Health
Murrumbidgee
Local Health District

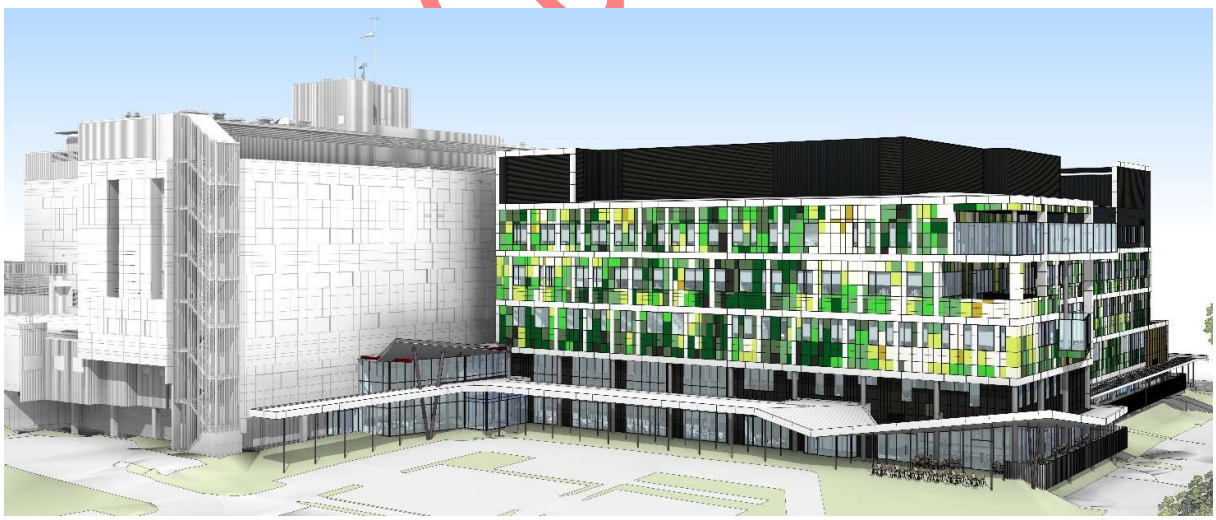
WAGGA WAGGA BASE HOSPITAL

AGED CARE INPATIENT UNIT

(WWACIPU)

MODEL OF CARE

December 2022



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1.0 Introduction

The Wagga Wagga Aged Care Inpatient Unit adheres to the Murrumbidgee Local Health District (MLHD) Strategic Plan. This document outlines the model of care this Unit. This model of care provides services to the aged population within a multidisciplinary environment focusing on Person Centred Care. The establishment of Aged Care units has an evidence base for reducing functional decline, mortality, length of stay, hospital readmission and the need for permanent care entry.

Section 1: Wagga Wagga Base Hospital Aged Care Inpatient Service

(a) Acute Aged Care Services

(b) Sub-acute Geriatric Evaluation & Management Care

Section 2: Linkaged to Outpatient Aged Care Services

The Wagga Wagga Base Hospital (WWBH) adhere to the Murrumbidgee Local Health District (MLHD) Strategic Plan 2021-2026. This plan provides an overarching framework that guides Wagga Wagga Aged Care Inpatient Unit (WWACIPU) purpose, vision, values and goals. These are as follows:

OUR PURPOSE

The Wagga Wagga Aged Care Inpatient Unit (WWACIPU) service aims to safeguard health and promote quality of life for older people through the enhanced provision and coordination of services. This is happening at a time when demographic changes in society are placing ever-increasing demands on service provision - a trend that will continue for decades to come.

Evidenced based, patient-centered care is provided by a Multidisciplinary Team of Physicians, Nurses, and Allied Health clinicians.

The WWACIPU aims to identify and focus on the main health issues currently confronting older people within the MLHD, to enhance the quality of life for older people in the district, empowering and supporting people to maintain optimal health, wellbeing and independence by means of direct intervention, coordination of care and services, and /or the provision of knowledge, advice and support.

OUR VISION

Holistic Health & Wellbeing
Aged Care services aspire to support and empower people and communities to take individual and collective responsibility for improving their own health as they age.

Lifting health outcomes
Guided by best practice methodologies, Aged Care services will continue to develop and implement more efficient and effective ways of working; pursuing research and innovation through collaborative teamwork and use of technology.

Workforce at its best
Investing in our people, Aged Care services recognise the expertise and professionalism of our staff. Only by promoting the individual and collective professional development of our workforce, can MLHD continue to meet the needs of its ageing population.

OUR GOALS

To achieve the MLHD Purpose and Vision the MLHD has identified four areas in which it needs to succeed.

1. Meeting current community expectations;
2. Preparing for the future;
3. Financial sustainability; and
4. Organisational efficiency

OUR VALUES

To reach our vision the organisation will work with our clinicians, staff, communities and partners in a way that promotes:

- Collaboration;
- Openness;
- Respect; and
- Empowerment

2.0 Definitions

The following are definitions of terms, abbreviations and acronyms used in this document.

Term	Definition
AARCS	Acute to Aged Related Care Service
ACAT	Aged Care Assessment Team
ADL	Activities of Daily Living
AT	Advanced Trainee
CNE	Clinical Nurse Educator
ECG	Electrocardiogram
EDD	Expected Discharge Date
GP	General Practitioner
IMS+	Incident Management System
ISBAR	Introduction, Situation, Background, Assessment, Recommendations
ALOS	Average Length of Stay
MLHD	Murrumbidgee Local Health District
MDT	Multidisciplinary Team
NIV	Non Invasive Ventilation
NUM	Nurse Unit Manager
NWAU	National Weighted Activity Unit
RN	Registered Nurse
REACH	Recognise Engage Act Call Help
SAGO	Standard Adult General Observations
SNAP	Subacute Nonacute Patient
WWBH	Wagga Wagga Base Hospital
WWACIPU	Wagga Wagga Aged Care Inpatient Unit

3.0 Service Model

3.1 Aim

- Improve the journey of older people with complex healthcare conditions, and their family members, through patient centred care
- Provide early multidisciplinary assessment of the older person, prevention of complications, and early mobilisation and reconditioning
- Improve patient/carer outcomes to support their return to living in the community

3.2 Principles of Care

- Consumer centered
- Evidence- based practice
- Establish clearly defined accountability and clear reporting structures
- Early identification and intervention for reversible conditions in the older person
- Patients are admitted under a WWBH Geriatrician
- Encourage early mobilisation and functional improvement and participation in Activities of Daily Living (ADL) and socialisation
- Improve manaAged Careent and timely transitioning of the older person through the acute setting using a Multidisciplinary team environment
- Promotes a wellness and restorative model of care approach to the older person.
- Set goals and define the expected discharge date (EDD) within 48-72 hours
- Provide detailed and comprehensive discharge planning in consultation/collaboration with AARCS, ACAT and Aged Care Community Services.

3.3 Description of Service Model

The Aged Care Inpatient Unit provies acute and sub acute care for patients >65 year of age with a focus on the >75 age group cohort. In the interests of improving Aboriginal and Torres Strait Islander Health outcomes, Aboriginal people > 50 years of ages are included in this cohort.

This service will focus on providing comprehensive geriatric assessment, to identify and manage acute and sub-acute care needs. Comprehensive geriatric assessment is a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail elderly person in order to develop a coordinated and integrated plan for treatment and long-term follow-up.

The Model of Care is characterized by the following features:

- Interdisciplinary assessment and management of the older person
- Twice weekly team case conference to discuss individualized patient's goals, therapy programs and establish discharge and follow up plans
- Care Coordination conferences for patients with complex needs and/or a prolonged episode of care, including family/carers and relevant community care providers
- A cohesive patient journey through acute and sub-acute services in the one inpatient unit
- Monthly Quality Improvement Meetings involving all team members to review improvement projects and incidents for example - complaints, falls, medication errors
- Multidiciplinary team (MDT) education

3.3 Summary of Evidence

Geriatrician-led multidisciplinary Care is the gold standard approach to acute aged care, and is strongly supported by the 'Australian & New Zealand Society for Geriatric Medicine – Position Statement 3 – Geriatric Medicine Services in and around General Hospitals' which can be found here:

https://anzsgm.org/wp-content/uploads/2021/03/Geriatric-Services-in-and-around-General-Hospitals-090219-4-1.pdf

4.0 Wagga Wagga Base Hospital Aged Care Inpatient Service

4.1 Operational Principles

The Aged Care inpatient service will reflect the following operational principles:

- Early assessment and referral by trained and specialised staff at initial point of contact
- Receiving care by appropriate skilled staff
- An multidisciplinary team approach to care
- Resource sharing across all specialities
- Coordination and communication between Medical, Nursing, Allied Health and Administration
- Flexible bed allocation so patients can seamlessly step-down from acute to sub-acute care to transition care as their needs change – patients would be admitted to an acute or sub-acute (GEM) bed type as appropriate, and type changed as appropriate throughout their admission.
- Utilisation of specifically designed infrastructure to support care, include delirium specific patient rooms and therapy areas

4.2 Hours of Operation

24 hours per day, 7 days per week

4.3 Patient Profile

Patients should be >65 years (ATSI >50 years) old and meet the following criteria:

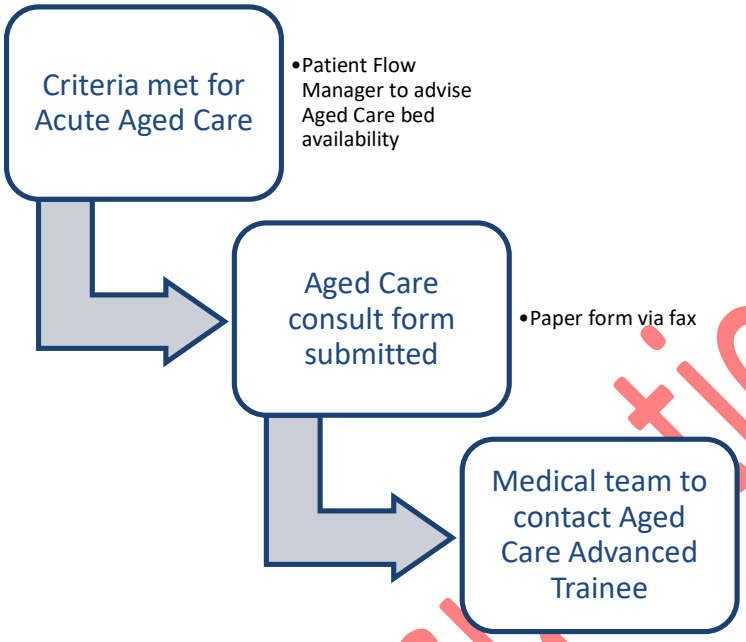
- Have one or more medical conditions with declining function
- Require complex, interdisciplinary assessment of physical, social and psychological issues
- Be at risk of functional impairment as a result of this hospital admission which may lead to increased levels of community or residential care
- Have realistic and achievable goals within a defined timeframe

4.4 Patient Exclusion Criteria

- Primarily awaiting High level Permanent residential care
- Requiring specialised treatments e.g. telemetry, NIV
- Palliative patients needing end of life care
- Pt deemed not likely to benefit from the model of care by the consultant geriatrician

4.5 Referral to Acute Aged Care Unit

Emergency Department referrals will be assessed dependent on Aged Care Inpatient Unit bed availability.



4.6 Discharge

- Carers or family members are encouraged to engage in care activities where appropriate, including feeding, re-orientation, supervision, ADLs
- Carers or family members will be encouraged to participate in care planning and discharge planning
- Discharges are coordinated at biweekly case conferences by the geriatrician in collaboration with the MDT, Nursing Unit Manager (NUM) and WWBH AARC nurse.

4.7 Case Conference

Bi-weekly case conferences are attended by Geriatrician, NUM, Nurses, Physiotherapists, Occupational Therapists, Social Worker, Speech Pathology, Dietetics, Pharmacist, Aboriginal Health Liason staff and other disciplines attend as appropriate for each patient.

Case conferencing provides an opportunity for collaborative discussion amongst the multidisciplinary team. The focus is goal setting and reviewing progress towards patient centred goal achievement and planning for a safe and sustainable discharge.

Patients and families will be asked to nominate one key contact who can be regularly contacted and updated regarding the care plan for the patient.

5.0 The Patient Journey

5.1 Overview

- All patients must be admitted under the direct care of a Geriatrician.
- Direct community admissions are accepted from Medical Specialist, General Practitioner, and Aged Care Clinicians, in consultation with the Geriatrician.
- If no aged care beds are available, patients felt suitable for admission will be admitted under the consultant of the day and may be referred by their team for a Geriatrics review by the usual pathway by contacting the geris AT.
- Assessments completed within 24hrs of arrival in Aged Care unit (72 hours if arriving Friday afternoon or on the weekend). Goals and EDD defined within 72 hours, in conjunction with patient and carers.

5.2 Screening & Prevention

- All acute and sub-acute adult patients admitted to WWBH will have the "Adult Risk Screen" completed within 24 hours of admission. Actions arising will link with further assessments required for the manaAged Careent of each individual.
- Aged Care patients will have comprehensive assessments completed by the multidisciplinary team
- Links with Community Aged Care Service, GPs and Specialists will be established to prevent readmission and decline of the older patient.

5.3 Diagnosis, Treatment/Intervention and Inpatient Care

- All patients accepted within the Aged Care Unit will have appropriate assessment by the Multidisciplinary team.
- Staff will complete and record baseline and ongoing observations on the SAGO chart and activate Clinical Reviews or Rapid Responses as per WWBH protocol.
- Ongoing interventions, therapy and management will be determined by the Multidisciplinary team on an individual patient basis.
- All clinical handovers must occur using the ISBAR Framework for communication. The handover must occur at the patients' bedside to ensure the patient and carers are informed of the patient's plan of care.

5.4 Discharge/ Disposition

- Discharge planning will begin on admission to the ward to optimise the planning process. Each discharge will be planned and all necessary interventions will be in place prior to discharge.
- Patients needing access to further re-ablement will be identified and flagged for admission to the Transitional Aged Care Program to ensure ACAT assessment and co-ordination is planned prior to discharge.
- Patients being discharged from the Aged Care Unit will require clearance from all relevant members of the Multidisciplinary Team.
- Links with General Practice (GP) are supported through timely and clinically relevant discharge summaries.
- If a suitable patient is for discharge, but is waiting for transport or paperwork, then the patient may be transferred to the Transit Unit on the morning of discharge.
- The Aged Care Unit will promote discharges/transfers to occur before 1000 am each day.
- Planned readmissions within 28 days will be flagged to avoid inclusion in unplanned 28 day readmission statistics.

Workforce (16 bed capacity)

(i) Medical

- Geriatrician Staff Specialist x 2FTE
- Geriatric Advanced Trainee
- JMO

- The Geriatrician will be the Admitting Medical Officer for all Aged Care patients and will have responsibility for the overall clinical / medical decision making for the patient's care.
- Medical staff are responsible for a detailed Medical assessment and mangement plan undertaken on admission. Plans will be reviewed whilst the patient is in the Aged Care Unit.
- It is expected an Estimated Date of Discharge will be identified within 48-72 hours of admission and coordination of discharge decision making processes will occur.
- It is expected that the Geriatric Medicine Team will review existing aged care patients and assess new admissions prior to 1030hrs on weekdays.
- It is expected that the Geriatric Medicine Advanced trainee will be present in the Aged Care Unit on a daily basis (4 days/week to accommodate 1 day/week in the community) to ensure all aspects of medical care has been followed through and care is planned for the following day.
- It is expected that the Geriatric Medicine Advanced trainee is available (4 days/week to accommodate 1 day/week in the community) to assist and support staff with issues related to the care and management of Aged Care Unit patients.
- It is expected that the Geriatrician and Advanced trainee will attend and participate in Multidisciplinary team meetings and Twice weekly case conferencing.
- Liaise with (all team members) Nursing and Allied Health clinicians.
- Involve the patient, family and carers in the development and implementation of managment plans
- Liaise with and refer to relevant external agencies as required
- After hours and at weekends the Medical Registrar on call will review patients as required and liaise with the on-call consultant of the day as required

(iii) Allied Health

The Acute Aged Care Unit will be supported by an Allied Health multi-disciplinary team including physiotherapy, occupational therapy, speech pathology, dietetics and social work staff with skills and experience in Aged Care. Allied health therapies are provided in the inpatient unit five days per week. The allied health team is operationally responsible to each acute discipline manager and considered a part of the Inpatient Aged Care team at WWBH.

(iv) Nursing

Nursing Unit Manager

- The Nursing Unit Manager (NUM) is responsible and accountable for the operational function, financial management, strategic planning, quality and safety of the unit. The NUM is the leader of the nursing workforce, ensuring that the practice of the staff is safe and efficient, while maintaining the standards of cares. They lead, direct and coordinate the patient care along with the Rehabilitation consultants and the multidisciplinary team via case conferences and multidisciplinary team meetings.

Clinical Nurse Educator

- The Clinical Nurse Educator (CNE) contributes to the promotion of the education, professional development and accreditation of nursing staff at all levels. The CNE fosters a learning environment that is centred on evidenced based practices and supports a culture of learning and skills development with the endeavour to provide high standards of patient care.

Nurses

The nursing team of the unit is comprised of a mix of Registered Nurses (RN) and Enrolled Nurses (EN) and Assistants in Nursing (AIN) whose role is the provision of patient centred care, evidence based practice. Nursing staff are responsible for the following:

- Complete comprehensive physical, functional and social assessments.
- The provision of patient centred care to the patient with the involvement of carers and family.
- To communicate and assist in planning for the patient's estimated date of discharge to the patient, family and carer.
- Attend case conferences and set patient centered goals.
- Utilise investigative and treatment protocols to ensure baseline diagnostics are completed when required.
- Facilitate standard investigations such a pathology, ECGs and radiological investigations.
- Provide close clinical observations-the frequency of observations will vary depending on the clinical status of the patient.
- Refer to relevant allied health professionals.
- Identify discharge needs and communicate these to relevant personnel.
- Assist the patient's with their ADLs whilst encouraging and facilitating a return to pre-morbid function.
- Education of patients and carers
- Maintenance of patient confidentiality and privacy

Staffing of the Aged Care Unit is based 1:4 (morning)– 1:5 (evening) – 1:7 (night) across seven days, as well as a nurse in-charge that does not have an allocated patient workload on evening and night shift.

NOTE : As with all patients, a risk assessment may determine that a patient's challenging behaviour may periodically require a 1: 1 increased patient supervision to ensure patient and staff safety and to optimise patient management.

5.5 Non-Clinical Support Services

- Security
- Hotel Services
- Wardsperson Services
- Aboriginal Health Liaison staff

5.6 Information Technology

Clinical information systems to support patient care are ehealth, Pexip for telehealth use, electronic medical record, internet access, shared drive access, ipm, patient flow portal, paging system, email and MLHD intranet site.

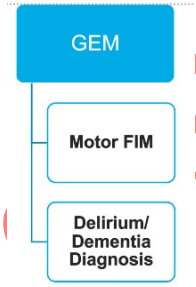
Interpreter services will be accessed when necessary via a telephone service

5.7 SNAP data collection (sub-acute care type)

Subacute and Non-Acute Patient (SNAP) data is primarily used by NSW Health for supporting and monitoring the delivery of safe and quality admitted patient services under the SNAP care types. It also enables review of service utilisation, identification of health service trends, appropriate allocation of resources, and monitoring of the performance of service delivery units against both local and national benchmarks. The data is also utilised in epidemiological studies and public health reporting at a state and national level and is a mandatory reporting requirement to the Commonwealth.

SNAP data is required to be captured for each SNAP episode of care for all patients who are formally admitted in NSW public hospitals, multi-purpose services, community health services and publically funded facilities. This includes same day and overnight patients.

Synaptix PROD (Production) is a state wide system developed by Ministry of Health and used by Local Health Districts to collect mandatory NSW Sub-Acute and Non-Acute Patient (SNAP) assessment, classification and palliative care phase information not currently collected in local source systems. The information collected is used by Ministry of Health in determining targets and counting National Weighted Activity Units (NWAU) for LHD funding



Governance Framework

5.8 Quality & Safety Systems

The WWBH has a dedicated Clinical Governance Manager, Work Health Safety and Manual Handling Coordinator and Infection Control Clinical Nurse Consultant to assist with quality and safety. Regular meetings and monitoring occurs at WWBH including

- IMS+;
- REACH (Recognise, Engage, Act, Call, Help is on its way);
- Mortality & Morbidity Meetings;
- Compliments & Complaints;
- Patient Surveys;
- Safe Work Practices;
- Chem Alert;
- Local Procedures, MLHD & State Policies;
- Audits;
- Work Health and Safety;
- Workplace Inspection;
- Ergonomic desk checklist;
- Risk assessments; and
- Infection Control standard precautions, policies and guidelines.

5.9 Performance Indicators

WWBH is committed to regular monitoring, review and evaluation of its procedures and guidelines. The necessary steps to ensure this happens will be initiated by senior clinicians and will occur in collaboration with staff members and educators.

Close monitoring of utilisation and performance indicators will be essential to ensure that the GEM unit is utilised optimally. The following data will be collected and used to monitor performance of the GEM:

- Monthly number of admissions discharges and transfers.
- Average length of stay (LOS).
- Discharge destination.
- Readmission rates.
- Adverse incidents – (IIMS).
- Morbidity and mortality rates.
- Patient/Family/Carer feedback.

6.0 Research & Education

All WWBH staff must complete mandatory training on My Health Learning.

Aged Care and Rehabilitation Services participate in weekly journal review sessions.

Aged Care Services actively participate in formal clinical research and quality improvement projects.

WWBH also have identified education packages that must be completed including basic life support and medication competency for indicated staff.

7.0 References and Related Policies

Lismore Base Hospital Geriatric Evaluation and Management (GEM) Unit – Business Rules. March 2011.

Draft Criteria for Referral to Geriatric Medicine at Liverpool Hospital (n.d) author/source unknown.

Geriatric Medicine Admission Guidelines (Liverpool Hospital) (n.d) author/source unknown.

Aged Care Network: Geriatric Evaluation & Management (GEM) Model of Care. For the older person in WA. Department of Health (2008).

Creditor, M.C. Hazards of Hospitalization of the Elderly, Annuals of Internal Medicine 1993; 118:219-223.

Palmer, R.M., Counsell, S. and Landefeld, C.S. Clinical Intervention Trials The Ace Unit, Clinics in Geriatric Medicine 1998; 14:831-849.

Williams, A. Patients with co-morbidities: perceptions of acute care services, Journal of Advanced Nursing, 2004; 46:13-22.

Acute Care of the Elderly (ACE) Model of Care. NSW Department of Health, June 2006

National Aged Care Alliance, Assessment and the aged care service system, January 2014.

Goulburn Valley Health Clinical Practice Guidelines manual, Version: 2

Murrumbidgee Local Health District, Strategic Plan 2018-2021.

Infection Control Policy & Prevention & Management of Multi-Resistent Organisms (MRO) PD 2007_084.

Appendices

Appendix 1: "Patient admissions cannot be deferred simply because same gender rooms or ward bays cannot be immediately provided. In such cases, every reasonable effort must be made to rectify the situation as soon as possible and staff must take extra care to ensure the patient's privacy and dignity is maintained, particularly in sleeping areas and bathroom facilities. Patients and carers must be informed if this does occur; they must also be told what is being done to address the situation and must be informed when a same gender room or ward bay will be provided. Staff must make it clear to patients and carers that NSW Health considers mixed gender rooms and ward bays to be the exception never the norm. When mixed gender rooms and ward bays are unavoidable, transfer to a same gender rooms or ward bay should be effected as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours" (NSW Health Policy Directive; Same Gender Accommodation PD2010-005, 2010, pg. 3).