QEII Older Persons Coordinated Care Service Project

20 August 2018 | Medicine and Chronic Disease
Status:
Implement

Access to coordinated care has been shown to improve outcomes for complex, frail older people. Successful programs are characterised by high quality, coordinated, multidisciplinary assessment and intervention including a Consultant Geriatrician, reliable implementation of care plans and review of progress. Optimal results are achieved when services are appropriately targeted.

At present at QEII, Comprehensive Geriatric Assessment (CGA) is available for all inpatients as a consultation service and through Geriatric Outpatients. However, multiple multidisciplinary teams can be involved and delivering efficient, coordinated care can be challenging. Such issues have an impact on emergency department wait times for all patients, inpatient length of stay and timely, effective communication with community-based healthcare providers. There is no access to CGA in the home at present.

In addition, access to interim care for people with behavioural disturbances in dementia is limited and more recently, there have also been issues with access to permanent placement in residential aged-care facilities for patients with typical dementia behaviours. Development of a robust behaviour management plan can facilitate care for these patients and support safe, timely transition back into the community.

The key components of the initiative are:

- A single service with a fully integrated multidisciplinary team including Physician in Geriatric Medicine, specialist Nurse and a Therapy Assistant
- Supported flow through the various components of care including carer and staff education
- Ability to explore care options in the community prior to admission to a residential aged-care facility
- Enhanced communication strategies especially timely coordinated discharge communication.

Aims & Goals:

To provide coordinated, efficient care and improved integration of care throughout the continuum for this cohort of vulnerable people. Predicted benefits include:

- Early case identification using a validated risk screening in the Emergency Department (ED)
- Rapid triage and selection of the appropriate care setting
- Comprehensive multidisciplinary assessment and management
- Focus on early decision making and behaviour care planning to support timely transfer to interim care or residential aged care facilities
- Improved linkages with community agencies especially interim care, nursing homes, CARE-PACT, General Practice and Dementia Behaviour Management and Assessment Service (DBMAS).

Evaluation/outcomes:

This project is due for completion in June 2019.

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Keywords:
Integrated Care, Aged Care
Last updated 26 July 2019