

Tasmanian Health Organisation – South

COMPLEX CHRONIC AND COMMUNITY SERVICE – ROYAL HOBART HOSPITAL



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# **Aged Care Services in Tasmania**

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# Overview

Tasmania is Australia's oldest state. According to 2011 ABS data, 16.3% of Tasmanians were aged 65 or older representing an increase of 1.3% since the 2006 census. Compared to other states and territories, Tasmania has lower than average healthcare outcomes in terms of life expectancy from birth and premature death rate.

Tasmania's rate of chronic disease is high and risk factors for poor health outcomes are significant, smoking, alcohol consumption, and obesity. Added to this are the difficulties related to ensuring adequate access of specialist medical services to the widely dispersed Tasmanian population. That Tasmania is Australia's "oldest state" is significant for healthcare planning. Old age is associated with frailty, neurodegenerative diseases, organ failures, cancer, and sudden death.

## Geriatric Medicine in Tasmania

Currently DGM in Tasmania is best represented, in terms of staff specialist appointments, in Tasmanian Health Organisation, South (THO-S). There are currently five full time staff specialist geriatricians working in the public sector in THO-S. There is one geriatrician who works fulltime in the private sector and one geriatrician who works in the private sector and also the RHH part time. There are 1.8 old age psychiatrists working out of Hobart, in the public sector and one in the private sector.

THO-North has one geriatrician based at the Launceston General Hospital. THO-NW has an old age psychiatrist. There are some private geriatric medical services provided in Launceston and the NW by fly in, fly out geriatricians from interstate.

It is emphasised that the adequate provision of specialist aged care services in the private sector is crucial to avoiding unnecessary admissions to public hospitals and to the residential aged care sector.



# **Current Public Sector Specialist Age Care Services**

The Department of Geriatric Medicine (DGM) in Hobart runs three inpatient areas:

## **Older Persons Unit**

The Older Persons Unit (OPU) has 16 beds at the RHH and accepts referrals from inpatient services at RHH, the Assessment Planning Unit (APU) and the RHH emergency department (ED). Drs Janina Skelton and Blair Adamczewski are currently providing the physician leadership on that ward. Length of stay (LOS) for OPU, calculated over the last year, is just over 12 days. This is probably a realistic number considering that virtually all OPU inpatients have either delirium or dementia, or both. Many are awaiting nursing home accommodation or acceptance into rehabilitation beds. Each of these factors is significant in increasing length of stay.

A systematic study of the effectiveness of Acute Geriatric Units (AGU) was reported in the British Medical Journal in 2009. This paper concluded that “care of people aged 65 or more with acute medical disorders in acute geriatric units produces a functional benefit compared with conventional care and increases the likelihood of living at home (rather than in institutional care) after discharge”.

The success of AGUs is related to the careful and individualised assessment of the medical, psychological, and functional capabilities/deficits of each elderly person. An appropriate clinical management plan can then be implemented.

## **Peacock Unit**

The Peacock Unit (P3) provides sub-acute beds for slower stream rehabilitation at the Repat Centre. These 22 beds are currently managed by Drs Andrea Lees and Scott Chamberlen. The average length of stay has been 19 days over the last one year. By far the most common referral source for P3 admissions is the RHH. Very few are admitted directly from the community. These beds are supported by Commonwealth funding through the Transitional Care Program.

It is considered that the availability of slower stream geriatric medicine beds is suboptimal. This has placed upstream pressure on beds at the RHH. Delayed access to rehabilitation facilities has negative clinical effects, increases length of stay, and leaves frail elderly RHH inpatients exposed for longer periods in hospital to accrue the many detrimental consequences of hospitalisation.

It is considered likely that a small reduction in acute care beds at RHH and an increase in subacute/rehabilitation/palliative care beds (possibly at the Repat Centre initially, and later in a specifically designed area in the redeveloped/new RHH) would make sense. This idea could be readily tested by the Clinical Redesign research process.

Dr Andrea Lees provides consultative services to the Aged Care Assessment Team (ACAT) adding to the quality and usefulness of their reports and assisting with the recognition of medically reversible/treatable aspects of the patients situation.

## **Jasmine Unit at Roy Fagan Centre**

The Jasmine Unit at the Roy Fagan Centre (locked secure facility) in Lenah Valley has 10 beds. The Jasmine Unit is designed to cater for people with particularly difficult to manage Behavioural and Psychiatric Symptoms of Dementia (BPSD) and protracted delirium, particularly when there are ongoing co-morbid medical issues requiring physician input. There are often complex, safety, accommodation and legal issues requiring intensive case management.

Dr Alison Cleary is providing locum services at the Jasmine Unit. Dr Cleary also works in the private sector at The Hobart Clinic and provides consultative services at the RHH and to the Dementia Behaviour Management Advisory Service (DBMAS) in community care settings. It is of considerable concern that Commonwealth funding for the Jasmine Unit beds will expire at the end of April 2015.

Loss of these beds would have a catastrophic blow back effect on the RHH (clinically, safety wise, and economically). Considerable thought has been put into plans for avoiding the worst consequences of this situation. It is considered important to ensure that Dr Cleary has an adequate contract to ensure that we do not lose the invaluable work that she does in this area. It is worth emphasising that the collocation of Old Age Psychiatrists and a Geriatrician has many advantages for patient care and cross specialty professional development.

## **Aged Service Southern Area Team**

Aged Service Southern Area Team (ASSAT) is a specialist nursing team who work in consultation with the RHH Geriatricians to promote independence, enhance wellbeing and improve quality of life of older people through responsive consultation, geriatric assessment, and goal setting that is patient centred.

Their target group is older people with complex needs who would benefit from specialised consultation, advice and continuing care.

ASSAT are responsible for the facilitation and coordination of off-site transfers to Peacock 3, Jasmine Unit and to Interim Care Beds. They provide a case management outreach service to Interim Care Bed (ICB) patients and work in liaison with their medical team and ICB facility to promote timely discharges.

ASSAT work with home teams to contribute to the decision making for nursing home placement, complete all RHH and off site Aged Care Assessment Team (ACAT) assessments and facilitate transfers for patients into permanent residential care. They provide a follow-up outreach service to these residents and aged care facilities. They also review all patients admitted to the RHH from residential aged care facilities and assist in their facilitation back to the aged care facility following their acute event.

ASSAT complete all Transitional Care Program (TCP) assessments for patients who transfer to Peacock 3. ASSAT assist in the identification, management and support of patients within RHH who have delirium, dementia and complex aged care issues and provide in-services both within the RHH and to RACFs.

They are involved in the training of Delirium Change Champions within the RHH.

An Outreach Specialist Dietitian works 2 days per week to provide consultation to nursing home residents and education to aged care facilities.

## **Outpatient Clinics**

Outpatient clinics are provided by geriatricians at the Repat Centre and in local healthcare sites as outreach services.

These clinics are for assessment and management of people with dementing illnesses, Parkinsonism, frailty, gait and balance problems and falls, and more general geriatric medical co-morbidity.

## **Parkinsonian Syndromes**

A multi-disciplinary clinic for people with Parkinson's Disease (PD) has been developed at the Repat Centre by Dr Scott Chamberlen and by Dr Frank Nicklason.

The DGM at RHH has provided a leadership role in the provision of services state-wide for people with PD. Dr Nicklason provides outpatient clinical services for people with PD in Tasmania's North West (three

days per four weeks) at the North West Regional Hospital, the Mersey Community Hospital, and the Northern Integrated Care Centre adjacent to the Launceston General Hospital. A three monthly clinic is held at the Deloraine Community Hospital.

Three PD nurse specialists have been appointed, one for each THO. Dr Nicklason and Dr Chamberlen have had major roles in educating and supporting the nurses in these positions and field many requests for help/advice from these nurses. This service has been rated very highly by service recipients and by the Tasmanian Parkinson's Disease Association.

Dr Nicklason has extended sabbatical leave in 2015 and is planning to use some of this time to improve the efficiency of the PD outreach service using tele-medicine (and by use of a wrist worn accelerometer which is able to provide remote feedback of motor control and some of the non-motor features of PD).

## **Regional Outreach Clinics**

Each of the geriatricians provides general geriatric medical outreach services.

- Dr Andrea Lees provides monthly services to the Huon region.
- Dr Chamberlen provides services to the Derwent Valley.
- Dr Nicklason provides services to the Tasman Region. This role will be shared with Dr Janina Skelton in 2015.
- Dr Blair Adamczewski provides monthly outreach services to the Midlands region.

Excellent working relationships have been forged with the local medical officers and residential care facilities.

## **Nursing Home Outreach**

The DGM is responsive to requests for medical assistance from residential aged care facilities. Sometimes aged care nurse specialists triage these requests. Very few admissions to RHH are from residential aged care facilities (RACF) (approx. one per day). Some admissions from RACFs are unavoidable e.g. for assessment and treatment of frailty fractures such as fractured neck of femur.

Dr Chamberlen has done much of this work in recent times. Dr Cleary has significant experience in this area and is happy to co-ordinate an ongoing service.

## **Hospital Avoidance**

Data collected by the Australian Institute of Health and Welfare for years 2010-2011 suggest that Tasmania is doing well in comparison to other Australian states and territories at avoiding unnecessary hospitalisations. For Tasmania and the ACT the rate of hospital admissions deemed to be "totally potentially preventable" is around 20/1000 population per year, considerably less than WA, Qld, Vic and the Australian average which is closer to 30/1000 per year.

That the ageing of Tasmania is placing more pressure on public hospital beds is underscored by the data showing an approx. 50% increase in all cause hospitalisations of people over 65 years of age in the 10 years to 2011. (State-wide Morbidity Database). This increase in inpatient activity has continued till the writing of this report.

It is clear that there is an ongoing need to provide appropriate community and acute hospital services for older Tasmanian people, to avoid unnecessary hospitalisation and unnecessary transfer to residential care. Dr Frank Nicklason, Dr Scott Chamberlen, Dr Martin Morrissey, Dr Blair Adamczewski, and Jane Davis (Aged Care nurse practitioner) are part of the Tasmanian Medicare Local process examining how better/more responsive community services can help us cope with the evident demographic changes. Online resources for General Practitioners have been developed for Parkinson's disease and for Dementia.





# Service planning beyond 2014

There is considerable scope to enhance the hospital experience of older patients in hospital, and at RHH specifically, given sufficient workforce.

## 1) Perioperative Care for Elderly People

The Aged Care Service at RHH has a particular interest in helping ensuring adequate pre-operative assessment and management, and post-operative care of elderly surgical patients. We believe we have a role in improving elective surgical throughput at RHH. One of our Advanced Trainees, Dr Mark Campbell is developing his clinical knowledge and expertise in the area of perioperative medicine for older patients. Careful assessment/selection and planning of elective surgery of older people can yield better results than the selection solely by the operating surgeon supplemented by an anaesthetics review.

Older people especially those over 80 years of age regularly have complex medical co-morbidity and higher risk of post-operative complications, including delirium. Post-operative delirium (POD) is often not detected, recorded in hospital files, or managed optimally. POD is associated with prolonged length of stay, falls and injury in hospital, loss of physical conditioning, prolonged length of stay, higher risk of long term institutional (nursing home) care, and mortality. Failure to adequately document delirium and other types of cognitive impairment means that the hospital is inadequately remunerated for its clinical activity. A recent example of this is an elderly man who had an aortic valve replacement recently. He was delirious post-operatively but this was not recognised. The hospital would have been paid an extra \$12,000 if delirium had been identified and documented in his care notes. Some statistics are relevant when considering the prevalence and impact of delirium at the RHH. Delirium is present on admission to hospital in 8-17% of patients. One out of six of these patients only are recognised in the Emergency Department. At least half of patients recovering surgery following fractured neck of femur become delirious; a minority are recognised. Around 50% of patients undergoing cardiac surgery aged over 70 years become delirious, 10% or less are recognised. Eighty percent or more of elderly ICU patients become delirious.

Delirium is associated with increased length of stay in hospital, increased adverse events in hospital such as falls, increased institutionalisation, poorer rehabilitation outcomes, poorer long term cognitive function, and increased mortality.

There are many benefits of better recognition of delirium and better appreciation of risk of delirium. Properly documenting delirium means that the hospital will be better remunerated for the care delivered and can afford to develop better care practices for these vulnerable patients.

It is considered likely that if we are able to provide an assessment service for pre-operative elective surgical cases then we will be able to avoid unnecessary/inadvisable surgery in some cases. It has been a clinical experience that the process of 'consenting' a patient for surgery has not always followed the procedure for true informed consent.

Informed consent relies on the patient being provided information on all the relevant personal benefits and risks of surgery and the non-surgical treatment options available. This must be done using language that is understandable and in a setting that ensures that a careful considered choice can be made without undue time pressure. Adequate preparation for surgery, with forward planning to address the possible post-operative complications would be a part of a perioperative service envisioned to be provided, at least partly, by the Geriatric Service.

Considerable work has already been done in the areas of orthopaedics and cardio-thoracic surgery and the sense is that the relevant surgeons and the clinical units more generally, are enthusiastic about our involvement.

## 2) Care Of People Who Have Cognitive Impairment and Other Neuro-degenerative Diseases

Major diseases include the syndromes Dementia and Parkinsonism. The specific pathological entities include:

- Alzheimer's Disease
- Vascular Dementia
- Post Traumatic Dementia
- Parkinson's Disease
- Huntington's Disease
- Motor Neurone Disease

The general principles in management for all these conditions are to maintain optimum quality of life for the affected people and for their carers, if possible in the community. This necessarily involves avoidance of the complications (through prevention and early intervention) which lead to premature placement in residential care and admissions to acute hospitals. This objective requires careful early assessment, education and planning, and case management/care co-ordination where necessary.

The care needs of people with established diagnoses of Dementia, Parkinsonism, and other degenerative neurological diseases are varied and are dependent on a number of factors which are not necessarily closely related to the disease processes themselves. Some key examples of these factors include: presence, or not, of committed, competent social supports (most notably family support); presence of complex medical co-morbid illnesses; and severity of functional impairment (executive cognitive dysfunction, psychiatric and behavioural symptoms, mobility and balance impairment, incontinence, vision and hearing impairment).

One way of evaluating the intensity of care needs of people with cognitive impairment is to look at a person's prior utilisation of health resources. People who are almost certainly going to need intensive initial assessment and case management/care co-ordination are those who have had frequent recurrent acute (and sub-acute) admissions to hospital, general practice presentations, and Emergency Department attendances. These people are somewhat pejoratively called 'frequent fliers'.

It follows that it would be helpful to identify high resource users, very carefully assess their needs, and consider intensive case management/care co-ordination to get the best mix of interventions/services to meet the identified needs. This approach has the advantage of more closely targeting those people and families that need most help. It is likely that the subgroup of people who need the most intensive intervention in the setting of a diagnosis of cognitive impairment would be about 10-20% of the total number of people identified with these syndromes.

Interventions for people/families of people with NDD should be undertaken on the basis of evidence of efficacy if possible.

To assist in the pre-hospital assessment of cognitive disorders a **multidisciplinary clinic approach** has considerable merit and track record. Participation from geriatrics, a neurologist with expertise in cognitive disorders, a palliative care physician, a neuropsychologist, a clinical nurse specialist, a social worker, and possibly occupational therapist is required.

Tasks of this team include accurate diagnosis, family counselling and education, organisation of appropriate supports, possibly on-road driving assessment, development of Goals of Care, and issues such as Enduring Power of Attorney and Enduring Guardianship.

## **Cognitive Care Group at the RHH**

The chief goals of elderly people revolve around preservation of the functional capabilities which allow them to live as independently as possible and which promote enjoyable physical, social, and mental activities. Meaningful participation in the lives of friends and family members and an adequate measure of comfort and dignity are markers of successful ageing.

Cognitive decline due to neuro-degenerative disease and cerebrovascular disease presents the major threat to these goals, as does physical frailty.

The Department of Geriatric Medicine has convened a multi-disciplinary Cognitive Care Group which aims to improve the recognition/further assessment and management of people at RHH with these problems.

Audit and research efforts are an integral part of this effort and plans to improve care of inpatients at RHH will be guided by the evidence. This group's activities will feed into the Clinical Redesign projects related to the Older Person at RHH Group (Chair Dr Blair Adamczewski), the General Medical Group (Chair Dr Nicole Hancock) and the Surgical Group (Dr Craig Quarmby).

## **National Rollout of the Dementia Care in Hospitals Program**

RHH has just been selected to be a participating member of the National Rollout of the Dementia Care in Hospitals Program with its strong research and clinical improvement goals. This project will necessarily require input from a suite of clinical disciplines including, Emergency Medicine, General Medicine, Palliative Medicine, Old Age Psychiatry, and the Surgical Disciplines.

### **3) A State-Wide Service for People with Parkinson's Disease and Related Disorders**

People with Parkinson's Disease in Tasmania may be seen by a variety of specialists including Neurologists, Geriatricians, General Physicians and Old Age Psychiatrists. Movement Disorders Specialists visit Launceston and Hobart from Victoria on a monthly basis.

At this point in time there is no Movement Disorders Specialist Neurologists based in Tasmania. This is likely to change in the near future as Dr Sarah Hewer is completing her Movement Disorders Fellowship in Victoria and is keen to return to her home state.

People with PD in Tasmania are well served by three PD nurse specialists who are regionally based, South (Chris Ashe), North (Sharon Wendon) and North West (Ann Dodd). The Geriatric Service of THO(S) has been steadily improving multidisciplinary care for people with PD. We now have very capable and knowledgeable Physiotherapists, Occupational Therapists, and Speech Therapists providing their assistance in a co-ordinated way from the Community Rehabilitation Unit at the Repat Centre.

Dr Krishna Kalpurath will be joining our service in 2015. He currently is a first year Advanced Trainee in Geriatric Medicine at LGH. Dr Kalpurath has expressed an interest in taking a role in PD care in the longer term.



## **Ideal Staffing**

- Two consultants on OPU to cover RHH, consults and ED rapid access.
- Two consultants on P3 to cover the ward, clinics.
- On part time community consultant (Jasmine, ACAT, Memory Clinic).
- One full time consultant for ortho-geriatric and surgical liaison (pre-op clinic, follow up).
- One consultant to provide clinical support to ED, APU, and EMU. This role could encompass NH outreach for acute medical problems and development of a geriatric “hot clinic”.
- One consultant for outreach into LGH/ NWRH (clinics, teaching and back fill for leave) and administrative activities.

## **Training Role of RHH for Geriatric Medicine**

Currently the RHH is accredited to train two advanced trainees in Geriatric Medicine, but for only one year of core training. This is far from ideal and it is deemed essential that this is rectified so that we are able to offer at least two years of core advanced training. Barriers to obtaining 2 year core training accreditation have been identified and require urgent attention. This training role is essential for the succession plan for geriatrics.



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