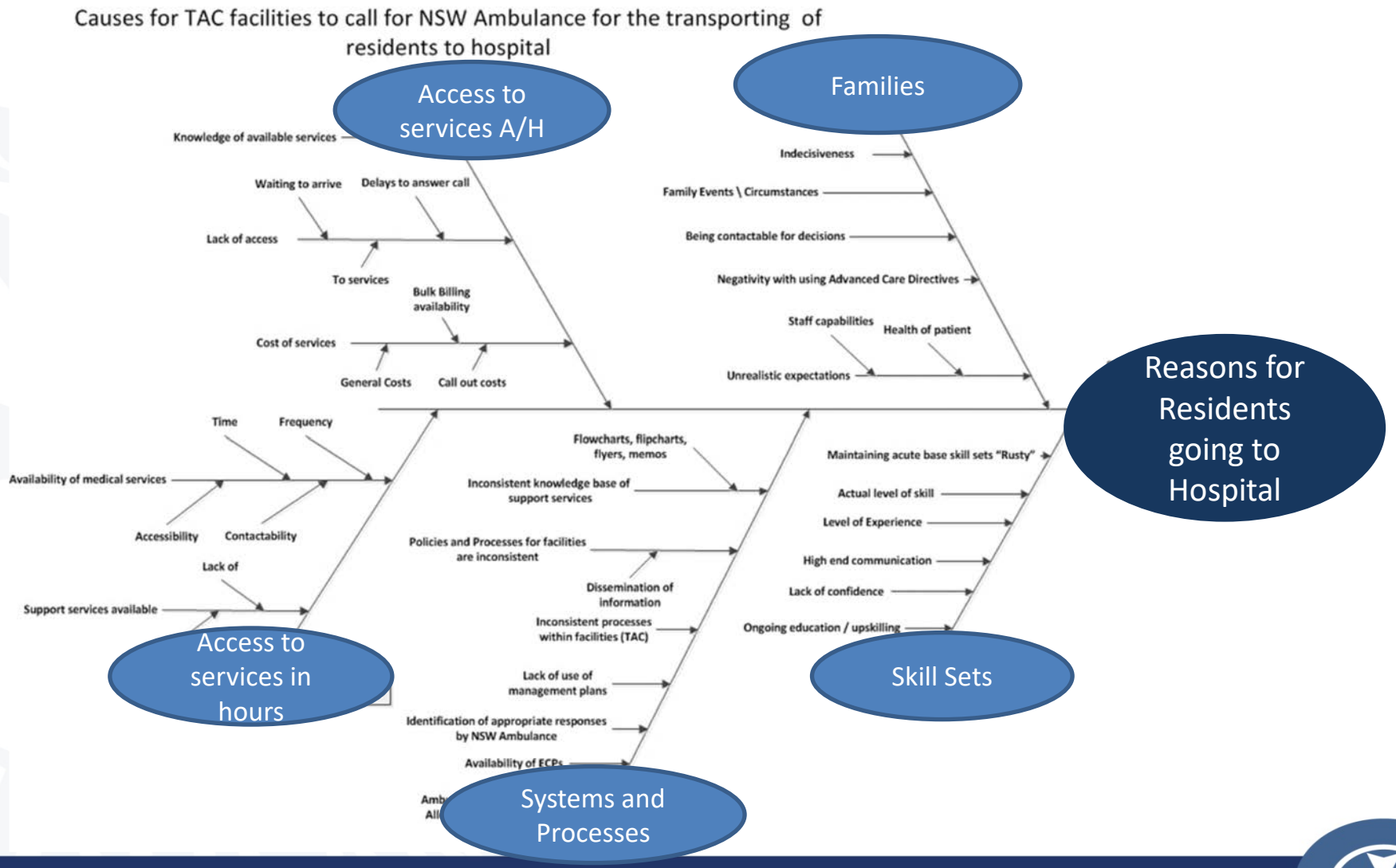
Right time, with the

Right people,

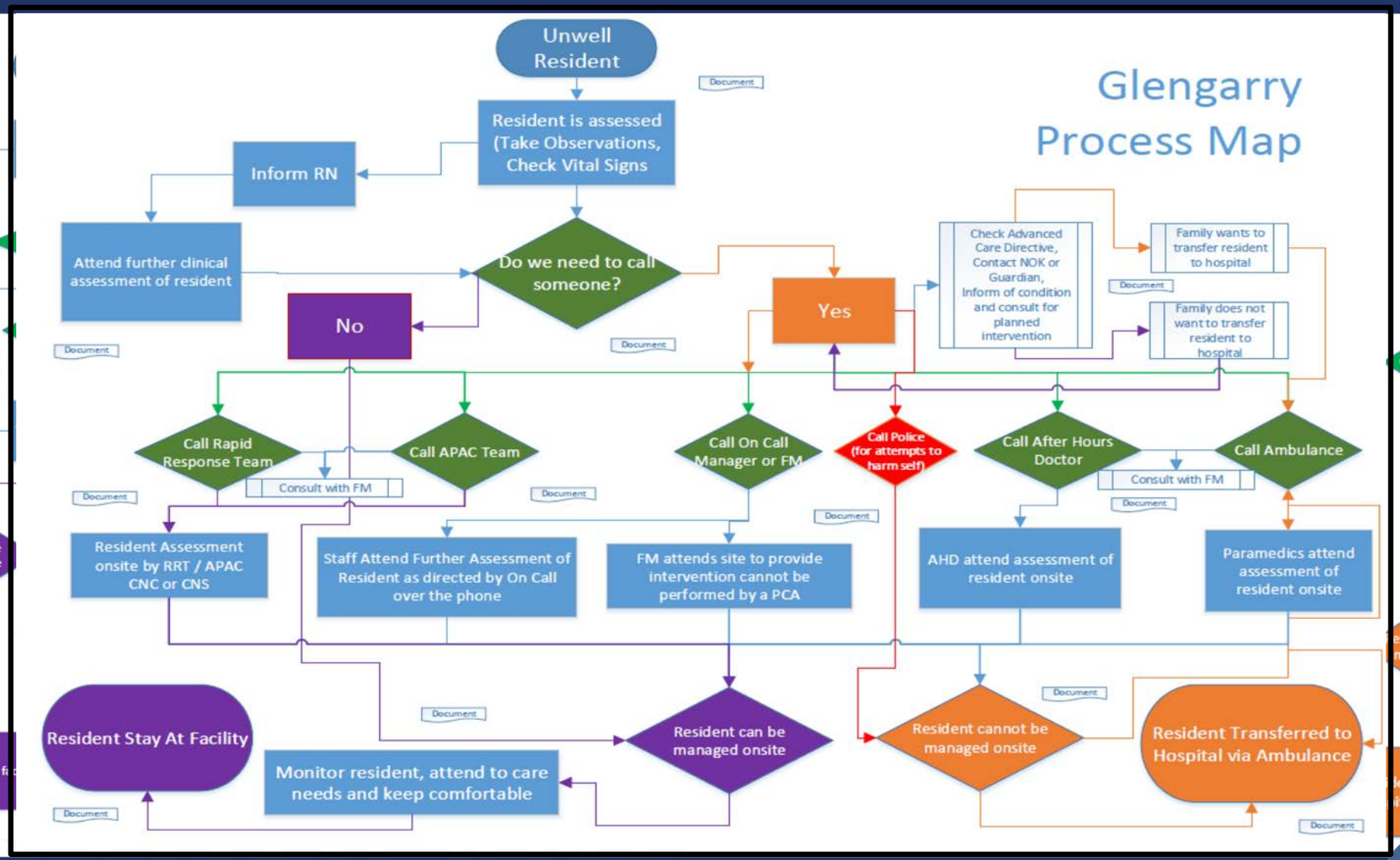
for their acute care needs,

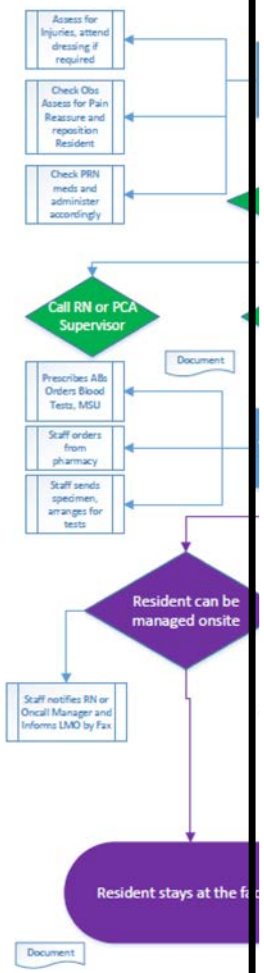
through the systematic processes that provide a positive experience for residents, family and staff involved.

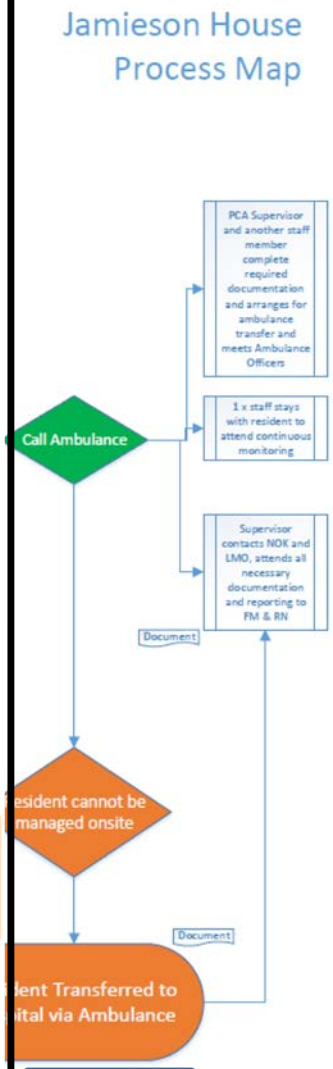
Analysis


Causes for TAC facilities to call for NSW Ambulance for the transporting of residents to hospital
Reasons for Residents going to Hospital
Access to services A/H
Knowledge of available services
Waiting to arrive
Delays to answer call
Lack of access
To services
Bulk Billing availability
Cost of services
General Costs
Call out costs
Families
Indecisiveness
Family Events \ Circumstances
Being contactable for decisions
Negativity with using Advanced Care Directives
Staff capabilities
Health of patient
Unrealistic expectations
Access to services in hours
Time
Frequency
Availability of medical services
Accessibility
Contactability
Lack of
Support services available
Systems and Processes
Flowcharts, flipcharts, flyers, memos
Inconsistent knowledge base of support services
Policies and Processes for facilities are inconsistent
Dissemination of information
Inconsistent processes within facilities (TAC)
Lack of use of management plans
Identification of appropriate responses by NSW Ambulance
Availability of ECPs
Skill Sets
Maintaining acute base skill sets "Rusty"
Actual level of skill
Level of Experience
High end communication
Lack of confidence
Ongoing education / upskilling

Analysis


Glengarry Process Map
Unwell Resident
Resident is assessed (Take Observations, Check Vital Signs
Inform RN
Attend further clinical assessment of resident
Do we need to call someone?
No
Yes
Check Advanced Care Directive, Contact NOK or Guardian, Inform of condition and consult for planned intervention
Family wants to transfer resident to hospital
Family does not want to transfer resident to hospital
Call Rapid Response Team
Call APAC Team
Consult with FM
Call On Call Manager or FM
Call Police (for attempts to harm self)
Call After Hours Doctor
Consult with FM
Call Ambulance
Resident Assessment onsite by RRT / APAC CNC or CNS
Staff Attend Further Assessment of Resident as directed by On Call over the phone
FM attends site to provide intervention cannot be performed by a PCA
AHD attend assessment of resident onsite
Paramedics attend assessment of resident onsite
Resident Stay At Facility
Monitor resident, attend to care needs and keep comfortable
Resident can be managed onsite
Resident cannot be managed onsite
Resident Transferred to Hospital via Ambulance
Document


Assess for Injuries, attend dressing if required
Check Obs Assess for Pain Reassure and reposition Resident
Check PRN meds and administer accordingly
Call RN or PCA Supervisor
Prescribes ABs Orders Blood Tests, MSU
Staff orders from pharmacy
Staff sends specimen, arranges for tests
Resident can be managed onsite
Staff notifies RN or Oncall Manager and Informs LMO by Fax
Resident stays at the fa
Document


Jamieson House Process Map
Call Ambulance
PCA Supervisor and another staff member complete required documentation and arranges for ambulance transfer and meets Ambulance Officers
1 x staff stays with resident to attend continuous monitoring
Supervisor contacts NOK and LMO, attends all necessary documentation and reporting to FM & RN
esident cannot be managed onsite
ent Transferred to ital via Ambulance
Document

What did we find

PAC4RAC Focus Area, Issues & Root Cause

No.	FOCUS AREA	ISSUE	Workshop Comments	ROOT CAUSE	Workshop Comments
			• Are they in place? Are they just not done? re they not there at all?	**1.1** Change in level of care within TAC and skill set of staff not changed accordingly	**Agreed**
				1.2 Engagement of medical staff	**Agreed**
				1.3 Family / Carer - lack of understanding and education of clinical management plans	**Agreed**
				2.1 Historical rostering practices based on level of resident activity	**Agreed**
				2.2 Change in level of care within TAC and skill set of staff not changed accordingly	**Agreed (Resident activity)**
				2.3 Opportunities to maintain acute base skill sets	**Agreed**
			• **GP knowledge of available hospital avoidance services**	**3.1** Availability and ability to contact for services	**Agreed**
				3.2 Different GPs for residents and use of contracted GPs	**Agreed**
				3.3 Base location of GPs	**Agreed**
			• **Availability of staff with skills and knowledge to provide effective handover**	**4.1** Content / use of form not valued by staff	**Agreed**
				4.2 Lack of local / outgoing structured handover	**Agreed**
			d map to	**5.1** Lack of consistency between sites for the requirements for calling an ambulance	**Agreed**
			Extended hours coverage of pital avoidance services	**5.2** Lack of knowledge of existing community service than can support	**Agreed**

Understanding and Access to Care Management Plans

Staff not confident with management of acute care conditions

Limited Access and Costs to Services

Lack of Structured Handovers

Inconsistent Processes to Escalate Care Within Facilities

Collaboration assists in a number of aspects

Some of the possibilities discussed

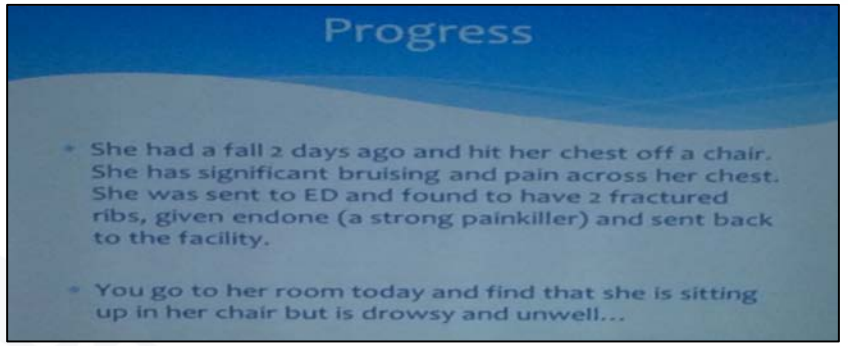
Keeping Staff, Residents and Families Updated

- Flyers
- Intranet
- Surveys
  - Communication
  - Education

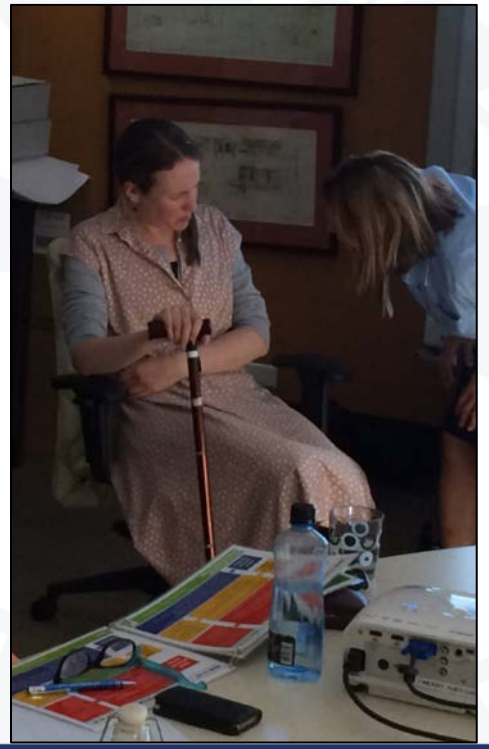
Enables better understanding, integration and collaboration amongst all stakeholders

Implementation and Education was not always easy

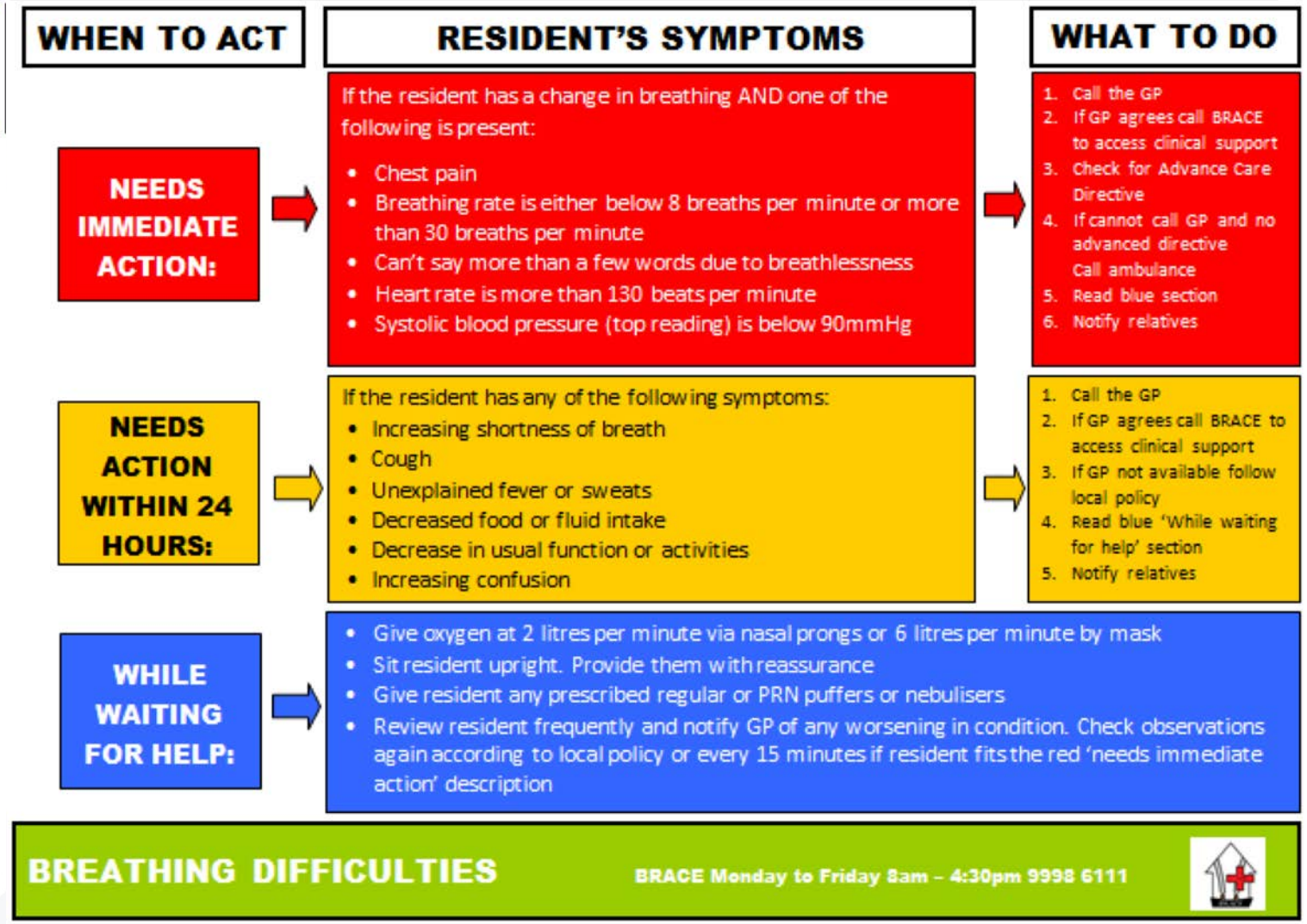
Community Service provides education



Training in the APAC flip chart for PCA's/ Empowering staff through this education



Charts were simplified for ease of use



WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has a change in breathing AND one of the following is present: • Chest pain • Breathing rate is either below 8 breaths per minute or more than 30 breaths per minute • Can't say more than a few words due to breathlessness • Heart rate is more than 130 beats per minute • Systolic blood pressure (top reading) is below 90mmHg	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Increasing shortness of breath • Cough • Unexplained fever or sweats • Decreased food or fluid intake • Decrease in usual function or activities • Increasing confusion	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Give oxygen at 2 litres per minute via nasal prongs or 6 litres per minute by mask • Sit resident upright. Provide them with reassurance • Give resident any prescribed regular or PRN puffers or nebulisers • Review resident frequently and notify GP of any worsening in condition. Check observations again according to local policy or every 15 minutes if resident fits the red 'needs immediate action' description	

BREATHING DIFFICULTIES BRACE Monday to Friday 8am – 4:30pm 9998 6111

Training in the APAC flip chart for PCA's/ Empowering staff through this education

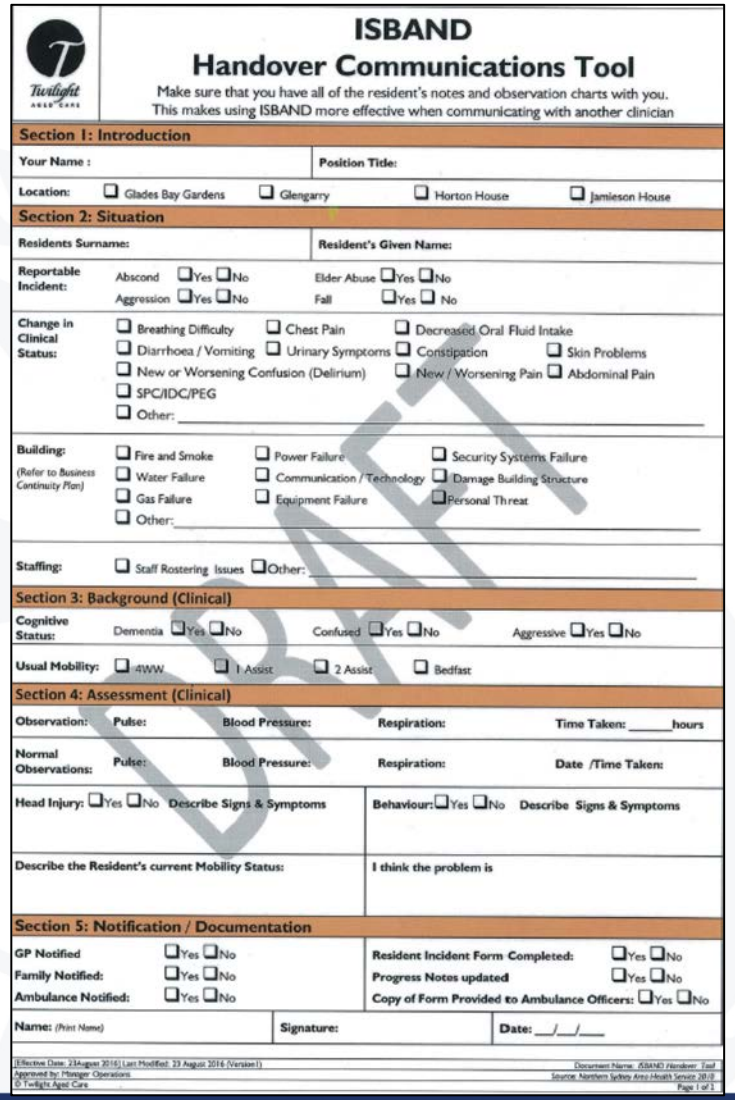
There was some Information Technology updating

Date & Time	* dd/mm/yyyy 00.00 (please use 24 hour time)
Reason for transfer	
Attached	Resident Details (from iCare) Medication Chart GP's Letters Copy of Care Plan Other
Other	* if selected above
What is the ususal mental status of the resident?	Orientated
What is the mental status of the resident at the time of the transfer?	Orientated
Belongings sent with the resident	* ie. dentures, walking frame etc.
Advanced Care Plan	-
Advanced Care Directive	-

Edit RACF transfer sheet to add box indicating advance care directive/end of life wishes

Handover forms and template created

Saw Heard Assessment ISBAR Implementation into facilities



ISBAND
Handover Communications Tool
Make sure that you have all of the resident's notes and observation charts with you.
This makes using ISBAND more effective when communicating with another clinician

Section 1: Introduction

Your Name : | Position Title:

Location: ☐ Glades Bay Gardens ☐ Glengarry ☐ Horton House ☐ Jamieson House

Section 2: Situation

Residents Surname: | Resident's Given Name:

Reportable Incident: Abscond ☐Yes ☐No Elder Abuse ☐Yes ☐No
Aggression ☐Yes ☐No Fall ☐Yes ☐ No

Change in Clinical Status: ☐ Breathing Difficulty ☐ Chest Pain ☐ Decreased Oral Fluid Intake
☐ Diarrhoea / Vomiting ☐ Urinary Symptoms ☐ Constipation ☐ Skin Problems
☐ New or Worsening Confusion (Delirium) ☐ New / Worsening Pain ☐ Abdominal Pain
☐ SPC/IDC/PEG
☐ Other: _____

Building: (Refer to Business Continuity Plan) ☐ Fire and Smoke ☐ Power Failure ☐ Security Systems Failure
☐ Water Failure ☐ Communication / Technology ☐ Damage Building Structure
☐ Gas Failure ☐ Equipment Failure ☐ Personal Threat
☐ Other: _____

Staffing: ☐ Staff Rostering Issues ☐Other: _____

Section 3: Background (Clinical)

Cognitive Status: Dementia ☐Yes ☐No Confused ☐Yes ☐No Aggressive ☐Yes ☐No

Usual Mobility: ☐ 4WW ☐ 1 Assist ☐ 2 Assist ☐ Bedfast

Section 4: Assessment (Clinical)

Observation: Pulse: Blood Pressure: Respiration: Time Taken: _____hours

Normal Observations: Pulse: Blood Pressure: Respiration: Date /Time Taken:

Head Injury: ☐Yes ☐No Describe Signs & Symptoms | Behaviour: ☐Yes ☐No Describe Signs & Symptoms

Describe the Resident's current Mobility Status: | I think the problem is

Section 5: Notification / Documentation

GP Notified ☐Yes ☐No
Family Notified: ☐Yes ☐No
Ambulance Notified: ☐Yes ☐No
Resident Incident Form Completed: ☐Yes ☐No
Progress Notes updated ☐Yes ☐No
Copy of Form Provided to Ambulance Officers: ☐Yes ☐No

Name: (Print Name) | Signature: | Date: __/__/____

[Effective Date: 23August 2016] Last Modified: 23 August 2016 (Version1) Document Name: ISBAND Handover Tool
Approved by: Manager Operations Source: Northern Sydney Area Health Service 2010
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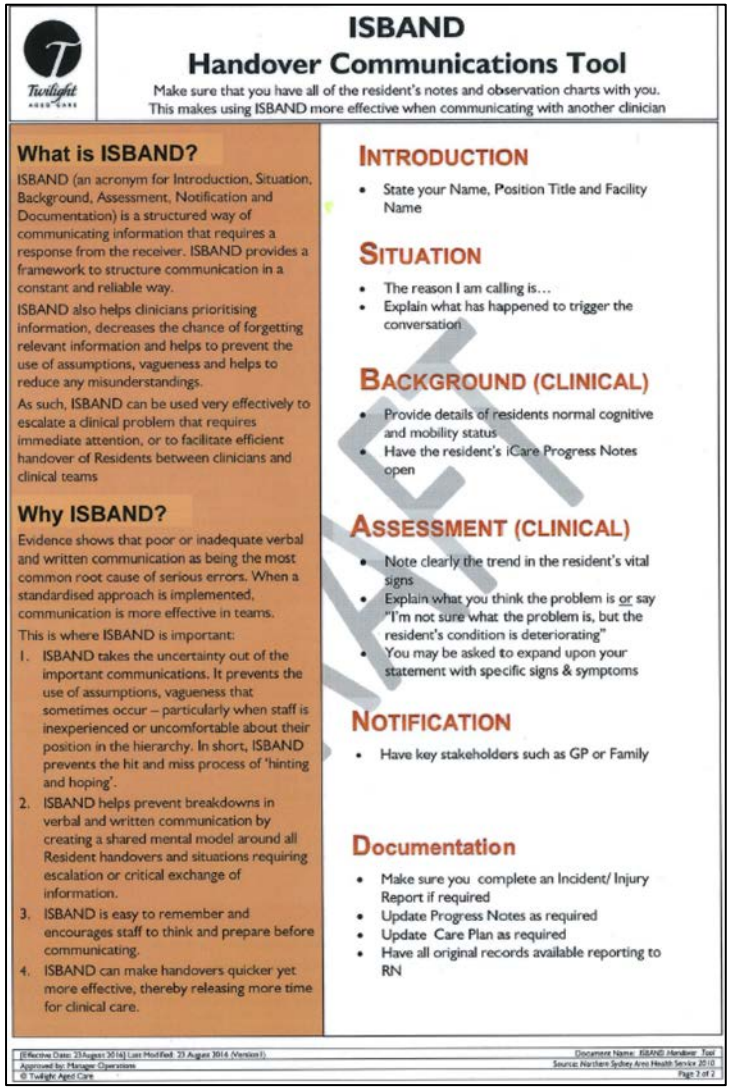

ISBAND
Handover Communications Tool
Make sure that you have all of the resident's notes and observation charts with you.
This makes using ISBAND more effective when communicating with another clinician

What is ISBAND?

ISBAND (an acronym for Introduction, Situation, Background, Assessment, Notification and Documentation) is a structured way of communicating information that requires a response from the receiver. ISBAND provides a framework to structure communication in a constant and reliable way.

ISBAND also helps clinicians prioritising information, decreases the chance of forgetting relevant information and helps to prevent the use of assumptions, vagueness and helps to reduce any misunderstandings.

As such, ISBAND can be used very effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover of Residents between clinicians and clinical teams

Why ISBAND?

Evidence shows that poor or inadequate verbal and written communication as being the most common root cause of serious errors. When a standardised approach is implemented, communication is more effective in teams.

This is where ISBAND is important:

1. ISBAND takes the uncertainty out of the important communications. It prevents the use of assumptions, vagueness that sometimes occur – particularly when staff is inexperienced or uncomfortable about their position in the hierarchy. In short, ISBAND prevents the hit and miss process of 'hinting and hoping'.
2. ISBAND helps prevent breakdowns in verbal and written communication by creating a shared mental model around all Resident handovers and situations requiring escalation or critical exchange of information.
3. ISBAND is easy to remember and encourages staff to think and prepare before communicating.
4. ISBAND can make handovers quicker yet more effective, thereby releasing more time for clinical care.

INTRODUCTION

- State your Name, Position Title and Facility Name

SITUATION

- The reason I am calling is…
- Explain what has happened to trigger the conversation

BACKGROUND (CLINICAL)

- Provide details of residents normal cognitive and mobility status
- Have the resident's iCare Progress Notes open

ASSESSMENT (CLINICAL)

- Note clearly the trend in the resident's vital signs
- Explain what you think the problem is or say "I'm not sure what the problem is, but the resident's condition is deteriorating"
- You may be asked to expand upon your statement with specific signs & symptoms

NOTIFICATION

- Have key stakeholders such as GP or Family

Documentation

- Make sure you complete an Incident/ Injury Report if required
- Update Progress Notes as required
- Update Care Plan as required
- Have all original records available reporting to RN

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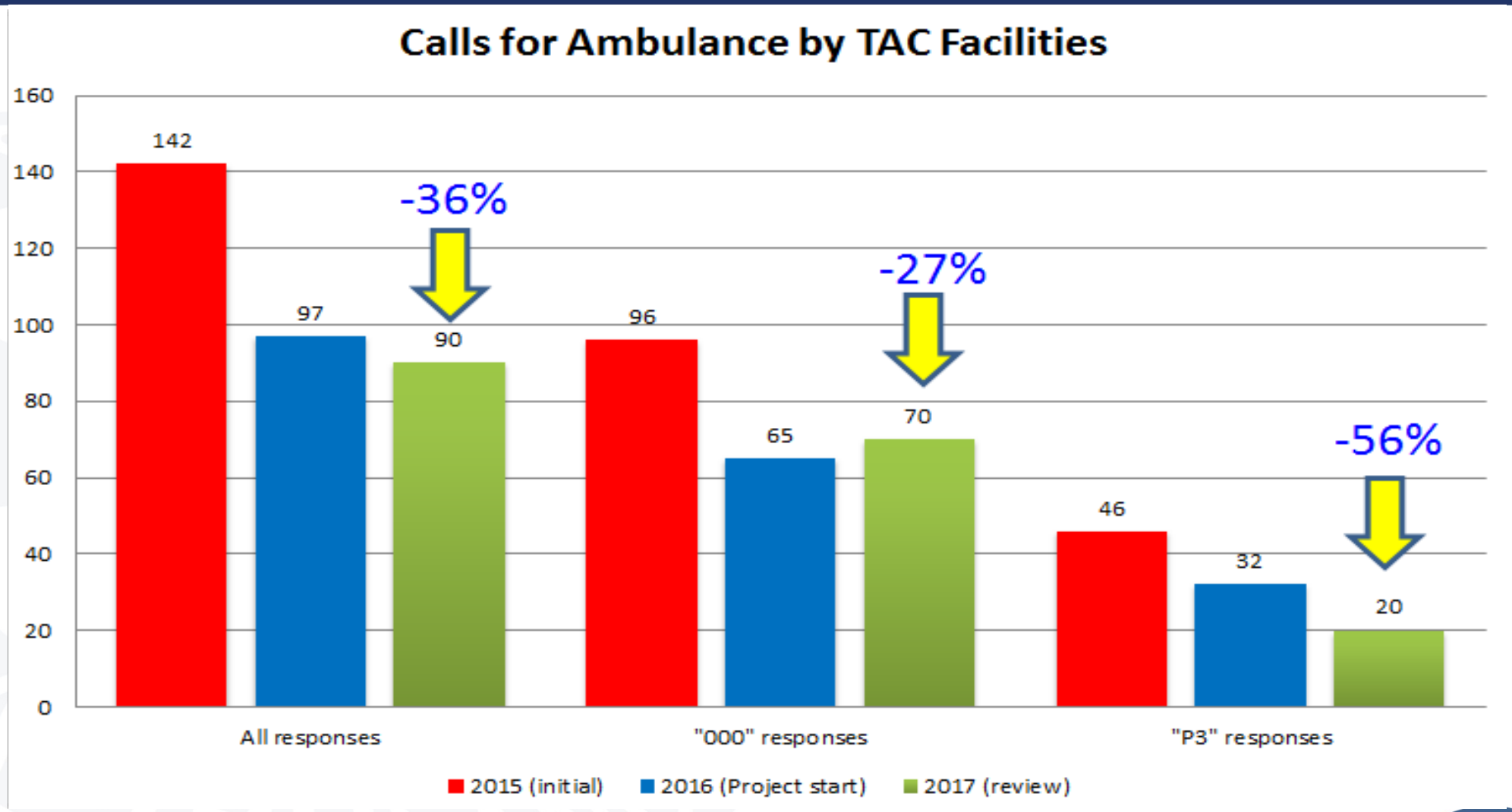
ISBAR training for staff to introduce any news of health change/deterioration

Results through working together



Lessons learnt assists for the next one

- Management of Time:
  - Work vs Project vs Personal
- Regular engagement of sponsors
- Need to share the responsibilities
- Importance of providing flexibility
- Ensuring version control with documents

The future looks good

- Ongoing education and training of Twilight Aged Care staff.
- Twilight Aged Care is looking at further collaborative work.
- North Sydney Local Health District identifying other RACFs.
- Engagement from other districts and hospitals.
- Promotion of the program through Whole of Health Program.

Acknowledgements

- Twilight Aged Care
- NSW Ambulance
- North Sydney Local Health District
- Sydney North Primary Health Network
- Agency of Clinical Innovation
- Whole of Health Program – NSW Health

Questions

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