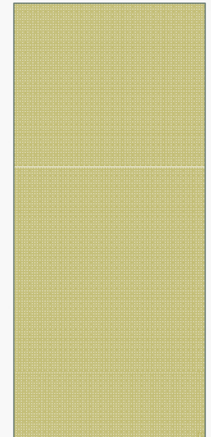
STRATEGIES TO IMPROVE SENIOR'S CARE

DR. ROGER BUTLER



GERIATRIC TRIAGE

- Time to care is increased disability
- Time to care is increased LOS in acute care
- Acute geriatric assessment units decrease acute geriatric mortality by 20%
- Geriatric focus in care is the essential

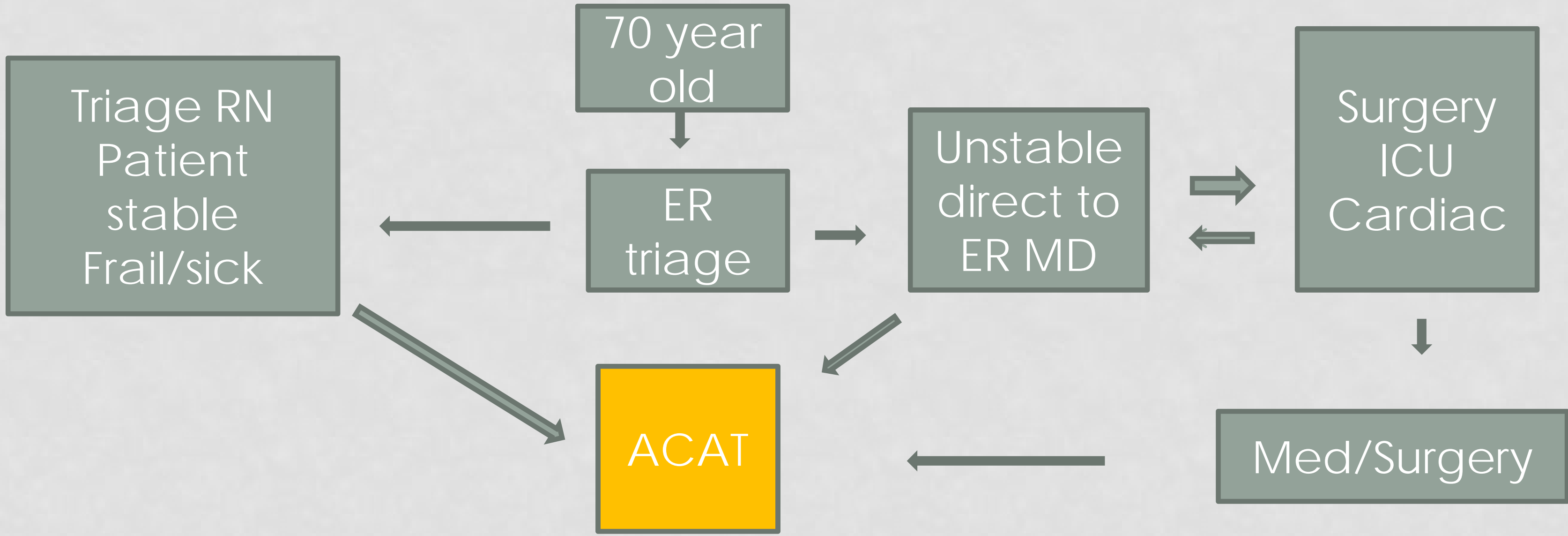
The very old and very young have fragile reserve capacity so time to treatment is essential.

70 YEAR OLD PRESENTS TO THE ER

- Direct from GP office
- Home care RN
- Nursing Home transfer
- Community emergency
- Ambulance or Regional transfer

ACAT
AGED CARE ADMISSION TOOL

- Rapid cognitive screen
- ADL's and iADL's
- Pressure sore risk assessment
- Fall risk assessment
- Home and support assessment
- 20-30 min to complete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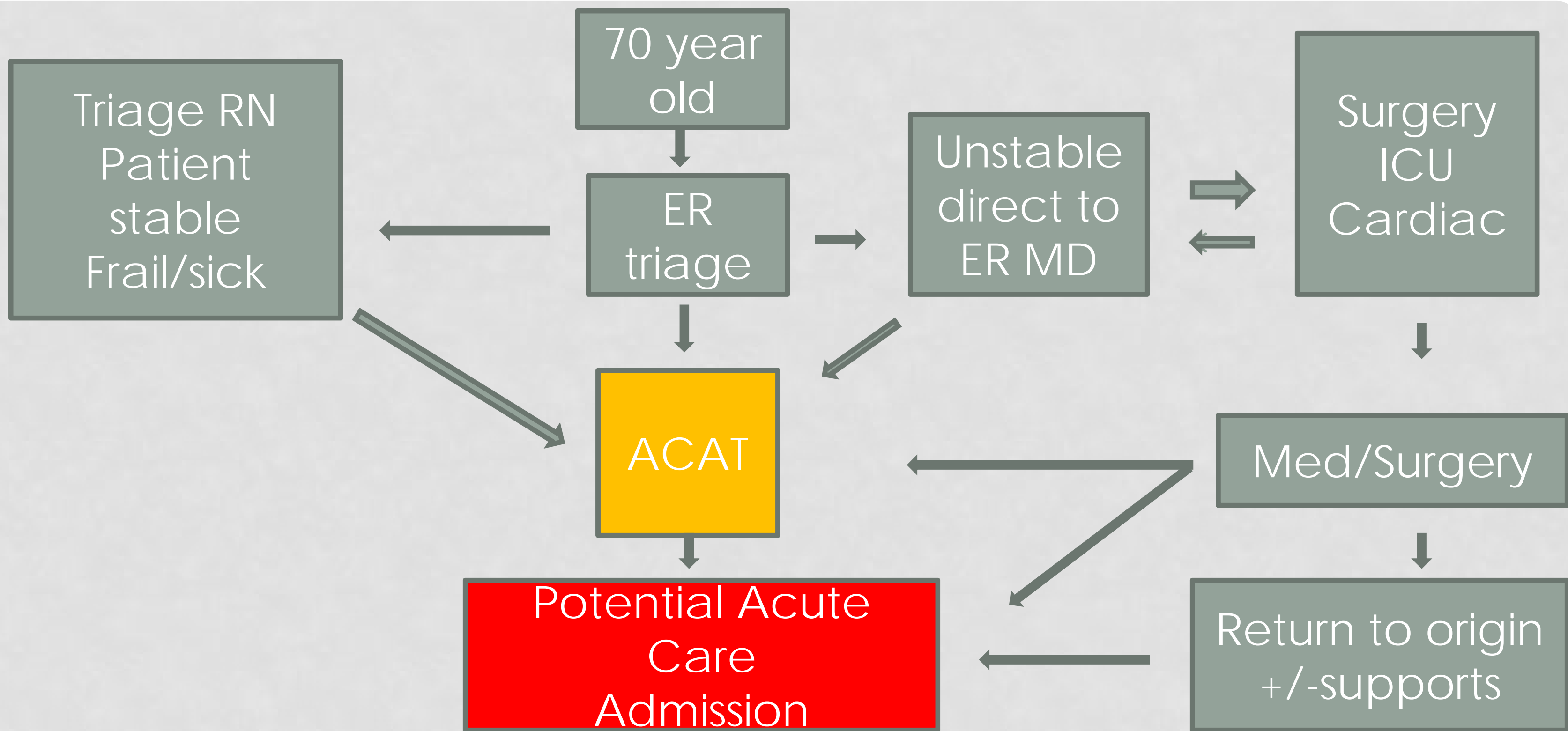
Triage RN Patient stable Frail/sick
ER triage
Unstable direct to ER MD
Surgery ICU Cardiac
ACAT
Med/Surgery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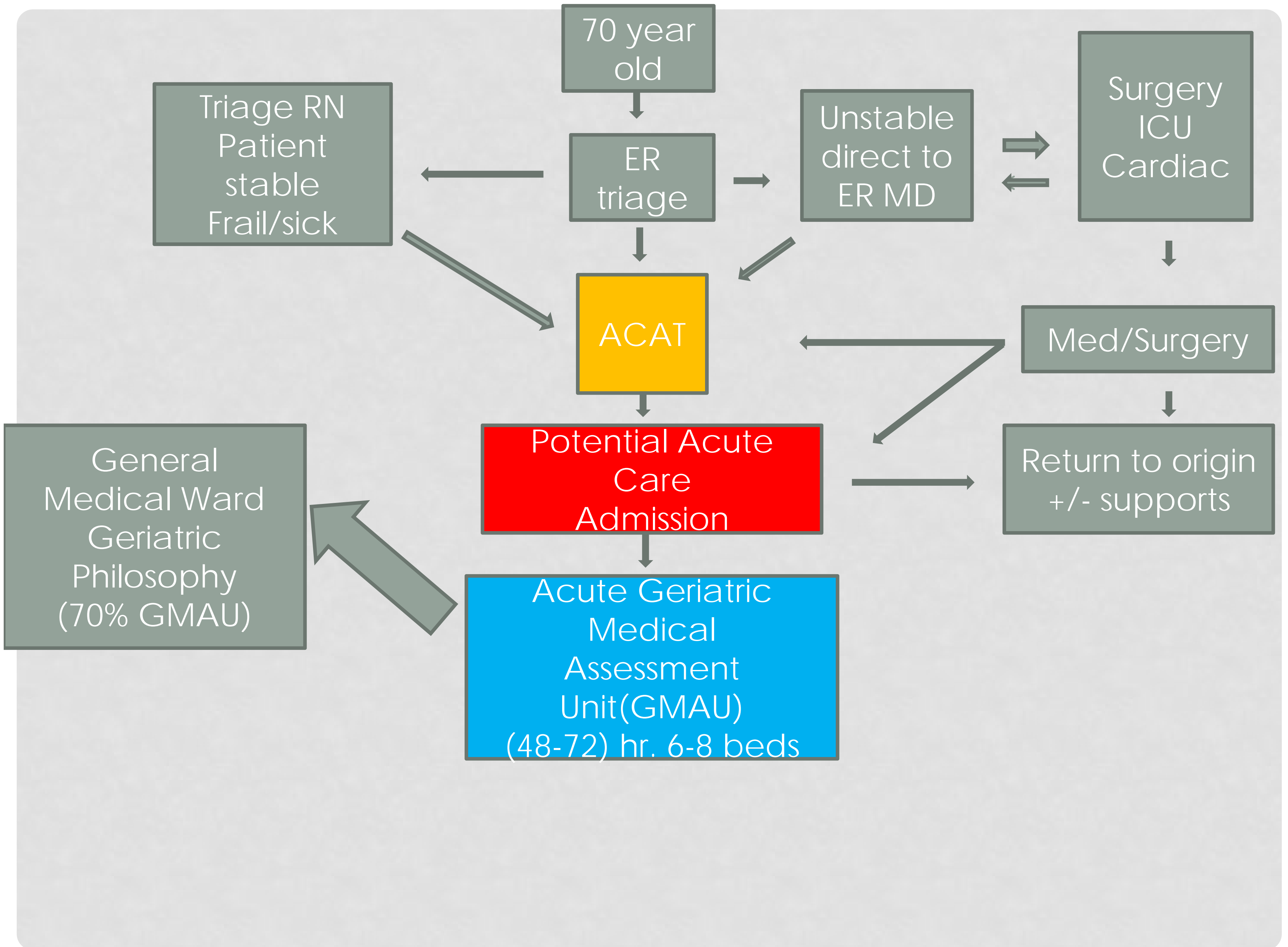
Potential Acute Care Admission
Return to origin +/-supports

ADMISSIONS

- 50-70% of seniors seen in 2 Sydney Aust ER's with 24,000 >70 yr old visits per year are admitted
- Each hospital has 65,000 ER visits per yr.
- The 70 and older cohort have the highest probability of admission to hospital by their mere virtue of coming to the ER.
- 49% admitted at HSC



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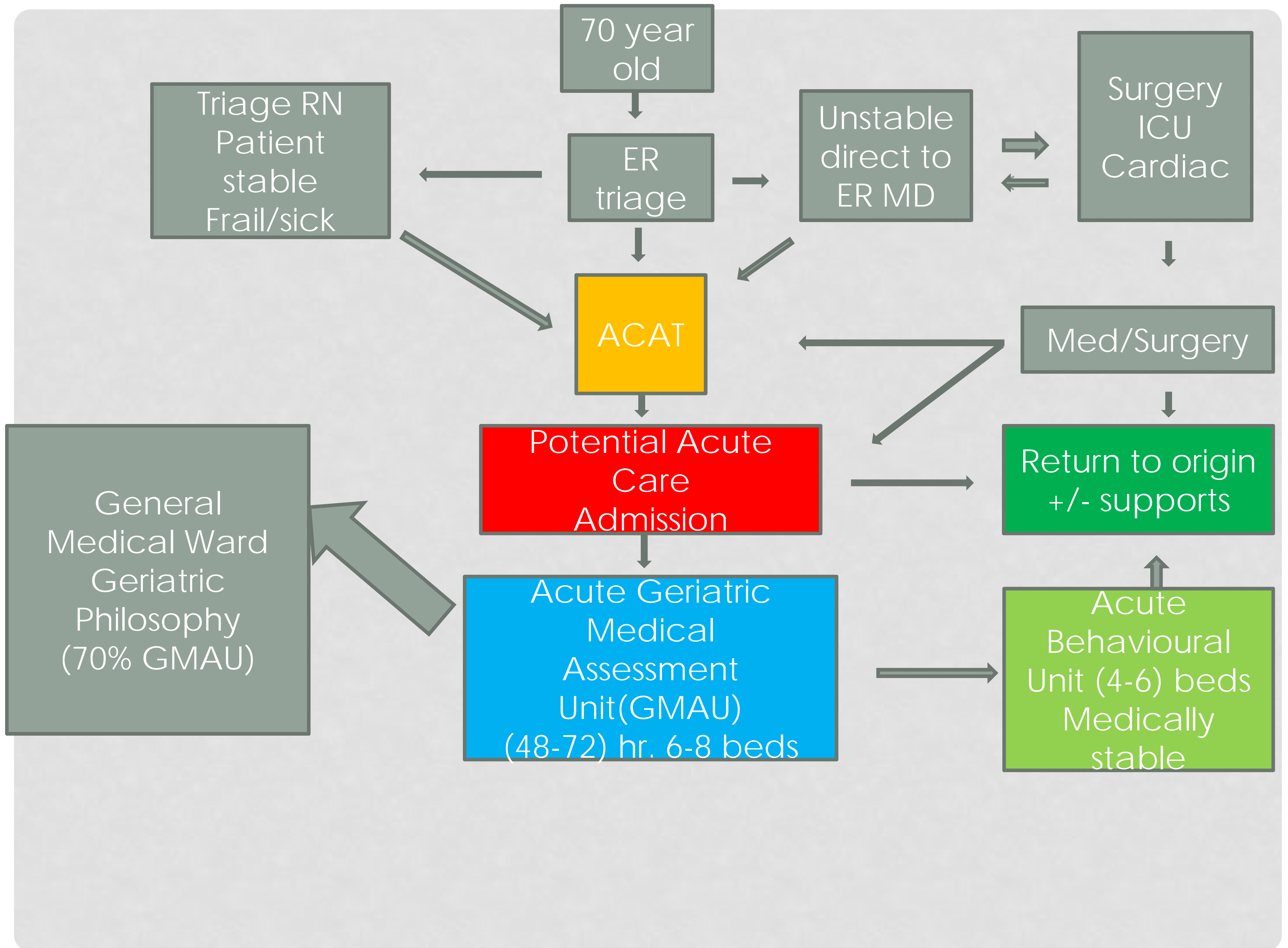
General
Medical Ward
Geriatric
Philosophy
(70% GMAU)
Potential Acute Care Admission
Return to origin
+/- supports
Acute Geriatric
Medical
Assessment
Unit(GMAU)
(48-72) hr. 6-8 beds

GERIATRIC ASSESSMENT UNIT

- 8 beds
- Higher staff ratio's
- Priority access to investigations
- Priority consult access
- All unstable frail /sick ie sepsis/delirium common diagnoses here
- Beds already on medicine but not prioritized



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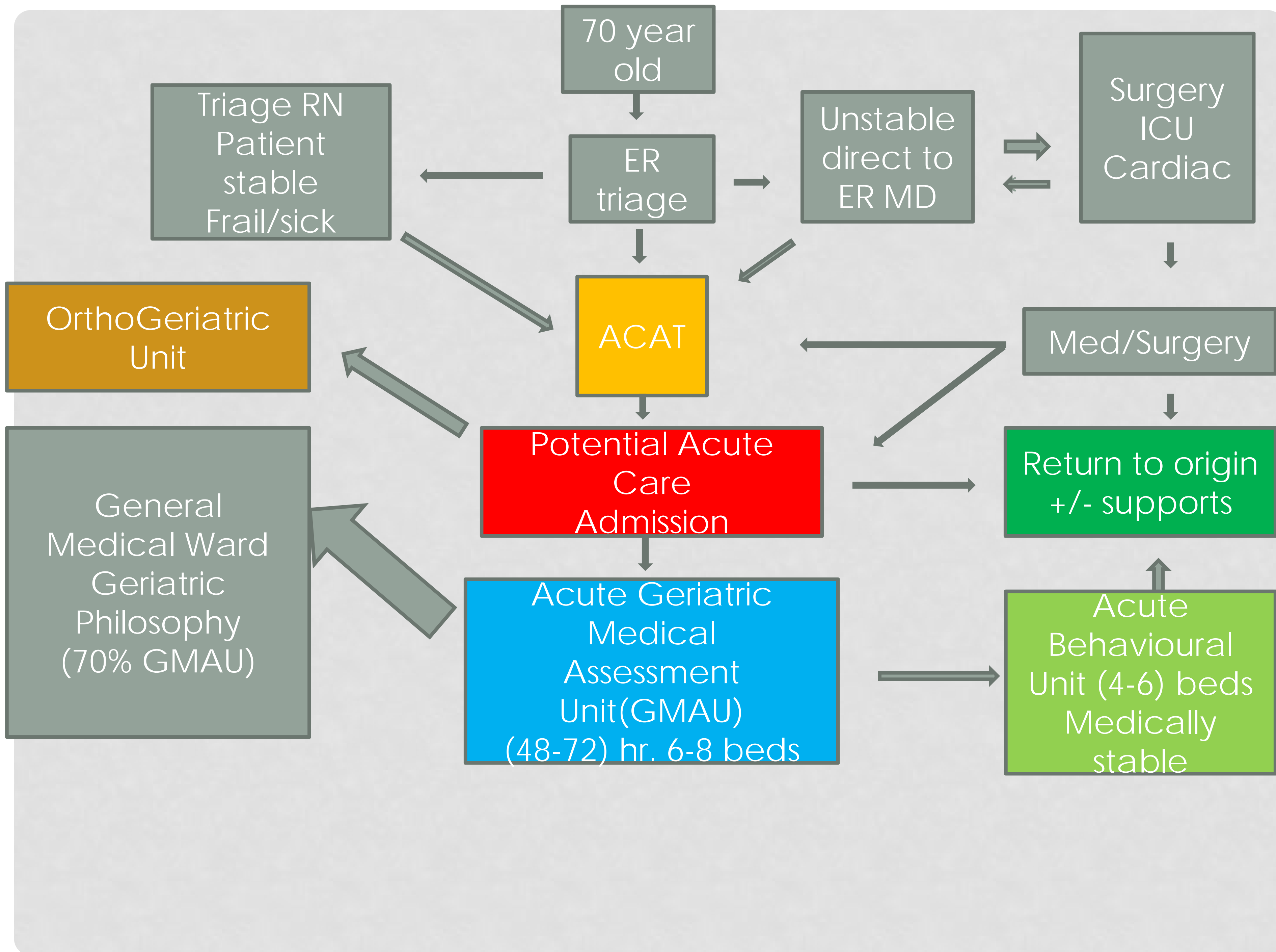
General Medical Ward Geriatric Philosophy (70% GMAU)
Acute Geriatric Medical Assessment Unit(GMAU) (48-72) hr. 6-8 beds
Acute Behavioural Unit (4-6) beds Medically stable

ACUTE BEHAVIOURAL UNIT

- 4-6 bed locked wandering unit
- Medically stable
- Usually off all psychotropics in 72 hours
- Geriatric psychiatrist runs unit
- Already in the system but at HMND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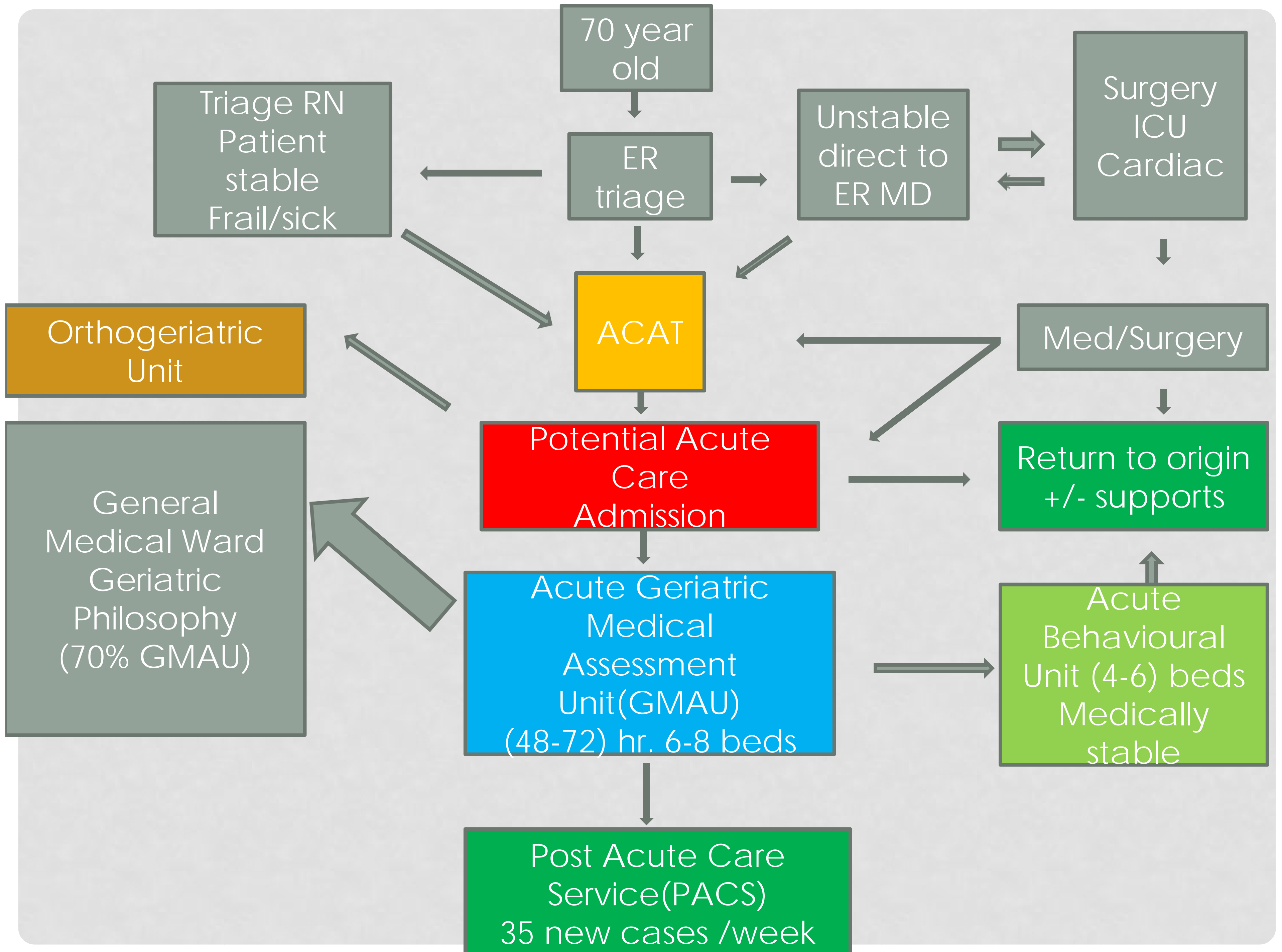
ORTHOGERIATRIC WARD

- Geriatric assessment initially preop
- Operative and 48 hour post op ortho care
- Post 48 hour shared care model predominantly geriatric
- Team rounds weekly
- Often direct discharge home with supports
- Early rehab focus.
- Could be direct transfer to PACS(post acute care service) or Rehab
- Could be co-managed with physiatrist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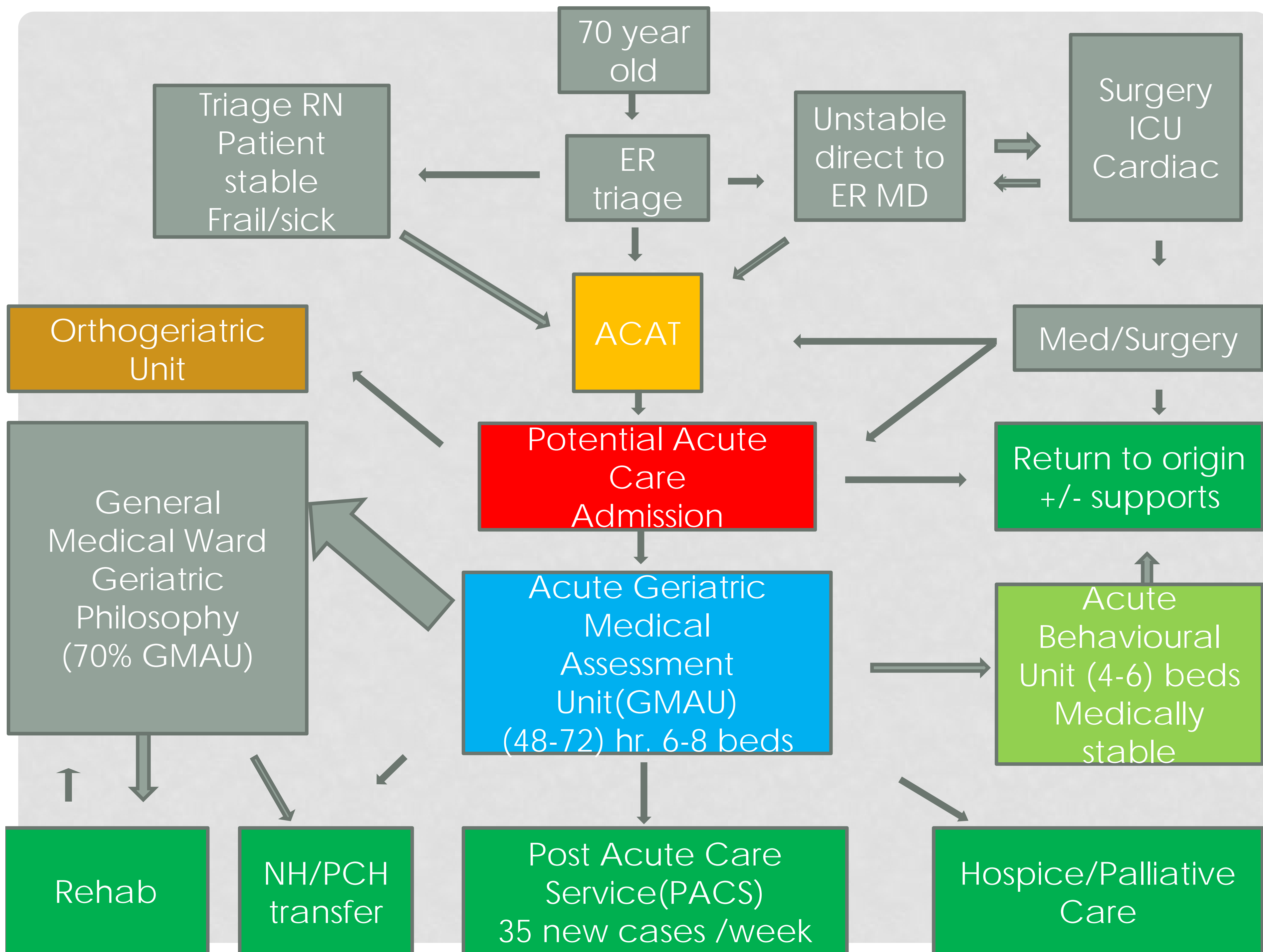
Post Acute Care Service(PACS) 35 new cases /week

PACS
POST ACUTE CARE SERVICE

- Direct home support up to 6 weeks post discharge
- 14 RN's ,2 OT's,1SW,2 Physio and,1 MD
- 35 patients on case load per week
- Acute infections,COPD,CHF,DVT-thromboemboli,TIA,Ischaemic CVA,AF and Falls with mobility issues.
- Family doctors need efficient handover/support/liasion with the program
- Fully funded from acute care savings in LOS.
- 10% referrals direct from ER and avoid admission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Rehab
NH/PCH transfer
Post Acute Care Service(PACS) 35 new cases /week
Hospice/Palliative Care

REFLECTIONS DOWN UNDER

- No patients seen on a stretcher in either ER over a 3 week period
- Private hosp add no benefit to the ER
- Private care erodes MD availability in the public sector
- Private care enhances elective “easy” procedures
- Philosophical change to elder care is paramount to beneficial change in the acute care of seniors
- I believe we can reorganize current acute services and greatly improve our care of seniors with little if any cost increase to the system