

Proposal to Develop an Older Adult and Rehabilitation Service within CCDHB

Consultation paper– September 2009

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1. Introduction

The purpose of this paper is to seek feedback into the principles, issues, impacts and the plan for the establishment of an Older Adult and Rehabilitation Service (OARS) within CCDHB.

The first phase of this project is to consult on the high level concept for an OARS service model for CCDHB , integrating Capital Coast Rehab and ward 5 medical services, implementing an in reach geriatrician consultation service into acute medicine , and possibly incorporating the stroke service . The proposed outcome of this phase will be a geriatric/Assessment treatment and rehabilitation service (AT&R) model across sites.

Following this consultation it is expected that a further narrower consultation will be required to seek input to a proposed structure.

2. Context

Assisting older people to remain active and engaged in their community is a key focus in the District Annual Plan. To achieve this older people require care and support that is integrated and coordinated between various health care providers in hospital and the community and social agencies.

Currently geriatric medicine is practiced in a number of different inpatient, outpatient and community settings reflecting the comprehensive nature of the speciality. Older patients, by far, represent the largest number of patients admitted to hospital with 'acute' medical illness, much of which is actually an acute deterioration in the setting of long-term illness. For these reasons, the acute illness deserves particular consideration.

The essence of geriatric medicine as a specialty is to assess and treat the medical and rehabilitative needs of older people. The medical need comprises the whole range of acute, acute-on-chronic and chronic illness. This is done through a process known as comprehensive geriatric assessment. There is a body of evidence which shows that the outcomes for older people with multiple pathologies and functional problems are better if they have their treatment overseen by a multidisciplinary team led by a consultant specialist in geriatric medicine.

The key internal and external factors leading to the need to improve how we deliver our care to the older population are:

- Demographic changes driving increasing demand;
- Rise in complexity of the needs of older patients;
- Recent changes to our internal processes – particularly establishment of a Medical Assessment and Planning Unit (MAPU);
- Alignment to contemporary care models for older people;
- Effective use of staff along the care continuum;

- The desire to improve the focus of geriatric care within CCDHB;
- The need for integration and enhancement of multi-disciplinary practices in care settings within and outside of the hospitals;
- Equitable access for people within our catchment;
- Workforce pressures – creating interesting and stimulating career opportunities within this area of practice to train, retain and develop all the disciplines involved.

The concept of OARS has been discussed informally within Assessment Treatment and Rehabilitation (AT&R) and medical services over the last few months.

Included in these discussions has been the commitment to a business case to seek additional beds in Wellington. Initially, it is proposed to develop an in-patient (OARS) service in Kenepuru Community Hospital and to give a clear commitment to develop the service across sites. This proposal will detail an ongoing phased development over the next two years. This time is necessary to up skill staff, refine process, build linkages to related processes and recruit Geriatricians.

A working group, with nursing, medical and allied health representation is in the process of being established to oversee the development and implementation of this concept.

3. **Purpose**

The purpose of an Older Adult Rehabilitation Service is to provide integrated care that will improve health outcomes for older people with complex medical, cognitive, functional and social needs.

4. **Draft Principles**

- Initially access to the service will be by referral from inpatient wards in Wellington Regional Hospital or the community and accepted by a geriatrician or liaison nurse from the OARS. Access criteria will be developed as part of the implementation;
- Comprehensive assessment will be developed within the OARS service. This will result in a comprehensive MDT management plan covering the four cornerstones of older person's medicine: medical health, physical health, psychological health and social functioning;
- Comprehensive and inclusive MDT practices and care planning including nurse/AH led clinics and liaison/key working roles;
- Appropriate staffing in terms of skill mix, discipline and support staff to promote an effective and efficient service, career development and training programmes. A clear indication of clinical care ratios so that professional development time is indicated;

- Development of competencies required around process, clinical management, MDT and key working.

The existing context, proposed purpose and draft principles raise a number of issues and impacts.

5. Impacts and Issues

One of the issues is what the service is called – in the paper we have referred to the service as OARS.

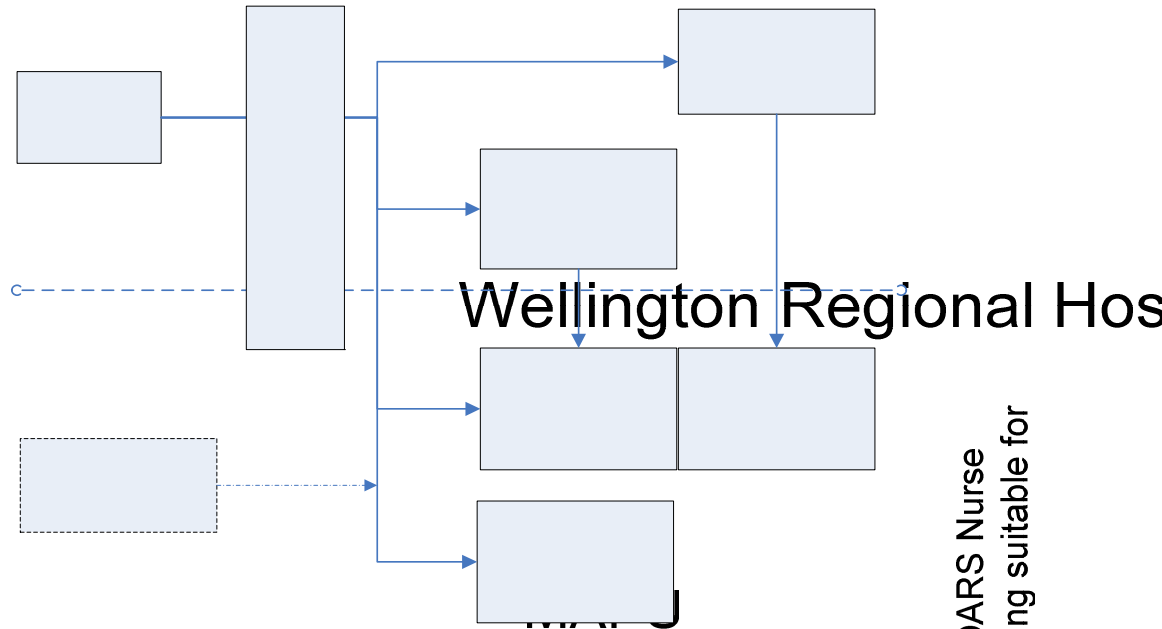
Q.1: What name would best describe this service and be meaningful for all of our stakeholders?

5.1. Inpatient OARS unit

It is proposed that to start with the OARS unit will consist of 60 beds at Kenepuru Hospital including the 40 in-patient rehabilitation beds on wards 6 and 7, and 20 in-patient beds for elderly medically ill patients on ward 5. In addition it is proposed to include the 6 Stroke Unit beds in Wellington Regional Hospital. To support development of the service a business case will be prepared to open or re-align an appropriate number of acute OARS beds within a designated ward in Wellington Regional Hospital.

The work undertaken within the medical redesign has influenced the approach to inpatient admissions and assessment. The majority of older persons admitted to the in-patient beds within the OARS service will transfer from the MAPU either after assessment by or discussion with consultant geriatricians. This is summarised below.

5.1.1. Figure 1 Major patient flows for the OARS



Older persons with acute medical illness will be admitted to the MAPU under the care of the on-call physician. It is proposed that Geriatricians will 'in-reach' to the MAPU during weekdays to identify those people suitable for transfer to the OARS in-patient beds and/or to provide specialist advice once the service is fully developed. Initially, it may be appropriate for the on-call physician to discuss referrals with the geriatricians based at Kenepuru Hospital, during the development phases.

Older persons could be admitted from the community directly to Ward 5 (Kenepuru Hospital) after discussion with a specialist geriatrician.

The current flows of patients in need of rehabilitation will remain unaltered. It is hoped that those with rehabilitation potential will be identified earlier by specialist geriatrician assessment in the MAPU.

Allied health staff in the therapies service will actively participate in the multi-disciplinary team (MDT) handover / ward round in both the MAPU and acute OARS beds. Community services will also need to become more integrated and participate in MDT conversations regarding ongoing care and triggers for readmitting people as in patients.

Adults identified by the OARS Nurse Liaison assessments as being suitable for rehabilitation

**Kenepuru
Campus**

**Community
Admissions**

- Q.2: Should the stroke service be integrated into this new OARS service and when should this occur?
- Q.3: Is the proposed model of acute geriatric beds in WRH accepted and are they a substitution for existing medical and surgical beds or are they additional beds?

Q.4: Is the concept of a consultant geriatrician providing in-reach / consult liaison services to surgical, orthopaedic and Psychogeriatric services acceptable?

5.2. Community Service for the OARS

The HHS community services support for the OARS service will focus on patients within or returning to the community. There will be key links and communication channels with the HHS, primary health and other community agencies in order to communicate and support self management and follow up.

Each patient will undergo a comprehensive MDT assessment (or updating of previous assessments undertaken in a ward) in order to co-ordinate an appropriate care plan across the disciplines to meet patient needs.

Q.5: Do you think the community allied health team should remain part of the therapies team or should they be part of the Capital Coast Rehab community team? Which model would best support the MDT approach required to support a coordinated OARS?

There are a range of possible approaches to integrating and aligning the various teams and a phased approach is preferred to enable ongoing safe delivery of services and a pace of change aligned to development of skills and infrastructure.

Initially, Community nursing and allied health services, provided as part of Capital Coast Rehab, CHS and Therapies will join the working group to develop a more detailed multidisciplinary service model across the inpatient and community setting.

A new nurse specialist / nurse practitioner candidate position has been funded to support the practice development and education of health providers in aged residential care to promote optimal outcomes for residents. This will complement and support existing ATR and CHS services.

In the future, funding and service options need to be explored to develop a multi-disciplinary rapid/early response team, with specialist geriatrician input to support community-based health-care. This team would provide support to those frail elderly people that need quick community assessment who would otherwise need to be admitted to hospital or in-reach into the hospital and facilitate the effective discharge of elderly people from hospital.

Q.6: Do you support the concept of a rapid / early response team and which service (Capital Coast Rehab or CHS/Therapies)?

5.3. Out-patient Service for the OARS

The outpatient OARS needs to compliment the other areas within the service to provide timely assessment across the MDT, manage the follow up of discharged patients where appropriate and utilise the specialist skills of the MDT through nursing and allied health led clinics. The cultural and demographic diversity of the community means that location of clinics needs to be considered and a close link is required with Primary Care to enable equitable and timely access.

The current provision of medical out-patient services will continue unaltered while investigating options for nurse/allied health led clinics. With the appointment of geriatricians to the OARS, specialist interest clinics can be developed, subject to funding and availability of a suitably skilled workforce.

5.4. Staffing

It is proposed that the OARS service will be staffed by a multidisciplinary team composed of geriatricians (SMOs and RMOs), rehabilitation specialist(s), senior nurses, RNs, social workers, occupational therapists physiotherapists, dieticians, speech and language therapists, pharmacists and psychologists. The ideal staffing model will require a detailed transition plan to develop the training frameworks and new ways of working.

5.4.1. Clinical leadership

The integrated OARS would be led by a single Clinical Leader.

5.4.2. Medical staffing model

When fully operational, OARS will be staffed by geriatricians and rehabilitation medicine specialists. A phased implementation is planned to transition from a general medical service to a service requiring geriatric specialists.

Discussions have commenced with Capital Coast Rehab senior medical staff to identify how SMO rosters will cover Wards 5, 6 and 7 during and following the change to a new model. This work was initiated as part of the proposal to implement a MAPU and it will continue, with the involvement of all relevant unions.

The impact on how RMOs (House Officers and Registrars) work within the service needs to be worked through as part of the year one implementation. Input is sought now on how best to do this. It is expected that an RMO with an interest in Geriatric Medicine would be a member of the working group and as part of the phase one work support the service to develop to become a sought after specialty training opportunity. This would involve identifying the changes to work practices and processes as well as the training infrastructure required.

5.4.3. Nursing and Allied Health staffing model

The following bullet points outline the key development needs identified for the nursing and allied health model:

- processes to integrate the care plans of all disciplines e.g. nursing, medical and allied health;
- comprehensive assessment tools and processes including the required training;
- Utilisation of key working models already undertaken in Capital Coast Rehab(where appropriate);
- support workers who will be an important resource requiring training, support and development;
- appropriate skill mix, experience and leadership abilities within our teams e.g. expert staff, education staff, novice staff;
- appropriate competencies within the relevant scopes of practice and career pathways;
- education and training packages for staff;
- appropriate clinical care ratios.

5.4.4. Management Model

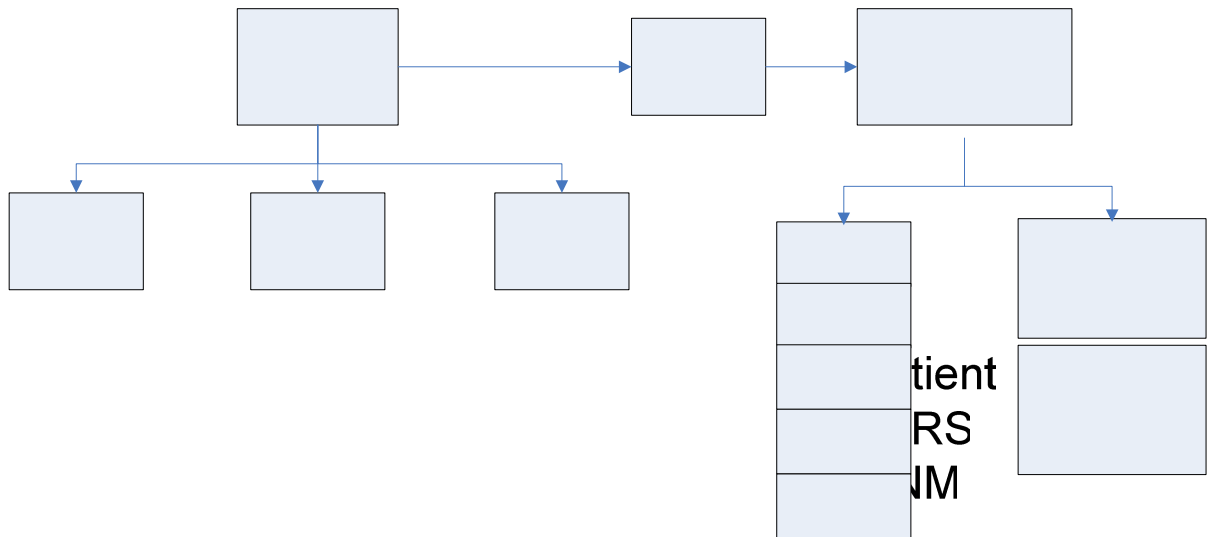
The following are some early thoughts on what the management structure may look like. More input is needed before moving to the next phase of implementation and your thoughts on an appropriate structure and team configuration would be appreciated.

Features of the picture below are:

1. Allied health staff in inpatient Capital Coast Rehab would be part of the therapies discipline specific teams and the nursing staff would report to the CNMs.
2. A modified CNM role is created and ACNM roles are implemented for wards 5, 6 and 7.
3. The stroke service is included in the inpatient OARS service.
4. Responsibility for the facility management of the proposed acute beds in Wellington sit with the WRH ward teams. Responsibility for clinical management would sit with the MDT led by the geriatrician.

Q.7: How should Community Health be integrated into this model/service?

5.4.5. Figure 2 – Thoughts on Structure



6. Proposed Quality measures

- Improvements in ADL scores from admission to discharge;
- Improvements in IADL scores from admission to discharge;
- Prevalence of falls or any injuries while under care of service;
- Changes in residence from admission to discharge, i.e. from home to rest home, rest home to home;
- Consumer satisfaction with service;
- Referral response times;
- Development and review of pathways of care with reference to best practice;
- Progress against service quality plans as per NZS 8134:2001 standards.

7. Key linkages with other projects

- MAPU development – assessment and admission.
- Medical model – model of care, training, development, common processes.
- Therapies consultation MAPU – alignment.
- CHS project – integration.

8. Next Steps

This is the first part of a two-stage consultation process. We are seeking your input in this first stage on the impacts raised in this paper, the timeline and the process going forward.

The likely impact on structure and staffing will be proposed in the next step of consultation. Until this process is complete and the final detailed OARS design and staffing requirements are determined the impact on any individual staff member cannot be known. Over the coming weeks people will have the opportunity to meet as a group or individually with members of the project team and we also invite you to signal your interest if you want to be part of the Working Group that provides governance over the implementation and development of OARS.

Stage 1 – Consultation on concept and structure
Consultation on the concept of the OARS and how it will work and how it might be structured.
Feedback received from interested and potentially impacted staff and unions.
Feedback considered and used to finalise the model and propose a structure.
Feedback to staff on decisions

Stage 2 – Consultation on the impact on people
Consultation with individuals about the impact on them personally.
Feedback received from impacted staff and unions.
Feedback considered and used to finalise the structure and implementation plan.

9. Feedback on this proposal

Your feedback to this paper can either be provided by attending one of the workshops, a one on one interview or by emailing Maree.Jowett@ccdhb.org.nz. We are interested in your feedback and will be happy to also meet with groups of people by request. Please contact Maree Jowett to make an appointment before October 23.

10. Time Line

10.1. Stage one:

- Concept paper distributed and on the intranet September 23

- Capture feedback via face to face meetings, workshops, written submissions\email\meetings between 23 September and 23 October
- Draft decision document 27 – 30 October

10.2. Stage two:

- Draft formal consultation paper 2 – 6 November
- Consultation period 9 November – 20 November
- Draft decision document released 27 November
- Commence implementation (detailed design work, training, recruitment, establish new roles) 4 December